

# RESEARCH REVIEW

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## ***In This Issue***

We present the fourth edition of *Research Review (RR)*, a publication of the *Joining Forces Joining Families* group. *RR* consists of summaries of research of interest to family advocacy, medical, and social service providers. These summaries consist of topics that provide tips for providers, issues not commonly encountered in family maltreatment, and innovations for research and practice. Among the child maltreatment articles are resilience in abused young children, three on child physical abuse, current information on infant colic, and educational neglect in children. Summaries on intimate partner violence (IPV) include relationships between animal abuse and IPV, conflicts in relationships and some strategies to de-escalate conflict, mortality and medical problems in abused women, and the complex needs of dysfunctional families.

## CHILD MALTREATMENT

### **Guidelines for Assessment of Suspected Physical Abuse of a Child**

The physical abuse of children can be difficult for case review committees and child protective services (CPS) to substantiate. Thorough assessment is essential for the welfare of the child. If an injury exists, they will attempt to determine whether the injuries were intentional (such as a result of harsh discipline) or unintentional (such as from an accident). If abuse is suspected, they will try to determine its severity and frequency.

An interdisciplinary approach is essential to collecting information bearing on the events of the case. The following are steps that will help assure a good assessment of suspected physical abuse of a child: (1) history of alleged circumstances of the injury; (2) examination of the child fully unclothed; (3) diagnostic workup and need for medical intervention;

(4) manage acute medical problems; (5) notify CPS and law enforcement as mandated by the state; (6) hospitalize the child if needed; (7) have social work perform an extensive social evaluation; and (8) consider forensic workup or refer to organization that specializes in child abuse cases.

These guidelines are intended for evaluation by medical staff when they are unsure of how to evaluate an injured or child that presents with vague symptoms. The guidelines may also assist social service personnel about how to evaluate an injured child or one with vague symptoms.

#### ***Reference***

Berkowitz, C.D. (2017). Physical abuse of children. *New England Journal of Medicine*; 376 (17): 1659–1666.

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## Resilience and Competency in Children from High-Risk Environments

Research on children raised in high-risk environments usually focuses on negative outcomes and their associated risk factors. However, a study of children who survive these exposures relatively unscathed can yield data on factors that contribute to adaptive functioning. Resilience is a term that is frequently encountered in recent psychosocial literature. It defies a consistent definition, but in general it is considered the ability to positively adapt following adversity and emerge at previous or improved levels of functioning.

Child resilience was studied in 943 families participating in the Longitudinal Studies of Child Abuse and Neglect (LONGSCAN), a consortium of five sites in the U.S. prospectively studying antecedents and outcomes of child maltreatment (Runyan, et al. 1998). Data were collected longitudinally of children at ages four and six and from their caregivers, mostly from high-risk environments. Participants included some families already reported for child maltreatment. Some of the high-risk characteristics of families were low income or socioeconomic problems such as poverty and community violence.

Children's functioning was assessed in behavioral, social, and developmental domains. Demographics were collected, and caregivers were assessed for depression. Resiliency was operationalized as competency based on the child's performance on standardized measures. Many children facing adversity fared well. The major finding was that 48% of the

children appeared resilient. Children were less likely to have been maltreated or to have depressed caregivers. They were also more likely to come from smaller households with fewer children in the home and to have an employed caregiver. These variables were considered as social capital.

However, a majority of children did not fare so well. Child maltreatment and caregiver depression were strongly associated with poor outcomes. These findings can allow caregivers and providers to recognize the complexity of development — children are often resilient. Healthcare providers and those working in family services may enhance child resilience in high-risk environments by effectively treating depressed caregivers and supporting their efforts to gain employment.

### References

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- Runyan, D.K., Curtis, P.A., Hunter, W. M., Black, M. M., Kotch, J. B., Bangdiwala, S., & Dubowitz, H. (1998). LONGSCAN: A consortium for longitudinal studies of maltreatment and the life course of children. *Aggression and Violence Behavior*; 3(3): 275–285.

*Resilience...defies a consistent definition, but in general it is considered the ability to positively adapt following adversity and emerge at previous or improved levels of functioning.*

**JOINING FORCES**  
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**RESEARCH REVIEW**



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## Many Factors are Associated with Fatal and Near-Fatal Child Physical Abuse

Identifying and responding to known child maltreatment risk factors can prevent harm to children. However, risk factors are many and none alone can predict future abuse. In cases of physical abuse resulting in death or near death, it is even more important to learn which risk factors can be identified early and can result in a preventive intervention.

A research team conducted a retrospective review of a series of 20 cases of children less than four years of age who were victims of fatal (10 cases) and near-fatal physical abuse (10 cases) (Pierce et al., 2017a). Near-fatal abuse was defined as an injury that places a child in a serious or critical condition. The median age of the children was 7.5 months, range 1–32 months. The fatally abused children were generally younger than the near-fatally abused children, median ages of 5 and 13.5 months, respectively. Of physically abused children less than one year old, eight were fatalities and five were near-fatalities.

Traumatic brain injury was the cause of the fatal or near-fatal event in 19/20 cases that presented for hospital care. An altered mental status of the child was observed due to shaking and punching or slamming the child. Ninety percent of cases had traumatic brain injuries, 80% had bruising, and 35% had fractures. The children had a male caregiver in 70% of cases. Nine out of 14 cases had prior medical documentation. Atypical bruising was the most common physical exam finding prior to the fatal or near-fatal event. All of the children with prior bruising subsequently had traumatic brain injury, of which four died. Three types of bruising occurred: (1) bruises on non-mobile infants, (2) uncommon location for bruising such as on the ears, buttocks, or eyes, and (3) patterned bruising consistent with inflicted injury. The authors noted that bruising, unlike fractures, rarely requires medical attention and may be often overlooked by medical and other professionals such as law enforcement personnel. Overlooking such injuries can send the child back to an unsafe environment and is a missed opportunity to provide additional safety assessment, family preventive measures, or other safety interventions.

A trauma history was given in only four of the 19 cases that presented for hospital care despite the presence of multiple injuries to body systems. Histories were presented

as falls, but the offenders later admitted that the stories were fabricated to cover up physical assaults. In the absence of a trauma history, an altered mental status of the child should be considered suggesting abuse.

Risk factors were abstracted from a wide variety of sources that resulted in four major groupings: social factors, violence, criminal history of perpetrator and non-perpetrator, and protective services history (Pierce et al., 2017b). Six risk factors were thought to be key predictors of both future mortality (fatalities) and morbidity (near-fatalities): violent criminal histories of a parent (all 20 cases), prior child social services involvement (n=17), negative or hostile attitudes about the child or the child's siblings (n=15), caregiver mental health issues (n=8), substance abuse histories (n=8), and prior intimate partner violence (n=6). Two sets of risk factors were present for almost all fatalities and near-fatalities: prior domestic violence and perpetrator criminal history. More social risk factors were present for fatalities than for near-fatalities. This suggests that while the presence of more social risk factors predicts fatal child physical abuse, concern should be heightened when many are present.

This study reveals many common risk factors for both fatal and near-fatal child physical abuse cases and emphasizes the high prevalence and importance of psychosocial risk factors, particularly for fatalities. The identification of risk factors prior to severe and fatal child abuse can help providers assess risk and work collaboratively to prevent these events. When evaluating children with evidence of trauma, altered mental status or atypical bruising should prompt careful and thorough evaluation for the presence of child abuse.

### References

- Pierce, M.C., Kaczor, K., Acker, D., Webb, T., Brenzel, A., Lorena, D.J., & Thompson R. (2017a). History, injury, and psychosocial risk factor commonalities among cases of fatal and near-fatal physical child abuse. *Child Abuse & Neglect*; 69: 263–277.
- Pierce MC, Kaczor K, Acker D, Webb T, Brenzel A, Lorenz DJ, Young A, & Thompson R. (2017b) Dataset on psychosocial risk factors in cases of fatal and near-fatal physical child abuse. *Data in Brief*; 14: 107–109.

*Health care providers encountering children with atypical or unexplained injuries should conduct further assessment when (1) there is patterned bruising that is consistent with inflicted injury, and (2) an altered mental status. In the absence of a trauma history, an altered mental status of the child should be considered suggesting abuse.*

## Supporting Parents Contending with Prolonged Crying in Infants: What to Do About Colic?

Crying is one of the many challenges that parents face with a new baby. Intractable crying (colic) by infants is a significant cause of various forms of child maltreatment, particularly head trauma from shaking (Barr, 2014). The prevalence of colic is unknown, but in a recent study of 3,006 mothers, colic was reported in 11.6% of the babies (Alexander, Zhu, Paul, & Kjerulff, 2017). Unfortunately, especially for new parents, there is no magic answer for resolving infant colic. Pärtty & Kalliomäki (2017) briefly reviewed the current state of medical knowledge and research on colic in a 2017 study with the conclusion that its origin remains unresolved and treatment options are limited.

Colic can occur in an infant less than five months of age. It usually involves repeated and prolonged crying periods with no obvious cause, the crying cannot be prevented or resolved, and there is no evidence of failure to thrive, fever, or illness (Benninga, Nurko, Faure, Hyman, Roberts, & Schechter, 2016).

What causes colic? During the first few months of life, there are large changes in the microorganisms in the gut. The development and activity of these microorganisms are affected by as yet unknown changes, which can produce pain that results in crying. Breast-feeding has not been shown to provide a protective effect and the incidence of colic is similar among formula-fed and breast-fed infants (Pärtty & Kalliomäki, 2017).

What can you do about it? There is no single recommended intervention for colic. Research into the origins and treatment of colic has yielded inconsistent results. Many remedies have been suggested although published studies of pain-relieving agents for colic are often of low to moderate quality (Biagioli, Tarasco, Oingue Moja, & Savino, 2016). The choice of treatment is a matter to be decided between family members and their family physician or pediatrician as the options are complex.

Social support of the family, particularly the mother, is associated with lower reported infant colic. In addition, the same is true for mothers who rated their relationship with their partner during pregnancy as extremely happy or perfect. Positive responses by the mother on the following ques-

tions were also protective against infant colic: “How much of the time is your partner warm, loving, and affectionate toward the baby?” and “How much of the time is your partner helpful to you?” (Alexander, Zhu, Paul, & Kjerulff, 2017).

Assisting parents in finding ways to reduce the stress associated with infant colic may reduce the incidence of parental harm to infants. Parents should be advised that (1) colic in some babies is a normal phase of their development, (2) it is not their fault, (3) remedies do not always work, but parents should continue to seek support and not neglect the baby, and (4) parents supporting each other is one of the most important methods of successfully getting through this phase of the baby’s development. Finally, providers should not minimize the parents’ frustration or their attempts to resolve colic.

### References

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- Pärtty A, & Kalliomäki M. (2017). Infant colic is still a mysterious disorder of the microbiota-gut-brain axis. *Acta Paediatrica*; 106: 528-529.

*Assisting parents in finding ways to reduce the stress associated with infant colic may reduce the incidence of parental harm to infants.*

## What is Educational Neglect? Differences for Children and Adolescents

Being attentive to a child's progress in learning and/or attendance in school may be part of a comprehensive evaluation for child neglect. An examination of 20 years (1993-2013) of child educational neglect reports in the Canadian province of Ontario found that in very young children, educational neglect was defined by a lack of parental involvement in learning and literacy activities such as teaching the alphabet, numbers, colors, shapes, and reading to the child. For older children and adolescents, neglect occurs when parents fail to ensure that their children regularly attend school and fail to promote their child's educational success.

When investigations involving educational neglect were compared to other types of neglect, caregivers were significantly more likely to have mental health issues and few social supports. Educational neglect was only one component of a generally neglectful and chaotic home environment. About one in five investigations found that the family had run out

of money for basic necessities and in 39% of families, social assistance was the primary source of income.

The responsibility for ensuring that young children attend school lies with caregivers, whereas more individual responsibility is placed on adolescents to maintain school attendance even in the face of their problems and family dysfunction. Teachers, counselors and healthcare providers should be alert to the failure of very young children to achieve basic literacy and for school absence as a potential marker of neglect that warrants further assessment of overall child and family well-being.

### Reference

van Wert, M., Fallon, B., Trocmé, N., & Collin-Vézina, D. (2017). Educational neglect: Understanding 20 years of child welfare. *Child Abuse & Neglect*; doi: 10.1016/j.chiabu.2017.04.034.

## Complex Needs of Families Related to Intimate Partner Violence, Mental Health, and Substance Abuse

Families investigated by CPS for an initial child abuse allegation, but whose reports are not substantiated, often have complex personal and family needs that do not go away when the case is closed. Often, these needs are centered on mental health, substance abuse, and intimate partner violence. These individuals often have a wide variety of educational, clinical, and life skills needs that can be assessed and treated.

The purpose of this study was to understand the needs and experiences of families whose cases were unfounded in order to develop preventive strategies. Family functioning was assessed by use of the Family Assessment Form (FAF) and dichotomized into those with (n=836) and without (1,172) complex needs. The FAF has 59 items making up eight subscales scored from 1 to 5 where higher scores mean worse functioning. Subscales measure living conditions, financial conditions, support to caregivers, caregiver-child interactions, developmental stimulation, interactions between caregivers, caregiver history, and caregiver personal characteristics. Complex needs were identified when the mean score of the FAF was 3 or higher for intimate partner violence, mental health, or substance abuse.

Half of family or parent or guardian caregivers with complex needs had a history of childhood abuse, almost half had 6-8 needs, and about a quarter had 3-5 needs. Ninety percent of caregivers without complex needs had zero to two needs. These findings highlight the importance of recognizing the many variations in families investigated for alleged child maltreatment that require accurate screening and services matched to their needs rather than a one-size-fits-all approach. Use of the FAF by social service providers is an innovative way of formulating specific intervention goals for families whether allegations of family abuse are substantiated or not. Accomplishment of specific goals can be an important preventive intervention at any level of family dysfunction.

### Reference

Simon, J.D., & Brooks, D. (2017). Identifying families with complex needs after an initial child abuse investigation: A comparison of demographics and needs related to domestic violence, mental health, and substance use. *Child Abuse & Neglect*; 67: 294-304.

*Families investigated by CPS often have many complex needs, often about mental health, substance abuse, and intimate partner violence.*

## Reasons for the End of an Intimate Relationship

There are many reasons for the breakup of an intimate relationship. Breakups can be costly emotionally and financially in terms of potential legal costs, loss of income from partner, lost time from work, alimony, child support, and other expenses. A recent study of 15,162 men and women in the Third National Survey of Sexual Attitudes and Lifestyle in Britain between 2010–2012 found a variety of reasons for breakups. Of this sample, 10.9% of men and 14.1% of women reported the end of a relationship during the past five years. Of these, 706 men and 1,254 women reported at least one reason for the breakup.

Sixteen percent of women and 4% of men reported intimate partner violence (IPV) as the reason for the breakdown of their relationship. The other most commonly reported reasons were that they grew apart (35.6% of women and 39.5% of men), arguments (30.3% and 27%, respectively), unfaithfulness (23% and 18%), lack of respect or appreciation (24.8% and 17.1%), not sharing housework (14.4% and 6.8%), money problems (11.8% and 7.3%), different interests or nothing in common (15.7% and 13.3%), and difficulties with sex (6.3% and 4.9%). IPV showed the greatest difference between genders, 16% for women and 4% for men. Women

were statistically significantly more likely to end the relationship for unfaithfulness, lack of respect, money problems, not sharing housework, and IPV.

Overall, the authors found that difficulties in communication and the deterioration of the quality of the relationship were the predominant reported reasons for the breakups. They suggested that promoting better communication and conflict resolution skills are important to pursue in relationship education and counseling. Suggestions for further research were for qualitative studies to assess how partnership characteristics and life course events may precede the deterioration and breakup of a relationship. Additional research could also address how couples overcome the relationship difficulties.

### Reference

Gravningen K, Mitchell KR, Wellings K, Johnson AM, Geary R, Jones KG ... Mercer CH. (2017). Reported reasons for breakdown of marriage and cohabitation in Britain: Findings from the Third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). *PLOS ONE*; 12(3):e0174129. doi: 10.1371/journal.pone.0174129.

## Five Strategies to De-escalate Conflict

Overheated conversations can lead to trouble. There are many ways to calm oneself and others depending on a person's own preference for methods. Among these are deep breathing, muscle relaxation, walking away, prayer, and many others. Keeping situations under control can avert violence, bad feelings, and other results of failure to manage a situation. The article reviewed here offers five remedies that can be used to defuse a tense situation involving potential or actual interpersonal conflict.

**Listen.** The first remedy to defuse a tense situation is to listen, to learn why we see it differently. Discard trying to decide who is right and who is wrong. Instead, try to understand how the other person sees the situation.

**Untangle intent from impact.** Attempts at having a good impact on others may not be seen the same way by them. Similar to learning to see things differently, try to determine how your behavior will impact others.

**Allow space for feelings.** Trying to reason things out may

leave out the importance of another person's feelings. Exploring emotions can help to explore a solution. For example, asking, "What are you feeling?" can open up a discussion of how to resolve the situation.

**Pursuing interests rather than positions.** To find the best way forward, learn what interest each person is pursuing rather than debating positions. Learning everyone's interest in a situation can create new options based on mutual understanding of goals.

**Sidestep the triangle.** When two people have what amounts to a minor disagreement, it is usually best to try to resolve it rather than bringing in another person. However, for one that may be more serious, consulting a professional may be the best course of action.

### Reference

Garrido AM. (2016). Five simple strategies to help keep things cool. *Health Progress*; July-August : 67-69.

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*Listen, untangle, allow space, pursue interests, sidestep the triangle.*

## Are there Effective Interventions for Adult Survivors of Adverse Childhood Experiences?

Medical and scientific literature has documented the negative health effects of adverse childhood experiences (ACEs) in children and adults. The question arises, what can be done for an adult with such history? Cognitive-behavioral therapies (CBT), when compared to other interventions offered to patients, have the most potential for improving health problems, particularly for mental health and health-risk behaviors. In addition to CBT, other therapies have shown promise, but they have more limited evidence of effectiveness.

There are numerous issues to consider for people with ACEs who present to primary care. Many come for a variety of physical health problems and with different experiences of ACEs. Providing specific interventions for each ACE does not appear to be necessary, as research has concluded that results of therapy are likely to generalize. Many people with

ACEs are unaware of their effects and may have limited motivation to pursue treatment, particularly when some CBT interventions require many sessions over months. However, research indicates that brief interventions can also show positive outcomes. Innovative primary care for adults with a history of ACEs that involves a behavioral health component may provide improved health and quality of life for these patients.

### Reference

Korotana LM, Dobson KS, Psuch D, & Josephson T. (2016). A review of primary care interventions to improve health outcomes in adult survivors of adverse childhood experiences. *Clinical Psychology Review*; 46: 59–90.

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*Cognitive-behavioral therapies have the most potential for improving health problems, particularly improving mental health and reducing health-risk behaviors, for survivors of ACEs.*

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## Abuse in Childhood Results in Higher Adult Mortality Rates for Women than for Men

Women who report having been victims of abuse in childhood continue to be vulnerable to premature mortality and should receive greater attention regarding health promotion. Adverse childhood experiences and childhood abuse are known to have negative effects on the development and health of children and adults. However, the effects of abuse on adult mortality have not been investigated. In the study reported here, a national sample (n=6,285) of the survey of Midlife Development in the U.S. of persons aged 25–74 in 1995–1996 was analyzed for their mortality through October 2015. The original data collection included reports of childhood severe physical abuse, moderate physical abuse, and emotional abuse. At follow-up, participants were 48% men, 91% were white, and the mean age was 46.9 years. Mortality rates for men and women were compared controlling for childhood socioeconomic status, personality traits, depression, history of major chronic diseases (cancer and heart disease), and health behaviors (smoking and alcohol).

When comparing all women and men who had reported histories of severe physical abuse, moderate physical abuse, or emotional abuse during childhood, women had higher mortality rates than men. Their mortality rates were also higher for the combined types of abuse. There was no explanation for this finding of why the long-term effects of childhood abuse resulted in higher mortality rates for women. Some suggestions were vulnerability to psychiatric disorders such as depression, negative health behaviors such as drug use, and biologically embedded changes in body systems across the lifespan, although none of these was investigated and mortality was not calculated for specific causes of death.

### Reference

Chen, E., Turiano, N.A., Mroczek, D.K., & Miller, G.E. (2016). Association of reports of childhood abuse and all-cause mortality rates in women. *JAMA Psychiatry*; 73(9): 920–927.

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*Women who were severely physically abused, moderately physically abused, or emotionally abused during childhood had higher mortality rates as adults than men.*

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## Adverse Health Effects of Intimate Partner Violence Victimization

Victims of intimate partner violence (IPV) suffer a myriad of injuries, psychological distress, medical problems, wasted time, and increased healthcare costs. Improving providers' ability to manage the healthcare needs of IPV victims can result in improved interventions. Recent improvements in computer technology makes possible the analysis of large volumes of data that can reveal previously unrecognized issues, a task that once was impossible for the individual researcher.

Data for this research was obtained from *Explorys*, a commercial platform that ties together millions of electronic health records from hospitals and providers to study adverse health effects following IPV. Analysis was limited to female victims of IPV since they were significantly more common than male victims. The investigation found 2,429 symptoms identified as prevalent among IPV victims. These covered a wide variety of pathologies, but could be grouped under four categories: acute symptoms such as injuries inflicted by the abuser; chronic symptoms, disorders, and cardiovascular problems; gynecological and pregnancy-related problems; and mental and behavioral health issues. The most common-

ly reported diagnoses were acute injuries including bruising, head and neck injuries, and multiple skin wounds. Each of the four categories above includes many conditions that can be addressed medically and socially for IPV victims. For example, cardiovascular problems can arise from repeated physiological arousal of the central nervous system. Gynecological and pregnancy-related problems include gynecological injuries, delays seeking prenatal care, and missed visits to the doctor. Mental and behavioral health problems include depression, PTSD, fear, anxiety, increased smoking, and substance abuse.

This research shows the breadth of physical and medical issues involved in IPV. For medical providers, especially in the emergency room, the treatment of acute injuries is a unique opportunity to address IPV and offer support to victims as well as referrals for further evaluation and management.

### Reference

Karakurt, G., Patel, V., Whiting, K., & Koyutürk, M. (2017). Mining electronic health records data: Domestic violence and adverse health effects. *Journal of Family Violence*; 32: 79–87.

## Animal Abuse is Often Linked to Intimate Partner Violence

An important link exists between the abuse of companion animals and intimate partner violence (IPV) against women. In a review of 94 studies, the co-occurrence of intentional animal abuse and IPV by male abusers was between 25–86%. The intentional injury of a pet of women who were not victims of IPV was 0–5%. Many abused women delay going to a shelter because they cannot take their animals with them. Women who reported threats or physical abuse against their animals were more likely to delay leaving their violent home, and many later returned out of concern for their animals.

Animal abuse by the IPV perpetrator can consist of threats to the animal, physical abuse of the animal, and prohibiting the female victim of IPV from supplying the animal's basic needs such as food, water, and veterinary care. Motives for such abuse by males include fun, desire to control, anger, revenge, dislike of the animal, discipline based on unrealistic expectations, and jealousy. Male abusers have also used threats of animal abuse as a type of psychological control. Males who abuse animals tend to talk to their pets only in terms of commands or threats, and consider them non-sentient property and a life stressor.

The involvement of children in animal abuse is also important. Children may be exposed to animal abuse in the home and in the community. They may risk their own safety

to protect their animals. Some participate in the abuse. Children who observe animal abuse are more likely to abuse animals. Animal abuse by children tends to occur at an early age and declines significantly by ages 10–12.

Veterinarians may not know that animal abuse can be a harbinger of IPV. Studies indicate that between about 43–86% of veterinarians do know about this link. They may be the first or the only professionals who have knowledge of abusive households, but may be reluctant to report suspicions of abuse due to lack of training and knowledge about the topic, ethical conflicts, possible adverse consequences of reporting, and professional confidentiality. Family advocacy and healthcare personnel should be aware of the connections between IPV and animal abuse and make this knowledge part of their clinical inquiries as well as with community veterinarians. Animal abuse is a unique window into violent families and could be an early entry for interventions that prevent later harm to humans and animals.

### Reference

Monsalve S, Ferreira F, & Garcia R. (2017). The connection between animal abuse and interpersonal violence: A review from the veterinary perspective. *Research in Veterinary Science*; 114: 18–26.