Child abuse and neglect: its perception by those who work with children

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حوادث الاعتداء على الأطفال وإهمالهم: كيف يدركها المتعاملون مع الأطفال

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خلاصة : تم تقييم مدى إدراك أطباء المدارس والاختصاصين الاجتماعيين والمدرسين لسوء معاملة الأطفال، وتقدير مدى معرفتهم بالعوامل المهيئة وقدرتهم على استعراف مؤشرات الاعتداء والإهمال ، ومدى استعدادهم للإبلاغ عن هذه الحالات . ولقد تبين أن أطباء المدارس كان لديهم إدراك أعلى بدرجة ملحوظة ومقدرة أكبر على التعرف على مؤشرات سوء المعاملة واستعداد أفضل للإبلاغ . غير أن معرفة العاملين جميعاً بالعوامل المهيئة لسوء معاملة الطفل كانت قاصرة ، فقد استطاع 80% من بينهم تحديد عاملين فقط من بين تلك العوامل ، وهما مشاكل الزواج والعائلة ، وتعاطي المواد المؤثرة نفسياً بطريق الحقن . إن من الأمور الملحة تنظيم برنامج تدريبي للعاملين مع الأطفال . وينبغي لمثل هذا البرنامج أن يحفز المهنيين على الإبلاغ عن هذه الحالات . كما ينبغي أن يعمل راسمو السياسات على إصدار تشريع يحتم الإبلاغ عن حالات سوء المعاملة ، وضمان الحماية الكافية للمبلِّغين .

ABSTRACT School physicians. social workers and teachers were evaluated to assess their perceptions of child maltreatment, knowledge of its predictors, ability to identify indicators of abuse and neglect, and their reporting intentions. Of these, school physicians had a significantly higher perception and showed greater capability of identifying indicators of maltreatment and better reporting intentions. However, the knowledge of all professionals regarding predictors of child maltreatment was deficient: only two factors, marital and family problems and parental psychoactive substance abuse, were recognized by more than 80% of them. A training programme for professionals working with children is recommended. Such a programme should also motivate professionals to report cases. Policy-makers should consider legislation mandating the reporting of cases of maltreatment and ensuring sufficient protection to the reporters.

L'enfant maltraité et négligé: perception par ceux qui travaillent auprès d'enfants

RESUME On a procédé à une évaluation des médecins scolaires, des travailleurs sociaux et des enseignants pour apprécier leur perception des mauvais traitements infligés aux enfants, leur connaissance des facteurs prédictifs, leur capacité à identifier les indicateurs de mauvais traitement et négligence, et intention de signaler les cas. Parmi ces personnes, les médecins scolaires avaient une bien meilleure perception et démontraient une capacité plus grande à identifier les indicateurs de mauvais traitement; ils manifestaient en outre une meilleure intention de signaler les cas. Toutefois, la connaissance de tous les professionnels en ce qui concerne les facteurs prédictifs des mauvais traitements infligés aux enfants était insuffisante: seuls deux facteurs, à savoir les problèmes matrimoniaux et familiaux et l'abus de substances psychotropes chez les parents, étaient reconnus par 80% d'entre eux. Un programme de formation des professionnels travaillant auprès d'enfants est vivement conseillé. Ce programme devrait également motiver les professionnels à signaler les cas. Les responsables politiques devraient envisager une législation rendant obligatoire la notification des cas de mauvais traitements et garantissant une protection suffisante à ceux qui les signalent.

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Introduction

Child maltreatment emerged as a relatively new arena and a distinct area of expertise with the introduction of "the battered child syndrome" into the medical literature in 1962 [*1*]. In the years that followed, children who were subjected to all forms of abuse or neglect became regularly encountered [*2*]. Subsequently, child maltreatment became recognized as a social problem in both developed and developing parts of the world [*3*]. Information gathered during the past decade has provided solid evidence that violence against children continues to increase [*4*]. The United States Third National Incidence Study of Child Abuse and Neglect revealed that the number of maltreated children increased from 1.4 million in 1986 to 2.8 million in 1993. During the same period, the number of seriously injured children rose from 143 000 to 570 000 [*5*].

Child maltreatment is more likely to exist in disrupted families [*5*] as well as among those living under unfavourable circumstances, suffering economic hardship [*6*] or isolated from the community social network [*5,7*]. It is also linked to some parental characteristics such as young maternal age [*8*], psychopathology [*5,9*] and psychoactive substance abuse [*5,10,11*].

Though limited to a special sector of the population, child maltreatment poses a major concern to professionals from various disciplines because of its immediate and long-term effects on children. In the United States of America, every year a substantial proportion of infants and children die as a result of maltreatment and even more children are left disabled [*12*]. Among survivors, maladjustment problems are frequently encountered during childhood [*13,14*] as well as in adult life [*13,15,16*]. Indeed, maltreated children are commonly in trouble in school both with learning difficulties and with general conduct problems [*13*]. They tend to be either depressed and isolated [*13*] or quite aggressive and trouble-making [*13,16*]. This behaviour often drifts into so-called juvenile delinquency, frequently starting with running away from home [*13*] and ending with the conviction of the child for serious juvenile crimes such as theft, breaking and entry, burglary and assaults [*17*]. As adults, people who were maltreated as children are more prone to develop a wide range of psychopathologies [*15*], sexual difficulties [*15,16*] and interpersonal problems [*15*]. More important, they themselves may become abusers and may repeat the cycle of maltreatment [*13*].

The problem of child maltreatment is multidimensional and has legal, social and medical ramifications that require the involvement of professionals of these disciplines. Although the problem has been extensively studied in Western societies over the past three decades, there is a scarcity of knowledge about child maltreatment in Arab countries [*18*]. In Egypt, a recent study found that children are subjected to physical abuse in a disciplinary context [*19*]. Considering this, are children subjected to other forms of maltreatment without this being recognized? The recognition of maltreated children relies in part on the willingness of professionals to accept that the condition exists [*20*]. It also relies on the ability of professionals to detect a case of maltreatment as the maltreatment manifests itself in the child [*21*]. Furthermore, knowledge of its predictors is indispensable for the prevention of maltreatment among high risk families [*22*].

Professionals who come in contact with children, such as physicians, teachers and social workers, need to be trained to recognize all components of child maltreatment, namely its patterns, predictors and indicators. This will ensure that high-risk children, particularly those who are actual-

ly maltreated, will be detected and managed appropriately. An effective and successful training programme should be preceded by an educational needs assessment in order to be tailored accordingly. With this perspective, this study was undertaken.

Methods

School physicians, teachers and social workers constituted the target population of this study. A list of teachers and social workers was obtained from the seven educational zones of Alexandria and a list of school physicians was obtained from the health insurance headquarters. A total of 500 professionals from the three disciplines were randomly selected using tables of random numbers. They were requested to fill in a questionnaire addressing aspects of child maltreatment based on a thorough review of the literature. The questionnaire consisted of five sections:

- demographic characteristics of participants, duration of work experience and postgraduate training in child mental health;
- perceptions of maltreatment in which 15 situations of child abuse and neglect were described;
- recognition of predictors of child maltreatment encompassing 14 cultural, socioeconomic, individual and familial determinants of maltreatment;
- identification of maltreatment indicators in which 12 relevant manifestations were presented;
- reporting intentions for 12 situations covering a wide range of abuse and neglect.

Responses were restricted to three coded choices: yes (1), undecided (2) and no (3).

With the coordination of the local directorate of education, a senior social worker assisted in the distribution and collection of the questionnaire. School physicians, teachers and social workers were handed the questionnaire form in an envelope along with a covering letter stating the purpose of the study. The letter also provided detailed instructions for filling in the questionnaire and emphasized the importance of leaving no questions unanswered. The completed forms were returned anonymously in sealed envelopes.

Of the 500 questionnaires distributed, a total of 459 were returned, yielding a response rate of 91.8%. The final sample constituted 144 primary school teachers, 74 preparatory and secondary school teachers, 163 social workers and 78 school physicians.

Data were analysed using *SPSS* (version 6). The mean, standard deviation and Pearson correlation coefficient were computed. The one-way analysis of variance followed by Scheffé for post hoc comparison was used as the test of significance. This was in addition to the Student *t*-test as well as the *t*-test for paired comparison. Significance was judged at the 5% level.

Four scales were developed after testing for internal consistency:

- perception scale for neglect situations: developed by summing responses to nine situations covering all areas of child neglect, yielding a score ranging from 9 to 27. Cronbach alpha reliability for this scale was 0.6018.
- perception scale for abuse situations: developed by summing responses to six situations describing physical and emotional abuse, yielding a score ranging from 6 to 18. Cronbach alpha reliability for this scale was 0.6460.
- scale for identification of maltreatment indicators: developed by summing the re-

sponses to 12 manifestations of maltreatment on children, yielding a score ranging from 12 to 36. Cronbach alpha reliability for this scale was 0.7503.

- reporting intentions scale: developed by summing the responses to 12 maltreatment situations, yielding a score ranging from 12 to 36. Cronbach alpha reliability for this scale was 0.8325.

There was considered to be a high level of agreement when expressed by at least 80% of participants. Lower scores in such areas indicated higher perception, better identification and more willingness to report.

Results

Most of the teachers and social workers enrolled in this study were women but the majority of the physicians were men. A substantial proportion were married and had children. Their ages ranged from 20 years to 59 years and their work experience varied from a few months to 36 years. The shortest duration of work experience was among primary school teachers (mean 9.75 ± 5.38 years) while the longest was among school physicians (mean 16.35 ± 7.56 years).

Table 1 lists six situations of physical and emotional abuse as well as nine situations of physical, emotional, nutritional, educational and medical care neglect. All six of the stated situations of abuse were perceived as a form of child maltreatment by over 80% of the study group of school physicians, social workers and primary school teachers. A high rate of agreement was encountered among preparatory and secondary school teachers in only four out of the six presented situations. The two exceptions were those situations describing forcing a child below working age to take a job while attending school and putting pepper in the child's mouth for saying obscene words.

A high level of agreement (over 80%) was encountered among school physicians in all nine situations describing forms of child neglect. This was not the case among teachers and social workers. A lower level of agreement was found among preparatory and secondary school teachers in situations involving educational neglect (ignoring teachers' instructions concerning the academic progress of the child, 79.7%) and lack of supervision (the child harms himself with a kitchen knife in his mother's presence, 77.0%). The latter situation was perceived as a form of maltreatment by 73.6% of primary school teachers. The lowest level of agreement was observed among social workers and all school teachers in the area of safety neglect (leaving a 10-year-old child to ride public transportation alone).

Enrolled professionals were more apt to perceive situations of abuse as forms of maltreatment than those of neglect, as their mean score on the abuse perception scale (1.15 ± 0.26) was significantly lower than that on the neglect perception scale (1.19 ± 0.23). This significant variation was observed among primary school teachers and social workers but not among physicians or preparatory and secondary school teachers (Table 2).

Only two factors in the ecological model underlying child maltreatment were recognized by over 80% of professionals in the three disciplines, i.e. marital and family problems (91.5%) and parental psychoactive substance abuse (87.6%). Other familial and parental factors as well as all those addressing the social, economic and child components of the model were recognized by a lower percentage of professionals (Table 3).

Table 1 **Professionals' perceptions of maltreatment situations**

Maltreatment situation	Primary school teachers (n = 144) %	Preparatory and secondary school teachers (n = 74) %	Social workers (n = 163) %	Physicians (n = 78) %	Total (n = 459) %
Abuse situations					
Burning a child for a misbehaviour	93.8	86.5	94.5	97.4	93.5
Severe beating that leaves marks in a disciplinary context	93.1	87.8	90.8	96.2	91.9
Forcing a child to take a job while attending school	83.3	77.0	82.8	87.2	82.8
Putting pepper in a child's mouth for saying obscene words	88.9	67.6	91.4	89.7	86.5
Cursing the day a child was born	90.3	83.8	90.2	92.3	89.5
Locking a child alone at home for long hours	85.4	86.5	90.2	92.3	88.5
Neglect situations					
Reluctance to provide protective clothes in winter	93.1	93.2	92.0	97.4	93.5
Inattention to child's cleanliness	92.4	93.2	91.4	96.2	92.8
Sending a child to school without breakfast or money to buy food	92.4	91.9	90.8	93.6	91.9
Refusal to provide long-term medical care for a child with chronic illness	85.4	91.9	83.4	92.3	86.9
Ignoring a child's complaint of not seeing the blackboard clearly by saying that he has to sit in the front desk	84.0	83.8	88.3	91.0	86.7
Ignoring teachers' instructions concerning the academic progress of the child	91.0	79.7	85.3	84.6	86.1
Not motivating a child to attend school regularly when he shows reluctance	88.9	85.1	82.2	85.9	85.4
A child harms himself with a kitchen knife in his mother's presence	73.6	77.0	84.0	91.0	80.8
Leaving a 10-year-old child to ride public transportation alone	42.4	43.2	59.5	82.1	55.3

Table 2 **Mean scores obtained by the studied professionals on the perception scales**

Studied professionals	Perception of abuse*	Perception of neglect*	Paired t value
Primary school teachers (n = 144)	1.16 ± 0.27	1.22 ± 0.20	2.90 (P = 0.004)
Preparatory and secondary school teachers (n = 74)	1.22 ± 0.31	1.21 ± 0.21	0.35 (P = 0.727)
Social workers (n = 163)	1.13 ± 0.24	1.21 ± 0.26	4.12 (P = 0.000)
Physicians (n = 78)	1.09 ± 0.24	1.11 ± 0.21	0.86 (P = 0.395)
Total (n = 459)	1.15 ± 0.26	1.19 ± 0.23	4.39 (P = 0.000)

**For purposes of comparison, the perception scores were divided by the number of items constituting the scale describing abuse (n = 6) and neglect (n = 9) situations yielding a minimum score of 1 and a maximum of 3*

An examination of responses shows that over 80% of professionals were able to identify only two indicators of child maltreatment, i.e. truancy from home (88.7%) and seeking love and affection from surrounding adults (84.7%). It also reveals that over 80% of school physicians were able to identify indicators that contain explicit signs of danger (attempting suicide) as well as implicit signs (bed wetting after a long period of control) in addition to indicators reflecting an externalizing type of behaviour (stealing food or money to buy food; aggression dominating the child's behaviour). A lower proportion of teachers and social workers were able to identify indicators that posed a threat to the child's life (attempting suicide), impeded normal development (regression in the child's milestones) and interfered with educational attainment (falling asleep in class) (Table 4).

Just over one-third of the enrolled professionals in the three disciplines had encountered maltreated children during their practice (Table 5). Physical abuse was by far the most frequently encountered form of maltreatment. Neglect ranked second but the type of neglect encountered varied between disciplines: primary school teachers encountered educational neglect; social workers, physical neglect; school physicians, medical care neglect; and preparatory and secondary school teachers, educational and physical neglect. This is in addition to less frequently encountered forms of maltreatment (Table 5).

Table 6 shows that reporting intentions of cases of maltreatment were expressed by less than 80% of the professionals with some variation between disciplines. Indeed, more than 80% of school physicians showed an intention to report cases involving physical, sexual and emotional abuse as well as medical care neglect. In almost all situations of child maltreatment, even the most serious and life-threatening ones, less than 80% of teachers and social workers had the intention to report. Professionals most frequently had the intention to report detected cases to other school personnel of a different discipline, whereas only a small percentage of them had the intention to report encountered maltreated children to the police, the office of social services or the non-abusive parent (Table 7).

Table 3 **Professionals' recognition of the risk factors of child maltreatment**

Risk factor for child maltreatment	Primary school teachers (*n* = 144) %	Preparatory and secondary school teachers (*n* = 74) %	Social workers (*n* = 163) %	Physicians (*n* =78) %	Total (*n* = 459) %
Marital and family problems	88.9	91.9	91.4	96.2	91.5
Parental substance abuse	86.8	87.8	87.7	88.5	87.6
Emotional immaturity of parents	76.4	82.4	78.5	76.9	78.2
Parental unemployment	66.0	83.8	74.2	84.6	74.9
Parents were themselves victims of maltreatment	55.6	56.8	67.5	73.1	63.0
Low level of parents' education	62.5	59.5	65.0	57.7	62.1
The child was unwanted at the time of pregnancy	56.9	52.7	63.2	65.4	59.9
Parents' perception of the child as personal property	57.6	40.5	57.1	65.4	56.0
Marriage of the parents at a very young age	54.2	60.8	55.8	52.6	55.6
Extreme poverty	52.8	41.9	57.1	69.2	55.3
Unrealistic expectations of the child	45.1	48.6	54.6	56.4	51.0
The child is disabled	24.3	44.6	32.5	32.1	31.8
The child is a girl	20.8	6.8	18.4	25.6	18.5
The child is a boy	11.8	10.8	8.6	11.5	10.5

A number of reporting inhibitors were stated by professionals in the three disciplines. Perception of the maltreatment as trivial and unworthy of reporting was the most frequently cited inhibitor (30.3%). Nearly a quarter of the professionals expressed fears about the problems which they would have to face with the child's family once disclosure was made (21.4%) and the absence of mandatory legislation ensuring the reporter's protection (26.1%), whereas 18.5% believed that reporting would not provide a solution for the child's problem. Concerns about intruding upon family privacy (16.8%) and disclosing family secrets (5.8%) were less frequently stated inhibitors.

Table 4 **Identified indicators of child maltreatment**

Indicator of child maltreatment	Primary school teachers (*n* = 144) %	Preparatory and secondary school teachers (*n* = 74) %	Social workers (*n* = 163) %	Physicians (*n* =78) %	Total (*n* = 459) %
Truancy from home	91.0	81.1	86.5	96.2	88.7
Seeks love and affection from surrounding adults	81.9	74.3	87.1	94.9	84.7
Steals food or steals money to buy food	78.5	75.7	76.7	84.6	78.4
Attempts suicide	79.9	75.7	70.6	93.6	78.2
Aggression dominates the child's behaviour	63.9	70.3	78.5	80.8	73.0
Is withdrawn	67.4	63.5	75.5	76.9	71.2
Female child is scared when an adult male approaches her	64.6	62.2	77.3	74.4	70.4
Wets the bed after a long period of control	59.0	67.6	69.3	82.1	68.0
Fails to express pain	63.2	59.5	67.5	79.5	66.9
Presence of injuries to the child's body	67.4	45.9	62.6	76.9	63.8
Regression in the child's developmental milestones	51.4	48.6	62.6	76.9	59.3
Falls asleep in class	59.0	40.5	54.6	59.0	54.5

Table 5 **Types of child maltreatment encountered by enrolled professionals**

Type of maltreatment[a]	Primary school teachers (*n* = 77)		Preparatory and secondary school teacher (*n* = 8)		Social workers (*n* = 55)		Physicians (*n* =34)		Total (*n* = 174)	
	No.	%	No.	%	No.	%	No.	%	No.	%
Physical abuse	51	66.2	4	50.0	35	63.6	25	73.5	115	66.1
Educational neglect	18	23.4	1	12.5	9	16.4	4	11.7	32	18.4
Physical neglect	8	10.4	1	12.5	16	29.1	1	2.9	26	14.9
Medical care neglect	4	5.2	0	0	2	3.6	8	23.5	14	8.1
Child labour	4	5.2	1	12.5	4	7.3	3	8.8	12	6.9
Emotional abuse	1	1.3	0	0	3	5.5	2	5.9	6	3.4
Gross safety neglect	2	2.6	0	0	3	5.5	1	2.9	6	3.4
Sexual abuse	0	0	1	12.5	2	3.6	3	8.8	6	3.4

[a] *Categories are not exclusive*

Table 6 **Professionals' reporting intentions of maltreatment situations**

Maltreatment situation	Primary school teachers (*n* = 144) %	Preparatory and secondary school teachers (*n* = 74) %	Social workers (*n* = 163) %	Physicians (*n* =78) %	Total (*n* = 459) %
A father has sexual relations with his daughter	77.1	70.3	81.0	80.8	78.0
A father fondles his daughter's genitalia	81.3	73.0	73.6	82.1	77.3
Parents refuse to provide long-term treatment for their chronically ill child	79.9	70.3	71.8	80.8	75.6
Parents beat their child with subsequent injuries	76.4	58.1	74.2	83.3	73.9
Parents burn their child with a cigarette	78.5	51.4	66.9	83.3	70.8
Locking the child at home alone for long hours	59.7	52.7	71.8	80.8	66.4
Parents ignore the child's complaint of myopia	72.9	55.4	60.1	76.9	66.2
Parents ignore teachers' instructions regarding the academic progress of the child	77.8	45.9	61.3	65.4	64.7
Parents constantly curse the child	69.4	47.3	57.7	83.3	64.1
Parents allow the child not to attend school	75.0	50.0	56.4	71.8	63.8
Parents let a child below working age take a job while attending school	49.3	35.1	50.3	59.0	49.0
Parents let a 10-year-old child ride public transportation alone	21.5	10.9	34.4	57.7	31.0

Table 7 **Personnel and agencies to which professionals intend to report**

Personnel/agency to which reporting is intended	Primary school teachers (n = 144) %	Preparatory and secondary school teachers (n = 74) %	Social workers (n = 163) %	Physicians (n =78) %
Social worker in charge	74.3	58.1	–	74.4
School physician	59.7	31.1	51.5	–
School principal	29.2	13.5	16.6	32.1
Police	6.9	5.4	11.0	25.6
Office of social services	1.4	0	1.8	0
Non-abusive parent	1.4	1.4	0.6	2.6

Table 8 **The mean perception, identification and reporting scores obtained by professionals**

General characteristic	Perception of abuse (6–18)[a]	Perception of neglect (9–27)[a]	Identification score (12–36)[a]	Reporting score (12–36)[a]
Sex				
Male	7.08 ± 1.92	10.51 ± 2.22	16.50 ± 4.84	19.67 ± 7.23
Female	6.82 ± 1.46	10.82 ± 2.01	16.82 ± 3.89	19.65 ± 5.80
t value	1.24	1.33	0.61	0.03
P value	0.216	0.185	0.542	0.976
Occupation				
Primary school teachers	6.95 ± 1.61	10.94 ± 1.82	16.89 ± 3.42	19.11 ± 4.79
Preparatory and secondary school teachers	7.34 ± 1.88	10.92 ± 1.91	17.86 ± 4.98	22.73 ± 7.27
Social workers	6.76 ± 1.44	10.87 ± 2.32	16.87 ± 3.90	19.91 ± 6.12
Physicians	6.56 ± 1.41	9.99 ± 1.88	15.19 ± 4.50	17.18 ± 6.07
F ratio	3.754	4.439	5.795	11.647
P value	0.014	0.004	0.0007	0.0000
Mental health training				
No	6.91 ± 1.63	10.74 ± 2.04	16.93 ± 4.19	19.70 ± 6.08
Yes	6.73 ± 1.32	10.63 ± 2.17	15.66 ± 3.67	19.42 ± 6.46
t value	0.93	0.37	2.10	0.37
P value	0.353	0.711	0.037	0.712

[a] *Minimum and maximum scores on the developed scale*

Significant statistical differences were observed in the mean score obtained by the studied professionals on abuse perceptions (F = 3.754, P = 0.014), neglect perceptions (F = 4.439, P = 0.004), identification (F = 5.795, P = 0.0007) and reporting (F = 11.647, P = 0.0000) scales in relation to their disciplines (Table 8). Post-hoc com-

Table 9 **Correlation between scores obtained on the developed scales and duration of working experience**

Developed scale	Years of experience	Reporting intention	Identification of indicators
Perception of abuse			
r	– 0.145	0.429	0.188
P value	0.002	0.000	0.000
Perception of neglect			
r	– 0.103	0.472	0.174
P value	0.027	0.000	0.000
Identification of indicators			
r	– 0.144	0.315	
P value	0.002	0.000	
Reporting intention			
r	– 0.050		
P value	0.285		

parison revealed that school physicians were significantly more apt to perceive situations of neglect, as indicated by their low mean score on this scale (9.99 ± 1.88), which was significantly lower than that of other professionals. Moreover, their mean score on the abuse perception scale (6.56 ± 1.41) was significantly lower than that of preparatory and secondary school teachers (7.34 ± 1.88), while comparable to the mean score of primary school teachers and social workers (Table 8).

That school physicians were more likely to identify indicators of maltreatment was indicated by a mean score on the identification scale (15.19 ± 4.50) which was significantly lower than that of professionals in the two other disciplines (Table 8).

The lowest reporting intentions were expressed by preparatory and secondary school teachers and their mean score (22.73 ± 7.27) on the reporting scale was significantly higher than that obtained by other professionals. The mean scores obtained by social workers, primary school teachers and school physicians were comparable (Table 8).

Previously received mental health training was coupled with significantly better identification of child maltreatment indicators (t = 2.10, P = 0.037). However, such training was found to affect neither the perception of the maltreatment nor the reporting intentions (Table 8).

The scores obtained by the professionals in the three disciplines on the perception, identification and reporting scales were significantly and positively correlated. On the other hand, the duration of working experience was significantly and negatively correlated with their scores on the perception and identification scales but not with their scores on the reporting scale (Table 9).

Discussion

Child abuse and neglect are often children's first introduction to the violent society in which they live. Combating violence, espe-

cially child abuse, requires a multifaceted approach to reinforce the value of human life and the commitment to a non-violent lifestyle [*23*]. Early preventive and interventive efforts to avert child maltreatment require knowledge of the risk factors that contribute to its occurrence. Accordingly, it is important to assess the knowledge of professionals working with children regarding predictors of abuse and neglect, as these professionals have a unique role to play in recognizing children at risk and families needing assistance before the maltreatment becomes established.

Most of the factors constituting the components of the ecological model [*24*] were recognized by a low proportion of professionals in this study. In particular those factors related to cultural and socioeconomic aspects and, to a lesser extent, individual and familial determinants of the problem were poorly recognized. Similar findings have been shown by recent studies conducted in Arab society [*18*] as well as in other societies [*25*]. It is surprising to note that the majority of professionals in this group failed to recognize that some children, such as the disabled and girls, are more likely to be maltreated simply because they are socially devalued. Girls are more frequently subjected to maltreatment [*26*], and given that they have a lower status in Arab society [*27*], this fact should be considered. Indeed, the tendency to minimize the cultural and social components of child maltreatment may result in a narrow interpretation of this phenomenon [*18,25*]. This negatively influences preventive efforts that, within the ecological model, aim at altering community and societal risks as well as reducing their potential to foster maltreatment [*22*].

It is accepted that cultures vary in their definitions of child abuse and neglect; nevertheless, each cultural group has criteria for identifying behaviour that is outside the realm of acceptable training and care of children. A high rate of perception of what is globally considered maltreatment was revealed by this study. The highest rate of agreement among professionals in this study was found in situations describing physical abuse such as burning and beating with subsequent injuries which occurred in a disciplinary context triggered by a child's misbehaviour. This is despite the fact that in Arab societies obedience and discipline of children are highly expected [*18*] and that violations of rules are considered to provide sufficient justification in themselves for punishment [*18,19*]. This high rate of agreement is attributed to the fact that these situations contain evident harmful physical sequelae. A lower rate of agreement, particularly among preparatory and secondary school teachers, was found in an analogous situation which had invisible physical consequences. Moreover, the awareness of the economic constraints which deprive some families from means of subsistence probably accounted for the fact that only two-thirds of this group of professionals perceived forced child labour as maltreatment. However, these professionals failed to recognize that child labour can actually perpetuate poverty; working children grow into adults trapped in unskilled and badly paid jobs [*28*], simply because they are unable to attain higher educational status.

Situations of neglect describing parental failure to meet the child's basic physical, nutritional, educational and medical needs were perceived as a form of maltreatment by a high proportion of professionals enrolled in this study as well as by others in similar cultures [*18*]. Sharifzadeh [*29*] attributes this to the nature of families with Middle Eastern roots which encourages interdependence and mutual support among members. Implicit in this doctrine is that parents must put aside their individual inter-

ests and fully attend to their children's needs [*26*,*29*]; therefore, any reluctance to provide care for a child is severely condemned [*27*]. Situations describing lack of supervision and safety neglect were recognized as a form of maltreatment by a lower proportion of professionals, particularly teachers and social workers. Unexpectedly, a low proportion of preparatory and secondary school teachers were able to perceive a situation pertinent to their domain as neglect, i.e. ignoring teachers' instructions concerning the academic progress of the child. This finding contradicts that of Shor et al. [*25*] which indicates that professionals tend to recognize maltreatment situations that are relevant to their field of specialization.

The tendency of professionals, particularly teachers and social workers, to perceive situations of abuse rather than neglect as child maltreatment is of concern. Nowadays, child neglect is commonly encountered [*2*]; however, it continues to be overlooked [*30*] as it is poorly perceived as a form of maltreatment [*25*]. It is possible that because such situations are perceived to be less intentional [*25*], less serious, as well as lacking definite and immediate harm, they are poorly perceived as forms of maltreatment. However, one should bear in mind that less serious forms of maltreatment are more likely to be endured repeatedly. The psychological and emotional consequences of maltreatment during childhood, as well as the physical consequences, should be considered, as they strongly interfere with the personal and social adjustment of the child [*31*]. More importantly, it is when the maltreatment is not too serious that intervention aiming at reducing or preventing its consequences [*31*] is more likely to succeed, provided that the case is identified and reported.

Identification and reporting of maltreatment are critical steps in improving the health status of maltreated children [*21*] and managing abusive parents [*21*,*32*]. Professionals seriously underreport and often mishandle suspected cases of maltreatment because they fail to recognize the signs of maltreatment [*33*]. In this group, a low overall identification rate was observed. It is not unlikely that this low ability to identify maltreatment is behind the fact that only one-third of the studied professionals reported that they had encountered neglected and abused children. That these professionals are most likely to have encountered physically abused children is probably a result of the presence of the physical evidence of maltreatment, i.e. injuries, in such cases rather than that physical abuse is more prevalent. Haj-Yahia et al. [*18*] and Shor et al. [*25*] report that maltreatment manifested by explicit signs of danger and externalizing types of behaviour was more frequently identified. In this study, school physicians were by far the most capable of identifying maltreatment indicators, even those with implicit signs of danger, unlike teachers and social workers.

Indeed, the role of this group of professionals in identifying maltreated children is underscored. Social workers, as counsellors, are often called to manage children with familial, social and economic difficulties that may precipitate maltreatment. Moreover, they encounter hundreds of children in their schools every day, unlike class teachers who see a limited number [*34*]. However, through extended contact with children and daily observations of their appearance and behaviour, teachers constitute the largest professional group capable of identifying cases of maltreatment [*8*]. Unfortunately, this role cannot be fulfilled if teachers are unfamiliar with the manifestations of maltreatment [*30*]. Several studies have found that teachers are the least informed professional group about the prob-

lem of maltreatment [*35*]. Teachers rate their knowledge in this area as being relatively low [*36*] and consider their lack of knowledge a barrier in identifying cases of maltreatment [*37,38*]. Since the diagnosis of maltreatment is based on the observation of its sequelae rather than on the observation of the abusive behaviour [*21*], professionals need to improve their capabilities of identifying the wide range of manifestations by which child maltreatment presents. This is especially important as the ability to identify maltreatment manifestations has great implications regarding whether professionals decide to report maltreatment [*32,34*].

Reasonable grounds for suspecting maltreatment should be established before a reporting decision is made [*34*]. Such a degree of suspicion is difficult to reach in cases of neglect [*34*] and results in a lower reporting tendency of this form of maltreatment [*25,33,34*]. Generally, in this group of professionals, low reporting intentions were expressed, being lowest among preparatory and secondary school teachers. Moreover, teachers, social workers and, to a lesser extent, school physicians had considerably lower intentions to report situations pertinent to neglect. This is not surprising as they were also less apt to recognize situations of child neglect as maltreatment. It is worth mentioning that the perception of the maltreatment as trivial and not worth reporting was the most frequently cited reporting inhibitor. Haslam [*39*] emphasizes that some professionals are less willing to report what may be seen as trivial misdemeanours and are disinclined to see fairly stable family relationships broken. This is not the case in abusive situations.

Levine [*36*] describes a reporting hierarchy in which physical abuse is most frequently reported. In this study a high reporting intention was expressed by school physicians in situations of physical abuse including sexual abuse. Moreover, sexual abuse was the only situation in which high reporting intentions were expressed by primary school teachers and social workers. Such high intentions of reporting sexually abused children have been emphasized [*18,25,34*]. However, reporting intentions favour limiting knowledge of the case to the school by involving school personnel of various disciplines rather than involving other agencies or the non-abusive parent. This may reflect the perception of the professionals that schools can effectively handle such cases, as discussed by Tite [*40*]. Nevertheless, the role of the non-abusive parent should not be underestimated as he or she can assist in solving the child's problem and in preventing further maltreatment.

Findings further document that the three steps in approaching the problem of child abuse and neglect are interrelated. Professionals who have a high awareness of what is considered child maltreatment are equally aware of how these factors might be reflected on the child's appearance and behaviour and, consequently, they have reasonable grounds for reporting suspected cases. Although professional experience and mental health training positively influence their awareness of the problem, these factors did not affect the reporting intentions of professionals. Can it be said that raising the awareness of professionals to the forms of maltreatment and its wide range of presentation will increase their willingness to report?

This study provides valuable information about what professionals need to know, feel and consider to improve their approach to the problem. Activities directed towards raising the awareness of all professionals, especially teachers and social workers, to the problem is urged. These activities should emphasize what is considered child maltreat-

ment and should stress situations of neglect. Professionals need to expand their knowledge of the underlying individual, familial, social and cultural factors and how these factors interact with each other to precipitate this phenomenon. Knowledge in this area will enable professionals to adopt a high risk approach to prevent maltreatment. Moreover, professionals must learn to recognize the manifestations of abuse and neglect, particularly those with implicit signs of danger and internalizing types of behaviour, in order to enhance their ability to identify maltreated children.

These efforts will be meaningless if policy makers do not consider mandatory reporting legislation which offers a reasonable degree of protection to the reporter. Other reporting inhibitors should be equally addressed. Concerns about intruding upon family privacy should be challenged by demonstrating the positive outcome of reporting for the child. It is only under these circumstances that physicians, teachers and social workers will approach the problem as partners, provide the best possible care to maltreating families and alleviate its consequences on the child.

Since school physicians, teachers and social workers do encounter cases of maltreatment ranging from neglect to sexual abuse, community-based studies are deemed essential to reveal the extent of this phenomenon, its determinants and its impact on children.

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