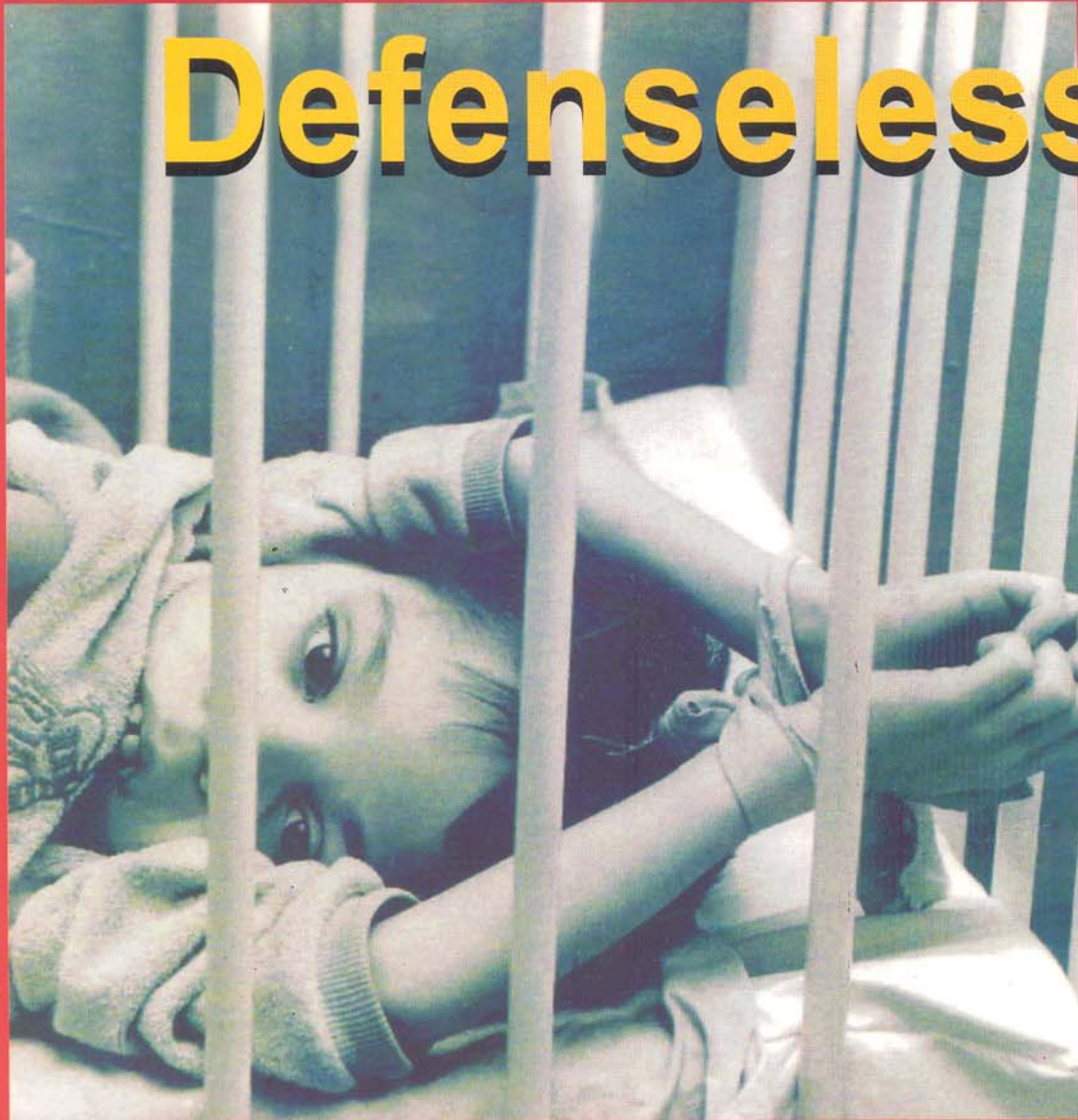


The **World** of the

# Defenseless



**Einar Helander MD, PhD**

# THE WORLD OF THE DEFENCELESS

The human ecology of child violence

Einar A. Helander

## The World of the Defenceless.

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Front-page photo: Ten-year-old girl straitjacketed to the bed and drugged 'because of overactivity'. No training or daily activities. Double incontinence, severe delay of milestones; is unable to walk and speak. She can no longer distinguish night from day. She is underweight because of years of malnourishment. She is a victim of the abuse and neglect at this institution because of the lack of care and the indifference of the staff and of insufficient Government funding. Reason for being in an institution: healthy infant abandoned by poor mother to the 'protection of the State,' no disabilities on arrival. Credit: P.O. Sjöberg, Sweden

**Published and circulated in India**

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All that is necessary for evil to triumph is for good men to do nothing.

*Edmund Burke (1729-1797)*

The world has slowly grown accustomed to the symptoms of moral decay. One misses the elementary reaction against injustice and for justice – that reaction which in the end represents man's only protection against a relapse into barbarism. I am firmly convinced that the passionate for justice and truth has done more to improve man's condition than calculating political shrewdness, which in the end only breeds distrust... Let us not shun the fight when it is unavoidable to preserve the right and the dignity of man.

*Albert Einstein (1879-1955)*

It is my firm conviction that nothing enduring can be built on violence.

*Mohandas Karamchand Gandhi (1869-1948)*

*On 15 June 2007, the United Nations General Assembly unanimously adopted a resolution declaring October 2 – Gandhi's birthday – to be the "International Day of Non-Violence."*



## FOREWORD

Dr. Einar Helander came to the Headquarters of the World Health Organization in 1974 to participate in the Organization's development of the rehabilitation component of the new primary health care strategy. During 14 of my 15 years as Director-General of WHO, I followed his work. In 1974, in a WHO document he summarized the challenge related to the unmet needs of persons with disabilities: "We have in our hands a growing moral, social, health and economic problem of vast proportions, which we are incapable of dealing with by using the conventional system". As responses to that challenge, he first developed the disability prevention programme and then the community-based rehabilitation (CBR) strategy. His approaches were always innovative; but also practical and cost-effective. Many were very unconventional – the CBR technology was based on observations of indigenous spontaneous methods and a thorough knowledge of the living conditions in the poor villages and urban marginal areas in the developing countries, where he spent most of his time. He realized that managerial capacity building was crucial and devoted many years to the teaching of CBR policies, planning, programme design, service delivery systems, quality/cost control methods and human rights in courses for participants from 90 countries. The CBR is now implanted in some 100 nations; the WHO technology manual has been translated into more than 50 languages.

In this new book he follows up his 30 years of field experience by outlining first the cruel, inhuman and degrading treatment to which at present some ten million abandoned children in residential institutions are subjected. He then continues with a thorough analysis of the global extent and consequences of child abuse and neglect. His descriptions are shocking, and so are his conclusions about the moral vacuum that seems to be a common feature among the perpetrators.

This book is carefully researched. Building on the vast published evidence and on his own observations, the author describes some of the most important features of the "world of the defenceless"; one of the most visible of which is its pervasive violence. It is cautiously estimated that over three billion people – half of the world's population – are the traumatized victims of childhood sexual, physical, psychological and other forms of abuse and that over one billion become disabled or meet a premature death as a consequence.

His criticism of 136 Governments' attitudes to human rights application is very frank. These Governments represent five billion citizens, and they will not allow any outside, independent and unfettered inspections of what takes place in their "orphanages" and other services for children. Another of his conclusions is that the present level of development aid – a few US dollars per person per year – is totally insufficient to bring about any significant reduction of the global poverty, which now leaves over one billion children severely neglected. Helander points out that with the present negative environment, it is not easy to mobilize true enthusiasm for assistance to human and economic development. For the time being, poor nations will have to rely mainly on what can be achieved by mobilizing their own national resources. He finally outlines a community-based primary prevention programme to reduce the global level of child violence.

I recommend this powerful book for reading and serious reflection: what is the future of a world where its people find themselves surrounded by oceans of contagious violence, immoral behaviour, lack of compassion, and unwillingness to change?

Halfdan Mahler, MD  
Director-General of the World Health Organization, 1973-1988.



## FOREWORD

The "Children and Violence – the World of the Defenceless" exposes a number of large-scale problems in the human environment.

The author is well known for his groundbreaking work to improve the quality of life and the independence of disabled persons. I met him for the first time over fifteen years ago in Bangalore. He worked during several years closely with my Karnataka State administration and with several local organizations to successfully prepare a State-wide community-based programme. In this book he draws from experience of 30 years of field work in many developing countries.

He has widened the perspective of the disabled defenceless to analyse the basic conditions of the poor, especially the children. The author has always been a strong spokesman for human rights and solidarity. He points out the many weaknesses in our nations, the widespread abuse, neglect, and violence – especially of children – the inadequate education system and the lack of security and justice in a world where most people struggle to get out of poverty. He strongly criticizes the attitudes of many donor agencies and the futility of official external aid. The very small amounts of such aid that reach the poor appear to be used more and more as an instrument for the globalization of power in the hands of the few and rich. He points to national mobilization for community development using grassroots resources as the tool to success.

Devolvement of democratic, people-oriented decision-making and decentralization of financing, changes that took place in India in the 1990s, are development factors of immense importance for poverty alleviation and progress.

I recommend all those concerned with development to read this frank and sincere analysis of the human condition, learning from the past and planning for a better future.

Rt. Hon H. D. Deve Gowda  
Prime Minister of India 1996-97  
Chief Minister of the State of Karnataka 1994-96





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## ACKNOWLEDGMENTS

The author is most grateful for the considerable help and advice he has got during the long process that resulted in this book. Through my parents, I was at a very early age directly exposed to the social work with the poor and disadvantaged in Sweden to whom they devoted many years of their lives.

Credit for much of the information in this book goes to all my informal contacts during 30 years of international work: most importantly to the children and their families in poor villages and marginal urban areas in developing countries, community leaders in these countries, non-governmental organizations, my colleagues, the many expatriates who have spent long years (some as many as 50 years) in the countries visited, anthropologists, local health and social workers, staff of national and community service delivery systems, teachers, legal experts, officials from national administrations and staff from the UN agencies and bilateral donor agencies, and diplomats who have offered me their knowledge and opinions.

Special thanks go to many of my colleagues in the World Health Organization, especially to Dr. Etienne Krug and Dr. Alexander Butchart at the Injury and Violence Programme. My most sincere thanks are due to Dr. Vincent Felitti for several years of guidance and technical expertise, and for reading the entire book. I have had the advantage of technical expertise from Mr. Joerg Mayer, Economist at UNCTAD, Geneva, Switzerland, Mr. Stefano Sensi at the Office of the High Commissioner for Human Rights, Geneva, Switzerland and Mr. Claes Sandström, Budget Director, WHO, Geneva, Switzerland.

I would like to mention the assistance and criticisms from Professor Bernhard Helander, Department of Cultural Anthropology, Uppsala, Sweden; Mr. Ture Jönsson, Department of Special Education, University of Gothenburg, Sweden; Mrs. Elena Kozhevnikova, Psychologist, St Petersburg, Russia; Dr. Padmani Mendis, MD Colombo, Sri Lanka; Mrs. Indumathi Rao, Co-ordinator, CBR Network, Bangalore, India; Mr. Jorge A. Restrepo, Coordinator, International Secretariat, Defence for Children International, Geneva, Switzerland; Professor Gunnar Stangvik, Special Education Department, University, Alta, Norway and Mrs. Maine Viklund-Olofsson, Star of Hope International, Sweden.

The personnel at the WHO Library have given me very valuable guidance and support in my efforts to cover the considerable amount of published literature on child abuse. For the photos and figures I am obliged to the Archives at WHO; Star of Hope International Stockholm; Dr. Vincent Felitti, La Jolla; Dr. Bruce Perry, Houston; Dr. James Williams, San Diego; Dr. Barton Schmitt, Denver; Dr. Céline Rozenblat, Lausanne; The Fordham Institute, Vassar College Poughkeepsie; and Volcano Press, Volcano. I am also grateful for the assistance with the editing by Mr. John Bland and Mrs. Hannelore Polanka, Geneva.

Finally, I am deeply thankful to my wife Margarida for her incalculable source of support and for having endured the sight of her husband sitting at the computer for years on end. She has read it all and engaged in hours of discussions, based on her own experience of social community work with children in Portugal, and on what she has seen in the many villages and slums, she has accompanied me to.

## PREFACE.

This global analysis of childhood violence builds on the experience of over 30 years of international work, most of the time as a staff member of the World Health Organization (WHO) and of the United Nations Development Programme (UNDP); and in cooperation with many bilateral governmental and non-governmental organizations. My first international observations go back to 1974, when I saw three women, all dressed in black just leaving the office of a doctor in a small town in a Middle East country. He told me that they were a mother and two daughters who had been raped during the previous night by the father when he was drunk. Such sexual abuse was common. The doctor was instructed to report such crimes to the police, but could not, as the girls refused to be examined, and under an Islamic ordinance, a woman had to present four male, Moslem witnesses in order to prove a case of sexual assault. Abortions were forbidden, any children in that country issuing from incest usually perished soon after birth.

During my career I have worked in 91 countries<sup>1</sup> and have personally examined thousands of children, at home, in health centres or institutions, observed them at play, in the streets, in schools and as underage workers. Main sources have been interviews with parents, local families, teachers and the leaders in poor villages and marginal urban areas where I have stayed long enough to win the confidence of the local population. In each country, there have been official meetings with several ministries – mostly Health and Social Welfare – to discuss child maltreatment problems, approaches, planning, technical assistance, training programmes, financing, management and the environmental political and cultural aspects.

Information given in this book has also originated from the professional staff of headquarters, regional and country offices of among others WHO, UNDP, The World Bank, The High Commission of Human Rights, The High Commission for Refugees, ILO, UNICEF, UNESCO, U.N. Population Fund, the U.N. Institute for Social Research, and the U.N. Conference on Trade and Development. I have met with colleagues with a long experience in their own countries, diplomats, social anthropologists, economists, criminologists, schoolteachers, religious leaders, local bankers, agricultural experts and personnel at local health centres, 'orphanages', hospitals, prisons and social programmes.

At the time of the 1978 Alma-Ata Declaration on Primary Health it was obvious that successful delivery of public care was related to the appropriate managerial training of the professionals. To fill this gap I wrote, in 1979, with two co-authors a manual on the technology of community-based rehabilitation – the fourth component of PHC<sup>2</sup>. It has been introduced in more than 100 countries. It was followed by other technical books focused directly on local and country planning, management and evaluation systems. Some 30 national, regional or international specific management courses/seminars have been held, many of these during the last 10 years. Some 200 professionals from 90 countries<sup>1</sup> have participated in these courses and they have contributed to the information in this book through an exchange of ideas and experience.

For this book, I have made an extensive study of published scientific literature, seeking confirmation of the field observations. In total, close to 20,000 articles, books and other printed material, originating from 129 countries have been identified and evaluated. The total information base is reviewed in Chapter Two; it originates from 151 countries<sup>1</sup>. The conclusion is that childhood violence has victimized about half of the world's population.

In the text, I have often quoted case studies, statistics, publications and official reports; the literature in this area is virtually inexhaustible. Yet, they often fall short of conveying the impressions of the human condition which can be directly observed. Beyond the descriptions of our asylums and camps and gulags and of the violence on the street and behind the façade

at home, there is other evidence that bears witness to the horrors. One of the most shocking initial observations concerned children in residential institutions. The children I have observed – and whenever possible examined – in these asylums amount to several thousands. It was also shocking to realize that some 4 million children (less than 5 years old), mainly girls, die annually because of intentional neglect or outright murder.

The text does not allow me to show the reader the glassy stare of the maltreated children who lost their minds; the desperation of those who have nothing to eat or the fright of those who get beaten up. It will not let you listen to the screams of those who are chained to walls in the mental hospitals' underground cellars and are spitting at visitors, or of the children who in these hospitals get electro-convulsive treatment (ECT) without anaesthesia as punishment. It is difficult to convey one's anger when you see severely disabled beggars being robbed of their 'daily income' by some young gangsters, armed with knives. It is sad to remember the boy who was in a correction home: he showed me his back covered with bloody marks after having been horsewhipped by the sadistic director for being five minutes late for breakfast. Once I sat down in a small African hut with a poor family to examine a boy who had fractures on both arms and both legs. It took me some moments until I was able to exclude all diagnoses except intentional trauma: the father had in his drunken fits of aggression fractured these bones and disabled his son for life.

It is difficult to explain my feelings of helplessness when I unexpectedly found several thousand people waiting for me at the market place at the end of the day hoping for miracles; or the memories of those who came to the squares or up the hills carrying children who could not walk; or of those who invited me home to see family members who were unable to feed themselves or to speak, or who were expecting me to cure children with severe deformities. I remember a long conversation with an African woman, a victim of polio, in a slum area; I met her on a narrow pathway, walking on her knees and elbows to get home through two decimetres of muddy rainwater on the ground. Many times, I have entered a house of a poor family to find that the child I was going to examine had just died. There were also the odours of the street people, many homeless since childhood, some freezing to death at night; and the touches from those locked up in dilapidated mental wards. I remember the group of Latin American street boys that I used to meet over a period of some weeks: before I left the country the one who always came to chat with me was 'gone'; the police had shot him dead during the night and dumped his body with the garbage.

Who are the defenceless? They are victims or potential victims of violence, of cruel, inhuman and degrading treatment and of injustice, who are unable to find protection because of

- Lack of capacity or social recognition to resist such acts, for instance if the victim is a child or a family who lives in poverty
- Lack of anybody willing and capable to help effectively when there are problems
- A system of impunity that protects the offenders
- Corruption, cover-ups or inaction inside the judicial system (police, prosecutors, judges)
- An uncaring public attitude that leads to lack of pressure on governments to provide sufficient funds for child defence and support
- Non-compliance by Governments with their Human Rights obligations and non-compliance by service providers with their ethical rules

The main defenceless group and the focus of this book are children under the age of 18; the global child population in 2006 was 2.3 billion. Their parents are the main perpetrators. This book seeks not only to describe the prevalence, manifestations and scope of child violence,

but also to assess the disabling life-long consequences which affect over a billion survivors. The results are shocking. Poverty is a main contributor to such violence; an analysis will be made of the efforts to alleviate it.

“Most traditional explanations of violence,” states Barak (2003), “remain partial and incomplete as they separately emphasize different yet related phenomena of violence, without ever trying to provide a comprehensive explanation or framework that encompasses the full range of interpersonal, institutional, and structural violence. In fact, most of these one-dimensional explanations of violence underscore the violent behaviour of individuals to the relative exclusion of the role of institutions and structures in violence”. This book combines research findings, statistics and personal observations – with focus on children – and uses the human ecology framework. It seeks to present a more inclusive picture of the extent and consequences of the violence in which we are immersed. Methods to prevent pervasive childhood violence exist and are analysed. Such prevention will only be effective if major alterations in human behaviour and in the culture of our societies occur. Our present world is unequal, dangerous, erratic and unsustainable. Consequently, the world of our children is contaminated by a chaotic human environment that seriously harms them; a change of course is urgent.

## ABBREVIATIONS

AB	Antisocial behaviour
ACE	Adverse Childhood Experiences
ACTH	Adrenocorticotrophic hormone
AIDS	Acquired Immuno-Deficiency Syndrome
APA	American Psychiatric Association
ADHD	Attention Deficit Hyperactivity Disorder
ASPD	Antisocial Personality Disorder
ASD	Acute Stress Disorder
CAT	Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
CBR	Community-Based Rehabilitation
CDC	Centers of Disease Control, Atlanta Georgia
CIDI	Composite International Diagnostic Interview
CRC	Convention on the Rights of the Child
CSA	Child sexual abuse
CU	Callous unemotional traits
DD	Development disability
DNA	Deoxyribonucleic acid
DQ	Development quotient
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th edition 1993 by AP
ECT	Electro-convulsive treatment
EEG	Electroencephalogram
EU	European Union
EURO	Currency of the European Union
FAO	United Nations Food and Agricultural Organization
GABA	$\gamma$ -aminobutyric acid
GDP	Gross Domestic Product
GNI	Gross National Income
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICD-X	International Classification of Diseases, 10 <sup>th</sup> edition 1993 by WHO.
ICF	International Classification of Functioning, Disability and Health by WHO
ILO	International Labour Organisation
IMF	International Monetary Fund
IQ	Intelligence Quotient
JAMA	Journal of the American Medical Association
LWOP	Life without parole (prison sentence)
M/m	age in months
MAO-A	Monoaminoxidase A
MDG	Millennium Development Goals
MDRI	Mental Disability Rights International
MR	Mental retardation
MRI	Magnetic Resonance Imaging
n.a.	not annotated
NGO	Non-governmental organization
OCHR	Office of the U.N. High Commissioner for Human Rights
ODD	Oppositional defiant disorder

OECD	Organization for Economic Co-operation and Development
OFC	Orbitofrontal cortex
OT	Oxytocin
PET	Positron emission tomography
PHC	Primary Health Care
POW	Prisoner of war
PTSD	Post-Traumatic Stress Disorder
RAD	Reactive Attachment Disorder
UDHR	Universal Declaration on Human Rights
UN	United Nations
UNAIDS	United Nations Agency for AIDS
UNCTAD	United Nations Conference on Trade and Development
UHDR	Universal Declaration on Human Rights
UNICEF	United Nations Fund for Children
UNHCR	United Nations High Commission for Refugees
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNRISD	United Nations Research Institute for Social Development
USAID	States Agency for International Development
US\$	United States Dollars
WB	World Bank
WFP	World Food Programme
WGI	Worldwide Governance indicators
WHO	World Health Organization
WMA	World Medical Association
WPA	World Psychiatric Association
WTO	World Trade Organization





## PART ONE: INTRODUCTION

# 1 You Cut a Rose and Release a Tornado

A stone thrown into the water creates circles on the surface; these last for a few minutes; the circles of childhood abuse may last for a lifetime. The calamitous consequences of such abuse may not be immediately visible or easy to detect; to adapt a meteorological explanation of how natural disasters may start: “you cut a rose and release a tornado”<sup>2</sup>.

A person who starts to study what at first appears to be a limited problem opens a keyhole to the world, trying to learn, to define problems, to find explanations, and to act. Looking through the next keyhole will give a contrasting perspective, and teach the viewer another lesson about the difference between appearances and realities. With growing knowledge, more opportunities to observe and a great deal of patience, the mists surrounding the obscurities and complexities of the violence-saturated human ecology will start to dispel. Eventually, the time will come when one will be able to fuse multiple, limited observations into a broader vision that exposes the dark corners of reality. The reality is that abusing, abandoning, and assassinating defenceless children are merely the symptoms of a much wider, unresolved predicament: that of an uncaring and cruel world. The next reality is that large-scale interpersonal violence – a drastic mass-destruction of human lives – has existed since time immemorial. Human history reveals the heritage of thousands of years of killings and abuse of millions of children that have taken place without much public reaction. Not until the 1960s was child abuse recognized by the medical establishment as a diagnostic entity and since then has major research finally created an awareness of its role in people’s lives.

The following pages serve to guide the reader to its main contents. The book’s starting point – after the Introduction (materials, methods, definitions and short history) in Part One – is the abuse and neglect experienced by some ten million children presently confined – hidden – incarcerated – and silenced – in residential institutions (Part Two, Chapter 5). The practices in many thousands of these amount to ‘cruel, inhuman and degrading treatment’ defined by international law as equivalent to torture (Chapter 4). In Chapter 5 follow descriptions of the abuse and neglect of some 400 million uprooted children who live without parents as biological or social orphans, forced to be soldiers, as labourers “in the worst conditions”, in refugee camps, as prostitutes or who are trafficked. Chapter 6 reviews the consequences of parent deprivation and of the alternatives for substitute parents and providing care, education and roofs for the homeless.

In Part Three, follows a comprehensive, global account of the prevalence of childhood abuse and neglect experienced by those who have grown up with their birth parents (Chapter 7). It is based in information from 151 countries<sup>1</sup>; the conclusion is that half of the world’s population has been victims of childhood violence before the age of 18. In Chapter 8 the prevalence of long-term, serious health and social consequences of the violence that has already occurred are assessed. There are also major judicial and economic effects, yet to be fully understood.

Part Four describes the most frequently used methods through which child violence can be prevented and treated. It includes a review of the explanations of why people become perpetrators (Chapter 9). Ten major contributors to childhood violence are reviewed. These include: pregnancy and delivery complications, conduct disorder, genetic factors, antisocial

personality disorder, maladaptive alcohol use, mental disorders among caregivers, family malfunction, violence in the society, lack of child support and services, and poverty. On the basis of present knowledge of the extent of the problem, and of the potential effectiveness of the interventions, the conclusion is that priority should be given to primary prevention. The availability and efficacy of existing care and rehabilitation services for abused and neglected children are reviewed in Chapter 10.

Part Five reviews the influence of the global systems in childhood violence, starting with the international law. Many nations are embarrassed by references to and discussions about, the lack of observance of the United Nations treaties on Human Rights in their countries (Chapter 11). A large majority of all United Nations' Member States have opted out of core parts of the international law. Children in these countries who are victims of 'cruel, inhuman or degrading treatment' and their representatives are not even allowed to communicate their problems to the Human Rights Council in Geneva.

The situation of the world's poor people is analyzed in Chapter 12. Poverty is widespread: close to 3,000 million people (45% of the world populations, 40% of them children) continue to be deprived of their necessities in spite of 50 years of international aid. The economic inequalities are large and growing and for children this means that for very large proportions of them quality education, food, safe water, decent housing and protection against violence is unavailable. Poverty-related, structural neglect affects over one billion children. Then follows an analysis of the international assistance programmes. Present official aid after subtraction of delivery and administrative costs amounts to a few US\$ per poor person per year and even that has never been shown to trickle down to the poor. These poor children cannot count on more than token assistance from rich donors.

Chapter 13 reviews the current United Nations Millennium Development Programme. This programme mentions neither community and interpersonal violence, nor the need to protect children. Many of the Goals of the Millennium Programme concern children. The Millennium Programme set a 25-year period (1990-2015) for completion of these goals, two thirds of that period has passed. A review of the present outcomes is made of each of the targets that apply to children (poverty, hunger, schooling, gender disparity, under-5 mortality, maternal mortality, spread of infective diseases, access to clean water and sanitation, decent and productive work for youth, and commitment to good governance).

There are very serious problems with the implementation of these targets, and most countries will not reach them by 2015. It is concluded that to progress – to give their children better life and to prevent childhood violence – poor nations have to build on their own strengths and learn how to mobilize their populations for progress, beginning during their childhood. Governments and people can cooperate: phasing-out indifferent, uncaring, and immobile bureaucracy; combating corruption and incompetence wherever it appears; supporting the local mobilization of their communities by increasing self-rule and decentralization, phasing-in a modernized, socially oriented education system and promoting justice, peace, and human rights of the poor. The present promotion of global 'crash' programmes based on dreams at the top of the global system should with few exceptions (such as the immunization projects) be changed. A new entry point for development is proposed: to work directly with people, build on what they have and do, and assist communities to generate gradual steps forward. To the extent that international aid is available it should be redirected to the civil society which is better placed for a role in these more humble, gradual approaches.

Finally, in Part Six follows an analysis of methods for a universal, community-based primary prevention of childhood violence. The reason for preferring universal prevention is its high prevalence and global presence. Abuse of children takes place across all cultures, societies, economic, social and religious strata. It is not just a problem seen in a few disadvantaged families. Four different strategies for coping with the problem of child violence are analyzed: family life education; community child watch; use of media for information about the consequences of childhood violence; and legislation. Because of the high prevalence of violence towards children, no country will have sufficient professional personnel to conduct a universal prevention programme. Consequently, ordinary people in the community need to be mobilized and trained (Chapter 14). Once in place, the positive results of an effective universal, community-based programme will be important: it will decrease social and health problems that now affect people on a massive scale and are the known outcomes of childhood violence: alcohol and drug addiction, criminality, chronic mental and physical disorders, decrease of productivity and creativity in the workforce, and fear. A short Chapter 15 contains the conclusions of the book.

### THE HUMAN ECOLOGY OF CHILDHOOD VIOLENCE

To organize better all the materials in this book, the author has applied the human ecology system. Ecology as a term was proposed in 1866 by Ernst Haeckel. Ecological scientists study all levels of the organization of life on earth and on the interrelations between organisms and their environment. Most ecology has focused on the physical environment, but eventually has come to include research on the social environment: human ecology.

This book describes the global, human-ecology context in which childhood violence takes place. This approach provides a broader, cross-disciplinary perspective, explaining how human-environment relations are influenced by a combination of environmental, political, economic, legal, psychological, physical, cultural, and societal forces, and the quality of basic human relationships. A well-known theoretical system has been developed by Urie Bronfenbrenner (1979, 2004), a leading United States psychologist. He seeks to explain the biological, environmental, demographic, and technical conditions of the life of all individuals as determined by an interactive and interrelated series of systems that already begin to have an influence in early childhood.

James Garbarino (1995) points out:

Applying a human ecology perspective to the issue will help us to see the wider aspects: it forces us to consider the concept of risk beyond the narrow confines of individual personality and family dynamics. In the ecological approach, both are 'causes' of parenting patterns and 'reflections' of broader sociocultural forces. - The social environment can become poisonous to the development of children and youth much as the physical environment can undermine their physical well-being. The term *social toxicity* parallels the concept of *physical toxicity* as a threat to human well-being and survival. A socially toxic environment contains widespread threats to the development of identity, competence, moral reasoning, trust, hope, and the other features of social maps that make for success in school, family, work, and the community.

To better understand human behaviour development Bronfenbrenner proposed the use of the functions and influences of four layers of environment systems; for this book some adaptations have been made to his system:

(1) The *microsystem*: the child has his/her own microsystem: the body with its cognitive, emotional and physiological components. The microsystem encompasses the relationships and

interactions a child has with his/her immediate surroundings; major parts of these influences such as beliefs and behaviour are affected by the parents. Children are cognitively, emotionally and physiologically influenced by violence and maltreatment; it affects their present and future behaviour, social functions and health.

(2) The *mesosystem* comprises relations among the major settings next to the person: the family, the school, friends and peers. Mesosystems make inputs into the child's microsystem, for instance by transfers of the parents', teachers' and peers' attitudes and behaviour. The influence is bi-directional; the child's behaviour also influences the parents, the teachers and its peers.

(3) The *exosystem* is the environment (mainly in the community) in which a child may or may not be directly involved, but which nonetheless indirectly affects him or her. Examples include: the parents' workplace experiences and local inter-family relationships, and their reactions related to poverty, frustration and powerlessness. The quality of the exosystem is related to community leadership and performance, the presence of services and utilities, the efforts to alleviate poverty, the reliability of the legal system and the behaviour environment, for instance community violence, racism, and women's status.

(4) The *macrosystem* (e.g. represented by the nation) includes a larger institutional context of culture, religion and politics; how the U.N. Human Rights obligations and national laws are implemented; the function and fairness of the national legal system. The quality of performance of the Government and its handling of the economy and of poor peoples' needs are important issues when it comes to prevent violence. Abject poverty is a reality for close to half of the World's population; it is one of the most important predictors for family violence against children.

(5) To these, a fifth level is proposed: *the global system*. Children's lives are influenced by many global factors such as: the development and follow-up of Governments' compliance with the United Nations Human Rights Covenants and Conventions; the global economy; trade regulations; international health campaigns; educational programmes; foreign media penetration leading to increasing pollution of national cultures. Among these factors, the rich countries' attitudes and actions (or lack of actions) related to poverty alleviation and respect of foreign cultures stand out.

Fig. 1.1. presents a schema showing the interactions between the different systems. The thicker arrow from the global to the macro-system reflects the view that the global influences on the economy dominate. The thinner arrows at that level indicate that the expressed needs of poor nations have an insufficient influence.

With the adaptations to this system, one will be able to describe: (a) *upstream*, (b) *downstream*, and (c) *parallel interactions*. For example:

(a) The knowledge of the extent of childhood violence (experienced at the level of the microsystem) may lead to upstream realization of the needs to strengthen: health services (provided at the level of the exosystem), government programmes for prevention (through the macrosystem), and initiatives to provide grants from donor nations for such programmes (global system);

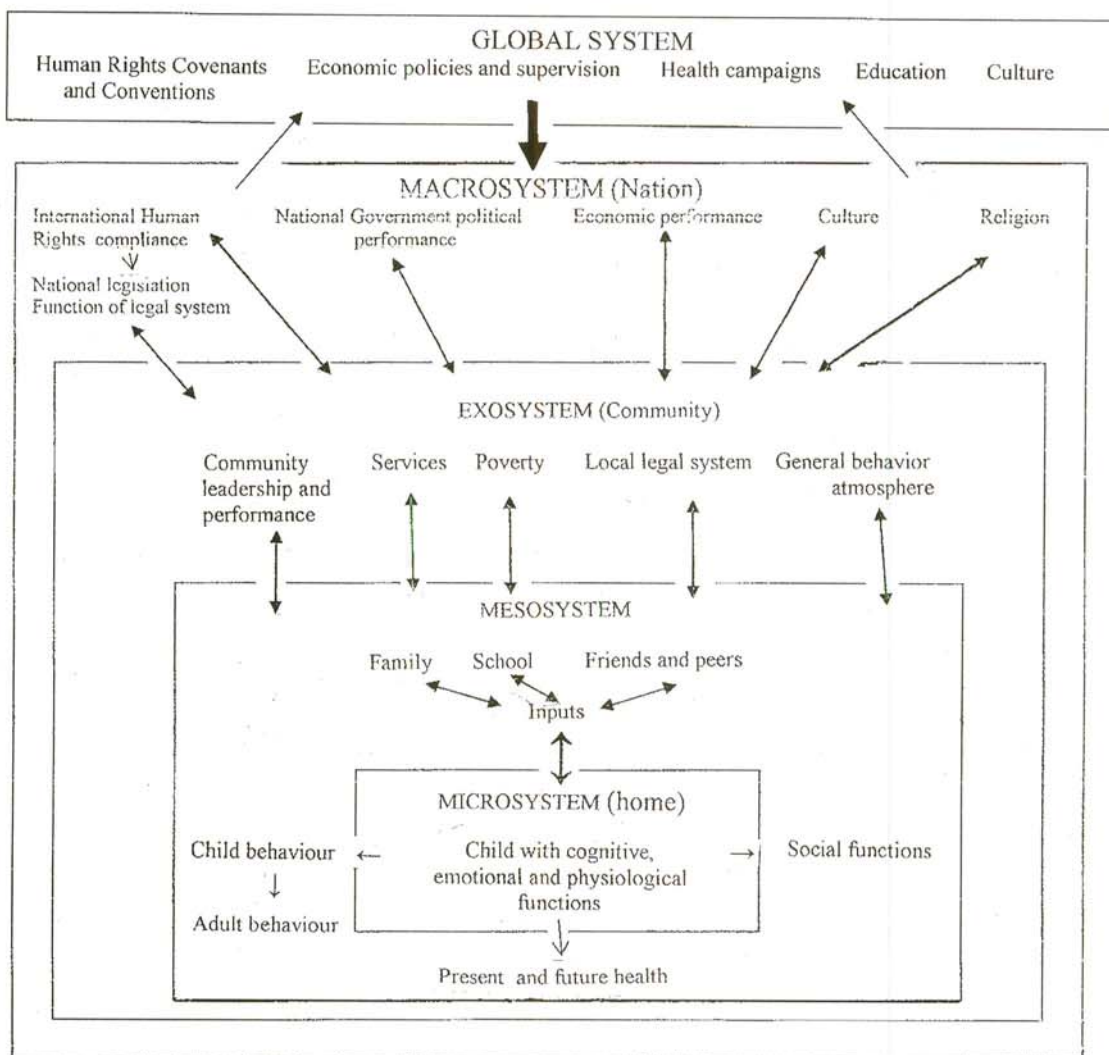
(b) Downstream interaction by the global system may include assistance to governments or regions (macrosystems) to eradicate poverty, as this is a main factor causing childhood maltreatment; knowing the global extent of such violence governments (macrosystems) may include pre-parent training programmes (proposed by a global agency, such as UNESCO) in the national school curriculum. Downstream interaction may also involve enforcing the implementation of global level human rights laws, leading to their integration in national

constitutions and laws (by the macrosystem) to be applied by the judicial system at the community (exosystem) and by legal referral levels;

(c) Parallel interactions might include the inter-exosystems, such as transfers of knowledge and skills needed for the setting up of community mobilization programmes, or international cooperation between neighbour countries to develop jointly technical personnel (inter-macrosystems).

The five ecological systems mentioned above all affect directly or indirectly our children: their behaviour, their social functions and health. They are the determinants of form, function and future of human cultures and social systems.

**Fig 1.1. Human ecology systems, schema of interactions**  
(based on Bronfenbrenner)



**The micro-and mesosystems – child, home, family, school, friends**

(a) The evidence is that about half of all children living in their immediate 'toxic' human environment become victims of sexual and/or physical and/or emotional abuse. Moreover,

millions are neglected, abandoned or assassinated. The main perpetrators are the parents; most of this violence occurs in the developing countries; can this be explained?

We need to open our minds to see the extent of frustration in the parents' human and physical environment: their poverty and hunger (most poor people own no land; many have just seasonal work), the lack of help when they are sick, their grief when close relatives and friends suddenly die from unexplained causes, and the miserable quality of education they have received. Women are often overburdened by work and frequent childbirths; they also have many chronic health conditions: recurrent fevers, anaemia, back and joint pains, toothache, gynaecological problems, depression and general tiredness. These factors influence their inter-action with their children. We need to appreciate what it means to live in an environment of general violence and insecurity where many (sometimes even women and children) carry a knife ready for attack or defence. Millions of people in small communities are raided repeatedly by armies and vigilantes. They passively watch the arriving fighters burning their houses, raping the women, killing the men and kidnapping the children. Furthermore, we need to recognize their feelings of powerlessness in the face of an inactive and corrupted – if it exists at all – judicial system. We need to comprehend the long-term effects of their failing struggle to keep hope alive, as they cannot see any signs of a better future.

Many parents live in loveless marriages or partnerships (a large proportion are consanguineous) arranged by others. This is one more explanation for the very high frequency of partner and child abuse, of prostitution and promiscuity. When poor people's debts to moneylenders and gamblers reach insurmountable levels, each year over a million of them sell their children to traffickers; these parents can have no illusions about their fates. When the man – frustrated by so many worries: lack of income, no food for the family, no money for his children to go to school – has lost his self-respect, he may seek to drown his sorrows in alcohol (often brewed by the women) or drugs. Then, what we see is a vicious circle, further increasing the violence.

Knowing these features of the human ecology, we may perhaps better understand – although not excuse – the extent of aggression towards defenceless children by their parents. Less understandable is the fact that frustrated abusers are also from better-educated upper and middle classes, and may live in the economically more developed regions. These parents may have been abused during their childhood; there may be conflicts at the work, marital problems, and alcohol and drug abuse. Both victims and perpetrators hide most child maltreatment; when revealed, it is a cause for denial, embarrassment and disbelief.

The children's friends and peers play a role in inspiring the abuse carried out by underage perpetrators. Some of this abuse is homosexual, especially when premarital contacts between boys and girls are forbidden and severely punished. Many schoolteachers in the developing countries are physically, sexually and emotionally abusive of their pupils. Several millions of especially vulnerable children exist: those with disabilities and those who live without parents, outside the 'normal' mesosystem: in residential institutions, as child soldiers, on the street, working in the worst labour conditions, in refugee camps, in prisons and as prostitutes. They are targets for very extensive abuse. Gendercide is common in some countries.

(b) The chronic consequences for the victims of childhood violence are extensive; affecting over a billion surviving children and adults in the world. The most common mental disorders are post-traumatic stress disorder, anxiety, depression, phobias, conduct disorder, borderline personality disorders and cognitive impairments. Victims adopt health-risk behaviours (alcohol, tobacco and illicit drugs), anti-social behaviour (aggression and delinquency),



promiscuity; they experience poor self-esteem, fear, nightmares, and some attempt or commit suicide. Their behaviour often leads to social ostracism; thus, they often choose to join groups or gangs outside the 'normal' environment, or just run away. Many victims have somatic consequences: fractures, head injuries, burns, bleedings, spinal cord injury and, the cruellest: 135 million women are sexually mutilated.

When they reach adulthood, the childhood victims have an increased risk for many common somatic diseases: ischemic heart disease, stroke, chronic obstructive pulmonary disease, hepatitis, gastro-intestinal and gynaecological disorders, chronic headache, obesity and so on. Their mortality rates are higher than those of non-abused people. Most of them remain in their meso- and exosystem with little or no health care or social support. Their impaired work capacity has serious economic consequences.

The health and social consequences for the victims have large-scale secondary effects on the family members; for example: anxiety, depression, fatigue, role impairments, increased work load at home, decreases in productivity and creativity, decreased incomes, social isolation, and/or family disruption. In a study of US residents by Kessler *et al.* (1995)<sup>5</sup> 61% of men and 51% of women experienced some traumatic event, including rape, molestation, physical attacks, combat, shock, threat with a weapon, accident, natural disaster with fire, witnessing gross violence, neglect, physical abuse and other qualifying trauma. For about half of those, there had been more than one such trauma. Although there appear to be few published studies on the secondary effects for families (mesosystem), one gets the impression that most families in the world have to cope with some of these secondary effects.

(c) Violence not only brings suffering to all its victims; it also creates feelings of helplessness, because others control one's destiny and the victim is often unable to escape from the continuation of maltreatment. It creates normlessness, because of distrust in the legal system when perpetrators enjoy impunity. Violence creates social isolation, because often it is taboo to mention one's violent experiences to others; and when nobody knows, nobody helps. Moreover, violence causes loss of faith in people in positions of trust or responsibility who are supposed to offer protection. For these reasons, action to prevent violence should be given high priority and visibility in all development programmes. Most people will be shocked to learn that childhood violence is so frequent, that it has such severe consequences, and that so little has been, and is being, done to prevent it.

(d) Let us now look at the *parallel* ecological interactions taking place at the micro- and mesosystems. Do other people, networks of friends, neighbour families, schoolmates or teachers have knowledge of the existing abuse, and will they help? Mostly not, because the truth remains hidden, and most victims do not tell anything until they are adults. The willingness to help is certainly there. Resilience exists, mostly when victims found confidants.

(e) The knowledge of the extent of childhood violence (experienced at microsystems) could lead to *upstream* realization of the need to strengthen health services (provided at the level of the exosystem), government programmes for prevention (through the macrosystem), and initiatives to provide grants from donor nations for such programmes (global system).

However, upstream communications are mostly thin. Community leaders and local organizations for health, social support and schools do not initiate sufficient action, as they are unaware of the real extent of violence against children. Macrosystems do not react as they should for several reasons: they accept physical and emotional abuse as part of 'normal education' (and it is legal in most countries), and they hear little about sexual abuse. In addition, their direct contacts with the realities of 'ordinary people' are often restricted or superficial.

(f) Hundreds of books have been published about and by child abusers and their victims: from Mark Twain, Charles Dickens, André Gide, Thomas Mann, Stephen King, to Jan Guillou

and Carylson Lehman. These authors have contributed to create upstream consciousness about the anguish of maltreated children and about the indifference of the meso- or exosystems in which they are abused. Analyses in some books have thrown light on the background of cruel dictators: Adolf Hitler, Joseph Stalin and Mao Zedong (Miller, 2002)<sup>3</sup>.

### **The exosystem (the community)**

The abuse of children at the micro-and mesosystems does not take place in a vacuum. In many countries, it often exists together with a pattern of incompetence, chaos and non-action by exosystem leaders facing and not knowing how to cope with a socially toxic society. The performance of the community leaders is sometimes excellent, but many exhibit indifference, obstruction, nepotism and corruption. Many human ecological, unresolved deficiencies of the exosystem directly or indirectly contribute to the continuation of childhood violence. There is not enough interaction between the grassroots and the exosystem, because:

(a) Effective, community-based violence prevention is lacking.

(b) The exosystems health services are insufficient, inaccessible or unavailable to assist the victims: between 36% and 50% of even serious cases of mental disorder (such as psychoses) do not now receive treatment even in the developed countries; for the developing ones, the rates are 77% to 85%. Treatments and rehabilitation of the victims are insufficient everywhere in the developing countries. This ecological problem further impairs the health of the victims.

(c) Community social personnel who intervene in cases of child abuse or neglect are often perceived as exercising impersonal police control rather than trying to help in a friendly way.

(d) Many are poor live in exosystems with major unresolved problems: lack of food, clean water, sewers, garbage disposal, proper roads, electricity, communication and so on. Among them are many families who have used land for centuries but do not have a legal title to it, and thus cannot get bank loans to increase the agricultural production. Banks (if they exist at all in developing countries' communities) have little or no venture capital for the poor. The – mostly unchecked – population growth adds to the lack of land, to the poverty and to the high mortality and morbidity rates among infants and pregnant mothers. It also adds to the pressure to urbanization (50% of the world's population now live in cities), moving them into extremely poor, unhygienic, highly polluted, crowded and unsafe marginal environments. These factors contribute to peoples' frustration, leading to community aggression and to child violence, abandonment and assassination.

(e) The education provided by the exosystem in developing countries is of poor quality. Instead of being a tool for liberation, enlightenment, and conscience-raising, it has often remained as an instrument of oppression by the elite leading to the creation of a caste of obedient serfs. Parents and teachers – unaware of the damage they cause – commonly resort to stiff physical and psychological punishment to instil obedience.

(f) The judicial exosystem – the police, the prosecutors, the judges – often malfunctions and there are few advocates to assist the poor. For the poor, the neglect of their lawful rights is a clear reality. Their experience of seeking justice often leads them to give up; those in power will “always win” by corruption or by the use of personal influence. This explains, among other things, the impunity enjoyed by those who are trusted by the defenceless children and who misuse their authority.

(g) Local leaders in the developing countries often fail to react in an appropriate manner to child violence in their communities, for instance, by introducing child watch schemes, improving the ‘social components’ of education or by reining in the local production of alcohol and the use of illicit drugs.

(h) Successful development is generated in exosystems (communities), which benefit from local mobilization programmes, especially when they are part of a macrosystem (national)

policy. The legal rights to raise and spend local taxes are of utmost importance for the economic, educational and social development of communities. These rights transfer the initiatives, legal responsibility, decision-making and ownership of the development programmes to local people. However, most countries have a long way to go to ensure the degree of independence that allows community leaders and councils to take their own action to meet the expressed needs of their people. The few examples set up to prevent childhood violence through adequate pre-parent education and home visits have been very successful.

(i) *Parallel* interactions could include the inter-exosystems, such as transfers of knowledge and skills needed for modernizing education, the setting up of community mobilization programmes, and judicial systems.

### **The macrosystem – national level**

The macrosystem has many functions, and their leaders vast responsibilities, some of them directly related to the human ecology of childhood violence. These functions are impeded by a host of problems, especially visible in the developing regions.

(a) The quality of governance in the developing countries is low and in most of them is decreasing. The World Bank (Kaufmann and Kraay, 2007) in 1996 introduced a scale rated from 0-100 to measure six dimensions showing the quality of governance. Individual assessments were made every other year individually for some 200 countries and territories. The World Bank's calculations indicate that from 1996-2006 the quality of Governance – which already at the start of the project was very low – declined or halted for 80% of all people in the developing countries. Such nation-building can hardly be rated as a success, and failure in the quality of governance negatively influences the quality of children's lives.

(b) The national politicians' and bureaucrats' dialogue with people at the grassroots is meagre.

(c) Poverty is the over-riding, mainly unsolved problem. The economic performance has been impressive in some countries, among them China and India (which together have one third of the world population). Still, the added income has mainly benefited the growing upper and middle classes; many poor are still left well behind. The economic inequalities are growing. Governments' budgets to cope with social issues are insufficient. Child neglect is everywhere accompanying poverty, corrective action is totally insufficient and the future consequences grave.

(d) There are many visible and many hidden ecological societal problems in countries composed of several ethnic, religious and political groups, tribes, clans and castes. There are often large economic, educational, social and political differences between them. The real or perceived lack of equality and the quest for power leads to hostilities, armed conflicts, religious persecution and racism. 'Vigilantes' and organized rebel armies, such as those in Algeria, Angola, Bosnia, Colombia, Congo, Ecuador, Guatemala, Guinea-Bissau, Iraq, Kenya, Kosovo, Lebanon, Mozambique, Nepal, Nicaragua, Nigeria, Northern Ireland, Peru, the Philippines, Russia, Rwanda, Sierra Leone, Somalia, Sri Lanka, South Africa, Tanzania, Timor Leste, and Uganda have caused violent intra-national conflicts. Several hundreds of 'wars' have taken place since the 1950s, creating a widespread atmosphere of terror, violence and insecurity: overall half of the dead and injured victims are children.

(e) Macrosystems have been largely unsuccessful in dealing with child prostitution, street children, beggars, child labour, abandonment of children, trafficking of children, people-smuggling, crime, alcoholism and substance abuse, reducing the access to weapons, coping with cruel, inhuman and degrading treatment and of continuing abuse of illicit drugs even in closed residential institutions and prisons.

(f) The national legal systems continue to be afflicted by slowness and corruption. Self-amnesty and impunity are troubling confirmations of the power the elite exercises over justice at the expense of the poor. The compliance is low or non-existent when it comes to important Human Rights, such as those related to the UN Child and Torture Conventions.

(g) The national education systems are in crisis. Although there have been some increases in primary school attendance, many children still do not complete the legal minimum of schooling. The training of teachers is insufficient. Secondary and tertiary education needs new direction; there is a lack of cooperation with national enterprises and the civil society.

(h) Health policies are not yet fully developed in many countries. Services are under-budgeted and according to WHO, a quarter of the poor in developing countries still lack primary health care.

(i) Cultural and religious forces in all countries should be mobilized to prevent childhood violence, but not much is seen of them. Non-governmental organizations are active, but their funds or personnel only allow them to scratch the surface. In some countries, they are unwelcome.

(j) Preserving the national culture from foreign and national pollution with media violence is important, but appears hard to resist because of the money involved.

(k) *Parallel* international cooperation between neighbour countries (inter-macrosystems) to develop jointly technical and managerial personnel is taking place; but needs expansion. Economic cooperation is developing fast in many regions; trade is growing and could lead to increases of the national resources to deal with the problems mentioned above.

### **The global system**

Many important international policies and programmes aimed at improving the human ecology are mediated through the United Nations organizations. They were designed to have important *downstream* effects.

(a) The first act of the U.N. was to formulate the Universal Declaration on Human Rights. It then took 20 years (to 1966) of heated disputes, watering down and wrangles over the formulations before the ratification of detailed legal treaties could even begin. The implementation of the treaties has been only partly successful. States known for their non-compliance with the international law have for years paralyzed decision-making in the Geneva-based Human Rights Commission, resulting in a "credibility deficit...which casts a shadow on the reputation of the U.N. system as a whole" (U.N. Secretary- General, 2005).

Such a massive failure has *downstream* human ecological effects – it cast shadows directly over the judicial macrosystem and indirectly over the exosystem. The experience that international laws do not have to be followed has a toxic influence over the application of national laws. 80% of all children are now denied the protection against abuse offered by international inspections. It strengthens the view that childhood violence may continue with impunity. Political leaders – role models for whole countries – are allowed to declare their non-adherence to core parts of the international law and act as they see useful for their own careers. There are no adverse consequences for them.

There is no doubt that had the U.N. Human Rights covenants and conventions been adopted with sincerity everywhere – they would have prevented a major proportion of the abuse that victimizes children today. Compliance with these laws would have reduced the arrogance and indifference – shown by many political leaders – to the victimization of the defenceless. The failures of the Human Rights system have large *downstream* effects, including for the environment of the children – the microsystem. It is urgent to better integrate the international law system in national constitutions and laws (by the macrosystem) to be applied by the judicial system at the community (exosystem) and by legal referral levels.

(b) Another global system initiative has been to provide funds for economic development: to “eradicate poverty”. However, the conclusion by the World Bank’s economists is that there is “no evidence that aid promotes growth even in good policy environments” (Burnside et al., 2000; Easterly et al., 2004). The reason for this international failure is above all that the funds provided by the rich countries have been too small to make any significant results. In spite of 50 years of international grants and loans amounting to US\$ 2.3 trillion (Easterly, 2005), close to 3,000 million poor people continue to be deprived of the bare necessities of life. “Structural neglect” – which is not caused by care-givers – but results from poverty (p.13) still concerns over one billion children. It does not seem realistic to believe that the failed global policies and programmes will change in the near future. The responsible organizations are seen to constantly increase their staffs and budgets, although the evidence – carefully managed by the stakeholders, so it will appear undisputed – would indicate that the programmes built on the chosen unique orthodox economic model for development do not and will not work.

One favourite idea is that a major poverty reduction will result from fair trade (as defined by WTO). Firstly, the economic gains were initially overestimated; secondly, the gains of increased trade are unlikely to reach the poor directly; thirdly, the trade negotiations have reached a dead point.

Another feature of global influence is the institutional control (the International Monetary Fund, the World Bank and the World Trade Organization) of economic development dominated by the rich countries. This has been severely criticized by many economists and by many developing countries, and has had damaging *downstream* effects (Stiglitz, 2002).

(c) International health campaigns have had several great successes, among them the eradication of smallpox and polio. These have been helpful examples for how countries can manage large-scale preventive systems. Further efforts are taking place for AIDS, malaria and tuberculosis. General health service development has, however, been slow – a reflection of lack of funds.

(d) Education needs much more support through international aid. It is unlikely that we will see much community development as long as education in the developing countries focuses on the primary level and does not send more students to the secondary and tertiary levels.

(e) The question of culture preservation is important. By exportation, the rich countries influence many aspects of daily life and culture in the poor and dependent countries: what people eat and drink, how they dress, the amounts of violence and sex they see on television and at the cinema, the music they listen to, the software they use, the toys and games that children have, and so forth. Poor and proud nations see their own language and traditions being submerged under the threats of an ever expanding and superior selling of imitations of foreign culture. Certainly, these transfers influence all the human ecology systems down to the micro level.

(f) *Downstream* interaction by the global system may include help to governments or regions (macrosystems) to eradicate poverty, as this is a main factor causing childhood violence. Knowing the global extent of such violence, global efforts should help governments (macrosystems) to set up and maintain pre-parent-training programmes and other child defence and support programmes in the national school curriculum. The necessity of improving the management competence in the recipient countries has not received enough attention.

Before presenting the evidence, a review will be made in Chapter 2 about the materials and methods of the published and informal information, on which the conclusions of this book are based. Chapter 3 will provide a short historical background.

## 2 Definitions, Materials and Methods

### DEFINITIONS

#### Definitions of violence and related behaviours

The definition of violence in this book is that of article 19 of the U.N. Convention on the Rights of the Child: "all forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse".

The following detailed definitions are by WHO (2002) and represent the international consensus for their use:

- Child sexual abuse (CSA) as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by the activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to: a) The inducement or coercion of a child to engage in any unlawful sexual activity, b) The exploitative use of a child in prostitution or other unlawful sexual practices, c) The exploitative use of children in pornographic performances and materials.

- Physical abuse in children is: that which results in actual not potential physical harm from an interaction or lack of interaction which is reasonably within the control of a parent or in a position of responsibility, power or trust. There may be single or repeated incidents.

- Emotional/psychological abuse: includes the failure to provide a developmentally appropriate, supportive environment, including...a primary attachment figure, so that the child can develop a stable and full range of emotional and social competencies commensurate with her or his personal potentials and in the context of the society in which the child dwells...acts towards the child /may/ cause ...harm to the child's health or physical, mental spiritual, moral or social development. These acts must be reasonably within the control of the parent or person in a relationship of responsibility, trust or power. Acts include restriction of movement, patterns of belittling, denigrating, scapegoating, threatening, scaring, discriminating, ridiculing or other forms of hostile and rejecting treatment

- Commercial or other exploitation of a child refers to the use of the child in work, or other activities for the benefit of others. This includes, but is not limited to, child labour and child prostitution. These activities are to the detriment of the child's physical and mental health, education, or spiritual, moral or social-emotional development.

- Care neglect is the failure of an adult caregiver to provide for the development of the child in terms of health, nutrition, shelter and safe living conditions, nurturing and emotional attachments, education and the opportunity for self actualization, in the presence of available and adequate resources.

- To this is added "structural neglect", which is the failure of the society, (macro-and global systems) to provide health care, nutrition, education, shelter, safe living and other conditions necessary for the development of the child. Most of this is related to poverty.

Some comments about the cultural aspects of these definitions follow. Children live in microsystems with rules dictated by cultures. For example, the perception of sexual abuse is very different in Western societies compared to many developing countries, where men and women; and indeed boys and girls never touch anyone of the other gender, unless it is a member of the same family. Verbal sexual harassment has recently become criminal in some Western societies, but has for many years been a taboo in less developed regions. The author has followed the WHO definition and in the prevalence estimates accepted definitions which mirror the local perceptions and cultural taboos. Peer abuse is in some cultures very common; it has not received enough attention (see p.56, Box 7.1.). Contact abusive incidents are by many researchers regularly seen as more severe than those with no contact. However, the latter may be highly terrifying; for instance, if a child was chased by a threatening exhibitionist, or witnessed the father severely assaulting the mother, or saw a classmate being viciously and unfairly humiliated by a teacher, or witnessed how a friend was beaten up and then sexually abused. Classifications need to be complemented with an assessment of how traumatic the incidence was to the child.

### **Definitions of mental disorders**

In this book, many mental disorders will be discussed. Diagnoses of mental disorders are frequently ascertained using standardized, thoroughly tested questionnaires such as CIDI (The Composite International Diagnostic Interview, Robins et al, 1988). Most results quoted are based on these techniques. The diagnoses of these disorders are universally standardized and appear in the *Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (APA)*; its latest version appeared in 1994 (DSM-IV), and in the *International Classification of Diagnoses (ICD-X)*, by the World Health Organization. The system represented by these two repositories is not definitive and has been criticized for being neither exclusive nor exhaustive. It does not sufficiently recognize that illness is a quantitative problem; there might be no clear break-off point between disorder/no disorder. A description of an 'unusual' behaviour or cluster of such behaviours should preferably not be labelled with a diagnosis without being anchored in an organic/somatic context. DSM-IV diagnoses appear to focus on antisocial behaviours rather than personality traits central to traditional conceptions. British Medical Journal (13/4 2002) states in an editorial: "the concept of what is and what is not a disease is extremely slippery", we should be aware of the risk for over-medicalization. Some symptoms seen as mental disorders, such as anxiety and depression may be completely normal reactions to frustrating life events.

### **Definition of disability**

According to WHO (2001b) disability is "an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environment and personal factors)." Definitions of disability are not globally standardized; neither are they – using WHO's system – straightforward to define; thus conclusions on prevalence are not easy. The WHO system which claims "to provide a scientific basis for understanding and studying health and health-related states, outcomes and determinants" on a "universal" scale (it includes a selection of environmental factors) but does not mention childhood violence, abuse, neglect, criminal behaviour, poverty or hunger; and malnutrition receives three words under "weight maintenance functions".

Many disabilities relate to environmental factors, of which poverty and hunger are the most important. For over one billion children these are combined with poor health; and about one fourth of them still lack primary health care. Hunger affects over 300 million children every

day; many more if droughts or floods or pests destroy their crops. 170 million children are underweight at the age of five and many grow up with stunted growth and reduced physical fitness. Poverty and hunger are traumatic and contribute to reduced capacity at school and work: impairments leading to functional limitations. Other environmental constraints – participation restrictions – may contribute to disability: gender bias, cultural and social status systems, lack of physical access and access to opportunities, ethnical differences and finally, the political and judicial power structures over which the ‘defenceless’ have no influence.

Very large numbers of people underachieve because of a health condition. Some persons with ‘hidden’ disabilities may appear, superficially, to function normally at work, in their families and in social contacts. However, on using deeper analysis, they may be found with significant role impairments (such as decreased quality and creativity at work, disturbed relations with their family members and friends, and so on) caused by mental and somatic disorders; for others the causes may be related to daily frustrations, poverty and hunger. The global estimates of the disabling consequences of childhood violence appear in Chapter 8.

### **Socio-economic definitions**

The operational definitions used in this book are:

- Evolution is the process of observed change in single sectors: such as the macro-economy, industrial innovations, communication networks, agriculture yields per hectare, polio eradication
- Development means the combined results – both positive and negative – of all evolutions, including, for instance, economic outcomes for the poor, human and physical ecological consequences, social restructuring;
- Progress means advancement towards a set of desirable goals, such as quality of life or happiness. Such goals are mainly seen as non-monetary. Do I as a person have opportunities for self-realization? Are my opinions, rights and freedoms respected? Are the members of my family and my friends getting on well; are they healthy and secure? Are we happier? Evaluating global progress includes analyzing the human perceptions of the totality of development effects resulting from all evolutions, including the quality of governance. Were others’ and mine goals met? Did humanity as a whole benefit or lose? Some people perceive progress during their lifetime as a zero-sum game, with losses in human dignity and a combination of decreasing compliance with human rights and escalating violence and terrorism outweighing the evolution in technology and economic growth.

## **MATERIALS AND METHODS**

The information in this book of the prevalence of abuse, neglect and violence has been collected from a large number of sources in 151 countries during 1974-2007<sup>1</sup>. The main difficulty from the beginning was to find reliable information in the developing countries. In many developing countries, surveys on childhood violence are still limited and not always built on representative samples. Published papers are mostly from countries with a tradition of research grants, and the recipient of a grant will seek publicity in one of the many journals which have developed as ‘a service’ for the ‘research industry’. But, in the developing countries, there are few such grants, and even specialists with a solid knowledge do not publish much. Also, publications from developing countries are not always included in the literature data bases.

In the preface, I recorded some personal observations from visits to 91 countries during the period 1974 to 2006. These were complemented with direct information from the participants from 90 countries who attended special management courses. Specific information about



prevalence and other related subjects were collected by screening *PubMed* articles from October 1963 to July 2007 on “child abuse”. The search yielded some 19,000 publications. From this ‘primary’ group of identified articles, cross-references were researched. Other sources include anthropological, economic, ecological, human rights, legal, psychological, counselling, health care, educational (ERIC database), diplomatic, newspapers, political and social books, articles and reports. Several important ones originate from the Injuries and Violence Prevention (WHO, 2002, 2004 a, b) and the Global Burden of Disease Programmes at WHO (Lopez *et al.*, 2006). Many unpublished reports from developing countries have been screened. Altogether close to 20,000 publications and reports have been reviewed (most of them published in peer-reviewed journals). Most of these originated in the USA. In some there are only indicative data; others represent carefully designed and analysed scientific contributions. I have not sought to give a full presentation of all information, methods, or problems of coding in each of all these documents, there are just too many. The trend in published data during the last 40 years is that reported prevalence rates of childhood violence have mostly been increasing, especially in the developing countries. When choosing which data to include, I considered the methods used, the size of the sample and the response rate.

There are also official sources of population data, special surveys (such as on poverty, health, education, disability, macroeconomic reports and other statistics) provided by many countries and by international organizations. Some child protection agencies, health services, institutions and hospitals and school health personnel keep records of child health, maltreatment, social and family problems. Alleged crimes against children are reported to the police. Some offenders are punished; such crimes are in many countries accounted for in their annual Justice Department statistics. Some such services do publish reports from which information can be retrieved. Many such reports, however, are not easily available, especially in developing countries, and knowledge about them can sometimes only be collected through country visits and personal contacts.

The primary purposes of the search related to childhood violence was to

- identify information that would lead to an assessment of the global number of victims,
- estimate the resulting health, social and economic consequences,
- analyze its causes and contributors,
- review interventions, actions and programmes for prevention and care.

### **Reliability of information**

The texts contain many estimates, based on published data. There are several methodological issues regarding the reliability of the results presented.

#### Official reports

Violence occurs everywhere: in the home, in schools, working environments, day-care or residential institutions, and public places; few of these possible sources collect and present data. Thus, country studies, patient files from hospitals, school reviews of violence, police reports, court records about convictions, criminological research do reflect part of the realities; but these sources commonly underreport. In Ireland, for example, in 1996, only two cases of child cruelty and neglect were reported to the police. In comparison, the Department of Health in Ireland received 903 such reports during the same year (European Forum for Child Welfare, 1998). In Canada (Macmillan *et al.*, 2003), a study was made of a random sample of 9,953 children to record their histories of maltreatment and contacts with the Child Protection Services in Ontario. Only 5.1% of those with a history of physical abuse and 8.7% of those with a history of sexual abuse were known to the Child Protection Agency. Some violent acts

are not criminal everywhere, hence they are not reported in some countries; for instance, physical abuse of family members (beating wives and children) is not routinely considered a crime or even disapproved. In Nigeria (Ovediran and Isiugo-Abanihe, 2005), for example, a large survey of married women found 66% of them expressing approval of wife beating (including punishment for burning food and not cooking on time).

The underestimations depend partly on the taboos; the truth is hidden and uncomfortable. Most survivors do not want to disclose the abuse to anybody because a member of their family was involved. Any reference to haunting memories is for them traumatic and increases the survivor's feelings of anxiety, stigma, shame and fear and may upset other people important to the survivor. These factors lead to drop-outs from study cohorts; almost all published articles do have a relatively high frequency of non-responders.

#### Surveys: representativity

It is common to find that most surveys have been made on non-institutionalized persons. In many developed countries, however, large number of persons are in institutions: prisons, special treatment institutions for alcoholics and drug addicts, nursing homes, shelters for those who have lived of the street or for abused women, special boarding schools for children with behaviour problems, residential homes for children who have been removed from the custody of the biological parents or have a disability. In developing countries, especially in large cities it is common to find thousands of people sleeping on the streets, in railway and metro stations, in parks, and other public places – they are unlikely to be included in “ordinary” surveys, as they have no fixed address and no telephone. If the purpose of the surveys is to identify health and social problems in order to design interventions, these groups cannot be excluded.

One conclusion in this book is that every other now living person has been a victim of childhood violence. In most surveys, comparisons are made between a group of victims and a control group of non-victims. As denial of childhood abuse is so common, there is a risk that control groups may be ‘contaminated’ and include persons with undeclared, hidden adverse childhood experiences.

#### Surveys: validity of techniques.

Survey techniques mostly consist of interviews, telephone contacts, or requests to fill out questionnaires. The latter are often very well developed and tested in North America and Western Europe. We have, however, to realize that what are measured are admissions of child abuse and not the incidents. Some of these are to be filled out in front of the surveyor (I have observed instances when the surveyor was a care-giver in a residential institution, in which case the children would not mention any of the institution's personnel among the abusers); others are self-administered, or they may be sent by mail with a response envelope enclosed. In the rush to get results many standardized questionnaires are translated literally and used with a minimum of preparations in the developing countries. This leads to many problems of misunderstanding. Abuse is never even mentioned by most people in the developing countries. Questionnaires should not be used without careful testing and analysis of every word. It is common to see Western scientists going to a developing country with one or several questionnaires and then discussing them with a local “expert”. I have a very long experience of such discussions. The final impression is that in these countries, even University professors seldom question anything that is proposed by Western scientists, and will rarely come up with any suggestions for change. The developing country counterpart will just be happy to get a chance to co-author a publication.

Some questionnaires undergo ‘improvements’ from time to time, so one cannot always compare the results of studies spaced several years apart. Also, similar questionnaires may be

used with change of interview techniques. One such example can be found in two studies by Straus and Gelles (1986). In 1975, they conducted the National Family Violence Survey to determine the incidence of child abuse and spousal abuse in the United States. The results were based on one-hour-long face-to-face interviews of parents in 1,146 households; the response rate was 65%. In 1985, they conducted a second survey (the National Family Violence Re-Survey) to update their findings. This time the results were based on 35-minute telephone interviews of parents in 1,428 households, the response rate was 85%. Their most striking discovery was that child abuse (which they defined as kicking, biting, punching, beating, threatening with a gun or knife, or using a gun or knife) had declined by 47% among two-parent families with at least one child aged 3 to 17. There were thirty-six incidents of child abuse per thousand children in 1975, but only nineteen per thousand children in 1985. Straus and Gelles had two alternatives for interpretation: (a) child abuse had decreased over that ten-year-period, or (b) respondents were more reluctant to admit to child abuse in 1985 than in 1975. Interestingly, the authors stated that “the differences in methodology should have led to higher, not lower, rates of reported violence, because (a) a telephone interview offers more anonymity and “leads to more truthfulness” , and (b) the response rate was higher and “a higher response rate tends to produce a higher rate of violence”. Their study is an interesting example of the methodological difficulties. One cannot compare face-to-face interviews with telephone calls (with the calls lasting 35 minutes while the interviews were for 60 minutes) Many poor and marginal people do not have a telephone and so the second sample may be biased. The basis for the belief that “anonymous” telephone calls would extract more of the truth may not be based on proper evidence. First, none of these calls are anonymous; the interviewer has the telephone number, and name of the family contacted, and may even tape-record the conversation. Second, a counterweight to truthfulness during the period 1975-85: it had become more commonly known in USA that many professionals are by law obliged to report crimes to the police; thus some respondents who feel uncomfortable with the police will not reveal crimes.

Regarding the veracity of retrospective reporting there are different opinions, but it appears unlikely that any significant proportion of violent incidences is invented; denial is more common than fabrication. A discussion on memory accuracy appears in Chapter 8.

#### Surveys: non-response rates

It is important to know all the consequences of childhood abuse and violence. The results published have several problems, increasing the likelihood of a high non-response rate, among them:

- (1) mortality (suicides, accidents, murder, diseases, alcoholism and drug abuse),
- (2) social and economic situation (poverty, unemployment, homeless, in institutions, prisoners, low literacy, intimidation, alcohol and substance abusers), depresses the likelihood of response
- (3) subject seen as too sensitive or taboo,
- (4) attempts or threats of abuse are not always taken seriously, therefore not considered worth mentioning or not identified by people as relevant,
- (5) a large proportion of the victims never mention the abuse to anybody.

A Swedish study (Swedin and Back, 2003) report on 30 children who had been exploited in the production of child pornography films. The average duration of the abusive acts was 22 months. Five children were drugged at the time of victimization, two were too young to understand what happened, but 23 were old enough and fully capable of describing the crime in detail. None of them spontaneously told anybody.

These factors influence the prevalence estimates in child violence surveys. Most experts agree that over-reporting of sexual abuse in developing countries is very uncommon, because of the resulting stigmatization.

It is common to find high attrition rates. Some studies show 50% non-responders or more. An example of the difficulties can be seen in Dunne and co-workers' Australian study (2003) at which 4,449 adults aged 18-59 were drawn from the electoral roll (which itself may not be complete). For 69% (=3,070) of them there was a valid telephone number. These persons were contacted and 61% (=1,873) agreed to participate in the interviews. Finally, after even more attrition 1,784 persons took part in the interviews. Thus, the dropout was 60% (2,665 of 4,449) of the original sample. Dunne *et al.* state: "the volunteers are broadly representative; of course it is not possible to know whether the sexual experience of the participants differed from the global population". When there is attrition, most scientists just look at the non-responders' age, gender and racial distribution, but do not screen school, social and criminal records, or try again. In spite of this important attrition rate, Dunne *et al.* reported 19.6% of the men and 25% of the women had experienced at least one incidence of non-penetrative, sexual body contact, 4% of the men and 12% of the women a penetrative experience. Supplementary studies of non-responders are needed.

It is well known that dropouts from statistical samples – especially those who do not have a telephone or a permanent address – are over-represented by persons who have previous criminal records and/or ongoing social problems with high prevalence of alcohol and substance abuse, unemployment and permanent homelessness. A United States economic long-term study (Fitzgerald *et al.*, 1998) showed that attrition is highly selective and is concentrated among those with unstable earnings, marriage and migration histories.

Many victims are afraid to report sexual assault to the police. In a US study Fitzgerald, Gottschalk and Moffitt (1998) noted the following reasons:

- further victimization by the offender;
- other forms of retribution by the offender or by the offender's friends or family;
- arrest, prosecution, and incarceration of an offender who may be a family member or friend and on whom the victim or others may depend;
- others finding out about the sexual assault (friends, family members, media, and the public);
- not being believed; and
- being traumatized by the criminal justice system response.

When studies with high attrition rates are presented, the data may seriously underestimate the prevalence of a health condition. When attrition rates are zero or very low many studies reveal higher prevalence rates of childhood violence as shown in Box 2.1.

#### **Box 2.1. Results of reported childhood violence when there are no or very low numbers of non-responders.**

Many studies reviewed in this book report abuse rates around 15%-20%; (for each of sexual and physical abuse). When the attrition is low, reporting rates of abuse are often substantially higher than the 15%-20% range. Himelein and McElrath (1996), who had a response rate of 97%, found that 26% of college women reported a history of contact child sexual abuse (CSA) ranging from fondling to rape. In the Cáceres *et al.* (2000) study in Peru where the supervisors (using a questionnaire) pointed out missing and contradictory answers to participants for revision, there was 98% participation in one group and 82% on the second group. Among those who had at least one sexual experience, males reported a 20% experience of

heterosexual lifetime coercion and the females a prevalence of 46%; for homosexual coercion it was 48% for the males and 41% for the females. In the Chen *et al.* (2004) study in Beijing there were no dropouts. 26% of the all-female participants had experienced sexual abuse before the age of 16 (at the median age of 12). High prevalence rates emerged from the Kim *et al.* (2000) study in China and the Republic of Korea. The group interviewed consisted of 4-6 grade (ages about 10-12 years) school children; there were no dropouts. Family violence during the last year had been experienced by 71% in China and in 69% of the children in Korea. The rates of corporal punishment by the teachers were 51% in China and 62% in Korea. In the Berrien *et al.* (1995) study (with 91% participation) of Russian school children severe physical abuse had victimized 29%. Finally, a large-scale Indian study of children aged 5-18 by Kacker (2007) with 96% response rate showed these prevalence: physical abuse experienced by 73% boys, 65% girls; sexual abuse by 48% boys, 39% girls and emotional abuse by 50% boys and 50% girls.

### **Socioeconomic and cultural factors influencing what is perceived as abuse and neglect**

For the reader unaccustomed to the situations in the developing countries a few general descriptions follow. Of course, these conditions show a very large variety.

#### Living conditions

Many children in developing countries live in extended families (with up to 50 members). The surroundings are often poor and contaminated with filth. Some 2 billion people lack basic sanitation and 1.5 billion have no access to clean and safe water. Electricity is rare in most rural areas, but is seen in marginal urban areas. The houses are often small, crowded and poorly constructed; they offer little protection against rains and storms. Most people sleep on the floor close to each other, perhaps on a thin mat. There may be lots of mosquitoes, flies, grasshoppers, stray dogs and cats, and large rats around. Winter heating in cold climates is very uncommon. The houses are sparsely furnished; kitchen equipment may consist of a few pots and pans, most people eat using their hands. Fire wood may be in very short supply. One quarter of all poor in developing countries do not have access to primary health care, and the quality of that care – when it exists – varies, with most of the staff concentrating on a short list of preventive measures; curative interventions are limited and rehabilitation virtually non-existent. Half of the world's pregnant women still lack access to skilled care at childbirth (World Health Organization, 2007).

130 million children do not attend school at all, and for many the drop-out rates are high, the quality of education poor and in some places teachers' absenteeism high. Books, papers, pens or writing materials at home are rare. School books remain in the school, so no studies can be carried out at home, – and besides most parents in poor countries are functionally illiterate. The family is usually ruled by someone with an iron hand, who makes most of the decisions. Children are brought up to be very obedient and loyal to the family.

Most poor families are very short of food and when eating males have precedence. What takes place in terms of violence against children and women is known by everybody, and so are the fights between men, women and children. Local alcoholic brews are made almost everywhere – mostly by women, using a variety of products: from bananas to corn to sorghum –; to many some local herbs may be added to such local brews (containing alkaloids that may cause temporary psychosis and aggression). When men consume such brews the result is increased domestic and community violence. Some 'beers' are distilled; these stronger drinks are often toxic and contain methanol, which causes brain damage and blindness. Maladaptive alcohol use is one of the root causes of domestic violence. Poor people in countries with culture of opium or cocaine growing are now increasingly using these drugs themselves

whereas they were formerly export commodities only. Gambling and therefore loss of essential family money or assets is common.

#### Women's position in society

Most tourists may know that a woman is not allowed to sit next to a Buddhist monk in a bus, and that patting children on the head is in some countries an unforgivable fault. Fewer may be aware of the fact that in many cultures a young girl of 12 who refuses to marry the man chosen by her parents (she may just be part of a business deal) will forever be stigmatized as severely mentally ill (although she is completely healthy) and may be unable to leave the house to go to the street, because other children will throw stones at her.

In most developing countries women are marginalized, many have little or no education, insufficient health care, may be barred from having their own property and inheritance, and play limited roles in politics. In many cultures, men cannot shake hands with women, and forcible kissing of women may be seen as sexual abuse; non-contact sexual abuse is frequently seen as serious sexual abuse (Kacker, 2007; Elbedour, 2006). Divorced and widowed women often face an uncertain future, they may lose care of their children and all of their belongings and many are abused and exploited by their family members.

In countries in the Middle East, Africa, and South Asia there is a tradition of arranged marriages to close relatives, most of them to first cousins. The proportion of consanguineous marriages varies from 20% to 60%; it is highest in rural areas. As, in some cultures, young boys' contacts with girls prior to marriage are forbidden; some homosexual pre-marital activities take the place of heterosexual ones; many underage boys are sodomized by their sexually frustrated older peers (Eskin *et al.*, 2005; Jekwes and Abrahams, 2002). In many cultures, homosexual practices are widespread, but their visibility is low. In many developing countries, boys and girls undergo initiation rites including physical, sexual and magic procedures that might be seen as abuse in Europe or North America. A girl who tries to escape from home with a boy-friend and who is caught may in some countries be stoned to death with the boy, even if there was no sexual intercourse. Members of the families involved may then start revenge killings. It is taken for granted that what happens in the family will never be told to any outsider. Breaking this taboo may have serious consequences. In Turkey, two TV series were started in 2004 to give women opportunities to discuss openly their problems of domestic abuse. In March 2005, a woman who had appeared on one of the talk-shows was soon after killed by gunshots by her own son, as she "had brought shame over the family". Some of these cultural habits 'travel' with emigrants who settle in developed countries, where the police might intervene when 'honour killings' or sexual mutilation (see below) of young girls take place. Prostitution is widespread and widely used, even in poor areas; sex workers – both male and female – are available.

There is a clear tendency to blame any sexually abusive event on the woman, who is the victim. For instance, a woman who is approached by an exhibitionist in a public place may be accused by the village men (even by those who were not present when the abusive event happened) of having provoked the exhibitionist by her 'own indecent behaviour'; she may be publicly stigmatized. Under an Islamic ordinance in force in Pakistan since 1979, a woman had to present four male witnesses in order to prove a case of sexual assault or rape.<sup>4</sup> It is interesting to see how women who go to the well to collect water often go in groups and stay together for a while. With the men absent, this is where they can discuss in confidence their experience of domestic abuse. This is the indigenous equivalent of cognitive group therapy.

About 135 million women have undergone female genital mutilation: the clitoris, most of the outer labia and the inner labia are cut and removed and the remaining outer labia are sutured, leaving a small opening at the posterior part, so urine and menstrual blood can pass.

The operation is seldom carried out by anyone with any medical training; sometimes it is the grandmother or a traditional midwife who does it. There is no anaesthesia, dirty knives, scissors or razor blades are used. The little girls (usually under-5) are screaming with pain, all are bleeding, some die from blood loss or infections. This has been 'obligatory' in some cultures, but it is unrelated to religion, and existed already 1,500 years ago. Un-mutilated girls are often perceived as worse than prostitutes. Currently, two million girls are annually at risk of this mutilation, an act that should be considered as severe sexual maltreatment. Most sexual mutilations take place in Africa and the Middle East<sup>5</sup> (WHO, 1995). The practice may be forbidden by law, but the law is not followed. Parents born in countries with this 'culture' who have emigrated to Western countries are known for taking their daughters 'back home' to have them mutilated, so they can escape prosecution in their adopted countries.

#### Physical punishment

Physical punishment is seen in many countries as a useful tool for education by both parents and teachers. It is a common part of the many children's human ecology. Such punishment unfortunately often causes great damage to the children. To establish a cut-off point between severe physical abuse (such as kicking, biting, punching, beating, threatening with a gun or knife, or using a gun or knife) and so-called lesser physical abuse or slapping children, appears not completely justified. All forms of physical punishment are associated with increased odds of major depression, alcohol abuse/dependence and externalizing problems in adulthood. The notion that physical punishment by a 'loving parent' does not have any ill consequences remains unproven (Afifi *et al.*, 2006).

#### Cultural anthropology.

Das, Kleinman, *et al.* (1997, 2000, and 2001) have in several books explored the social and cultural anthropological questions about violence. They give many examples of the situation in several different cultures: the state terror, local conflicts, threats through narratives of supernatural activities, and the suffering brought upon poor marginalized communities and their efforts to recover from the consequences of violence. Their final title is "*Remaking a World*" reflecting their perceptions of the seriousness of the present level of violence.

#### Information problems

Finally, a few words about the information problems. Languages are a barrier to communication. By 2007, 6,912 known living human languages have been registered (Gordon, 2007). Even the official language(s) of a country may not be understood by large numbers of its citizens. Translators may be unavailable for this multiplicity of language variations. Difficulties to understand are obvious for example among refugees, and at legal processes. Spoken languages do not always have a written language. Local vocabularies may be small. For example, few people may know that the Somali language has no word for "bacteria". Arabic language does not have a proper translation for "human rights".

There are now in many poor areas radios and sometimes television sets screening Government information programmes. Internet access is still uncommon in poor countries, but mobile telephone systems are expanding. Newspapers reach very few people. Most persons have never heard of international aid or the United Nations, or the Human Rights Conventions. If a country receives international criticism for its human rights situation, most of the population is unlikely to hear about it.

### 3 Mirrors of the Past

Historically, the situation of children is less known by systematic studies or statistics than by anecdotes, diaries and letters, mostly written by people of the upper classes. By Year AD 1, the world population was just 200 million; by 1000, it had increased to some 300 million. By 1750, the entire world population was estimated at less than 800 million, by 1800 at one billion. One hundred years later (1900), it reached 1.7 billion. In 1945, it was 2.3 billion; the less developed regions then counted for 1.6 billion. By 1960, the world total crossed the three billion mark and by 1999, it reached six billion; over 80% lived in the less developed regions. It appears that the population might exceed seven billion by 2015 and nine billion before 2050. The population growth is concentrated to the developing countries. The more developed countries have shown little growth: between 1950 and 2000, it only increased from 800,000 to 1,100,000, and will show little growth until 2050. 28% of the world populations are children aged under-15. (U.N. Population Division, 2006; Wikipedia, 2007). The world is getting crowded and that affects children.

Children's lives have in the past been influenced by poverty among some 80-90% of them, their education was non-existent or of poor quality; the health services lacked effective interventions, many infants and women giving birth died early. Infanticide has existed since time immemorial. Religious offerings, especially of the firstborn, are known from the Bible, as well as from the histories of Assyria, Egypt, Greece, Rome, and China. Firstborn sacrifice was once common among many peoples; the motive was the offering of one's most precious possession to the deities to make sure, for instance, that the next harvest would be good. Infanticide was common in Europe at least until the end of the 19th century. In historic times, child mortality rates were enormous: in 1700, in Finland children under-age-10 counted for 76% of all deaths; in 1800 it was 61% (Pelo, 2000). The infant mortality rates in USA were 216 per 1000 in 1840, 214 in 1880, 116 in 1900, 82 in 1920, and 10 in 1980 (Haines, 2006). By the end of the 1920s, some European countries still had infant mortality rates of 60 per 1000, which is the average rate for the developing countries at present.

Communicable diseases in the past ravaged whole populations: leprosy, bubonic plague, smallpox, tuberculosis, cholera, scabies, erysipelas, typhoid, anthrax, trachoma, syphilis, gonorrhoea, sleeping sickness, and dancing mania. The Black Death (bubonic plague) during the mid-14 century killed one third of Europe's population; about 1000 villages disappeared completely. It took 150 years for the population of Western Europe to reach the pre-plague level.

The growth of population increased urbanization, especially after industrialization started in the early 1800s. People moved to cramped and unhygienic lodgings, infectious diseases were rampant, and as there were no contraceptives many children were born. Poor families abandoned infants by the millions to orphanages.

This book takes a critical view on the performance of many present Governments, the institutions of the macrosystem. Our history is full of similar observations. This is how the French Revolution leader Brissot (1754-1793), described the situation in France – then the country with the highest population in Europe – in the 1790s (Aullard, 1883)



Laws are not carried into effect, authorities act without force and are despised, crime remains unpunished, property is attacked, the safety of the individual violated, the morality of the people corrupted, no constitution, no government, no justice functions.

### **The discovery of child “battering “**

The discovery and description of child abuse as a diagnostic entity did not appear until the second half of the 19th century. Then, the French forensic physician Ambroise Tardieu (1818-1879) in 1860 described 32 battered (severely abused) children, of which 18 died and in 1868 reported his observations on infanticide, built on pathological studies of 555 children. His contemporaries rejected his conclusions that child abuse was a major problem and that preventive measures were needed. His work was consigned to oblivion.

During the times of Tardieu, industrialization and urbanization had led to the establishment of thousands of orphanages for abandoned children in Europe and Northern America. It is estimated that in these about 100 million children died from neglect and abuse in orphanages during the period 1800-1940.<sup>6</sup> This horror has received little publicity. The abuse of children at such institutions and at work became a matter of concern to many new non-governmental organizations. Henry Bergh (1811-1888) founded the American Society for the Prevention of Cruelty to Animals in 1866. His attention was in 1874 drawn to the plights of a young abused child Mary Ellen, and based on this experience in 1878 he created the Massachusetts Society for the Prevention of Cruelty to Children, followed by The New York Society in 1875. The National Society for the Prevention of Cruelty to Children was set up in the United Kingdom in 1884. Australia followed with the Children's Protection Society in 1896. Today thousands of such NGOs “to save the children” exist; they carry out a lot of important work.

Sigmund Freud in 1896<sup>7</sup> published articles based on the seduction theory of ‘neurosis’ (the term then included several mental disorders: depression, post-traumatic stress, phobias, depressive, paranoid, obsessive-compulsive, and personality) built on clinical observations of his patients. Virtually without exception, they recounted experiences of child sexual abuse, usually by the father. He drew the conclusion that childhood sexual abuse was a precondition for their illness. In a letter in the spring of 1896 Freud told his friend Fliess (a doctor who became his confidant) that he was increasingly convinced that there was a great deal of perverse activity involving children, much of it by the fathers. And Freud went on to tell Fliess, “My own father unfortunately was one of these perverts, and is responsible for the neurosis of my brother and that of several of my sisters”. Freud’s peers were outraged by his theory, and one of them called it “a scientific fairy tale”. Under immense pressure, he withdrew it in 1897. Like Tardieu, he did not manage to convince his peers.

These groundbreaking efforts were soon forgotten and the rediscovery had to wait – for 100 years after Tardieu and 65 years after Freud – until 1962 when Kempe and his colleagues described “the battered child syndrome” (Kempe *et al.*, 1962). They had surveyed 88 hospitals and identified 302 children who had been “battered” (the term was later on changed to abused). At that time, they concluded that child abuse in USA was a very limited problem for perhaps a few hundred children victimized by a small group of seriously pathological persons. Time would show that these assumptions were underestimates. Kempe went on to start an international society for the prevention of child abuse and neglect, an international journal and a research centre, an important legacy.

Over thousands of years, children in most countries have been subjected to corporal punishment; it has been the most common method to install ‘discipline’. Many parents believe

that it is 'character-building' and there has emerged a culture of parental behaviour that often started by beating infants for crying and ended with using cane, rods, belts, paddles or whips for teen-agers. Already in the 11th century Saint Anselm, Archbishop of Canterbury was speaking out against what he saw as the cruel treatment of children (Wicksteed, 1936). The 17th century English philosopher John Locke wrote a number of influential works in which he opposed authoritarianism. In "*Some Thoughts Concerning Education*" (1692) he explicitly criticized the central role of corporal punishment in education:

I desire to know what vice can be nam'd, which parents, and those about children, do not season them with, and drop into 'em the seeds of, as soon as they are capable to receive them? I do not mean by the examples they give, and the patterns they set before them, which is encouragement enough; but that which I would take notice of here is, the downright teaching them vice, and actual putting them out of the way of virtue. Before they can go, they principle 'em with violence, revenge, and cruelty. Give me a blow, that I may beat him, is a lesson which most children every day hear; and it is thought nothing, because their hands have not strength to do any mischief. But I ask, does not this corrupt their mind? Is not this the way of force and violence, that they are set in? And if they have been taught when little, to strike and hurt others by proxy, and encourag'd to rejoice in the harm they have brought upon them, and see them suffer, are they not prepar'd to do it when they are strong enough to be felt themselves, and can strike to some purpose?

Locke's work was highly influential, and in part influenced Polish legislators to ban corporal punishment from Poland's schools in 1783, the first country to do so. Those countries that followed waited another 200 years before adopting this ban, still they are just about 30.

#### **Does child violence increase or decrease ?**

Jones and Finkelhor in 2003 reported that in the 1990s, the cases of sexual abuse known by child protective agencies in USA declined from about 150,000 in 1992 to 92,000 in 1999. In the Canadian province of Ontario, there was also a decline in substantiated sexual abuse by 49% from 1993 to 1998, while physical abuse and neglect cases increased during the same period. They write:

one possible explanation is that it reflects a decline in the incidence of sexual abuse, evidence, perhaps, that the investment by the US...to protect children from sexual abuse...can work effectively.

A more long-term review shows that according to the United States total Crime Index Rates (US Justice Department, 2003) per 100,000 inhabitants went from 1,888 in 1960 to 5,898 in 1991, and then dropped more than 50% from 1993 to 2004. From 2004-05 it went up again by 1.3%. A similar decrease was seen in the UK: according to the British Crime Survey (2005) violent crime has fallen by 43% since a peak in 1995.

Barclay and Tavares (2003) published international comparisons between violent crime rates from 1997 to 2001 and found the following: European countries increased by 22% (the highest increase was 50% in France, 49% in Spain, 35% in Netherlands, 29% in Portugal, 26% in England and Wales), Australia by 22%, and Japan by 79%, while USA showed a reduction of 12%. Over this 4-year period, police-recorded crimes increased in France by 16%, Spain by 10%, Netherlands by 10%, Portugal by 16%, England and Wales by 22%, Australia by 18%, Japan by 38%. In these countries, the increase of violent crime was higher than the increase of the total crime rate. USA showed a decrease of 11% of its total recorded crime rates.

It appears that historically violent crime rates show cyclical trends. Eisner (2003) presents historical trends from the 13<sup>th</sup> to the 20<sup>th</sup> century. He states that serious interpersonal violence decreased remarkably between mid-sixteenth and the early twentieth century in Europe. Various regions differed but the age and sex patterns in serious violent offending changed very little over several centuries. There have been 'bursts' of increases seen after 1850, 1900 and 1960.

The changes noted by Jones and Finkelhor are impressive, but they are not universal, as many other countries show increases, maybe this confirms that violence follows a globally uneven cyclical pattern.

Garbarino (1993) has made some reflections about what happened to parenting in 100 years time as he tried to imagine what the problems were in 1893:

1. The problem of substance abuse and addiction was recognized as an insidious and powerful destructive force in family life.
2. There was evidence of a widening gap between rich and poor, and already many voices called for action to improve the conditions of the poor, particularly the 'worthy' poor.
3. Traditional American values and institutions were being challenged by the influx of immigrants who did not speak English and who were perceived to make disproportionate demands on the human service systems, suppressing wages by accepting low pay, long hours, and inferior working conditions.
4. The legacy of slavery and the reality of racism lurked behind the public facade of democracy, and broke out in dramatic incidents from time to time.
5. To their contemporaries, growing numbers of girls and women appeared to be in moral jeopardy due to the frequency of premarital sex and pregnancy, and the sex industry, in fact, flourished.
6. Child abuse was entering the public consciousness and there was a sense that juvenile crime was escalating.
7. Significant numbers of families were not 'intact,' as mothers frequently died in childbirth and fathers often abandoned families.

"Does anything ever really change?", asks Garbarino "Reading contemporary analyses of parenting issues in the 1990's, we see that there have been changes in the past 100 years: divorce and unmarried teen births have replaced maternal death and paternal separation in the dynamic of 'incomplete'" families; overtly homosexual adults now assert claims on parental roles publicly; efforts intended to integrate employment and maternity have become common; and, a structural analysis of child abuse as a social problem has arisen. These are real changes, of course, and they demand policy adjustments and innovations at all levels of public life".

Dube *et al.*(2003) in another United States' study, examined the relationship of the number of adverse childhood experiences (ACE) to six health problems among four successive birth cohorts (born 1900-1931, 1932-1946, 1947-1961, 1962-1978 ) to assess the strength and consistency of these relationships in face of secular influences the 20th century brought in changing health behaviours and conditions. The study concludes that

ACEs increased the risk of numerous health behaviours and outcomes for all the 20th century birth cohorts included in the study, suggesting that the effects of ACEs on the risk of various health problems are unaffected by social or secular changes. Research showing detrimental and lasting neurobiological effects of child abuse on the developing brain provides a plausible explanation for the consistency and dose-response relationships found for each health problem across birth cohorts, despite changing secular influences.

**PART TWO. THE EVIDENCE  
THE MICRO-SYSTEM: VIOLENCE TOWARDS  
BIOLOGICAL AND SOCIAL ORPHANS**

## 4 Children in Residential Institutions

Some ten million children are at present estimated to live in residential institutions (Stockholm University, Sweden, 2003). The four main groups are: (a) healthy infants abandoned by the parents, (b) children with disabilities, (c) children removed from malfunctioning families voluntarily or by legal authorities, or because the child shows behaviour that cannot be controlled by the parents, and (d) children in penal institution. Such cases are illustrated below.

Most child institutions are inaccessible to outsiders. Modern mass media have played an important role in revealing the realities hidden from the public. Protests against abusive 'care' appeared already hundreds of years ago, but change was mostly resisted. Societies have been prejudiced: the role of the 'poorhouse' and other asylums was to 'protect the public' at the expense of the protection of children and other poor residents.

This Chapter illustrates the abuse in a variety of residential institutions; the examples are characteristic of what the author has observed in some 50 countries. Some countries have not been identified. Naming a country is not always productive, and – rather than encouraging future co-operation with the visiting professional – it may result in a defensive attitude. The facts from the identified countries are in the public domain.

### DISASTER IN ROMANIA

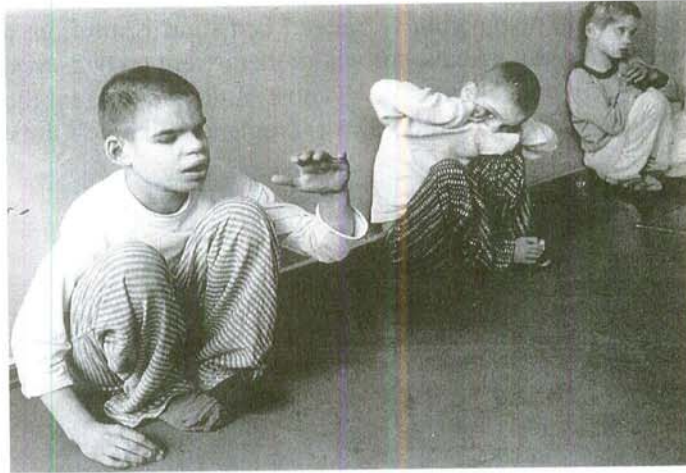
In December 1989 President Ceaușescu's regime (1965-1989) collapsed. There were demonstrations and the army defected. Ceaușescu and his wife were captured, tried, convicted on charges of mass murder and corruption, and executed.

During the days which followed, a large number of television crews and international organizations entered Romania, where they discovered a human disaster of epic proportions. Over 200,000 children and adults lived in some 600 residential institutions under terrible conditions. The author has made eight visits to Romania, the last in late 2006 and can confirm the descriptions given by non-governmental organizations. Below follows an account from a non-governmental organization of their observations of residential institutions during the summer of 1990; with few variations these observations are typical of all the institutions at the death of Ceaușescu:

Children aged 0-4 years were kept in 'child homes'. Their families had faced severe poverty, unemployment, and famine and abandoned these children at birth. The 167 children in this institution were mostly kept in their beds, almost without care, inadequately fed, severely underweight and with stunted growth. Hygienic conditions were abominable: the children lying in their own urine and excrement. The smell was unbearable. The facilities had not been repaired for several years, so the roofs were leaky, sewers and electricity were malfunctioning. Because of the lack of personnel (one 'helper' for 40-50 children), there was no time for human contact; children were left with severe sensory and emotional deprivation; many were intimidated and beaten.

The children were fed with big bottles containing water and milk powder; no other food was available. Because of malnutrition, they looked like 'sacks of bone'. Some of the bigger children who were less affected could eat by themselves in a dining room. Their food was some soup with the appearance of 'pig food'. Many children were on heavy doses of

sedatives (to 'protect them'). During the 1980s, medical experiments had been carried out on many of these children. They had been 'treated with micro-transfusions'; and because unchecked HIV-contaminated blood had been used – several hundred children died of AIDS in the 1990s.



*The teen-age boy to the left was born blind and abandoned by the mother. He sits all day long by himself, rocking, is sensorially and emotionally deprived and has "fled into a world of his own". The boy in the centre was also abandoned by the mother at birth, initially he was healthy. He shows clear signs of being very afraid, the result of abusive beatings and threats by the personnel. The third boy to the right is autistic and has no contact with anybody. None of them has proper clothes and shoes. All are incontinent, none can speak, all are malnourished. The 'child home' has no activities, no training in daily activities or any education. The children receive no visits from their families.*

*Credit Star of Hope, Sweden*

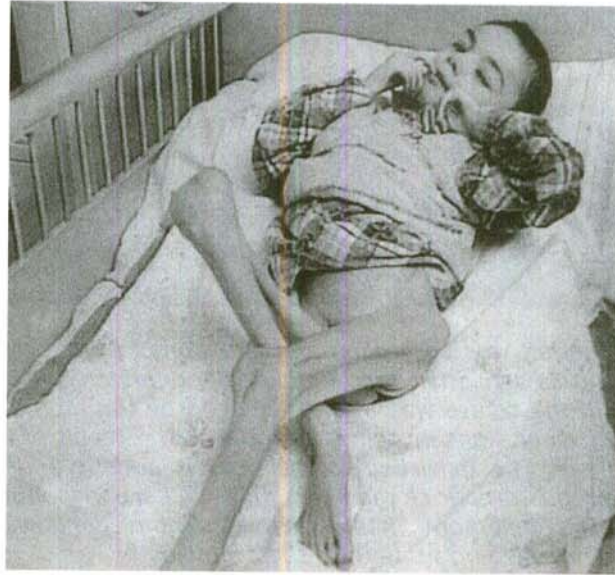
The outcome of this warehousing – for those who survived – was induced mental retardation and behaviour disturbance. There were no activities, no toys, no training or stimulation of the infants and small children. The children were nameless, had no name on the bed, or any identification tags. There were some records, but they were insufficient to identify any children. Most children were rocking back and forth in their beds, and some were self-aggressive.

The personnel were very indifferent to the needs of the children. Everything was following a set time schedule: diapers were changed and food given, but nobody spoke with the children during these procedures. When this work was completed, the personnel spent their remaining time outside the dormitory, with no one looking after the children.

When the children reached the age of 3-4, they were transferred to larger "placement" centres headed by medical doctors. An example follows of a centre with 230 children, aged 3-18, all were considered untreatable. This centre was in a building with two floors, fenced in, and had no garden. Upon entering, the director-physician explained that because there was no hope for improvement of the 'inmates,' the personnel were few and only occupied with basic care. There was one care-provider for each group of 50 children at daytime and one at night for all the 230 children. Here, the children were in bedrooms with several in the windowless cellar. Two to three children often shared a bed. The beds were cage-like and too small even for one child of their ages; the children could not stretch out; their arms and legs had become crooked. The children were in rags or naked; the condition were the same as in the centre described above. All children had their hair shaved off; several had visible scars on their heads, the result of previous aggression. The water supply was frequently cut,

the sewers did not function and very little electricity was available. Many children froze to death during the following winter because of lack of heating, food, and care.

The children were very frightened by persons in white coats, and would try to avoid physical and even eye contact with them; because the staff had physically and psychologically abused them. There were no proper records; the names of most children had been lost. Because they sometimes changed beds and institution, at the end nobody knew who they were. The last arrivals, for whom there were no beds available were hidden in the cellar; they were all soiled and naked – most of them sitting on the potty, rocking all day long. Some of them were eating their own excrement. (Viklund-Olofsson, 2005)



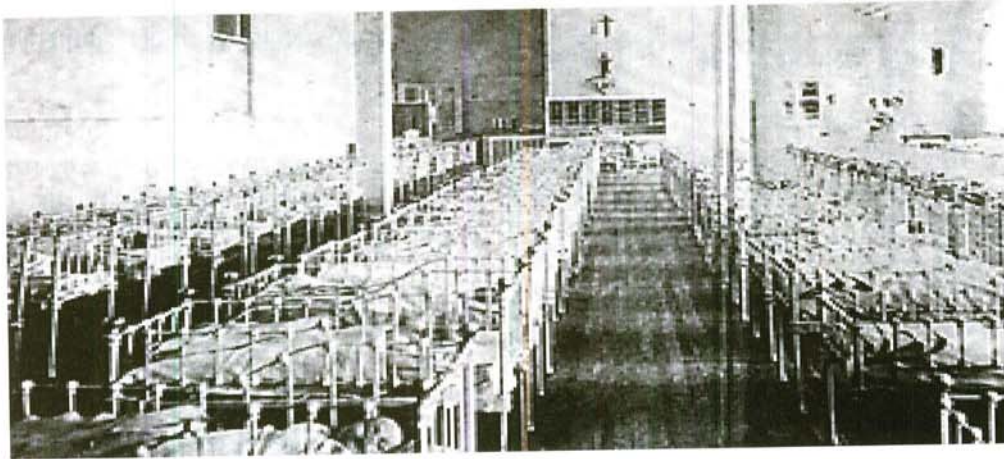
*Abandoned at birth with no disability, this girl has spent more than 10 years as a "resident". The crookedness of her legs has advanced and is now permanent. She cannot stretch out her body because the bed is too short. She is severely malnourished and doubly incontinent. She has never learnt to speak, because nobody ever spoke to her.*

*Credit Star of Hope, Sweden*

There are other problems in the institutions in Romania. Not only did the children become victims of abuse, neglect, and intentional killing. Reports have also emerged of organized baby-selling and trafficking by the personnel. This has been possible because of incomplete record-keeping and lack of inspections; hundreds of children in institutions have gone 'missing'.

The new Romanian government in early 1990 reinstated abortion on demand; it had been forbidden by Ceaușescu. This resulted in very high rates (World Health Organization, 2005): 1990 1,000,000; 1995 500,000; 2000 250,000 (234,521 children born). The 1990 rate is the highest ever recorded in any country (Romania population in 1990 22 million). Although access to contraceptives was legalized; only 30% of women were using them. The poverty rates are still very high, average for the country 30%; for families with three or more children 60%

A major policy change started in 2004: some abandoned infants are now transferred directly from the maternity wards to salaried foster parents. Not all problems have, however, yet been solved: a May 2006 Internet report from MDRI describes child institutions with teenagers weighing no more than 27 pounds. Some children were tied down with bed sheets, their arms and legs twisted and left to atrophy. Infants are still abandoned.



*Hopital de la Misericorde in Montreal, Canada, home to 3,000 abandoned children from the 1930s into the 1960s. Although most were healthy at arrival, all were classified as mental patients, so the institution could receive federal funding. All boys were christened Joseph by the nuns and monks that ran the hospital and the girls were christened Marie. Because of wide-spread sexual and physical abuse and serious neglect by the staff, many of these orphans as adults pursued a court process for an apology and compensation from the province, but lost.*

### CONTROVERSY IN CHINA

I visited China three times in the 1980s and the 1990s and became aware of the rumours of violence against children in residential institutions. These institutions mostly received healthy infants (80-90% girls) abandoned at birth by the mother. China's Ministry of Civil Affairs in 1989 (Atlantic Monthly Affairs, 1996) issued for the first (and last) time an annual report which stated the annual mortality rate in these institutions: the ratio of deaths to admissions in that year was 58%. In four provinces, the death-to-admissions ratio exceeded 90%. A doctor working at one of the institutions in 1996 described what was going on:

Children were selected for death if they had some deformity, were badly behaved or demanding, or simply not liked. A consultation meeting took place between the staff, at which it was decided to deprive those selected of food and drink. Once the starvation took hold, the child became ill...the orphanage doctors were asked to perform a 'medical consultation,' which served as a ritual, marking the child for subsequent termination of care or life-saving intervention. Some children were normal – abandoned for economic reasons. Whatever the condition the children were initially in, they were dying from starvation, diarrhoea and vomiting, and general medical neglect. The dead children were then cremated; the diagnoses were frequently congenital maldevelopment of the brain, or even hare lip and cleft palate. (Human Rights Watch, 1996 a; Woods, 1996).

These reports got follow-ups. In 1996, an American film team entered China as tourists, and just walked into several of these institutions, filming what they saw. Nobody hindered them:

We were able to film infants tied to wicker chairs. In filthy clothes and wearing trousers split wide at the crotch, their legs are held wide. Beneath some of the chairs, there are potties and old washing bowls. Others simply urinate and defecate straight onto the floor. With no toys or other distractions, they rock back and forth relentlessly. We discovered that, although they were described as orphans, very few were; their parents have abandoned them at birth. Under-staffed and under-funded, these institutions are just not prepared for the



relentless tide of rejected babies. These infants lay five to a cot in summer temperatures of over a 100°F (Woods, 1996).

The film has been screened in 37 countries, with some 100 million viewers. The authorities, embarrassed at what had been discovered, issued several statements denying the descriptions, and later advertised that improvements were taking place. Some of the problems in that country, however, seem to persist. An article in the London Times in January 2006 describes a Chinese “boarding school with about 215 boys aged eight to eighteen, who are considered ‘uneducable’, are compelled to dress in camouflage jackets, sleep in trucks, study in tents.”

### **THE “SNAKE PIT”: WILLOWBROOK, NEW YORK, U.S.A.**

The Willowbrook State School was an official New York State institution on Staten Island in New York. It had premises of 375 acres with 40-50 low buildings; with an initial capacity of about 3,000 beds. In 1947 it started to accommodate children and adults with mental retardation to give them education. The number of residents increased; by 1963 6,000 residents were crammed into a space set for 4,275. The overcrowding went with serious understaffing and an almost complete absence of educational and recreational activities. By 1967, there were 59 nurses for some 6,000 residents. Senator Robert Kennedy, during a visit in 1965 described the hospital as “less comfortable and cheerful than the cages in which we put animals in a zoo...a new snake pit.” The descriptions below originate mainly from two books (Rothman and Rothman, 1984; Rivera, 1972) and contain quotes made by witnesses during the court procedures. The scandal finally broke in January 1972, when a TV team filmed one of the wards.

The ward had 60 retarded children with only one attendant to take care of them. Most were naked, lying in their own excrements, some in straitjackets. The TV crew noted the foul air, heard wailing noises and saw distorted bodies and limbs. The walls were full of smeared faeces. Some were in rooms without any furniture, lying on the floor. (Rivera, 1972)

The film was screened several times and was followed by a Court process. The general conditions at Willowbrook were:

The residents were either naked or in rags and tags, many toilets could not be flushed, the odours were incredible, flies and other insects abounded. Buildings were un-repaired, roofs leaking, windows broken. There were almost no records of the patients, and medical diagnoses were inaccurate, laboratory and physical evaluations were absent. Proper food was not always available. Willowbrook was a symbol of public abuse against powerless citizens. (Rothman and Rothman, 1984)

The following are quotes from the Court:

Parents reported: we found our daughter with her ear bitten off, part of the nose torn off and her knees completely bruised, black and blue and scratches on her face and arms...cockroaches have taken over the buildings...the clients are all undernourished. Residents drink water from toilets. An average 100 violent incidents were reported each month. A nurse testified to the Court about a leg plaster of a resident: It was rotten and broken in several places, there was an extremely foul odour from his cast, the odour of urine and faeces...before the cast was removed there were maggots crawling out from underneath...we picked them off the cast with forceps...we picked off 35 or 40...when the cast was off there were numerous maggots in the wound itself and there was a large black

bug embedded in the wound. Nudity is commonplace because no clothing is available. The gross disabilities and bizarre behaviour that the visitors saw, legs twisted into brambles and residents banging their heads against the wall, were not the reason for incarceration but the result of incarceration. 75%-95% were heavily sedated.

A paediatrician noted: 10.00 p.m. Door of seclusion room opened by request; bare unlighted room, closed screen 2x2 inches, mattress and crumpled sheet and single thin blanket on the floor, barefoot 17-year-old girl in dingy loose gown standing by the door – pale pastry appearance, took my hand when offered – responded to questions with gestures and monosyllables. Had been in seclusion for 7 years; heavily tranquilized, teeth extracted long ago because ‘she bit someone’ – no signs of aggressive behaviour during our visit. Residents had their names written on their legs with indelible ink. A doctor told the Court: Willowbrook is dangerous for children. It breeds more than disease. It breeds battered children. The children are left unattended. There is a mortality rate of three or four a week – all preventable. (Federal Court of the Eastern District of New York, 1972: *New York ARC v. Rockefeller*).

During this period, a medical experiment was carried out permitted by the authorities, but not by the parents or custodians of the clients. Children were deliberately infected with hepatitis virus, to try out a new vaccine.

The staffing of this institution was a big problem. An official report stated that:

the situation was critical. The care of the patients has been seriously deteriorating, resulting in high rate of absenteeism, lowering of morale, restlessness, irritation, increasing subordination, and what is potentially an explosive situation among the employees of the institution. It was indeed very difficult to find any personnel willing to work at Willowbrook. As a result, the turnover of the staff, which mostly had no training for the job, was very high (Rothman et Rothman, 1984).

The Court took over the detailed supervision of Willowbrook; it lasted until 1986. During that time, some 2,600 of the 5,400 residents at Willowbrook were removed and entered into living arrangements in the community that were decent, safe, and rehabilitative. Most of these alternative services consisted of small apartments for four to six persons, fully integrated in the community and with a presence of all necessary staff and necessities for a good quality of life. Some other clients were transferred to residential care in other centres that were somewhat better than Willowbrook. By 1988, all clients of Willowbrook had left, and the institution was closed. The Federal Department of Health and Welfare and New York State have rules and legal standards.<sup>8</sup> The Joint Commission for the Accreditation of Hospitals supervises the care in residential institutions. These standards, however, had been seriously disregarded in Willowbrook. Annual inspections had been held as required, but no action was taken to correct the problems. Nobody was ever charged.

In 1999, State agencies in United States reported 245,720 individuals with mental retardation and developmental disabilities living in nursing homes, psychiatric facilities, or congregate care (institutional) settings. In 2001, 542,000 children were in public care in the USA. It was estimated that of those, about 12,000 children under the age of 5 were in residential institutions (US Department of Health and Human Services, 2001). The conditions have certainly improved, but are still far from what should be attainable in the world's richest country.

### NAMELESS CHILDREN

I visited this Asian country in the 1990s at the official invitation of its Government. On my arrival, the Director of Social Welfare gave an overview of the country's services for disabled persons. He invited me for an accompanied visit to a "model" residential centre for "custodial care" of severely disabled persons managed by his Department. It was located in an isolated rural area, and surrounded by a high wall. Inside, there was a well-kept garden and the houses, built eight years before, – were all in excellent condition. The cost for the centre was fully paid by the Government.

The centre had 266 places, of which 229 were occupied. Some 50 staff was directly engaged in the care. The 'inmates' (the official term used) had severe disabilities. They had arrived as children to various other 'homes' in the country, at the request of the parents to whom the Government had promised 'specialized care'. The pavilion I visited was their final destination in life. I was not shown the other residential buildings because "the personnel were doing the annual cleaning," and so I could not enter. I heard screams and tumult from these pavilions; on hearing those, the Director was embarrassed and offered some improbable excuses.

The pavilion looked extremely orderly, which made me suspect it had been specially prepared for my visit. It had a large dormitory with about 50 beds. Next to it were offices for the staff, bathrooms and other utility rooms; all impeccably clean. In the dormitory, the "inmates" were lying in cage-like beds made of metal bars. It was difficult to establish any age or gender among these clients – because their heads were shaved ("to avoid head lice"). Most of the beds were too short for their occupants, who were lying in crooked positions, with contractures in both arms and legs, their bodies permanently deformed. They were very emaciated; the muscles were mostly gone. I was informed that the clients were fed mashed food, using tubes or bottles. All were doubly incontinent; the personnel changed their diapers a few times a day. The windows were all open, but this did little to dispel the heavy odour of excrement and urine; most of the clients were wet in their beds. The children were all semi-comatose. I could not establish eye contact with any of them; they looked up to the ceiling or to the side of the bed, their eyes blank, unfocused, without expression. They did not seem to notice my presence. Nobody spoke or reacted to touch. Some of them were quietly engaged in sexual self-stimulation.

I interviewed the staff – none of whom had accompanied me during the two rounds through the dormitory. They were seated next door, and were reluctant to give any information at all. I asked for the medical records, and was informed that there were none, and that the staff did not know what the initial conditions had been. The Director told me that these children were the "most severely un-trainable inmates"; the main disorder was mental retardation. The personnel had been informed that all possible remedies had already been tried and proven ineffective before their arrival. A few of the clients were on medication for epilepsy; no other medication such as sedatives was given (according to the Director – a statement that lacked credibility). The tasks of the staff were limited to feeding them, distributing medicines, washing them, changing the diapers, and keeping the premises clean.

Because I did not see any names on the beds, I asked for a list of their names. The nurse told me that the children at arrival did not have names with them, except for a few who had come from neighbourhood residential centres; the patients were now known only by their bed number. There were no records of addresses, parents or relatives, or of any birth dates.

With 40 hours of work per week per employee, there were 65 minutes of personnel time for each of the present 229 clients during each 24-hour period – totally insufficient, even for the

'basic care'. There were actually more personnel per animal in the Zoo, which I had the opportunity to visit later on. No training programmes for the resident clients existed, just "storage." No parents or other family members came; and no children had ever been taken back home – quite naturally as they had no names. When I asked about the sexual self-stimulation, the personnel were very embarrassed and said that they had hoped that I "would not notice it." It appeared to me that this was the only remaining sign that here were still human beings, creating an ultimate moment of pleasure in a life that they had lost because of the unspeakable neglect so cruelly applied to them.

### **ALL NAKED**

In an African country, I officially visited a large mental hospital built about 1870. Most of it was taken up by persons with mental disorders, many of them lying on their beds the whole day, sleeping and heavily sedated – not moving and not speaking. In the more 'lively' parts of the hospital, there were "tempest departments," where patients had their arms and legs strapped, some of them were chained to the walls in windowless cellars and screams filled the air.

There were two pavilions for the children and adults with mental retardation, one for males and one for females; each housing about 75 clients. Most of them had been admitted as small children. Whenever the door was opened, about five or six of them escaped into the courtyard, all of them naked and without shoes. They did not run far, and were quietly brought back in. Inside each pavilion, there were two large dormitories. All clients were undressed, and I was told that the hospital did not have enough budget for the laundry. Incontinence was common; the place was smeared with excrement and urine, reflecting the chaotic state of affairs. Disorder reigned everywhere. The beds had no sheets; many mattresses were broken and rather dirty, with traces of excrement. Some of the children were extremely friendly and obviously glad to meet us, utter strangers. The ward for the mentally retarded girls and women was similar.

About 100 meters away, separated by a barbed wire fence was the occupational therapy unit. There, two therapists were training five of the newly arrived children, who were wearing dresses and shoes. The therapists told me that the quality of the 'care' was deplorable; none of the mentally retarded clients should ever have been admitted to this asylum. The therapists were trying to convince the Government to close it all down, to ask as many of the families as possible to take their children back home, and to offer families or foster families economic support and day-care, and move the adults to homes in their birth communities.

### **UNITED KINGDOM, ABUSE IN CHILDREN'S HOMES.**

The Waterhouse Inquiry in 2000 published a report dealing with accusations of abuse and neglect in 40 residential child care facilities in Wales. The residents were mainly children removed by the authorities from malfunctioning families, or because of the children's behaviour. Problems of paedophilia and sexual abuse in these institutions had first been exposed by a senior child care official working for the local Council 1976-87. In 1987, she was dismissed after breaking ranks and informing the police of her observations. She was vilified and condemned at every turn, and despite her innumerable approaches to the Welsh Office, the Department of Health, the Home Office, various Home Secretaries and Ministers of Health, and to the Prime Minister, she only encountered apathy and insurmountable obstacles.

In 1991, the matter was exposed by a television channel and two newspapers. The Welsh Police mounted a huge investigation and subsequently referred some 800 allegations to the Crown Prosecution Service. This damning report was, however, suppressed. Fewer than 3% of these referrals proceeded to trial to the dismay and mystification of many of the victims and of the adults who knew the extent and nature of the abuse.

The Wales Child Abuse Tribunal of Inquiry was announced in 1996, after more than a decade of mounting public and political concern. It was chaired by Sir Ronald Waterhouse. The Tribunal took evidence from 575 witnesses and from 259 complainants alleging abuse while they were in residence. Some 9,500 social services files were made available and 3,500 statements made to police. There were 43,000 pages of evidence of complaints about some 40 homes, as well as foster placements. Most attention was focused on sexual abuse of boys by staff and paedophiles outside the care system, but there was also sexual abuse of girls and boys by women staff. Physical and emotional abuse were also common, including hitting and throttling children, bullying and belittling them. Punishments included scrubbing floors with toothbrushes, or performing garden tasks using cutlery. The inquiry found that the quality of care, and standard of education, were below acceptable levels.

The majority of complaints were made against the deputy principal at Bryn Estyn home:

He regularly invited resident boys – five to six at a time – to his flat for ‘recreation’. These boys were given drinks (including some alcohol) and light food, and were watching television, playing cards, board games etc. The boys were required to dress in pyjamas without underwear. If they were wearing underpants, they were ordered to remove them. The deputy principal had a number of favourites who were sexually assaulted at these parties.

The lives of these already disturbed children were grossly poisoned by a leading authority figure in whom they should have been able to place their trust. They felt soiled, guilty, and embarrassed. Most had trouble in their future sexual relationships.

There had been widespread physical and sexual abuse of boys and, more limited, of girls, in some 40 local authority homes – much of it by senior administrators and care workers. Some of the children had for a period of over ten years been continually abused by the principals of the homes. Life in such homes was a form of purgatory or worse from which children emerged more damaged than they had entered. The Tribunal criticized the staff of the homes, the social services, the Welsh Office, and the central Government for inaction. (Waterhouse Inquiry, 2000).

The main offender was convicted in July 1994 and sentenced to 10 years in prison.

## **CHILDREN IN DETENTION.**

I have visited closed prisons and halfway houses in several countries and seen examples both of good quality and of absolute hell; those in Nigeria are ‘life threatening’ (US Department of State, 2000). To meet children in prisons in developing countries is common. In some developing countries, the prison does not offer food, so unless the family comes with it all the time the prisoner will not survive. Inside, drug abuse, peer violence, sex deprivation and mental disorders are some of the over-riding problems, including among juveniles. Shackling of prisoners is routine in many countries. The shackles are tight, heavy, and painful, and reportedly have led to gangrene and amputation in several cases. In Pakistan, minors routinely were shackled and sexual abuse of child detainees by police and guards is common

(US Department of State, 2003). Some children develop drug habits while in these institutions and are supplied drugs by their guards. A high proportion of them have been childhood victims of sexual, physical, and/or emotional abuse, neglected educationally, live in inadequate housing and are malnourished.

Children in detention are frequently subjected to violence by staff, as a form of control or punishment, often for minor infractions. In at least 77 countries corporal and other violent punishments are accepted as legal disciplinary measures in penal institutions (Global Initiative, 2006). Children may be beaten, caned, painfully restrained, and subjected to humiliating treatment such as being stripped naked and caned in front of other detainees. Girls in detention facilities are at particular risk of physical and sexual abuse, mainly when supervised by male staff (Report of the Special Rapporteur, 1999).

Over nine million people in the world are kept in penal institutions (Walmsley, 2006). Half are in three countries: USA, China, and Russia. Among them are about one million juveniles (Sickmund, 2004). Most of these are charged with petty crimes, and are first-time offenders. Many are detained because of truancy, vagrancy, or homelessness.

In most countries, a child less than ten years old cannot be charged with a criminal offence. A common legal rule (*doli incapax*) is a presumption that a child aged 10-14 because of immaturity is "incapable of crime". This does, however, not imply that society takes no action: the child may be sent to a foster family or be referred to in a detention institution for juveniles where in principle there will be access to appropriate rehabilitation programmes: counselling, education, survival skills training, group work, health care and gradual return to the community. Some countries treat juvenile offenders with a degree of leniency: suspended sentences, access to non-institutional rehabilitation and education programmes, community work and social control/supervision.

Some very young children live in prisons because their mothers are there; many became pregnant because they were raped by prison guards. Approximately 10 million children in the U.S.A. have had one or both parents incarcerated. These children and youth have little or no voice about who, in the absence of the parent, is the primary caregiver, who will take care of them, or if they will be allowed to visit or communicate with the incarcerated parent (Reed et Reed, 1997).

Juveniles under 18 commit a relatively high proportion of all crimes, and those of them sentenced for violent crime in the United States have more than doubled during the last 30 years. In USA, some 150,000 juveniles were estimated to be in custody in 2005, out of whom at least 10% were in prisons for adults (Sickmund, 2004). At least 2,225 offenders in USA serve life without parole (LWOP) sentences for crimes committed before they were 18, a few were as young as 13 at the time of the offence. An estimated 59% were sentenced to LWOP for their first-ever criminal conviction. Only twelve other countries have laws that allow children to be sentenced to LWOP, but outside the USA there very few cases (Human Rights Watch and Amnesty International, 2005). A high proportion (some say all) of the youths in jails and prisons have mental disorders, but their access to treatment is limited. In the USA, 11,000 incarcerated youths in 1996 committed 17,500 acts of suicidal behaviour. (US Justice Department, 2002) An estimated 12% have mental retardation (Petersilia, 1997). Among infective diseases, tuberculosis, hepatitis, and AIDS are the most common, and many are infected during the incarceration.

The U.N. Special Rapporteur in 2000 stated at the U.N. General Assembly:

The conditions of detention for children in pre-trial centres and prisons continue to be of concern. Severe overcrowding, unsanitary conditions, and inadequate and/or insufficient food and clothing are often exacerbated by a shortage or absence of adequately trained professionals. The resulting lack of appropriate attention to the medical, emotional, educational, rehabilitative, and recreational needs of detained children can result in conditions that amount to cruel or inhuman treatment.

The Rapporteur continues to receive information according to which children were allegedly at risk of deliberate acts of torture, including forms of sexual abuse. Children in detention are severely abused, humiliated, and physically restrained; strip searches are carried out and some spend time in total isolation. Other prisoners and the staff are responsible for the very high degree of violence inside prisons; children should never be incarcerated.

A report from Brazil (a country that has adopted one of the most progressive juvenile justice laws) states:

many facilities are decaying, filthy, smelly, dangerously overcrowded (some have occupancy rates of 130% above the legal levels), and failing to meet basic standards of health and hygiene. Beatings by prison staff using pieces of wood are common, and complaints of ill-treatment are never investigated by state detention authorities. At night some youths are obliged to defecate and urinate in plastic jugs, because the guards will not let them out to the toilets. Many sleep on rat-infested floors; cellblocks often have standing water on the floor (Bochenek and Dalgadoi, 2006).

United Nations in 1985 issued (U.N. General Assembly Resolution 40/33) "Minimum Rules for the Administration of Juvenile Justice" (The Beijing Rules) and in 1990 Rules for the Protection of Juveniles Deprived of their Liberty (U.N. General Assembly Resolution 45/113). It appears that in many countries the extent of compliance is low or non-existent.

Research has been carried out of many programmes that describe efforts to facilitate the transfer of juvenile criminals back to community life (Reddington and Wallace, 2004). Early intervention programmes are important and cost-effective (Greenwood, 2005) by strengthening the family, supporting core institutions, promoting delinquency prevention, intervening immediately and effectively when delinquent behaviour occurs. By identifying and controlling the small group of serious, violent, and chronic juvenile offenders, juvenile crime rates would be lowered. Childhood violence increases criminality, thus its prevention should be cost-effective.

In spite of the abuse and neglect described above, it is not proposed to close all child 'homes'. In many situations such as when children are removed from malfunctioning or abusive families, they must be received in a substitute home. The options for a substitute mesosystem are discussed in Chapter 6.

## 5 Children on their own

A large group of children – other than those in residential institutions – live without a family. Six groups of uprooted children are described below: orphans, child soldiers, street children, refugee children, child labourers, and child prostitutes.

### ORPHANS

The word orphan means different things in different cultures (UNICEF, UNAIDS and USAID, 2002). In many, it is a child who has lost both parents (double orphans) by death, or by permanent separation. Half-orphans are those who have one surviving parent. The term social orphan is used for children who live on their own without parents. In 2005, the UNICEF estimated the number of orphans in Africa at 38 million, 12% of the population (11 million due to AIDS), in Asia 65 million, 6% of the population (5 million due to AIDS); and in Latin America 9 million, 5% of the population (2 million due to AIDS). There are a total of 112 million orphans (28 million due to AIDS). The proportion of half-orphans is not known. The number of AIDS orphans is increasing, especially in Africa. Adult AIDS victims – since 1981 25 million have died – often leave behind many dependent children. In many developing societies, the extended family takes care of orphaned children. In AIDS-epidemic areas, not enough adults of the extended family may now be left to take care of this traditional function. Building orphanages is generally considered the most expensive and – because of the negative effects described in previous Chapter – the least desirable solution. In the view of most experts the best solution for the developing nations is to set up an alternative model of institutions involving the transformation of children's homes into community-based resource centres that help families support children in the community. Such centres would provide day-care (thus partly relieving substitute parents), support groups, counselling, training in parenting skills, and skills training programs for older orphans. Where circumstances prevent immediate care, institutionalized care is best used as a temporary measure until more appropriate placement can be arranged. Many Governments and NGOs support programmes for the orphans in developing countries, and the funds are welcome, but insufficient. No organization has yet published estimates of the requirements for funds to implement such a programme. If just half of the 112 million orphans in the developing countries were to receive supporting programmes costing US \$ 2 per day per child (corresponding to the World Bank poverty level), the total annual costs would amount to US\$ 41 billion.

*This girl from Tanzania is an AIDS orphan. She was taken care of by an international non-governmental organization. The international community does provide excellent help for some, but unfortunately not enough. For that reason, AIDS/HIV infections continue to spread.*  
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### CHILD SOLDIERS

The U.N. Convention on the Rights of the Child states, "States Parties shall take all feasible measures to ensure that persons who have not attained the age of fifteen years do not take a direct part in hostilities. The Parties shall ensure protection and care of children affected by an armed conflict" (Article 38). In 1998, the recruitment of children under the age of fifteen and their use in hostilities was identified as a war crime by the statute of the International Criminal Court. The Court established in the Netherlands has jurisdiction to prosecute those responsible for the use of child soldiers.

In 1996, Mrs. Graça Machel carried out a U. N. study<sup>9</sup> on the impact of armed conflict on children: some 300,000 children under the age of 15 were used as child soldiers and exposed to daily horrific violence. The report covered all parts of the world where armed conflicts had taken place during the last decade. According to UNICEF, in just one decade, two million children have been killed, up to five million have been disabled, 12 million made homeless, 300,000 forced to fight, one million orphaned or separated from families, and 10 million have been psychologically traumatized.

Thousands of Sierra Leonean boys and girls have been abducted to provide slave labour for troops. A second generation of child soldiers is being born of girls forced into sexual slavery. Child warriors have been used in over 30 countries, among them: Angola, Colombia, D.P Congo, Iraq, Lebanon, Liberia, Sierra Leone, Sudan, and Uganda. Thousands of children were not just quietly asked to join, but abducted by force by the "rebels". New recruits in Sierra Leone were often forced – as part of their initiation – to murder their parents. These children took part in all forms of warfare. They had their own AK-47s and M-16s and used them at the front lines of combat. They acted as spies, messengers, as advance human mine detectors, and they were engaged in suicide missions. Many were drugged to overcome their reluctance to carry out the killings, beheadings, hangings, rapes, and burnings alive of their victims. In Sierra Leone, Foday Sankoh, a rebel leader expected his soldiers to subsist by eating the flesh and drinking the blood of freshly-killed victims, some of whom were their own family members. In Uganda, a rebel group that calls itself The Lord's Resistance Army, led by Joseph Kony, has abducted more than 20,000 children. Some are forced to fight, some carry bags, others have sex with the fighters. By way of initiation, many are obliged to club, stamp, or bite to death their friends and relatives, and then lick their brains, drink their blood, and even eat their boiled flesh. A 14-year-old girl soldier in Sierra Leone stated: "I've seen people get their hands cut off, a ten-year-old girl raped and then die, and so many men and women burned alive. So many times, I just cried inside my heart because I didn't dare cry out loud" (Human Rights Watch, 2004).

The development of lighter weapons – such as the AK47 – means that boys as young as eight can be armed. The smallest boys are placed closest to the enemy. In war, they are said to be fearless. Children are often less demanding soldiers than adults are. They are cheaper to keep as they eat less and are easier to manipulate. "The unpredictability of small children makes them better fighters". Some are sent into battle high on drugs to give them courage. In combat, children are often captured and threatened. They fight for whoever controls them, in order to stay alive. In continuous civil war, many children have fought for both sides. Thousands of Sierra Leonean boys and girls have been abducted to provide sex services and slave labour for troops; many acquire sexually transmitted diseases and HIV/AIDS. Now a second generation of child soldiers is being born of girl soldiers forced into sexual slavery. In Uganda, Human Rights Watch (2004) interviewed girls who had been impregnated by rebel commanders, and then forced to strap their babies on their backs and take up arms against Ugandan security forces.

According to Human Rights Watch (2004) in Colombia, tens of thousands of children have been used in the various military or rebel armed forces. Government-backed paramilitaries

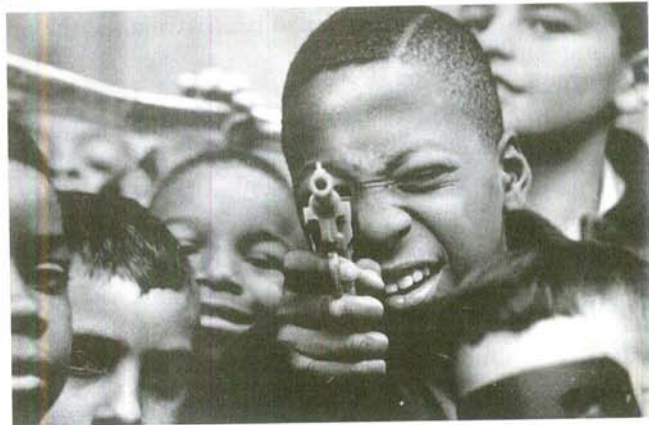
recruited them as young as eight. Guerrilla forces used children to collect intelligence, make and deploy mines, and serve as advance troops in ambush attacks. In southern Lebanon, boys as young as twelve were conscripted by force to the South Lebanon Army (SLA), a pro-Israeli auxiliary militia. When men and boys refused to serve, fled the region to avoid conscription, or deserted the SLA forces, their entire families were sometimes expelled from their homes. The issue is still unresolved and will remain so, until the vague threats of punishment of the war lords are replaced by action that ends the offenders' present impunity and sends them to prison.

### STREET CHILDREN

One might distinguish between children on the street, who have homes to which they return almost every day; and children of the street who have chosen the street as their home: it is there they seek shelter, livelihood, and companionship; they may have occasional contacts with their families. There is no globally consistent way of calculating data on street children. Prevalence estimates by several organizations (Streetchildren, 2006) are available for countries with 71% of the World's population. In these, the total number children of the street are reported as 5.8 million. Based on these data one might extrapolate that globally some 6.5 million are living homeless of the street. Some 20 million more children might be on the street. These are most likely underestimates. India might have 18 million street children: a proportion belong to families where all members live of the street. A large-scale India study (Kacker, 2007) revealed that 67% of all street boys and 68% of all street girls had been physically abused; 55% had been sexually abused. A study of drug-using street-involved youth in Vancouver, Canada revealed high prevalence rates 73% for physical abuse; 32.4% for sexual abuse; 86.8% for emotional abuse; 84.5% for physical neglect; and 93% for emotional neglect (Stoltz *et al*, 2007).

Street children live from begging, doing small jobs, or selling trinkets or polishing shoes; some enter prostitution, and some join criminal gangs. Criminal child gangs may fight battles against each other for territory. Some children have run away from home or they have been thrown out by the parents, the reason is sometimes parental child abuse. Some have been abandoned, and some of them are in night shelters.

*Street boys in a Latin American country. Many of them join gangs and make the community unsafe.*  
© World Health Organization



These children are targets of sexual and economic exploitation, trafficking for organs, general violence, and assassination and abuse by police and security forces. Many acquire sexually transmitted diseases, including HIV/AIDS. When apprehended by the police – innocent or not of crimes – they might be put in “preventive custody” or in prisons with adults, where many are raped. Such custody may last for years. Their rights to competent legal assistance are mostly denied (Human Rights Watch, 1996 b). In Colombia in the 1990s,

thousands of children were murdered by "death squads". Indian street children are routinely detained illegally, beaten, and tortured and sometimes killed by police. Several factors contribute to this phenomenon: police perceptions of street children, widespread corruption, a culture of police violence, inadequacy and non-implementation of legal safeguards, and the level of impunity that law enforcement officials enjoy.

Most of Brazil's street children expect to be killed before they are 18. Between 4 and 5 adolescents are murdered daily, just in Rio. The murders are carried out by the police and by drug gangs. The death squads have been met with little opposition from ordinary people, who feel threatened by gangs of children. Some members of the police force also fear the children, who are becoming knowledgeable witnesses to corrupt criminal activities by officials in the drug and prostitution business (Jubilee Action, 2000).

In many countries some parents abandon their children, some as young as eight years old, sometimes by bussing them to a nearby big city and leaving them on the street. One example, describing my recent observations in a Caribbean island follows.

Parents on this island bring their teen-age children from the rural areas to the capital. When they arrive, the parent just leaves the child outside the bus station and disappears. The reasons for abandoning these children are poverty, poor school performance, and disobedience or 'trouble-making' by the children at home. Some are mentally retarded and some as young as eight, and do not know how (or do not want) to return back home; they stay on the street. Many go to sleep and share food in a big empty warehouse in the harbour.

Most of the young girls are soon picked up by men and taken home to serve as a combination of home-helpers and sexual partners. Therefore, the population at the warehouse is mainly boys. The boys live from begging on the streets or small jobs. Several are sexually exploited. Food is from the garbage or stolen. Some of them get infective diseases and die. The police from time to time harass them and confiscate their earnings from begging. The killing of street children so widely practiced by the police in Brazil and Guatemala did not seem to be common in this island. The boys I talked with were undernourished, looked unhealthy, and were very frightened. The local Psychiatric Hospital was studying these children and managed by counselling to return some of them home after an intensive search for the parents. Others were given shelter by NGOs and referred to vocational apprenticeship. All services for children with mental retardation were at that time centralized to the capital. If decentralized day-centres had been available, the practice of abandoning these children would diminish.

Street children are often addicted to alcohol or drugs and need detoxification and rehabilitation. No global data are available, although all countries report that a high proportion of the children are exposed to drugs or/and alcohol, and that almost all children try them. Some do not come from poor families. Tyler *et al.* (2004) showed that 75% of all homeless and runaway adolescents in Seattle had experienced sexual and physical abuse at home. Sullivan and Knutson (2000 b) collected data in USA about 39,352 children who had run away from hospitals and 40,211 who have run away from schools. The children in their study most likely to run away were those with behaviour disorders, mental retardation and some type of communication disorder. The most common factors associated with run-aways were physical and sexual abuse, and high levels of domestic violence; they also had shown low academic performance, poor school attendance, and more family stress factors.

Matchinda (1999) sampled 210 street children in Yaounde, Cameroon. The major reason for running away from home was combined severe physical and psychological abuse by the parents. A 2004 report about a group of similar children in Ethiopia confirms their high vulnerability: 55% had been raped and a further 26% had been sexually assaulted (Lalor, 2004). Rajani and Kudrati (1996) carried out a study of street children made in Mwanza (a large city in Tanzania) and noted that only 5% of boys' and 15% of girls' sexual behaviour is

“stereotypical prostitution”. Widely spread was the initiation rite of forced anal sex with new boys in the group – a ‘rite of passage’ in identity formation. Boys that were more docile were then frequently abused by the more dominant ones. This form of abuse of boys – as ‘faggots’ – was the worst form of humiliation among street boys. Street girls adopted a social role of adult sexual beings with the primary responsibility to satisfy one’s male partner. Their relationships had little mutuality, and were frequently rough or even violent and characterized by power and intimidation. Because the continuum between love and abuse is so blurred, and because they have very low self-esteem, street girls often accept violence and humiliation in the pursuit of love and connection. This confusion undermines their ability to seek healthy options. A study by the International Labour Organisation (2001) of juvenile prostitution revealed that a common reason for girls to leave home were “problem with father”, fights and maltreatment “and poverty.

Huang *et al.* in 2004 made a study of 115 abandoned street children who agreed to be interviewed in La Paz, Bolivia; 95% were abused by the police, 84% were absent from school, 26% were engaged in robbery, 88% inhaled paint thinner, 58% used alcohol, and 53% had a serious medical problem; the risks increased rapidly with age. These authors also made a comparison with 35 formerly abandoned street children in La Paz, Bolivia who chose to enter a local orphanage; it was evident that operating homes for them had a positive effect. Such well equipped small homes with loving, competent personnel and good health and education programmes are mostly successful.

### CHILD LABOURERS

Article 32 of the U.N. Child Convention protects children from economic exploitation and work that is likely to be hazardous to the child’s development, or to interfere with the child’s education. It calls on states to take legislative and other measures, including sanctions and penalties, to guarantee this protection to children. The 174 Member States of the International Labour Organisation (ILO) in 1999 adopted the Convention on the “Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour”. The term child refers to anyone under the age of eighteen, and “the worst forms of child labour” include the sale and trafficking of children, debt bondage, forced or compulsory labour (including the forced recruitment of children for use in armed conflict), using children for prostitution or the production of pornography, using children for illegal activities, particularly drug trafficking, and other work which is likely to “harm the health, safety or morals of children.”

The International Labour Organisation (2006) estimated that 218 million children between the ages of five and fourteen work in developing countries, about half of them full time; 73 million are aged 5-9 years. 61% of these are in Asia, 32 % in Africa, and 7 % in Latin America. Here are some national, officially reported examples of child labour: Albania 4,700, Bolivia 800,000, Colombia 2.5 million, Ethiopia 3.5 million, India 100 million, Philippines 3.7 million. Of those, 126 million were in hazardous situations or conditions, such as in mines, with chemicals and pesticides in agriculture, or with dangerous machinery. They are everywhere; some are invisible as domestic servants, in workshops, or plantations. ILO has calculated that some 6.6 million children are working under the “worst conditions of labour” as defined in Article 3 of Convention 182 (not including those engaged in prostitution, see below). Of those, 5.7 million are in forced or bonded labour, 0.6 million in illicit activities and 0.3 million in armed conflicts.

Slavery still exists; on a global scale it is estimated to between 15 and 30 million people.

There are many examples of under-age work related child violence. In India, I received an informal document describing the conditions during bonded labour of young boys. They were locked up day and night, worked 12-14 hours/day, and were given no salary and very little food. If they tried to run away, their ‘owner’ would shoot to kill them. The parents had sold

them to pay debts to local loan sharks. In the India national study (Kacker, 2007), 65% of working children were under pressure to work from their unemployed parents and 76% handed over their earnings to the parents. 52% of the boys and 48% of the girls reported physical abuse; 62% of both reported sexual abuse. Other reports on child labour confirm the high risk for children of exposure to chemical and physical health hazards. In Bangladesh, the sexual abuse of child domestic workers is widely recognized (Rahman, 1995). Hadi in 2000 studied a group of 4,643 children aged 10-15 years in villages in Bangladesh. 21% of the children were in the labour force, although this was forbidden by law. Of these children, 2.3% were physically abused, 2% financially exploited, 1.7% forced to engage in inappropriate activities and 3% forced to work long hours. Out-of-school children and the children of illiterate, landless, and unskilled labourers were most likely to be abused.

In a world where 130 million children receive no education at all and where most other children finish primary school – if they get that far – before the age of 12, there must be alternative occupation by that age. There are, states ILO, degrees between exploitation of bonded children who are locked up day and night, undernourished and shot at if they try to run away, and practices that are more benign; helping, for example their families with daily chores: looking after younger children, assisting with cooking, doing light tasks in agriculture or animal husbandry or at the market, and age-appropriate apprenticeships. Aggressive elimination of all jobs for children is seen as a “negative approach” and might result in sending the children to the street to find alternative “income” through begging, crimes, or prostitution. Some organizations recommend the use of international economic sanctions to decrease child labour, or targeting certain employers or Governments. However, such approaches have proven nearly impossible to monitor; and ILO estimates that only about 5% of all working children are engaged in export industries. One should seek better means for the prevention of “the worst forms of child labour”, and – as the “extra” income is needed in poor families all over the world – try to arrange alternatives for unemployed adult family members. When secondary school education becomes the rule, child labour should decrease considerably.

Many development organizations provide assistance to remove children from hazardous environments, providing rehabilitation, and social reintegration. They are given access to individualized gradual and nuanced programmes with free basic education and meals at school. If there are no family contacts, permanent lodging and food has to be found and, if possible vocational training. Other organizations have helped to reduce child labour by providing jobs for their unemployed parents.

### **REFUGEE AND DISPLACED CHILDREN**

Article 22 of the Child Convention grants special protection to refugee children especially if not accompanied by their parents or if they are fleeing war. Like all children, they have under the Child Convention the rights to life, physical integrity, adequate food and medical care, education, and to be free from discrimination, exploitation, and abuse.

The UN High Commissioner for Refugees (2007) co-ordinates the activities related to refugees, but there are considerable political, financial, and logistical challenges in protecting the human rights of refugee children. By end-2006 the number of refugees (9.9 million), displaced persons (12.9 million) and asylum seekers (740,000), stateless persons (15 million) and others under the protection of UNHCR has surpassed a record 33 million, of which some 45% are children under age 18 and 11% underage of 5. They were uprooted by increasing persecution, intolerance, and violence around the world. Half are in Asia. Persons internally displaced in 2006, were Palestinians 4.3 million, Iraqis 4 million, Afghans 3.5 million, Colombians 2 million, and Sudanese 2 million. UNHCR, just as other international assistance organizations and NGOs has severe budget problems; “donor fatigue” has limited their

resources. By end-2006, 45% of all refugees were children under age 18, 11% under age 5. Refugee children are vulnerable. They suffer human rights abuses in countries of asylum: hazardous labour exploitation, aggression, neglect, denial of education, poor health care, sexual violence, cross-border attacks, kidnapping, militarization of refugee camps, and recruitment as child soldiers. They may be abducted, mutilated or murdered.



*Refugees: women and children waiting for food and shelter, while the men have stayed behind to continue the battle. Once uprooted, they may for many years stay away from home. © World Health Organization.*

### **CHILD PROSTITUTES**

Child prostitution is rapidly increasing; sex exploitation of children is spiralling out of control. This is explained by several factors: poverty, wars (with sex service demand by soldiers), increased tourism, and lack of viable opportunities for earning a living. The AIDS epidemics have increased the 'market' for underage sex workers, who are seen as uninfected; they are preferably virgins, and some aged 10-12 years. In some countries it is believed that sex with a virgin girl will cure an AIDS-infected man, and will also help a poor man to become rich (Lalor,2004)<sup>10</sup> A 2005 article in *The Lancet* (Rekart) estimates that at present there are globally nine million girls and one million boys in prostitution. Not all have joined the sex trade voluntarily. Some have been sold by the parents to pay off debts to a local moneylender, and some have been lured away by promises of jobs. Some have been kidnapped on the street: in India, it is estimated that 25% of child prostitutes have been abducted and sold. In Lithuania, 10-12 year old children living in residential centres have been used as actors in pornographic movies.(ECPAT, 2005) Child trafficking and outright "exportation" of "candidates" for sex work sometimes include children from neighbouring countries, this decreases the risk that they will run away. The brothel owner often forbids the young girls or boy to go out and confiscates their identification papers, so they are "slaves". They are threatened with being killed or disfigured with acid if they try to get away. In many countries sex work is decriminalized for adult workers; if not, local bribes are paid to the police to close their eyes. Brothel owners are known for making "arrangements" for underage prostitutes, as their presence is illegal.

Religious temple prostitution (Devadasi cults) has been practised for hundreds of years in Hindu religion areas (Sen and Nair, 2004; Varhade, 1998; Human Rights Watch, 2006). These cults originate from very ancient higher-caste temple traditions. Girls aged 5-9 from poor, low-caste homes are dedicated by an initiation rite to the deity in the local temple during full moon. After a girl is married to the deity by special rite, she is branded with a hot iron on both shoulders and her breast. She is then employed by the temple priest. Sometimes, even before

menarche, she is auctioned off for her virginity; the deflowering ceremony is the privilege of the highest bidder. The market value of a girl falls after she attains puberty, when she is said to have no recourse other than prostitution. Yellama is represented as the principal goddess worshipped, but the practice of Devadasi is prevalent in many other temple towns and with many other deities. By law, Devadasi prostitution is forbidden in India since 1935; efforts are still going on by the Government and some NGOs to eradicate it. In spite of the illegal status of the Devadasi girls, 4,000-5,000 new girls are recruited each year. In Delhi they constitute 50%, and in Mumbai, Pune, Solapur, and Sangli, about 15% of all prostitutes.

Global estimates on child prostitution were published in 2005 by Rekart (2005). The estimates of the annual incidence of health complications appear in Table 5.1. Rekart estimates that the total global number of child prostitutes is 10 million, of which 9 million are girls and 1 million boys. Children born to prostitutes have a very high frequency of health problems, such as HIV infections; many die early. The annual occurrence of adverse health effects in infants born to child prostitutes are assessed at: 190,000 infant deaths, 237,000 with complications related to sexually transmitted (non-HIV) diseases, 250,000 HIV infected, 55,000 deaths from HIV infection, and 8,000 infected by papillomavirus.

**Table 5.1. Health complications among 10 million child prostitutes, annual incidence**  
Modified after Rekart, 2005

Complications	Annual incidence
Substance abuse	90%
Post-traumatic stress disorder	67%
Papilloma virus infection	45%
Rape	25%
Physical assault	25%
Sexually transmitted diseases	23%
Abortions	21%
Hepatitis B infection	20%
Attempted suicide	16%

Sex work is extremely dangerous, and the harm that results includes violence (physical assaults, rape, murder) numerous infectious diseases, pregnancies often followed by abortions, alcohol and substance abuse, mental health complications, and malnutrition. Most prostitutes have a history of adverse childhood experiences. A study by the US Justice Department (2003, b) showed that in the USA 325,000 children are sexually exploited annually. Of that figure, 121,911 ran away from home and 51,602 were thrown out of their homes by a parent or guardian. They are not all poor: 75% of children who are victims of commercial sexual exploitation are from middle class backgrounds. 40% of the girls who engaged in prostitution were sexually abused at home, as were 30% of the boys. A Canadian study (Farley, Lynne and Cotton, 2005) of First Nations sex workers in 2005 revealed that 82% had a history of childhood sexual abuse, by an average of four perpetrators; 72% reported childhood physical abuse. 90% had been physically assaulted and 78% raped while working as prostitutes. 72% of them met the criteria for post-traumatic stress disorder. 95% wanted to leave prostitution; 86% had experienced homelessness. A 2003 study (Pedersen and Hegna, 2003) of 10,828 children aged 14-17 (response rate 94.3%) in Oslo, Norway revealed that the adolescents who sold sex were 1.4% of the sample. There were three times as many boys as girls; most of the clients were assumed homosexual or bisexual men. Most of the children were under the legal age of 16, when they started. There was no association with socio-demographic variables or residential area in Oslo; some children were from upper- or middle-class families.

Adolescents who take part in these activities run a considerable risk of acquiring a sexually transmittable disease, drug use, or delinquent and criminal behaviour.

Many people with important positions are involved in child abuse, knowing that it is a crime; they may appear as socially well-functioning. Sex tourism to child prostitutes in countries such as Morocco, Sri Lanka, Philippines, and Thailand involves well-to-do men, who on rare occasions receive prison sentences. Production of child pornography and human trafficking requires organizations with large economic resources. Many expatriates have been investigated for sexual exploitation of the people in developing countries they are there to help. These offenders seldom get caught, most escape unscathed because of high-level protection.

Many government and non-governmental programmes exist to prevent and punish child trafficking, child pornography, and child prostitution. Unfortunately, they are totally insufficient. It is urgent to help children to escape from sex work, and to reduce the adverse health consequences.

### **VIOLENCE AGAINST CHILDREN IN CYBERSPACE**

Assisted by Internet, new forms of child violence have appeared during the last decades. These include child pornography (see p.18) and 'live' online sexual abuse for paying customers, online sexual solicitation, cyber stalking and bullying, and access to illegal and harmful materials. Child exploiters use cyberspace to network for child sex tourism and trafficking. ECPAT International (2005) reports that

the effects of new technologies are pervasive, cause deep and lasting physical and psychological damage to the child victims, and are outstripping the resources of law enforcement agencies. Weak laws and fragmented industry action is exposing children around the world to increasingly serious violence. The child pornography industry is worth billions of dollars a year, although most child sex abuse images are traded for non-monetary gain. The main free-to-view sites have been traced to the Commonwealth of Independent States, the USA, Spain, Thailand, Japan, and the Republic of Korea. More than half of the child sex abuse images sold for profit are generated from the United States, and nearly a quarter from Russia. These countries are also the main hosts of commercial child pornography websites, followed by Spain and Sweden. Millions of child sex abuse images circulate online, and through mobile phones and peer networks. Interpol's shared child pornography database contains images of between 10,000 and 20,000 individual child victims, of whom fewer than 350 have ever been located. Urgent, wide-ranging actions are needed by governments, the industry, and all sectors of the community to combat the rise in violence against children in cyberspace.

### **TRAFFICKING**

Trafficking in human beings is defined as the recruitment, transportation, transfer, harbouring, or receipt of persons for the purpose of exploitation. Most trafficking is carried out using force, coercion, fraud, or deception; for children, often by persons who abuse a position of trust or power or employ outright abduction or theft. Some of it has been described above. The exploitation includes among others the following forced activities: prostitution, participation as soldiers in wars, labour (see above), participation in pornographic movies or Internet sex, and other practices that amount to slavery, servitude, or removal of organs; some children are known to have been killed to provide "total organ harvest". People smuggling is differently defined from 'trafficking', as it does not involve the use of force.



The extent of international child trafficking is not known; the US State Department has estimated that between 600,000 and 820,000 men, women, and children are trafficked across international borders each year – approximately 50 % are minors (Fleck, 2004, US. State Department, 2005).



*Nepalese girl in Kathmandu.  
She may not know it, but  
5,000-10,000 girls like her are  
each year abducted from the  
streets or sold by the parents for  
prostitution.<sup>11</sup>  
Millions of children are  
trafficked each year  
© World Health Organization*

Trafficking is forbidden in international legislation by:

- The Convention concerning the Prohibition and Immediate Action for the Elimination of the Worst Forms of Child Labour or Worst Forms of Child Labour Convention (ILO, no. 182, 1999), ratified by 132 countries,
- The Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (UN General Assembly, 2000)
- The European Convention on Action Against Trafficking in Human Beings (2005), signed by 34 countries.

Human trafficking is one of the economically biggest international criminal industries. Many national judicial systems, the international police and customs authorities are involved in the attempts to control it. Many children's charities are helping to take care of children who manage to escape; repatriation is common. (Wolthuis and Blank, 2001; Brian *et al.*, 2004). In spite of these efforts, there has been a "dramatic" rise in this exploitation of children.

The children described in this Chapter need to find homes, either with substitute parents or, if not possible, in a well-staffed, high quality child residential institution. The issues related to such transfers are discussed in the next Chapter.

## 6 Parent Deprivation: Consequences and Alternatives

Children who are brought up away from their parents, in an institution, suffer many negative and destructive effects. The degrading effects are physical, psychological, social, and mostly long-lasting. The residential system is no substitute for the care, the attachment, and the emotional development that develop in a family setting. It may sometimes be unavoidable to remove a child from its family home for social or for "moral" reasons, or because of parental abuse; this must be seen as the least desirable solution.

Research into childhood deprivation in institutions has been published in a large number of books and in scientific journals. Lie (1999) has formulated these conclusions at the end of an extensive review of all 92 such articles published between 1940 and 1989:

- (1) Institutional care, particularly in inadequate orphanages with few care-givers and poor stimulation, is disastrous for the child.
- (2) Different forms of deprivation: maternal, emotional, sensory, perceptual, and opportunities for imitation, – interact and cause the disorders observed.
- (3) All available studies agree that those who grow up in orphanages are handicapped, also when compared to infants who grow up in inadequate families.
- (4) Observations made even in adequately equipped and staffed orphanages, supervised by the most distinguished experts, have nevertheless shown that many children in long-stay orphanages have a high prevalence of problems, with difficulties persisting into adulthood and into the next generation.

Frank *et al.* (1996) reviewing "a large body of medical knowledge" state that:

infants and young children are uniquely vulnerable to the medical and psychosocial hazards of institutional care, negative effects that cannot be reduced to a tolerable level even with massive expenditure. Scientific experience consistently shows that, in the short term, orphanage placement puts young children at increased risk of serious illness and delayed language development. In the long term, institutionalization in early childhood increases the likelihood that impoverished children will grow into psychiatrically impaired and economically unproductive adults.

### REACTIVE ATTACHMENT DISORDER

Normal attachment develops during the child's first two to three years of life. Problems with the caregiver-child relationship during that time, such as an orphanage experience, interfere with the normal development of a healthy and secure attachment. There are wide ranges of attachment difficulties. If an infant's needs are not met consistently in a loving, nurturing way, attachment will not occur normally and may manifest itself in a variety of symptoms. When the first-year-of-life attachment-cycle is undermined, mistrust begins to define the perspective of the child, and attachment problems result. The developmental stages following the first three years continue to be distorted and/or retarded.

It should be noted that this description relates to Western 'modern' families, who live on their own. In other situations, there are multiple nurturing figures: grandparents, older siblings, aunts and uncles, long-time family employees, and so on. Attachment also develops with them. This is often seen in developing countries. Another factor that contributes to early bonding in the developing countries is the mother's habit of strapping the infant to her back and carrying it along during day-time, until the next baby arrives and takes over the place.

Based on this and other evidence (Boris *et al.* 1998; Cicchetti, 1990; Carlson 1998), the WHO in ICD-X, and the APA in DSM-IV included 'Reactive Attachment Disorder' (RAD) among the list of mental disorders of infancy or early childhood. RAD is defined as a psychophysiological condition with markedly disturbed and developmentally inappropriate social relatedness in most contexts; it begins before five years of age and is associated with grossly pathological care. This pathological care-giving behaviour may consist of any form of neglect, abuse, mistreatment or abandonment. Due to violence by caregivers, RAD sufferers have difficulty forming healthy relationships with them, with peers, and with families. RAD can reportedly be diagnosed as early as the first month of life. There are several articles describing dyadic treatments for RAD (Speltz, 2002; Becker-Weidman, 2006; Hughes, 2003).

### **BIOLOGICAL CORRELATES**

Neurobiological mechanisms underlie the formation of bonding in infants and children. Based on research, it is known that oxytocin (OT) and vasopressin (VP), which are part of the neurohypophyseal peptide (AVP) system, are critical for the establishment of social recognition and bonding, and for the regulation of emotional behaviours. Fries et coworkers (2005) have recently published a study of a group of 18 children who had been abandoned at birth to 'orphanages'. They had then resided there for an average of 17 months. After that period, they had transferred to adoptive homes where they had been for an average of 35 months at the time of the study. The results of the measurements of the OT and AVP peptides were compared with 21 children of the same age who had been reared by their biological parents. Early neglect leads to decreased levels of OT and AVP. The study showed that even after 3 years of rearing in relatively stable, enriched, and nurturing family environments following the "orphanage" experience, the normal levels of OT and AVP had not been restored. Social deprivation inhibits the AVP system, which is critical for recognizing familiar individuals, a key component in social bonding. The data provide a potential explanation for how the nature and quality of children's environments shape the brain-behavioural systems underlying complex human emotions. More about oxytocin and vasopressin in the regulation of human behaviour follows in Chapter 9.

### **FAMILY SUPPORT**

In developed countries, the alternative to residential care could be technical and economic support to the families; using community-based and home care services, day centres for training and for education inclusive facilities. The World Health Organization has published a monograph by the well-known psychiatrist Bowlby (1951), where he states:

There are today governments prepared to spend up to 10 Pounds a week on the residential care of infants who would tremble to give half this sum to a widow, an unmarried mother, or a grandmother to help her care for the baby at home. Indeed, nothing is more characteristic of both public and voluntary attitudes towards the problem than a willingness to spend large sums of money looking after children away from their homes, coupled with a haggling stinginess in giving aid to the home itself. These problems should be solved by methods other than retaining the children in an institution.

In the poor countries, Government economic child support is rare. Until now it has been common to see the extended family helping, but in urban areas such willingness is declining. When there is no help, infants may be abandoned or neglected, and some will die.

### **SUBSTITUTE FAMILIES**

When needed for children who are by legal decision removed from their biological parent(s) – arrangements should be made for substitute family-based care (see also p. 125).

## Adoption

Many countries have national legal adoption procedures. There is in existence since 1993 "The Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption"<sup>12</sup> Its key principles include: ensuring that intercountry adoptions take place in the best interests of children: preventing the abduction, exploitation, sale, or trafficking of children. By February 2007, 70 countries had ratified and three had signed the Convention. There are rules for the process by which parents give up their child for adoption. After an application by the adopting parent(s), there follows a determination of eligibility, and assessment of suitability, to adopt. These are mostly carried out by national authorities with specialized personnel and may be time-consuming. If one were to handle the adoption with respect to available scientific knowledge, all such children should be transferred to the adoptive parents within a period not exceeding six months, preferably even less. Many infants awaiting adoption, however, are sent to child residential institutions, and some stay for years. During that time they acquire RAD, for many with life-long consequences. A study by the US National Adoption Center found that 52% of adoptable children had symptoms of RAD (Boris et al. 1998) Governments should lose no time to speed up the heavily bureaucratized adoption system that causes a lot of damage to defenceless children (Brodzinsky *et al.* 1992).

## Foster parents

Foster parents in developed countries are usually paid for taking over the care of children who are biological or social orphans, or who have been removed by judicial authorities. An example of such a transfer appears in Box 6.1 (Helander, 2007)<sup>13</sup>.

### **Box 6.1. Children transferred from a residential centre to foster families'**

Twenty-eight children in a small town in Romania have during the last few years been transferred from the local residential centre to foster families. The children were 4-17 years old at the time of the transfer, 17 were girls, 11 boys. All except one had lived in residential centres since soon after birth. They had been healthy infants abandoned soon after birth, and had no disability when they arrived. The reason for institutionalization was poverty. All had been raised in at least two such centres since they were born; several had been to three or more centres. To transfer the children to foster families was a challenge; for they all had severe induced disabilities caused by the years spent in institutions.

The foster parents were carefully selected and trained before the change took place, and social workers are still giving them continuous support and advice. Twelve of the foster parents had previously been employed by the residential centre. They were all paid a salary for the work; their homes were nice and well-equipped. I have interviewed all parents and seen all the children twice. The parents told me that they were happy with their 'new children', and the social workers confirmed that there were no major problems for the children to adjust to the new homes.

During the children's stay in the centres, their functions had become affected to the degree of severe disability. Only four were fully continent, one was wetting, and 23 were both soiling and wetting. Fourteen could not eat alone and 26 could not wash themselves. Many were unable to dress alone and some had mobility problems.

Sixteen of the children had been transferred already in 2001 and 2002; thus at my examination they had been with the foster parents for 2-3 years. Within months after the transfer to the foster families, most the "functional" deficiencies described above had been overcome with training. All were fully continent. Only one child still had problems walking, all but one was eating alone, but nine still needed help with washing.

Twelve other children were transferred in 2004, and had only been with the foster parents for three months when I saw them last time; there were not yet much change, except that now only eight instead of 11 children were both soiling and wetting.

But there were also emotional and behavioural problems. All 28 children had pronounced post-traumatic stress disorder with nightmares, depression, anxiety, and crying. They were overly dependent on constant affection, and some had difficult behaviour. These symptoms have been slow to disappear, in some there have been minor improvements.

The most striking symptom was their speech problems. Only one could speak (a child admitted at age 5 already speaking) when they left the centre. Even after daily training by the foster parents during three years, none of them is able to speak more than a few very simple short syllables. No children were autistic or had hearing problems. This will make it difficult for them to attend school and find jobs and incomes as adults. The speech problems are likely to remain unresolved for life; children who have not learnt to speak phonemes before the age of 6 will never speak, probably the brain cells involved in speech have been 'pruned off.'

Brain scans of children from Romanian orphanages show decrease of brain size and grave disturbances of brain function (Perry, 2002), see p. 93.

Sylvestre *et al.* (2002) in a Canadian report estimated the prevalence of communication problems among children under the age of three taken into care for parental negligence. In a representative sample of 84 such children 46.4 % presented problems in at least one area of communication. The seriousness of the condition increased with age; boys were more affected than girls.

Foster parents may face many difficulties and need training and supervision. Neglected children may show lack of skills in daily life activities; they may be malnourished and not used to proper hygiene. After transfer to foster parents, many physical consequences such as weight and height are often normalized within one year. Change of foster parents should be avoided, as it is traumatic for the children and may lead to adult consequences. For example, Marilyn Monroe's father left before she was born; her mother had a mental disorder, so she become a "ward of the State", first stayed in a 'child home' and then experienced 12 different foster families. She felt unwanted and unworthy of love, growing up with her emotional needs unmet (Asbury, 2003).

Children who have been transferred for severe behavioural problems or early significant delinquency may need foster parents who are professionals (e.g. psychologists, social workers), a system that has been tried with success in some developed countries.

### **Residential homes**

Residential homes for children removed from the parents may be the last resort when no other solution can be found, for example if one cannot find any substitute families willing to take care of them. Such homes should be very small, aiming at creating a family atmosphere; large inputs for training, social education, and professional advice – if available – should be sought. Treatments with dyadic psychotherapy for RAD have proven effective and should be integrated.

Residential homes of this type are found in many developing countries. Quite a lot of them are managed by NGOs for the groups of children mentioned in Chapter 5. Many of those that I have visited have good qualities, and are different from the mostly huge government-managed institutions that were described in Chapter 4.

In the following Part, the evidence will be presented about violence against children who live in their birth homes, and of the short- and long-term consequences of child violence.

PART THREE: THE EVIDENCE OF DAMAGING  
EFFECTS BY THE MESOSYSTEM: CHILDHOOD  
VIOLENCE OCCURRING IN BIRTH HOMES, AND ITS  
CONSEQUENCES

## 7 Prevalence of Childhood Violence

In the previous Chapters, we dealt with the children whose microsystem lacked the most important component of the mesosystem: the parents. This Chapter will examine how common violence is among 'ordinary' children, who live with their birth families.

### SEXUAL ABUSE

Many studies originating in Western countries differentiate between three levels of child sexual abuse:

- (1) non-contact (exhibitionism, verbal threats, harassing or inappropriate proposals, photographing sexual parts of children and adolescents, showing children how to masturbate, asking the child to masturbate);
- (2) contact without penetration, and
- (3) penetration/intercourse.

In the studies appearing below, different definitions of levels of reported sexual abuse have been used (see p. 13-14, 19-21). One specific issue is whether to include non-contact sexual abuse. WHO (Andrews, *et al.*, 2003) when applying a narrow CSA definition (criteria 2 and 3 above) had a prevalence of 19%; those who applied a broad definition (criteria 1, 2 and 3 above) had a 23% prevalence rate. When only one question was asked to assess CSA, the prevalence was 14%; with more than one question it went up to 23%. Other studies (Gorey and Leslie, 1997) use narrow CSA to include only criterion 3 above, middle includes 2 and 3 and broad 1, 2 and 3. Cultural factors have to be kept in mind while reading published studies. In some countries, verbal sexual harassment, forced kissing and hugging are taboos and are included in the statistics of sexual abuse (see Ethiopia Table 7.1., India and Israeli Bedouin-Arabs in Table 7.4.): in many countries, this is serious abuse.

#### Sexual abuse in developed countries.

There are few prospective longitudinal studies of risk factors for sexual abuse. Fergusson *et al.* (1996) followed, from birth to age 16, a cohort of 1,265 children born in Christchurch, New Zealand, in 1977. At 18, retrospective reports of sexual abuse before age of 16 were obtained and risk factors that had been prospectively assessed were examined. Of the 1,019 subjects interviewed at age 18, 10.4% indicated that they had been sexually abused (17.3% females and 3.4% males). Major risk factors were: female gender of the victim, marital conflict in parents, poor parental attachment, paternal overprotection, parental alcoholism, and other social problems. The level of prediction was, however, weak. Collin-Vezina and Cyr (2003) studied trans-generational transmission of sexual violence and found that of parents who themselves were molested in childhood, one third of the men and half of the women went on to molest their own children. Ertem *et al.* (2000) made a review all articles of such transmission and found that only one of ten studies fulfilled all desirable scientific criteria; that study showed an increased relative risk of intergenerational physical abuse by 12.6.

Recidivism is common; Doren (1998) calculated that the lifetime rate for extrafamilial sexual abusers is 52% and for rapists 39%; the percentage of new offences at the end of 25 years was 26% for rapists and 32% for child molesters. Arszman and Schapiro (2000) analyzed the records of 31 paedophiles who confessed between 1994 and 1999. The 31 perpetrators confessed 101 acts of sexual abuse of 47 victims, some of whom were victimized multiple times. Out of the 47 victims, 45 were old enough to provide a history describing 111 acts of abuse. Holmes and Sammel (2005) made a study of abuse rates among criminals. They found that 10-20% of all non-criminal boys were sexually abused, in comparison the rates

among criminals are much higher: 33% of male juvenile delinquents, 40% of sexual perpetrators, and 76% of serial rapists reported CSA. 31% of women in prisons in USA in 1991 and 95% of prostitutes had been sexually abused as children.

Holmes and Slap (1998) have undertaken a meta-analysis of 166 studies of boys, published in peer-reviewed journals, representing 149 samples. The authors conclude that sexual abuse of boys is "common, underreported, under-recognized, and underrated." The US Department of Health and Human Services (1997) stated that boys experience 48.5% of all childhood abuse. In the past abuse of boys may have been underestimated. Terry and Tallon (2005) have compiled a major review of the literature of sexual abuse. Sperry and Gilbert (2005) culled an archival data set containing retrospective reports of childhood sexual experiences for instances of sexual abuse by child peers. They found 8% of females and 4% of males reporting at least one experience of sexual abuse before age 12 (mean age 8.2) by a child peer. These experiences involved some degree of force, and were clearly unwanted, and were perceived as "mostly negative". Their findings suggest that child peer abuse may be associated with adverse mental outcomes.

Other studies were made in the Czech Republic (Rarboch, 1996), Denmark (Fabricius *et al.*, 1998; Riis *et al.*, 1998), Finland (Sariola, 1994), Greece (Agathonos-Georgopoulou and Brown, 1997), Japan (Nakamura, 2002; Ikedar, 1995; Tarimura *et al.*, 1995), Norway (Bendixen *et al.*, 1994), Poland (Deres and Kulik-Rechberger, 2001), and the United Kingdom (Mackenzie. *et al.*, 1993. Morris *et al.*, 1997). These generally confirm reported sexual abuse prevalence of 15% to 20%. In some countries it is lower (Documentation Française (2002) and in others it is higher.



*This 13-year-old girl was drugged by her date and then raped. The offender left sucking marks on her neck. Credit Dr. James Williams, © Volcano Press USA*

### **Sexual abuse in developing countries.**

In developing countries, talking openly about sex is often a taboo, even among professionals. There is little or no knowledge about symptoms of abuse and neglect in general. The truth is slowly "seeping" in from abroad, and initially becomes known to professionals in the health and social services. Crimes become apparent, such as infections of minors by sexually transmitted diseases, physical damage, and detection of pregnancies among under-age girls (Haj-Yahia and Tamish, 2001), many caused by incest and rape, which are cultural taboos. When the evidence becomes better known, the avalanche of knowledge emerges and the demands for action start. The level of abuse of all types in the developing countries will eventually be identified as being on the same or on a higher level than in the "affluent" nations. Some developing country studies reveal that boys have the same or higher sexual abuse rate than girls (South Africa: Petersen *et al.*, 2005; in Israel (Zeira *et al.*, 2002) and in India: (Kacker *et al.*, 2007). This may be typical in several other countries with a high rate of



peer abuse of boys. Many articles from developing countries confirm a high incidence of CSA, although there are many cultural constraints hampering the account of sexual abuse. In Pakistan (US State Department, 2004) evidentiary requirements for sexual offences include that four adult male Muslims must witness the act. Half of all rape victims there were juveniles. Very few rapes were, however, reported to the police because the women risk being prosecuted for adultery; 80% of the women who are in jail in that country are there because of alleged adultery. In Ecuador (US State Department, 2004) a woman can only file a complaint for rape if she can produce a witness. Of 3,083 rapes reported; 656 persons were charged; but only 118 prosecuted.

A large proportion of sexual abuse is related to socialization into unequal gender relations, rape myths, peer pressure, and sexual urge. A detailed example from South Africa follows (Box 7.1.)

#### **Box 7.1. Sexual behaviour among the youth in South Africa.**

Peterson, Bhana et McKay (2005) report from South Africa one of the highest rates of sexual violence in the world: at least 44% of females and 29% of males had experienced childhood sexual abuse; girls aged 12-17 are at particularly high risk. There are multiple streams of influence for adolescent boys and girls becoming either victims or perpetrators of sexual violence. In several representative groups of high-school children/adolescents aged 13 to 16 years, in-depth individual interviews and "focus group" discussions were made.

The adolescents mentioned the following factors:

(1) Cultural/environmental influences. The boys are socialized from an early age into traditional patriarchal notions of masculinity, which promote and legitimize unequal gender power relations. Rape myths are held by many, for example, that men are unable to control their sexual urges. Sexual violence is a strategy used by boys/men to put girls/women in their place if they become too independent and assertive. Sexual abuse of children was understood by the researcher as a mechanism that was sometimes used to punish the mother of the child, if she did not comply with her partner's demands. Sex was viewed as a commodity that could be exchanged for favours, normally food or money. Sexual abuse within and without the family was often condoned because of economic dependence on the abuser. Poverty plays a direct role in increasing a child's vulnerability to falling victim to sexual abuse, disparities in id they values emerged as risk influences contributing to intra-personal anger and increasing the risk of boys becoming perpetrators of sexual violence. There is also the absurd and perverse notion that having intercourse with a virgin will cure HIV/AIDS.

(2) Situation context/normative influences. Social norms and social pressures prescribe that boys/men should have sexual relations as a marker of their masculinity. Boys/men commit rape to show masculinity if they have no partner. Perceived norms are weakening the traditional protective role that brothers have played in protecting their sisters from rape and abuse by other boys; there is a "sell-out" as part of boys' friendship with other boys. Lack of adequate role model by fathers emerged as a risk: they were often absent from home, or were poor models leaving the mothers with the burden of raising their sons on their own. Modelling of violence against girls/women is contributory when such violence is regarded as normative behaviour. When boys reach puberty, there is poor parental monitoring or outright neglect; this increases the possibility of affiliation with negative peer groups. Traditional parental support is eroding, and that includes support for the girls. The formal justice system is inadequate, and community social controls have been eroded.

(3) Intra-personal level influences. There is evidence that a child who is abused and neglected is likely to become a sexual abuser later in life. Abused girls in particular, but also some boys, later lack assertiveness and refusal skills as a consequence.

In South Africa, as in many other countries, the low status of women contributes to their victimization. Education should include learning to change the present aggressive attitudes and behaviour of the males and the submissive behaviour of the females.

Female genital mutilation affects some 135 million women (see p. 21).

During the last 30 years of civil wars and unrest, rapes of thousands of women and underage girls have been committed as part of "a strategy of intimidation" in Algeria, Angola, Bosnia, Colombia, DR Congo, Liberia, Rwanda, Sierra Leone, and Uganda.

Small-scale studies of childhood sexual abuse have been published from Bangladesh (Rahman,1995), Bahrain (Al-Mahroos et al., 2005), Botswana (Mathoma *et al.*, 2006), Cameroon (Rwenge, 2000; Menick and Ngoh, 2003), El Salvador (Barthauer and Leventhal,1999), Ethiopia (Lakew, 2001; Mulugeta *et al.*, 1998), Hong Kong (Tang, 2002), Hungary (Csorba *et al.*, 2006), Indonesia (Hakimi *et al.*, 2001), Lesotho (Brown *et al.*, 2006), Malawi (Lema,1997), Malaysia (Sing *et al.*,1996), Papua New Guinea (Johnson and Ambihaipahar,1999), Pitcairn Island<sup>14</sup>, Republic of Korea (Hong *et al.*, 2004) Singapore (Yiminget Fung, 2003), South Africa (Adedoyin and Adegoke,1995; Howard et al., 1991), Sri Lanka (Miles, 2000), Swaziland (Mathoma *et al.*, 2006), Tanzania (Rajani 1998), and Zimbabwe (Watts,1998). The selection below reflects the presently available results from a variety of countries; the quality and methods used differ. Some studies were presented in Box 2.1. (p.19) and more are appear in Table 7.4 (Combined abuse), (p.69-73). The specific problems affecting most of these studies are the high attrition rates and under-reporting among the responders, described in Chapter 2.

**Table 7.1. Prevalence of sexual abuse, selected studies**

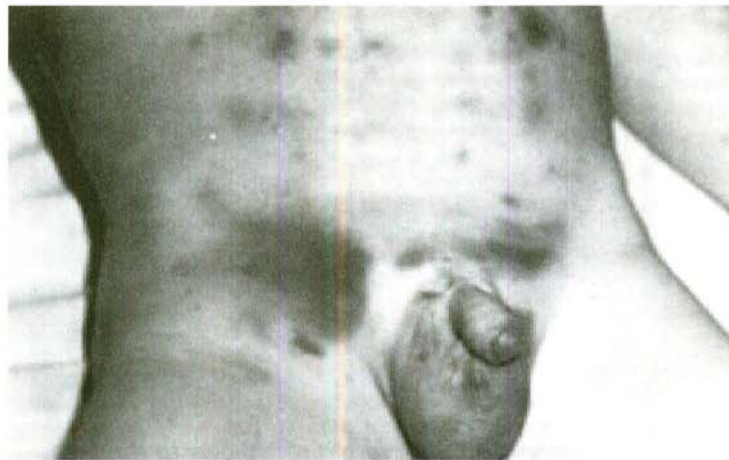
Country	Authors	Type of study, comments	Results
Antigua and Barbados	University of California, 2006	Sample of women in Barbados	30% reported undesired sexual contact with a relative or with someone more than 5 years older than them before age 16.
Australia	Goldman and Padayachi 1997	Group of undergraduate students	18.6 % male, 44.6% female forced into unwanted sexual acts; incest had a prevalence of 10% of males, 19% of females.
China	Chen <i>et al.</i> 2004	Study of 892 students in Beijing; there were no dropouts	26% of the all-female participants had experienced sexual abuse before the age of 16
Costa Rica	University of California, 2006	Costa Rica college students	32% of women and 13% of men reported unwanted sexual activity during childhood.
Costa Rica	Heise <i>et al.</i> 2002	Study of pregnant girls aged 12-16, admitted at hospitals	95% of pregnant girls aged 12-16 subjected to incest or rape.
Ethiopia	Worku <i>et al.</i> 2006	323 female students from grade 9 (age about 14-15 years)	Prevalence of CSA 69%, most common was aggressive verbal harassment 51%; sexual intercourse 18%. 7% unwanted pregnancy, 6% sexually transmitted disease.

Germany	Wetzels <i>et al.</i> 1995	Sample of 2,104 women aged 20-59	15% reported that they had been victims of (attempted) violent intercourse.
Great Britain	Cawson <i>et al.</i> 2000	Young adults (aged 18-24) in retrospective self-reports	16% had experienced contact sexual abuse 11% unwanted sexual assault before age 13.
Ireland	McGee <i>et al.</i> 2003	Random selection of adults (n=3118) Telephone interviews Response rate 71%	20% of women reported contact and 10% non-contact childhood sexual abuse. 16% of men reported contact and 7% non-contact childhood sexual abuse. 67% of abused girls and 62% of abused boys were abused before the age of 12. For 58% of girls and 42% of boys, the abuse lasted more than one year. Women reported 42% life-time sexual abuse or assault (penetration/attempted penetration 31%), men 28% life-time sexual abuse or assault (penetration/attempted penetration 21%). 28% of the women and 20% of the men were re-victimized by a different perpetrator.
Israel	Schein <i>et al.</i> 2000	1005 randomly selected patients attending family practitioners, aged 18-55, response rate 81%	31% of females and 16% of males reported childhood sexual abuse. Victims knew 55% of the perpetrators. 26% of female and 7% of the male victims reported intra-family abuse.
Jordan	Jumaian, 2001	Male college students	27% sexually abused before age 14.
Korea, Republic of	Shim 1992	Population study	17% of women reported attempted or completed rape.
Morocco	Alami et Kadri 2004	Interviews with a representative sample of 728 women, aged 20 and above	9.2% reported childhood sexual abuse. Those abused during their childhood suffered sexual disturbances as adults.
Nicaragua	Olsson <i>et al.</i> 2000	Representative urban sample of literate men and women aged 25-44. 289 men and 322 women were invited to take part in the survey, and 53% of the men and 66% of the women participated	20% male, 26% female reported sexual abuse, occurring before age 19. Women were victims of attempted or complete rape twice as often as men. 1/3 of the men and 2/3 of the women were abused by family members. Median age at first abuse 10 years for both boys and girls.

Peru	Heise <i>et al.</i> 1992	Study of pregnant girls aged 12-16, admitted for childbirth at hospitals	90% of the girls were pregnant because of incest or rape.
Romania	Artemis, 2000	851 girls and 416 boys, aged 14 to 19 attending school, interviews	19% of the girls and 4% of the boys had experienced sexual acts against their will, in half of the cases by somebody they knew.
Sierra Leone	Coker and Richter 1998	Population sample	50% of all women respondents had been coerced to have sex by a male partner. Many of them were underage. Sexually mutilated women were at a significantly higher risk.
South Africa	Collings, 1991	Female university students  Male university students.	44% of 94 female students had as children experienced sexual abuse or harassment; for half it had been contact sex abuse. 29% of the male students had been victims of child sexual abuse.
South Africa	Madu and Pelzer, 2001	414 high school students aged about 15-16	CSA rates were 60% for the boys and 53% for the girls. Among them, 87% were kissed sexually, 61% were touched sexually, 29% were victims of oral/anal/vaginal intercourse. "Friend" was the highest indicated perpetrator in all patterns of sexual abuse. Many victims (87%) perceived themselves as not sexually abused as a child.
Sweden	Krantz and Östergren 2000	Rural sample, women 40-50 years old	32% had experienced childhood sexual abuse; 16% sexual abuse as adults.
Switzerland	Bouvier <i>et al.</i> 1999	Random sample of 1193 14-19 year-olds	11% of males and 34% of females had experienced child sexual abuse.
Switzerland	Torella <i>et al.</i> 1994 Niederberger, 2002	Initially representative sample of Swiss-German women, dropout rate 58%	Sexual abuse prevalence 40% overall and 15% for severe abuse. Average age of first abuse 11 years, 25% experienced first sexual abuse before age 9.
Taiwan	Luo, 1996	Estimates based on official reports.	Annually over 10,000 sex crimes, 42% relating to children and adolescents. In a brutal child sexual abuse incident, "the abuser dragged, with a bamboo stick, the intestines out of a dying 5-year old girl."

Taiwan	Luo, 1998	Conclusion based on local culture.	In "Marrying my rapist?" Luo states "patriarchal control over women's sexuality has been transformed into a cultural fetish for female chastity"
Tanzania	Matasha <i>et al.</i> 1998	Random sample of 892 school children aged 12-19, in which 85% of the boys and 58% of the girls were sexually active. 14% of girls (mean age 14) had been pregnant; half of those had an illegal abortion.	Nearly half of the sexually active girls and 7% of the boys reported their first sexual experience as forced. Half of the primary school girls had already had sex with adults, including teachers and relatives.
Tanzania	McCran <i>et al.</i> 2006	Sample of 487 university students, mean age 29 (20- 53).No attrition	Prevalence rate for CSA 31% for females and 25% for males, at age 13.
Turkey	Elal <i>et al.</i> 2000	Study of 1,597 college students by self report	CSA (broad definition) experienced by 16.0% of males and 28.0% of females.
Turkey	Eskin <i>et al.</i> 2005	1,262 university students	28% reported at least one instance of sexual abuse during childhood, those with a homosexual or bisexual orientation had increased risk for suicidal ideation.
USA	Felitti <i>et al.</i> 1998	Survey by Kaiser Permanente, (HMO) in California. It included 17,000 adults; 71% response rate; mean age 56 years.	22% experienced contact sexual abuse during childhood or adolescence. 8% responders excluded because they did not reply to the questions about childhood sexual abuse, thus the prevalence might be higher.
USA	Gorey and Leslie 1997	Review of 16 studies of child sexual abuse	Average prevalence of female CSA 22.3%; male 8.5%. Response rates 25% to 98%. In studies between 1969 and 1985 the response rate averaged 68%; after 1985 the response rate dropped to 49%. Those responding in surveys after 1984 reported systematically higher prevalence rates of abuse than those before 1984. Child abuse definitions influenced prevalence rates: female CSA, narrow definition 8.3%, middle 17.8%, broad 36.3%, male CSA narrow 6.6%, middle 7.2% and broad 11.5%.

USA American Indians	Robin <i>et al.</i> 1997	Sample of 582 American Indians	49 % of females and 14% of males had been sexually abused, 78% by family members. The victims showed a high frequency of subsequent psychiatric disorders.
USA	Wyatt <i>et al.</i> 1999	Los Angeles County sample of 10,204 women aged 18-36 years	34 % had experienced at least one incident of sexual body contact, 75% of those very severe before age 18. The refusal rate for the interviews was 29%. No changes in prevalence rate over the last 10 years. Most incidents were not reported.
Zimbabwe	Nhundu <i>et al.</i> 2001	Teacher-perpetrated sexual abuse	All perpetrators were male teachers. 98 out of 110 victims were girls. The mean age of victims was 12 years; in 70% the abuse was penetration. 83% of teacher perpetrators were dismissed from their jobs.
21countries	Finkelhor, 1994	Retrospective study of 21 countries	3%-29% of males, 7% to 29% of females, reported sexual abuse. Many studies showed females abused 1.5 to 3 times more than were men. One third of the above was intrafamilial.



*Bruises on the lower abdomens, pubis or perineum should raise suspicion for sexual abuse. Credit Dr. James Williams, ©Volcano Press USA*

### PHYSICAL ABUSE

There is less published information on physical than on sexual abuse. In many countries it is legal to physically punish children. It is forbidden by law in about 17 countries. In 24 additional countries, corporal punishment in school is forbidden (Global initiative, 2006).

### Physical abuse in developed countries

Children suffer physical abuse from three major groups: parents, teachers and other children. Working children have a high probability of being abused by their employer or supervisor.

The reported incidence and severity of physical abuse by parents tends to vary considerably in the world. This is partly objective reality and partly the result of inadequate or dishonest record keeping. Many experts share the opinion that physical abuse is more common than sexual abuse. Data registered by authorities are much lower than those based on sample surveys. In the OECD countries the number of reported cases of child abuse and neglect has risen, reflecting increasing awareness of the issue (Innocenti, 2003): in the USA, reporting increased five-fold over a period of 20 years. A 1997 federal law in United States establishes the rights of parents physically to punish their children (Dietz, 2000). The US Prosecutors Research Office has, however, in 2004 produced some guidelines for the Courts (Vieth, 2004). They state:

- Parental license to discipline is not a license to maim a child
- Spanking preceded by an explanation of the infraction and followed by an affirmation of parental love looks like discipline. Take away an explanation of the infraction; take away the affirmation of love and the conduct looks less like discipline. Add a litany of derogatory insults hurled at the child and a pattern and location of injuries unexpected from a spanking, and the picture of child abuse develops.

Teachers play a large role in physical punishment. According to the National Coalition to Abolish Corporal Punishment in Schools, 342,038 US school children were hit by teachers in 2000. In Canada, the Criminal Code allows "reasonable" force on the part of a teacher or a parent as a disciplinary measure. A Mexican code reads: "Persons exerting legal tutoring have the faculty to moderately correct and punish their children".



*Eye trauma resulting from direct blows to the face.  
Credit Dr. Barton Schmitt, © Volcano Press USA*

McCormick in 1992 showed that 67% of primary health care physicians and paediatricians sampled in USA approve the use of physical punishment. Countries with poverty and lower general-education levels practice abuse of children more than the richer ones. In USA, children living below the poverty level experience twice as much reported abuse as those above that level do. Half of those investigated by the US Child Protection Services live in

welfare-supported families. To beat children is seen by many parents as “part of the normal upbringing”. In OECD countries 20% to 75 % of women report that the husbands regularly beat them (Innocenti, 2003). Some of these countries are outside the Western sphere, and have higher rates. Severe physical abuse of intimate partners is noticeable not just among poor people and, it often has severe traumatic effects on children: in many developing countries, ‘wives’ are as young as 12 years. When there is physical abuse of women, there is most often physical abuse of children. More data appear in Table 7.3.

### **Physical abuse in developing countries**

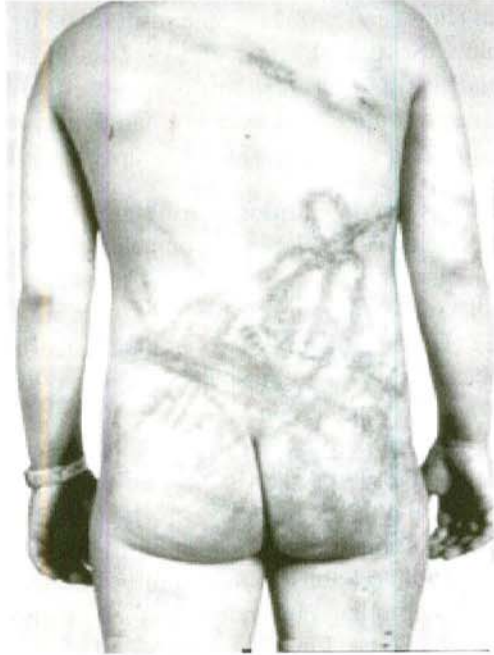
Most people in developing countries sincerely believe that corporal, psychological, and emotional punishment is beneficial for all children; parents and teachers argue that deliberately inflicted pain is ‘character building’ and vital to the ‘development of strength and endurance’ (Hesketh *et al.*, 2000, National Clearinghouse, 2000). Very high incidence numbers of ‘childbeating’ were found in Nicaragua: 69% (Ellsberg, 2000); Papua New Guinea: 67% (Johnson and Ambihapahar, 1999); Turkey: 58%, (Dietz, 2000); and Kuwait: 86% (Qasem, 1998). Most abuse, even when the health consequences are very serious, is never reported to the police and the perpetrator is virtually assured of impunity. Immigrants might ‘travel with or inherit’ their ethnic attitudes and behaviours, originating in from their ‘root’ countries. Ferrari (2002) compared 150 parents in USA of Hispanic, African, and European descent. A history of childhood abuse was found to be predictive of the use of both physical and verbal punishment by mothers, but not for fathers. Cultural factors/beliefs were predictive of fathers’ parenting behaviours, but not mothers’. Ethnicity, as a demographic variable, continued to be a significant predictor of parenting behaviours and attitudes for all parents, controlling for cultural factors. Hesketh *et al.* (2000) published a questionnaire-based communication about the views and experiences of 331 paediatricians and nurses, made in eight hospitals in two provinces in Eastern China, one rather wealthy and one very poor. The response rate was 98%. None of them had any training in the recognition and management of child abuse. When asked about their professional experience of clinically observed child abuse, almost no cases were mentioned. 86% would not consider it child abuse when faced with an injured child. Almost all believed that physical punishment is widely used by Chinese parents and half of the respondents stated that beating as punishment was acceptable at any age.

Community violence is common in developing countries: fist fights and use of guns, knives, machetes, and other hand weapons are very common. In some parts of the world – such as the border between Chad and Sudan – not only men, but also women, carry knives with them all the time “for their own defence” (Helander, 2003). A UNICEF study in Somalia (Helander, 1988) (before the civil war) covered four district hospitals each of them serving about 100,000 people. The author states that “it was surprising to find that in the hospital records dating two years back, the only patients admitted for treatment in the hospital consisted of hundreds of cases listed as ‘wounds’ (dhawac). The hospital staff described these ‘wounds’ as resulting from domestic violence and other forms of community fighting. Other patients coming to the hospital had not been admitted as in-patients”. Witnessing family and community violence is traumatic to children’s health. Severe physical abuse of intimate partners often victimizes children.

Violence awareness is increasing in the developing countries. The level of abuse of all types in the developing countries will eventually be identified as being on the same or on a higher level than in the “affluent” nations. Small-scale studies of childhood physical abuse have been published from Bahrain (Al-Mahroos *et al.*, 2005), Cambodia (Nelson and Zimmermann, 1996), Ghana (Forjuoh, 1995), Kenya (Sukjumbo and Bwibo, 1993, Kuwait (Al-Moosa *et al.*, 2003), Mexico (Baker *et al.*, 2005), Nigeria (Chianu, 2000) and Palau (Collier,



1999). Some studies were presented in Box 2.1. (p.19) and more appear in Table 7.3 (Combined abuse, p.69-73).



*Whip injury: this 10- year-old child was beaten with a braided rope.*  
Credit Dr. James Williams,  
©Volcano Press USA

**Table 7. 2 Prevalence of physical abuse, selected studies**

Country	Authors	Type of study	Results
Canada	Macmillan <i>et al.</i> 1997	Community sample of 9.953	31% (severe 11%) of males and 21% (severe 9%) of females were victims of physical abuse.
Chile	Vargas <i>et al.</i> 1995	Sample of children and parents in (1) state and (2) private schools	80% of parents in group (1) and 57% in group (2) admitted child battering; mothers were leading abusers. Children reported parental physical abuse: 86% in state and 54 % in private schools.
Egypt	Youssef <i>et al.</i> 1998 a, 1998 b	2,401 high school pupils, aged 11-20, parents' and teachers' behaviour studied	38% severely punished by parents; of those, 26% reported physical abuse causing fractures, loss of consciousness, concussion, and a permanent disability. In 25% the abuse required medical consultation. The risk of corporal punishment increased with low parental education, unskilled father, father's use of alcohol, living in cramped quarters, and when there were constant fights and quarrels among family members. 80% of the boys and 62 % of the girls incurred physical punishment from their teachers. 26% of the boys and 18% of the girls suffered injuries (contusions, fractures, and loss of consciousness).

Ethiopia	Ketsela and Kebede 1997	Sample of 649 children in state schools	78% of all schoolchildren physically punished; 21% urban and 64% rural children reported bruises and swelling from parental punishment, but only 6 visited a health centre.
Germany	Pfeifer <i>et al.</i> 1999	Sample 14,000 pupils age 15-16	During the last 12 months, 15.3% had been subjected to physical abuse.
Great Britain	Leach 1999	London Maternity service, clinical sample	97% of all 4-year-olds were physically punished, half of them more than once a week. 25% of these children were regularly hit with straps or canes
Hong Kong	Tang 1998	1019 children under 16, selected randomly.	Minor physical violence 53%, severe battering to 46%. Highest rate of severe violence among boys aged 3-6, mainly by mothers. These high findings "can be understood in light of the cultural values concerning parent-child relation and child-rearing practices in contemporary Chinese societies; filial piety obliges parents to assert authority and inflict punishment."
India	Segal 1995	Selected sample of 319 adult professionals Interviews and test instruments.	57% had been engaged in "normal physical violence," 42% in abusive behaviours, and 3% in extremely violent behaviours with their children.
Israel	Benbenitshty <i>et al.</i> 2002	Representative sample of 5,472 students aged 9-12 years. Questionnaire, scale for reporting physical and psychological maltreatment	Physical and psychological maltreatment by school staff recorded. One third of the children reported emotional maltreatment, 22% at least one instance of physical maltreatment. Most vulnerable: males, students in Arab schools and in schools with low-income and low-education families.
Jamaica	Gardner <i>et al.</i> 2003	1,710 randomly selected secondary school children.	33% had been victims of violence and 60% had family members who had been victims of violence. 82% thought that violent television could increase aggressive behaviour.
Republic of Korea	Hahm <i>et al.</i> 2001	Population study	67% of the parents had whipped their children, and 45% had kicked, hit, or beaten them.
Spain	Paúl <i>et al.</i> 1995	Sample of undergraduate students	29% physically abused before age 13; 7.5% had injuries,
Thailand	Isaranurug <i>et al.</i> 2002	Sample of 212 sixth grade students	95% violently treated by parents, 77% beaten by cane or belt. 95% emotional (scolded using rude language) violence.
Turkey	Bilir <i>et al.</i> 1986	16,000 Turkish children	36% physically abused before age 5.

USA	Flisher <i>et al.</i> 1997	Community sample of 660 9-17- year- olds and caretakers in New York and Puerto Rico.	26% of the sample physically abused
USA	Trocme and Lindsey, 1996	Population sample	94% of 3-4 year old children smacked, spanked, or beaten. 40% of children aged 13 were regularly hit; at 15 , 25% were still hit or beaten by their parents
USA	Straus and Stewart, 1999	Nationally representative sample	Parents hit 35% of infants, 94% of 3-4-year-olds, 50% of 12-year-olds, 33% of 14 year-olds an average of six times a year. Severe hitting (with a belt or a paddle) was 28% between ages 5-12
USA	Holmes and Sammel, 2005	Random sample of 298 men	51% had a history of childhood physical abuse, 73% were abused by parent.
Database study, Europe	Lampe, 2002	MEDLINE, PubMed, Psyn dex, Psycinfo.	Physical abuse ranged from 5% to 50%. There were large differences in definitions and data gathering techniques, thus more precise conclusions were not possible.

*This poor family lives in a peri-urban slum area. The child has been hit on the head by the father (to the left).  
© World Health Organization*



**EMOTIONAL/PSYCHOLOGICAL ABUSE**

Emotional/psychological abuse of children is difficult to research because it not easy to detect, assess, and substantiate; a great deal of it goes unreported; it is, however, probably the most prevalent of all forms of abuse. Several authors state that emotional abuse is often more destructive than other abuse.

The Canada Department of Health (1995) survey of women found that 36% had experienced emotional abuse while growing up. In the Kaiser study (Felitti *et al.*, 1998), 11% of the responders had been psychologically abused as children at home. Scher *et al.* (2004) report from a US representative community adult sample (98% response) a prevalence of 34% of childhood emotional abuse and emotional neglect. In the national India Study (Kacker, 2007) the emotional abuse rates for children, aged 5-18 was 50% for both boys and girls. The WorldSAFE study (WHO, 2002) reveals the following examples of psychological punishment by the mother during the last six months: (a) yelled or screamed at her child: Chile 84%,

Egypt 72%, India 70%, Philippines 62%, and USA 85%; (b) cursed at the child: Egypt 51%, USA 24%, (c). threatened to kick the child out of the household: Philippines 26%; (d) threatened abandonment: Egypt 10%, India 20%, Philippines 48%; (e) threatened with evil spirits: Egypt 12%, India 20%, Philippines 24 %; (f) locked the child out of the household: Philippines 12%.

While frequently applying psychological and emotional abuse, school teachers in many developing countries cause great harm. Community abuse is often directed towards immigrants, and members of minority ethnic and religious groups.

Nhundu and Shumba (2001) studied teacher behaviour in Zimbabwe. It revealed a high incidence of "belittling, absence of a positive emotional atmosphere, verbal abuse, shouting, scolding, use of vulgar language, humiliation and negative labeling of pupils, and terrorizing of pupils by teachers". The female teachers were the main perpetrators. In a representative sample of 202 residents, aged 16-25, in Bangkok, 32% reported emotional abuse (Jirapramukpitak *et al.*, 2005).

Combined physical and psychological abuse by peers and siblings include name-calling, hitting, pushing, social exclusion, threats, bullying, and theft. An often cited estimate of bullying is that 50% of children aged 6-10, and 25% of children aged 11-16 get regularly bullied. Other estimates cite that one child in seven is bullied, and that 85% of that bullying is by peers. WHO's Global School-based Health Survey (2003) based on data from 15 developing countries in 2003 assessed that 20%-65% of all children were bullied during the last 30 days. In this study, reporting from 35 countries in Europe and North America WHO found that on an average 34% of all 11-15 year-olds were bullied during the previous few months. Many children have at some time experienced such abuse; in some countries, this abuse may be daily and less vulnerable persons may perhaps think that it is "normal". However, others may suffer and show withdrawal and depression or may commit suicide.

### CARE NEGLECT

Neglect of care is the most common reason for registration by social child-protection agencies in the developed countries. In the USA (U.S. Department of Health and Human Services, (2007) in 2005 63% of all registered cases (which are just 1% of the population) concerned neglect. The parents or care-takers fail to provide the daily needs for food, clothing, accommodation, schooling, appropriate education at home, health care, security, and/or a "moral" and healthy environment. One might distinguish between structural and intentional neglect. An example of structural neglect is when the child does not go to school because there is no school, or when it is hungry because there is not enough food; 130 million children mostly in the developing countries, do not attend school. In the USA approximately 1.3 to 1.5 million or 2% of the national population under 18 run away or are thrown out of home by their parents each year; many of them are abused and some killed. Some population data are available: Romania (Roturo, 1996):11%; UK (Cawson *et al.*, 2000):18% of respondents had experienced some absence of care in their childhood and 20% had experienced less than adequate supervision.

Parents of neglected or children may have their parental rights suspended or terminated. In several developed countries, at least 2-10 per 1,000 children are annually taken into public care for these reasons. Such public reaction is rare in the developing countries.

Straus and Savage (2005) reported on the prevalence of neglectful behaviour by parents of university students in 17 countries (six in Europe, USA, Canada, two in Latin America, five in Asia, Australia and New Zealand). Between 3.2% and 36% (median 12%) of the sample reported neglect. It should be noted that university students rarely come from poor families.

The prevalence of both intentional and structural neglect is high in many poor countries. Child neglect was studied in a random sample of 1164 children in China (Pan *et al.*, 2005): 28% of children aged 3-6 years were neglected, boys more than girls, the highest prevalence was in single parent families (43%); Brazil (Gonçales *et al.*, 1999): 26%; Iran (Sheikhattari *et al.*, 2006): neglect at home 83%, at school 66%; Kenya, (African Network, 2000) 22% of all children reported intentional parent neglect. Some African children are neglected at home, because of a malfunctioning family or because the “moral” environment or the parents’ health situation are unacceptable.

The dominant prevalence of child neglect is structural; a detailed review appears in Chapters 12 and 13.

### **ECONOMIC ABUSE AND EXPLOITATION**

Economic abuse or exploitation of an underage child includes work, services, or other activities benefiting a person who is in responsibility, trust, power, or has authority over the person abused. Descriptions and prevalence data appeared in Chapter 5.

### **COMBINED ABUSE AND NEGLECT**

Combined abuse and neglect is common; it appears that sexual and physical abuse are sometimes combined and accompanied by verbal psychological abuse and neglect.

There are few numerical studies showing the combinations of sexual, physical and psychological abuse. One such study of partner abuse was published by Ellsberg *et al.* (2000) from Nicaragua. Among 360 women, 263 had been abused. The most common was psychological, reported by 257. 77 of the women had experienced a combination with sexual abuse and 109 with physically abuse, and 74 with both. There was an overlap between physical and sexual abuse: of 188 physically abused women, 74 had also been sexually abused. Abuse of pregnant women may cause damage to the fetus with serious consequences (Chapter 9). In the USA, American Indians, Alaskan natives and African Americans have a higher combined abuse and neglect rate than the white population (National Clearinghouse, 2000). A description of combined physical and emotional abuse in Palestine appears in Box 7.3.

#### **Box 7.1. Combined abuse in occupied Palestine**

Haj-Yahia and Abdo-Kalot in 2003 published results of research on combined psychological and physical abuse in Palestine using a convenience sample of 1,185 students from 13 private Palestinian secondary schools in the West Bank and Jerusalem. The main findings were 37% of children had witnessed their fathers cursing the mother, using abusive language, or calling the mother names and threatening to hit her. 31% had witnessed their fathers slapping, pushing, or kicking the mother, or attacking her continuously with a stick, club, or other harmful objects. During their adolescence, 37% of the participants had witnessed their fathers ridiculing and attacking the ideas of their mothers, and cursing them for being a failure. 25% had witnessed their fathers throwing, smashing, hitting, and kicking something while attacking the mother, or seeing their fathers strangle or trying to strangle their mothers. The lower the father’s education, the greater was the likelihood that the mother had been psychologically and physically abused. Participants living in rural areas, or in refugee camps, reported more father-to-mother abuse than those living in urban areas. The more the families were exposed to political stressors, the more the fathers abused the mothers.

In an analysis of mother-to-father violence during childhood, 11% of the participants had witnessed their mothers threatening to hit or throwing something at, the father, and 27% witnessed the mother ridiculing the father and accusing him of being a failure. 8% of the

participants had witnessed the mothers slapping, pushing, or kicking and attacking, or shoving the father. During their adolescence, 38% of participants had witnessed the mothers arguing heatedly with the fathers, and yelling or doing something to insult him; 5% indicated that they had witnessed their mothers throwing, smashing, or kicking something on/at their fathers; 3% had witnessed their mothers strangling or trying to strangle their fathers.

The student participants and their siblings in over 50% of cases reported that their parents had argued heatedly with them and their siblings, cursing them, using abusive language, calling them names and yelling at them, or doing something to insult them. 40% had been threatened with direct physical attacks, 19% reported that the parents had threatened them and their siblings with a knife, a gun, a stick, a chair, or with some other kind of injurious or lethal weapon. 35% had witnessed the parents attacking their children continuously with a stick, club, or other harmful object. The lower the income of the family, the poorer the housing conditions, and the lower the level of education of the parents, the more elevated and frequent became the psychological and physical abuse.

In Palestine, the combined effects of occupation, military and civil violence, poverty, and unemployment have led to widespread frustrations, and to the breakdown of many intra-familial relations (see Khamis, Table 7.3) Physical and verbal aggression are at extremely high levels. The authors have researched sexual abuse in another article (Haj-Yahia and Tamish, 2001), and shown that such abuse among Palestinian children living in Israel was very high, especially among boys, and did exceed the prevalence among Jewish Israeli teenagers. Similar situations exist in other countries with high population stress.

**Table 7.3. Combined abuse and neglect, selected studies.**

Country	Authors	Type of study and comments	Results
Arab peninsula	Al-Mahroos 2007	Reports from professional contacts about observed physical and sexual abuse and severe neglect, some of it combined.	27 cases from Kuwait, 11 from Saudi Arabia, 5 from Oman, 150 from Bahrain. Yemeni population-based surveys revealed widespread use of corporal punishment and cruelty to children, ranging from 51%-81%. Child abuse is ignored or may even be tolerated; abused children continue to suffer, most abusers go free, and unpunished. Very difficult to break silence, respond to and prevent child abuse and neglect.
Brazil	Gonçales <i>et al.</i> 1999	976 children from Rio exposed to domestic violence	39% had been exposed to physical abuse, 26% to neglect, 26% to psychological abuse, and 7% to sexual abuse; 44% of cases referred to a Court.
Canada	Trocme <i>et al.</i> 2002	Representative sample of 7,672 officially reported child maltreatment investigations (total 135,573, = 2.2% of all children)	Maltreatment was substantiated in 45% of the investigations and in an additional 22% remained suspected. Causes for investigation were physical abuse (31%), sexual abuse (11%), neglect (46%), emotional maltreatment (37%), and extreme verbal abuse (13%). Many children suffered from combinations.

India	Kacker, Ministry of Women and Child Development, 2007	<p>Multistage purposive sampling design. Questionnaire used. Total sample 18,200, response rate 96%</p> <p>Included (i) children aged 5-18 in five groups : (a) living with family not in school; (b) living with family in school; (c) in institutional care; (d) working; (e) on the street;</p> <p>(ii) Adults aged 18-24</p> <p>(iii) Stakeholders: older persons, working, mostly parents</p>	<p>Children: physical abuse 73% of boys, 65% of girls; by mothers 51% , by fathers 38% by others 11%. In 15% the abuse resulted in swelling or bleeding or causing serious physical injury to the child; sexual abuse 48% of boys, 39% of girls; emotional abuse 50% of boys, 50% of girls. Only minor differences between the five child groups. 65% of children going to school were physically abused there.</p> <p>In institutions the caregivers are often the abusers. The prevalence of sexual abuse was higher in upper and middle classes compared to the lower classes. The majority of the abusers were people known to the child. 21% suffered severe sexual abuse, more boys than girls. –</p> <p>Adults (abuse before age 18): physical abuse 53% of men, 47% of women; sexual abuse 61% of men, 41% of women; emotional abuse 51% of men, 49% of women --</p> <p>45% of stakeholders felt that physical punishment was necessary. The most suitable forms of punishments suggested by them were: scolding and shouting 35%, slapping, beating with a stick 11%, locking up the child and denying food 11%. 32% said that children should work.</p>
Iran	Sheikhhattari <i>et al.</i> 2006	Sample of 1,370 school students aged 11-18	Physical maltreatment at home 40%, at school 44%; mental maltreatment at home 78%, at school 66%; neglect at home 83%, at school 66%. Rural children more maltreated than urban, females less than males.
Israel	Khuory-Kassbri 2006	Nationally representative sample of 17,465 Students in grades 4-11, 9% attrition. Report of school staff abuse.	<p>Primary schools: 31% emotional and 24% physical abuse; Junior high schools: 35% emotional, 25% physical, 8% sexual abuse; High schools 35% emotional, 18% physical and 8% sexual abuse.</p> <p>Sexual abuse of boys (9.7%) higher than of girls (6.4%). Arab students much more abused than Jewish.</p>
Israel	Elbedour <i>et al.</i> 2006	217 Bedouin-Arab female high school students, aged 14-18 years	<p>During last month at least once been physically abused by father (17%), by mother, (44%) by siblings . Psychological abuse by family members 50%.</p> <p>Sexual abuse 53%; this incidence included 16% requests for sex, which are considered abusive in this culture</p>

Palestine	Khamis 2000	1000 Palestinian school children aged 12-16. Of these, 6 % had a physical or sensory disability, 12% were working.	14% had been physically abused by a family member. 24 % affected by the political violence, (a family member killed, injured, imprisoned, or their homes demolished by the occupying forces). 9 children reported sexual abuse. Children living with a single parent less abused than those with two parents at home. Disabled children more abused than non-disabled. Economic hardship was a significant cause. Psychological maltreatment was less common where families followed traditional values: dominance by the men and submission by the women, children more obedient and submissive to authority. The overwhelming effects of the political situation were clear.
Portugal	Machado <i>et al.</i> 2007	Representative sample of 2,391 parents in Northern Portugal all in two-parent families with children under-18.	26% reported at least one act of emotional or physical abuse towards a child during the previous year; 12% was physical and 22% emotional. The self-reported support for physical punishment was higher in parents who reported using abusive behaviour.
Romania	Rotoru 1996	488 parents and 796 school pupils in Romania were studied.	14% reported verbal aggression; 16% of the parents admitted such abuse; 28% of the pupils said they had been physically punished and 23% reported severe punishment. Parents admitted to administering such physical. Punishment is 26% and 22%, respectively. 11% of the children said they had been neglected, 9 % of the parents admitted such neglect. In rural areas, abuse and neglect more common than in urban ones.
Russia	Berrien <i>et al.</i> 1995	Sample of 412 children aged 11-16 in a school for "intellectually talented children" in Siberia, drop-out rate 9%	29% severely physically abused by parents, 4% required medical attention. 46% had witnessed abuse of other children. For 98% punishment included psychological distress, restrictions, strict verbal reprimand, and enforced labour; 2.4% refused to stay in parents' home.
South Africa	Madu, 2001	559 high school children aged about 13-16	Self reported prevalence rates of abuse: 71% were psychologically abused (14% extreme), 27 % physically abused, 35% emotionally abused and 10% ritually abused. It appeared that these various forms of abuse are widespread, suggesting that a much more serious problem may exist than has been recognised.



Turkey	Vahip and Doğanavşargil 2006	Combined community studies	Physical violence in 36% of families, verbal violence in 53%, 46% of all children physically abused. 72% of women subjected to psychological, physical or sexual violence during past and present pregnancies.
USA	Scher <i>et al.</i> 2004	Representative community sample of 9000 adult men and women, aged 18-65. Telephone interviews using a Childhood Trauma Questionnaire, 98% response rate	35.1% (men 41%, women 30%) of the sample met criteria for at least one form of childhood maltreatment; 13.5% (men 13%, women 14%) met criteria for more than one form. Most common: physical abuse and physical neglect (42%), and emotional abuse and emotional neglect (34%), sexual abuse 15%; many co-occurring. Persons with no schooling or elementary education compared to college educated have significantly higher odds ratios for emotional neglect (3.63) and for physical neglect (2.47)
USA American armed forces	Rosen and Martin 1996	Sample of 1,060 male and 305 female soldiers (mean age 26 years),	49% of women and 15% of men reported a childhood history of sexual abuse. 48% of the women and 50% of the men had a history of physical abuse. 34% of females and 11% of males had experienced both.
USA	Finkelhor <i>et al.</i> 2005, 2007	Nationally representative sample of 2,030 children and youth aged 2 to 17 years.	53% were victims of physical assault in the study year; 27% of a property offence; 14% of child maltreatment; 8% of sexual victimization; 36% had witnessed violence or experienced another form of indirect victimization. Only 29% had no direct or indirect victimization. The mean number of victimizations for a child or youth was 3. A child or youth with one victimization had a 69% chance of another during a single year. Children experiencing four or more different kinds of victimization in a single year (poly-victims) comprised 22% of the sample. Results suggest that cumulative exposure to multiple forms of victimization over a child's life-course represents a substantial source of mental health risk.
USA	U.S. Department of Health and Human Services 2007	National data, based on reports from 2005 (3.6 million children :1.2% of the population reported)	62.8% of victims experienced neglect, 16.6% physical abuse, 9.3% sexual abuse, 7.1% psychological maltreatment, and 2% medical neglect. In addition, 14.3% of victims experienced other types of maltreatment such as abandonment, threats of harm to the child, or congenital drug addiction.

### CHILD DEATH CAUSED BY VIOLENCE AND NEGLECT

In 2000, there were throughout the world an estimated 57,000 homicides of children under 15 (WHO, 2002). Infanticide still goes on in the industrialized countries, as evidenced by Innocenti (2003), Glass (1999), and Southall *et al.* (1997). Fatal violence against children aged under-5 in high-income countries is estimated at 2.2/100,000 boys and 1.8/100,000 girls. In low- to middle-income countries, the rates are 2-3 times higher. The highest homicide rates for children under five are in Africa – 17.9/100,000 boys and 12.7/100,000 girls. All child murders are underreported (Innocenti, 2003).

In a report of 459 forensic autopsies of battered children (aged 0-4) by the Japan Society of Legal Medicine (1995) it was found that the cause of death was head injuries in 35%, suffocation 8%, strangulation 7% and drowning 7%. Among the assailants were the biological mother in 49% of the cases, the biological father in 16% and a stepfather in 10%. The battered children were emaciated and had stunted growth in 31%; there were abrasions and bruises in 32%, numerous internal injuries (bowels, liver and lungs), subdural haematoma in 32%, oedema in 17%, thymus atrophy in 13%. Some of the murdered children were mentally retarded, in others the disability was induced by long-term cruelty, abuse and neglect.

In several African countries, I was informed about the practice of putting newborn babies to death by starvation on the advice of the traditional midwife (Amoako, 1976). Most of these babies were visibly deformed or were a younger twin (twins are in some countries seen as a bad omen). Killing by neglect or abuse, a yet-to-be-named infant appears to be socially acceptable among very poor families, who already have 'too many mouths to feed'. Laime (1997) in a 1997 Peruvian rural study followed 23 local children under the age of seven during one year. Young children are thought to have "loose body-soul connections", making them vulnerable to diseases. Traditional health concepts such as 'uraña' (fright) explain the deaths among children – caused by neglect – in a 'culturally acceptable' way.

From Senegal, Menick *et al.* (2000) reviewed 164 cases of infanticide diagnosed during 27 years. The reason for infanticide was in only 3% caused by mothers with mental disorders. The main reason for the killing by Muslim mothers was that they were unmarried and in their families, a pregnancy before the wedding was dishonourable. Attitudes of rejection are similar in Christian and Hindu families in many other developing countries. Another reason for child murder by married mothers was that the husband was away abroad working, sometimes for several years, and children whom he had not fathered were unwelcome.

Kassim *et al.* (1995) report on childhood deaths caused by physical abuse in Malaysia: 766 cases were registered by the authorities; the average age of children being 2 years and 5 months. Most frequent causes of death were intracranial haemorrhage and intra-abdominal trauma. The traumas were all very severe: perforated intestines, liver rupture, aorta rupture, strangulation, cervical and skull fractures, poisoning; two newborns died after having been thrown into the river.

In most poor countries, little official attention is paid to the causes of children's death. Most are buried next day. Few pathologists are available to examine suspicious deaths. The data in Table 7.4 reflect the negative attitudes among parents towards girls in some Asian countries and the lack of any community programme to help them (Fikree et Pasha, 2004). The Table compares the male to female infant population at censuses from five Asian countries. The extremely high male to female ratios for Harayana and Punjab are the highest recorded in the world (Premi, 2001; Ravamudan, 2003)

An estimated 40 million females are 'missing' in China's population statistics (Coale and Banister, 1994). Gendercide and fatal child neglect are common in many countries; girls and children with a disability are common victims. Among those responsible for these losses are 'orphanages' and other 'child protection institutions'. A preference for boys can be seen, for

instance in China where 85 % of children sent to 'orphanages' are girls (Chan, 1995, Croll, 2001, Lavelly, 2001). In Japan during 1980-1990, 191 newborn infants were abandoned in coin-operated lockers in the railway stations (Kouno *et al.*, 1995); when found most were dead.

**.Table 7. 4 Male/female ratio in Asian countries recorded as live births**

Country/age group	Male to females %, total
Bangladesh 1988 (0-1)	107.0
China 1930-1940 (0-1)	118.0
1982 (0-1)	107.6
1999 (0-1)	119.5
India 1970 (0-1)	106.6
2001 (0-6)	107.9
Harayana et Punjab 2000	126.1
Pakistan 1988 (0-1)	109.0
World total 2000 (0-4)	104.6

(UN population data 2002)



*This family illustrates the intentional neglect that is a common experience for girls and the reason why so many of them die before the age of five. This Indian mother and her older son are holding 2-year old twins, the well-fed twin brother to the right and the seriously malnourished twin sister to the left of the photo. © World Health Organization*

The same preferences for sons are very visible in India; they are accompanied by an excessive mortality among girl infants, and to selective abortion as soon as the gender of the unborn child is known. (Allahbadia, 2002; Arnold *et al.* 1998). Thousands of newborns – especially girls – in South and South-East Asia are abandoned behind bushes, with the garbage, in suitcases, in trains, in the forest, on the steps of orphanages or drowned. In India there are many reports that indicate filicide through neglect. The highest number comes from the Kallar community, Tamil Nadu. An average 1200 children are born annually in this area, and of those, some 600 are girls. The Government hospital made a study which revealed that 570 of these girls die within a few days; physicians attributed this to maternal filicide (Sabu, 1997). The infant mortality rate in India has gone down from 180-163 in 1950-55 to 61/1000 in 2000-2005, but is still about 12 times higher than in the developed countries.

The under-5 mortality rate in 2005 was 89/1000 in the developing countries, more than 20 times higher than the most developed countries (Sweden 3.4/1000 – in 1930 it was 59/1000 – equivalent to the average of what is now 75 years later reported by the developing countries). Of the some 110 million children born annually at present in developing countries, at least 9%

die before the age of five, which equals ten million a year. Many deaths (estimated at 40%, which includes gendercide, neglected and disabled children) are caused by abuse and avoidable neglect.

## VIOLENCE EXPERIENCED BY DISABLED CHILDREN

A review follows of the violence against a very vulnerable group: children with disabilities most of whom live with their family. The methodological difficulties in analyzing the prevalence of disability were described in Chapter 2. Another difficulty is that disabled persons may not have fully understood that they have been victims of abuse or neglect during their childhood. Some of them, such as those who have severe mental retardation, speech impairments, deafness or autism may not be able to communicate their experience of violence. Prevalence assessments are constrained by the fact that many, especially girls in the developing countries, die very young. The assessments below are based on available scientific surveys, official data (reports to the police or authorities), my own observations and examinations of children. Most underestimate the problems. Some studies are made on non-representative samples, are convenience studies or are 'anecdotal'. Some of the interviewed have been asked to complete questionnaires under the supervision of persons who were the offenders and they may not have dared to tell the truth. More comprehensive data gathering is needed.

### Prevalence of violence against disabled children

There are a number of scientific studies of the prevalence of violence against children with disabilities. Govindshenoy and Spencer in 2007 reviewed all population-based studies published from 1996-2006 and concluded that the evidence base for an association of disability with abuse and neglect is weak. Children with disabilities are by most researchers seen as exposed to an increased risk compared to normal children. Table 7.5. shows the results from ten studies; almost all from the USA. I have been unable to find any published

**Table 7.5. Violence against children with disabilities, selected studies.**

Country	Author	Groups researched for childhood violence	Prevalence
USA	Ammerman <i>et al.</i> 1989	Multi-handicapped children in two US psychiatric institutions	39% sexually abused
USA	Zigler 1979	Mentally retarded (MR) children	45% extensive physical abuse or neglect
USA	Sullivan <i>et al.</i> 1991	Deaf boys and deaf girls	54% childhood sexual abuse of boys and 50% of girls
USA	Chamberlain <i>et al.</i> 1984	Adolescent girls with MR	25% sexually abused
USA	Tharinger <i>et al.</i> 1990	Sexual abuse and exploitation of children and adults with MR and other handicaps	88% exploited, most during childhood; 35% girls had physical evidence of sexual abuse, 6% were sexually assaulted; 6% got sexually transmitted disease.
USA	Welbourne <i>et al.</i> 1983	Blind females	50% sexually abused, mostly during childhood
Sweden	Lundqvist <i>et al.</i> 2004	Mentally ill women in therapy	25% to 77% experienced childhood sexual abuse.

USA	American Academy of Pediatrics. 2001	Review of maltreatment of children with disabilities.	Children with disabilities are 1.8 times more likely to be neglected, 1.6 times more likely to physically abused, and 2.2 times more likely to be sexually abused
USA	Valenti-Hein and Schwartz, 1995	Perons with developmental disabilities (DD).	90 % will experience sexual abuse, mostly before age 18. 49 % will experience 10 or more abusive incidents
USA	Sullivan and Knutson 2000	Population study (merger of school and official social and police records) of 46,900 children, 8% (3,262) had a disability	Rate of maltreatment among disabled children 31%; among the non-disabled 11%. 84% neglect, 49% physical abuse, and 9% sexual abuse (many combined). Victims: behaviour disorder (53%), speech/ language problems (37%), mental retardation (28%). Neglect, physical abuse, emotional abuse and sexual abuse were about four times higher than among non-disabled. Maltreatment started in preschool (29%), elementary school (35%), middle school (23%), and high school (13%). Most perpetrators were family members. The study is likely underreporting, as some disabled children are not in school and official records are incomplete.

Sobsey and co-workers (Sobsey, 1990, 1991; Sobsey *et al* 1995; Sobsey, 2000) published detailed studies about violence and abuse in the lives of people with disabilities. Maltreatment occurs during the victims' childhood. Sobsey (2000) in a convenience sample of 152 people with disabilities, found that 60% had experienced penetrative sex, and 62% had been abused ten times or more; 42% had physical injuries after the abuse, and 95% of the victims reported emotional problems. 58% were infected with sexually transmitted disease. Half of them were under 21 when the abuse started, 36% 7-17 years old, and 7% 1-6 years old. 83% were females and 17% males. Sobsey *et al.* (1995) found that the following factors contributed to vulnerability: 32% inadequate knowledge or impaired judgment, 24% inadequate knowledge or impaired judgment, and 13 % too much trust in others. For 67 % the abuse occurred at home and for 11% in the vehicles used for their transportation to programmed activities; 20 % took place in institutions that the victims visited because of their participation in rehabilitation programmes. The offenders had an average age of 34 years; some were as young as ten and some over 80; 89 % were male. The victims knew 90% of the offenders. Only 20% were family members, 49% paid caregivers. Some offenders had abused up to 70 people before arrest. Only 25% of sexual abuse cases involving people with DD were ever reported, Non-disclosure promotes an environment ready for continued victimization. Only 8% of the offenders were convicted.

The N.Y. State Office of Mental Health (1989) reported on child abuse at a Children's Psychiatric Centre. Over several years many young children (aged 5-12) were engaged in sexual activity with other children; these incidents occurred and persisted because of deficient

management, clinical, and supervisory practices at the facility. Many disabled children are regularly teased or bullied at school by other children, especially if they are small and weak.

### **Violence against children with disabilities in developing countries**

In the developing nations, there are few children as maltreated as those with disabilities. Exact information from these countries is seldom available; one has to rely on informal information. I have interviewed responsible administrators and professionals in about 50 developing countries and they have all confirmed that such abuse is very common, especially in boarding institutions and special schools. The Secretary (top civil servant) of the Union Ministry of Social Welfare in India told me that in his country this was the most abused group. Sexual abuse is often combined with other physical and psychological abuse, intimidation, threats, bullying and, when possible, with economic exploitation. Some articles have been published from developing countries: Bode *et al.* (2001) report from Nigeria on widespread parental abuse and neglect of children with congenital deformities; the abuse was detected when these children were hospitalized for surgery.

*This teen-age girl from the Caribbean was almost totally deaf. Deaf girls are among the most abused, but she was taken care of by the local Community-Based Rehabilitation Programme. She was protected and taught lip-reading and sign language, and was able to finish high school.*  
© World Health Organization.



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Some disabled children end up as beggars or prostitutes; many die because of gross neglect or from sexually transmittable diseases. Poverty has many hidden corners, and bitter disillusionment follows these human beings. There are few people – or nobody – to protect them. In the absence of published evidence, a few author-observed instances of abuse follow.

*Abuse in a home for disabled adolescents.* A physically disabled (wheelchair user) European expatriate went to an African country to set up a 'home', for which he had obtained the necessary funds at home. He rented a villa in the capital and built dormitories. He then 'collected' a dozen or so disabled adolescent boys, whom he lodged and fed. There was no rehabilitation or job-training. By court order, he was also custodian of five non-disabled

young male criminals just out of prison. One day the expatriate had a fatal accident. The local Church took over and employed a couple to look after the boys. When they went through the belongings of the expatriate, they found his diary. In it, he had in graphic detail recounted his sexual 'experiences' with all those who were in his custody. Interviews with the boys confirmed the story; they had never dared to complain, for the expatriate threatened them with being thrown out to the street or sent back to prison. Besides, they thought that nobody would believe them—the expatriate had good connections with high-ranking officials and the Church.

*Special schools in developing countries.* In a boarding high school for blind students in a West African country, the principal informed me that he had taken over the school only three months earlier. The reason was that the previous principal and about half of the specialized teachers had been fired. They had had extensive sexual contacts with the blind girls and girls some had become pregnant. When a pregnancy was detected, the girl was asked return to her family and was not allowed back.

In another African country, a group of deaf people from Sweden visited several boarding high schools for deaf and hard-at-hearing adolescent boys and girls. They communicated with the students using sign language. The visitors found out that the teachers had sexually abused almost all girls and boys. Several girls had left the school when they became pregnant; that was the end of 'special education'.

In a Middle East country, a male employee was sexually abusing several mentally retarded boys in a residential centre. He was discreetly moved away – to another school for mentally retarded boys! The responsible doctor at the Ministry informed me about many similar cases.

A paediatrician in an Asian country described the conditions of the children in the local blind school. Almost all children were already sexually abused by age seven. No parent dared to report the abuse to the police because they feared, first, that the police would take no action and, secondly, that the children would be dismissed from the school, the only special education establishment available.

### Early death of disabled children

In countries with a very high under-5 mortality rate (Sub-Saharan Africa and South Asia) the observed prevalence of disability among children aged 0-9 is only about one third of that in developed countries (such as UK). These deaths are explained by parental neglect and extreme poverty resulting in malnutrition with untreated respiratory infections and diarrhoea.

The results from a prevalence study in the State of Gujarat in India (BMA, Ahmedabad, 1997, Table 7.6) shows that the prevalence of disability is twice as high in the male group as in the female one. Although small gender differences may be expected, the numbers reveal a larger degree of fatal neglect of disabled girls than of disabled boys. It is highest in the groups with polio and with deafness.

**Table 7.6. Results of disability survey in Gujarat, India 1997**

Type of disability	% of all disability, both genders	% of all disability, males	% of all disability, females	Difference male as % of female
Blind	8.4	5.0	3.4	+ 47
Vision impairment	9.2	5.8	3.5	+ 66
Deaf	19.4	13.1	6.3	+ 108
Orthopaedic impairment	56.7	38.4	18.3	+ 110
Mental retardation	6.3	4.1	2.2	+ 86
<b>TOTAL</b>	100.0	66.4	33.6	+ 99

Yacoub *et al.* (1995) have published a study of a cohort of newborn children in Pakistan followed up until the age of 24 months. They found a rate of severe mental retardation of 11/1000. The mortality due to neglect of these children, aged 2-24 months, was 36%, all caused by respiratory infection.

In the developed countries, a decrease in the mortality of disabled children has taken place. Annerén (2002) researched Down's syndrome children in Sweden. In 1920-30 the life expectancy was 2.3 years, in 1950-60 15 years, in 1970-80 45 years and in 1990-2000 57 years. Instead of letting these children die untreated (in accordance with the cost-utility concept) from congenital heart defects and leukaemia, they now are treated and survive. By contrast, in 1982, the Indiana Supreme Court in USA ruled that doctors and parents could allow the starvation death of a retarded infant (Encyclopaedia Britannica, 2003). Based on studies of 1,164 known homicides and 63 attempted homicides of persons with developmental disabilities Sobsey *et al.* (1995) concluded that "mercy-killing" of disabled children is frequent and that the murderer usually receives a lenient or no punishment.

The conclusion is that at least 50% of all children with disabilities experience sexual, physical and emotional abuse, and neglect, often in combination.

### **OTHER VIOLENCE AND TRAUMA**

In addition to interpersonal violence, there are millions of child victims of wars, civil wars, ethnic cleansing, and similar events. Several hundred have occurred during the last 30 years. In these, not only are people killed but millions of civilians (one-third is under-18) are wounded, raped, and tortured or exposed to army, police, and prison staff brutality. They are robbed of their houses, their properties are destroyed; family members are killed or disappear. Violence occurs increasingly in schools, in transportation vehicles, and as random shooting in public places; especially in countries with an abundance of private guns.

Other events that traumatize the surviving victims are natural disasters such as earthquakes, flooding, hurricanes, land slides, tsunamis, droughts, and fires. Another group consists of man-made disasters: toxic, chemical and nuclear accidents, mine explosions, dam collapses and transport accidents. During the period 1994-2003, 2.7 billion people were affected by such events; on average one disaster took place every day (Louvain University, Belgium, 2004). Many of them, including children, become disabled because of these events; physical and mental health problems will follow them for the rest of their lives.

### **ESTIMATES OF THE GLOBAL PREVALENCE OF CHILDHOOD VIOLENCE**

There are some 2,300 million children (under age 18) in the world, 300 million in the developed regions and about 2,000 million in the developing regions (U.N. Population Division, 2006). When estimating the global prevalence of childhood violence, greater weights will be given to the data from developing countries. For example, in South Asia there are 440 million children in India, 55 million in Bangladesh, 79 million in Pakistan, 20 million in Myanmar, and 16 million in Nepal; the total comes to 610 million. From these five countries there are only 'usable' data from India, these will be extrapolated to its neighbours; their combined weight is considerable for the global estimate. In China, there are 360 million, in Taiwan 6 million, in Hong Kong one million, in Democratic People's Republic of Korea 9 million and in the Republic of Korea 11 million; thus in this region, there are 388 million children; the few data from these countries are quantitatively important for the global estimates. These two geographical regions together have half of the children in the developing regions. Africa has about a quarter, 450 million, and Latin America 185 million children. Examples below are from Box 2.1, Tables 7.1, 7.4, and 7.6. I have found it justified quoting the studies below, which have high prevalence rates. Many of them have low attrition rates,



and it is rare that responders to anonymous interviews would invent abusive events (Chapter 2).

## ABUSE

### Childhood sexual abuse

*Developed countries:* Australia (Goldman and Padayachi, 1997) male 19%, female 45% ; Ireland (McGee *et al.*, 2003) male 24%, female 30%; Israel, Jewish population (Schein *et al.*, 2000) male 16%, female 31%; Sweden (Krantz. and Östergren, 2000) female 32%; Switzerland (Niederberger, 2002) female 40%; USA (Finkelhor *et al.*, 1990) male 16%, female 27%; USA (Gorey and Leslie 1997): broad definition male 12%, female 36%

*Developing countries:* China (Chen *et al.*, 2004) female 26%; Costa Rica (University of California, 2006) male 13%, female 32%; India (Kacker, 2007) male 48%, female 39%; Israel, Arab population (Elbedour *et al.*, 2006) female 53%; Jordan (Jumaian, 2001): male 27%; Peru (Cáceres *et al.*, 2000) determined lifetime sexual coercion rates among adolescents and young people. Of those with heterosexual experience males reported 20%, female 46%; for those with homosexual experience males reported 48%, female 41%; Tanzania (McCranr *et al.*, 2006) male 25%, female 31%; Turkey ( Eskin *et al.*, 2005) male and female 28%; USA (American Indians) (Robin *et al.*, 1997) male 14%, female 49%.

A conservative global estimate based on the above studies is that about one third of all now living persons was sexually abused before age 18. The impression is that sexual abuse of males is in many studies underreported. With a global population of 6.5 billion, the survivors (adults and children) of sexual abuse are assessed at about 2,100 million people.

### Childhood physical abuse

Many country studies show that very large proportions of children receive corporal punishment. This includes 80% in Chile, 78% in Ethiopia, 97% in Great Britain, 69% in India, 95% in Thailand, and 94% in USA (parents hit 35% of infants, 94% of 3-4-year-olds and 50% of 12-year-olds, 33% of 14 year-olds, an average of six times a year). Below is a list of studies with data about severe such punishment using straps or canes or whipping, causing bruises, lacerations, burns, bite marks, swelling, or haematomas to the face or other parts of the body, bleedings, fractures, loss of consciousness, concussion, and permanent disability.

*Developed countries:* Canada (Macmillan *et al.*, 1997): male 11%, female 9%; Great Britain (Leach 1999): 25% of all 4-year-olds regularly hit with straps or canes; Romania (Roturo, 1996): 23%; Russia (Berrien *et al.*, 1995): 29%; USA (Straus and Stewart, 1999): severe hitting (with a belt or a paddle) 28%.

*Developing countries:* .Brazil (Gonçales *et al.*, 1999): 39%; Egypt (Youssef *et al.*, 1998a, 1998 b): 38% severely punished by parents, 26% reported fractures, loss of consciousness, concussion, or a permanent disability. Teacher abuse: 26% boys and 18% girls suffered injuries (contusions, fractures and loss of consciousness); Ethiopia (Ketsela and Kebede, 1997): 21% urban and 64% rural children reported bruises and swelling from parental punishment; Hong Kong (Tang, 1998): 46%; highest rate of severe violence among boys aged 3-6, mainly by mothers; India (Kacker, 2007): of the 73% boys and 65% girls who were physically abused, in 15% they had swelling or bleeding or serious physical injury; Republic of Korea (Hahm and Guterman 2001): 67% of the parents whipped their children, and 45% had kicked, hit or beaten them, Thailand (Isaranurug *et al.* 2002): 77% beaten by cane or belt.

Physical abuse or violence towards children is extremely common. A conservative estimate of severe physical abuse provides a global prevalence of 20%. Applying the estimate to the total global population of 6.5 billion, the survivors of such abuse are assessed at 1,300 million people.

**Childhood psychological and emotional abuse**

*Developed countries:* Portugal (Machado *et al.*, 2007): 22%; Romania (Roturo, 1996):14% reported verbal aggression; USA (Scher *et al.*, 2004): emotional abuse and emotional neglect 34%; Israel, Jewish population, emotional abuse (Elbedour *et al.*, 2006): 35%.

*Developing countries:* Brazil (Gonçales *et al.*, 1999): 26% psychological abuse; India (Kacker, 2007): emotional abuse 50% boys, 50% girls; Iran (Sheikhhattari *et al.*, 2006): mental maltreatment at home 78%, at school 66%; Israel, Arab population, (Elbedour *et al.*, 2006): psychological abuse by family members 50%; Palestine (Haj-Yahia and Abdo-Kaloti, 2003): 37%; South Africa (Madu, 2001): 35% emotionally abused; Thailand (Jirapramukpitak *et al.*, 2005): 32% emotional abuse; Turkey (Vahip and Doğanavşargil, 2006): verbal violence 53%.

Over 75% of all children experience parents yelling and screaming or cursing at them (World Health Organization, 2002); in some countries they are threatened with evil spirits or told that they will be sent away.

Psychological and emotional abuse are very common. It is concluded that at least 50% of all people have been emotionally or psychologically abused in a major way during their lives. This would include long-term, very upsetting or repeated verbal, psychological, and emotional aggression at home, at school, at work, or during leisure activities. Some of these abusive acts occurred in combination with physical and/or sexual abuse, or with physical neglect. Very severe psychological abuse during childhood is conservatively estimated at 30%; this implies that the surviving victims are 1,900 million individuals.

. Table 7.7. sums up the prevalence estimates of childhood abuse made above.

**Table 7.7. Global estimates of the prevalence of childhood abuse**

Type of violence	Basis of estimates	Estimated global prevalence of victims (adults and children)
Sexual abuse	33% abused during their childhood. Female sexual mutilation: 135 million	2,100 million
Physical abuse	20% severely abused during their childhood	1,300 million
Emotional/psychological abuse	30% severely abused during their childhood	1,900 million

**NEGLECT****Child caregiver neglect**

In the developed countries, it appears that 1%-4% of all children are annually investigated by child protection authorities for child maltreatment. While child neglect is the type of maltreatment most frequently reported to and acted on by official agencies, its proportion of all maltreatment in the general population is comparatively smaller. In studies, using such reports the proportion of neglected children is: Canada (Trocmé *et al.*, 2002): 46%, and USA (U.S. Department of Health and Human Services, 2007): 63%.

Some general population data are available: Brazil (Gonçales *et al.*, 1999): 26%; China 28 % (Pan *et al.*, 2005); Iran (Sheikhhattari *et al.*, 2006): neglect at home 83%, at school 66%; Kenya African Network (2000) 22%; Romania (Roturo, 1996):11%; UK (Cawson *et al.*, 2000):18% of respondents had experienced some absence of care in their childhood and 20% had experienced less than adequate supervision. Straus et Savage (2005) summarized data from 17 countries (six in Europe, USA, Canada, two in Latin America, five in Asia, Australia and New Zealand), the median was 12%.

The published evidence based on representative populations in developing countries is scant, in the absence of enough such data the global prevalence of child care-giver neglect is estimated at 12%.

#### **Child structural neglect.**

Calculations of structural (or circumstantial) neglect are presented in Chapter 13. The victims are children for whom the society has not provided adequate health care, nutrition, education, permanent shelter, safe living and other conditions necessary for their development. Most is related to poverty. Globally the prevalence is estimated at over one billion children, in the developing countries, in the developed ones there are about 100 million children under the poverty level.

**Table 7. 8. Global estimates of the prevalence of childhood neglect**

<b>Type of neglect of children</b>	<b>Basis of estimates</b>	<b>Estimated global prevalence of victims, children only</b>
Care-giver intentional neglect	Child authorities' reports and population surveys, a balanced estimate of the 1,200 million children not included below is 12%	140-150 million
Structural care neglect of children	Children living in poverty both in the developed and developing countries. Excessive death rates are partly caused by neglect, especially gendercide.	1,100 million Annually some 10 million children living in poverty die, most of these deaths are preventable.

When calculating the combined global prevalence we need to take into account the frequency of exposure to multiple forms of childhood violence. We do not have much accurate data to assist in this estimate. Kessler *et al* (1995) in a US sample calculated the lifetime prevalence of trauma (rape, molestation, physical attacks, combat, shock, threat with a weapon, accident, natural disaster with fire, witness gross violence, neglect, physical abuse and other qualifying trauma): 61% of men and 51% of women had experienced such trauma. For about half of them, there had been more than one such trauma. Elklit (2002) studied 390 Danish school children aged 12-15 and found that 78% males and 87% females had been exposed to at least one potentially traumatic event. The most distressing subjective events were rape, suicide attempts, death in the family, serious illness, and childhood abuse. Male Icelandic school children aged 12-15 years reported 74% and females 79% at least one traumatic event (Böðvarsdóttir and Elklit, 2007). Data about combined abuse are reported by Rosen et Martin (1996) for American soldiers (see p.72) and by Ellsberg *et al.*, (2000) from Nicaragua, (see p 68.).

Scher *et al.*(2004) found that one third (35.1%) of their sample met criteria for at least one form of childhood maltreatment and 13.5% met criteria for more than one form. Finkelhor *et al.* (2005, 2007) in a US nationally representative sample of 2,030 children and youth aged 2 to 17 years found that during the study year only 29% had no direct or indirect victimization. The mean number of victimizations for a child or youth was three. A child or youth with one victimization had a 69% chance of another during a single year. Felitti (2002) registered adverse childhood experiences (ACEs) in a very large middle-class US sample and found that only 36% did not report any such experiences.

One more factor to consider is the influence on the prevalence rates of the groups mentioned in Chapters 4 and 5 (Table 7.8). These groups, totalling 390 million (17% of all children), are seldom included in “ordinary” prevalence research, which often describe their participants as non-institutionalized persons, with a home address or a telephone or appearing in the voters’ register. Social and biological orphans are underrepresented in such surveys and so are large marginal groups of adults.

**Table 7.8. Social and biological orphans**

<b>Group</b>	<b>Estimated global prevalence, children</b>
Children in residential institutions, including prisons	10 million
Biological orphans	112 million
Child soldiers	300,000
Street children	25 million
Child labourers	218 million
Refugee and displaced children	15 million
Child prostitutes	10 million
Trafficked children	400,000
<b>Total</b>	<b>390 million</b>

It would seem reasonable to conclude that 50% of all people in the world have been victims of childhood abuse before age of 18. When child neglect is added, this global estimate is likely to be higher. Maltreatment of children takes place across all cultures, societies, economic, social, and religious strata. It appears to be higher in the devoting countries than in the developed ones.

The group of sexual perpetrators might be as large as the victims’ group, some abuse several children, but one child may be abused by more than one person. Although parents dominate as abusers, adolescents may in some cultures be responsible for a considerable proportion of such abuse (p.56, 118-119). Among the perpetrators of emotional and physical abuse both parents, or parent substitutes and teachers are involved. Some abusers are previous victims abusing others. We should note that for structural neglect the major part of the responsibility rests with government authorities.

These very high prevalence estimates are painful and disturbing and call for an examination of human nature. Even more troubling is the fact that the main group of perpetrators is the parents. Man’s destructive behaviour seems to have few limits. The injurious consequences for the individual are reviewed in Chapter 8. These effects remain chronic for a very large proportion. Time does not heal; time conceals.

Although it is clear that childhood violence is extremely common, as well as frightening, this does not imply that it is too late or hopeless to turn the tide. Few perpetrators are ‘monsters’; most are frustrated, unhappy, traumatized by having been abused and humiliated during their own childhood, and misguided by an environment that does little to discourage violence and to prevent harmful and irrational child rearing habits.

## 8 Microsystem Consequences and Upstream Effects of Childhood Violence

*“Childhood is not the shortest period of our lives but the longest as it stays with us until our death” (Lombardo, 2001).*

This Chapter presents assessments of the health and social consequences for the victims of childhood violence. It includes a short estimate of the global judicial and economical burdens to society.

### HEALTH AND SOCIAL CONSEQUENCES

An important method used to measure the effects of childhood violence is used in the Adverse Childhood Experiences (ACE) studies by Felitti *et al.* (1991, 1998, 2002). It is based on observations of ten categories of adverse childhood experiences, taking place before the age of 18, among 17,337 adult Kaiser Health Plan Members, mean age 56:

- (1) recurrent and severe physical abuse,
- (2) recurrent and severe emotional abuse,
- (3) contact sexual abuse;
- (4) growing up in a household with an alcoholic or drug abuser,
- (5) a household member being imprisoned,
- (6) a mentally ill, chronically depressed, or institutionalized household member,
- (7) the mother being treated violently,
- (8) both biological parents not being present,
- (9) emotional neglect and
- (10) physical neglect.

The experience of any of these categories was scored one point. Felitti and his co-workers have studied a large number of consequences related to ACE scores and, published some 50 articles. Some of these studies include only the first 8 categories listed above.

**Fig 8.1. Consequences of adverse childhood experiences**  
(Source, Felitti, 2003)



### SOMATIC CONSEQUENCES OF CHILDHOOD VIOLENCE

Persons subjected to physical abuse may have fractures, head trauma with brain damage, whiplash injuries, spinal cord injuries caused by falls, gunshots, and assaults with a knife, blindness, burns, wounds, cuts and other skin lesions, traumatic damage to interior organs, poisoning and other complications. It is common to see abused children with hematomas, burns from cigarettes or scalding, bruises from beatings and whipping, traumas to the head and eyes, and periorbital hematomas and damage to abdominal organs; very often these traumas are repeated.

An estimated 135 million women have been sexually mutilated during childhood (for details see Chapter 2). Common immediate side effects are: severe bleeding, tetanus and other infections, exquisite pain, and death. A majority of the survivors will have long-term problems with incontinence and urinary tract infections; sexual intercourse can be very painful. For some women, the sexual mutilation is repeated after the birth of the first child.

Acute effects of sexual abuse are common: some studies report 20% with severe somatic injuries – many of the genital organs – requiring treatment (Sobsey, 2000). Sexually abused children may have vaginal infections and difficulties in sitting and walking. Kawsar *et al* (2004) found in a U.K. clinical study of 98 girls who had been raped or sexually assaulted (aged 0-16 years) that sexually transmitted diseases had a prevalence of 26%. 81% also reported current psychological difficulties and 15% had attempted self-harm; 29% were unknown to the social services. The high prevalence of AIDS and gonorrhea among children is indicated by reports from Somalia (Amhmand, 1992), Cameroon (Menick and Nghoh, 2003), Botswana and Zimbabwe (Lalor, 2004), South Africa (Collings, 1991), and by WHO (2002): 1.25% of all children in Zimbabwe will have experienced abusive penetrative sex with an AIDS/HIV infected person before the age of 18. In Botswana, the figure was almost 2% (Lalor, 2004).



*Children in a hospital in a developing country. All of them have burns, many caused by the parents' neglect and some by physical abuse. © World Health Organization*

There are also many long-term secondary physical health effects, which appear when the maltreated children reach adulthood; these lead to increased mortality. The ACE Study (Felitti, 1998) has shown that adults with scores of 4 or more categories of ACE have a prevalence of ischemic heart disease of 5.6% versus 3.7% for those with 0 ACE score, stroke 4.1% vs. 2.6%, chronic obstructive pulmonary disease, 8.7% vs. 2.8%, hepatitis 10.7% vs. 5.3%, severe obesity 12.0% vs. 5.4%, chronic headache 45% vs. 25%.

Physical and sexual abuse increases the risk of subsequent eating disorders with self-induced vomiting or use of laxatives and diuretics to reduce weight (Neumark-Sztainer et al., 1997). Chronic fatigue and headache, menstrual problems, and gastro-intestinal disorders are more prevalent among persons with childhood sexual abuse (Taylor et Jason, 2001). Berkowitz (1998) found that gastrointestinal disorders increased from 10% in non-abused population to 33% after CSA; 44% of all women visiting gastroenterology practice had been abused; and 64% of women with chronic pelvic pain had experienced CSA compared to 23% of non-abused women (Leserman and Drossman, 2007)

The cautious global estimate is that childhood violence has lead to life-long somatic disability for at least 300-400 million people. Some of this is associated with premature death.

### **MENTAL, BEHAVIOURAL AND SOCIAL CONSEQUENCES OF CHILDHOOD VIOLENCE**

The information below is mainly based on studies in developed countries (all except those otherwise specified were made in USA).

Swanston *et al.* in 2003 published a prospective study of 103 sexually abused children in Australia. These children were compared with a matched group of non-abused children studied during the same period. After 9 years, 49 of the abused and 68 of the non-abused children were available for interviews. The abused children had significantly higher scores of depression, lack of self-esteem, anxiety, fearful behaviour, and despair. They had histories of bingeing, self-induced vomiting, smoking, using amphetamines, ecstasy, and cocaine. All their families were classified as malfunctioning. Fergusson and Lynskey (1997) made a prospective study of a birth cohort of 1,265 New Zealand children followed to the age of 18. The group was assessed on exposure to physical punishment/maltreatment, with several measures of psychosocial adjustment. Much of the elevated risk that was identified among those physically abused had arisen from the social context within which harsh and abusive treatment occurs; exposure to such treatment during childhood leads to elevated rates of violent offending, substance and alcohol abuse, suicide attempts, being a victim of violence, and mental health problems. Yanowitz *et al.* (2003) state that physical and emotional abuse by teachers leads to lower self-esteem, heightened aggression, academic difficulties, and poor social interaction skills among the pupils.

Flisher *et al.* (1997) found that physical abuse was significantly associated with global impairment, poor social competence, major depression, conduct disorder, oppositional defiant disorder, agoraphobia, overanxious disorder, and generalized anxiety disorder. Knutson *et al.* (2005) established that when children are exposed to care neglect, supervision neglect, and punitive care, the level of aggression increases significantly. Empathy-inducing, positive parenting practices give rise to less antisocial behaviour than punishment-based, negative parenting practice. Keily *et al.* (2001) studied a group of 578 children from their start in kindergarten until the eighth grade. Comparisons were made between maltreated and non-maltreated children; these showed that the children that were harmed early (before 5 years) showed significantly higher rates of behaviour problems than those who were maltreated after the age of 5, and those from the non-maltreated children.

#### **Cognitive impairment**

Child physical neglect has the most profound effects on cognitive functioning and academic achievement. Sameroff *et al.* in 1987 showed that the average IQ scores of 4-year-old children are related to their exposure to a number of psychological and social risk factors. These include parental influences, such as rigid and punitive childrearing style, parental

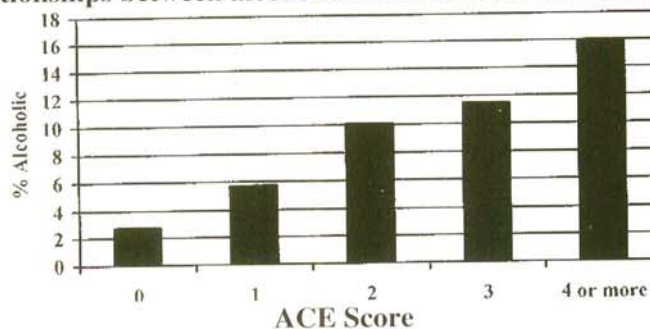
substance abuse, low parental educational attainment, father absence, poverty, and so on. In the ACE study (Felitti, 2003) the average IQ for children with 0, 1 or 2 of the factors is 113. When a 3rd and 4th risk factor are added, the average IQ scores drops to 93, with the further addition of the 5th through 8th risk factors the average IQ scores becomes 85.

Friedrich (1998) reviewed some additional factors, such as pre-abuse difficulties, stressful life events, level of IQ, developmental differences, family variables, such as quality of mother-daughter relationship, problem-solving capacity of the family, pre-existing, long-standing and adverse psychosocial circumstances, substance abuse, single-parent families, and so on. Friedrich points out that CSA is often combined with physical and psychological abuse, domestic violence, and neglect. Richards et Wadsworth (2004) analyzed 1,339 representative males and females from the British National Survey of Health and Development. They found that early adverse circumstances were strongly associated with lower cognitive ability in childhood and adolescence, and were detectable on measures of verbal ability, memory, and speed and concentration even as far as in midlife. Many abused children have delayed developmental milestones; they may after a traumatic event regress in cognitive development and in daily life abilities and communications skills. The authors state that in view of the persistence of child poverty in the industrialized world these findings give cause for concern.

**Addiction.**

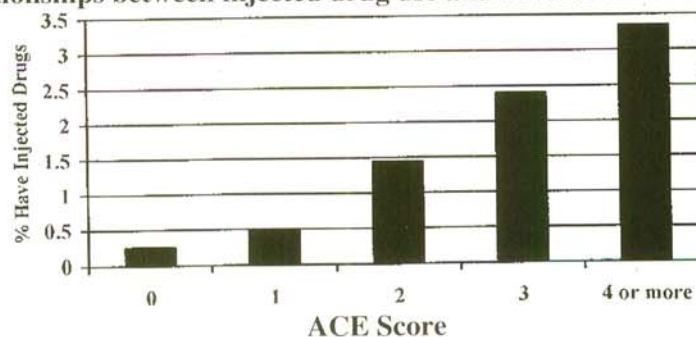
The ACE Study (Felitti, 2003) relates self-reported alcoholism and use of injected illegal drugs to adverse childhood experiences. Fig 8.2. shows that there is more than a 500% increase in adult alcoholism among subjects having an ACE Score of 4 or more.

**Fig . 8.2. Relationships between alcoholism and adverse childhood experiences**



The likelihood of injection of street drugs increases strongly and in a graded fashion as the ACE Score increases (Felitti, 2002) (Fig. 8.3.). For instance, a male child with an ACE Score of 6, when compared to a male child with an ACE Score of 0, has a 46-fold increase in the likelihood of becoming an injection drug user sometime later in life

**Fig . 8.3. Relationships between injected drug use and adverse childhood experiences**





### **Suicide attempts.**

The likelihood that an ACE Score 4 or higher individual will attempt suicide later in life is increased by ten times compared with an ACE Score 0 individual (Dube et al., 2003).

### **Criminality.**

Child physical abuse has serious effects on aggression and subsequent violent behaviour. Physically abused or neglected children are more likely than others to commit violent crimes later in life. Several US studies have been made. Widom (2000) examined criminal records of children who had been abused and/or neglected and followed them during 25 years. At their approximate age of 33, she found that early childhood abuse and neglect increased the risk of arrest as a juvenile by 55%, and the risk of being arrested for a violent crime while juvenile by 96%. Abused and neglected children became chronic offenders 1.6 times more than the controls. Zingraff *et al.* (1993) showed that abused and neglected children who had been removed from their homes were 4.8 times more likely to be arrested as juveniles and 11 times more likely to be arrested for a violent crime than the matched controls. English *et al.* (2002) reported that 19.6% of abused and neglected children versus 4.1% of the controls had a juvenile arrest record. 41.7% of the abused and neglected group versus 21.1% of controls had an adult arrest. Rebellon and Van Gundy (2005) showed that parental physical abuse is associated with a doubling (97%) in violent offence counts and an increase of 240% in property offence compared with matched controls. Swanston (2003) reports that sexual abuse increases the odds ratio of juvenile (2.4) and adult (2.0) arrests.

### **Post-traumatic stress disorder (PTSD)**

PTSD is highly frequent among victims of childhood violence. For these patients the overwhelming traumatic event is re-experienced, causing intense fear, helplessness, horror, and avoidance of stimuli associated with the trauma (WHO, 2002; Collings, 1995; Neumann *et al.*, 1996). Briggs et Joyce in 1997 showed that the severity of PTSD was proportionate to the extent of CSA and whether it involved sexual intercourse and the repetition of the abuse. There was a high level of co-morbidity with other mental disorders.

The presence of memory defects among abuse victims is disputed. The common theory was that the victims were seeking unconsciously to forget the abusive event or repeated events. If pronounced, this mechanism was seen as symptom of a mental disorder; dissociation, which is characterized by a disruption in the usually integrated functions of consciousness, memory, identity, and perception of the environment. Dissociation was according to this theory seen to be employed by children who could not escape from the threat or abuse; it would be a means of mentally withdrawing from a horrific situation by separating it from conscious awareness. Studies by Mulder *et al.* (1998) have shown that among individuals exposed to physical childhood abuse, the rate of frequent dissociation is five times higher than in non-abused persons. As regards persons exposed to CSA, the rate is two and a half times higher, this increase, however, is not directly related to the CSA but to the degree of concurrent physical abuse and psychiatric illness. Melchert (1998), however, studying 553 college students (of whom 27% had been abused), failed to find any significant association between childhood abuse and any lack of memory of it. Widom *et al.* (2004) have disputed the general accuracy of retrospective reports of childhood violence. Alexander *et al.* (2005) have, however, examined predictors of memory accuracy and errors 12 to 21 years after the abuse ended for individuals with legal experiences resulting from documented CSA. They showed that "severity of PTSD symptoms was positively associated with memory accuracy". Victims' memories are more distinct than are those of bystanders.

### Other mental consequences

The mental consequences of CSA are multifaceted. Finkelhor et Browne in 1986 proposed four mechanisms that would explain the outcomes:

- Traumatic sexualization, inappropriate conditioning of the child's sexual responsiveness, and the socialization of the child into faulty beliefs and assumptions about sexual behaviour;
- Betrayal: the child's confidence and trust in persons who should protect him/her from harm have become shattered;
- Stigmatization: the child's positive self-image is disturbed by the shame that is instilled,
- Powerlessness: intense fear of death and injury, and repeated frustration of not being able to stop or escape from the harmful experience or get help from others; this is part of the post-traumatic stress disorder.

Among the psychological health effects, Finkelhor and Browne list fear, anxiety, depression, anger, hostility, inappropriate sexual behaviour, poor self-esteem, tendency towards substance abuse, and difficulty with close relationships.

Childhood violence has negative effects on the biological capacity for bonding and attachment (Neumann *et al.* 1996). Without predictable, responsive, nurturing, and sensory-enriched care-giving, the infant's potential for normal bonding and attachments will be unrealized. Problems with bonding and attachment lead to a fragile biological and emotional foundation for the forming of future relationships (Boney-McCoy and Finkelhor, 1996). The psychological impact for children witnessing violence, especially at home, is alarming; it may lead to PTSD, disrupted sleeping and feeding routines, poor weight gain, anxiety and rage, dropping out of school, drug use and running away from home (Knapp, 1998); the bonding process is severely disturbed.

Manmade disasters such as release of toxic substances, collapses of dams or bridges, traffic accidents, occupational accidents, wars and state-organized violence expose people to traumas; the resulting mental health effects are similar to those caused by interpersonal violence. Natural disasters are common, and after disasters health symptoms are common (WHO, 1992). Some 80% to 90% of all disasters occur in developing countries where the population is unprotected and unprepared even where some disaster, such as flooding, is known to recur every year. In these countries, the mortality and morbidity caused by disasters is high, and doubtless includes a large proportion of the two billion children who live there.

### The prevalence of mental disability caused by childhood violence

Very large numbers of people underachieve because of a health condition. For example, in a US study with a response rate of 73%, Kessler *et al.* (2003) estimated that the lifetime prevalence of an episode of major depression was 16%; of these about 6% had taken place during the most recent 12 months. Of persons with depression, many had experienced very severe, severe, or moderate role impairment: 69% at home, 54% at work, 63% in relationships, 71% socially; overall 87% had at least one of these role impairments; these indicate current disability. Most likely Kessler's *et al.* assessments are too low; among the 27% non-responders in his study there could be many additional persons with depression. WHO estimated that the global incidence of unipolar major depression was 109 million persons, and 59 million of them were disabled. These numbers are, however, probably underestimates as they are built on samples that had 13% to 55% non-responders (WHO, 2001). Mental disorders among care-givers are prevalent (see p. 108).

The disabling effects of abuse, neglect, and violence are both somatic and mental. Persons with role impairments may appear, superficially, to function normally at work, in their families, and in social contacts; however by using deeper analysis, many may have significant disabilities (such as tiredness, decreased quality, quantity, and creativity at work) due to

mental and somatic disorders, or due to their daily frustrations, poverty and hunger. Parent role malfunctioning often leads to child violence.

Many health effects are lifelong and severely hinder normal functioning and lead to physical and economic dependence and restricted social participation. The prevalence of PTSD and other mental disorders have been studied in several surveys; the high frequency of co-morbidity is notable, it implies that the condition is severe, often long-lasting, and difficult to treat. Many of the first studies of PTSD related to war victims, including camp victims from Nazi Germany.<sup>15</sup>

**Table 8.1 Mental symptoms related to childhood violence**

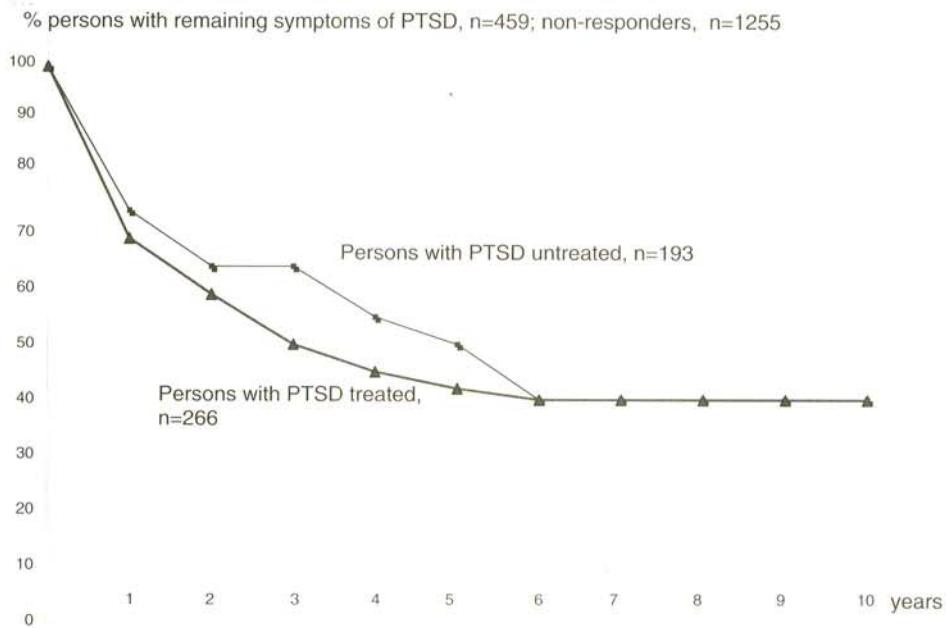
<b>Authors</b>	<b>Groups of victims</b>	<b>Findings of mental symptoms</b>
Ackerman <i>et al.</i> 1998 USA	204 children aged 7-13, referred to hospital after sexual or physical abuse or both.	34% PTSD, 36% phobia, 29% ADHD, 36% oppositional defiance, 39% separation anxiety, 21% conduct disorder, 20% overanxious, 19% dysthymia; abused girls are more internalizing; boys externalizing
Böðvarsdóttir and Elklit Iceland 2007	Icelandic national representative sample of 206 students (mean age 14) Prevalence and impact of 20 potentially traumatic and negative life events	74% of the girls and 79% of the boys were exposed to at least one event. Most common were the death of a family member, threat of violence, and traffic accidents. Lifetime PTSD 16%, subclinical PTSD (missing full diagnosis with one symptom) another 12%
Chen 2004 China	Women students from medical school in China	26% abused before age 16, median age 12. Victims reported higher levels of depression, less healthy; some had suicide thoughts, anxious of about attacks in the street, and had a higher proportion smoking and drinking alcohol than non-victimized students.
Elklit 2002 Denmark	Representative study of 390 Danish school children age 12-15	78 % of males and 87% of females had been exposed to at least one traumatic event. Most distressing were rape, suicide attempts, death in the family, serious illness, and childhood abuse. Lifetime prevalence of PTSD 9.0%, subclinical PTSD another 14.1%
Famarulo and Fenton 1996 USA	117 abused children removed from parental care	35% PTSD, high rates of ADHD, anxiety disorders, brief psychotic disorders, PTSD group had more mood disorders and increased suicide ideation.
Felitti and Anda 2003	ACE Study 17,337 adults (see above)	Population risks attributed to ACE : chronic depression 41%, suicide attempts 58%, alcoholism 65%, illicit drug use 50%, injected drug use 68%, being sexually assaulted 62%, as adult exposed to domestic violence 52%.
Flisher <i>et al.</i> 1997 USA	Interviewed a community sample of 660 9-17-year-olds and their care-takers in New York and Puerto Rico.	26% physically abused, this was associated with global impairment, poor social competence, major depression, conduct disorder, oppositional defiant disorder, agoraphobia, overanxious disorder, and generalized anxiety disorder.

<p>Kendall-Tackett, Williams and Finkelhor 1993 USA</p>	<p>A synthesis of 45 studies including comparisons with non-abused children.</p>	<p>Victims of CSA had general PTSD (53%), promiscuity (38%), general behaviour problems (37%), poor self-esteem (35%), fear (33%), nightmares (31%), neurotic mental illness (30%), and aggression including delinquency (29%), depression (28%), anxiety (28%), and inappropriate sexual behaviour (28%). Compared with non-abused children, the CSA consistently showed more PTSD and sexualized behaviour. CSA strongly related to depression, aggression, and withdrawal. Separate comparisons for age groups 0-6, 7-12 and 13-18, yielded more focused and consistent findings than with mixed age groups. About 2/3 of the children had symptoms and 1/3 had not. About 2/3 of the victimized children showed recovery during the first 12-18 months after the event.</p>
<p>Nader <i>et al.</i> 1993 Kuwait</p>	<p>Kuwaiti children exposed to the Iraqi occupation and the Gulf War</p>	<p>2 years afterwards, 70% had moderate to severe PTSD</p>
<p>Shaw and Krause 2002 USA</p>	<p>US national survey of persons aged 25-74, 2,788 persons had complete data (response rate 61%). Mailed questionnaire.</p>	<p>24% experienced childhood physical violence with early onset of psychological disorder, setting in motion a vicious cycle of recurring disorder during the life course. Many somatic disorders are also related to such abuse.</p>
<p>Silverman <i>et al.</i> 1996 USA</p>	<p>Working class community. Sample of 777 kindergarten children screened for health development, behavioural, and academic factors. Follow-ups until children were 21. Because of school transfers, the attrition rate after 10 years was 22%, but after that time until age 21 95% could be interviewed.</p>	<p>At age 21, 11% reported physical or sexual abuse before age 18. 80% of the abused met criteria for at least one psychiatric disorder. Compared with non-abused schoolmates, they had significant impairments both at age 15 and 21: more depression (23%), anxiety, emotional-behavioural problems (45%), suicidal ideation (18%), and suicide attempts (17%). At 21, physically abused males had 40% drug-abuse dependence (vs. 4% of non-abused) and 10% PTSD (vs. 0.6% of non-abused); for females PTSD was 41.7% (vs. 3.4%) Sexually abused females had PTSD in 34.8% (vs.1.8%).</p>
<p>Stein <i>et al.</i> 1996 USA</p>	<p>Compared a group of 125 patients with anxiety disorders with a matched group drawn from a community sample.</p>	<p>Childhood physical abuse: 16% of the male and 33% of female patients, in comparison sample 8%. CSA among 45% of women patients vs. 15% in the comparison group.</p>

The Table confirms the high prevalence of comorbid mental disorders, and the many linkages between such disorders and childhood abuse.

The chronicity of PTSD was analyzed by Kessler *et al.* in a 1995 study; it was part of the US National Comorbid Survey. Initially 8098 participants, aged 15-54 were included; the response rate was 82%. Lifetime prevalence of PTSD was 5.0% in men and 10.4 in women. Survival curves during the first 6 years show recovery among 60%, (Fig 8.4). Of those with PTSD symptoms, 266 respondents did and 193 did not receive treatment. Kessler's *et al.* conclusion is that patients who received treatment had somewhat less (statistically significant  $p < 0.05$ ) symptoms during the first 5-6 years; after that period - until the end of the 10-year observation period - there was no benefit from treatment. Their conclusions may be challenged: they were built on just 405 subjects, with 1,255 non-responders.

**Fig. 8.4. Survival curves based on duration of symptoms for respondents who did and did not receive treatment for PTSD (modified from Kessler, 1995).**



Based on the above study the proportion of victims who will remain chronically affected appears to be some 40%, irrespective of psychiatric treatment; it may be higher, as many studies have significant attrition rates. Most exposed persons with these kinds of mental problems live in the developing countries, and there the availability of any Western-type treatment is very restricted: there is no money to pay for the medicines, and cognitive group therapy for violence victims may be culturally incompatible. All victims have a high frequency of significant role impairments. It is estimated that one third of the victims of childhood violence remain with long-term mental disability (including significant role impairment). This would imply a global prevalence of persons with mental disability of about 1,000 million persons.

### NEUROBIOLOGICAL CORRELATES TO CHILDHOOD VIOLENCE

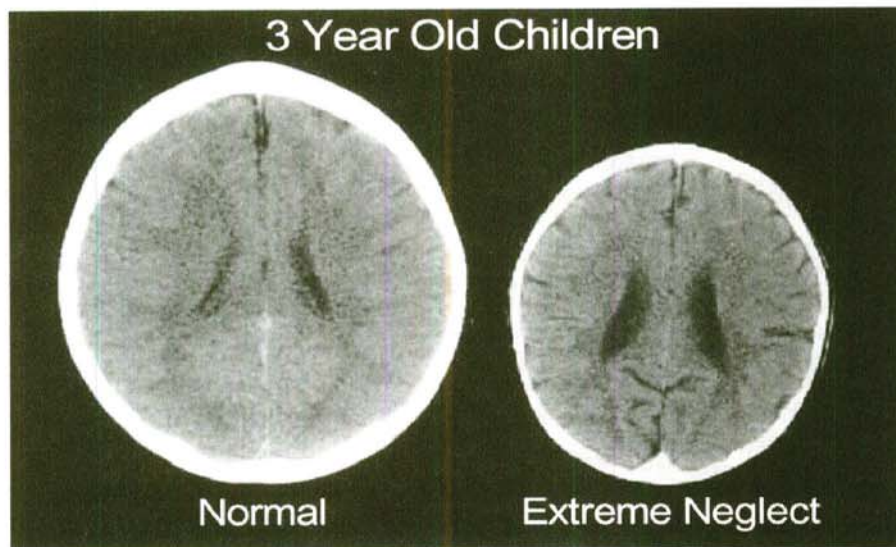
It may be useful to give a brief account of the brain processes related to the mental consequences of childhood violence. The environment in which a child grows up whether favourable or unfavourable, interact with all the processes of neurodevelopment:

neurogenesis, migration, differentiation, apoptosis, arborization, synaptogenesis, synaptic sculpting, and myelination (Perry, 2002).

### **The influence by child neglect on childhood brain development and function.**

The brain has at birth some 100 billion neurons. These have threadlike axons, but anatomically do not form a connected network; each cell is an independent unit. For a nervous signal to travel across the system, the axon releases a chemical product (neurotransmitter) to bridge the gap between its signalling axon and the signal-receiving dendrite of the adjacent nerve cell. A synapse is formed; during the first three years of life, in response to environmental stimulation, each nerve cell of a normal child forms some 15,000 synapses; totally some 1,000 trillion synapses (Eliot, 2001). If such a specific such pathway is used often, there emerges a memory effect. If a certain pathway is not used, the nerve cell may disappear. This is seen among infants and very young children; they have at birth many more nerve cells than adults, but many unused will be 'pruned off'. The brain develops its functioning and ability to change because of its past and ongoing usage; the transmitting action leaves biochemical 'memory traces'. The memory systems of children who have not yet gone through the phase of 'pruning' are especially sensitive to the biochemical processes triggered by abuse, and neglect.

If the environmental stimulation is severely reduced, such as among the abandoned children in the 'orphanages' described in Chapter 4, the development of synapses will be severely reduced (see Fig 8.5). Child neglect in young children affects the early brain development resulting in excessive pruning off of neurons, much smaller brains, and loss of essential brain functions (see p.51.)



*Fig 8.5. Brain CT scan with comparison between an extremely neglected and a normal child. The neglected child's brain is significantly smaller than average (3rd percentile) and has enlarged ventricles, cortical atrophy and a reduction of the head circumference. © B. Perry*

### **The influence by violence-related stress reactions on childhood brain development and function**

High levels of psychological or physical arousal, such as those caused by childhood violence trigger stress reactions. These were first studied by Selye in the 1930s, who described

the general adaptation syndrome to stress. It begins with an alarm reaction in the hypothalamus. This is followed by a stage of resistance, and, if the stressor is not removed, leads to a final stage of exhaustion. The hypothalamus stimulates the sympathetic nervous system, activating the pituitary to produce adrenocorticotropic hormone (ACTH) which stimulates the adrenals to produce cortisol. The sympathetic nervous system increases the production of epinephrine and norepinephrine. These hormones mobilize the body to deal with the stressor. In the second stage of resistance, local reactions seek to normalize the hormone levels. If these responses are insufficient, exhaustion will follow and the hormonal levels become excessive. If this occurs, the person may become mentally disturbed, withdrawn, or maladjusted.

### **Hormonal, biochemical, metabolic and anatomical correlates**

High levels of cortisol caused by abuse depress brain cell function. Hippocampal damage identified by the anatomical decrease of its volume or depletion of its glucocorticoid receptors in PTSD leads to an increase in adrenal secretion. Impaired adrenocortical secretion leads to loss of granula cells in the hippocampus, which could explain the deficits in cognition. Because of stress, the hypothalamus increases or reduces the release also of other hormones. The growth hormone is lowered in physically and sexually abused boys (Jensen, 1991). Women who have been sexually abused and developed PTSD have elevated levels of thyroid hormones (Friedman *et al.*, 2005). PTSD patients (Bremner *et al.*, 2003, 2005) have increased left amygdala activation, with fear acquisition, and decreased anterior cingulate function during extinction, in comparison with controls. Anxiety disorders are related to an induced abnormal functioning of the amygdala. These overreact at stressful, abusive events and then hormones and other biochemical substances start 'flooding' the body. Emotional memory is centralized to the amygdala and the medial frontal cortex, which together with the hypothalamus control a wide variety of hormones. Fear and anxiety during traumatic events influence the biochemical agents used for neurotransmission. Because of their effects on the amygdala-hypothalamus brain regions, such emotions increase or reduce the release of hormones: cortisol, epinephrine and nor-epinephrine, gonadotropin-releasing hormone, growth hormone, to name just a few. The biochemical changes serve to encode emotionally-charged memories so that the abuse victim may not be able to forget them.

Anxiety disorders, such as PTSD, are accompanied by important changes in the endocrine functions and in serotonin metabolism (Cicchetti and Rogosh, 2001; Gonzales-Heydrich *et al.*, 2001; Newport 2004; Rinne *et al.*, 2002). With stress, not only ACTH is released but also endorphins that reduce pain. The noradrenergic system (related to the causation of anxiety, fear, sleeping problems, and intrusive thoughts) malfunctions; in PTSD an elevated level of nocturnal noradrenergic metabolites has been found, which might cause the sleep problems. Nutt and Malizia (2004) suggest that the hallmark symptoms of PTSD may be related to a failure of higher brain regions (hippocampus and the medial frontal cortex) to dampen the exaggerated symptoms of of arousal and distress that are mediated through the amygdala in response to reminders of the traumatic event. Taylor *et.al.* (2006) conclude that neural responses to emotional stimuli are associated with childhood stress.

In PTSD, there are anatomical changes in the brain caused by traumatic events; they are 'upstream', secondary consequences. The hippocampus volume is reduced; its neuronal integrity and functional integrity is disturbed in PTSD (Shin *et al.*, 2006, Driessen *et al.*, 2000; Pederson *et al.*, 2004; Schmal *et al.*, 2004). Compared to normal subjects, subjects with PTSD have smaller intracranial, cerebral, and prefrontal cortex, reduced prefrontal cortex white matter, smaller right temporal-lobe volumes, and smaller volumes of the corpus callosum and its sub-regions. Brain volume changes are positively correlated with the age of onset of

trauma and negatively correlated with the duration of the abuse (De Bellis *et al.*, 2002). Early abuse has deleterious effect on the brain cortical development (Knapp, 1998). PTSD causes a reduced neuronal viability in the prefrontal cortex (Mathew *et al.*, 2004), and in the cerebellum (Anderson *et al.*, 2002). In children with generalized anxiety disorder there is an association with pathological fear activation in the amygdala, ventral prefrontal cortex and anterior cingulate cortex. (McClure *et al.*, 2007) Brain-scan has shown that the blood flow to certain memory-related parts of the brain is redirected when the formerly abused person is exposed to retrieval of his or her memories of the childhood event (Shin *et al.*, 1999). Sexually abused women with PTSD show increased amygdala activation with fear acquisition compared with controls (Bremner *et al.*, 2005). A group of young women, who had been exposed to severe childhood physical/sexual abuse, were studied using positron emission tomography. Compared to a matched control group, they had reduced glucose intake in brain cortex areas involved in memory consolidation and retrieval that are part of a network of active brain regions that continuously gather information about the world around and within us and transfer this information to the cortex. (Lange *et al.*, 2005) have shown that early life stress is associated with smaller anterior cingulate cortex and caudate volumes. Close to 1,000 publications studying anatomical and functional alterations of the central nervous system using neuroimaging are now available. Etkin and Wager, (2007) have recently published a meta-analysis of emotional processing in PTSD, social anxiety disorder and specific phobia. They suggest that the mechanism for emotional dysregulation symptoms in PTSD extend beyond an exaggerated fear response.

The conclusion is that childhood violence has been shown to be associated with smaller volumes of parts of the brain, implying that cells have been damaged or have disappeared; evidently, this damage is widespread, combined with a 'cascade' of biochemical, hormonal, and metabolic alterations.

### **Repair or replacement of damaged brain functions**

It is currently debated whether damaged neocortical cells can be repaired or replaced. The conventional view was that nerve cells lacked this ability, and this appeared to be confirmed by clinical observations in several neurological diseases. However, in 1992, Reynolds and Weiss were the first to isolate neural progenitor and stem cells from mouse brain tissue. Numerous experiments indicate that brain cells can re-form in mammals, including humans (Colucci-D'Amato *et al.*, 2006). Complex factors are involved in cell renewal (Pluchino *et al.*, 2007); how to foster repair is still insufficiently understood. Studies by Bhardwaj *et al.* (2006) using  $C^{14}$  techniques indicate that no cell division or replacement takes place in necrotic nerve cells during the person's life from infancy to adulthood. The more specific question if the nerve cells which have been damaged or disappeared as a reaction to PTSD caused by childhood abuse can be repaired or replaced is influenced by the findings by Gould et Gross (2002). They showed that the presence of long-term stress reactions prevents the repair functions of adult stem cells in the brain. At present, there is no evidence that the widespread alterations of the function of the brain cells comprising changes in the brain biochemistry, metabolism, hormonal regulation and anatomy resulting from childhood abuse can be restored.

### **Resilience.**

People with a type of personality called hardiness have the ability to withstand even severe and prolonged stress. They are highly committed to what they do, have a strong need to control the events around them, and a willingness to accept challenges. These characteristics are likely to make them resilient also to the effects of childhood abuse. Other factors that contribute to resilience are social support from others, optimism, humour in the face of



difficulty, and positive illusions. About one fourth to one third of all victims of childhood abuse and neglect appear to be resilient and do not develop the mental symptoms associated with the majority. McGloin and Widom (2001) have shown that resilient victims meet the criteria for success in eight domains: employment, homelessness, education, social activity, psychiatric disorder, substance abuse, official arrest, and reports of violence. 22% of 676 substantially abused and neglected individuals met these criteria and were therefore considered resilient.

In the Kendall-Tackett's *et al.* (1993) review, about one third of the abused college students were resilient. Barnes and Bell (2003) suggest that the factors included in resilience include: (1) intellectual and physical ability, toughness; (2) adaptive psychological factors (ego resilience, motivation, humour, hardiness, and perceptions of self, emotional wellbeing, hope, life situation, optimism, happiness, and trust; (3) spiritual attributes; (4) attributes of posttraumatic growth; (5) interpersonal skills and relations, connectedness, and social support; (6) positive life events and socioeconomic status.

Himelein and McElrath (1996) described a group of 180 female college students (responders 97%), of whom 45 (26%) reported contact CSA before age 15. They then made an in-depth study on a subsample of 20 CSA survivors. They showed that the resilient group revealed a greater tendency to engage in four cognitive strategies: disclosing and discussing CSA, minimization, positive reframing, and refusal to dwell on the experience. Positive illusion is strongly associated with psychological well-being. It appears that there are no studies of resilience published from the developing countries; in these, cultural and socio-economic factors leading to resilience may be very different. Outcomes of childhood violence generally worsen as risk factors pile up in children's lives, and then, resilience is less common (Masten, 1997; Egeland *et al.*, 1993; Garmezy and Masten, 1994). At very high levels of trauma, no child is expected to be resilient until a safe and more normative environment for development is restored. Thus, in cases of massive trauma due to war or chronic child abuse, resilience refers to good recovery after trauma has ended. It is possible for a child to be resilient and still suffer from residual effects of trauma. Resilience does not mean invulnerable or unscathed (Masten, (1997).

### **JUDICIAL UPSTREAM CONSEQUENCES**

Child abuse and neglect, may lead to interventions by social protection agencies; and to judicial action against the perpetrator. A meta-analysis of 21 US studies of criminal justice decisions related to child sexual abuse was published in 2003 by Cross *et al.* The rates of referral to prosecution, filing charges, and incarceration varied. The rate of carrying case forward without dismissal was high: 72% or greater. For cases carried forward, plea rates averaged 83% and conviction rates 94%. Diversion, guilty plea, and trial and conviction rates were the same for child abuse and all violent crimes.

The US Bureau of Justice Statistics (2002) concluded that for the period 1994-98 only 32% of sexual assaults against persons aged 12 or older were reported to law enforcement. A three-year longitudinal study by the Bureau of 4,008 adult women found that 84% respondents who identified themselves, as rape victims did not report the crime to authorities. No current studies indicate the rate of reporting for child sexual assault, although it is generally assumed that these assaults are similarly underreported.

Finkelhor and Jones (2004) report that that between 1991 and 1997, the number of individuals incarcerated in US state correctional facilities for sex crimes against children rose 39%, from 43,500 to 60,700, having already more than doubled from 19,900 in 1986. These totals do not include the large numbers of sexual abusers who receive sanctions which do not

involve incarceration for a year or more. About 60% of all known child sex offenders are under conditional supervision in the community. Incarceration may have diminished the incidence of sexual abuse.

The situation in South Africa (population 45 million) may serve as comparison. The South African Human Rights Commission stated that in 2002 there were about 173,000 cases of child abuse on the rolls of South African courts (Conradie, 2003). (There are 747 courts and 273 prisons in South Africa). The conviction rate was 7%. The daily average of incarcerated persons was 181,000, representing 80% overpopulation; one third of them were awaiting trial. 3,500 incarcerated persons have been sentenced to life imprisonment. Similar conditions are seen in many developing countries.

The judicial system has no capacity anywhere of dealing with the enormous numbers of crimes against children, nor will it ever have, should the present crime level persist. The global number of persons known to be in prisons for all crimes is just about nine million (Walmsley, 2006). The costs to the society of the judicial consequences are already very high.

### ECONOMIC UPSTREAM CONSEQUENCES

Calculations have been made both for small groups of affected children and for countries. A detailed review has been published in 2004 by WHO. WHO quotes the USA estimate of losses due to violence as being 3.3% of GDP. A main part relates to lost earnings and opportunity cost of lost time. The costs of violence in percentage of GDP are for Brazil 10.5%, Colombia 24.5%, El Salvador 24.9%, Peru 5.1% and Venezuela 11.8%. Daro in 1988 cautiously calculated the cost in lost earnings of a group of 24,000 maltreated children living in the USA to US\$ 658-1,300 million per year. Irazuzta *et al.* in 1994, made cost estimates for 13 abused children out of 937 who were admitted to paediatric intensive care units in USA. While the abused children represented only 1.4% of all admissions, they had the highest severity of illness: 7 of them died of head trauma, and an additional 4 left the hospital with severe residual symptoms. These results were worse than those of any other group of children in emergency care. The medical bills for the acute care averaged US\$ 35,641 per abused child (daily charges US\$ 5,294). In this report, no calculations of the post-hospital costs were made.

The studies of costs related to childhood violence show large differences – it is not easy to make these calculations. Still, even the highest are very conservative and mostly built on official incidence reports, which underestimate the reality. Estimates of costs for treatment of the victims most often only cover short-term expenditure, but not care for the long-term consequences described above (addiction, risk behaviour, chronic mental disorders, and increased disease and disability rates). Most childhood abuse is hidden; these victims may indeed seek health care; a very large proportion of the doctors, however, are not in the habit of routinely asking about childhood violence, and the victims seldom volunteer such information. These costs are insufficiently recognized:

- the victims' rehabilitation, including re-integration to society,
- decrease of educational achievements (reflecting decreases in cognitive functions),
- loss of quality and creativity at work, (not just unemployment, underemployment and absenteeism),
- reduction of not only of cognitive abilities but also of non-cognitive abilities (motivation, self control, risks aversion temperament, time preference). (Heckman 2007)
- the community effects of the doubling of violent and non-violent criminality, and
- family problems, such as with the next generation of children of abused parents

- and finally, economists are never seen to include the costs of lost dignity and human suffering in their calculations.

Heckman, Knudsen, Cameron, and Shonkoff, (2006) have pointed out that neglect-related damage to children’s neurobiological development will lead to reductions of the future quality of a country’s workforce. Such changes carry a high economic cost. (Heckman, Stixrud, and Urzua (2006). The productive work time lost by employees with a major depressive disorder was estimated in a US study (Stewart *et al.* 2003) at 5.6 hours/week vs. the normal 1.5 hours/week. The 2-week prevalence of any depressive disorder was 9.4%; the production losses – for this disorder alone – in USA amounted to US \$31 billion/year. Anda *et al.* (2004) in a cohort of 9,633 employed persons found that worker performance impairment among persons with ACE Score 4 was twice that of those with score 0.

We may cautiously convert the direct and indirect costs cited for the USA to an approximate estimate of the global costs of violence (Table 8.2.). The GNP of the USA in 2001 was 29% of the global GNP. In the Table, the extrapolation is based on the assumption that the direct and indirect costs are proportional to the combined GNPs (71% of the global GNP) of the group of 221 countries and territories outside the USA for which GNP data are available. Indeed, the estimate is so high that it exceeds the annual national GNP of all individual countries in the world, except seven.

**Table 8.2. Estimates of direct and indirect annual global costs of violence.**

<b>Cost level in USA and the world</b>	<b>Total direct and indirect costs in USA, US\$ billion</b>	<b>Extrapolated to whole world, US\$ billion.</b>	<b>Number of countries with national GNP in excess of the global costs calculated in the previous column</b>
3.3% of national GNP	387	1,400	7

This annual estimate of US\$ 1.4 trillion emphasizes the urgency of finding preventive alternatives.

PART FOUR: ROLES OF EXO- AND  
MACROSYSTEMS

## 9 Causes and Contributors to Childhood Violence

To initiate and provide resources for preventive and curative child violence services for populations, is a role for communities, and governments: the exo- and macrosystems. The information in this Chapter will clarify some of the basic issues. It seeks to:

(a) Identify the major causes and contributors to child violence. Why are people abusing children; do they have diseases or genetic factors that explain their aggression; or is it caused by adverse environmental factors in their lives? How much is related to alcohol use? What are the roles of social, cultural, and economic factors? Is the problem the lack of family life preparation: they never got a chance to acquire the knowledge and skills for their most important task in life: educating their children? Do we live in a violent, uncaring, and indifferent society that does little to meet families' needs and prevent the damage to our children? Is child protection failing? Do people learn how to become violent? Are there cultural factors, such as those related to gender?

(b) Estimate their relative prevalence; this not easy because we lack information about the exact occurrence, especially in the developing countries. Childhood violence may also be the result of combinations of causes.

(c) Analyze the present knowledge about the effectiveness of preventing each of the causes and contributors. Again, our knowledge is mainly based in the developed countries and may not be transplanted to other cultures.

(d) Suggest priorities for preventive action. Should prevention be targeted just at families which have been reported to protection authorities, or should it be a programme for all?

The factors discussed imply interaction between all levels of the human ecology system. The information below comes mostly from North American and European sources; if existing, data from the developing countries is included.

### HEALTH-RELATED CAUSES APPEARING IN CHILDHOOD

#### Pregnancy and delivery complications

Mednick in 1971 studied the records of violent criminals in the Danish penal system. Fifteen of the sixteen most violent criminals were found to have had an extraordinarily difficult birth and the sixteenth had an epileptic mother. In a second study, Kandel and Mednick (1999) compared pregnancy and delivery events between three groups: a) 15 violent criminals, b) 24 property criminals and c) 177 non-offenders. Delivery complications such as ruptured uterus, umbilical cord prolapse, difficult labour, etc., were correlated to violent offending. Their conclusion was that 80% of violent offenders rated high in delivery complications, compared with 30% of property offenders and 47% of non-offenders (the significance level is low as their numbers are small). Raine *et al.* (1990) reported a significant association between birth complications and early maternal rejection, and violent crime at age 18. While only 4.5% of the subjects had both risk factors, this small group accounted for 18% of all violent crimes. The effect was specific to violence and was not observed for non-violent criminal acts. Beck and Shaw (2005) studied birth records in addition to longitudinal data that were collected on 310 low-income boys followed from birth until 10 years of age. Perinatal complications emerged as a predictor of antisocial behaviour but only in the context of other family risk factors. According to maternal reports, boys experiencing high levels of perinatal complications, parental rejection, and family adversity showed significantly higher levels of antisocial behaviour than boys did with lower levels of these risk factors. This finding was partially corroborated by young people's self-reports: boys experiencing high levels of perinatal complications and family adversity reported more antisocial activity than boys

experiencing no risk or risk in only one domain. Nathanielsz (1999) has in a monograph extensively reviewed the role of pregnancy and birth complications for the health of children.

A team at the University of Groningen in The Netherlands studied two consecutive cohorts totalling 3,162 singleton infants born in 1975 and 1978 and then followed them for 25 years (Tuin-Bastra, 2004). Obstetric data were collected and quantitatively scored using a list of 74 items describing the pre-and perinatal condition of the mother and of the fetus. Data included social and economic variables, past pregnancies, non-obstetric condition of the mother, obstetric aspects of the pregnancy, parturition and the child's immediate post-natal condition. For sub-samples, follow-up data on childhood detailed neurological status (Touwen *et al.*, 1980) to diagnose clusters of dysfunctions; school performance tests and standardized questionnaires of behavioural and emotional problems were applied, including interviews with the teachers and the parents. The latest part of the study includes a follow-up of a sample aged 20-25 years. The social and economic status was noted as well as the present habits of smoking, alcohol consumption, and substance use. Psychiatric interviews were made using a General Health Questionnaire (Goldberg, 1972). This was followed by the administration of the subscales of Symptom Checklist 90 (Derogates, 1977) for depression and anxiety and of an interview, using the Composite International Diagnostic Interview (CIDI) form (Robins *et al.*, 1988), which covered 12 sections of DSM-IV disorders. Complications during pregnancy and at delivery lead to a higher frequency of serious emotional problems, especially externalizing behaviour among boys, and to underperformance in school. The consequences are in line with conduct disorder. In young adulthood, it is associated with a significantly higher prevalence of anxiety and depression, to a high prevalence of co-morbid psychiatric disorders, of alcohol and substance use, and of smoking.

Some recent articles about biochemical factors related to pregnancy and birth complications have been published. De Werth *et al.* (2003) report that children of mothers with high prenatal cortisol level display more crying, fussing, and had negative facial expressions. Huizink *et al.* (2003) found that (1) high amounts of daily hassles in early pregnancy were associated with lower mental development score at 8 months, (2) High levels of pregnancy-specific anxiety in mid-pregnancy predicted lower mental and motor development scores at 8 months, and (3) early morning values of cortisol in late pregnancy were negatively related to both mental and motor development at 3 months. Niederhofer and Reiter (2004) showed a significant correlation between prenatal maternal stresses, prenatal temperament of the child, and his/her school marks at the age of 6 years. Davis *et al.* (2007) examined 247 full-term infants. Elevated levels of mothers' prenatal cortisol at 30-32 weeks of gestation, but not earlier in pregnancy, was significantly associated with greater maternal report of infant negative reactivity. Prenatal anxiety and depression predicted infant temperament. There were clear associations between maternal cortisol and depression. Glynn *et al.* (2007) report that among breastfed infants, higher maternal cortisol levels were associated with increased infant fear behaviour; this reaction did not exist among the formula-fed infants.

During their pregnancies, high proportions of women – especially in developing countries – are subjected to psychological, physical, or sexual violence by their partners; this would cause biochemical and hormonal stress reactions in the pregnant women, which by placenta transfer influence the development of the fetus' brain and neural system. Such stress may be more pronounced if these mothers are malnourished, anaemic, and have episodes of recurrent communicable diseases. Disturbances to the supply of energy or of other chemical components that serve to build the fetus' brain or to regulate its functions before delivery may result in damage to the neural cells. After birth, the infant's metabolism is regulated by hormones such as catecholamines. These perinatal disturbances of the oxygen supply or other complications might harm the parts of the neural system that is involved in emotional

regulation. This may explain the Groningen findings of clusters of neurological dysfunction combined with emotional and behaviour problems among children, lasting into adulthood.

### Conduct disorder

**(i) Diagnosis and prevalence.** Conduct disorder refers to a group of behavioural and emotional problems in youngsters. These children and adolescents have great difficulty following rules and behaving in a socially acceptable way. They may exhibit (DSM IV, 1994):

- a) aggression to people and animals;
- b) deliberate destruction of property;
- c) deceitfulness, lying, or stealing;
- d) serious violations of rules: stays out at night, runs away from home, truant from school, precocious sexual activity, early involvement in prostitution;
- e) poor school performance; poor relations with peers, some expelled from school because of their behaviour or problems with the law.

Such children may have a combination with mood disorders, anxiety, PTSD, substance abuse, ADHD, learning problems, or thought disorders. Rates of depression, suicidal thoughts, suicide attempts, and suicide itself are all higher in children with conduct disorder (Shaffer et al., 1994). Between a quarter and a half of highly antisocial children become antisocial adults (American Academy of Child and Adolescent Psychiatry, 2004).

Conduct disorder is more common among boys than girls; the rate among boys in the general population ranges from 6%-16%, for girls 2%-9%. It can start early, before age 10. Oppositional defiant disorder is sometimes a precursor. The first sign of an emerging conduct disorder with aggressive behaviour may occur by the ages of 4 or 5 and may then be stable. Parents often react negatively to these children, withdrawing love and punishing them.

**(ii) Etiology.** The aetiology of conduct disorder is not fully known. Twin studies have indicated a role of psychosocial components, but also of genetic ones. The gene GABRA2 is significantly associated with childhood conduct disorder (Dick *et al.*, 2006). This gene produces parts of the receptor for the brain's primary inhibitory neurotransmitter,  $\gamma$ -aminobutyric acid (GABA). When GABA binds to the GABA-receptors on a nerve cell, it inhibits the firing of that cell. GABA is also involved with the body's responses to alcohol, such as loss of physical coordination, effect on mood, and alcohol withdrawal symptoms. Frequent risk factors are diseases causing brain damage, child abuse, and traumatic life experiences. Lack of bonding to the parents is common due to maternal rejection, separation from parents, institutionalization, parents' mental disorders, parental marital discord, large family size, crowding, and poverty.

**(iii) Treatment.** Children with conduct disorder without treatment may become unable to adapt to the demands of adulthood and continue to have problems with relationships and holding a job. They may become delinquent and antisocial (Stouthammer-Loeber *et al.*, 2001).

Their treatment is complex because of the child's uncooperative attitude, fear, and distrust of adults. Parents need assistance in devising and carrying out special, long-term behaviour therapy programs and medication in the home (American Academy of Child et Adolescent Psychiatry (2004). Loeber (1991) challenged the notion that many children outgrow early conduct problems. The stability of antisocial behaviours is often underestimated. Data suggest that the malleability of child behaviours decreases as children grow older, leading to a higher continuity of antisocial behaviour possibly from early adolescence onward.

A recent meta-review of psychosocial treatments for children and adolescents identified 82 studies conducted between 1966 and 1995 involving 5,272 young people (Brestan and Eyberg, 1998). By applying criteria established by the APA Task Force to all studies, just two treatments met criteria for well-established treatment (success in reducing problem behaviours), and ten for probably efficacious treatment. These treatments were (1) a parent-

training program based on the manual, "Living with Children" (Bernal *et al.*, 1980) and (2) a videotape modelling parent training (Carey, 2002).

### **Genetic indicators that predict adult violent behaviour**

Several studies have been published about the gene MAO-A; its low-activity version has been linked to aggressive behaviour. The gene is involved in the production of monoamine-oxidase A. This enzyme breaks down several neurotransmitters such as serotonin and dopamine; the low-activity version leads to increased tissue levels of these transmitters. One third of all men have this version. It is rare among women. A study in New Zealand (Carey, 2002) of 1,037 men, aged 30, showed that the low-activity gene alone was not linked to antisocial behaviour. Only those men with a combination of the gene variation, and moderate or severe child abuse, were more likely to commit crimes. That group made up 12% of the study group, but was responsible for 44% of all crimes. As adults, 85% of those who had been severely maltreated as children (sexual abuse, physical abuse, and frequent changes of caregiver or rejection by the mother) had the gene version for low MAO-A activity (Carey, 2002). A 2006 meta-analysis confirms the findings (Kim-Cohen *et al.*, 2006).

Examinations of genes alone will not reveal enough information; gene expression (penetrance) has to be studied: the process indicating that genetic information actively directs the structures and functions of a living cell. Although all the body cells have the same genes, the specialized cells have selective DNA expression through the RNA. The regulation of RNA synthesis may be influenced by hormones.

Differences in gene expression may explain why some genes – which supposedly would be markers for violence – are also found in ordinary non-violent persons. It is likely that research related to hidden information encoded by cellular chromatin might serve better to explain the role and extent of gene expression.

Another technique for studying genetic influence is twin studies. A 2005 publication by Viding *et al.* have shown that individuals with early warning signs of life-long psychopathy: callous unemotional traits (CU) and high levels of antisocial behaviour (AB) can be identified among 7-year old children. In their study, schoolteachers provided ratings at the end of the first school year for 3,687 same-sex twin pairs. The authors analysed a subgroup of 612 monozygotic twins with extreme CU, many in combination with extreme AB. The CU among monozygotic co-twins were similar in 73%; a group of dizygotic co-twins were similar only in 39%. Two thirds of the difference between the extreme CU children and the population is explained genetically. Out of 3,687 twin pairs, 459 pairs (12.5%) showed extreme CU and 364 pairs (9.9%) showed extreme AB. Assessments of AB in the absence of concomitant CU, showed no genetic influence. For the subgroup of children with AB (and in the absence of CU) the authors recommend preventive action. These children are "probably amenable to traditional interventions aimed at improving family, school, and neighbourhood conditions". The fact that antisocial behaviour can be identified at the age of seven gives opportunities for early detection and targeted interventions. The authors are following up the children in their study group at the age of nine.

The present genetic evidence has not indicated any single gene, or even a small number of genes, that can be used to predict increased risk of antisocial behaviour. Having a gene is a possible propensity, not a predictor.



## HEALTH-RELATED CAUSES APPEARING IN ADULTHOOD

### Gender distribution

As discussed in Chapters 7 and 8, most perpetrators are the child's parents. The gender distribution is discussed by some authors. Newton (2001) claims that males and females perpetrate physical abuse against their own children at surprisingly similar rates: "Among all abused children, those abused by their birth parents were about equally likely to have been abused by mothers as by fathers (50% and 58%, respectively), but those abused by step-parents, parent-substitutes, or other non-parental perpetrators were much more likely to be abused by males (80% to 90% by males versus 14% to 15% by females). The high percentage of female offenders quoted above is unfair because it includes child neglect, in which mothers are named at rates that are absurd, given that women accused of child neglect are almost always single mothers. The fathers who abandon their children are almost never convicted of child neglect." Newton's conclusions only relate to physical abuse.

Other evidence would support the opinion that males are more abusive and violent than females. Most of intimate partner abuse is perpetrated by men. Heise *et al* (2002) has in 50 population studies shown that such abuse is experienced annually by 10% to 70% of the women interviewed. About 10 times more men are in prison because of child abuse than women are. Men are responsible for most sexual abuse, assault and coercion of underage boys and girls, with reported prevalence rates sometimes exceeding 40%. Men are overwhelmingly the clients of underage female and male prostitutes. 89% percent of those who abuse disabled children are men. Most child murderers are men. War violence, riots, uprisings, and related mass killings of children and rapes of women are acts of men. It would appear justified to assume that between 60% and 75% of the perpetrators are males.

### Antisocial personality disorder (ASPD)

Personality disorders are a group of serious mental disorders that according to DSM-IV lead to a long-term pattern of inner experience and behaviour deviating markedly from the expectations of the culture of the individual who exhibits it. To be diagnosed as a personality disorder, a behavioural pattern must cause significant distress or impairment in personal, social, and/or occupational situations (DSM-IV, 1994).

#### (i) Diagnosis and prevalence.

DSM-IV has formulated the following criteria:

Diagnostic criteria for ASPD (which includes psychopathy) include a pervasive pattern of disregard for and violation of the rights of others and inability or unwillingness to conform to what is considered the norms of society. The disorder involves a history of chronic antisocial behaviour starting before age 15 and continuing into adulthood. The person affected shows irresponsible and antisocial behaviour, indicated by academic failure, poor job performance, illegal activities, recklessness, and impulsive behaviour. Symptoms may include dysphoria, inability to tolerate boredom, feeling victimized, and a diminished capacity for intimacy.

ASPD, also known as psychopathic personality or sociopathic personality often brings a person into conflict with society because of amoral and unethical behaviour. Complications from ASPD include frequent imprisonment for unlawful behaviour, alcoholism, and drug abuse. People with this disorder may appear charming on the surface, but they are likely to be aggressive and irritable as well as irresponsible across all areas. They may have numerous somatic complaints and possibly attempt suicide, but due to their use of manipulative behaviour, it is difficult to separate what is true and what is not.

A study of a representative US sample revealed that 51% of 1422 ASPD respondents lacked remorse (Goldstein *et al.*, 2006).

DSM-IV estimates the prevalence of ASPD in the USA to be about 3% of men and 1% of women. In USA, some 80% of all prisoners have ASPD. (Hart and Hare, 1996)

**(ii) Etiology.** The aetiology of ASPD is disputed. It would be reasonable to assume that adverse childhood experiences play a significant role. Other ASPDs appear to have the same aetiology as those mentioned for conduct disorder above.

**(iii) Treatment.** Goldstein *et al.* (2006) report:

Persons with ASPD are highly unresponsive to any form of treatment, in part because they rarely seek treatment voluntarily. If they do seek help, it is usually in an attempt to find relief from depression or emotional distress. Although there are medications that are effective in treating some of the symptoms of the disorder, non-compliance with medication regimens or abuse of the drugs prevents the widespread use of these medications. The most successful treatment programs for ASPD are long-term structured residential settings in which the patient systematically earns privileges as he or she modifies behaviour. In other words, if an ASPD person is placed in an environment in which they cannot victimize others, their behaviour may improve. It is unlikely, however, that they would maintain good behaviour if they left the disciplined environment.

#### **Maladaptive alcohol use.**

**(i) Diagnosis and prevalence.** DSM-IV (1994) classifies alcohol abuse as a maladaptive pattern of substance use leading to clinically significant impairment or distress, manifested by at least one of recurrent problems:

- (a) failure to fulfil major role obligations at work, school, home,
- (b) use in situations in which it is physically hazardous,
- (c) alcohol-related legal problems,
- (d) continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.

Over time, abuse may progress to dependence. Some users abuse alcohol for long periods without developing dependence. Dependence is suspected when alcohol use is accompanied by signs of the following: i) abuse, ii) compulsive drinking behaviour, iii) higher than normal tolerance, and iv) withdrawal.

Alcohol is implicated in child violence. Many perpetrators act under the acute or chronic influence of drinking. Some perpetrators may qualify as alcohol abusers, and some as alcohol dependent. But for others, their use of alcohol in the context of child abuse may be occasional. The interim term "maladaptive alcohol use," is proposed to include all alternatives.

A US study (Langhinrichsen-Rohling, 2005) showed that alcohol facilitates violence: the odds of physical aggression were 8-11 times higher on drinking days for men in domestic violence treatment programmes. Alcohol is implicated in many crimes. Alcohol abuse leads to many health problems: brain damage, memory defects, liver cirrhosis, heart disease, arteriosclerosis, poor nutrition, injuries, and co-morbid mental disorders.

Alcoholic drinks are available everywhere even where alcohol is a taboo e.g. in Hindu and Muslim areas. They are used by increasing numbers of people: alcoholic drinks are in developing countries made from e.g. palm wine, sorghum, bananas, corn malt, or sugar cane. There, local beers and country liquor (such as akpetshie, chibuku, enguli, tonton omwenge, waragi) are found almost everywhere. Local herbs are often added; several of these are known to contain alkaloids, which cause mental disturbance so severe they may result in temporary psychosis and aggression, including murders. The brewers are mostly women. Some products are distilled; many of these are toxic; some contain methanol which causes blindness, and brain damage, and sometimes death. Drunken men fight with knives, machetes and guns; they rape, commit incest, some kill. Community permissiveness of alcohol abuse appears to

increase with poverty: drinking makes the poor man forget his worries – that there is no food in the house; that he cannot pay his children's school fees or their health care; that his self-esteem is gone or that he is oppressed.

Five examples from different parts of the world follow.

United States. In the USA (Bridget, 1998) 5.6% of the population are assessed to be chronic alcoholics. In 1998, there were 10.4 million drinkers aged 12 to 20. Of these, 5.1 million were binge drinkers (drank five or more drinks on at least one occasion in the month before the survey). Two million were heavy drinkers: binge drinking at least five times that month. The average age when young people first try alcohol is 11 years for boys and 13 years for girls. According to research by the National Institute on Alcohol Abuse and Alcoholism, adolescents who begin drinking before age 15 are four times more likely to develop alcohol dependence than those who begin drinking at age 21. Data from a 1999 U.S. National Household Survey indicate that while 915,000 young people aged 12-20 reported alcohol dependence in the past year, only 16% of them received treatment. Several large-scale school surveys suggest that 4-20% of teenagers have either a current or past diagnosis of alcohol abuse or alcohol dependence (Martin *et al.*, 1998). Five million alcoholic parents have at least one child at home under the age of 18. Of these children 58% smoke cigarettes and 35% use illicit drugs (US National Survey on Drug Use and Health, 2004).

India. Gupta *et al.* (2003) carried out a study in Mumbai, India. Fifty thousand men from lower and lower-middle society were interviewed. The study included only urban men aged 45+, had an attrition rate of 50%, and excluded people from higher social groups. 19 % were currently consuming alcoholic beverages; 75% of these could be characterized as heavy drinkers. These findings are lower than the 25%-50% found among men (vs.10% among women) in other Indian surveys. Most alcohol beverages are home-made: beer and distilled country liquor. The percentage of Christians who had any experience of alcohol was 61%, 59% among the Buddhists, 26% among the Hindus, and 9% among the Muslims. The prevalence of experience of alcohol was 27% among the illiterates and 18% among college educated. Another Indian study confirmed that drinking and alcohol-related problems are higher among the poor (Chakravarthy, 1990). Prohibition has a limited effect in India, as alcoholic beverages are mostly home-produced and difficult to control (Rahman, 2003). Alcohol consumption per capita in the South-Asia subcontinent increased by 50% from 1980 to 2000 (Butchart and Poznyak, 2005).

Russia. Nicholson *et al.* (2005) report from Russia (study of 10,475 male and 3,128 females), that of the 61% responders 14% of the men never drank, 41% were occasional drinkers, and 13% frequent binge drinkers; among women the numbers were 54%, 5%, and 17%, respectively. 80% of all alcohol consumed is vodka; a considerable proportion comes from illicit production.

Chile. Of Chile's adolescents 22%, aged 10-19 have consumed alcohol at least once in the past year, and 30% of high school seniors drink alcohol frequently (Naveillan et Vargas, 1989). Very young children in Chile are given alcoholic drinks and may acquire neurological and mental damage. It is known that the police arrests drunken children in the street as early as at age 8. Children who regularly become drunk are often violent. Some are street children, but others live in 'ordinary families'. The Chile Government in 2006 declared that dealing with child alcohol use was a national priority<sup>16</sup>.

South Africa. Indicators (Parry, 2002) point to the widespread maladaptive use of alcohol. In 2000, patients in trauma units often tested positive for alcohol, ranging from 40.3% (Durban) to 91.8% (Port Elizabeth). Persons who died in these hospitals often tested positive for alcohol, ranging from 40.3% (Durban) to 67.2% (Port Elizabeth). Alcohol misuse occurs among all sectors. School surveys reflect harmful drinking patterns among students, with

53.3% and 36.5% of male students in Durban and Cape Town, respectively, reporting heavy-drinking episodes by Grade 11 (age about 16-17 years).

**(ii) Relations between childhood violence and alcohol.** Butchart and Poznyak (2005) quote:

In the USA, 35% of parental child abusers had consumed either alcohol or drugs at the time of the incident. In Germany, 32% of fatal child abusers were under the influence of alcohol at the time of the crime, and 37% of the offenders suffered from chronic alcoholism. In Canada, alcohol or drug use was reported in 34% of child welfare investigations. In Australia, alcohol or drug use was a contributing factor in 57% of child out-of-home care applications. In London, England, parental substance use was present in 52% of families on the child protection register, with alcohol the principal substance used.

A wide range of alcohol-related risk factors have been identified that increase a child's risk of being maltreated. These include: having young, poor, unemployed or socially isolated parents; having a history of domestic violence in the home; living in a single parent family, and living in an overcrowded household. Having a parent with a history of harmful or hazardous alcohol use increases the risk of childhood violence. When both parents experience problems with alcohol, the risk of child violence is even greater. In addition to being a high grade marker for the parent's emotional turmoil, alcohol has a significant disinhibiting effect that often worsens an already bad situation. Adolescents with low parental involvement, or who report physical or sexual abuse, are more likely to be influenced by social pressures, including parental example, to drink alcohol and are at greater risk of regular drinking because of their need for the anti-anxiety effects of alcohol. Such frequent drinking by adolescents is linked to problems such as truancy, poor school performance, and delinquent behaviour; these can further increase the risk of physical abuse by a parent. Children who have experienced violence more likely to drink heavily as adults, and have higher potential for physically abusing their own children in later life.

This is further confirmed by other studies, where the victims reveal that sexual assault, rape, and physical abuse of children and adolescents are often carried out by drunken, disinhibited aggressors often attempting to intoxicate also the victim.

**(iii) The effectiveness of treating alcoholics** is disputed. Several million alcoholics all over the world receive alcoholism treatment on any given day. The techniques of therapy for alcoholics have traditionally been based on clinical intuition, with little rigorous validation of their effectiveness. Only a minority of alcoholics report abstinent one year after treatment, many have dry periods alternating with wet relapses. Most are unable to stop drinking totally. However, few programs attempt to deal with the psychodynamic issues underlying alcoholism. A key feature of Alcoholics Anonymous is the group support and acceptance that supplies a key childhood life experience missing in the lives of most of its members.

Aston (1999) presented the largest study ever made of the effectiveness of treating alcoholism: Project MATCH was carried out in the United States 1989-1997. It was a multi-site clinical trial of alcohol dependent volunteers (n=1726). The participants were offered three different 12-week high-quality outpatient programmes: (a) 12-step self-help program (12 sessions); (b) motivational enhancement therapy (4 sessions); and (c) cognitive behaviour therapy (12 sessions).

The patients' participation was excellent and 90% were followed up over a 15 month period. The patients in all three groups showed major improvements: a) the number of drinking days diminished from 25/month to 6/month; b) the volume of drinking decreased from an average of 15 drinks/day to 3/day; c) there were significant decreases in the use of other drugs, and improvements in liver function. There were few significant outcome differences between the three treatments.

There was, however, one surprising feature: the patients' improvements took place during the first week, and then remained more or less on the same level, apparently uninfluenced by the therapies. Also, a group of 100 dropouts from the programme, who had no treatments, reached positive results of about the same size. The conclusion was that the patients selected for treatment were very extremely well motivated.

Enrolling in this study suggests that the alcoholic had crystallized a decision to reduce or abstain from drinking (Naveillan and Vargas, 1989). Topping the list of client characteristics linked to treatment success – and even more important than the initial severity of their alcohol problems – was their readiness to change behaviour. Over three years down, this still had a profound impact on abstinence and restraint when drinking (Aston, 1999).

The magnitude of positive results of the MATCH study is explained by (Aston, 1999):

the exclusion of young people under the age of 18, of those who were drug dependent, of recent injectors, of the psychotic, of the potentially violent, of the socially isolated or homeless and of those currently under justice supervision, There were very few highly disturbed outpatients. The study thus can only afford limited clues about how to handle the most disturbed and violent drinkers and those ordered into treatment by the courts.

Those mentioned are the alcoholics with the most pronounced problems: poor motivation and the experiences of treating them are rather negative. It is among these that we will unfortunately find some of the violent child abusers; we should, however, also realize that adverse childhood experiences contribute 65% to the population risk for alcoholism (Felitti et Anda, 2003).

### **Disorders among caregivers.**

#### **A. Mental disorders.**

**(i) Diagnosis and prevalence.** Diagnoses of mental disorders are often carried out using the Composite International Diagnostic Interview (CIDI). The prevalence throughout a person's lifetime of any mental disorder in community-based samples is high, for example 48 % in USA (Kessler *et al.*, 1994); 41.2 % in the Netherlands (Bijl *et al.*, 1998) and 47.5% in Brazil (Santos *et al.*, 2006). Prevalence rates are higher for women than for men. The most common of these disorders among women are anxiety (about 33%) and mood disorders (about 20%).

*This mother's child is dying, there is no help; no health services in her village. In many poor countries like hers between 10% and 20% of the children die, a very traumatic event, causing depressive disorder, anxiety and stress to the mother, not knowing what will happen next to her family. Her health condition is further impaired by her own malnutrition and anaemia.*  
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The conclusion is that close to every other person is during the lifetime affected by a mental disorder. That disorder may occur when that person is the caregiver of a child. About one third to one half of those affected had a period of mental disorder during the last 12 months, and during the duration of the disorder about 70% of them experienced role impairment at home, at work, in relationships, and socially (Kessler *et al.*, 1994). Care-givers, mothers and fathers, carry out the physical and psychological punishment of their children. The presence of mental disorders among them significantly contributes to their own behaviour towards their children and may cause persisting behaviour problems among the children (Mash and Johnston, 1983; Mezey *et al.*, 2005).

**(ii) Aetiology.** Many ecological factors contribute: poverty, lack of education, spouse abuse (in many populations affecting 40%-70% of all women), poor marital relations, daily stress, diseases and death among close family members and friends, low levels of social and emotional support, poor parental competence, growing up with abusive and neglectful parents, alcohol abuse, lack of medical care and other community services. Other causes are related to, for instance, among women post-partum depression, general tiredness because of work overload in combination with anaemia and malnutrition. The children's behaviour also contributes, and it is common to see that this may lead to their punishment.

**(iii) Treatment.** Treatments are available in developed countries, and will reduce the mental symptoms over time, but will not be very effective as long as the root causes prevail. In the developing countries, mental health care, except for the well-to-do, is very insufficient or does not exist, and the root causes are more difficult to resolve as many are based in poverty and hunger.

#### **B. Foetal abuse and neglect.**

Some mothers use of alcohol and drugs during the pregnancy. Relevant scientific studies mostly deal with their alcohol and illicit drug use which damages the fetus. Alcohol is a leading teratogen; the incidence of foetal alcohol spectrum disorder (FASD) in USA is 2.2/1,000 live births (Wattendorf *et al.*, 2005). In Italy, the prevalence is 3.7 to 7.4 per 1000 schoolchildren. (May *et al.*, 2006). The highest prevalence of FASD worldwide is reported among first-grade children in a wine-growing region in the Western Cape province of South Africa: 40.5 to 46.4 per 1,000 children aged 5-9 years (May *et al.*, 2000). Prevalence rates of FASD probably underestimate its incidence, as some of these children meet an early death. The main complication is brain damage. The disorder may lead to neurological, cardiac, facial and joint deformities, stunted physical and emotional development, mental retardation, memory and attention deficits, a tendency to impulsive behaviour, inability to reason from cause to effect, a failure to comprehend the concept of time, difficulty telling fantasy from reality, inability to control sexual impulses, and an apparent lack of remorse. Among babies born to cocaine/crack-using mothers, the frequency of mental retardation is high. Smoking during pregnancy may delay fetus growth and intellectual development, and cause behaviour disturbances. Children with foetal neglect symptoms are exposed to very disturbed mesosystems and many will of there are resources be removed to substitute families.

### **NEUROBIOLOGICAL CORRELATES OF VIOLENT BEHAVIOUR**

It would seem reasonable to a priori assume that serious pathological behaviour would be reflected in neurobiological correlates, scientific evidence supports this hypothesis. Biochemical, hormonal, physiological and anatomical aberrations are found among violent offenders. These changes can be explained in three ways:

(a) downstream: the neurobiological aberrations are primary and lead to the aggressive behaviour (the causes could be genetic, prenatal or perinatal, or postnatal brain damage through infections, direct trauma or thrombosis); or

(b) upstream: the perpetrator's behaviour (related to his/her abuse of others, lifestyle problems such as chronic drug abuse, including amphetamine (Rogers *et al.*, 1999) induces secondary changes in the brain.

(c) a combination: the violent person may have been a victim of child violence causing upstream neurobiological effects, when acting violent the upstream damage is enforced and further increases downstream aggressive behaviour.

These questions are ethically important. Hart and Hare (1996) support the primary downstream hypothesis, the brain-based aetiology: they found no convincing evidence that psychopathy is the direct result of early social or environmental factors. If the causes of violent action is just seen as downstream, does it imply that these individuals are predisposed to become criminals and, does this excuse them from legal and moral responsibility (Popma et Raine, 2006)? Among them are some who have committed horrible crimes against children: and murder. Responsible or not, the conclusion is that they should be locked up; the public needs to be protected, especially from callous repeaters.

A number of recent neurobiological studies show that significant aberrations have been identified also among psychopaths. Lapiere *et al.* (1995) made comparisons between a group of criminal psychopaths and criminal non-psychopaths. The psychopaths differed in having impairments in the orbito-frontal-ventral part of the brain, which is involved in instrumental learning and response reversal. Raine *et al.* (2003) found that corpus callosum had a larger than normal volume, which indicated either an atypical neurodevelopmental process with a deficit of axonal pruning, or increased white myelination. Kiehl *et al.* (2004, 2006) have in separate studies of psychopaths shown temporal lobe and limbic abnormalities, which are involved in semantic processing. Tiihonen *et al.* (2000) identified amygdaloid loss, which appears to explain the psychopaths' lack of remorse. Early damage to the prefrontal cortex impairs the social and moral behaviour (Soderstrom *et al.*, 2000) and in non-psychotic violent offenders, regional blood flow to the prefrontal cortex is reduced. Birbaumer *et al.* (2005) using magnetic resonance imaging revealed that while healthy controls showed enhanced differential activation in the limbic circuit during acquisition of fear, the psychopaths displayed no such activity.

The Canadian Psychiatric Journal in 2001 published an article on the neuropsychopharmacology of criminality and aggression. A summary follows.

About 40% of the propensity toward antisocial behaviour may be attributable to heredity, specifically violent impulsive behaviour. Impulsive violent offenders have diminished serotonergic function. In addition to genetic factors, the serotonergic system is influenced by environmental factors; this influence is complex. Some of it may occur during developmental phases, such as birth complications and maternal rejection which are associated with early onset violent behaviour. Serotonin may be one of the mediators of environmental influence on the brain. Changes in serotonin function in humans may relate to socioeconomic status, sustained childhood abuse, and histories of impulsive aggressive behaviour.

Hypoglycaemia has been associated with aggression; it is thought to lead to impaired cognitive processes and judgment, which may increase the risk of aggression or impulsivity. A study of impulsive violent offenders with APD and offenders with intermittent explosive disorder were shown to have lower glucose nadir after glucose challenge, compared with normal volunteers. Heritability was suggested by the finding that impulsive violent offenders with criminal fathers had lower glucose nadirs than those without criminal fathers.

The role of testosterone in impulsive aggression is well documented in animal studies, but the role of testosterone in human aggression is less clear. Violent aggression in men, on the whole, seems more correlated with abnormalities of serotonergic function. The serotonin function may be modulated by sex hormones.

Positron emission spectroscopy was carried out to study brain activity in 41 murderers pleading not guilty by reason of insanity. It was found that murderers had reduced metabolism in the prefrontal cortex, superior parietal gyros, left angular gyros, and in the corpus callosum. Asymmetry was also noted in the amygdala, thalamus, and medial temporal lobe. Looking specifically at impulsive aggression in subjects with personality disorder, six impulsive-aggressive patients were compared with five healthy volunteers. Patients with impulsive aggression showed significantly blunted metabolic responses in orbital frontal, adjacent ventral medial, and cingulate cortex, but not in the inferior parietal lobe. The highly serotonergically innervated prefrontal cortex may be involved in the regulation of impulsive aggression. In this sense, a theory of serotonergically mediated inhibition of impulsive aggression is not biologically deterministic because the influence of environmental variables as a modulator of serotonergic function is significant from moment to moment as well as over a lifetime and serotonin's role in behaviour is only in the context of the complicated relationship between brain, mind, and environment.

Oxytocin and vasopressin are two neuropeptides released into the blood from the pituitary gland, and from centrally-projecting oxytocin neurons. It is the latter and the oxytocin receptors in the brain that are responsible for their behaviour effects (De Weid *et al.*, 1991). These peptides have been intensely studied since the 1950s. Many results confirm their involvement in emotional processes. Oxytocin facilitates bonding between offspring and parents and between males and females, whereas vasopressin is involved in aggressive behaviour. The bonding process is built on social recognition formation and the formation of social memories, mediated by these neuropeptides. Oxytocin and vasopressin are important in the modulation of anxiety, and may be involved in anti-depressive like effects. Vasopressin facilitates memory processing. Oxytocin acts as a natural amnesic agent by impairing memory consolidation and retrieval (Caldwell and Young, 2006; Takayanagi *et al.*, 2005).

Some studies of the health condition and neurobiology of paedophiles have been carried out. These indicate serious disturbances of the brain function and a high prevalence of chronic and therapy-resistant psychiatric co-morbidity. Fagan *et al.* (2002) published a review about paedophilia, based on an analysis of a Medline research (1965-2002) of a total of 447 articles on paedophilia and 137 on molestation. Proximate risk factors include comorbid psychiatric disorders and substance abuse disorders. Galli *et al.* (1999) published a study of 22 boys aged 13-17 years who had molested a younger child at least once. All met the lifetime criteria for paedophilia, 21 had two or more paraphilias, 18 had a mood disorder, 12 a bipolar disorder, 12 an anxiety disorder, 11 substance abuse and 12 an impulse-control disorder; 12 of 17 subjects who were further examined had ADHD and 16 had conduct disorder. Perez-Albeniz (2003) compared a group of 36 high-risk persons with 38 matched low-risk (for child abuse) parents. The high-risk parents showed higher deficit in dispositional empathy, less feelings of warmth and compassion, and more anxiety. Keenan and Ward (2000) suggest that the intimacy deficits, empathy deficits and cognitive distortions seen among sexual offenders point to a lack of awareness of other people's beliefs, desirable perspectives, and needs.

Studies of the neurobiology of the perpetrators have attracted some researchers. Maes *et al.* (2001 a, b) have shown that paedophilic men had elevated plasma epinephrine and nor-epinephrine, and abnormal cortisol and luteinizing hormone reactions. In response to stress, the hypothalamus produces corticotropin-releasing hormone, which depresses the reproductive system. It prevents the release of gonadotropin that regulates reproduction and



sexual behaviour. Glucocorticoids also inhibit the production of testosterone, estrogen and progesterone, and of the luteinizing hormone that prompts the production of ovulation and sperms. It is not easy to establish any patterns common to all, or any pattern of primary causality because such changes are well-recognized as occurring as the result of child abuse, which typically is not recognized, if not denied. These differences may also be secondary to their own abusive behaviour. These factors may have led to a combination of mental disorders causing their criminal acts. Studies of genetic factors among sexual offenders have not yielded any conclusive results.

Among violent offenders there is a 'cascade' of complex, interrelated brain changes which damage its biochemical and hormonal regulation, which are reflected in significant anatomical, metabolic and circulatory disturbances. Most of these changes appear to be attributable to genetic factors in combination with the perpetrator's own experiences of childhood violence. The perpetrators' behaviour is anchored in an organic context. The lack of effectiveness of therapeutic interventions in many clients with personality disorders may depend on an irreversible fixation of these neurobiological alterations. Furthermore, neuropharmaca are most often limited to influencing only single biochemical brain pathways, such as serotonin uptake; in view of the cascade of changes that take place, such medication is unlikely to exert more than minor effects. Thus, large-scale violence prevention programmes cannot build on presently available methods for therapeutic interventions to "correct" the behaviour of the perpetrators.

### **Conclusions regarding health-related causes of child violence**

Health-related causes of child violence are important. Severe personality disorders explain some of the worst instances of extreme cruelty to children by perpetrators with callous and unemotional traits. These people are responsible for much of the long-lasting and high recurrence rate of child abuse; they lack remorse. Some may be members of the 'upper classes' and have important jobs, while their abuse of children remains hidden. I find it difficult to accept the DSM-IV-proposed low prevalence of ASPD, especially as Viding *et al.* (2005) revealed a prevalence of 12.5% "extremely callous unemotional behaviour (CU)" among 7-year-old children, whom Viding *et al.* then did not even consider treating. The very high prevalence of extreme CU shows that it is urgent to identify the means to cure it. Although there are some effective methods to treat children with conduct disorder, the treatments for ASPD are not effective. The reason is their fixed, irreversible neurobiological impairments.

Maladaptive alcohol use is one of the most common contributors to child abuse, alcohol makes people who in a sober situation control their aggression, lose their inhibitions and become violent. It has proven difficult to reduce alcohol consumption in the general population, and binge drinking among the young. It is urgent to stop women from consuming alcohol while they are pregnant. More research is needed concerning the groups of unmotivated alcoholics which were not included in the MATCH study. Mental disorders, some temporary, among caregivers are very common and often related to environmental factors (poor marital relations, daily stress, somatic diseases poverty and hunger, and so on). These will for most continue as long as the root factors remain unresolved; they have negative effects on the children.

## **THE SOCIAL SYSTEM**

### **Family malfunction related to incompetent and ignorant parenting.**

The most important cause of childhood violence is the malfunction of families. Parents are the main group of perpetrators. The most important cause of childhood violence is abusive, incompetent and ignorant parenting, not only in poor families, but also in affluent ones.

The most common is neglect. Parents do not provide food, education, health care, acceptable lodging, security, and so on. Even worse, many parents do not care about these problems. Spouse abuse is common and creates an atmosphere of fear. Criminality and substance abuse further complicate the problems. In such families it is common to see that the essential emotional contacts between parents and children have been neglected right from the beginning, so there is no bonding and no creation of empathy. In abusive families, many children lose their perception of identity (Bastian, 1994)

The children who could not cope with life in whatever setting were those who did not understand who they were, why they were there and what was happening to them.

The next common cause is emotional abuse, yelling, screaming and cursing, scolding, name-calling, humiliation, threats to throw the child out of the house, locking out the child, threats with magic and evil spirits or, sheer terrorizing.

This is combined with physical abuse, which in many cultures is seen as positive for character-building. All parents know that sexual abuse is legally forbidden and a taboo, yet one third of them get involved in such abuse. Skute *et al.* (1998) revealed that exposure to intra-familial violence is a risk factor for the development of sexually abusive behaviour. Boys who are victims of sexual abuse are more likely to become abusers of other children in their early adolescence if they have experienced or witnessed intra-familial violence (odds ratio 39.7). Marital violence impacts on the emotional and behavioural development of children. In some families, the contacts between 15-year old children and their parents seem distant (Box 9.1, Ngwudike, 2005).

#### **Box 9.1. Child-parent relations in the USA.**

The Program for International Student Assessment 2000 by OECD, revealed the following about child-parent relations in the USA; students were 15 years old. (a) Students eating dinner with parents around a table: 8% never, 8% a few times a year, 5% once a month, 11% several times a month, 23% several times a week, and 37% every day; (b) parents discussing their schoolwork: 3% never, 6% a few times a year, 8% once a month, 15% several times a month, 21% several times a week, and 41% every day; (c) parents discussing books, films, or television programs with them, 12% never, 15% a few times a year, 12% once a month, 20% several times a month, 19% several times a week, and 16% every day (d) how often their mothers worked with them on homework, 33.% never, 19% a few times a year, 12% once a month, 13% several times a month, 11% several times a week, and 6% every day. (e) how often their fathers worked with them on homework, 45% never, 17% a few times a year, 11% once a month, 10% several times a month, 7% several times a week, and 3% every day.

The most common recommendations for preventing family malfunction are: family life preparations supported by pre-parental education and home visits, described in Chapter 14.

A detailed review of violence prevention was published in 2004 by WHO. The strategies are arranged by age group and demonstrated effectiveness, built on US studies:

Children aged 0-3: Home visiting services; parenting training, therapeutic foster care.

Children aged 3-11: Social development training; pre-school enrichment.

Children aged 12-19: Social development training, educational incentives for at-risk, for disadvantaged high school students: school-based dating violence prevention programmes, academic enrichment programmes, mentoring, family therapy.

Preventive research has centred on poor, undereducated, or disadvantaged families. There are clear links between violence against children and the social malfunctioning of families, institutions and services in the community and the society at large.

Such interventions are often called 'social engineering'. In the welfare statistics, a few categories of vulnerable children in disadvantaged families dominate; they are the ones most often targeted by 'engineering' programmes:

- (1) children with parents abusing alcohol or illicit drugs, or have a mental disorder, or are criminal
- (2) when there is abuse or neglect at home, for instance reported by neighbours or teachers
- (3) children reported by teachers for mental disorders,
- (4) children with a disability,
- (5) children with serious relationship problems (for instance, with foreign roots, of different ethnicity, religion or culture, with language barriers), and
- (6) children in conflict with the law.

The concentration on these groups is biased; abusers are everywhere (Box 9.2.)

### Box 9.2. Child abuse among upper and middle classes

Kacker in the large 2007 India study of child abuse states that the prevalence of sexual abuse in the upper and upper middle classes was proportionally higher than in lower and lower middle classes. Holla and Gupta (2005) describe from India. "A 5-year-old boy from a well-to-do family was brought by his father and stepmother with fracture of right tibia, severe malnutrition, multiple abrasions, bruises, scars, hemiparesis, psychomotor retardation, and old fractures in both ulnas and right humerus. Skeletal survey showed 15 fractures involving ribs, metacarpals, mandible, ulnas, right humerus and right tibia and old subdural hematomas. Brittle bones and neuropathy were excluded. The child was moved to the grandparents. A medico-legal report and involvement of social organizations yielded no action."

### Identification of future perpetrators using social methods.

Table 9.1. lists some social predictors of aggression and violent crimes published by several authors from developed countries. They mainly concern young boys, the main group showing criminal behaviour as adolescents or adults; an important target group for prevention.

**Table 9.1 Examples of studies of factors related to aggression and violent crimes**

Factors	Symptoms	Comments
Individual	Early aggressiveness,	School boys aged 10-13 were rated by teachers for aggression. Two thirds with high scores had been arrested for violent offences by age 26. In a control group with low scores the arrest rate was one sixth.(Stattin and Magnusson, Sweden, 1989)
Family	Parental criminality/ anti-social behaviour Childhood violence  Inconsistent discipline and low level of parent involvement	Risk for violent criminality increases 3.8 times compared to a group with non-criminal parents. (Baker and Mednick, USA,1984) Physically abused or neglected children are more likely than others to commit violent crimes as adults. (Smith and Thornberry, USA, 1995) Boys with overly strict parents reported the highest rate of subsequent violence; boys with overly permissive parents reported the second highest level of violence. Least violence found among boys not belonging to these groups. (Park and Comstock, USA,1994)

School	Poor academic results Truancy	Academic failure predicts later violent behaviour. (Maguin and Loeber, USA, 1996) Pupils with high truancy rates at ages 12-14 more likely to show future violent behaviour. (Wells and Rankin, USA, 1988)
Peer relations	Delinquent siblings or peers Gang membership	Having delinquent siblings by age 10 predicts convictions for violence. (Farrington, USA, 1989) Delinquent adolescent peers, including gang members, have a negative influence (Moffitt, USA 1993)
Community factors	Poverty  Neighbourhood disorganization	Boys raised in poverty have higher criminality. Self-reported felony assault and robbery were twice as common among young people brought up in poverty compared to controls from the middle class. (Elliott <i>et al.</i> , USA, 1989) High presence of criminals, drug-sellers, gangs, availability of drugs and weapons and poor housing are predictors of violence at age 18. (Maguin <i>et al.</i> , USA, 1995)

A set of recommendations for the USA was drafted in the Summary Chapter of the 1999 San Diego Child Maltreatment Conference (Sadler *et al.*, 1999). Because the problems of child maltreatment have existed for many centuries, many estimated that it would take 100 years to eradicate it (Chadwick, 1999). This may reflect these authors' views of the past: cannibalism, ritual human sacrifice, and the practice of suttee took a long time to eliminate. Not until 180 years after Jenner's introduction of smallpox vaccine in 1796 was the disease finally eradicated. We are still struggling with efforts to eliminate capital punishment of children and of persons with mental retardation, female sexual mutilation, the right to possess guns, illicit drug business inside the closed gates of prisons and, the abuse of children in government institutions. The 'partial' success with the stop-smoking evolution required "a dogged, relentless campaign to communicate the database to the people, and consistent advocacy in the halls of government" (Garbarino, 1996).

## CULTURAL AND ECONOMIC SYSTEMS.

### Violence in the Society

#### The individual's frustrations in daily life.

One of the explanations proposed for 'understanding' why interpersonal violence is so common is the frustrating economic and physical insecurity that appears to be part of our everyday life. In 2005, community violence exploded in the suburbs of many French cities: during 21 nights, over 10,000 vehicles were burnt, 200 public buildings destroyed, 1,300 policemen injured, 3,200 persons arrested, and 400 offenders sentenced to prison terms. A US study (Rapp *et al.*, 1986) showed that teenagers experienced 40% of all robberies and 36% of all personal attacks against them while at school (where they spend about 25% of their time). A Danish study (Balvig, 1999) of 1,270 8th-grade (mean age 14) students from three different regions of the country found that 44% had experienced a theft, 16% had been beaten, and 36% threatened with violence within a period of 12 months. 26% of them came from a split home.

There are many factors that argue that violence is even more common in developing countries than in the industrialized ones: the high number of fist and knife fights; the more widely spread abuse and neglect of women and children; the greater degree of frustrating

poverty and the lack of political clout among the poor; the hierarchical power system that does not allow those of 'lower rank' to comment on or to contradict what 'elders and leaders' say and do; the insufficiency, unreliability, and corruption of the police, security, and judicial systems; the non-compliance with U.N. Human Rights; the oppressive education system with abusive teachers; civil unrest, local wars, and the fact that 85% of all natural disasters occur in developing countries. Among the many problems are the increasing levels of alcoholism and use of drugs, such as heroin, cocaine, amphetamines, hallucinogens, and qat.

### **The culture of violence.**

The 'weapons culture' accounts to a very large part for the avalanche of violence. Oxfam estimated in 2003 that 639 million handguns are in the hands of 'ordinary people', one for each fourth man aged over 15. Mocan and Tekin (2006) in a US study showed that having a gun at home increases the propensity to committing crime by 30% among adolescents. Duggan (2001) reports that decreases in gun ownership during the 1990s explains about one third of the decrease of crimes during that period. Other private weapons for stabbing (knives, machetes, daggers) are impossible to count; not only men use them—also women and children.

Another part of the violence culture appears in the products of the entertainment industry. Many children are exposed to emotional, psychological, sexual, and physical violence on television. "Soap operas", action movies, songs, video clips, and computer games for children often soaked in violence. A six-year-old child playing his games can be seen to 'kill' several hundred 'virtual persons' a day; the quicker the better. Developing countries are increasingly invaded by these expressions of foreign cultures. Violence attracts people's attention and produces strong emotional reactions that enforce desire. Marketers call this 'arousal', it helps to sell the 'merchandise'; it may be addictive, which could explain why, during the last decades, media have gradually increased the doses of graphic violence. Several meta-analyses indicate that exposures to media violence increases short-term aggressive behaviour towards both friends and strangers but may not lead to increases of homicides or physical assaults (Park and Comstock, 1994; Wood *et al.*, 1991). Anderson *et al.* (2001) state:

- Media violence increases the likelihood of aggressive and violent behaviour in the immediate situation and over time;
- research evidence is consistent, clear and conclusive;
- negative effects of media violence are large enough to warrant serious concern ;
- most parents seriously underestimate the long-term impact of media violence;
- violent video games are likely to be more harmful than violent movies or television;
- self-imposed regulation is not working;

Media exposure to violence is still relatively uncommon among the poorest people in the developing countries. In the future, it will be increasingly difficult for them to escape.

### **Risk factors**

The U.S. Department of Justice brought together a group of 22 researchers to analyze current research on risk and protective factors and the development of serious and violent offending careers (Table 9.2). and show a comparative ranking of "malleable" predictors of violent or serious delinquency at ages 15-25 (Hawkins *et al.*, 2000).

### **The breeding of criminal behaviour.**

Not all violence is criminal; exceptions are, for instance, some levels of physical abuse of family members, or of school children, and – most important – collective violence: wars, occupation, and action by armies, police and security forces in many countries. Most crimes are non-violent, but violent perpetrators are frequently involved in stealing (Canter and Kirby,

**Table 9.2. Predictors of violent or serious delinquency by age group**

<b>Ranking of ages 6-11 and ages 12-14 predictors of violent or serious delinquency at ages 15-25. Correlations between the predictor and the outcome</b>	
<b>Predictors at ages 6-11</b>	<b>Predictors at ages 12-14</b>
<b>Rank 1 Group</b>	
General offences (.38)	Social ties (.39)
Substance abuse (.30)	Antisocial peers (.37)
<b>Rank 2 Group</b>	
Gender (male) (.26)	General offences (.26)
Family socioeconomic status (.24)	
Antisocial parents (.23)	
<b>Rank 3 Group</b>	
Aggression (.21)	Aggression (.19)
Ethnicity (.20)	School attitude/performance (.19)
	Psychological condition (.19)
	Parent-child relations (.19)
	Gender (male) (.19)
	Physical violence (.18)
<b>Rank 4 Group</b>	
Psychological condition (.15)	Antisocial parents (.16)
Parent-child relations (.15)	Person crimes (.14)
Social ties (.15)	Problem behaviour (.12)
Problem behaviour (.13)	IQ (.11)
School attitude/performance (.13)	
Medical/physical characteristics (.12)	
IQ (.12)	
Other family characteristics (.12)	
<b>Rank 5 Group</b>	
Broken home (.09)	Broken home (.10)
Abusive parents (.07)	Family socioeconomic status (.10)
Antisocial peers (.04)	Abusive parents (.09)
	Other family characteristics (.08)
	Substance abuse (.06)
	Ethnicity (.04)

1995), vandalism (Mitchell and Rosa, 1979), and drug selling (Maguin *et al.*, 1995). In self-reporting questionnaires, they admit to a high frequency of participation in non-violent crimes (Farrington, 1989). Criminologists tell us that criminal behaviour is an adaptation to the perpetrator's social environment. (Giddens, 2001; Hirschi, 1969; Merton, 1968). The theory of 'differential association' suggests that criminal behaviour is learned from other criminal persons. The more the individual is exposed to unlawful persons, the more likely he/she will learn and adopt their values, as the basis for his/her own 'behaviour'. It is important not to be in the wrong place at the wrong time with the wrong persons. According to Laws and Marshall (1990) "Deviant sexual interests may be learned through the same mechanisms by which conventional sexuality is learned...maladaptive behaviour can result from quantitative and qualitative combinations of processes that are themselves intrinsically orderly, strictly

determined, and normal in origin.” Ward and Keenan (1999) state that child molesters’ cognitive distortions are generated by maladaptive implicit theories concerning the nature of victims (children as sexual objects), the offender (entitlement), and the world (uncontrollability and nature of harm”).

A criminal individual often gangs up with a social group of persons that shares his/her attitudes and behaviour. Gangs breed and attract crime (Shaw and McKay’s, 1972). There is evidence of an inter-generational disposition to mete out corporal punishment, supporting the theory of “social learning” (Muller *et al.*, 1995), while other studies concerning transmission of sexual abuse indicate that such transmission may have other causes (Mahlangu and Sibindi 1995; Collin-Vézina and Cyr, 2003). One-third of sexually abusive men and half of the mothers of sexually abused children mention that they were sexually abused during their childhood.

The Merton (1968) theory of anomie proposes that criminality is a result of the perpetrator’s inability to identify any legally acceptable means to reach the individual goals that society expects, including the unreachable success goals some parents seek for their children. Therefore, the perpetrator – seeking escape from frustrating realities – decides to use socially unacceptable means. Other criminologists (Giddens, 2001) portray the delinquent as an individual who subscribes generally to the morals of society but who is able to justify to himself particular forms of delinquent behaviour by a process of “neutralization,” in which the behaviour is redefined in moral terms to make it acceptable. To give an example: a young girl who has learnt that abortion is “unacceptable” finds herself pregnant and then decides to have an abortion. Then, she changes her opinion: abortion is now “acceptable as an ultimate solution”. Other examples are the members of terrorist groups, who have been co-opted to work in the name of a political or religious creed. Such groups may resort to violence in all forms and even take pride in claiming responsibility for atrocious acts: killing innocent people, raping women, and torturing and murdering their victims. Illicit drugs and alcohol contribute to weaken any “moral” inhibitions the individual might have learnt previously.

Some criminologists blame delinquency not on the individual but on the political and legal systems in the society (Giddens, 2001): “The law is seen as an instrument by which the powerful and affluent maintain their position and coerce the poor into patterns of behaviour that preserve the status quo.”

The theory of ‘differential association’, learning violence from others, would apply to many violent perpetrators. How do perpetrators learn? Most abuse starts early in life with the parents administering physical punishment, an intimidating experience for all small children, who quickly understand that human power is exercised by use of brutal physical force. Although ‘learning’ appears to be the preferred theory to explain the development of interpersonal violence, we should not exclude looking into other ‘mechanisms’ that are discussed: genetic factors and bio-neurological changes.

Passive bystanders play a role. When a brutal father abuses the child in the presence of the mother – is there any reaction from her to stop the violence? Do bystanders encourage the act by complete agreement or by passive acceptance? Or is the mother just another victim, too frightened to interfere because she is subjugated by the offender? (Slab *et al.*, 1995).

Zingraff *et al.* (2005) showed that in a representative sample of 4,293 children aged 12-15 in Canada self-reports by them revealed a criminality rate of 43% among the boys, and 36% among the girls. Among the younger children, these were mostly petty crimes, but with increasing age the seriousness of the crimes augmented. It was shown in Chapter 8 that victims of childhood violence commit twice as many crimes as non-abused children.

Adolescents, aged 13-17 commit a substantial proportion of sex crimes, in the USA, in 2003, 17% of all arrests for sex crimes and about one third all sex offences against children were by this group, almost all were males.(National Center on Sexual Behaviour of Youth,

2003). Many of them self-report high rates of sexual victimization; Weinrott (1998) as high as 50%. Adolescent sex offenders are different from adult sex offenders; they have lower recidivism rates, engage in fewer abusive behaviours over shorter times, and exhibit less aggressive sexual behaviour.

### **Paedophile activism**

We must not underestimate how insidious can be activists for child abuse. Among them are some organized paedophile groups. Modern paedophile activism originated in the 1930s in the Netherlands and then it was focused on Western Europe (Thomason, 2006; Wikipedia: Pedophilia, 2007). The Dutch psychologist Bernard in 1972 published "*Sex met kinderen*" (Sex with children) laying the foundation for the pedophile activism movement, first in Western Europe, then in Northern America. In 1979, the Dutch Parliament received a demand for the decriminalization of sexual activities between children and pedophile adults. This petition was authored by the Dutch Society for Sexual Reform, which reported a membership of 240,000. It was supported among others by: all leading politicians in the country, the General Teachers Association, a large number of university professors, physicians, psychiatrists, psychologists, and some more or less famous private people. Alarmed by the success of the petition the section of child and youth psychiatry of The Netherlands Society for Psychiatry publicly opposed the demands for decriminalization. (Thomason, 2006)

In 1981, the Dutch Protestant Foundation for Responsible Family Development sold and distributed tens of thousands of copies of a book entitled "*Pedophilia*", illustrated with photos in and to Dutch elementary schools. Citations:

far from all sexual contacts or sexual relations between a child and an adult imply sexual abuse. Many sexual contacts between adults and children do not have to result in any damage, and there are also sexual contacts which are pleasant and valued by the child...the present laws are meant to protect children...in reality they do more harm than good. Advice to parents: Friendship between a pedophile and a child is no reason for panic or fear. Nor is there any reason for this, even if sexual contact is a part of the relationship.

In 2006, a Dutch political party (PNVD) founded by three paedophile activists demanded the decriminalization of adult sexual activities with children aged 12-16. They proposed the legalization of child pornography, and of the practice of human sex with animals, and the screening of pornographic films on daytime television. The party was legalized by a Dutch Tribunal based on "the pillars of states with democratic rights".

United Nations in 1994 granted consultative U.N. status to a number of paedophilic non-governmental organizations among them: the US North American Man/Boy Love Association (NAMBLA) and Project TRUTH, the Dutch Martijn, and the German Association for Sexual Equality. The pedophile promotion activities of these cannot have been unknown to the U.N.; many NAMBLA members have been arrested by FBI for child molestation. Under pressure from the USA, the U.N. soon after suspended these organizations consultative status (Thomason, 2006).

### **SOCIAL EXPENDITURES DIMINISH CHILD POVERTY**

Malfunctioning in the society, especially in the developing countries, is also linked to social, cultural, educational, and economic factors (among them, poverty and hunger). In these countries, much of the consequences of social malfunctioning is swept under the carpet of oblivion. Often, ignorant or insensitive politicians, or their economic advisers, allocate budgets to the 'social' Ministries that are far from commensurate with the needs.

Increasing social, public expenditure for children will diminish their violent treatments. Poverty and hunger are associated with of child violence. Although children bear no

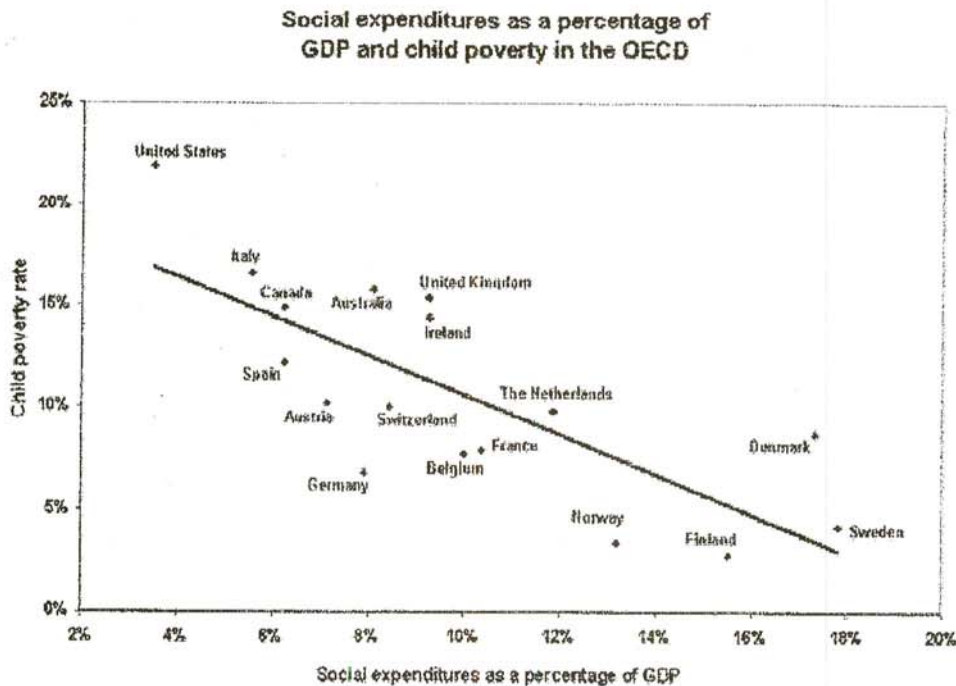


responsibility for living in poverty, they are penalized not only in childhood but later in life if their health or education suffers from a lack of resources. All economies face the trade-off between how much money should be spent and what level of childhood poverty is acceptable.

The data in Fig 9.1. compare social economic expenditures and child poverty rates of the rich, industrialized countries that belong to the Organization for Economic Cooperation and Development OECD.

This comparison provides a yardstick for gauging the commitment of the U.S. government to reducing child poverty and its lifelong effects. Countries with higher social expenditures – as a percentage of their gross domestic products – have dramatically lower poverty rates among children. The line in the figure shows the correlation between expenditures and child poverty rates for all countries. Individually, the Nordic countries – Sweden, Norway, and Finland – stand out, with child poverty rates between 2.8% and 4.2%. The United States has the lowest expenditures and the highest child poverty rate – five times as much as the Nordics. The paucity of social expenditures addressing high poverty rates in the United States is not due to a lack of resources – high per capita income and high productivity make it possible for the United States to afford much greater social welfare spending. Moreover, other OECD countries that spend more on both poverty reduction and family-friendly policies have done so while maintaining competitive rates of productivity and income growth” (OECD, 2004).

**Fig. 9.1. Social expenditures diminish poverty and violence towards children**



Increases in national income combined with growing inequality are not correlated with better social health. Fig 9.2 illustrates the relationship between social health indicators and national income in the United States (Fordham Index).

The Fordham Index of Social Health is based on sixteen social indicators. Since 1970 these five have improved: infant mortality, high school dropouts, poverty among the elderly, homicides, alcohol-related traffic fatalities; while these eleven have worsened: child abuse, child poverty, teenage suicide, teenage drug abuse, unemployment, average weekly wages,

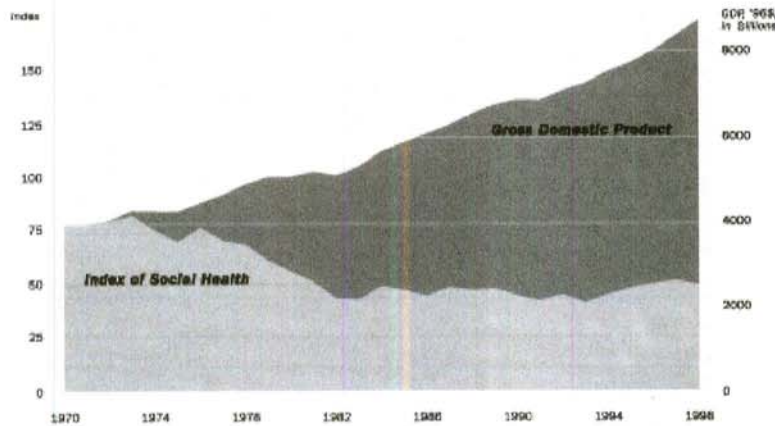
health insurance coverage, out-of-pocket health costs among the elderly, food stamp coverage, access to affordable housing, and income inequality. Between 1973 and 2005, the Index declined from 74 to 53. Although the national per capita income more than doubled

the period 1970-2005, the overall wellbeing of the US population decreased (Miringhoff, 1996, 1999). There appears to be relation between what is illustrated in Fig. 9.1. and in Fig.9.2.: insufficient (and short-sighted) levels of social expenditure leads to decreasing social health; this certainly affects the children.

### Fig 9.2. Social health does not increase when the GDP goes up.

Source: Fordham Institute for Innovation in Social Policy

Index of Social Health and Gross Domestic Product, 1970-1998



### The impact of poverty in the developing countries

The situation in many developing countries is complex; half of the children live in poverty, and malnutrition affects 25%-30% of them (Chapter 12 and 13). Poverty is traumatic and using the WHO definition can be seen as maltreatment as it causes "actual or potential harm to health, survival, development or dignity". Many developing nations lack policies and plans to guide efforts to prevent childhood violence.

Child murder rates in poor and middle-income countries are two to three times higher than in the richer countries; in Africa these rates are about seven times higher. Violence is in many poor countries aggravated by wars, civil unrest, criminal gangs, and mafias. Local conflicts and efforts to repress them by police brutality mostly lead to an escalation of the already high levels of violence, fear and insecurity. Violence is known for its contagion; when the conflict is 'over,' subsequent rates of counter-violence and revenge crimes remain elevated.

### ANALYSING THE POTENTIALS FOR PREVENTION

Most of this Chapter has analyzed the perpetrators: who they are, which are the most common explanations for their behaviour; and to review the evidence of the effectiveness of what is or may be done to prevent their aggression and violence. The important role of our social institutions has been reviewed. One of the limitations for our conclusions is that most published evidence has originated from the developed countries, especially the United States, and not enough from the developing countries.

A very large number of different actions can be taken to prevent child violence. The judgment on what to prioritize is difficult. In spite of several decades of research, we have neither quantitative data nor enough broad-based experience of interventions in different cultures to make the necessary cost-effectiveness calculations to assist our decision-making. Lacking these, I have in Table 9.3 cautiously assessed what we know about the relative

prevalence of the ten major causes of childhood violence described in this Chapter: which have low prevalence, which are more common and which have the highest prevalence. This is followed by estimates of the potential effectiveness of primary prevention for each of them.

**Table 9.3. Relative prevalence and potential primary prevention effectiveness of some major causes of childhood violence**

Causes	Relative prevalence	Potential effectiveness of primary prevention
Health-related causes appearing in childhood		
<i>Pregnancy and delivery complications</i>	Moderate	Moderate
<i>Conduct disorder</i>	Moderate	Low
<i>Genetic factors</i>	Moderate	Low
Health-related causes appearing in adulthood		
<i>Antisocial personality disorder</i>	Rare to moderate	Low
<i>Maladaptive alcohol use</i>	High	Moderate
<i>Mental disorders among caregivers</i>	Moderate	Low
Social factors		
<i>Family malfunction</i>	Very high	High
Cultural and economic factors		
<i>Violence in the society</i>	High	Moderate
<i>Lack of child support and services</i>	High	High
<i>Poverty</i>	Very high	(High)

It would be reasonable to give priority to the primary prevention of the causes with highest prevalence and then to choose to assign priority to those which have a combination of very high or high prevalence with the highest potential effectiveness. These are: family malfunction, lack of child support and poverty. It should be remarked that the estimated 'high' potential for poverty prevention depends on international support; it is analyzed in Chapters 12 and 13.

There are two main options for how to carry out primary prevention of childhood violence:

A. The targeted prevention of violence, which builds on the following assumptions:

(1) That those persons or groups with a risk of becoming perpetrators can at an early phase be identified, using methods that are reliable, easy to apply, and affordable (especially in the developing countries) on a large scale.

(2) That programmes (applied to the individuals identified) exist that will eliminate or reduce in a measurable way the root factors which cause people to maltreat children; the expectation is that these interventions will lead to a decrease of the identified persons' abusive or neglectful behaviour, and that as a result the general level of abuse and neglect will diminish.

In spite of the impressive research on neurobiological "markers", there are, however, yet few reliable methods to identify and to 'cure' high-risk future offenders, while they are still very young. It is unlikely (see Chapter 10) that diagnostic and curative methods will be available in the near future that can be applied on a large scale in the developing countries, where 85% of all violent offenders live. This is why targeted prevention has critical limits. These limits can be reduced by more research.

B. The *universal prevention* of violence is the option that aims at generating broad societal changes, using general population education and development programmes aimed at preventing violence. It implies that children everywhere, irrespective of their social status (avoiding the present bias targeting mainly poor, disadvantaged families) should be raised in a benign and supportive manner so that they might fully develop their potential as non-violent, altruistic and generous human beings.

In the choice between these two, one has to consider the very high prevalence of perpetrators and victims. This supports the proposal that the *first line of defence* of violence towards children should be a community-based primary prevention programmes (it is described in Chapter 14). The *second level of defence* should be directed towards solving the problems that remain in spite of primary prevention, and those that are too severe to be dealt with at the community level. For this, professional personnel working in a referral system are required. More clinical research is needed to clarify many of the causes and treatments mentioned above, among others pregnancy disorders, conduct disorder, callous unemotional behaviour, antisocial behaviour disorder and maladaptive alcohol use. Research programmes should be set up and funded in developing countries, where there is a dearth of professionals.

# 10 Human Services for the Child Victims: Care of Somatic and Mental Disorders and Rehabilitation

Providing services for the child victims is the responsibility of the exo- and macrosystems: the community and the governments. The sheer numbers of clients for treatment appears, however, to be beyond the capacity of all existing health care system. The service needs for the victims are not only for acute problems, but also for long-term chronic disorders (Felitti et al., 1991, 1998), and for psychosocial support and rehabilitation programmes. The term 'human services' is employed here to indicate the wide range and inclusive nature of the interventions required. A group of US paediatricians (Adams *et al.*, 2007) have issued guidelines for the medical care of children who may have been sexually abused.

## TREATMENTS

When assessing the availability of treatments for the victims of childhood violence, we need to look at the larger picture of the world's health expenditure. In 2004, that expenditure was US\$ 4.1 trillion. The world's 30 richest countries (the members of OECD) which make up 20% of the world population spent 90% of this expenditure; this equals US\$ 3,170 per capita. In Africa and South-East Asia, with 37% of the world's population, they spend 2% (US\$ 36 per capita) of the global health resources (WHO, 2007 b).

### Treatment of somatic consequences

Somatic sequels to child violence are common. Medical resources to repair acute injuries are required for simple wounds, burns, spinal cord injury, brain damage, complicated fractures, and so on. Adverse childhood experiences increase the prevalence of some important somatic diseases appearing in adult age, for which curative health care should be available. In developing countries, simple tasks are carried out by the primary health care (PHC) system, but for 750 million poor people there is no PHC yet. To the extent that they exist, hospitals in these countries assist with treatment for acute injuries. Care for chronic sequels such as extensive burns, spinal cord injury, brain damage or complicated fractures are not widely available.

Furthermore, the health personnel in these countries are rarely aware of the 'hidden' causes of child trauma and seldom initiate follow-ups to protect children from further abuse and neglect. Some patients with somatic sequels cannot be cured by medical interventions: among them the millions of sexually mutilated women. Infectious diseases, such as HIV/AIDS, may spread to children by sexual abuse, and for this disease medicaments are insufficiently available. Poverty-related protein-calorie malnutrition and avitaminosis affects hundreds of millions of neglected children. When grown up many have stunted growth, reduced muscular strength, low physical energy and fitness; this makes them less fit for jobs that require physical strength and endurance. Malaria and tuberculosis are common among neglected children in the developing countries (see p.133-134).

### Treatment of mental consequences

The mental health problems are exacerbated by the world-wide lack of psychiatric care. WHO (2001 a) states that between 36% and 50% of all serious cases of mental disorder (such as psychoses) do not now receive treatment in the developed countries; for the developing ones, the corresponding rates are 77% to 85%. The WHO survey of 192 countries showed that worldwide there were about 4 psychiatrists for 100,000 people, the distribution varied from 9.8 in Europe to 0.04 in Africa. .

Given the high prevalence of stress and the comorbid mental disorders, it is important that clear guidelines on how to treat these disorders are available. The most recent review of the results of the available treatment, entitled "Practice guidelines for the treatment of patients with acute stress disorder (ASD) and post-traumatic stress disorder (PTSD)", was issued by American Psychiatric Association (APA) in 2004. The guidelines are very carefully formulated; the text quotes 284 references. However, the experts' conclusion is "there are limited data to guide the clinician". "The first interventions consist of stabilizing and supportive medical care and supportive psychiatric care and assessment". This process should "include functional assessment, determining the availability of basic care resources (e.g. safe housing, social support network, companion care, food, and clothing), identifying previous traumatic experiences and comorbid physical or psychiatric disorders." It is recommended to "ensure physical and psychological safety, required medical care" and to evaluate the "risk for suicide and potential harm to others". The specific treatment strategies consist of psychopharmacology and psychotherapeutic interventions. The present evidence of pharmacological treatment is, however, "limited and preliminary". Selective serotonin reuptake inhibitors are recommended as first-line treatment for PTSD. Cognitive behaviour therapy given over a few sessions, beginning 2-3 weeks after trauma exposure "may speed recovery and prevent PTSD. In contrast, psychological debriefings or single-session techniques are not recommended, as they may increase symptoms in some settings and appear to be ineffective in treating individuals with ASD and preventing PTSD".

These Guidelines are carefully formulated, and conclude that the evidence of treatment efficacy is still thin. The factors that appear to facilitate resilience in USA (see p. 95) – which some recommend for general use as therapy – would appear culturally difficult to apply in many developing countries. In most such countries, for an individual to share openly her/his experience of sexual and other abuse with outsiders is often culturally constrained. Some researchers state that psychiatric therapeutic interventions for maltreated children have no effect. Tebbutt *et al.* (1997), for example, made a 5-year follow-up of 68 (out of an initial 84) abused children and found that, over these years, there were no significant changes in low self-esteem (43%) depression (43%), and behavioural dysfunction (46%). Some had improved during that period, while others had deteriorated; he sums up: the treatments had no effect.

At present, the efficacy of psychiatric treatment of post-traumatic stress disorder for the victims of child violence does not appear convincing in the eyes of the leading experts. A possible explanation of the lack of therapeutic efficacy is that the already existing anatomical, biochemical and hormonal alterations brain changes, which remain organically fixed and permanent may no longer be influenced by therapy, using existing technology. If so, this would support the clinical experience that early intervention is crucial when attempting to break the cycle of neurobiological damage before it has become fixed. However, early reporting is often prevented due to reluctance on the part of the victim or due to threats or other interference by the offender. Victims need easier local access to an authority or to the social system or to a non-governmental organization.

Some recent studies have focused on neurobiological processes aimed at extinguishing the intrusive and malignant memories of past abuse. A challenging question is: can a "retrograde, targeted amnesia" be generated? Loss of consciousness during a traumatic event creates retrograde amnesia that protects against PTSD (O'Brien and Nutt, 1998). It should be easier to extinguish memories immediately after the abusive event, rather than trying to eliminate the "engraved" memories of victimization that took place years ago, especially if the abuse was often repeated and if the victim was a child at the time of the abuse. Recent studies by Strange *et al.* (2003) and Pitman *et al.* (2002) of the effects of the  $\beta$ -blocker propranolol showed that it blocks the stress hormones released after a traumatic event. Early administration of this drug may decrease the intensity of the memories. A series of profound, inter-related biochemical

processes are involved in memory extinction. To 'cure' victims of PTSD innovative techniques have to be invented such as interfering with gene expression and protein synthesis in the hippocampus (Vianna *et al.*, 2004). Present pharmacotherapy is moderately effective but far from ideally targeted (Hageman *et al.*, 2001). The present knowledge is built on research in developed countries, mainly USA. It might not be applicable in countries with other cultures, especially if their child-rearing customs are different.

Many children from the high-risk groups are substance abusers. While staying in an institution they may have been overdosed with sedatives, street children may have been sniffing glue or chemical solvents, or others again may have used alcohol, cocaine, heroin or some local addictive drug while they were soldiers or child prostitutes. Immediate steps have to be taken to deal with the addiction.

### **SOCIAL SUPPORT AND REHABILITATION**

There are many practical books about how to work with abused children (Doyle, 2006), the following text only seeks to give a short resume.

#### **First contact.**

All child victims of violence need personalized support in an environment that creates a feeling of warmth, security, empathy and stability. The first contact person may be a social worker, a psychologist, a doctor or police. That person should listen to what the victim tells about the trauma and give all the time needed to understand. If appropriate, contacts should be sought with the perpetrator, or persons who can confirm the violence. There may be a lot of immediate practical problems, such as money, clothes, personal hygiene and lodging.

#### **Removal of an abused child.**

There is a lot a debate regarding the removal of children from their birth families (Chapter 6). Doyle (2006) explains that the notion of 'blood-tie' has been important in practice and policy and that the belief is common that (Colwell Report, 1976):

there is a strong physical tie between a child and his parent by virtue of his physical inheritance and the fact of conception and child-bearing. The term 'natural parent' somehow implies that any kind of substitute for the parent is to a degree 'unnatural'.

Some countries allow continued contact between a removed child living with the foster family and the birth parents; the hope among the latter is that the child will be returned them. In some circumstances, this might be possible, for example, if the reason is temporary disease or, if the abusive parent is removed. On the other hand, the system to continue contact with the birth family is criticized because of common disputes between them and the foster parents, and because the child is disturbed by "not knowing, where it belongs". Efforts have made to increase the parenting skills and improve behaviour among abusive parents, but a recent meta-analysis (Barlow *et al.*, 2006) failed to reveal any effectiveness of parenting programmes for physically abusive or neglectful parents. This failure may depend on the irreversible fixation of neurobiological damage, described in the previous Chapter, or continuing alcoholism and/or criminality. If the child has been abused over a long period, or if the abuse has revealed serious cruelty or lack of remorse in perpetrator, continued contacts with the birth family are usually seen as inappropriate.

For older children there are alternatives to foster families, such as shelters organized by local, non-governmental organizations. If the child or adolescent was involved with a gang or an armed group, disengaging from that gang/group may expose them to threats. Therefore, their shelter should be located away from the gang's or group's territory.

### **Psychosocial rehabilitation**

After the acute period, the victims should be offered long-term, supervised multi-sectoral services, palliative and supportive interventions, commonly referred to as “psychosocial rehabilitation”. These include education, vocational training, assistance for employment, provision of permanent lodging and security. Skills training programmes exist to prevent re-victimization of sexual abuse survivors (Cloitre, 1998).

### **The reintegration of the survivors of violence**

How will the abused child be integrated into the community? Some children from ‘bad families’ may be rejected by others. Greater community awareness is needed to make its members sensitive to the needs of human contacts for the children who have lived their lives unprotected and been abused. In some developed countries, there are support groups of families offering their homes for visits (sometimes called solidarity families) and young people’s friendship groups have successfully been initiated in many places.

In developing countries, the difficulties may be close to insurmountable; for the victims there is not much escape and no resources for removal; they will remain among the people and families that abused them. Some abused children will run away to urban areas, and we find them on the streets, away from their family tormentors, still exposed to the risks for continued abuse. A group of social researchers have presented some experiences from developing countries.

Das and Kleinman (2001) point out that in communities where people by necessity continue to live with murderers who killed their family members, or with rapists, torturers and abusers:

no glib appeal to ‘our common humanity’ can restore the confidence to inhabit each other’s lives again. Instead it is by first reformulating their notions of “normality” as a changing norm, much as the experience of a disease changes our expectations of health, that communities can respond to the destruction of trust in their everyday lives...At the level of the ordinary, the everyday social realities, states of rebuilding and accommodation are as complex as are the networks of individual lives of victims, perpetrators, victim-perpetrators, internal resisters, and critics and witnesses.

Perera (2001) describes:

culturally authorized forms providing a coping strategy by which survivors of civil conflict continue to live in the midst of torturers and murderers, long after mass violence has ended but in settings in which there is official silence, a state compliant with offenders, and no judicial ways of seeking justice...The situation may look normal from the outside, but this is mere seeming. Memories of terror continue, as does the desire for witnessing and for a response to deep grievances. Story-telling, ritual, and possession – all symbolic means embedded in old religions – provide ways by which the traumatized continue to find meaning in their suffering, to exist and to rebuild their relationships.

Metha et Chatter (2001) state that:

The altered everyday is marked by a new knowledge and memory of loss, but also a practical wisdom of negotiating this loss. It tells us that reparation cannot take the form of justice; co-existence is possible only if the acts are deliberately set aside.

Is there a way to negotiate a community and family “healing process”? The present evidence as to the effectiveness of such projects is yet very thin, very often; the victims face memories of a reality that cannot easily be swept under the carpet. It would seem irrational to apply forgiveness to cruel, violent criminals; it may just encourage them and others to continue. The



proposal of forgiveness is just a confirmation of the fact that poor people are deprived of their legal rights and have no political clout.

PART FIVE: THE GLOBAL SYSTEM: PERSPECTIVES  
OF HUMAN RIGHTS, EVOLUTION, DEVELOPMENT  
AND PROGRESS

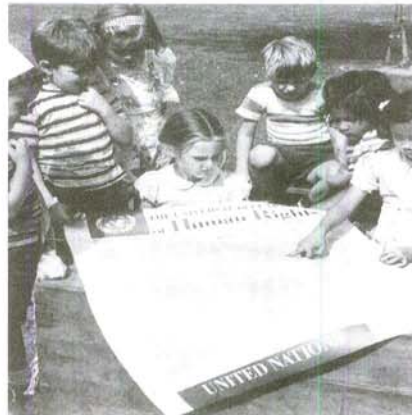
# 11 Human Rights and Human Wrongs

The United Nations at its inception in 1948 proclaimed a legal code of conduct for all its Member States: the Universal Declaration of Human Rights (UDHR). Following this, an extensive system of International Treaties: Covenants and Conventions has been built up by the United Nations and its High Commissioner for Human Rights. The idea was that UN basic principles of justice – the international law – would be part of all national laws. The legal international treaties – Covenants and Conventions – were designed to bind all nations to a framework of citizen's rights under the control of the U.N. Human Rights Commission.

In this Chapter the questions are:

- (1) What is the intended role of international laws in the life of children?
- (2) Are these legal treaties fully accepted by all countries – the macrosystems of the human ecology? (Office of the United Nations High Commissioner for Human Rights, 2006)
- (3) Globally, to what extent are children legally protected from violence; or using the formulation in UHDR “cruel, inhuman and degrading treatment and punishment”?
- (4) Which are the ethical rules for health personnel, and are they followed?

*Very few of the world's children have ever heard about Human Rights – their rights. The texts of the United Nations' many Declarations, Covenants and Conventions are rarely available to them. Also, the legal texts are often written in a language unfamiliar to children. The U.N. launched the Decade for Human Rights Education 1995-2004. The photo shows the efforts to include human rights education in all schools.*  
© World Health Organization



Human rights issues have always been controversial. It took 20 years – until 1966 – of wrangling between the U.N. Member States to agree to the formulations of the first Covenants: one about economic, social and cultural rights (ICESCR), the second about civil and political rights (ICCPR). Then it took another 10 years before they went into force (1976). Both were binding upon ratification, but Governments had the right to refuse ratification and still by 2006, 36 and 34 respectively, have not ratified these basic international treaties<sup>17,18</sup>. This reflects no doubt a high degree of political dissonance, and reluctance among many Governments to accept even a minimum of legal obligations to their own peoples. The Covenants are of specific interest to children, as they contain clear statements about the responsibility of Governments to protect children from “cruel, inhuman and degrading treatment and punishment” and to “accord the family the widest possible protection and assistance”, further specifying that “special measures should be taken on behalf of children and young persons; and “recognize the right of everyone to education.” The ICCPR Covenant did not allow the Human Rights Commission to “receive and consider, communications from individuals claiming to be victims of violations of any of the rights set forth in the Covenant.” ICCPR, however, has an Optional Protocol which “enables the Human Rights Committee to receive and consider such communications. 89 countries with combined populations of 4.8 billion have not ratified this Protocol (among them Japan, United States and United

Kingdom). Thus, from almost 80% of the world's population there will be no communications about violence towards children received by the Committee.

The Covenants were followed by more detailed Conventions. From 1966 to 2006 41 Conventions, Protocols and Optional Protocols have been accepted by the U.N. General Assembly.<sup>19</sup> The U.N. Conventions are only part of a much larger non-U.N. framework of international treaties, for example the Hague Convention on adoptions.<sup>20</sup>

In the context of this book the U.N. Convention on Rights of the Child (CRC) and the U.N. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) are the most important. Below are some excerpts of the CRC Articles:

Article 3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities...as well as competent supervision.

Article 6. States Parties recognize that every child has the inherent right to life. States Parties shall ensure to the maximum extent possible the survival and development of the child.

Article 19. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child. Protective measures...include effective...social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

Article 23. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

Article 28. States Parties recognize the right of the child to education and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular: (a) Make primary education compulsory and available free to all...(e) Take measures to encourage regular attendance at schools and the reduction of dropout rates.

Article 37. States Parties shall ensure that no child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment.

Article 39. States Parties shall...promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

The CRC has been ratified by all countries, except Somalia (which has no Government) and the USA. Many States do not comply, as they should with these articles; some disregard them on a massive scale.

The U.N. Geneva-based Committee on the Rights of the Child is the body of independent representatives that monitors the country implementation of CRC. All States are obliged to submit regular reports (every five years) to the Committee on how the rights are being implemented. The Committee examines each report and addresses its concerns and recommendations to the State party in the form of "concluding observations." The Committee cannot consider complaints from individuals; these may be raised before other committees with appropriate competence. States who disregard their obligations receive no punishment or sanctions. Legal means to enforce this Convention are not used.

A common excuse for States to delay action to meet the needs of vulnerable children is that resources are not available. Lack of resources is the excuse for understaffing residential institutions and neglecting community child defence, support programmes, halting child abandonment and care for its social orphans. Regarding this restriction, the U.N. Human Rights Commission states:

even in times of severe resources constraint...the vulnerable members of society can and indeed must be protected by the adoption of relatively low-cost targeted programmes. States' obligations are not exhausted until all appropriate measures have been taken to ensure the realization of a right. Such measures include, *inter alia*, administrative, financial, educational and social measures. If a State claims that it is unable to meet even its minimum obligations because of lack of resources, it must be at least able to demonstrate that every effort has been made to use all resources that are at its disposal in an effort to satisfy, as a matter of priority, these minimum obligations.

In September 2000, the Commission had a general discussion about State violence suffered by children living in institutions managed, licensed or supervised by States. The Commission recommended urgent attention to ensuring the establishment and effective functioning of systems to monitor the treatment received by children deprived of a family.

The second in the context of this book, most important U.N. Convention is Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT). Article 19 of the CRC (see above) defined exactly what cruel, inhuman and degrading treatment and punishment means. The following CAT Article explains the States' responsibilities:

*Article 16.* Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment...when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. In particular, the obligations contained in Articles 10, 11, 12 and 13 shall apply with the substitution for references to torture of references to other forms of cruel, inhuman or degrading treatment or punishment.

This article is unambiguous, but there are two major problems. The first is that by June 2006, 56 countries had not ratified the CAT. Another 80 have used the option to opt out of all their responsibilities related to CAT<sup>21</sup>. This is possible and completely legal:

No action can be taken by the Human Rights Commission unless the States Parties also make the declaration mentioned in Article 22 paragraph 1, that. Article states: A State Party to this Convention may at any time declare under this article that it recognizes the competence of the Committee to receive and consider communications from or on behalf of individuals subject to its jurisdiction who claim to be victims of a violation by a State Party of the provisions of the Convention. The Committee shall receive no communication if it concerns a State Party which has not made such a declaration.

Thus out of 193 U.N. Member States 136 are not bound by the CAT. These countries have a combined population of about five billion, of which some 2 billion are children. A legal and moral vacuum affects 80% of the global population; this makes the CAT close to meaningless. As shown above ICCPR has similar restrictions.

The second problem is the constraints to enforce UNHCR inspections (United Nations Human Rights Fact Sheet). These are allowed only on invitation by the Government of the nation in question, and often there is a delay of several months between the request and the Government agreement, giving Governments opportunities not only to 'clean up' substandard

practices but also to move away abused persons that they want to hide. Governments have a right to refuse the setting up of a national U.N. Human Rights office, to refuse accreditation for a country Representative, and, if granted, to restrict his/her entrance to the institutions in question and his/her asking questions to be answered by alleged victims. In short, Governments have made a mockery of the international inspection system

Several hundred million children experience cruel, inhuman and degrading treatment. There does not seem to be much public reaction, perhaps because most abuse is hidden and the victims silenced. The macrosystems of justice do little in 136 countries to protect their own abused. A few local organizations may represent these children's interests, but the victims are often without the judicial means of seeking help. Pressures have been applied to change what is criminal behaviour on a large scale, but these have made little impact. Poor people everywhere have gained little trust in the fairness of the police, the prosecutors and the courts.

In March 2005, the Secretary-General of the United Nations in a report (*In Larger Freedom*) confirming the concerns in this Chapter, stated:

The Human Rights Commission's capacity to perform its tasks has been increasingly undermined by its declining credibility and professionalism. In particular, States have sought membership of the Commission not to strengthen Human Rights, but to protect themselves against criticism or to criticize others. As a result a credibility deficit has developed, which casts a shadow on the reputation of the UN system as a whole.

The Secretary-General proposed to replace the Commission – which does not “meet the expectations of men and women everywhere” – with a UN Human Rights Council, directly elected by the General Assembly, “which should work in a more professional way, with the Councillors taking their responsibilities more seriously.” These changes started by mid-2006<sup>22</sup>. It is, however, doubtful if the non-compliance can be reduced if not supervised and enforced by Courts rather than by the voting Members of a Commission or a Council.

The failures to implement the international law at the levels of the global and of the macrosystem have had downstream consequences for the children's human ecology. Human Rights are unknown by most 'ordinary people' in the developing countries, and in some it might be a good idea not to mention them. The legal means to protect children are poorly implemented; consequently, many suffer “cruel, inhuman and degrading treatment and punishment”. The effects of the international Rights described in this Chapter, when effectively applied, should be important and should reduce the levels of child violence.

### **LEGAL OBLIGATIONS OF MEDICAL PERSONNEL**

Regrettably, some of the macrosystem guardians, such as doctors, whose influence could transform the treatment of children in institutions, for example, fail to take action. Most ethical rules for medical personnel are built on the Oath of Hippocrates (460-377 B.C.). This Oath is an ethical code or ideal, an appeal for the right conduct. In one or other of its many versions, it has guided the practice of medicine throughout the world for more than 2,000 years.

The World Medical Association (WMA) was set up in 1948 as a reaction to the atrocities committed during and after the wartime by members of the medical profession in Europe. The WMA promotes policies in accord with the Hippocratic tradition, represented in modern form first in the Declaration of Geneva, 1948 (Bloch, 1997). Since 1975, many declarations have been made by the WMA; the WHO and the U.N. on the role of the physician in protecting human rights of those who are in their care

The following undertakings are from universally adopted declarations<sup>23</sup>:

- (a) The physician shall not countenance, condone or participate in the practice of torture in any situation. (Tokyo Declaration, WMA, 1975)
- (b) The physician shall not provide any premises or knowledge to facilitate the practice of torture. (Tokyo Declaration)
- (c) The physician shall not be present during any procedure related to torture, cruel, inhumane or degrading treatment. (Tokyo Declaration)
- (d) Unjustified medications, abuse by other patients, by staff or other acts causing mental distress or discomfort are not allowed. (UN Principles on the protection of persons with mental illness. 1991)
- (e) Seclusion and physical restraints are forbidden (except when it is the only means available to prevent immediate or imminent harm to the patient or others). (UN Principles)
- (f) Sterilization is prohibited; psychosurgery or other irreversible treatment or other experimental treatments without informed consent are forbidden. (UN Principles)

These policies reflect the obligations the medical profession imposes upon itself in any bioethical analysis. These initiatives were taken because many psychiatrists have pointed out that psychiatry 'lost its anchor' when its professionals accepted to take part in the euthanasia programme in Nazi Germany, and in the suppression of political dissent in the Soviet Union and other communist countries, and in human experiments and brainwashing of prisoners carried out in many other places, including in USA and Canada.

The rules are not followed by a large numbers of physicians and other medical personnel. This is matter of great concern, especially when the victims are defenceless, downtrodden, or vulnerable children. It is particularly deplorable that those who are directly responsible for breaking or allowing others to break these rules enjoy virtual impunity. It is a fact that the homes – described in this book – in which inert, traumatized children are stored, have not received the necessary supervision and support from the medical establishment.

*With arms and hands totally constrained by a straitjacket, this boy is left alone without supervision in a room empty of furniture. No shoes, no proper clothes, no activities, no contact, except when he is spoon-fed and has to be cleaned: he is doubly incontinent. Such treatment is cruel, inhuman and degrading, and forbidden. This institution's head is a medical doctor totally out compliance with his professional obligations. Credit Star of Hope, Sweden*



When it comes to the examples of violence and cruel treatment in institutions or other settings described in this book, how can we explain the active participation and complicity of so many apparently decent and well-meaning people? How can the atrocities described just continue? We may consider four factors:

- Obedience to authority. Experiments on obedience were made by the US psychologist Stanley Milgram in the 1960s (1974). His conclusions apply to the situation of many children in institutions: Ordinary decent and law-abiding people /including doctors are/ willing to inflict severe and brutal pain on others just if they were given an order by an authoritative person (such a person may even be a doctor). Human nature, cannot be counted on to insulate the citizens from brutality and inhumane treatment at the direction of malevolent authority.
- Social group conformity, pressure from the peer group.
- The acquired pattern of denigrating myths about the victims of the cruel and uncaring conduct.
- Bureaucratic behaviour distancing basic personnel from the decision-makers.

The compliance with the obligations of medical personnel has to be better enforced. Children living in their microsystems are in many countries poorly protected against cruel, inhuman and degrading treatment and punishment.



# 12 Poverty, Inequality and Solidarity

## POVERTY

This and the following Chapter deal with the situation of the poor in the world. It also scrutinizes the role of the international community in the present, massive structural neglect of over one billion children. In 2005, there were about 2,140 million children in the developing countries aged 0-18, or slightly more than 40% of their population. In very poor countries, about 50% are children. About half of all these children are affected by poverty. The World Bank<sup>24</sup> describes the situation for poor people in the developing world; for each problem between 40% and 50% of those affected are children:

- 800 million people go hungry
- 750 million people do not have access to primary health care
- 2.4 billion people lack basic sanitation and one billion access to improved water sources
- A number of diseases, both communicable and non-communicable are more common among the poor in the developing countries than they are in developed ones. About 45 million people are infected by HIV/AIDS and its incidence is growing. 250 million people are presumed to have malaria annually worldwide and 1.1 million to die annually from that disease. 1.5 million are annually dying from tuberculosis.
- The mean survival in poor developing countries is 49 years, 77 years in the developed ones. The under-five mortality rate is 84/1,000; 11 million children die each year from preventable diseases.
- 130 million children of school age (21%) in 1998 had no access to basic education, and millions more received substandard education resulting in little learning. An estimated 900 million people, especially girls and women, today are functionally illiterate because they have been denied an education as children. Insufficient degrees of literacy lead to limitations in adaptive skills and to dependency on others for support.

*The Bank houses the wealth of the few; its entrance offers a place to sleep for one of the many homeless.*

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Poverty, states United Nations Development Programme (1997):

is a complex and multidimensional phenomenon. It is not simply a matter of incomes that are too low to meet basic subsistence needs. It is a symptom of imbedded structural imbalances, which manifest themselves in all realms of human existence...highly correlated with social exclusion, marginalization, vulnerability, powerlessness, isolation...is reflected

in malnutrition, poor health, low literacy, inadequate housing and living conditions...no access to basic infrastructure and services...lack of access to land, credit, technology and institutions...productive assets and resources needed to ensure sustainable livelihoods...people in poverty are deprived of legal rights and political clout to make their collective voice heard...the power differential helps to keep people in poverty invisible, isolated, marginalized and vulnerable.

To this description, we need to add the pervasive violence. Poverty is a 'culture'; to change it is not a question of money alone. A person's capacity to break out of poverty is reduced when he/she goes to bed and wakes up every morning hungry and with little or no reserves to draw upon. Poverty is an evil circle; it is mentally and physically traumatic, and will require generations to alleviate. For a child to grow up in a poor family that lacks almost everything is harrowing.

Regarding the number of the poor: the World Bank<sup>24</sup> defines for the developing nations those who live on less than US\$ 2 a day as poor, and as absolutely poor those who live on less than US\$ 1 a day. The measurements are based on the individual's consumption and not on his/her income. About 80% of the poor live in Asia. In 2004, the number of people living in absolute poverty was estimated at about one billion; those living in poverty were 2.6 billion. The developing countries in 2004 had 5,1 billion people, thus close to three fourths of them (72%) were under the poverty level. The arbitrary choice of US\$ 1 and US\$ 2 has been criticized. In some countries health care and education carry high costs to be paid by the families, in others it is a free public service. Thus, when official income levels increase over the US\$ 2 level, while at the same time public services disappear or are reduced, a part of population seen as escaping poverty will in reality remain poor, one such example is China. (The Economist, 2007).

In developed countries the 'poverty lines' for a person are higher; an often used amount is "60% of the minimum salary level". In USA, it was by 2005 US\$ 14.40/ day per person: USA had 37 million living in poverty (13% of the population) including 13 million children (US Accountability Office, 2007). In Russia, the poverty level was US\$ 4; at that level, 60% of the children in Russia were below the poverty level in 2001. In the European Union (15 countries) there were, in 1997, 57 million poor (17% of households, 20% of children) In Eastern and Central Europe poverty increased from 4% of the population in 1988 to 32% in 1994, the number of poor people from 14 to 119 million (about one third were children)<sup>24</sup>.

Chambers (1995) published a list of the poorest among the poor (Box 12.1.).

#### **Box 12.1. The poorest among the poor.**

*A list of some criteria used by local people in "ill-being" grouping and ranking: sources in Asia and sub-Saharan Africa. Those at the top are seen as worst off by fellow community members:*

- (1) Disabled (e.g. blind, crippled, mentally impaired, chronically sick)
- (2) Widowed
- (3) Lacking land, livestock, farm equipment, grinding mil
- (4) Cannot send children to school
- (5) Having more mouths-to-feed, fewer hands to help
- (6) Lacking able-bodied members who can fend for their families in the event of crisis
- (7) With bad housing
- (8) Having vices (e.g. alcoholism)
- (9) Being "poor in people"; lacking social supports
- (10) Having to put children in employment
- (11) Single parents
- (12) Having to accept demeaning or low status work

- (13) Having food security for only a few months each year  
 (14) Being dependent on common property resources.”

The Sri Lanka Ministry of Social Welfare (2003) published a study of poverty among adult disabled persons. Almost all fell below the poverty line of US\$ 2/day and 60% below US\$ 1/day. The national employment rate was about 90%, but only 15% of disabled persons had a job. Primary schooling is obligatory; but only 61% of the disabled children started school at all and their dropout rate was high.

Concerning widows (about 7-8% of the population) poverty is common (Owen, 1996). Thousands of them are still young, and have children. They are often blamed for the death of the husband. Many are humiliated, hounded from their homes and denied access to essential resources such as shelter and land to grow food. Their children are sometimes taken away and maltreated in the substitute families. There are many irrevocable long term implications for the future well-being of these children.

To be landless or to have to share common land or other resources is a fate for many hundred millions. Those families who use land ‘by tradition’ rarely have legal title to it, and for that reason they seldom have access to bank loans to buy better seeds, fertilizers, machines, and other equipment that would help them to increase their farming outputs. Successful programmes to assist landless people exist, but help only a small proportion of them. Poor families do not always have food for their children, and cannot afford sending them to school, because there are school fees (some illegal) to be paid, and the children may not have clothes. Chambers’ list represents some 75% of all absolutely – and it seems at present chronically – poor. To provide them a way out of poverty is major challenge.

Another group of very poor people – without development programmes consists of 350 million indigenous people living in 70 countries, half of them children. They account for an astonishing diversity of cultures, and have a vast and irreplaceable amount of knowledge, skills and ways to understand and relate to the world. For them political and cultural violence is a devastating reality (International Work Group for Indigenous Affairs, 2004).

### INEQUALITY

The economic inequalities between countries and between individuals in countries are pronounced. Table 12.1. shows the ‘official’ world macroeconomic data (UNCTAD, 2006)

**Table 12.1. World official macroeconomic data, 2004.**

Region	Population millions	% of world total pop	GDP total US\$ billions	GDP/capita/Year US\$	GDP/Capita/day US\$	% of world GDP
Whole world	6,389	100.0	40,960	6,411	<b>18</b>	100.0
Developed countries,	957	15.0	31,618	33,039	<b>91</b>	77.3
USA*	295	4.6	11,713	39,705	<b>109</b>	28.6
25 EU countries*	458	7.2	12,766	27,873	<b>76</b>	31.2
Developing countries	5,001	78.3	8,408	1,682	<b>3.8</b>	21.6
China*	1,285	20.3	1,649	1,283	<b>3.5</b>	4.0
India*	1,088	16.9	681	626	<b>1.7</b>	1.7
South-East Europe, CIS	332	5.2	935	2,816	<b>7.7</b>	2.3

\*USA and the European Union countries are also included in Developed market economy countries, total. China and India are also included in Developing countries.

The Table shows the enormous inequalities between countries (column 6). Similarly, the individual differences are very large and increasing: the world's richest 1% receives as much income as the poorest 57%, and the richest 2% own 50% of all the assets in the world. The combined incomes of the richest 25 million Americans (USA) equal those of almost 2 billion poor people. More money when unequally distributed does not seem to solve social problems (see p. 120). Neither is money the best indicator of happiness (Easterlin, 1995, 2003).

The reasons for the increasing inequalities and persistence of poverty are many and some are disputed. Some of the views are: The policies of the rich countries to alleviate poverty have proven ineffective. Some urgent actions, such as attention to family planning, to the malfunctioning judicial systems, to human rights and to violence prevention have been sidelined. The planning processes among the donor organizations are poor<sup>25</sup>, and the outcome evaluations are built on unreliable data collection<sup>26</sup>. The rich industrialized countries have not been sufficiently helpful; some experts claim that more is needed to motivate the rich populations to show more generosity, and pay better attention to the targeting, management and evaluation of donor inputs. Others consider the whole approach as misdirected. (Easterly, 2005)

The failure is also attributed to the recipient countries: corruption, internal power struggles, large-scale insecurity, government incompetence, instability, and community violence. The Governments of most poor countries have given insufficient attention to the quality of education, the development of managerial skills, the importance of using community mobilization programmes and providing the poor with legal security through an expanded judicial system. They have remained overly dependent on the production of commodities; their problems are compounded by regulatory problems, and a lack of measures to encourage industrial and services development and to protect investments. They have been unable to benefit from the enormous technological evolution, as their citizens lack the education and the skills required to use the new methods.

The obvious question is: knowing the problem why have the donor countries during 50 years of assistance neglected the management training of civil servants and political leaders? Why have they not created sufficient numbers of national and regional schools for public administration? Why are, for example, not more the 13,000 employees at the World Bank in Washington working in the field?

*This is a gypsy camp in Egypt. The people who live here have never heard of international aid. Here is poverty at its lowest level. Will these children ever see a better future?*  
© World Health Organization



The World Bank has introduced pro-poor policies. These are built on the findings that rapid growth, combined with low initial inequality and pro-poor distributional change, could

significantly reduce poverty. Growth is less efficient in lowering poverty levels in countries with high initial inequality or in which the distributional pattern of growth favors the non-poor (Bourguignon 2004; Ravallion 1997, 2004). In the late 1990s the term *pro-poor growth* became popular as economists recognized that accelerating poverty reduction required both more rapid growth and lower inequality (Aghion *et al*, 1999). High initial inequality is a brake on poverty reduction. Asset inequality predicts lower future growth rates. Income redistribution accelerates the rate of poverty reduction (World Bank, 2007).

## SOLIDARITY

### The origins of international development aid

To understand better the implications on the lives of the world's children of international development aid a short summary of its origins follows. The first large-scale programme for development was the Marshall Plan 1948-52 to assist rebuilding Europe after the World War II (Arkes 1972)<sup>15</sup>. Aid was offered to all of Europe, including the Soviet bloc, but Stalin refused and denounced the plan as a capitalist plot. During the last decades, the achievements of the Marshall Plan have been re-evaluated: in reality its effects were mixed. (OEEC Report, 1948; Kostrzewa, 1990; Cowen 1985). The European economic growth started some years later and was related to the introduction of free market policies, a major step forward was the creation of the European Economic Community in 1957.

The fact that Western Europe was rebuilt and its economy functioning well 10-15 years after the devastating Second World War encouraged the idea that a similar development could be achieved in the poor developing countries, for instance, in double that time. There emerged a conviction that economic planning, careful identification of the needs, followed by some economic aid for implementation was all that was necessary to close the gap between the rich and the poor countries. These plans met early opposition from many economists, including Peter Bauer and Milton Friedman who in the 1960s argued that aid would not work. Nevertheless, development programmes started and have been maintained for about 50 years. They turned out to be a technocratic fantasy.

Any 'analogy' between the Marshall plan for Europe and the aid to developing countries is misconceived. The Marshall aid was targeted only at some 300 million Europeans. Europe had by tradition existing institutions (public administration, education, health care, judiciary, transportation, and so on) and an educated population, industries, services and banks. Developing countries lacked functioning institutions, public administration, managerial capacity, infrastructures – for many even tax collection systems. In these countries – in the late 1950s – illiteracy was widespread, primary health care virtually non-existent, the judiciary system (where it existed) under-funded and biased, and corruption was seen at all levels. In the developing countries, the type and size of the needs were infinitely different from those in Europe, and their combined populations were at that time already seven times larger than those of Europe and rapidly growing.

## DEVELOPMENT CONTRIBUTIONS

The size the official development aid (OECD, 2007) appears in Table 12.2.

**Table 12.2. Official development aid (ODA) in % of donor countries GDP**

Year	ODA US\$ million	ODA, % of donor countries gross national income	Population, less developed regions, millions	ODA US\$/ person of less developed regions (gross)
1956	3,3	n.a	1,937	1.6
1960	4,7	0.51	2,109	2.2
1965	6,5	0.48	2,371	2.7
1970	5,4	0.33	2,688	2.5
1975	13,3	0.34	3,027	4.4
1980	26,2	0.35	3,360	7.8
1985	28,8	0.33	3,729	7.7
1990	52,7	0.33	4,131	12.8
1995	58,8	0.26	4,518	13.0
2000	53,7	0.22	4,892	10.9
2005	104,8*	0.33*	5,253	20.3*
2006	103.9*	0.30*	5,330	19.5*

\* these numbers are not comparable with the others as they include very large amounts of funds for debt relief and for natural disasters.

Support to development programmes (after adjustment for inflation) have not increased from 1990 to 2006, except for the amounts for Afghanistan (US\$ 2.2 billion) and Iraq (US\$ 21.4 billion); the 2005 increase is also explained by large allocations for debt relief and emergencies (US\$ 36 billion); these contributions are helpful, but will not assist long-term economic development (World Bank, 2006)<sup>24</sup>. The development programme aid has remained on the level of some US\$ 50-65 billion from 1990-2006, which equals about US\$ 12-14 (gross amount) per person in the developing countries per year. ODA in 2006 fell 5.1% and is expected to fall further in 2007. According to the WB, the expansion of global aid through 2006 has stalled despite donor promises at several international meetings, disbursements have fallen. (World Bank, 2007)<sup>24</sup>

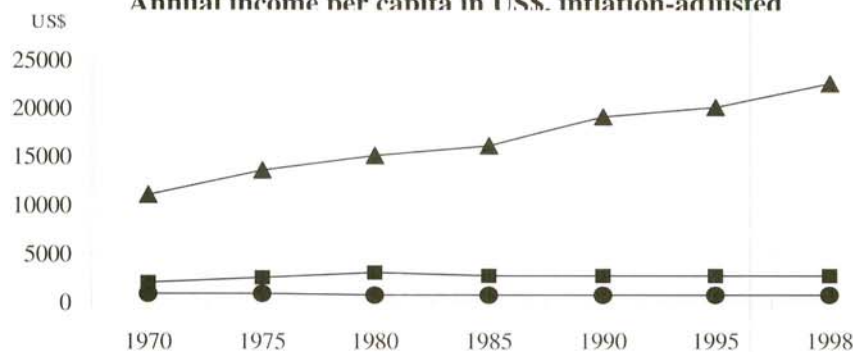
If we take a longer perspective, we will find that in 1960 ODA per capita amounted to US\$ 61 and in 2002, it was US\$ 67 (adjusted for inflation). During the same period the income of donor countries went from US\$ 11,308 per capita to US\$ 28,500, thus the ODA increased 10% and the donors' income by 152% (Global Health Watch, 2005).

Only part of the development aid is spent in the "recipient countries" and even less will reach poor children. Firstly, the administrative costs of the donors have to be deducted<sup>27</sup>. Secondly, the recipient Governments have to cover their administrative costs<sup>28</sup>. Some of the grants are used for the purchase of industrial and services from the donor country, although those often may be purchased at lower prices from other sources. Many ministerial cars, computers and other office equipment are bought using the foreign donations. In addition there is the corruption factor.<sup>29</sup> It is easy to see why the proportion of the development aid sent to the recipient country that will reach the children is going to be small. It seems reasonable to assume that the bilateral and multilateral aid available, "benefiting the poor" would be equivalent to about US\$ 4-6 per person per year (net amount) annually equivalent to two to three day's average consumption by the poor. Even these small amounts do, however, not trickle down much; the trickle-down economic theory was never much more than a belief, an "article of faith," unsupported by any research (Stiglitz, 2002). What is being done is welcome. I have both seen well administered, good quality development programmes (most of them small) and others (often with large budgets) in which the funds have been squandered.

### WILL PRESENT METHODS FOR DEVELOPMENT AID REDUCE POVERTY?

The effects of external economic aid on the economic development of the poor nations are disputed. Burnside, Dollar, Easterly *et al* (2000, 2004) – economists at the World Bank – carried out studies for the period 1970-97. The conclusion (made by Easterly) was that there is “no evidence that aid promotes growth even in good policy environments”. Fig. 12.1 (Rozenblat, 2002) confirms that the main income growth has been among the richest third of the recipient populations.

**Fig. 12.1. Comparative changes in income 1970-1998.**  
Annual income per capita in US\$, inflation-adjusted



The lines on the chart show the average annual income levels, adjusted for inflation, in three groups of nations. The lower line represents the income level in the one-third poorest countries in the world, the intermediate line the average income in the one-third group of middle-income countries, and the upper line the income in the one-third richest countries<sup>5</sup>.

The populations of the richest one third of these countries (top line) have seen their average annual income double from about US\$ 11,000 to about US\$ 22,000 over the last 30 years. The lowest two lines of Fig. 13.1, representing the poorer two thirds of the world's countries, remain for the last 30 years at approximately the same levels of poverty. The efforts to increase the income for the least affluent two-thirds of the world's populations have failed. Credit Céline Rozenblat

Development assistance has been ineffective as a means to reduce poverty. It certainly has had some small-scale results. Some experts claim that because of the insufficient amounts provided and because of the management problems described<sup>25,26</sup>, the early expectations of international aid have not materialized: these proponents argue for very large increases in international aid. Others point to the fact that “spending \$2.3 trillion (measured in today's dollars) in aid over the past five decades has left the most aid-intensive regions, like Africa, wallowing in continued stagnation; it's fair to say this approach has not been a great success” (Easterly, 2005). Children in developing countries have seen little action, and during these years their numbers have more than doubled and childhood violence is growing. Is the international community capable of reducing these levels, to prevent its causes and to help the victims? Or should we look for other approaches, such as piecemeal reforms and using small-scale community-based programmes? In the following Chapter, we will examine the activities of the United Nations Millennium Development Programme, the largest effort ever to address the main economic, health and social problems in the developing countries.

# 13 The Sacrifice of the Poor

## THE UNITED NATIONS DECLARATION OF THE MILLENNIUM DEVELOPMENT PROGRAMME

The latest international efforts to advance economic and social development – to “eradicate poverty” – are described in the Millennium Development Programme and its Millennium Development Goals (MDGs) which were adopted in 2000 by the largest summit of Chiefs of States and of Governments ever seen in New York. It was made retroactive to 1990. The Programme has eight MDGs, 18 targets, and 48 indicators. The Programme was to meet all its targets by 2015; it may be noted that during the Programme period 1990-2015, the world population grows by 2 billion people, this increase is concentrated to the Programme’s target countries.

The Millennium Plan was formulated and supported by the United Nations and six of its specialized agencies, the World Bank, the International Monetary Fund, the Organization for Economic Co-operation and Development (OECD), United Nations’ Development Programme, UNICEF, and some large, non-governmental organizations. It was built on the separate concerns of the summits of the 1990s and of the major specialized agencies, arranged as a concerted, holistic Plan. The traditions of the “individual” prescriptions included in the Plan were already many decades long; the extent to which they have succeeded or failed in the past had often more to do with national efforts than with the international donor inputs.

We are now just six years away from the end-point of the 25-year Millennium Programme. Before reviewing the official data, we must realize that there are problems with the official numbers used in poverty measurements<sup>30</sup>, population size<sup>31</sup>, number of children<sup>32</sup>, morbidity and mortality<sup>33</sup>, and literacy<sup>34</sup>. The evaluation of Millennium Development Goals include information of variable accuracy from some 200 nations and territories, collected by multiple organizations over a period of 25 years. Few surveyors will remain with the MDG during the entire period. Thousands of individual surveyors have been instructed separately, sometimes inadequately. They do not reliably apply the same standard criteria for, consumption assessments, seriousness and diagnostic criteria of health problems and hunger, and checking of education, literacy, and employment. Data is therefore of highly varying quality, such that its use in assessing Millennium goals is of uncertain reliability. Indeed, some insiders wonder if positive outcomes may at times be the result of invented data.

The World Bank<sup>24</sup> has been and is still reminding its personnel that missing data, unclear application of indicators, and lack of reliable statistics limit its ability to monitor progress. The review below will examine the implications for the world’s children of the present results of the Millennium Programme. The data below, unless specified, are from the World Bank.

### **Goal 1: Eradicate extreme poverty and hunger**

*Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than \$1 a day*

This poverty goal implies a reduction from 29% to 14.5% of the proportion of people living on less than a dollar a day. According to the World Bank people living on less than US \$1 a day were in 1990 1,276 million; in 2004 it had fallen by 290 million to 986 million, of whom about 40% are children. China alone reported a fall of 246 million, implying that elsewhere the number of people living in extreme poverty had hardly changed. In Sub-Saharan Africa



there was an increase of 58 million poor people. In 1990, 2.7 billion people in the world were living on less than US \$2 a day; in 2004, the estimate was 2.6 billion.

Experts hope that the economic poverty reduction goals for 2015 will be reached globally, largely due to the strong economic growth in China and India. In China there were in 2005 593 million people under the poverty level of US \$2/day and in India, there were 807 million. Together these two countries have 1.4 billion poor people (under US \$2/day). There are now 202 million (16.1%) in China and 350 million (34.7%) in India living on less than US \$1 per day. The outcomes of poverty alleviation in China and India are obviously important; but those of China are disputed (see p. 137).

It should be noted that the economic growth in China and in India is mostly 'home-grown', based on national mobilization and resources; neither of them has received any significant external assistance at any time. Their economies are growing because they introduced economic market policies and succeeded to produce, trade, and create major export industries, and to attract foreign investments. They also have large domestic markets.

Experts generally do not expect the poverty-reduction goals to be reached in most other regions, particularly not in sub-Saharan Africa, where GDP per capita shrank 14 percent, and poverty rose from 41 percent in 1981 to 46 percent in 2001, adding 150 million people living in extreme poverty. Without the financial resources needed, and with about 1.7 billion more people added (1990-2015) to the populations in the developing countries, there likely will be by 2015 more poor people in absolute numbers (with somewhat less in relative numbers). Although the Least Developing Countries (LDCs) have higher rates of economic growth than in the past, this is not yet translating into poverty reduction and improved human well-being.

*Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger*

In 1997-99, there were some 815 million undernourished people in the world (World Food Programme, 2006); 40% were children. Poor or insufficient nutrition has caused impaired growth among some 226 million children. In addition, over 2 billion people worldwide, many children, suffer from micronutrient malnutrition. Their diets supply inadequate amounts of vitamins and essential minerals such as vitamin A, iron, iodine, zinc, and vitamin C. Micronutrients are essential for human growth and development, especially for children. Because of hunger, millions of people, including 6 million children under the age of five, die each year. Most are dying because they lack adequate food and essential nutrients, which leaves them weak, underweight, and vulnerable to infections. Chronic undernutrition in childhood is linked to slower cognitive development that affects learning at school, and produces serious health impairments later in life that reduce their economic productivity. Undernourished infants lose their curiosity, motivation, and even the will to play. Millions leave school prematurely. All too often, child hunger is trans-generational: 17 million children are born underweight annually, the result of their mothers' malnutrition before and during pregnancy.

After decreasing by 37 million during the first half of the 1990s, the number of hungry people in developing countries increased by 18 million in the second half. Overall, from 1990 to 2003, the hungry had an insignificant decrease from 823 to 820 million. One recognizes that the reduction of hunger foreseen in the Millennium programme is not taking place: the goal of reducing by half the undernourished people by 2015 cannot be reached.

The UN agencies and the NGOs that distribute foods to the hungry are seriously underfinanced. From a record of almost 17 million tonnes in 1993, global food aid fell to 9.9 million tonnes in 1995, 7.6 million tonnes in 1996, and 5.1 million tonnes in 2004. The World Food Programme delivers food to 77 million people in 82 countries; its deliveries – which are

almost 50% of all global food deliveries – have been hit by increasing food prices and costs for transportation; its budget has not kept pace with these increases.

*Here, food is distributed to families in Sahel but, as desert areas increase and as the population grows, their chance of escaping hunger is nil.*  
© World Health Organization



### **Goal 2: Achieve universal primary education**

*Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling*

Attaining this goal would require enrolling some 200 million more children in primary school than there are today, an increase of 41% over current levels. However, from 2000 to 2006 just an additional 35 million children were completing primary school. The World Bank calculations do not make it clear that for 200 million additional children aged 5-14, with a teacher to pupil rate of 1 to 50, some 4 million teachers need to be quickly added. According to a World Bank study, only 37 of 155 developing countries analyzed have by 2004 achieved universal primary completion. Based on trends in the 1990s, another 32 are likely to achieve that goal. But 70 countries risk not reaching the goal. In several of them, completion rates have stagnated or even fallen in recent years. If current trends persist, children in more than half of developing countries will not complete a full course of primary education in 2015. An important but insufficiently addressed question is whether the quality of education is maintained as the number of schoolchildren increases. "Most poor children who attend primary school in the developing world learn shockingly little." More efforts are needed to monitor outcomes and to understand what students are actually learning and retaining.

### **Goal 3: Promote gender equality and empower women**

*Target 4: Eliminate gender disparity in primary and secondary education, preferably by 2005 and in all levels of education no later than 2015*

Progress in gender equality and women's empowerment has been uneven. Concerted national efforts have helped raise girls' enrolments in the past decade so that gender parity for primary school enrolments has been reached in 83 of 106 reporting countries. Yet, in the same period, the increase in women's participation in the economy and in political decision-making

has been modest at best. According to the World Bank, the results of gender equality programmes at all levels of education are less than comforting.

**Goal 4: Reduce child mortality**

*Target 5: Reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate*

**Goal 5: Improve maternal health**

*Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality*

The prospects in the health sector are grave. The clear impression is that we do not really know how much of existing state health programmes reach the poor. The same problem is shared with the civil society projects. Only 64 countries, mostly those with high income, have complete mortality data<sup>33</sup>. Thus, no developing country has reliable information about Goals 4 and 5; the following statistics are rough estimates only. Infant mortality rates in low- and middle-income countries, may have fallen from 86 per 1,000 live births in 1980 to 60 in 2002. 46 countries, however, still have under-5 mortality rates between 100 and 280 per 1,000 (World Health Report 2005, WHO) while, as an example, Sweden has an infant mortality rate of 3 per 1,000, and other high-income countries rates of 5 per 1,000.

In the 42 countries that account for 90% of child deaths, 80% of children are not given oral rehydration therapy when needed; 61% of children under six months are not exclusively breastfed; 60% do not receive treatment for acute respiratory infections; and 45% do not get vitamin A supplements. The gap in survival between the richest and poorest children in the world is increasing. The well-off are improving, while survival of the poorest is worsening.

The maternal mortality rate may also have diminished during the same period but is still assessed at 684 per 100,000 births in low-and middle-income countries as against 14 in the high-income countries. The highest registered is in Afghanistan: 1,600 per 100,000 (Ahmad, 2004). An estimated 529,000 women die in pregnancy and childbirth each year; 99% of them in developing countries. The goal of reducing child and maternal mortality of the Millennium Programme will not be achieved because only 15% to 20% of all countries are on track.

**Goal 6: Combat HIV/AIDS, malaria, and other diseases**

*Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS*

*Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases*

The worldwide incidence of HIV is rising. The number of people living with HIV has gone up from some 30 million in 2000 to 40 million in 2006. (WHO, 2007 b). The annual global numbers of deaths from HIV/AIDS are projected to increase from 2.8 million in 2002 to 6.5 million in 2030. The situation is catastrophic, and not significantly an artefact of better reporting.

In 2004, 107 countries reported malaria transmission risks. To diagnose malaria a microscopic examination of blood films or an antigen detection test is needed. These require specialized laboratories which are rare in developing countries. Precise statistics are unknown because many cases occur in rural areas where people do not have access to health care. Consequently, the majority of cases are undocumented. What follows are guesstimates: about 350-500 million cases of malaria occur annually; each year, approximately 50 million women living in malaria-endemic countries become pregnant, over half in tropical Africa. An estimated 10,000 of these women and 200,000 of their infants die because of malaria during pregnancy. In Africa, one in twenty children dies of malaria before age 5. In children who survive, malarial anaemia is common. The number of people living in malaria-exposed areas have increased since the 1980s; the severity of infection and the number of deaths will indeed continue to increase (Hay, 2004; WHO, 2007 b).

In 2005, there were 8.8 million new cases of tuberculosis. The total numbers of newly detected cases are increasing. WHO (2007 b) concludes the “1990s prevalence and mortality rates will not have been halved by 2015.”

**Goal 7: Ensure environmental sustainability**

*Target 10: Halve by 2015 the proportion of people without sustainable access to safe drinking water*

This implies providing another 1.5 billion people with water and 2 billion with sanitation. The rate of progress of this Millennium goal is only half of what is needed. At the current rate of development, only 20% of all countries will achieve the goal; in the low-income countries, only 10% will do so. Nearly 80% of all child deaths in the developing countries are caused by contaminated water (WHO and UNICEF, 2000).

*Target 11: Have achieved by 2020 a significant improvement in the lives of at least 100 million slum dwellers*

This goal mainly refers to the provision of safe water and sanitation in slums. Half of the world’s population is urbanized; most live in slums. The size of their living quarters is very small – not much space for children – and there is a lack of public facilities: water, sewers, electricity, and latrines. Schools and health services may be missing. Violence and aggression are common. Massive investments are needed to provide decent living conditions; poor countries do not have the means. Not much improvement in Target 11 can be expected to occur during the remaining 7 years of the underfinanced Millennium programme.



Children in a slum.  
© World Health Organization.

**Goal 8: Develop a global partnership for development**

*Target 12: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system (includes a commitment to good governance, development, and poverty reduction – both nationally and internationally)*

The commitment to good governance.

The World Bank concluded that efforts to improve the quality of governance were important for the overall development process. It in the mid-1990s, created a new Group for *Worldwide Governance Indicators (WGI)* (Kaufmann and Kraay, 2007). The Bank introduced six “dimensions” to measure the quality of Governments; the indicators of these are based on several hundred individual variables measuring governance, drawn from 37 separate data sources constructed by 31 different organizations. Based on the indicators each of the six dimensions are rated from 0 to 100; the higher the better. Results cover 213 countries and territories from 1996-2006 were presented in a paper by the World Bank in 2007 and on its Internet site (World Bank, 2007). The Governance group “supports the collection, rigorous analysis, careful interpretation, and transparent dissemination of data for empirical research,

capacity-building, and learning programs". The WGI group is very clear about the difficulties in making the measurements, and presents the margins of error of its data. The indicators are:

**1. Voice and Accountability** includes a number of indicators measuring various aspects of the political process, civil liberties, political and human rights, measuring the extent to which citizens of a country are able to participate in the selection of governments.

**2. Political Stability and Absence of Violence** combines several indicators, which measure perceptions of the likelihood that the government in power will be destabilized or overthrown by possibly unconstitutional and/or violent means, including domestic violence and terrorism.

**3. Government Effectiveness** combines responses on the quality of public service provision, the quality of the bureaucracy, the competence of civil servants, the independence of the civil service from political pressures, and the credibility of the government's commitment to policies.

**4. Regulatory Quality** focuses more on the policies themselves, including measures of the incidence of market-unfriendly policies such as price controls or inadequate bank supervision, as well as perceptions of the burdens imposed by excessive regulation in areas such as foreign trade and business development.

**5. Rule of Law** includes several indicators which measure the extent to which agents have confidence in and abide by the rules of society. These include perceptions of the incidence of crime, the effectiveness and predictability of the judiciary, and the enforceability of contracts.

**6. Control of Corruption** is a measure of the extent of corruption, conventionally defined as the exercise of public power for private gain. It is based on scores of variables from polls of experts and surveys.

Five of these dimensions are of direct importance to children's lives. The first mentions the compliance with 'human rights'; the second takes up 'domestic violence'; the third the 'quality of public services' (such as prevention of child violence and care of the victims) and the 'governments commitment to policies' (such as child support and alleviation of poverty); the fifth 'the incidence of crimes' (such as child abuse) and 'the effectiveness and predictability of the judiciary' (related to the failure to convict child abusers and the impunity the perpetrators enjoy including government employees who commit child abuse); and the sixth corruption (which robs the poor).

The WGI Group presents its results mainly country by country. In the context of this book, it appeared valuable to evaluate this component of the global ecology system. What quality is of governance is experienced by our children and their families and what are the implications? A presentation based on the World Bank's original data follows.

Table 13.1 shows the combined governance performance calculations from the 19 most populated developing countries: Argentina, Bangladesh, Brazil, China, Colombia, Congo D.R., Egypt, Ethiopia, India, Indonesia, Iran, Myanmar, Nigeria, Pakistan, Philippines, South Africa, Sudan, Thailand, and Vietnam. Mexico and the Republic of Korea were excluded as they belong to OECD. These 19 countries' combined populations in 2006 were 4,020 million people, about three quarters of the developing world's total population of 5,244 billion (US Census Bureau, 2007). The WGI percentile rates for each of the six dimensions were multiplied by the population numbers separately for each country in 1996 and 2006; thus, the results from the 19 countries were weighted individually, the larger the population the higher weight. The combined weights of the 19 countries were then added and divided by their combined populations (in 1996 and 2006); the dimension score averages appear in the Table 13.1. The average percentile ranks were already in 1996 low: these countries had large governing problems. Since 1996, four of the six dimensions of Governance performance showed negative changes, and the average for all six has been reduced by 5.4%.

**Table 13.1. Changes from 1996 to 2006 of the six World Bank dimensions for Government performance in the 19 most populated developing countries.**

<b>WGI Government performance dimensions</b>	<b>Combined Government performance indicators of WGI dimensions, 1996</b>	<b>Combined Government performance indicators of WGI dimensions, 2006</b>	<b>Difference: absolute value</b>
Voice and Accountability	27.0	29.6	+2.6
Political Stability and Absence of Violence	24.0	24.5	+0.5
Government Effectiveness	52.5	49.4	-3.1
Regulatory Quality	46.8	42.8	-4.0
Rule of Law	46.2	42.0	-4.2
Control of Corruption	41.6	37.7	-3.9
Total /average	<b>238.1/39.7</b>	<b>226.0/37.7</b>	<b>-12.1 (-5.4%)</b>
Population million	3,513	4,020	

Combined scores of the six dimensions are available from the WGI Group for the 48 countries of Sub-Saharan Africa and for the countries of the former Soviet Union. These are reproduced below in Table 13.2. together with a few selected large countries as comparisons.

**Table 13.2. Analysis of the changes from 1996 to 2004 of the average performance on World Bank dimensions for Government performance in selected countries.**

<b>Region/country</b>	<b>Average Gov. performance indicators of WGI dimensions, 1996</b>	<b>Average Gov. performance indicators of WGI dimensions, 2006</b>	<b>Difference absolute value 1996-2006</b>	<b>Population million 2006</b>
1. Sub-Saharan Africa, average	31.1	30.3	-0.8	751 (353 included in Table 13.1)
2. Former Soviet Union	23.0	20.9	-2.1	283
3. United States	91.2	84.9	-6.3	302
4. Japan	79.9	86.1	+6.2	128
5. Mexico	44.6	49.6	+5.0	106
6. Germany	93.1	90.0	-3.1	82
7. Turkey	45.3	49.6	+5.6	75
8. France	84.9	83.9	-1.0	64
9. United Kingdom	90.3	88.9	-1.4	61
10. Italy	84.9	83.9	-1.0	59

The countries of the former Soviet Union have the lowest scores on the WGI dimensions, even lower than Sub-Saharan Africa. Even several developed countries show negative changes (Table 13.2 shows decreases in such countries with totally 568 million population).

Table 13.3. shows a comparison between China and India. In 1996, the average WGI scores were about the same for both countries. 10 years later, India has achieved a 10% increase, whereas China has 16% lower average score.

**Table 13.3. WGI dimensions development in China and India**

WGI performance dimensions	China 1996	China 2006	India 1996	India 2006
Voice and Accountability	4.8	4.8	55.2	58.2
Political Stability and Absence of Violence	34.6	33.2	14.9	22.1
Government Effectiveness	66.8	55.5	50.7	54.0
Regulatory Quality	54.1	46.3	44.4	48.3
Rule of Law	48.1	45.2	61.0	57.1
Control of Corruption	56.3	37.9	40.3	52.9
Average	<b>44.1</b>	<b>37.2</b>	<b>44.4</b>	<b>48.8</b>

The results are that during the last 10 years the quality of governance has declined for three groups accounted for in Tables 13.1. and 13.2: 4,020 million in 19 developing countries, 398 million in the Sub-Saharan Africa (not already included in Table 13.1) and, 302 million in the countries of the former Soviet Union, the total is 4,720 million, close to three quarter of the world population. This quality is a very important part of children's quality of life. Violence related to the lack of rule of law is growing. Even after having considered the margin of error, the results imply that for over half of them part of that quality has been lost.

Whatever the World Bank and other organizations have attempted to implement, the efforts to raise the quality of governance have yet to succeed. It is interesting to reflect on a disclaimer which appears on the published documents produced by the World Bank's staff: "The data and research reported here do not reflect the official views of the World Bank, its Executive Directors, or the countries they represent. The Worldwide Governance Indicators (WGI) are not used by the World Bank Group to allocate resources or for any other official purpose". Were the results of the Bank's own governance study an embarrassment?

*Target 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth*

Enlarging the chances of young people to find and keep decent work is critical to achieving the UN Millennium Development Goals (Somavia, 2004). Youth unemployment worldwide is, however, at an all-time high. Young people aged 15-24 represent nearly half the world's jobless although they are only 25 per cent of the global working age population. The number of unemployed youth increased by 27% from 1993-2003 because this population grew 10.5 per cent during that period to some 1.1 billion in 2003, but youth employment grew only 0.2%. An additional one billion youth will enter the global labour market in the next decade, mostly in developing countries – places where jobs are least likely to be found. Experts predict that only 300 million new jobs will be created over the same period, leaving an employment gap that expectedly will exacerbate poverty, worsen public health, and dampen economic growth in countries already struggling to provide the basics to their citizens. Too few of the developing world's children will have any chance of finding a job when grown up.

The Millennium Programme and its predecessors have not included action in three important areas affecting development:

(1) Family planning/birth control programmes have met resistance from religious and cultural groups in many countries. The populations of developing countries are predicted to grow from 6 billion (2000) to 9 billion (2050), yet the Millennium Development Goals do not include any targets for family planning/birth control. The overcrowding of the world is a serious ecological problem, and gains in MDGs may readily be offset by the population explosion. This bodes ill for the future of our children. The estimated cost of universal access to sexual and reproductive health services is US \$23 billion for 2005. Donor nations thus have to triple their current financial commitments.

(2) A decentralized judicial system. For the poor, the neglect and abuse of their legal rights is a clear reality. Their experience in seeking justice often leads them to give up; those in power will 'always win', by corruption or by the use of personal influence. The impunity enjoyed by those who misuse their authority and maltreat children also must end. In the above Tables, the "rule of law" has received low and decreasing scores. It is well known that the justice system is both severely under-dimensioned and malfunctioning in developing countries, yet the Millennium Programme does not address this blatant inequality. Support to the informal system in the developing countries through the training of lay judges could help.

(3) Prevention of violence. In the 2000 Millennium Development Programme there is no single reference to violence or child abuse. By 2005, evidently under pressure (United Nations Millennium Programme, 2005) a few words were added with a recommendation to "focus" on "freedom from violence" as part of the women's and girls' health programme. This recommendation is welcome, but is vague and insufficient, given the magnitude of the problem. Although the economic development is threatened by increasing violence, there are still no specific Millennium Goals about violence.

## CONCLUSIONS AND ALTERNATIVES

### The global neglect of children

The summary above shows the extent of global, structural child neglect. Over one billion children live in poverty, most of them in substandard housing, with lack of clean water and sanitation. One fifth of them don't even start school, and many of those who do double classes or drop out. What they find in school is mostly of poor quality. The school curriculum emphasises mostly the basic skills and learning obedient behaviour. The basic skills may soon be lost, because few of them have pen and paper at home, and reading materials are scant. Insufficient attention is given to comprehension, critical analysis and conscientization. Development in these poor countries would be enhanced if the curriculum included learning progress-oriented knowledge and problem-solving skills. Parents' poor education leads to under stimulation of their children. Health services do not exist for about one quarter of the poor, and the quality is often insufficient, especially when it comes to curative services. Child nutrition is a large problem both regarding protein-calorie and micronutrient supply. Millions of children continue to die, although almost all deaths could have been prevented. The prospects for young people to find income are meagre.

The chances for a child of fully realizing its inborn potentialities are further impaired by

- health conditions of pregnant mothers: her undernourishment leading to anaemia, inadequate supply of vitamins and essential minerals, stress, marital conflicts, mental disorders; all contribute to negative effects for the foetus development, including the neurobiological
- the high frequency of underweight infants and of perinatal complications
- incompetent parenting, including under stimulation of the child during the early years



It is difficult to escape the conclusion that structural neglect causes large-scale impairments, among them: low body weight and size, low muscular strength, and endurance, neurobiological deficiencies, reduced cognitive and non-cognitive functions. These effects often continue to the next generation. The costs to the individuals and to the society are very high.

Who is responsible for this large-size neglect? The primary caregivers – mostly the family – cannot be blamed for circumstances over which they have no power. The responsibility is found in the functioning of poor countries macro-institutions and in the lack of appropriate development assistance. The structures of the macro- and global systems have failed to provide what is needed to prevent a massive child neglect leading to the destruction of lives.

### **The outcome of the Millennium Programme**

More than two thirds of the time between 1990 and 2015 has now passed, and for many nations, the results of the MDGs related to children are still insufficient and do not appear promising. The fact that most of the goals will not be reached is sad and discouraging. Rogerson *et al.* (2004) sum up:

many low-income countries have no realistic chance of meeting some, if not most, MDGs, virtually regardless of their efforts, or of the size and quality of outside support in the intervening period. The intermediate group, where greater efforts now could yet tip the balance, will shrink quickly – well before 2010 and probably much earlier. During the period of 2005-2010, therefore, and perhaps already by 2005-6, the MDGs will probably cease to be an effective reference point both for very successful and very unsuccessful countries, and may lose their potency for most of the undecided category.

The Millennium Declaration promised: “We will spare no efforts to free our fellow men, women and children from the abject and dehumanising conditions of extreme poverty, to which more than a billion of them are currently subjected.” At the 2000 Summit the public was told to expect rapid improvements. It is now evident that the Programme is in deep trouble. In spite of all rhetoric, a large proportion of this generation of the poorest – including the children – in the developing countries is being sacrificed. Most of the destitute, the excluded, the vulnerable and downtrodden will – as in the past – continue to live a life without dignity and rights, without mercy, and they will die in misery under catastrophic and inhumane conditions.

Utopian ideas become dangerous and destabilizing when they succeed in eliciting enthusiasm, hopes and energies among the poor and oppressed for ends that will not be achieved. To convey hope and then to fail to deliver is cynical and immoral. Could this failure have been foreseen? Indeed, the World Bank, in its 1997 World Development Report – three years before the Millennium Declaration – stated:

the notion that good advisers and technical experts would formulate good policies, which good governments would then implement for the good of society, was outdated: the institutional assumptions implicit in this world view were, as we all realize today, too simplistic... Governments embarked on fanciful schemes. Private investors, lacking confidence in public policies or in the steadfastness of leaders, held back. Powerful rulers acted arbitrarily. Corruption became endemic. Development faltered, and poverty endured.

One undisputed effect of the monolithic economic order is the growing inequality – described in Chapter 12 – showing that the world’s richest 1% receives as much income as the

poorest 57%; the richest 2% own 50% of all the assets in the world; and the combined incomes of the richest 25 million Americans (USA) equal those of almost 2 billion poor people. This outcome of the Western World's concept of progress can only be described as a colossal failure. The many proposals of global action to correct the enormous inequalities in income and assets have not translated from rhetoric to positive changes; on the contrary, the inequalities are actually growing. The implications for most of the world's children, and hence for the future, are bleak.

### **Seeking a new focus**

The time for rethinking is overdue. International assistance in the past has largely been a deception. This costly deception has been allowed to continue without proper attention to its actual results<sup>25,26</sup>. The conclusion is that poor nations have to use their own strengths and learn how to mobilize their own populations to rectify their existing conditions to create a better future for their children. They should look to China and India, who have succeeded so well without almost any outside help. Donors can contribute to children's programmes using a 'piecemeal reform' approach. Easterly (2005) proposes that the stakeholders

would humbly acknowledge that nobody can fully grasp the complexity of the political, social, technological, ecological and economic systems that underlie poverty. It would eschew the arrogance that 'we' know exactly how to fix 'them.' It would shy away from the hubris of what /is labeled/ the 'breathtaking opportunity' that 'we' have to spread democracy, technology, prosperity and perpetual peace to the entire planet. Large-scale crash programs, especially by outsiders, often produce unintended consequences. The simple dreams at the top run afoul of insufficient knowledge of the complex realities at the bottom. The Big Plans are impossible to evaluate scientifically afterward. Nor can you hold any specific agency accountable for their success or failure. Piecemeal reform, by contrast, motivates specific actors to take small steps, one at a time, then tests whether that small step made poor people better off, holds accountable the agency that implemented the small step, and considers the next small step.

To sum up: children in the developing countries can be better helped in other ways than our present attempts to force large-scale programmes upon the global human ecological system. We might re-consider our present penchant for assisting governments of poor nations, which is related to the huge role that intergovernmental organizations have been given. Instead, it might be better to try to reach directly people via the civil society. The complexity of poor countries' socio-cultural heritage, the importance of their human potential and the positive experience of community mobilization in these countries should no longer be ignored. Encouraging and assisting piecemeal, local projects by communities has proven effective. The author has observed and been involved in the setting up of hundreds of them in many countries (Helander, 1999, 2007). These work well, because they build on new entry points: working directly with the people. Decentralization and empowerment of poor communities is a promising path for improving the future of our children.



**PART SIX. PRIMARY CHILD VIOLENCE PREVENTION  
BY EXOSYSTEMS**

# 14 A Community-based Child Defence and Support (CDS) Programme

## INTRODUCTION

There are 2.3 billion children under the age of 18 in the world; about two billion live in developing countries. To prevent them from becoming victims of violence using a programme of defence and support is an enormous task. It will take a few generations to see real improvements.

In Chapter 9, the reasons were given for assigning priority to a universal programme: no child should be left behind. The main objective of a universal programme is to reduce the rate of violence towards children.

The focus of the actions described in this Chapter is to:

- (a) promote family life preparation and
- (b) assist the family with guidance and support.
- (c) create public awareness using media
- (d) to increase the protection of children through legislation that forbids all forms of abuse

At the core of action is the fostering of caring adults, who will understand and provide the social, emotional, physical and cognitive needs of the growing child, and establish patterns of interaction, mutual trust and security in a spirit of love, empathy and fairness. The preparations need to start early in life.



*It is easy to forget children with disabilities in family preparation programmes. The mentally retarded children seen here have the benefit of modern approach: they learn to avoid strangers; they are normally very affectionate and will approach any unknown person without any hesitation. This increases their risk for abuse.*

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The discussion below will mainly deal with these priorities. An obvious reason for the choice of primary prevention instead of secondary is that the results of the latter are less effective; this might be caused by the presence of the neurobiological changes described earlier (p. 93-95, 107-109).

## APPROACHES TO PROMOTE REDUCTION OF CHILD VIOLENCE

Effective child abuse prevention has over time tended to more and more focus on parent education and home visiting programmes. The four different strategies for coping with the problem of childhood violence will be discussed.

### (1) Family life preparation.

The most commonly mentioned primary prevention programmes are known as pre-parent and parent education. The first major handbook on parent education was published in 1981 (Fine). The Council of Europe has recently published a book about parenting in contemporary Europe (Daly, 2007). McDermott (2002) in a meta-analysis cites no less than 142 articles and books describing twenty-four main different approaches to parent and pre-parent education, most of these have been developed in North America. A few are reproduced in Table 14.1.

**Table 14.1. Examples of approaches to parent and pre-parent education**

Author	Type of intervention
Luster and Youatt 1989 USA	High-school programme. Students interacting with children, in natural settings and observing patterns of parent-child interaction
Webster-Stratton 1994 Great Britain	Using videos for parents with conduct disorder children to learn model behaviour.
Brown <i>et al.</i> 1998 USA	Role-playing, coaching and modelling; practical exercises rather than theory or lessons or discussions. There should be early training of parents in simple readily applicable skills so they can see changes in child behaviour quickly.
Taylor 1997 USA	Student-centred training with role-play which allows them to express hidden feelings. Learning to estimate how the learner's behaviour affects others. Problem-solving exercises.
Tomison 1998 Australia	Group work with students to discuss how they have been parented and how they want to be as parents
Clabby and Elias 1992 USA	Developing parents' and children's competence in communication, teamwork, and joint decision-making; understand their own and others needs, manage conflicts and disagreements
Smith <i>et al.</i> 1994 USA	Learn to manage personal stress (for parents)
Chalk and King 1998 USA	Groups of parents offered training in social skills and problem-solving. The resulting quality of parenting was better than just learning about child development
Jaffe <i>et al.</i> 1992 USA	Letting teen-agers participate in their family plans and activity decisions, developing skills to use when they become parents.

The education programmes listed above include training in skills that go beyond those of 'primary child care'; and even include components of empowering adolescents. These aspects

are valuable; they, however, amount to more than pre-parental or parental education. To include all these, this book will use the term *family life preparation*.

**(2) Child community watch.** Supervision – “watch” – of children consists of visits to homes, and observations in schools and at leisure time activities. The emphasis should be on supporting, not controlling, the mesosystem, and preventing malfunction. Home visits bring services into the home; thus, families do not need to seek these outside, which may be inconvenient, and often requires long waiting times. During such visits observations can be made of the family’s needs, modifications initiated and resources provided. The home visitor will be able to build a friendly relationship with the family. Home visits have in the past mostly been used for targeted families with social problems, it would be desirable to make these universal; the reasons are firstly that half of all children are maltreated, and secondly that it will then be non-stigmatizing. It is, however, questionable if this will be agreeable to everybody. If not home visits can be replaced by observations in schools and in the community, these will be discussed below.

**(3) Publicity** about the consequences of abuse, addressing the widespread ignorance among the public. Wherever destructive child education practices exist, they have to be replaced. An anti-alcohol campaign is needed. Major media – where they exist – should be used: television, radio, press, posters, inclusion of aspects of child violence prevention in entertainment programmes and cinema films

**(4) Introduction of laws.** Sexual abuse is illegal everywhere, but in most countries laws do not forbid physical and emotional abuse of children. The Child Convention clearly forbids all types of abuse:

States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child. Protective measures...include effective...social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement (Article 19).

These four strategies will be more effective if operated in combination. Programmes can be communicated in many ways: by one-to-one education, in groups (such as in schools, at home with the family or in community programmes); and by using media, books and information campaigns.

## 1. FAMILY LIFE PREPARATION

Before entering the detailed analysis, it is proposed to look first at the semantics. Which are the terms used for the methods that parents use to shape child behaviour? The most common term is discipline; sometimes punishment, correction, reform. These terms are in people’s minds associated with a negative view of child education: discipline is closely related to punishment using corporal and emotional abuse. Keeping the term ‘discipline’ will only prolong the misuse of parental authority, and thus the term discipline can be or should not be rescued even if it is renamed “positive discipline”.

Socialization is the process by which human beings learn to adopt the behaviour patterns of the meso-, exo- and macrosystems in which they live. The most important time when socialization occurs is between the ages of one and ten. Socialization can be carried out without resorting to violence. The challenge is to establish a parental base of practical skills and knowledge to apply in childhood socialization. That would for most people imply a break with the parent behaviour inherited from our previous generations, or being part of the 'culture'.

Parents', teachers' and peer groups' influence in child behaviour is a type of 'modulation'. To "modulate an activity or process means to alter or adjust it in order to make it more suitable to a peculiar set of circumstances." (Collins Dictionary, 2002). Modulation – in our context – means educating children by guiding, use reasoning to explain why there are certain rules to follow, empowering and coaching them to success in their future life in the society of the adults, while preserving their integrity, dignity, personality and creativity. Scientific studies of behaviour modulation have been published (MacPhail, 1990); these confirm the essential role in human behaviour both of the neurobiological system and of the modulatory effects of the environment.

Family life preparation programmes have been applied to different age groups:

- a) very young children, some starting already at the age of 3, fostering empathy and social skills,
- b) teenage children, including appropriate components described in Table 14.1
- c) as an addition to prenatal programmes for mothers pregnant with the first child,
- d) parents with one or several young children.

For each of these the activities are different. The programme seeks to develop the future or present parents' skills in child education, promoting a caring, consistent, supportive and safe environment for the child, while strengthening the bonding between parents and children.

All parent education programs are thought to assist families primarily by increasing parental knowledge and reducing parental stress. Parent education programs achieve these results by training parents in behavioural management techniques, problem solving and personal coping skills (Garbarino, 1995).

### **Parenting style and its correlates**

In all family life preparation programmes analyzes of parenting style are important. How do parents behave while educating their children? Parental styles include the combination of two elements: parental responsiveness (warmth) and parental demandingness (behaviour control). Warmth and control can be either high or low; this creates four different combinations of parental styles: indulgent, authoritarian, authoritative, and uninvolved (Baumrind, 1973, 1991). Parenting style has been found to predict child well-being in the domains of social competence, academic performance, psychosocial development, and problem behaviour in the USA, a summary follows:

(1) Indulgent parents (permissive) are high in warmth and low in control. They are lenient, do not require mature behaviour, allow considerable self-regulation, and avoid confrontation. Children of permissive parents tend to be relatively immature. They have difficulty controlling their impulses, accepting responsibility for social actions, and acting independently. Adolescents from indulgent homes are more likely to be involved in problem behaviour and perform less well in school, but they have higher self-esteem, better social skills, and lower levels of depression. Baumrind (1973) observed that permissive parents compared to authoritative and authoritarian parents, were the most likely to report explosive



attacks of rage in which they inflicted more pain or injury upon the child than they had intended. Permissive parents apparently became violent when they felt that they could neither control the child's behaviour nor tolerate its effect upon themselves.

(2) Authoritarian parents are high in control, but low in warmth. They are obedience- and status-oriented, and expect their orders to be obeyed without explanation. These parents provide well-ordered and structured environments with clearly stated rules. Authoritarian parents can be intrusive in their use of power. Children of authoritarian parents lack social skills with their peers. This was especially true for boys. They often withdraw from playful interactions and rarely initiate contact with other children. In situations of moral conflict, such as telling the truth, they tended to look to teachers and other outside authorities to decide what was right. These children seemed to lack spontaneity and intellectual curiosity.

Adolescents from authoritarian families tend to perform moderately well in school and be uninvolved in problem behaviour, but they have poorer social skills, lower self-esteem, and higher levels of depression.

(3) Authoritative parents are both high in both warmth and control. They monitor and impart clear standards for their children's conduct. They are assertive, but not intrusive and restrictive. Their disciplinary methods are supportive, rather than punitive. They want their children to be assertive as well as socially responsible, and self-regulated as well as cooperative. Children of authoritative parents are able to do more for themselves, are more self-controlled, more willing to explore, and more content, compared to children of authoritarian or permissive parents. Girls in this group are especially independent and boys especially socially responsible. Probably as a result of having parents who explain things like rewards and punishments, children in this group understood and accepted social rules. They rate as more socially and instrumentally competent than those whose parents are nonauthoritative

(4) Uninvolved (neglecting) parents are low in both responsiveness and demandingness. Some are even rejecting. Children and adolescents whose parents are uninvolved perform most poorly in all domains.

Parenting styles differ in the extent of psychological control: some are intruding into the psychological and emotional development of the child through use of practices such as guilt induction, withdrawal of love, or shaming. Authoritarian parents expect their children to accept their judgments, values, and goals without questioning. In contrast, authoritative parents are more open to give and take with their children and make greater use of explanations.

Authoritative upbringing is associated with both instrumental and social competence and lower levels of problem behaviour in both boys and girls at all developmental stages. The benefits of authoritative parenting and the detrimental effects of uninvolved parenting are evident as early as in preschool and continue into early adulthood. Just as authoritative parents appear to be able to balance their conformity demands with their respect for their children's individuality, so children from authoritative homes appear to be able to balance the claims of external conformity and achievement demands with their need for individuation and autonomy (Darling, 1999; Thurber, 2003).

One would expect that the risk for child abuse would be highest among the authoritarian parents, and child neglect highest among the uninvolved. Evidently, emphasis on authoritative skills should be part of the family life preparation. It should be recognized that parental styles are also influenced by the dyadic relations between child and parents. Lagace-Seguin et

d'Entremont (2006) in a Canadian study of 68 children (mean age 51 months) and their mothers and teachers showed that less than optimal parenting (authoritarian parenting style and emotion dismissing emotional style) predicted maternal depression (see p.108) over and above child transgressions (aggressive, asocial, excluding, anxious and hyperactive behaviours). Mothers who engage in less than optimal parenting strategies experience augmented levels of depression. Overall, mothers' parenting styles appear to be more salient in determining their negative moods than their children's transgressions.

The American Academy of Child and Adolescent Psychiatry in 2004 and the International Association for Childhood Education (Paintal) have issued recommendations to parents to adopt the authoritative style. Quotes follow from the latter:

- Set acceptable limits for behaviour. These should be firm, consistent, appropriate to the age of the child, and acceptable. For example, although a 5-year-old child may be able to resist the urge to touch things, it is not reasonable to expect that a 2-year-old will be able to follow such a rule. Therefore, parents may need to protect breakable items at home, and to keep children away from fireplaces, chemicals used at home or in agriculture, electrical outlets, and other dangerous objects. The parents should calmly explain to the child why these limits are needed.
- Teach children how to solve conflicts, for instance about toys or duties at home. They should learn to listen actively, speak clearly, show trust and be trustworthy, accept differences, set group goals, negotiate and mediate conflicts. They need to learn how to share, and to be fair and helpful at home.
- Reason and talk with children in a simple way that is easily understood at the child's age. Such interactions will help the child to develop its intelligence.
- Be a role model of patience, kindness, empathy, and cooperation. Parents and teachers should be aware of the powerful influence their actions have on a child's or group's behaviour.
- When there is an opportunity, let the children practice rational problem solving. Encourage them to think about alternatives and the effect of each alternative.
- Encourage and praise children. A nonverbal response such as a smile or a nod, or a small word such as "good" or "right" is an incentive that builds children's confidence.
- Allow children to participate in setting rules – and identifying consequences for breaking them. It will make it easier for them to learn how to manage their own behaviour.
- As a parent or a teacher be consistent and predictable. Capriciousness scares children.
- Encourage children's autonomy – allow them to think for themselves, and to monitor their own behaviour let their conscience guide them.

The parental style system has to a limited extent been studied in some developing countries; many different varieties of such styles exist, and sometimes older children take over the parental role. Whiting and Whiting (1975) studied six countries; an example follows:

children in the Gusii tribe in Nyansongo, Kenya, exhibited more authoritarian and aggressive behaviour than did children in a small New England town. The authors guessed this was partly because older Gusii children were left at home to serve as substitute parents to the Gusii toddlers, while the mothers and fathers tended the fields. Perhaps Gusii children's cultural role as surrogate parents engendered more bossy behaviour. On the other hand, Gusii children also tended to be more nurturing and responsible than their U.S. peers.

In developing countries, the authoritarian style appears to be very common: children are expected to obey without any explanations. The young poor do not have much opportunity to

develop their full potential. It is difficult to overcome poverty and generate economic growth in the face of invariable discouragement and pervasive social control. Dairy et Menshar (2006) report on a study of parenting styles in Egypt carried out among 351 adolescents:

In rural communities, the authoritarian style was more predominant in the parenting of male adolescents, while the authoritative style was more predominant in the parenting of female adolescents. In urban communities, on the other hand, the authoritarian style was more predominant in the parenting of female adolescents. Female adolescents reported a higher frequency of psychological disorders. Mental health was associated with authoritative parenting, but not with authoritarian parenting. It seems that authoritarian parenting within an authoritarian culture is not as harmful as within a liberal culture.

In Box 14.1 appears a description of the goals of child education in China

**Box 14.1. The six liberations in China.**

The children should be set free in six respects. Their minds should be liberated, so that they r think in a lively and way and engage in innovative and creative thinking. Their eyes should be taught to read and observe, in order to widen their perspective. They should remove the plugs from their ears and listen to the songs of insects and birds in their natural surroundings, to fine music, and to moving tales. Their mouths should come unruffled, and they should be given more opportunity to express themselves through reciting, story-telling, participating in intellectual games, competitions and public speaking. Their hands should be unbound to enable them to do physical work and acquire skills in preparation for the future. Last but not least, their legs should be unshackled, to allow them to go into nature and society, to interact with people and make acquaintances. It is through these six liberations that they will acquire courage to engage in all sorts of social practice and build up their abilities.

**Needs of children and caregivers.**

As the risks for child violence are increased when parents lack knowledge of child development, have insufficient rearing skills and are under stress, a well designed child violence prevention programme should include components addressing the needs of children and caregivers. These needs are not the same in all cultures or countries; studies of needs – if not already known – should precede the initiation of preventive programmes. Programme content may have to be revised based on regular evaluations.

**Bonding and attachment**

The bonding and attachment process is very important. A person's capability for attachment is defined as the life-long ability to maintain emotional relations. Bonding is the process of forming an attachment. Such relations are a necessary part of human life to learn, to love, survive and procreate. Without emotional relationships the person will remain distant, isolated, self-absorbed, and without close friends. Loving and caring relations make life a pleasure. The bonding process involves the human brain. Neurobiological processes take place, which have a lasting effect during adult life. Most bonding takes place early and will lead to the capacity in childhood to recognize close family members and friends, develop love, sharing, empathy and reducing aggression. Attachments formed by bonding will determine much of that individual's feelings of security throughout life.

A study in Ireland (Marsa *et al.*, 2004), serves to illustrate the importance of bonding during early childhood. The authors compared four groups: 29 child offenders, 30 violent offenders, 30 non-violent offenders and 30 community controls. A secure adult attachment style was four

times less common in the child offender group than in any of the other three groups. 93% of the sex offenders had an insecure adult attachment style. The sex offenders group, when compared to the community group, reported significantly lower levels of maternal and parental care and significantly higher levels of maternal and pubertal overprotection during their childhood. Compared with all three comparison groups the sexual offenders reported significantly more emotional loneliness.

A programme which results in the strengthening of early bonding should contribute to improving the parents' attitudes to the child; it will create a home atmosphere of love and empathy; it will inhibit aggression, and reduce the risks for future child abuse and intentional neglect. It is recommended to be a part of the Child Defence and Support Programme.

### **Fostering empathy**

Programmes to foster empathy among very young children are based on the evidence that aggression and abusive parent behaviour is closely related to low levels of empathy. An example of a successful programme is Roots Of Empathy (ROE), initiated in 1981 in Canada by Mary Gordon. It is at present functioning in 1,141 classes with 28,525 children in Canada. So far, more than 67,000 children from kindergarten to grade 8 have taken part in the programme.

As poor parenting and aggression cut across all socio-economic levels of the community, empathy needs to be fostered in all children. The Roots Of Empathy program teaches children as young as three years of age about the necessary affective side of parenting – empathy, and emotional literacy. Each class "adopts" a baby who visits the classroom along with a parent and a trained instructor meeting the children for 27 sessions. Curricula are designed for four grade levels: Kindergarten, Grades 1-3, Grades 4-6, and Grades 7-8. During a family visit, the students observe, ask questions, discuss the baby's behaviour, the sounds she makes, and her temperament, gaining insights into the infant's growth and development and learning to respond appropriately to what the baby is trying to "tell them" through physical cues. It increases students' knowledge of human development, learning, and infant safety, better preparing them to be responsible and responsive parents. Each level of the curriculum deepens the students' understanding of the tremendous amount of time, patience, love, and energy required to parent a child properly. Instructors work with the students to recognize the baby's emotions, and as they become more comfortable identifying and labeling the feelings of others, they are able to explore and discuss their own feelings. It helps them recognize the feelings of their peers and understand how violent actions (like bullying) affect others. Children learn the importance of warm, responsive care which is a process of reading the baby's cues to respond to the baby's needs.

The results have been evaluated using pre-tests and post-tests in ROE classes and comparison non-ROE classes to determine:

- (a) Increased emotion knowledge, social understanding and pro-social behaviour with peers
- (b) Decreased aggression with peers and decreased proactive aggression (e.g. bullying)

The children showed significant improvements in all these categories...a decrease in average rating of proactive aggression, while the children in comparison classes showed an increase in average rating of proactive aggression. In ROE classrooms 88% of students who demonstrated some proactive aggression at pre-test showed a reduction at post-test (Gordon, 2005).

The earlier in life family life preparation programmes start the better will the results in cognitive functioning and socialization be. Thus, the introduction of community preschools is important, and the economic costs incurred have a very high return rate. (Heckman, 2006:).

For older children there are many models of school programmes which offer a combination of interactive child contacts, observing and reflecting on patterns of child-parent interaction in natural settings, fostering empathic awareness, role-playing, acquiring negotiating skills, learn teamwork, and so on (Table 14.1). Sexual education and sexual behaviour are subjects of importance in programmes for teenagers.

For adults programmes have been offering training in child care, social skills, flexible problem-solving and stress management. There are positive effects of activities that increase parents' ability of empathic awareness: to recognize the emotions experienced by their children.

### **The experience of some large- and small-scale programmes at preschool levels.**

The cognitive and social skills, and the motivation and stability of the adult population in the developing countries should in principle augment considerably with increased preschools:

early experiences have a uniquely powerful influence on the development of cognitive and social skills, as well as on brain architecture and neurochemistry; both skill development and brain maturation are hierarchical processes in which higher level functions depend on, and build on, lower level functions. The capacity for change in the foundations of human skill development and neural circuitry is highest earlier in life and decreases over time (Knudsen *et al.*, 2006).

Many preschool programmes for poor and disadvantaged populations exist. They are – in relation to the needs – rare in many developing countries. In all Francophone African countries, French Government assistance has been given to set up a model preschool in the capital. Similar projects have been funded by many non-governmental organizations.

There are some large-scale, long-term programmes, such as the 1965 Head Start Programme in USA (2006), and the 1975 Integrated Child Development Services (ICDS) programme in India (Gupta, 2001). These both continue, and have served millions of children. In the USA, there have been several small-scale research projects: among them the Early Training Programme for 92 children 1962-64, the Perry preschool programme 1962-67 for 128 children, the Abecedarian Programme 1972-77 for 111 children, the Chicago Parent Centre Programme operating in the public schools since 1967; it has an ongoing evaluation study for 1,539 children (Belfield, 2006).

The evaluation results of these vary. The large-scale programmes have been seriously criticized. The US Department of Health and Human Services in 2003 issued a report about Head Start describing:

the limited educational progress for the enrolled children and the problems resulting from a fragmented approach to early childhood programs and services...most children enter and leave Head Start with below-average skill and knowledge levels.

The Indian ICDS (Gupta, 2001):

promised to inexpensively increase the human capital of the nation and, thus, promote its rapid development. Investing in children, the logic went, was investing in the nation's future. Another, closely related payoff was its potential to bring down fertility rates. Better

health, education, and increased rates of survival for children were expected to have long-term effects in slowing down population growth. The progress of ICDS has, however been slow, there are budgetary constraints, and the bureaucracy manages these programmes top-down, the anganwadi workers who run the programme at community level, are bogged down with paperwork, and the absentee rate both of the staff and of the children are high.

The US small-scale research projects have reported positive social results. The Perry School reported (Schweinhart, 2005) that at age 27 those who had participated in the programme during childhood had half as many criminal arrests, higher earnings and three times as many owned their home. There were many behavioural impacts; the Perry, Abecedarian and Chicago programmes reported the following gains (compared with control groups): teenage parent 13% lower, single parent 14% lower, abortion 22% lower, drug user 21% lower, adults needing treatment for drug or alcohol abuse 12% lower (Belfield, 2006).

The conclusion is that large-scale programmes directly managed by Governments do not work as well as small-scale ones based in communities.

### **Cost-effectiveness studies of child violence prevention.**

Several theoretical cost-effectiveness estimates of child violence prevention programmes have been made. Two examples are mentioned below.

1. Colorado estimates (Gould and O'Brien, 1995). In 1995, the State University of Colorado made a cost-effectiveness study related to child maltreatment in that State. The authors concluded that maltreatment costs some US\$ 400 million per year; preventive costs were US\$ 24 million. Thus, if one were to prevent just 6% of child maltreatment, this would offset the costs of prevention.

2. Michigan estimates (Caldwell, 1992). The annual costs for child abuse in Michigan were estimated at US\$ 823 million in 1992; the costs of a prevention programme at US\$ 43 million annually. The calculated cost advantage to prevention was 19 to 1.

In practice, it may turn out to be much more difficult and costly than estimated to implement such programmes, and their success rates are not exactly known from practice. Furthermore, there might be political problems, which will be described below.

### **Do family life preparation programmes work?**

Holzer *et al.* (2006) evaluated twenty articles about parent education programmes in Australia, Canada and USA. They all fulfilled scientific criteria for evaluation quality. Three were meta-analyses. Eighteen articles reported successful results following participation in a parent education program.

The results of the evaluations included:

- (1) fewer incidents of child maltreatment (however, only a small number of studies directly measured this outcome);
- (2) a reduction in the prevalence of negative/unhelpful parenting attributions (for example, a parent attributing a child's behaviour to malicious intent);
- (3) a greater ability to use positive/productive discipline strategies rather than punitive strategies;
- (4) increased parental competence and self-efficacy; and greater parental knowledge/awareness of child development, risk factors for maltreatment, and child outcomes following abuse and neglect.

When reviewing reports of parenting programmes that have failed, it is clear that those that start at a very early age are more successful than those which start later on; those provided to parents who are habitual abusers of their children have very limited value.

## 2. COMMUNITY SUPERVISION – “CHILD WATCH”

Regarding home visitation, a ‘classical’ study by Olds *et al.* (1997, 2002) published research of 324 low-income, unmarried women (expecting their first child) with a follow-up over 15 years. (Olds *et al.* first reported on home visiting in 1986). A home visitation programme was set up with nurses (9 visits during pregnancy and 23 visits from the child’s birthday until the age of 2 years). Comparisons were made with a matched group of women who did not receive any home visits. In the intervention group the incidence rate of child abuse and neglect was reduced by almost 50%; the number of subsequent births went down from 1.6 to 1.3, with an increased spacing between the first and second child of 65 vs. 37 months. The use of welfare was reduced by one third. Behavioural impairments due to the use of alcohol and other drugs went down by two thirds and the number of police arrests by 75%.

The experience of community visiting services to targeted risk families is positive. Such services have mainly been provided to those with low social status (poverty, unemployment, spouse abuse, alcohol and drug problems, delinquency, or criminality). Child violence, however, also occurs among upper- and middle-class families, though underreported and undetected unless revealed by the victim later in life. For this reason, universal home visits are desirable. At this point of time, however, the tasks a) to c) below might not be acceptable to everyone. Other components of a much wider community-based ‘watch’ programme may not pose many problems, such as those mentioned under points d) to o).

A person in charge of a “child watch” programme could undertake these tasks:

- a) Regular home visits to provide family support and advice, and hands-on guidance
- b) Inform the parents how they can follow the various stages of child development, and the importance of the bonding process,
- c) Advise the family about how children are negatively influenced by parents’ alcohol and drug abuse, and by violence and neglect at home, inform them of alternatives to spanking and emotional abuse,
- d) Ensure that the children are benefiting from existing services: health, social, and education,
- e) Observe children and parents at health controls; ensure that sick children and sick parents are treated,
- f) Provide access to childcare day centres (if existing), and observe the children there, making sure that there is no symptoms of abuse or neglect among the children and that they are treated by the staff in a loving, nurturing and respectful way.
- g) Help the community to set up preschools (if not existing), and follow the teachers’ behaviour and the children’s mental, physical and academic progress in these schools
- h) Brief the teachers on appropriate child education methods, and on how children’s behaviour problems can be solved
- i) Regular visits, observations and teacher contacts at primary and secondary schools
- j) Organize and supervise community leisure activities
- k) Introduce family life preparation for all teen-agers, who have not been reached by early childhood training programmes. This includes discussions about sexual behaviour
- l) Teach children human rights and responsibilities
- m) Encourage teen-agers’ participation in family plans and activity decisions
- n) Assist needing families with direct economic help, provide food, clothes and improved housing,
- o) Identify abandoned and run-away children living of the street, engaged in prostitution and gangs members, and initiate community arrangements for their living, daily needs and education.

It has been shown that programme quality outcomes increase when (Olds, 2002)<sup>30</sup>

- services were delivered by more highly trained and qualified home visitors;
- home visitors were experienced in dealing with the complex needs of many 'at risk' clients;
- the programmes had long enough duration and visiting frequency to impact on risk factors that contribute to child violence;
- programmes were matched to the needs of the client group; and
- programmes focused on improving both maternal and child outcomes.

In home-visiting activities carried out in developing countries, existing groups of personnel can be used: teachers, health workers, social workers, and so on. Another option is to recruit purpose-motivated staff locally, including community volunteers. (Barnet et al., 2002) All staff will need a training programme. Evidently, depending on the local communities' and their decision-makers' attitudes, programmes of "child watch" will be designed to reflect their cultural values and build on analyses of the root causes of ongoing child violence.

#### **Do home visiting programmes work?**

In February 2002, the Centers for Disease Control and Prevention Task Force on Community Preventive Services concluded, "there is strong evidence to recommend home visitation to reduce child maltreatment." The group based this recommendation on a review of 25 studies that found an overall 39 % reduction of child maltreatment in high-risk families.

Higgins *et al.* (2006) have reviewed twelve articles on home visiting, all of these fulfilled scientific requirements on evaluation. These revealed:

- (1) there were fewer incidents of child maltreatment (when this outcome was directly measured);
- (2) enhanced parental knowledge and parenting skills;
- (3) improvements in children's cognitive and social development; and
- 4) increased linking of parents to health care and other service.

Barnet *et al.* (2002) have in a randomized trial used trained community volunteers to provide parenting training, and noted a significant better parent behaviour.

It is concluded that targeted home visiting programmes are effective. Still, they have their political aspects.

Plummer (2001) reviewed 87 home visitation programmes for the prevention of child abuse. He pointed out that, in real life, setting up and maintaining such programmes is associated with many difficulties: lack of adequate and secure funding, community and leadership level of denial, competing agendas, and community indifference. In principle, prevention of childhood violence should be much less costly than post-abuse and neglect interventions; it would also decrease the high level of human suffering. Many social engineering projects have however, had economic difficulties. High initial costs and "savings" unlikely to appear until much later easily discourage the funding politicians, who would like to see results – not in ten to twenty years – but in good time before the next election.

The conclusion is that programmes with direct government funding often have problems, because politicians want rapid changes and might withdraw funds if results are not quickly visible. Programmes lacking success (Head Start and ICDS) have been operated top-down with insufficient community participation. The conclusion is that child violence prevention programmes need to be assigned to the civil society and build on community mobilization to reduce the problems described by Plummer.



### **3. PUBLICITY ABOUT THE CONSEQUENCES OF CHILDHOOD VIOLENCE**

Parents and the public are often ignorant about the medico-social health consequences of incompetent parenting. These were described in Chapters 8 and 9. What may be most unknown are the scientific findings that violence leads to specific changes in the brain's circulation, biochemistry, and hormonal production. These in turn cause cell damage or destruction in parts of the brain. These cells cannot be repaired. This grim result suggests that much more effort must be made to prevent childhood abuse and neglect which now does irreversible harm to millions of young victims. Society reaps what it sows in the way it nurtures its children.

The U.S. Parents and Teachers Against Violence in Education, in 2003, and the American Academy of Paediatrics in 2005 issued very strongly formulated recommendation to discourage parents to use physical punishment for children's education. In 2001, a large number of NGOs and private individuals launched the Global Initiative to end all corporal punishment of children. It is supported by several UN agencies, such as UNICEF, UNESCO and the High Commission of Human Rights

United States Parents and Teachers Against Violence in Education, (2003) state that:

parents who fail to manage their children calmly, gently and patiently, but instead rely on physical punishment; tend to produce aggressive, assaultive children. The more severe and the earlier the mistreatment, the worse is the outcome. The lowest incidence of antisocial behaviour is always associated with children who are reared from infancy in attentive, supportive, non-violent, non-spanking families

### **4. INTRODUCTION OF LAWS THAT FORBID ABUSE OF CHILDREN**

Sexual abuse is forbidden in all countries. The legal age limit for consensual sex varies; it is mostly 16-18 years. Consensual sex under the legal age is regarded as statutory rape, but in many countries, legal authorities – if reported – may choose not to prosecute those involved, especially if both partners are underage. In many developing countries, children as young as twelve marry, among them the rules about sexual relations differ.

A growing number of countries, mainly in Europe, have introduced laws that forbid physical abuse at home and in schools<sup>35</sup>. Breaking the law will lead to fines or imprisonment for the adult. So far, it seems that cases are rarely brought to court. There are no regrets from the parents of those countries which have introduced this type of legislation. Some accused teachers have claimed that their physical aggression was self-defence, and it is clear that the violence generated by schoolchildren, especially teenagers, has increased in many countries. Many schools have introduced security guards, control of weapons, such as guns and knives, which some children bring with them to school. It is, however, important that the widespread teacher abuse be eliminated. To formulate rules about emotional abuse will require clear definitions of what is forbidden.

A study from Sweden confirms that legislation in combination with public education is highly effective. Swedish law in 1979 forbids all physical punishment and any other humiliating treatment. In 1980, 51% of all parents used such punishment during the previous year, in 2000, only 8% did (Save the Children, Sweden, 2005).

The scarcity of legal consequences for the perpetrators depends (at least in the developing countries) on the failure to establish a proper, fully decentralized judicial system and keep it free from personal influence and corruption. In many countries, there is no easily available, affordable and accessible local "judicial delivery system" that ensures that justice works for all with fairness and independence. Many developing countries still have the remnants of local

mediation systems – for example, those traditionally maintained by local African Chiefs, Arab Sheiks and Indian Maharajas, who used to preside over the community justice system. As complexities arrived with urbanization, industrialization, increased mobility of people and commercialization, the traditional system has lost much of its importance. Public judicial services are needed to fill this vacuum with a component of security and support to defend the abused children and punish the perpetrators.

### **COMMUNITY-BASED ACTION**

The reasons for proposing a community-based approach for the child violence prevention programme – small-scale projects managed by local groups of concerned parents – are:

- (1) Small-size programmes in comparison with large Government-managed ones are closer to the people and their needs; parents can have a direct influence over what their children receive and will have ownership to the programme.
- (2) The existence of a core group of non-abusing parents in the community is important. Knowledge about them will spread quickly, especially through the children. Peer influence among them will help to make children reject abusive treatment.
- (3) No country will ever have enough professionals to deal with the large-scale child violence that exists in all societies. They must be complemented with community volunteers, who should be trained for their work.
- (4) Local programmes are less bureaucratized and have lower overhead costs (more cost-effective)
- (5) The scientific experience favours small-scale projects
- (6) The risks for funding constraints are lower; the programme should be able to avoid seeing promises outrun delivery
- (7) Supporting the civil society and mobilize communities is a priority of today's Governments that cannot afford to do everything. Most Governments seek to reduce the number of persons employed by them and outsource functions to extra-governmental organizations or enterprises.

#### **Experience of community mobilization**

The UN Research Institute for Social Development (1994) defines community mobilization as the act of making something moving: people are assembled, organized, and made to perform certain functions. It focuses on the ability of the members of the movement to acquire resources and mobilize people in order to advance their goals (Kendall, 2005). It emerged in the 1970s and is viewed as rational: social institutions and social actors taking political action (Buechler, 1999).

The reasons to avoid too much top-down bureaucratic interference are described in several anthropological studies by Das, Kleinman and co-workers (2001). Such interference can be devastating, especially when several Government agencies are involved:

In small communities inhabiting increasingly uncertain worlds...the effects of bureaucratic responses to human problems...can and often do deepen and make more intractable the problems they seek to ameliorate.

There are many community mobilization initiatives functioning well, enabling local populations to escape from extreme poverty, examples seen by the author include: Argentina, Peru, Mexico, Guatemala, St Lucia, Benin, Botswana, Mauritania, Chad, Côte d'Ivoire, Zimbabwe, India, Indonesia, the Republic of Korea, Thailand, Iran, Palestine, Nepal and the Philippines.

India, in 1992, took a great step forward to encourage community initiatives and to mobilize local resources through a transfer of the authority to plan for, raise and spend locally collected taxes, organize local elections (with quotas for women); the 1992 Constitutional Amendment encourages:

- more power in the hands of the rural people to determine their own destiny;
- enhancing the capabilities of the rural people to involve themselves in the planning from below;
- decentralizing the execution of all development activities with effective participation of peoples; and
- re-orienting development administration based on the philosophy of popular participation.



*This African village has a community mobilization programme for health. The first step is to set up a local health committee, consisting of community members. One or several health workers are chosen and receive training. Then they visit the homes to give advice on child and mother care, breast-feeding, nutrition, immunization, and infectious diseases (such as diarrhoea, AIDS, tuberculosis, malaria). A health centre is set up with simple equipment and with essential medicines for treatment of common diseases. The health committee is in charge of the local management and meets with local officials to discuss what can be done to meet further the specific health needs of the community for prevention of diseases and curative care. © World Health Organization*

There are many community mobilization initiatives functioning well, enabling local populations to escape from extreme poverty, examples seen by the author include: Argentina, Peru, Mexico, Guatemala, St Lucia, Benin, Botswana, Mauritania, Chad, Côte d'Ivoire, Zimbabwe, India, Indonesia, the Republic of Korea, Thailand, Iran, Palestine, Nepal and the Philippines.

The author has a 25-year experience about local management of the WHO's community-based rehabilitation programmes for persons with disabilities, which now exist in about 100 countries. A detailed description is published elsewhere (Helander, 1999). There are many culture-dependent challenges for community mobilization programmes. The roles and functions of the various stake-holders have to be defined: local administrators versus community leaders; the membership of the community committee and the roles of its leaders

and institutions,; managerial responsibility and methods of decision-making; and inputs of resources, and so on. Details of a model for the preparation of a CDS programme appear in Annex 1.

The action for the prevention of violence against children should preferably be taken by a community-based organization. Support by the Government and local authorities should be sought. Community members should discover the fact that it is possible for them to transform the future of their children. To use all available, appropriate means to stop violence, abuse, maltreatment and neglect affecting children should be seen as a joint responsibility, because such acts have long-term consequences for us all.

Bronfenbrenner (1990) sums up:

The effective functioning of child-rearing processes in the family and other child settings requires public policies and practices that provide place, time, stability, status, recognition, belief systems, customs, and actions in support of child-rearing activities not only on the part of parents, caregivers, teachers, and other professional personnel, but also relatives, friends, neighbours, co-workers, communities, and the major economic, social, and political institutions of the entire society.

# 15 Conclusions

Violence is a complex and not yet fully understood cultural phenomenon. It has ecological determinants as well as genetic roots. There is an 'archaeology' of human evil behaviour, which travels as a dominating theme through our past, leaving us with many disturbing questions about human nature. The better known historic evidence concerns past rulers and tyrants who were using methods of intimidation, torture and execution, or threats of eternal condemnation. After their departure, they left traditions of Machiavellian prescriptions for their successors. We are now experiencing the era of terrorism: we fear threats – real or imagined – on a daily basis. We are also, finally, becoming aware of the less recognized evidence: the avalanche of domestic and community violence.

Violence is most often an expression of force in a situation of inequality: this is why children and other "defenceless" people so frequently become victims. This is also, why so many perpetrators escape justice. Violence, however, is also exhibited by frustrated and powerless people who are desperate for change; such violence is frequently misdirected towards innocent victims. Violence towards children is extremely common in all cultures, societies, economic, social and religious strata. The damage inflicted on individuals and on community life is massive and increasing. Still, even in our times, it is insufficiently recognized as the most basic cause of many of our health and social problems. This short book can only serve to describe some of its contexts and why is "allowed" to occur.

The failure to prevent childhood violence is shared by all human ecology systems. The victims' trauma is aggravated by repression of facts, embarrassment, shame, secrecy, and taboos. These are compounded by the victims' feelings that there is nobody who will help, and that not even the judicial system can be trusted to bring the perpetrators to justice. It is further enhanced by widespread public indifference, which appears to be related to the ignorance not just of the extent of the problem but also of its serious consequences. Among these is violence against children, which causes organic (and at present irreparable) stress-related damage to the emotional and cognitive functions of the brain with impairments of its biochemistry, hormonal production, circulation, and metabolism, all leading to brain cell malfunction or destruction. Among the socio-medical sequels are the high population risks attributed to adverse childhood experiences: for chronic depression 41%, suicide attempts 58%, alcoholism 65%, illicit drug use 50%, injected drug use 68%, sexual assault 62%, domestic violence 52%, and a doubling of the criminality rate.

Yet, there should be hope.

Micro- and mesosystems: much can be changed: parents should not remain the major problem but, through better preparation, be part of the solution. School education should not be limited to cognitive training, but also be a tool for learning and practising social and emotional skills, and empathy. Children should better know their rights and responsibilities.

Exo- and macrosystems: Our communities and nations are ill prepared for assisting the victims of childhood violence; perpetrators mostly escape justice. Primary violence prevention barely exists and is mainly concentrated on small groups of socially and economically marginal people. Social, technical, and economic support to the families does exist, but far short of actual needs. Major efforts to deal with these short-comings will be essential.

The global system has great potentials, but has largely failed, firstly because most nations have not accepted the international law model created by the United Nations; secondly because international organizations have not succeeded in their ambitions to fulfil their priority development programmes. These have never included any action for the prevention of violence or assisting the victims.

To solve these problems a massive public education campaign is required in order to activate resources for violence prevention. We must be honest about the large-scale violence against children; we must open our media to the realities that are now hidden: people need to see what occurs in the life of the defenceless; they need to understand the pain of the victims.

World leaders have a choice, either countries, communities, and families allow the continuation of a destructive and abusive child-rearing system which jeopardizes each nation's development and culture; or they create better conditions for their children to be raised in a positive social environment that builds progress, peace, humanity, productivity, and creativity. The choice is between the alternative of establishing and maintaining primary child violence prevention, or the alternative of building more prisons for the perpetrators and more hospitals for the victims. Each violent act that is allowed to occur contributes to and authorizes the existing problem. Primary prevention is possible; future generations can largely be saved from childhood violence, but the change will not occur unless we generate a complete cultural change in the way most of our children are brought up. Because of the large extent of childhood violence, such change is unlikely to occur unless *communities* are mobilized. As explained in the previous chapter, it is a community responsibility to act using all available and appropriate means to stop violence, abuse, maltreatment, and neglect of children because such acts have long-term consequences for us all. Most governments' present attempts to deal with social pathologies by providing more health care and more police avoids solving the root problems.

Increased efforts are needed to develop further our scientific tools to improve the basic knowledge about the many causes and consequences of childhood violence. This should allow us to identify more effective methods to lessen the suffering of the victims.

Peace on earth is only possible if we can create a non-violent culture, the starting point of which is peace in our homes and communities – and in our own minds.

## NOTES

1. List of 151 countries from which information has been obtained; (v = 91 working visits; c = 90 country planning and management courses held; w = 130 written (published or documented) information.

Africa: Algeria (c.), Angola (vcw), Benin (vcw), Botswana (vcw), Cameroon (w), Cape Verde (c), Chad (vcw), Congo (v), Congo D.R. (c), Cote d'Ivoire (vcw), Egypt (vcw), Eritrea (c), Ethiopia (vcw), Gabon (vw), Gambia (vcw), Ghana (vcw), Kenya (vcw), Lesotho (c,w), Liberia (w), Libya (w), Madagascar (c), Malawi (cw), Mauritania (vcw), Mauritius (vw), Mozambique (cw), Morocco (vw), Namibia (cw), Nigeria (vcw), Rwanda (c), Senegal (vcw), Sierra Leone (w), Somalia (vcw), South Africa (vcw), Sudan (w), Swaziland (cw), Tanzania (vcw), Togo (vw), Uganda (w), Zambia (vcw), Zimbabwe (vcw). (40)

America: Antigua (w), Argentina (v), Aruba (c), Bahamas (vc), Barbados (vcw), Belize (w), Bolivia (vw), Brazil (vcw), Canada (vcw), Chile (vw), Colombia (cw), Costa Rica (w), Ecuador (vw), El Salvador (w), Guatemala (vcw), Guyana (cw), Honduras (vc), Jamaica (w), Mexico (vcw), Nicaragua (w), Panama (vc), Peru (vw), Puerto Rico (w), St Lucia (vcw), Trinidad and Tobago (vw), United States (vcw), Uruguay (v), Venezuela (vw) (28)

Asia: Afghanistan (cw), Bahrain (vw), Bangladesh (vw), Bhutan (c); Cambodia (cw), China (vcw), Hong Kong (vcw), India (vcw), Indonesia (vcw), Iran (vcw), Iraq (vcw), Israel (vw), Japan (vcw), Jordan (vcw), Korea (Republic of) (vcw), Korea PDR (w), Kuwait (cw), Laos (c), Lebanon (vcw), Malaysia (vcw), Mongolia (c), Myanmar (vcw), Nepal (vcw), Oman (vw), Pakistan (vw), Palestine (vcw), Papua New Guinea (cw), Philippines (vcw), Saudi Arabia (vw), Singapore (vw), Sri Lanka (vcw), Syria (v), Taiwan (vw), Thailand (vcw), United Arab Emirates (vcw), Vietnam (vcw), Yemen (cw) (37)

Europe: Albania (w), Austria (vw), Belarus (cw), Belgium (vcw), Bosnia and Herzegovina (w), Bulgaria (cw), Croatia (w), Cyprus (vcw), Czech Republic (vw), Denmark (vw), Estonia (c), Finland (vcw), France (vcw), Germany (vcw), Greece (w), Hungary (v, w), Iceland (w), Ireland (w), Italy (vcw), Kazakhstan (w), Kyrgyzstan (w), Latvia (vcw), Lithuania (c), Macedonia (w), Moldova (cw), Montenegro (v), Netherlands (vw), Norway (vcw), Poland (vw), Portugal (vcw), Romania (vcw), Russian Federation (vcw), Serbia (vw), Slovenia (w), Spain (vw), Sweden (vcw), Switzerland (vw), Tajikistan (w), Turkey (w), Ukraine (w), United Kingdom (vcw) (41).

Oceania: Australia (cw), Fiji (cw), New Zealand (w), Palau (w), Pitcairn (w) (5)

2. Sensitivity to initial meteorological conditions is known as the "butterfly effect", based on a 1972 paper by Edward Lorenz at the American Association for the Advancement of Science in Washington, D.C. entitled *Predictability: Does the Flap of a Butterfly's Wings in Brazil set off a Tornado in Texas?* The flapping wing represents a small change in the initial condition of the system, which causes a chain of events leading to large-scale phenomena. Had the butterfly not flapped its wings, there would have been no tornado. Cutting a rose (meaning abusing a child) is seen here as a similar initial event causing large-scale human consequences, a 'tornado' in the lives of the victims.

3. Miller, Alice in several books describes the childhood background of some tyrants. (*The Childhood Trauma, lecture on October 22, 1998*). Hitler from the age of 3 until 13 (when the father died) was severely beaten and humiliated almost every day by his father who used a rhinoceros whip. Once he was thrown out of the house and stood for four hours outside in the snow. Hitler himself has described the conditions at home: "a battle is carried on between the parents themselves, and almost every day, in forms which in vulgarity often leave nothing to be desired, then, if only very gradually, the results of such visual instruction must ultimately become apparent in the children. The character they will inevitably assume if the quarrel takes the form of brutal attacks by the father against the mother, of drunken beatings, is hard for anyone who does not know this milieu to imagine. At the age of six the pitiable little boy suspects the existence of things which can fill even an adult with nothing but horror." Hitler's own father had suffered similar abuse ('poisonous pedagogy') at home (Mein Kampf, 1925). Hitler killed some 7-8 million defenceless – many children – in the Holocaust. World War II resulted in the deaths of over 60 million people, the deadliest conflict in human history. – Mao Zedong grew up in similar circumstances; his authoritarian father was brutal and tyrannized the family. He was often beaten by him, and humiliated in front of others. Mao at rare instances admitted the full extent of the rage he felt for his own father, a very severe teacher who had tried through beatings to "make a man"

out of his son. He said that he would like to torment others as he had been tormented himself. For decades, he held power and was responsible for 70 million deaths at peacetime, more than any other 20<sup>th</sup> century leader. – Stalin grew up in Georgia; his father attempted to drown his frustration with liquor and whipped his son almost every day. His mother displayed psychotic traits, was completely incapable of defending her son and was usually away from home either praying in church or running the priest's household. Stalin caused millions to suffer and die because even at the height of his power his actions were determined by unconscious, infantile fear of powerlessness. – These three tyrants came from middle-class families. Miller's conclusions are, "The same might be true of many other tyrants. They often drew on ideologies to disguise the truth and their own paranoia. And the masses chimed in enthusiastically because they were unaware of the real motives, including those in their own biographies. The infantile revenge fantasies of individuals would be of no account if society did not regularly show such naive eagerness in helping to make them come true. Mad tyrants would not have any power if society understood that it is their damaged brains which are constantly driving them to avoid dangers that no longer exist".

4. This Pakistani law was changed in 2006 to allow for DNA testing and somewhat less strict requirements to prove rape.

5. The author in 1986 interviewed some 80 Somali women who were sexually mutilated.

6. This information is based on research of data from European and North American orphanages, for which admission and annual mortality rates are published.

7. The letters by Sigmund Freud to his friend and confessor Wilhelm Fliess (1887-1904, published in 1985) have been surrounded by controversy. Marie Bonaparte, a well known French psychoanalyst with Freud's daughter Anna in 1954 published *The Origins of Psycho-Analysis: Letters to Wilhelm Fliess, Drafts and Notes, 1887-1902, by Sigmund Freud*. Freud had wanted these letters destroyed. Anna Freud removed certain letters from her father which might cast doubt on his veracity. Not until 1985 (Anna Freud died in 1982) were these letters published unedited by Jeffrey M. Masson: *The Complete Letters of Sigmund Freud to Wilhelm Fliess 1887-1904*, Harvard University Press. Freud's suppression of the seduction theory was by some seen as lack of intellectual integrity; Masson explains it as the result of his attackers' viciousness and the surrounding culture of rabid anti-Semitism.

8. Department of Health and Welfare, USA at that time had official standards for institutions: Guidelines for Facilities for the Mentally Retarded, (1972, 15 pages); and detailed rules by the Joint Commission for the Accreditation of Hospitals: Standards for Residential Facilities for the Mentally Retarded (1972, 159 pages) The professionals in charge of inspections and accreditation at Willowbrook knew that the institution was not following these standards, yet they continued year after year to close their eyes to the inhumane malpractices.

9. Report by Graça Machel, Expert of the Secretary-General of the United Nations, [www.unicef.org/graca](http://www.unicef.org/graca). The quote from Sierra Leone is from *The Economist* on 9 August 2003, the one from Uganda is from *The Economist* May 7, 2005. – A 2006 statement about widows by Mrs. Machel reads, "a common feature of widowhood is the violence perpetrated against them at the hands of near relatives and condoned by the inaction of governments. Many widows are hounded from their homes and denied access to essential resources such as shelter and land to grow food. They are also subject to degrading and life-threatening traditional practices. They have no status and often they are figures of shame and ridicule. This neglect of millions of widows has irrevocable long term implications for the future well-being and sustainable development of all our societies".

10. Lalor, K. (2004), Sexual abuse in Tanzania and Kenya. *Child Abuse Negl*, 28, p. 833. The author recounts a survey, according to which most Tanzanian Members of Parliament believe that witchdoctors "advise people looking for material wealth to have sexual intercourse with virgin girls or their sisters, their mothers and the like."

11. Interview with the Nepalese Ambassador to India. Hindu Online, "Victims of the Dark", 29 September 1996 describes the conditions among the prostitutes in Mumbai. In a raid carried out of 140 brothels, only 65 girls were above 18 and 238 were from Nepal.

12. The *Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption* was completed in 1993 under the auspices of the Hague Conference on Private International Law, an international organization begun in 1893.

13. Author's observations.



14. Helander, E. (2005). In the small island of Pitcairn, with only 47 inhabitants, there has for many years been widespread child sexual abuse. Six men, including the mayor, were in 2004 convicted and given long prison terms

15. Helander, E. (1965), Health status of survivors from the Nazi concentration camps, 20 years afterwards. *Unpublished report*. During the early months of 1945, Count Folke Bernadotte, President of the Swedish Red Cross and his staff evacuated about 30,000 mostly Jewish concentration camp victims from Nazi Germany to Sweden; many remained there. Some of them were children. In 1965, at the request of the Swedish Social Security Department, I examined a group of about 80 of them. They all had very pronounced symptoms of PTSD (this diagnosis was not established at that time) and comorbid disorders. Although they had undergone psychiatric and rehabilitation treatment during 20 years, they all had been therapy-resistant. They were recommended for disability pensions.

16. Chilean Government press release: 27 June 2006. The President announced that next year, "treatment and rehabilitation of adolescents who abuse and are addicted to alcohol and drugs" would be included under the AUGE plan, covering a variety of treatment programs in high-quality public and private facilities throughout the country. She also expressed concern about alcohol consumption, prevalent among 32% of adolescents and 60% of young people.

17. The following 36 States Parties have not ratified the ICCPR: Andorra, Antigua and Barbuda, Bahamas, Bahrain, Bhutan, Botswana, Brunei Darussalam, Comoros, Cook Islands, Cuba, Fiji, Holy See, Kiribati, Malaysia, Maldives, Marshall Islands, Micronesia, Mozambique, Myanmar, Niue, Oman, Pakistan, Palau, Papua New Guinea, Qatar, Saint Kitts and Nevis, Saint Lucia, Samoa, Saudi Arabia, Singapore, Solomon Islands, Tonga, Tuvalu, United Arab Emirates, Vanuatu.

18. The following 34 States Parties have not ratified the ICESCR: Antigua and Barbuda, Bahamas, Bahrain, Bhutan, Brunei Darussalam, Comoros, Cook Islands, Cuba, Fiji, Holy See, Kazakhstan, Kiribati, Malaysia, Maldives, Marshall Islands, Micronesia, Mozambique, Myanmar, Nauru, Niue, Oman, Pakistan, Palau, Papua New Guinea, Qatar, Saint Kitts and Nevis, Saint Lucia, Samoa, Saudi Arabia, Singapore, Tonga, Tuvalu, United Arab Emirates, Vanuatu.

19. A complete list of UN treaties is available on Internet. A Protocol is an additional legal instrument that complements and adds to a treaty. It is not automatically binding to those Member States that have ratified the treaty; it has to be independently ratified.

20. The total non-UN treaties are several thousand, see Internet. For the Convention on Adoptions see note 12.

21. The following States Parties have: A. Not ratified the CAT; 44 States: Angola, Bahamas, Barbados, Bhutan, Brunei Darussalam, Central African Republic, Cook Islands, Democratic People's Republic of Korea, Dominica, Eritrea, Fiji, Grenada, Haiti, Islamic Republic of Iran, Iraq, Jamaica, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia, Myanmar, Niue, Oman, Pakistan, Palau, Papua New Guinea, Rwanda, Saint Kitts and Nevis, Saint Lucia, Samoa, Singapore, Solomon Islands, Suriname, Thailand, Tonga, Trinidad and Tobago, Tuvalu, United Arab Emirates, United Republic of Tanzania, Tajikistan, Vanuatu, Viet Nam, Zimbabwe.

B. Signed but not ratified the CAT; 12 States: Andorra, Comoros, Dominican Republic, Gambia, Guinea Bissau, India, Madagascar, Nauru, San Marino, Sao Tomé and Príncipe, Sudan.

C. Ratified CAT, but have not made the Declaration referred to in Article 22.1: 80 States : Afghanistan, Albania, Antigua and Barbuda, Armenia, Azerbaijan, Bahrain, Bangladesh, Belarus, Belize, Benin, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Chad, China, Colombia, Congo, Croatia, Côte d'Ivoire, Czech Republic, Cuba, Democratic Republic of the Congo, Djibouti, Egypt, Equatorial Guinea, El Salvador, Equatorial Guinea, Estonia, Ethiopia, Gabon, Georgia, Guatemala, Guinea, Guyana, Holy See, Honduras, Indonesia, Israel, Japan, Jordan, Kazakhstan, Kenya, Kuwait, Kyrgyzstan, Latvia, Lebanon, Lesotho, Liberia, Libyan Arab Jamahiriya, Liechtenstein, Lithuania, Madagascar, Malawi, Maldives, Mali, Malta, Mauritania, Mauritius, Monaco, Mongolia, Morocco, Mozambique, Namibia, Nepal, Nicaragua, Niger, Nigeria, Panama, Philippines, Qatar, Republic of Korea, Republic of Moldova, Romania, Saint Vincent and the Grenadines, Saudi Arabia, Serbia and Montenegro, Seychelles, Sierra Leone, Slovakia, Slovenia, Somalia, Sri Lanka, Swaziland, Syrian Arab Republic, Tajikistan, The Former Yugoslav Republic of Macedonia, Timor Leste, Turkmenistan, Uganda, United Kingdom of Great Britain and Northern Ireland, United States of America, Uzbekistan, Yemen, Zambia.

22. In 2006, the U.N., General Assembly elected 47 members to the Council. Six of these members came from countries which had not ratified the ICCPR and the ICESCR, 3 had not ratified the CAT and 17 had not made the CAT Declaration in Article 22. *The Economist* writes in a leading article (14 January 2006): "If the agreement /on reform of the Human Rights Commission/ is stymied, the next-best solution will be to wind the existing commission up altogether. Human rights matter too much for the UN to continue to shunt the subject off to a cynical talking shop that has become the home to the worst violators. That just blackens the overall reputation of the UN."

23. These declarations have been universally adopted:

- (a) World Medical Association: Declaration of Tokyo, October 1975;
- (b) The Hawaii Declaration by the World Psychiatric Association adopted 1978;
- (c) The Second Hawaii Declaration, adopted at the General Assembly of the WPA in 1983;
- (d) United Nations Principles for the Protection of Persons with Mental Illness, adopted by the UN General Assembly in 1991, Resolution 46/119;
- (e) The Madrid Declaration by WPA in 1996;
- (f) World Health Organization: Guidelines for the protection of human rights of persons with mental disorders, 1996.

24. The texts in Chapter 12 and 13 are built on information from articles, books and newsletters published by the World Bank, the United Nations Development Programme, The International Labour Organisation, UNESCO, UNICEF, World Food Programme and the World Health Organization during the period 1995-2007. They are available on Internet.

25. Many development programmes are sub-optimally designed and take a short-term perspective; large parts of the funds are either underutilized or squandered by capital or equipment destruction or by mismanagement. The evaluation procedures are open to critical questioning. Banerjee et He (2003) well-known economists at the Massachusetts Institute of Technology claim, "donor agencies are not particularly skilled of evaluating and comparing proposals for funding, neither do they make proper use of existing scientific evidence. The World Bank is not particularly effective either in dealing with countries that default or in promoting countries, projects and ideas that are likely to do well. We argue that this is probably related to the fact that the Bank does not make adequate use of scientific evidence in its decision-making and suggest ways to improve matters. Projects funded generously by the Bank do worse than those with smaller funding do. Policy makers may be forgiven if they resist the Bank's views on best practice."

Pritchett (2003), a long-term World Bank employee and now Professor of the Practice of Economic Development at the Kennedy School of Government at Harvard University, writes in a 2001 article: "Nearly all World Bank discussions of policies and project design had the character of 'ignorant armies clashing by the night'— there was heated debate amongst advocates of various activities but rarely any firm evidence presented and considered about the likely impact of the proposed actions. There was never any definitive evidence that would inform decisions of funding one broad set of activities versus another."

26. Pritchett in: "It Pays to be Ignorant: A Simply Political Economy of Rigorous Program Evaluation". *Journal of Policy Reform*, 5(4), 2002 "examines the systematic incentives to avoid rigorous evaluation. A model has been built in which advocates seek to mobilize public resources and choose between persuasion without rigorous evaluation and using rigorous evaluation. In many scenarios, advocates will choose not to perform a rigorous evaluation because it will be used against them politically.

Korten et Siv (1989) state "The introduction of a new data source /related to an ongoing development project/is seldom sufficient in itself to improve decision-making in a development organization. It is the sad reality that most development agencies do not have the capacity to use nor an interest in using field data – even if they have it. Such data may actually complicate the design and construction process because...the data challenge the viability of standardized solutions and highlight the need for actions that may delay project completion and require changes in the budget. Responding to such data may result in reprimands from superiors who are not evaluated in terms of the performance of the resulting /project/...but rather in terms of budget expenditures, schedules and facilities constructed...we may need a new more committed generation of doers rather than of file-keepers and speechwriters.

27. The overhead costs incurred by the donors include fund-raising, administration and personnel at headquarters and at country and field offices, preparations, meetings, planning in detail, travels,

information and publications, evaluation, accounting and auditing. Some amounts are passed on to multi-lateral agencies and their overhead costs are high. Other grants are transferred to non-governmental organizations; again, it is common to see expensive administrations. Giving away money directly to the poor would not incur much administrative costs, but to provide services, assist in setting up health and education programmes, roads, ports, and so on lead to high overheads. These costs may be estimated at about 50% of the gross donor amounts.

28. The recipient Governments have to cover their administrative costs; and are required to prepare complicated 'logical framework plans'; prove that they have paid attention to the 'conditionalities'; dispense and co-ordinate the use of the funds; account for these; and audit the funds. There are costs for travel and attending meetings in the donor's home country. Some grants are used for the purchase of industrial and other products from the donor country, although the same products may be purchased at lower prices from other sources. Many ministerial cars, computers and other office equipment are bought using the foreign donations. In addition, there is the corruption factor. It is easy to see why the proportion of the development aid sent to the "recipient country that will reach the 'people' is going to be small. It seems reasonable to assume that the bilateral and multilateral aid or loans theoretically available directly "benefiting the poor" would be equivalent to about US\$ 4-6/person/year, i.e. the equivalent of about two day's average consumption of a poor person.

29. The Swedish International Development Agency (Sida), in August 2004, asked the Government of Mozambique to return US\$ 500,000 granted to the Ministry of Education. The funds had been inappropriately used for – among other things – sending the Minister's relatives abroad on 'fellowships,' paying dentistry (while they were abroad), and expensive restaurants. A Portuguese NGO intending to start a programme in the same country was requested by the Minister for an 'envelope' of US\$ 25,000 in cash to get permission to start. It is interesting to see that Mozambique was still in January 2005 included by U.N. (MDG publication *Investing in Development*, p. 17) in the list of "well governed countries." Its WB Governance dimension for corruption was, in 2004, 24.6. In this publication, the WB states that a distinct cause of poor governance is "genuinely corrupt leadership," and "in such countries there is little hope for major reductions in poverty". – SIDA, Sweden, took an internationally well-known reverend to Court in South Africa for fraud and corruption. He had received large funds for development work. The reverend was convicted.

30. The U.N. Statistical Yearbook writes about its own economic data in 2003: "Much work needs to be done in this /comparability and reliability of data/ area and; for this reason, some tables can only serve as a first source of data, which require further adjustment before being used or more in-depth analytical studies...there are many limitations, for a variety of reasons...One common cause of non-comparability of economic data is the different valuations of statistical aggregates, such as national income, wages and salaries, output of industries and so forth. Comparison of these and similar series originally expressed in a common currency, for example United States dollars, through the use of exchange rates is not always satisfactory owing to frequent wide valuations in market rates and differences between official rates and rates which could be indicated by unofficial markets or purchasing power parities. For this reason data...are subject to certain distortions and can be used as only a rough approximation of the relative amounts involved".

Deaton (2000), a well-known U.S. economist asks if "the poverty estimates as constructed by the World Bank can bear the burden placed on them. One specific difficulty is the use of purchasing power parity (PPP) exchange rates, whose revision induces large changes in poverty estimates for the same countries in the same years. Another area of dispute is the discrepancy in many countries between national accounts statistics, which are used to compute growth rates, and survey estimates, which are used to compute poverty estimates. To a considerable extent, the failure of world poverty to diminish in the face of world growth is the failure of household survey data to be consistent with national income data. The details of survey design are also important. In India, changing the reference period for reporting consumption removes around 200 million people, a sixth of the world total, if not from poverty, at least from the poverty counts."

When the 1996 method was used in Thailand that country saw its poverty rate suddenly decrease to 0.1%, the lowest in the world (UNDP, 1997, p. 37). The same question marks are due when UNDP estimated the proportion of extremely poor people in Uganda at 37% in 2002 and at 82% in 2003; in Pakistan that proportion was quoted as being 31% in 2002 and 13% in 2003. Publishing poverty

research results of this quality creates scepticism as to the reliability of the poverty measurements of the Millennium Programme.

Reddy et Pogge (2005) state: "The World Bank's approach to estimating the extent, distribution and trend of global income poverty is neither meaningful nor reliable. The Bank uses an arbitrary international poverty line that is not adequately anchored in any specification of the real requirements of human beings. Moreover, it employs a concept of purchasing power equivalence that is neither well defined nor appropriate for poverty assessment. These difficulties are inherent in the Bank's "money-metric" approach and cannot be credibly overcome without dispensing with this approach altogether. In addition, the Bank extrapolates incorrectly from limited data and thereby creates an appearance of precision that masks the high probable error of its estimates. It is difficult to judge the nature and extent of the errors in global poverty estimates that these three flaws produce. However, there is reason to believe that the Bank's approach may have led it to understate the extent of global income poverty and to infer without adequate justification that global income poverty has steeply declined in the recent period."

31. The official numbers of the populations of many developing countries are sometimes not very exact. For example, the UN Population Division, in 2002, published the 2005 projected population for Oman as 3,020,000. However, in 2003, a census was carried out showing that the population was 2,341,000 with a projection for 2005 of 2,425,000, thus the UN had overestimated the population by some 600,000, or 25% of the real population. UN, for the period 2000-2005, estimated the annual growth at 68,000, instead the Oman national census found the annual growth to be 42,000, so the UN estimate was 62% above the real.

32. UNICEF (2002) estimates that some 131 million children are born each year in the world. However, the same organization also tells us that we do not even know how many children there are in the world, and how many are born each year. Still details are produced about the numbers we do not know: "In 2002, one third of the children in the world were not registered. The distributions for the different regions of un-registered children were in: Sub-Saharan Africa 78%, Central Asia 44%, East Asia and the Pacific 35%, Middle East and Northern Africa 19%, Americas 8% and Europe 3%." In Bolivia, about 778,000 (9.4% of total population) are not legally registered, and do not have birth certificates to prove their identity. 62% of these are children and adolescents".

33. No developing country has reliable and complete data about mortality. WHO (Lopez et al., 2006) report that only 64 of its 192 Member States, mostly high-income countries, have complete mortality data, for 77 there are no recent data, or no data at all. "Ideal systems for cause-of-death-reporting operate only in 29 countries. In the remaining countries, mortality statistics suffer from one or more of the following problems: incomplete registration of births and deaths, lay reporting of the cause of death, poor coverage and incorrect reporting of ages. For the majority of the world's populations – there are no 'proper' mortality diagnoses". Neither are the data about length of life built on good quality data. Death, in developing countries, may be attributed to "old age", "evil spirits", "visitation from God", "magic", real or imagined "poisoning", "fever", or "malaria (undiagnosed, so it could be something else)". "The sum of deaths claimed by different WHO programmes exceeded the total number of deaths in the world"

34. The literacy rate is not always well known. Few poor people have books at home, or pens and papers to write; literacy skills acquired in primary school may soon be lost. Some data submitted to UNESCO regarding education have been collected with the help of payments to the responsible official in the Ministry of Education to have the information "produced" and delivered on time. Numbers about school attendance, doubling of classes, drop-out and literacy rates are often produced on the basis of guesstimates.

35. Corporal punishment is according to available information forbidden in Austria, Bulgaria, Croatia, Cyprus, Denmark, Finland, Germany, Greece, Hungary, Iceland, Israel, Latvia, Norway, Romania, Sweden, the Netherlands, and Ukraine. In the following countries such punishment is forbidden in schools: American Samoa, Belgium, China, Cyprus, Fiji, France, Ireland, Italy, Japan, Kenya, Luxembourg, Namibia, New Zealand, Poland, Portugal, Russia, South Africa, Switzerland, Thailand, Trinidad and Tobago, Turkey, United Kingdom, Zambia and Zimbabwe.

## ANNEX. A CHILD DEFENCE AND SUPPORT PROGRAMME

There are large differences between countries, and what follows are simple guidelines that need adaptations.

The CDS programme is proposed to have:

- *a first line of defence and support* consisting of a community level primary prevention programme,
- *a second level of defence and support* directed towards solving the problems that remain in spite of the primary prevention, including those that are too complex to be dealt with at the community level. For the latter, a referral system, and if available, professional personnel are required.

### A. THE COMMUNITY LEVEL PROGRAMME

Below follows suggestions for how the programme can be prepared and set up step by step.

#### Preparatory phase.

##### Step 1.

Finding out the present situation and the needs of the population. This may be done using a combination of two methods:

- (a) community visits to meet families, children, teachers, health and social services, representatives of the judiciary and community leaders. The focus should be on seeing families at home and having separate meetings with the children and with the teachers.
- (b) based on this information conduct a national survey

##### Step 2

Review existing services, their effectiveness and costs.  
Review existing legislation and the experience of its effectiveness.  
Review past and ongoing research in related subjects in the country.

##### Step 3

Based on the information outline a detailed action plan. Formulate general objectives and set medium-term targets. Define the evaluation process, which should be done by an independent evaluator engaged at the start of the programme. Community evaluation should be included.

##### Step 4.

- (a) Preparation of printed and audiovisual materials to be used in communities
- (b) Training of personnel for community work. Two different persons are needed: one with skills for the family life preparation at preschools and schools, and the second for the community watch programme.

In developed countries, these may be recruited among teachers, social workers, psychologists and paediatric nurses. In the developing countries, one has to look for interested and suitable community facilitators. In some part of the world they will be volunteers without remuneration; in others, some compensation, or a salary, will be needed. The community should contribute this compensation.

##### Step 5. Awareness-building (sensitization)

Awareness can be created in two ways:

- (a) By media through national radio and television programmes and articles in newspapers. Their content should be carefully structured: people will be advised about the frequency and consequences of child violence, and how to prevent such abuse. Interviews with maltreated people should be included: they will describe their experience, their pain and frustrations and how they may or may not have overcome the haunting experience. Resilience as a mechanism should be included.
- (b) by community visits. Trained persons (see above) can start building awareness through information/sensitisation at community meetings. One approach is to invite a number of local leaders for information and discussion. Cases may be presented (e.g. by video) of maltreated persons, and the expected result of CDS explained.

People in the communities of the developing countries need to be informed that:

- child violence is common (although to a large extent hidden);
- child violence is followed by many consequences: difficult and aggressive behaviour, increased criminality, alcoholism, drug abuse, suicides, mental disorders and a doubling
- of many common diseases. In many persons who were abused as children, one will find damage to the brain, such damage cannot be repaired.

- there are simple methods of training and educating children at an early age that will transfer parenting skills and knowledge about child education that reduces problems when they become parents. Training can also be made for parents that already have children.
- parents can form a community committee to set up the programme and ask for public support for it. Such support may, however not be complete, thus voluntary efforts by the community will be needed. Members of the committee should abstain from corporal and psychological punishment of their children.

#### **Step 6. Community organization**

Each community will need a management structure to plan for the programme, supervise the programme's quality, mobilise resources, establish links with authorities and technical expertise at the district, and evaluate the programme.

Appropriate training should be provided for those who undertake the management. It is important that the community understands that once a CDS programme is started, it has to be maintained.

#### **Initiation and maintenance phase**

##### **Step 7. Implementation**

The programme starts with the training the community members. These include, for example: (in countries, where professional staff is unavailable) community workers who, after training, are willing to undertake the home visiting programme, and school teachers trained for the family life preparation taught in the school.

It is important that the professionals – if available – regularly re-visit the communities for technical guidance. There might be referrals for children with difficult problems see below.

##### **Step 8. Evaluation at the community level**

It is important that communities thoroughly evaluate the outcome of the programme. A simple first tool is to count the number of children whose parents have changed their parental style. A more elaborate system is to evaluate:

- *relevance*: did the families and children feel that the programme is meeting their needs?
- *effectiveness*: did the children trained with CDS improve their knowledge, behaviour, and attitudes?
- *efficiency*: have the resources provided by the community, and supplemented by the government, been used in the most efficient way?
- *sustainability*: are we as a community able to continue this programme using the existing resources?
- *impact*: have the attitudes of the community members who have taken part in CDS improved? Are the children participating happier, better behaved and are they listened to?

The community itself should take an active part in this evaluation; for the larger-scale national evaluation, an independent evaluator should be engaged.

### **B. THE REFERRAL SYSTEM.**

As indicated above, the community level programme will be supervised by professionals (or in developing countries persons with more advanced training and experience than the community worker). When problems cannot be solved at the community level because the interventions are complex or unusual, then the responsibility for the continued action will be taken over by the referral level. How to build up that level will vary depending on the resources and culture of each nation.

The community will now decide what to do. Interested community members should meet and discuss their interest, how the local administration can be carried out and if they can use some of their time to guide the project.

A community may reject the programme. The reasons for rejection may be several among them:

- that they believe that there is no child violence in their community
- nobody in the community has time or is willing to help.

Then the matter can be brought up at a later opportunity.

Once a community is decided to start a programme, there may be certain formalities: informing the authorities and obtain formal permission. Other local stake-holders should be informed: teachers, health services, judicial authorities, local administrators and local politicians. Their cooperation should be sought. It should be made clear that the CDS will have no political or religious affiliation.

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