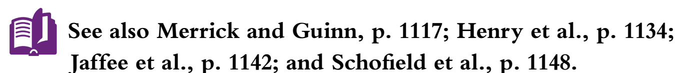
Child Maltreatment: Daunting and Universally Prevalent


See also Merrick and Guinn, p. 1117; Henry et al., p. 1134; Jaffee et al., p. 1142; and Schofield et al., p. 1148.

Violence against children continues to prevail around the world, both in high-income and in medium- or low-income countries. And, within these countries, this maltreatment affects disadvantaged and disenfranchised communities disproportionately.

Child maltreatment is broadly defined by the World Health Organization as

> . . . the abuse and neglect of people under 18 years of age. It includes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.[1(p1),2]

Child maltreatment is just one of the many forms of violence exerted individually or collectively on people through their lives. Although every individual who has experienced and survived violence is likely to suffer from negative health consequences both in the short and long term, child maltreatment constitutes a particularly significant expression of violence, considering the high physical and psychological vulnerability of children and the severity of impacts their exposure to violence may have as they grow through adolescence and adulthood and even beyond, across generations. The literature abounds with reports of studies of child maltreatment that have explored the predisposing risk factors and the influence of adverse structural, cultural, social, economic, and environmental factors on the vulnerability of children to violence or neglect. Studies have also documented the array of negative consequences of the exposure of children to maltreatment. Three articles presented in this issue of *AJPH,* by Jaffee et al. (p. 1142), Henry et al. (p. 1134), and Schofield et al. (p. 1148), provide abundant references to many if not all the relevant publications. Guidance documents addressing the multiple facets of recognized causes of child maltreatment and recommending mitigating or remedial actions have been issued by prominent public health institutions, including the World Health Organization (WHO)[1] and the US Centers for Disease Control and Prevention (CDC).[2] Yet, as imperfect as the reporting and documentation of such events may be, the verdict is clear.

ONE IN FOUR ADULTS WORLDWIDE

From a review of data from 133 countries, the 2014 WHO report on violence estimated that nearly one in four adults worldwide had been physically abused as children, while 20% of women and 5% to 10% of men reported having been sexually abused as children. In the United States, data collected from Child Protective Services determined that, annually by 2012, approximately 676 000 children were victims of child maltreatment, and about 1750 children had died because of abuse or neglect. This estimate was regarded as very conservative because of the underreporting of such events.[3] Worthy of note, from an economic perspective, is the estimated cost of child maltreatment. For example, the lifetime economic cost of child maltreatment in the United States was estimated at $124 billion, with the average lifetime cost per victim of nonfatal maltreatment being around $210 000 and fatal maltreatment roughly $1.2 million.[4] These data should not overshadow the severity of the personal and transgenerational health and social consequences of child maltreatment, but they do provide an overview of the magnitude of the socioeconomic impacts of this daunting public health issue.

THE *AJPH* SPECIAL SECTION

Confronted with the importance of the problem caused by child maltreatment, not to mention the complexity of the intertwined root causes of and impacts on children's health, growth, and development, the reader of the three articles selected for this issue of the *AJPH* will discern the roles that public health practitioners can play to actively help alleviate the burden of child maltreatment on individuals and on society as a whole. These three articles add considerable value to the existing literature for at least three reasons.

First, the articles build on evidence collected longitudinally, through cohorts of children followed up over long periods of time, thereby departing from the more frequent but less informative use of cross-sectional studies on the subject. Specifically, drawing upon the data collected in the Rochester Intergenerational Study that spanned nearly three decades from 1988 to 2016, one of the studies presented here documented the harmful effect of child maltreatment on economic outcomes in adulthood (Henry et al.); participants were followed from age 5 through 18 years for the Environmental Risk Study establishing that child maltreatment predicts poor economic and educational outcomes in the transition to adulthood (Jaffee et al.); and, through a combination of retrospective and prospective measures across adolescence, the Family Transition Project assessed the intergenerational continuity in adverse childhood experiences in rural community environments (Schofield et al).

Second, each article is focused on one or a few selected plausible outcomes of child maltreatment or adverse childhood experiences and suggests interventions or environmental factors that may enhance the prevention of some

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of these outcomes in the short and long term.

Third, all three of the studies conclude that if child maltreatment is to be prevented and responded to adequately, multiple actors must play a role. Here is a call for the engagement of public health practitioners in addressing issues for which they are often ill-prepared.

CHILD'S BEST INTEREST

Several public health approaches to child maltreatment have been recommended by different institutions and authors. Space limitations in this editorial do not permit a full review of the commonality and differences between the recognized strategies. Among the existing guidance documents is the CDC technical package on "Preventing Child Abuse and Neglect,"[5] proposing a comprehensive set of strategies and actions ranging from policy to public health practice levels. The International Society for the Prevention of Child Abuse and Neglect has published numerous papers relevant to these issues, including a Child Maltreatment Evaluation and Treatment Curriculum, which could be of practical interest to medical, nursing, and public health schools.[6]

Other authors have advocated human-rights–based approaches as analytical and action frameworks, upholding the rights of the child entrenched in the eponymous international convention to which all nations in the world (except the United States) are party.[7] All of these strategies and approaches converge toward enhancing the supportive role of parents, caretakers, and institutions, and in particular public health systems, in promoting and protecting "the best interests of the child" by safeguarding, first and foremost, the child's physical and mental health, growth, and development in a more equitable society. AJPH

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Is It Unethical to Use Fear in Public Health Campaigns?

See also Fairchild et al., p. 1180.

There are enduring, almost perennial debates on the efficacy and ethics of fear campaigns in public health that reemerge with whack-a-mole frequency, as eloquently chronicled by Fairchild et al. (p. 1180). Supported by evidence-based reasoning about motivating behavior change and deterrence,[1] these campaigns intentionally present disturbing images and narratives designed to arouse fear, regret, and disgust.

Having health problems can be a profoundly negative experience unappreciated by those not living with them. Pain, immobility, disfigurement, depression, isolation, and financial problems are common sequelae of disease and injury. It is beyond argument that these outcomes are self-evidently anticipated and experienced as adverse, undesirable, and so best avoided. Efforts to prevent them are therefore, prima facie, ethically beneficent and virtuous.

FIVE CRITICISMS

Criticism of the ethics of fear messaging takes five broad directions. First, it is often asserted that fear campaigns should be opposed because they are ineffective: they simply "don't work" very well. Fairchild et al. note that this argument persists despite the weight of evidence. The ineffectiveness argument can be valid independent of the content of failed campaigns: "positive" ineffective campaigns should be subject to the same criticism. Yet sustained criticism of ineffective positive campaigns is uncommon, suggesting this criticism is enlisted to support more primary objections about fear campaigns.

Second, critics argue that such campaigns target victims, not causes of health problems, and so are soft options mounted in lieu of more politically challenging upstream policy reform of social determinants of health, such as education, employment, and income distribution as well as legislative, fiscal, and product safety law reforms.

It is difficult to recall any major prescription for prevention in the past 40 years not involving advocacy of comprehensive strategies of both policy reforms and motivational interventions. For

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