It is the pediatrician’s role to promote the child’s well-being and to help parents raise healthy, well-adjusted children. Pediatricians, therefore, can play an important role in the prevention of child maltreatment. Previous clinical reports and policy statements from the American Academy of Pediatrics have focused on improving the identification and management of child maltreatment. This clinical report outlines how the pediatrician can help to strengthen families and promote safe, stable, nurturing relationships with the aim of preventing maltreatment. After describing some of the triggers and factors that place children at risk for maltreatment, the report describes how pediatricians can identify family strengths, recognize risk factors, provide helpful guidance, and refer families to programs and other resources with the goal of strengthening families, preventing child maltreatment, and enhancing child development.
Crying is a common trigger for child abuse and is the most common trigger of abusive head trauma. In a study of infants who suffered abusive head trauma, almost all of the parents had sought help for their infant's crying previously from their primary care physician. All infants cry; crying generally begins in the first month of life, and the duration of crying increases and peaks between 2 and 4 months of age. The incidence of abusive head trauma parallels this normal developmental crying curve and may serve as additional corroborative of the association between crying and abuse.

The severity and frequency of caregivers’ adverse responses to crying have largely been underappreciated. In a study, almost 6% of parents of 6-month-old infants admitted that they had smothered, slapped, or shaken their infant at least once because of his or her crying.

Discipline can become abusive, as when punishment is used inappropriately in response to a child’s developmentally normal behaviors. Unprepared parents may mistake separation anxiety, normal exploratory play, and normal negativism, for example, for abnormal behaviors or unacceptable behavior and resort to punitive measures to correct them. Apart from its possible effects on emotional development, corporal punishment may result in serious physical injuries for the child. When mothers in the Carolinas were interviewed, 4.3% of them admitted using harsh physical techniques when disciplining their children. These practices included beating, burning, kicking, or hitting a child with an object somewhere other than on the buttocks; 2.3% of the mothers said that they shook children younger than 2 years as a form of discipline.

Toilet-training and toilet accidents are another common trigger for child abuse. Immersion burns are frequently inflicted in response to soiling and enuresis by caregivers who believe that the children should be able to control these behaviors. Genital bruising and immersion burns are common child abuse injuries associated with toilet-training. The average age of children who have been intentionally burned is 32 months, which is about the same age many children are being toilet trained and, thus, the same age at which some are accidentally soiling or wetting themselves.

Factors That Place a Child at Risk for Child Maltreatment

Many disparate factors may combine to make a child more likely to be abused or neglected. Using an ecology model as a framework for considering risk, certain characteristics of the child, the parent, and the environment may place a child at risk, as shown in Table 1. Often, multiple factors coexist and are interrelated, which increases the risk for the child.

Children with disabilities are approximately 3 times more likely to be maltreated than are children without disabilities.
may make children with disabilities more vulnerable to maltreatment.27 The child’s disability may place additional emotional or financial demands on the family. A child who is heavily dependent on others beyond infancy may engender resentment. Further complicating matters, the child with disabilities may be conditioned to obey caregivers without question and, thus, may lack the ability to disclose abuse. If children have been taught to accept painful touch as normal, they may not be able to distinguish when boundaries are crossed.

Children born prematurely may also be at increased risk of being maltreated.28–30 Some preterm infants may be more at risk for abuse, because the infants are perceived as less attractive and more demanding by their parents.28 Some experts have suggested that the early and sometimes prolonged separation of these infants from their parents may contribute to their vulnerability. Some preterm children may be more vulnerable because they have special needs or require special care, including additional physician visits or special therapy. All of this care may place an additional financial and/or emotional strain on the family.

Likewise, the child who is unplanned or unwanted is at risk for maltreatment.31 An unplanned pregnancy may place an extra financial and/or emotional burden on the family.30 Parent factors also may make a child more vulnerable to being maltreated. Factors that may decrease a parent’s ability to cope with the stresses of parenting include low self-esteem; poor impulse control, including a tendency to lash out in response to stress; substance use; and alcohol abuse.30,32 Young maternal and paternal age are risk factors for maltreatment.33,34 and young maternal age is strongly associated with infant homicide.35 Parents who were abused or neglected themselves as children may parent in the only style they have learned.30,31 A parent’s depression or other mental illnesses,34,36 particularly postpartum depression, affect a child’s growth and development and may place the child at risk for maltreatment. Depression is a significant problem for both fathers and mothers.37 Parents who have a negative view of themselves and their children and parents who devalue their children are at risk of maltreating their children. Oates et al30 found that mothers who had maltreated their children tended to rate their children as below average, whereas control mothers viewed their infants as normal or above average.

Lack of knowledge about child-rearing can increase the caregiver’s level of frustration with the child’s behavior. Parents vary widely in their knowledge of child development and what they should reasonably expect from a child at a given age. Parents who maltreat their children are more likely to have developmentally inappropriate and unrealistic expectations for their child’s behavior and to have a negative perception of normal behaviors.28 Oates et al30 also found that parents who maltreated their children were more likely to have a punitive child-rearing style and were stricter. When the maltreated children behaved well, they were rarely praised, compared with the children in the control group, who were praised for good behavior.

Environmental factors can add to parents’ stress. Parents who are isolated and who have low levels of social support are at increased risk of maltreating their child.38 Poverty, unemployment, low maternal education, and single parenting are risk factors associated with physical child abuse.36,39–42 Having a non–biologically related male living in a single-female–headed home is a risk factor for child maltreatment and for fatal child maltreatment.43–45 Adult intimate partner violence and child maltreatment are closely linked.46 Children who live with an adult victim of intimate partner violence are at an increased risk of being physically abused. In addition, children who are exposed to violence in the home are affected emotionally, cognitively, and behaviorally.47 Exposure to this toxic environment is often considered a form of child maltreatment.

These factors may interact and increase the child’s vulnerability to maltreatment. Infants who are not nurtured properly in their first months may not learn to regulate their emotions, because development of this vital task is enhanced by early parental attention and support.48 As the infants become more challenging to their parents, this complex interplay may increase their risk for abuse. Adults who are socially isolated may lack standards for comparison of their child’s behaviors, or role models and resources for themselves. Food or employment insecurity, poor access to community services, or simply the lack of community feedback can exacerbate stress and anxiety. Even if no single factor would be sufficient to overwhelm the caregiver, the combination of stresses may precipitate an abusive crisis.49,50

**Protective Factors**

Besides assessing a child’s risk for maltreatment, the pediatrician should identify and consider the child’s and family’s strengths. Maltreatment occurs when factors specifically pertinent to the child and factors relevant to the parent, the community, and to the environment interact, which creates a “perfect storm” for abuse and/or neglect.31–53 In other words,
maltreatment occurs when risk factors are greater than protective factors and stressors exceed the supports.

Several factors seem to both protect a child from maltreatment and provide children with resilience to the effects of child maltreatment, as shown in Table 2.54–56 Using the same ecologic framework, protective factors include attributes of the child and the family as well as support from outside the family. Although many studies have focused on how these behaviors may trigger a physical response or physical abuse, it is likely that these behaviors also trigger other forms of maltreatment, including sexual abuse. Prevention may require changing some cultural beliefs and social policy and improving education and economic opportunities.

**PREVENTION AND INTERVENTION PROGRAMS**

It is not the intent of this report to review and evaluate all of the available prevention and intervention programs. Instead, the report will discuss some of the programs as examples and, when available, cite any evidence for their effectiveness.

**Hospital- and Office-Based Intervention Programs**

Programs have been developed to help parents to better cope with a child’s crying. Dias et al57 implemented a program in nurseries in western New York designed to teach new parents about violent infant-shaking and alternatives to use when infants cried. They found that the incidence of abusive head injuries decreased by 47% during the first 5 years of the program. A similar program, the Period of PURPLE Crying, also uses a brief video and written material to educate new parents about normal crying and how to cope with an infant’s crying. This program has been shown to improve mothers’ knowledge about crying and to improve their behavioral response to it.58,59 Although both of these programs represent promising models, neither program has yet demonstrated strong evidence that they are effective as a primary prevention of abusive head trauma.

One office-based prevention model, the Safe Environment for Every Child (SEEK) model, was tested in a resident continuity clinic over a 3-year period.60 Residents were trained to recognize factors that placed a family at risk for maltreatment. Study families were screened for risk factors, and a team that consisted of a resident and a social worker addressed any identified risk factors. When the families were compared with a control group, the prevention program resulted in fewer reports of child maltreatment made to child protective services, fewer incidents of medical noncompliance and delayed immunizations, and less harsh punishment by parents. Although some of the differences between the control group and intervention group were of modest significance, participation in this program improved the residents’ sense of competence and comfort when addressing risk behaviors.

The AAP developed Connected Kids: Safe, Strong, Secure, an office intervention originally known as the Violence Intervention and Prevention Program (VIPP). This program was modeled after The Injury Prevention Program (TIPP), also from the AAP.51 The Connected Kids program uses a resilience-based approach to anticipatory guidance and is designed to help primary care physicians use their therapeutic relationship to support families as a means of violence prevention. The Connected Kids program includes a clinical guide, online training materials, and parent education materials and educates both pediatricians and parents about discipline, parenting, and other issues. Brochures on child development show parents that normal problematic child behaviors—from crying to climbing—arise from the child’s normal growth and development and advocate that these behaviors be addressed with guidance rather than punishment. The Connected Kids program has not been

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**TABLE 2: Protective Factors**

<table>
<thead>
<tr>
<th>Dispositional/Temperamental Attributes of the Child</th>
<th>Warm and Secure Family Relationships</th>
<th>Availability of Extrafamilial Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above-average cognitive ability</td>
<td>Presence of a caring and supportive adult</td>
<td>Structured school environment</td>
</tr>
<tr>
<td>High ego control (high degree of impulse control and modulation)</td>
<td>Positive family changes (eg, family interventions, father no longer allowed on visitations)</td>
<td>Involvement with a religious community</td>
</tr>
<tr>
<td>Internal locus of control (belief in one’s ability to control own destiny)</td>
<td></td>
<td>Involvement in extracurricular activities or hobbies</td>
</tr>
<tr>
<td>External attribution of blame (attribute cause to something outside oneself [eg, some external pressure])</td>
<td></td>
<td>Access to good health, educational, and social welfare services</td>
</tr>
<tr>
<td>Presence of spirituality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ego control and ego resilience (able to modify impulses and insulate themselves from environmental distracters)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High self-esteem or sense of self-worth</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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evaluated formally, but a study on implementation of Connected Kids was conducted in 2007 with 27 pediatricians over a 6-month period, with a focus on improving parental supervision and monitoring during middle childhood. Findings from the project indicate that the Connected Kids program is appealing to pediatricians, implementation is feasible, and use is sustainable over a period of 6 months. More information about the Connected Kids program is available at www.aap.org/connectedkids.

Practicing Safety, a program conducted by the AAP and funded by the Doris Duke Charitable Foundation, developed expanded anticipatory guidance modules for use in primary care offices. The 7 modules provide pediatricians with suggested assessment, guidance, and resources to help parents cope with crying, help them parent, ensure their children’s safety when they are in the care of others, improve the family environment, provide effective discipline, assist with sleeping and eating, and help with toilet-training (www.aap.org/practicingsafety). The program was tested in 8 practices in New Jersey and Pennsylvania, and parent and staff reports showed a significant increase in maternal depression screening. Staff reports also showed an increase in discussion and use of resources on coping with crying, discipline, and toilet-training. The toolkit was revised and was implemented by 14 practices in the AAP Quality Improvement Innovation Network (QuIIN); the next steps are being developed.

**Community Prevention Programs and Resources**

Home-visitation programs, in which targeted families receive regular contact with trained personnel, are a prevention model that has been widely used and are supported by the AAP. The Nurse-Family Partnership model developed by Olds et al has been rigorously tested. The model, which uses trained nurses, has demonstrated improvements in maternal and child functioning and showed a trend toward reduced childhood mortality rates from preventable causes.

The other hand, Healthy Families, a home-visitation program that uses trained paraprofessionals, has been tested in a number of states, but it has not been shown to reduce child abuse or child abuse risk factors. Cincinnati’s “Every Child Succeeds” program used both the Nurse-Family Partnership model and the Healthy Families model and provided home-visiting to mothers at high risk (adolescent, unmarried, low income, or suboptimal education) and first-time mothers. They found that intensive home-visiting reduced the risk of infant death during the first year of life. The Task Force on Community Preventive Services found that, in the 21 programs for which records were available, home-visiting was associated with a median reduction in child abuse of more than 50%.

Although pediatricians have long been familiar with therapeutic preschools and with parenting programs, study results have suggested that these interventions are more effective when multiple modalities are combined with those that target the entire family. Reynolds and Robertson reported that participation in school-based child-parent centers, which provided extensive family education and support, reduced maltreatment by 50% in a population at high risk. Other study results have shown significant effects when community-based parent-child interventions are targeted at specific populations, combine peer and professional support, and provide some services directly to the children.

Parent-training programs, such as the Triple P program, Sure Start, Family Connections, Healthy Families America, and Together for Kids, aim to improve parenting skills and parents’ emotional adjustment. The quality of the programs, however, is variable. The Triple P program resulted in a positive reduction of maltreatment in 1 study, but the program needs to be replicated and reassessed to determine its effectiveness. A comparison of the effectiveness of parent-training programs is available through the Cochrane Database of Systematic Reviews. More information about child abuse–prevention programs, local resources, and program evaluation can be found at www.childwelfare.gov/preventing/programs/types/homevisit.cfm.

**The Role of Pediatricians**

It is important for pediatricians to recognize and respond to ongoing maltreatment. Universal prevention of child maltreatment must begin with an approach that assesses the caregivers’ strengths and deficits and connects the family with community resources that will protect the dependent children before abuse or neglect occurs. The schedule of routine health care visits recommended by the AAP provides ample opportunity for the clinician to observe and assess parenting practices at the very times when a child would be expected to initiate new and possibly challenging behaviors.

The third edition of Bright Futures (http://brightfutures.aap.org/about.html) from the AAP provides pediatricians with guidelines for anticipatory guidance and prioritizes topics for discussion at each health supervision visit. This multimedia program includes the Bright Futures guidelines in a manual format, pocket guide, and personal digital assistant (PDA) version in addition to toolkits, PowerPoint presentations, and health-promotion information sheets.
A clinician may receive answers or observe behaviors that suggest the family’s resilience is compromised in some significant way. Such compromise may derive from child factors, parental deficits, or environmental stressors. If the family’s ability to nurture and protect the child is compromised, that child must be considered at risk for abuse, and action should be taken. Unless the child is felt to have been abused in some way, such action rarely entails referral to child protective services but frequently goes beyond the scope of a typical office visit. Efforts may be as straightforward as taking the time to elicit a more comprehensive history or counseling a frustrated parent. A more complicated case may involve referral to a community agency for evidence-based parent training or for intervention for intimate partner violence. If there is significant doubt about the child’s safety, the caregivers’ ability to protect, or maltreatment is suspected, the pediatrician should, of course, contact child protective services.

**GUIDANCE FOR THE PEDIATRICIAN**

1. Obtain a thorough social history, initially and periodically, throughout a patient’s childhood. The parent-screening tool included in the *Bright Futures* tool and resource kit (available at http://brightfutures.aap.org) can be used to help screen for risk factors and problems; identify and build on family strengths, resilience, and mediating factors; identify and address parents’ concerns; and reinforce effective parenting. Reinforcement builds strength and a sense of competence.

2. Acknowledge the frustration and anger that often accompany parenting. Provide anticipatory guidance about developmental stages that may be stressful or serve as a trigger for child maltreatment. A health visit framework can be helpful (see Table 3) or refer to the Connected Kids counseling schedule (http://aap.org/connectedkids).

3. Talk with parents about their infant’s crying and how they are coping with it. Learn their perception of their infant’s crying and which strategies they use to cope. The pediatrician should provide parents with insight into the infant’s behavior and teach alternative responses.

4. When caring for children with disabilities, be cognizant of their increased vulnerability and watch for signs of maltreatment. Provide families with information about the child’s condition. Activities may include giving out handouts or having group instructional sessions with parents. Validate the parent’s stresses and provide them with techniques to manage the stress. Provide the family with information about respite care, which allows someone else to care for the child so that the parents or other family members can take a break. Identify families at greater risk of abusing their child. Help educate older children about how to protect themselves against abuse and that they should share uncomfortable, abusive, or concerning experiences with a trusted adult.

5. Be alert to signs and symptoms of parental intimate partner violence and postpartum depression. Instruments are available

### TABLE 3  Incorporating Primary Maltreatment Prevention Into the Health Supervision Visit

<table>
<thead>
<tr>
<th>Parent Coping Skills and Support System</th>
<th>Prenatal or first visit</th>
<th>Newborn</th>
<th>First months</th>
<th>Cruiser/toddler</th>
<th>Preschool</th>
<th>School</th>
<th>Adolescence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who lives in the home? History of mental health problems, substance abuse/alcohol abuse, or intimate partner violence?</td>
<td>Infant crying</td>
<td>Infant crying</td>
<td>Discipline = teaching</td>
<td>Discipline = teaching</td>
<td>Discipline = teaching</td>
<td>Discipline = teaching</td>
<td></td>
</tr>
<tr>
<td>How were the parents parented and disciplined?</td>
<td>Expectations</td>
<td>Normal development and expectations</td>
<td>Toilet-training</td>
<td>Normal development and appropriate expectations</td>
<td>Discipline = teaching</td>
<td>Model nonviolent anger management and conflict resolution</td>
<td></td>
</tr>
<tr>
<td>What were the parents’ experience(s) with trauma?</td>
<td>Identify 3 friends or family members who can help (safety line)</td>
<td>Maternal depression</td>
<td>Identify 3 friends or family members who can help (safety line)</td>
<td>Identifying 3 friends or family members who can help (safety line)</td>
<td>Identify 3 friends or family members who can help (safety line)</td>
<td>Identify 3 friends or family members who can help (safety line)</td>
<td></td>
</tr>
<tr>
<td>Are there financial problems and/or poverty?</td>
<td>Loving is not “spoiling”</td>
<td>Loving is not “spoiling”</td>
<td>Loving is not “spoiling”</td>
<td>Loving is not “spoiling”</td>
<td>Loving is not “spoiling”</td>
<td>Loving is not “spoiling”</td>
<td></td>
</tr>
<tr>
<td>Was the pregnancy planned?</td>
<td>Who will care for the infant?</td>
<td>Who will care for the infant?</td>
<td>Who will care for the infant?</td>
<td>Who will care for the infant?</td>
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</tr>
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</table>

Note that topics may be reintroduced at successive visits.
that can be used by clinicians to identify depression in mothers and fathers.\textsuperscript{37,82} Familiarize yourself with appropriate community resources, and know how to respond if a caregiver reports intimate partner violence or depression.

6. Guide parents in providing effective discipline.\textsuperscript{83} Encourage parents to use alternatives to corporal punishment, such as time out techniques and positive reinforcement. Brochures such as those developed for the Connected Kids program (http://aap.org/connectedkids) and Bright Futures (http://brightfutures.aap.org) can be used to supplement this discussion.

7. Talk to parents about normal sexual development and counsel them about how to prevent sexual abuse. The AAP has developed an educational toolkit that helps health care professionals talk to parents and patients about sexual

**REFERENCES**


7. Finkel MA. "I can tell you because you're a doctor." \textit{Pediatrics}. 2008;122(2):442


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FROM THE AMERICAN ACADEMY OF PEDIATRICS
# The Pediatrician's Role in Child Maltreatment Prevention

Emalee G. Flaherty, John Stirling, Jr and The Committee on Child Abuse and Neglect

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