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CASE REPORT

# Child Maltreatment

## Types and effects: Series of six cases from a university hospital in Oman

*Muna Al-Saadoon[1] Marwan Al-Sharbati,[2] Ibtisam El Nour,[3] Basma Al-Said[2]

# إساءة معاملة الأطفال

## أنواعه ونتائجه: تقرير ست حالات من مستشفى جامعي في عُمان

منى السعدون، مروان الشربتي، ابتسام النور، بسمة آل سعيد

**الملخص**: إساءة معاملة الأطفال واسعة الانتشار في العالم، وتكون على عدة أنواع، وقد تهدد حياة الأطفال (خاصة صغار السن) ونوعية حياتهم إلى حد كبير، مما يؤدي إلى نتائج كارثية بعيدة المدى على مستوى الطفل والعائلة والمجتمع. ندرج هنا تقريرا لست حالات لأطفال تعرّضوا لإساءة معاملة تمّ تشخيصها من قبل فريق حماية الطفل بقسم طب الأطفال وقسم الطب السلوكي في مستشفى جامعة السلطان قابوس. الهدف من هذا التقرير هو زيادة الوعي اتجاه إساءة معاملة الأطفال عند العاملين في القطاع الطبي، وإلقاء الضوء على صعوبات التشخيص وتوفير العلاج المناسب للأطفال المساء معاملتهم. ولو أنّ نظام الرعاية الطبية في عُمان يُقدّم العلاج، لكن من الواضح أنّ هناك فجوات في النظام الحالي تؤثّر على جودة الخدمات التي تُقدّم لحماية الأطفال وتوفير الرعاية لهم ولعائلاتهم.

مفتاح الكلمات: إساءة معاملة، أطفال، مراهقون/يافعون، حوادث مقصودة، إهمال، تقرير حالة، عُمان.

**ABSTRACT:** Child maltreatment (CM) is common worldwide, and can take many forms. It may even endanger the child's life, especially when younger children are the victims. CM affects the child's quality of life and consequently leads to long term issues to be dealt with by the child, family and community. This case series discusses six children who have been subjected to CM, and diagnosed by the child protection team of the departments of Child Health and Behavioural Medicine at Sultan Qaboos University Hospital (SQUH), Oman. The aim of this case series is to increase the level of awareness of CM among Oman's medical professionals and to highlight the difficulties encountered in diagnosing and providing optimal care for these children. Although treatment is provided in Oman's health care system, it is clear that there are gaps in the existing system which affect the quality of child protection services provided to the children and their families.

***Keywords:*** Maltreatment; Abuse; Child; Adolescent; Non accidental injuries, Negligence; Case report; Oman.

Child abuse or maltreatment constitutes 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]

Article 19 of the Convention on the Right of the Child (CRC) clearly states the need of all countries to put into place legislative and administrative measures to protect children from violence and abuse.[2] Data concerning child maltreatment (CM) is scarce in Arab countries, but in recent years medical professionals of the Arabian Peninsula have recognised that CM exists, as is evident due to the increase in publications about CM in medical journals.[3–8] A study from Bahrain reported 150 cases of maltreated children, in which the mean age was 7±4 years. The majority of the children were males (53%). In that study, physical abuse constituted 33% of the instances of maltreatment, while sexual abuse was found in 58%, and combined physical and sexual abuse in 7%.[3] A school-based study from Yemen noted that 80% of mothers in rural areas were using physical discipline compared to 59% of mothers living in urban areas. Boys were significantly more likely to be spanked than girls.[4]

The outcome of CM may be very serious, leading to death in extreme instances. To whatever extent

*Departments of [1]Child Health and [2]Behavioural Medicine, College of Medicine & Health Sciences, Sultan Qaboos University, Muscat, Oman; Departments of [3]Child Health and [4]Behavioural Medicine, Sultan Qaboos University Hopsital, Muscat, Oman;*
*Corresponding Author e-mail: munasa@squ.edu.om*

CM is committed, it negatively and significantly affects quality of life. In the USA in 2007, among 3.2 million referrals for CM, 794,000 cases were determined to be victims of CM (out of 5.8 millions cases of alleged maltreatment).[9,10] Younger children are more often subjected to maltreatment and are more susceptible to its disastrous effects. For example, the infant rate of victimisation during 2007 was 21.9 per 1,000 children, with a slight predominance of females (52% females versus 48% males). An estimated 1,760 children died during the same year because of CM, with an overall rate of 2.35 deaths per 100,000. Of these children, 75% were under four years old.[10]

The long term consequences of CM, if the child survives the abuse, depend on many factors, including the intelligence and the resilience of the child/adolescent; the severity, duration, frequency, and type of maltreatment; the presence of family and social support, and, finally, the relationship between the victim and the abuser. According to different theories of personality development, the importance of positive experiences during childhood and adolescence is clearly highlighted for the proper "crystallisation" of a balanced, normal personality. Conversely, the negative experiences will be responsible for defects in personality. For example, according to Maslow's humanistic theory of the hierarchy of needs, individuals cannot become fully actualised, neither living nor working to their full potential, without all their basic needs having been met.[11] CM disrupts the satisfaction of all of an individual's needs, whether they are physiological needs, or the need for safety, love and belonging, and self-esteem.

Another example of a possible effect of CM is illustrated through the psychoanalytic approach of personality development described by Erick Erickson. During a person's lifetime, he or she must pass through eight stages of psychosocial development in order to develop healthily. Erickson stresses the importance of trustful relationships between the child and his carer during early stages of development (trust versus mistrust stage). If a child fails to experience trust and is constantly frustrated because his or her needs are not being met, the child may end up with a deep-seated feeling of worthlessness and a mistrust of the world in general. This results in difficult relationships in the future.[12]

It is not surprising that victims of CM will exhibit a long series of abnormal behaviours and emotions, and distorted thoughts. These may include poor self-image, an inability to trust or love others, aggressive and antisocial behavior, anger spells and rage, social withdrawal, self-mutilation, suicidal thoughts, and passivity. Also, the maltreated child may exhibit fear of engaging in new relationships or activities, anxiety, poor school performance, depression, flashbacks, sleep problems, and possibly drug and alcohol abuse. Treatment for CM is multidisciplinary, and should be conducted in a team setting which involves parents, teachers, psychologists, social workers, psychiatrists, paediatricians, family doctors, police, and lawyers. Treatment should be offered to the child, family and the abuser. Different therapeutic approaches should be implemented, including cognitive behavioural therapy, psychotherapy, art therapy, social support and medications when required.[13,14] Thus, early recognition of the abuse and prompt intervention will reduce the possibility of long-term negative effects.

Children in the Arab Peninsula are subjected to all forms of CM, but it is either ignored or tolerated, and physical discipline is accepted in child rearing practice in the cultural context; hence, maltreated children continue to suffer and most abusers go free.[7] Failure to identify these cases is another major issue that delays diagnosis. Therefore, strong collaboration among different parties (medical professionals, religious persons, teachers, mass media, lawyers, and politicians, etc.) is essential to protect children's health, safety and rights, and let them live a life which enables healthy development. Our literature review identified three articles which describe cases of CM originating in Oman. The first describes 5 children who were treated for epilepsy, but diagnosed after treatment as victims of Münchausen syndrome by proxy.[5] A second paper reported factitious hypoglycaemia and a third raised the question concerning vehicle entrapment as child neglect.[6,8]

In this paper, we report six cases of CM from SQUH, with the aim of highlighting the existence of the problem. In order to increase the level of awareness of this potentially devastating problem, methods of diagnosis are discussed as are the challenges faced by the child protection team in case management.

It is important to mention here that all of the cases were diagnosed based on the clinical and social information gathered by the child protection team in the Departments of Child Health and Behavioural Medicine at SQUH. The electronic medical records of all suspected cases of CM between the years 2007–2010 were reviewed. Six cases which represent different types and severity of CM were selected for this case series.

## Case 1

A newborn boy, the result of an unwanted pregnancy, was transferred from the post-natal ward to the Neonatology Unit at the age of two days for treatment of neonatal sepsis. The mother had abandoned the baby after admission. She was brought back after a few days by the police. The case was referred to the Ministry of Social Development for social evaluation and support. The child was discharged with his mother after a few days following completion of the treatment, even though the SQUH Child Protection Team advised against discharge. At the age of 1 month, the baby was brought by his father and stepmother to the emergency room in a state of cardio-respiratory arrest, with bleeding from the nose and mouth. Resuscitation was performed, but efforts were not successful and it was not possible to revive him.

## Case 2

A 12 year-old girl was admitted to the Paediatric Intensive Care Unit with fulminant hepatic and multi-organ failure. All investigations as to possible causes of the above were negative, but the girl had high mercury levels. Parents admitted to applying mercury as a traditional treatment for hair lice. The girl, who had been completely normal prior to the lice treatment, unfortunately died of acute mercury poisoning.

## Case 3

A 22 month-old girl was admitted to the hospital following apparent strangulation. She had been playing unattended in a swing in her house when the child's mother had found her hanging from the neck by the swing's rope. The child was unresponsive, floppy, and not breathing, and required mouth-to-mouth resuscitation and chest compressions at home. On arrival at the emergency room she was conscious but drowsy, with a weak cry petechial rash on the face and neck, and bruises around the neck. The child was admitted and treated as an inpatient and fortunately survived. At the time of discharge, no neurological deficit was detected, but the girl will need long term follow-up for neurological sequelae.

## Case 4

A 12-year-old girl was referred to SQUH for an evaluation of chronic abdominal pain, bloody stool, perianal abscess and progressive weight loss over the previous year. She had been seen previously by many paediatricians, but her mother repeatedly refused to consent to any invasive diagnostic investigations**.** Upper and lower gastrointestinal tract endoscopies were done at SQUH and the diagnosis of inflammatory bowel disease was established. The child was started on both immunosuppressive and supportive therapies for Crohn's disease. Later on, poor compliance with treatment was suspected based on uncontrolled symptoms and a non-reduction in inflammatory indices. A subsequent colonoscopy showed persistent lesions and the mother admitted to not giving the child her medications. The child subsequently developed a urinary tract infection and the mother refused admission for intravenous antibiotics. The child was then discharged against medical advice.

## Case 5

A 3 year-old boy was brought to the clinic by his mother, who had observed remarkable changes in his behaviour. The boy had become aggressive and had begun expressing sexualised behaviors. The parents were separated and in the process of divorce. The boy's mother suspected recurrent sexual abuse of the child by three teenaged male relatives during the weekly visits to the father's family home. Accordingly, the child was seen once in the local health centre and reported to have bruises around the anus. The child was referred to a paediatric psychologist for analysis and therapy. The huge efforts of the mother and the child protection team resulted in a stop to the abuse. The child and mother are currently receiving psychotherapy.

## Case 6

A 7 month-old boy with recurrent episodes of limb fractures was referred from a peripheral hospital. The boy's medical history had been unremarkable apart from of a cystic hygroma in the right side of the neck which was surgically removed at the age of two months. A few days after being discharged after the cystic hygroma removal surgery, the mother noticed reduced movements of the boy's right upper arm. Evaluation at the local hospital revealed a fracture of the lower end of the right humerus**.** At the age of four months, a second fracture of the lower end of the left femur was diagnosed after the mother observed reduced movements of the left leg. Investigations for bone diseases were negative at that stage. A third new fracture of the left humerus was diagnosed at the age of six months. The patient was then referred to SQUH for the possibility of physical maltreatment**.** The parents denied any history of trauma preceding any of the above mentioned fractures. It is important to note that the mother suffers from hypothyroidism and she is on medication. The parents informed us that they sent an expatriate housemaid back to her country ten days after the first event without revealing the reasons for termination of her contract. The mother claimed that she sees a female *jinn* (spirit of evil) that watches her and her son. Her husband confirmed that the *jinn* is hurting their baby. The parents were extensively counselled concerning the apparent non-accidental injury. The child has been under close follow-up for the last three years and no fractures or major injuries have been noted.

## Discussion

CM, also known as child abuse and neglect, is common worldwide. The exact incidence and rates of prevalence of CM are not well known as only a minority of the children who are countable as abused or neglected would be reported to, and investigated in, centres and institutions dealing with child protection.[15] There are many definitions of CM; however, the *Keeping Children and Families Safe Act* of 2003 defines child/adolescent abuse and neglect as: "Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation".[16] CM is divided into four classifications: neglect, physical, sexual, and psychological (emotional) maltreatment. Child neglect is the most common type observed, which includes various categories: physical, medical, emotional, and educational neglect, or, inadequate supervision which leads to accidental poisoning and injury.[17,18] A child may be subjected to one or more forms of CM at the same time. It is widely accepted that it is difficult to define neglect, as it is difficult to know whether neglect should include actual harm or potential harm. Additionally, one must recognise and address contributory factors when defining cases.[19]

In this paper, we have reported cases of children subjected to different types of CM. The first baby in case 1 was unwanted, as evidenced by the mother trying to abandon the child. In the end, the mother was forced to take the child as according to the rules of the orphanage only children of unknown parentage could be accommodated. This illustrates the need for cultural flexibility in dealing with children in potentially abusive situations.

Case 2 reflects the harmful effect of a traditional medication which had been prescribed by a local healer and given with good intentions by the parents. This case has exposed the need for community health education regarding harmful consequences of heavy metals which are elemental to some traditional treatments.

Case 3 illustrates the need for quality supervision of toddlers. According to the history obtained from the mother, the child had been unattended while playing on the swing. The Child Protection Committee raised questions regarding the height of the swing and the possibility that a 2 year-old child could have independently become entangled in the rope. Was the incident a result of an intentional act by an adult or was it an unintentional act by other children? Lack of a proper investigative system left the questions unanswered.

Case 4 is one of the most common ethical problems faced by paediatricians in Oman: refusal of investigations and medical treatments by a caregiver. As of the publication of this article, there is no law by which a physician can stop parents from removing a child from hospital against medical advice, regardless of the child's medical status. Refusal of the mother to consent to investigations and therapy delayed the diagnosis of Crohn's disease in this child, and interfered with the control of the

child's symptoms.

Case 5 is an example of the consequences of family disharmony and parental separation when there is inadequate supervision during a child's visit to the non-custodial parent. The child indirectly disclosed the abuse, which had taken place during visits to the father's family home, during consultations with the paediatric psychologist.

In case 6, the baby presented with 3 bone fractures between the ages of 2 and 6 months; none were preceded by trauma. Considering the developmental motor capabilities of the baby, the diagnosis of non-accidental physical maltreatment was discussed with the parents. Sending the housemaid home after the first incident may reflect acceptance of the parents that the baby was subjected to an intentional trauma. Parents blamed the last two events on an evil spirit. No further events were noted on follow up.

All six of the cases were assessed by one or more members of the child protection team, which is composed of 2 paediatricians, a paediatric ophthalmologist, a child psychiatrist, a psychologist, and a nurse. It is evident from the reported cases that the investigation of all cases, with regard to social circumstances, and the financial and psychological status of the care providers and the children were incomplete or absent. The management lacks the protective and supportive aspect of care necessary for such cases.

Researchers have shown that CM may lead to the development of many negative behaviours and emotions that affect the quality of life of such unfortunate children.[20] Negligence, the incidence of which approaches 60% of identified cases, is the most common type of maltreatment and is associated with, and predisposes children and adolescents to, other types of maltreatment, including physical and sexual abuse. On the other hand, psychological maltreatment is implicitly associated with other types of maltreatment.[18]

Management of such cases is critical and urgent and should be performed quickly and effectively to protect the lives of the victims. The policy adopted at SQUH is to educate the parents, and to involve them in order to protect the children from further abuse. Parents are also encouraged to design solutions to the problem of abuse of their children. SQUH's policy is to avoid blaming the parents. The idea is to make them part of the solution and not part of the problem, especially when it is widely known that, in Oman, there is no legislation to foster such children in special homes. As there is no foster care support system for children subjected to violence, all surviving children must be sent home to the same environment from which they have come and followed closely by their paediatricians.

## Conclusion

CM exists in Oman as elsewhere. These 6 cases represent different forms of CM faced by the paediatricians of SQUH in Oman. This article exposes the need for community education regarding children's rights, the need for judicious support to protect these children, the deficiency of supportive multi-disciplinary teams, the lack of experienced investigators, proper social support and the unavailability of a place of safety for those unfortunate victims of CM. We are shedding light on child abuse and neglect in Oman while waiting for the different governmental authorities to develop an efficient and effective system for child protection.

### DISCLOSURE

This case series was presented during the 2010-2011 academic year under the title *I Deserve More Care*. It was presented as part of SCRAPS (Surgery, Clinical Disciplines, Radiology, Anatomy, Psychiatry & Laboratory Sciences), the weekly clinico-pathological presentations in the College of Medicine & Health Sciences at Sultan Qaboos University Hospital. It was awarded third prize in the annual SCRAPS prize giving.

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