Definition, Measuring and Prevalence of Child Neglect - a Study of Children Aged 0-1 Year

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PRESENTATION OF PROBLEM

What kind of life does the youngest part of the Danish population live; i.e., children under the age of one year? Do they live a good and secure life with their parents? Do they live a life troubled by stressed parents as well as scarcity of love, time and attention? Are they subjected to maltreatment, neglect or abuse?

It is difficult to answer the above questions. What is an indisputable definition of "a good and secure life" and of other fine words? Although everybody has a suggestion, nobody can claim that their definition is the ultimate definition. Any definition will always be suspectible of several interpretations. Perhaps a good and secure life is what we - i.e., our common culture or society - agree it should be.

The study *Child abuse and neglect?* (Christensen, 1992) may be regarded as an attempt to concretize the discussion about what a good and secure life means for the youngest in our society. The study includes: 1. a clarification of the concepts "care" and "abuse and neglect", as well as a specification of which parental actions - or lack of actions - could sensibly be characterized as child abuse and neglect. And 2. an estimate of the number of Danish children subjected to what the study characterizes as child abuse and neglect; an account of where these children live, which relief measures have been implemented, and whether the children's families are subjected to psycho-social strain.

DEFINITION: CLARIFICATION OF CONCEPTS

A primary prerequisite for discussing the concept child abuse and neglect in a meaningful way is a conceptual clarification. In the study "Families under strain" (Christensen, 1991), care is defined in a general sense as "considering the child's physical and emotional needs so that it can grow up a reasonably harmonious person. That is, considering the child's need for food, shelter, clothes, education, love."

In the book "Care and development" (Diderichsen & Thyssen, 1991), care is descibed in a similar way. An example can be found on page 19: "Care is based on efforts where the caring person acts on the basis of another person's (the child's) needs in a way that seeks to comply with the needs of this other person." In this connection, communication is described as a key concept in relation to care. In case the caring person does not meet the child's needs, i.e., does not live up to his or her responsibility for providing the child with the necessary care and love; and if he or she is not capable of establishing the necessary contact and communication with the child (so that the child may enter a dialogue with and learn from its surroundings) this caring person fails to fulfill his or her responsibility for providing care, and it is possible to speak of child abuse and neglect.

Broadly speaking, child abuse and neglect may thus be described as a failure to live up to one's obligation to provide care for the child. This general characterization emphasizes the normative aspects of the child abuse and neglect concept; aspects which also appear from one of the most prevalent and internationally used definitions according to which child abuse and neglect or cruelty to children takes place when harm, often repeatedly, is inflicted upon children through actions or serious neglects on the part of the parents or guardians, and when these actions are in defiance of society's norms and laws regarding care for children and young people and other citizens, and when they are not the result of unforeseen contingency (Kempe & Kempe, 1983, pp.18-21).

Child abuse and neglect cannot be regarded as one limited act, nor as leading to one limited set of consequences. Child abuse and neglect must be characterized as a continuum of actions with parents at one end of the scale who more or less passively refrain from giving their children sufficient care, thereby eventually causing them harm unintendedly. At the other end of the scale, we find parents who actively or wilfully abuse their children, either physically in the form of e.g. violence, maltreatment, sexual exploitation, or emotionally in the form of e.g. anxiety-causing confinement to uncomfortable places, degrading or humiliating treatment, verbal spitefulness or threats.

The consequences of the wilfully inflicted physical abuse are immediately observable and predictable. As for the harmful effects on the child's emotional and psychological state of mind, there is also extensive knowledge of the consequences which child abuse and neglect may have on a child. Harmful effects may be observed both on the fundamental development of the child's personality and on the child's relationships with other people (see e.g. Chistensen, 1991). Both categories are harmful effects which, other things being equal, are known to render the abused child more difficult living conditions.

During the Nordic Conference on Child Welfare in Copenhagen in June 1991, one of the things which Bengt Börjeson (Börjeson, 1991) spoke of was the importance of focusing more on the relations between child and parents when estimating the harmful effects of a given parental failure to provide care for the child (see also Sloth,

1991). That is, he emphasized the importance of not just focusing on the physically injurious acts. The non-physical acts, which, to a large extent, are characterized by the relationship between child and parents, are equally important when discussing child abuse and neglect. Furthermore, when discussing the possibilities of preventing child abuse and neglect this relationship may be of even greater significance. E.g., does the child-parent relationship include positive elements for the child and its development? Is the parents' inability to recognize their children as living beings a result of the former's own problems of abuse or own miserable condition? Or, is it possible to speak of parents' direct hostility towards their children? The two first cases represent passive forms of child abuse and neglect ("sins of omission") whereas the last case must be characterized as active child abuse and neglect, which may be compared to active physical maltreatment.

The answers to the questions concerning the child-parent relations are crucial to the way in which child abuse and neglect can be understood and, consequently, also crucial in relation to the measures that one finds ought to be implemented in order to improve the child's chances of obtaining an ordinary good life.

Basic needs and welfare

When defining the concept child abuse and neglect, it is important to emphasize the normative aspects. That the concept is normative does, among other things, mean that it is firmly anchored in general social legislation and mentality. In 1992, the words "basic needs" and "welfare" were among the most significant in Danish legislation in relation to ensuring children and young people as good a childhood and adolescence as possible (with the adjustment of the Danish Social Assistance Act on 01 January 1993, the words "health" and "development" were introduced instead).

If a child's *basic needs* are thought to be threatened, it implies that the child "has difficulties in relation to its everyday environment, school or community, or that the child incidentally lives in an unfavorable environment." (Circular of 12.12.86 concerning counselling and supervision, according to the Social Assistance Act; quoted from Olsen, 1988). In such a case, relief measures towards the child and its family are to be implemented in anticipation of supporting "the upbringing, in the broadest sense of the word, with all the obligations this involves" (ibid). These measures constitute an offer which is to be implemented in collaboration with the parents, and they are free to either accept or refuse the offer.

If a child's *welfare* is threatened the situation is considerably more serious, and the public authorities are obliged to intervene with or without the parents' acceptance. In this case, the child's possibilities of growing up under satisfactory conditions are seriously threatened; in legislative terms it is regarded as "absolutely imperative for the sake of the child's welfare" (ibid) that relief measures are implemented. That these relief measures are an urgent necessity (in case they have to be implemented without the parents' consent; ultimately by removing the child from its home) is highly emphasized in legislation as well as in circulars: "As soon as it becomes a question of relief measures without consent, stricter demands regarding the foundation on which to make a decision to implement relief measures must be made. Such a decision must be based on an assumption that, generally speaking, isolated actions or acts of negligence indicating that problems of

support and upbringing are not solved quite satisfactorily are not sufficient evidence. Conditions justifying the implementation of relief measures outside the home without consent must, to a larger extent, reflect a certain behavior on the part of the child or the parents; that is to say that they must have manifested themselves in a number of actions or acts of negligence attesting to the fact that the child or young person has serious problems" (ibid).

The number of threatened children is unknown

There are no surveys which reveal how many children are presumably exposed to threats against their basic needs and/or welfare. As for threats against welfare, estimates based on the number of children placed outside their home exist. Schultz Jørgensen et al. (1989) estimate that among the 15,607 children and young people placed outside their home (with or without their parents' consent) in 1987, there are 6,500-7,000 children about whom it must be presumed that the sections on basic needs and welfare have been applied. Contrary to the other well over 8,000 removed children, these 6,500-7,000 children are not removed from their home due to problems of support (because of parents' death or illness, e.g.), physical or emotional handicaps; nor are they placed on a boarding school due to general conflicts in the family connected to the 15-17-year-olds. According to Schultz Jørgensen et al., "it must be expected that, for this group, it is a question of a so-called foundation of removal which is strongly connected to strained family circumstances in a very real and serious sense." I.e., circumstances which can be interpreted as a threat to the child's welfare according to the Social Assistance Act.

It is even more difficult to come up with exact figures when it comes to the number of children whose basic needs are threatened; in other words, how many children are there, on behalf of whom public authorities are to intervene with an offer of help, advice and guidance. Generally, it must be assumed that more children are threatened with regard to their basic needs than with regard to their welfare. However, when it comes to making an estimate there are several difficulties. Without further proof, an attempt to estimate the number of children based on certain implemented relief measures is not possible. First of all, parents are free to decide whether or not they want to accept the offered help; secondly, it is difficult to make an estimate because there are many different actions, symptoms or reactions which can lead to many different offers of help. Thirdly, it is very difficult to define when exactly a child's basic needs are threatened. In order for the Act to be applied, an interpretation of the concept basic needs is necessary (and, of course, the same is true of the concept welfare). What are the referred-to difficulties - specifically - and which other circumstances must be considered unsatisfactory?

Welfare - basic needs - child abuse and neglect

When discussing conditions where the child's basic needs (and sometimes also welfare) are threatened, words such as "maltreatment", "violence", "physical abuse", "physical harm", "neglect", and "lack of parental ability" are commonly employed (Schultz Jørgensen & Nissen, 1990).

A concept of a broader and more general nature is the concept "child abuse and neglect", which Schultz Jørgensen & Nissen (ibid) characterize as a concept that does not distinguish "be-

tween intentional and unintentional actions, nor between negligence of care due to greater or smaller parental ability". When it comes to circumstances regarding the basic needs of children, this concept must be considered more well-suited to characterize what is going on than terms such as maltreatment, violence, etc. which all implicitly indicate an intention. Schultz Jørgensen & Nissen (ibid) find that the concept ought to be developed further if it is to be used more specifically. Like Goll & Harder (1986) they are of the opinion that perhaps the concept - because of its broadness and imprecision - is less applicable when it comes to diagnosing, intervention and treatment; especially with social- and health services as a point of departure. At the same time, however, they underline that the concept may be developed further with advantage, and they quote Merrick (1984) for emphasizing that the concept has an advantage over other expressions of abuse because it describes a situation in which a parent or another adult "disregards his or her responsibility towards a child"; namely the responsibility attached to providing care.

It is this last use of the concept child abuse and neglect which is developed further in the study of child abuse and neglect among children aged 0-3 years. "Child abuse and neglect" is used as a concept which can help shed light upon the large area of difficulties, problems, conditions in which a child's basic needs, first and foremost, are threatened - and, to a smaller extent, the child's welfare.

Child abuse and neglect in "real life"; an example

After all these words and theoretical considerations one feels impelled to ask: "Well, how does it show; what is child abuse and neglect - in real life?" In the universe of the present study, "real life" is defined as the circumstances observed by the visiting health nurses when they believe they are faced with a child who is subjected to child abuse and neglect; a child whose basic needs or welfare is threatened. Now, let us see how the group of health nurses who followed the project have described their experiences from "real life" in an example to be used for examination. The example is based on specific experiences, but all names and information which may be used to identify the family have been changed.

Joy, 8 days old.

"I listen to the mother telling me about the birth, about how long it took, how much it hurt, etc. At the same time she tells me about their dog and about how strangely it behaves now. The father does not say anything.

After 15 minutes I try to lead the conversation on to their newborn baby. I ask them if I can see the baby.

I notice that my question provokes both of them. Instead of just getting the baby, they sit rigidly and bicker about which one of them should go downstairs to fetch the baby who has been sleeping outside in the street for an hour after they have returned from a walk in town. It is ten degrees Celcius outside.

I think: fatigue, lack of sleep, problems regarding division of labor between the two, the risk connected to leaving such a small child unattended for an hour, and how they separate their own needs from those of the baby and those of the dog.

When the baby is brought back I see a small pale sleeping child. As the mother undresses the baby, I notice that she is very unsure of how to

handle her baby. The girl wakes up and her mother's insecure movements seem to call forth all reflexes. She flutters her arms and legs wildly and starts screaming.

The mother cannot get the child to stop crying. On the contrary, I can see that the child's crying irritates her a little. The mother hands me the baby.

As *I explain and show* how the baby needs to be held in its mother's hands and arms, we get the baby to calm down, *together.*

I examine the baby without clothes and I see a thin pale child who is still 200 grams below her birth weight 8 days ago (2,300 grams). The physical examination, which I always make during my visits, covers the child's entire body, an overall impression of strength, symmetry and motoric patterns. With respect to Joy, I notice a slightly hollow fontanel, a slightly reduced turgur (signs of fluid deficiency); rather slow similar reflexes, slight bleeding from the navel and still a small piece of moist umbilical cord. Her skin is slightly spotted around nates. Other than that, she is a healthy baby, but deficient of fluids and seems a little neglected. My overall impression of this baby and her family right now is that they do not understand each other's needs and that they do not know how to find out.

The father hands me the discharge papers from the hospital from which it appears that the child is breast-fed and that there were no problems during the five days mother and child spent there. Together we read what it says.

While examining the baby, I explain the parents all along (i.e., most of the time only the mother watches) what I am doing; I answer the mother's questions and, among other things, I show her how to treat the navel.

At this point both mother and child have calmed down and the father has gone for a walk with the dog.

After dressing the baby again, we sit down in the living room and the mother lights a cigarette.

Based on what the parents told me at the beginning of my visit, my own observations while the baby was undressed, and the topics which the mother now wishes to discuss (e.g., she is not quite sure whether the baby gets enough to eat), we continue the next part of the visit.

Now, *I strive to* - in accordance with the parents' wishes - make them understand and interpret the baby's wishes and needs and to make them respond to these in a sensible way.

As for this visit, the most important aim of our discussion was to make sure that the parents understand their child's need for fluids and food; to clarify whether or not to breast-feed full-time, how to stimulate breast-feeding, in which situations the parents should decide to give a supplement, and different ways of comforting and calming down the baby. The family's new circadian rhythm and new relations and forms of being together.

I understand the mother's (and the father's) body language and elaborating questions as a sign that they understand what we are discussing, but also as an indicator of when to end our conversation.

We end the visit by writing, together, an entry in "Baby's Book" about the things the family wants to remember from my visit, and we make arrangements for my next visit.

On my way down the stairs I reflect on the loose ends of my visit: The family's network? - The parents' shared interest in their child? - The mother's physique? - The baby's physique, will to live, or problems? - The family's way of structuring their everyday life, their housing environment,

and their division of labor? - The parents' patience? - Time for love? What was their relationship like before the baby was born? And how do they expect to prioritize now? - Economic and work conditions? - Etc."

Joy, 6 months old.

"I notice that since my first visit Joy has learned to roll over on the floor, to reach out for everything in an unsteady way, and to put everything into her mouth, including the dog's bone and bowl. She is thin, her increase in weight since last time is not satisfactory. Her skin is pale; she is raw and full of spots around her buttocks. I *notice* that she smells strongly of urine and sour food because her clothes and she herself have not been washed. She looks at me with big eyes but I cannot get her to smile. *Other than that, I can see* that the mother is sitting on the couch and that the child, who has been placed in the corner of the couch, is about to fall over on her side. *I listen* to what the mother tells me; she is very angry with the staff at the day-care center because they have called her in for a talk about Joy's hygiene - "they say she smells of pee".

When Joy, after several attempts to attract her mother's attention, falls down on the edge of the couch with resigned cries, her mother pulls her up by jerking her one arm. Joy does not respond significantly to her mother's indifferent handling of her, but a moment later she cries a little again.

I tell the mother that the staff at the day-care center has contacted me as well regarding their concern about Joy's poor hygiene and the eating problems that she has according to their experience. While I tell her this, I sit down on the couch and place Joy between us and hold her stomach and support the upper part of her body.

I sense that the mother is on her guard now and once again I have to explain about my close collaboration with the day-care center and remind her that during my last visit she had agreed to my visiting Joy at the day-care center every now and then. *The mother tells me that she feels bad when she hears that we talk about them "behind her back"* and *I suggest* that we visit the day-care center together and make some arrangements. The mother is not very motivated; she has kept Joy home from the day-care center for two weeks now since the staff accused her of not taking care of Joy properly.

Once again I have to remind the mother why *we once agreed* that it was important for Joy to spend time at the day-care center. Joy wolfs down her food far too violently, she regurgitates a lot after every meal, and she does not gain weight. Furthermore, the mother has expressed a wish to have the daytime at her disposal, and I have given them guidance regarding Joy's needs for daily stimulation and informed them that the staff at the day-care center can help them fulfill these needs.

At the end of this discussion, the mother decides that she will bring Joy to the day-care center the following day, and we agree to meet there at 3 pm so that we both can participate in the discussion with the staff about Joy's growth and well-being.

We then talk about Joy's motoric development and *I commend the family* for letting her develop her motoric abilities on the floor. However, *I voice* my doubts concerning the expediency of letting Joy and the dog share bowl and bones!

Subsequently, we start discussing Joy's eating problems as the mother brings her a bottle just then. Joy is placed in the corner of the couch, the bottle is put in her mouth with a pillow underneath the bottle to support it. The mother reaches for her cigarette and looks at me expectantly. I ask

her how much is in the bottle and how many bottles Joy gets per day. It turns out that she gets a little less than one and a half liters ready-mixed breast milk substitute a day and a little gruel every now and then. She tastes the family's dinner whenever they have something that can be mashed. In no time, Joy has wolfed down her bottle; it has rolled down onto the floor where the dog plays with it. Now Joy regurgitates on the pillow and my pants and the mother reacts by saying: "There you see, she regurgitates every time she eats." I feel like replying: "I would bloody well think so, too, when she is fed flat on her back with no breaks where she can burp, and when she swallows it that fast." But we have discussed this so many times so this time I decide to ask the mother why she lays her down when she gives her the bottle? "I have tried to put her in a slanting chair with the bottle, but then she regurgitates even more", the mother replies.

Once again I show the mother how she can make the meal more pleasant for Joy by putting her on her lap, and I explain how she can control how much Joy eats at a time and that she should provide plenty of breaks for burping. I then choose to *go deeper into the problem* and ask the mother what she thinks of the regurgitation. Does she think that anything is wrong with Joy's stomach, with the food, or does she know other babies who regurgitate and why they do it? *I tell her that I think* that one of the reasons why Joy regurgitates is that she is left alone with the bottle and that she needs to be held by her parents so that she can make eye-contact while she is eating.

The mother is clearly unpleasantly affected now that we talk about the eating problems in this way, and, consequently, I go on *to give her some specific information* on how some children stop regurgitating when they get a supplement of mashed food, whereas others regurgitate for a long time.

This time I thus only succeeded in talking a little bit about the contact between mother and child.

Finally, Joy has to be changed and I grab the opportunity to *demonstrate* a thorough washing of the baby's buttocks and skin care in general. At the same time, the mother shows me how she can make Joy laugh when she puts her own face close to Joy's with a broad grin.

During the last part of the visit, I decide to concentrate on the contact between mother and child. As for the other matters: the regurgitation, the eating problems and the hygiene, we agree to discuss them further with the staff at the day-care center the following day.

When I look at this family, which *resources* do I find that they have that could be involved in our further collaboration? On the face of it, *I can see* that the mother is *amenable* to using me *as a partner or intermediary* in relation to the conflicts she finds that she has with the *staff at the day-care center.*

Apart from that, I wonder whether the other offers which are part of the visiting health nurse arrangement would be useful for her. E.g., whether she would feel like and think she would benefit from spending time with other young and adult unemployed people who have small children? Or, whether she could be motivated - with support and care - to make use of the day folk high school arrangement?"

Joy's story turned into a questionnaire

When you read the story about Joy it is evident that her parents, for different reasons, are not

capable of giving their child the care that she needs. I.e., Joy is one of those children who is subjected to child abuse and neglect. The story also reveals some of the nurse's feelings; how difficult it can be to help and, nevertheless, how anxious she is to support the family as much as possible.

If this study were a qualitative survey, the story about Joy and a number of other - different or similar - stories could serve as the data material that was to be analyzed. The analysis would then deal with, e.g., aspects regarding the contents of the form of child abuse and neglect which Joy is subjected to, the parents' situation, and/or the helpers' possibilities. The analysis would thus contribute to an improved understanding of child abuse and neglect.

However, in this case we deal with a quantitative survey - an attempt to measure the extent of child abuse and neglect - and the task is thus a different one. The task is rather to convert the contents of Joy's (and other's) story into something that can be measured; into something that can be formulated as questions and thereby into something the extent of which can be examined. Is Joy the only child in Denmark living under such conditions, or are there 10 children, 100 children, 1,000 children or 10,000 children who live like Joy?

Put differently, it means that the concept child abuse and neglect has to be operationalized into a number of actions or conditions which it would be possible for the health nurse to immediately observe and which, in principle, any health nurse would notice if she visited the family.

MEASURING: MAKING CHILD ABUSE AND NEGLECT MEASURABLE

The present attempt to convert the child abuse and neglect concept into something measurable is based on existing Danish analyses and surveys of care, lack of care, child abuse and neglect, and cruelty to children or violence against children (see e.g. Christensen, 1990; Dalgaard et al., 1983; Merrick, 1984; Michelsen et al., 1985a; b; Vesterdal, 1978). These surveys distinguish between actively (willfully) or passively (unintentionally) inflicted harmful effects, and between physical and emotional harmful effects. Michelsen et al., 1985a, distinguish between active and passive *violence* and between violence and *abuse and neglect.*

In the present study, the term abuse and neglect is used as the principal concept. A distinction is made as to whether the abuse and neglect is a result of the parents' active or passive actions; and as to whether the active or passive actions primarily have been in conflict with either the physical or the emotional care of the child. Analogous to Michelsen et al.'s (1985a) distinction between four forms of violence against children, the present study distinguishes between four forms of abuse and neglect; four abuse and neglect categories: *Active physical abuse and neglect* when harm is done to children as a result of adults' active or willful actions; *passive physical abuse and neglect* when children are exposed to serious neglect on the part of the adult; *active emotional abuse and neglect* when the adult constantly exposes the child to verbal insults, confinement, threats and rejections; and, finally, *passive emotional abuse and neglect* when children are subjected to abuse and neglect or understimulation due to parents' inability to provide security, care and love, e.g. because of psychic disorder, drug abuse (alcohol, medicine, narcotics), social problems, etc.

In the present study, the four abuse and neglect categories have been specified according to a number of observable signs or symptoms which the health nurse will be able to notice in her ordinary contact with the family. The health nurse is thus not asked to estimate whether she thinks that a smaller or larger number of children are subjected to child abuse and neglect. Great importance has been attached to constructing the questionnaire in such a way that the questions deal with a number of specific conditions which the health nurse will know for certain if she has observed or not. Separately, these conditions can be seen as signs of child abuse and neglect, based on the existing psychological and socio-medical knowledge of the subject. The specific formulation of the observable signs or symptoms are, to a large extent, based on "The Encyclopedia of Child Abuse", Clark & Clark, 1989.

Active physical child abuse and neglect

In the present study, active physical abuse and neglect is characterized as parental actions which are not unforeseen contingencies (i.e., they are not unintended accidents). In other words, harm is actively or willfully inflicted upon the child. Often, active physical abuse and neglect involves bruises or other signs, such as fractures, soft part injuries, burns, or bleeding beneath the dura mater. The operationalization of active physical child abuse and neglect is based on eight observable signs or symptoms which the nurses are asked to look for:

- broken arms, legs, ribs, etc.;
- bruises;

- burns (from cigarettes, iron, grill, scolding, etc.);
- marks from physical punishment (buttocks, cheeks, limbs);
- marks from human bites;
- scratches or abrasions around mouth, lips, gums, eyes;
- scratches or abrasions around genitals; and
- strong blushing and irritation around mouth and genitals.

Passive physical child abuse and neglect

The present study characterizes passive physical abuse and neglect as serious neglects on the part of the adult with the result that the child's physical needs are not satisfied so that its state of health is jeopardized.

The specific signs/symptoms which the nurses are asked to look for are the following:

- child is left without adult supervision for longer periods of time (1-2 hours or more);
- repeatedly, child has not been picked up from day-care center by the end of the day;
- child has been abandoned by parents for several days;
- child is malnourished (not enough food, or is fed on a too irregular basis);
- child is malnourished (too much food);
- child is neglected in terms of necessary medical treatment when ill or with regard to routine medical check-ups;
- child is extraordinary tired or atonic;
- child appears not to be properly looked after; appears untidy or dirty; and
- child is not dressed appropriately according to season and weather.

Active emotional child abuse and neglect

Active psychological or emotional abuse and neglect takes place when the parent exposes the child to a non-physical harming act.

In operationalized terms, active emotional abuse and neglect can be described by the following items:

- child is kept in confinement from time to time;
- child is threatened with violence/beating;
- child is threatened with loss of parents' love or loss of important relations;
- child is spoken to or talked about in an insulting way (wicked, stupid, ugly, impossible, a child nobody likes);
- parents react in a hostile way to the child's needs (child is regarded as an antagonist; as someone who actively opposes the parents);
- child is actively ignored by parents for longer periods of time. Parents do not listen to nor talk to the child;
- child is restricted from being together with other children and/or adults;
- child is taken care of by a large number of changing or coincidental adults; and
- child is mostly taken care of by older but not grown-up siblings.

Passive emotional child abuse and neglect

The present study characterizes passive psychological or emotional abuse and neglect as cases where the child is subjected to serious neglects of an emotional character due to parents' inability to provide security, care, love. This kind of neglect may cause developmental damages.

In specific operational terms, passive emotional abuse and neglect is characterized by the following conditions in a child's life:

- child has witnessed physical violence against mother or other instances of violence in the home;
- child has often been taken care of by drunk or otherwise intoxicated adults;
- the family's daily life is characterized by unpredictability;
- only to a small extent do parents respond to child's emotional needs; they are primarily preoccupied with their own emotional state of mind;
- only to a small extent are parents able to interpret the child's physical signals about inclination/disinclination and limits; and
- child is often rejected at the emotional level by parents.

Recapitulation of observable signs

In the questionnaire survey, child abuse and neglect is defined according to the above-mentioned signs/symptoms, classified in the four abuse and neglect categories: active physical abuse and neglect, passive physical abuse and neglect, active emotional abuse and neglect, and passive emotional abuse and neglect. This is what the nurses have been asked about, and this is what constitutes the foundation for the analysis.

If the individual observable signs or symptoms within each of the four abuse and neglect categories are seen in isolation - and seen separately from the abuse and neglect context - it can of course be discussed what it leads to. However, when presented in the context of child abuse and neglect, it is possible to professionally document that for each of the described signs/symptoms it makes sense to use them as circumstances which indicate a possibly occuring case of child abuse and neglect. Most health nurses possess this professional knowledge and will know what the signs/symptoms presumably indicate. In the subsequent analyses, child abuse and neglect is thus defined as described, with the deficiencies it might involve.

EMPIRICAL METHOD

The survey's empirical data have been obtained by means of a questionnaire which was mailed to every health nurse in Denmark. Among the health nurses, who at the time of the survey were working as visiting health nurses, 83 per cent (1,031 health nurses) answered the questionnaire wholly or partly. The questionnaire included four parts:

1. First, the individual health nurse was asked to answer a number of general questions regarding the age of the children she worked with (the survey was limited to children aged 0-3 years) and regarding the type of municipality she worked in (urban/rural). Subsequently, she was asked how many 0-year-old, 1-year-old, 2-year-old, and 3-year-old children she visited in her district. These figures state the total number of children embraced by the survey.

2. The next part of the questionnaire aimed at getting the health nurse to make a delimitation of the number of children whom she had visited at some point for "social reasons", based on a concern about the child's basic needs and/or welfare. The survey refers to these children as *"children in need of special care for social reasons"*. In order to specify the concept "children in need of special care for social reasons", social reasons were defined as "reasons in connection with e.g. poor housing conditions, developmental problems, family problems, economic problems, problems of abuse, or other conditions which may influence the child's basic needs and welfare". This second part of the questionnaire ended with information about how many 0-, 1-, 2-, and 3-year-old children in need of special care for social reasons the health nurse visited in her district.

3. The third part of the questionnaire contained only questions regarding children in need of special care for social reasons. In this part, the health nurses were asked to state occurrence of the four categories of signs or symptoms of child abuse and neglect, described under the four headings: active physical abuse and neglect, passive physical abuse and neglect, active emotional abuse and neglect, and passive emotional abuse and neglect. It was emphasized that the health nurses were only to state signs observed directly during their contact with the children and their families. For every single sign, the number of children with whom the sign in question could be observed has been stated. Subsequently, it is stated how many children in all showed signs from each of the four categories. This information constitutes the basis on which the estimate of the number of children subjected to child abuse and neglect has been made, and on which the characteristic of child abuse and neglect has been formulated.

4. The fourth and final part of the questionnaire included a number of questions regarding offered relief measures and psycho-social strains in the families.

The returned questionnaires contained information about a total of 78,625 children, distributed as follows: 50,151 0-year-olds; 18,042 1-year-olds; 6,798 2-year-olds; and 3,634 3-year-olds. These figures reflect the visiting health nurse arrangement as it functions in most municipalities; that is to say that there is a fixed number of visits which are conducted within the child's first year. After that, children with special needs are offered more visits until the age of six, although with an expected

reduction in the number of children receiving visits the older the children of a particular year get.

If we allow for approximately 55,000 children to be born in Denmark every year, it means that the information about the 0-year-olds covers approximately 90 per cent of all children born that year.

Consequently, information about the occurrence and nature of child abuse and neglect among children under the age of one year may be considered representative for this age group. The figures for children aged 1-3 years have to be characterized as minimum figures as it must be assumed that there are children within this age group who are subjected to child abuse and neglect but who are no longer in contact with the health nurse. In the following, solely results regarding children under the age of one year will be presented.

Methodological limitations

The applied method contains a number of inherent difficulties and limitations. First of all, it is generally difficult to examine conditions such as child abuse and neglect. It is not like examining working hours, income conditions, or voluntary participation in social work, just to give a few examples. The very phenomenon that is to be analyzed cannot be used when asking questions. If we asked 1,000 health nurses: "How many children in your district are subjected to child abuse and neglect?", we would most likely be able to come up with a figure; and an average figure as well. However, we would not know how to interpret the results. The problem is that there is no unambiguous and certainly no concrete definition of the concept which is to be examined.

The first task is consequently to define and operationalize the concept so that it is possible to ask questions from which you can expect to get understandable answers.

The next difficulty is a common methodological problem with respect to questionnaire surveys: do the answers indeed reflect what was meant by the questions? In this respect, the present survey probably manages better than many other questionnaire surveys. The questionnaires are answered by health nurses, exclusively, and they only contain questions which are related to the health nurses' shared professional knowledge and experience. The fact that a group of health nurses have followed the survey right from the start and that they have participated in the formulation of the questions has further minimized these problems. Language and concepts commonly used by health nurses have thus been taken into account.

A third problem - and also a matter of principle - is that information has been collected via key persons. Every health nurse has filled out her questionnaire with information about all children in her district; i.e., every questionnaire contains information about several children. This means that, first of all, all information has been filtered through the health nurse's understanding of the conditions. Secondly, only information about the health nurse's observations is included. Circumstances which are not known to her with certainty are not included in the survey.

In connection with the analysis of the collected data there is another limitation in that it is not possible to investigate correlations in the material regarding the individual child or the individual family. It is only possible to get information about the number of children who have been subjected to child abuse and neglect, as defined by the survey, and to distribute this information according to type of municipality. Correlations can only be analyzed as correlations in the individual health

nurse's observations. To give an example: if a health nurse visits many children with problem X, will she then also visit many children with parents who can be characterized by condition Y? If there is a correlation between the two a hypothesis could be made that it indicates a correlation in the lives of the children and their parents. However, this correlation cannot be documented by means of the present survey. It can only be regarded as a hypothesis and as a hopefully meaningful point of departure for further consideration or investigation.

As mentioned, the questionnaire was constructed in such a way that the health nurse, after having stated how many children aged 0-3 years she visited in her district, was asked to state how many children she visited due to social reasons - based on a concern for the child's basic needs and/or welfare. In the survey, these children are referred to as *"children in need of special care for social reasons"*. In the questionnaire, "social reasons" were characterized as "e.g. poor housing conditions, developmental problems, family problems, economic problems, problems of abuse, or other conditions which may influence the child's basic needs and welfare". Compared to common practice within the health services, the use of the concept "social reasons" has thus been expanded a little. At the same time, the use of the concept "children in need of special care" has been limited compared to how this concept is usually characterized. Children with special needs which are caused exclusively by illness, handicap, or acute family crises have not been included. With the concept "children in need of special care for social reasons", *a new category* has thus been created with the greatest importance attached to a combination of social reasons in the above-mentioned sense and a concern for the child's basic needs and welfare. This limitation of the concept is based on experiences from the survey "Families under strain" (Christensen, 1991).

Children in need of special care for social reasons

The survey reveals that *10 per cent of children under the age of one year can be characterized as children in need of special care for social reasons*; i.e., among the 0-year-olds the health nurses find that in 10 per cent of the cases there is reason to be concerned about whether the child's basic needs and welfare are provided for to a reasonable degree.

The estimate of how many children have been subjected to child abuse and neglect has been made through questions asked within the group of children in need of special care for social reasons. That is to say that the percentage of 0-1-year-old children subjected to abuse and neglect, as defined by the survey, cannot exceed 10 per cent. Most likely, the percentage will be less than 10 per cent since not all children in need of special care for social reasons have been subjected to abuse and neglect by their parents. To give an example, a child may be characterized as a child in need of special care for social reasons (meaning that the family consequently receives extra support), based on an assessment that the family lives in a situation of social strain. The parents may, however, live up to their obligations in terms of providing care for their children.

Percentage of 0-year-olds subjected to child abuse and neglect

It appears from Table 1 that *at least 4 per cent of 0-year-old children are subjected to child abuse and neglect.* One per cent have been subjected to active physical abuse and neglect; four per cent to passive physical abuse and neglect; two per cent to active emotional abuse and neglect; and four per cent to passive emotional abuse and neglect. It is not possible to estimate how many children have been subjected to more than one type of abuse and neglect.

It also appears from Table 1 that there is a majority of children who have been subjected to passive forms of abuse and neglect. This is fol-

lowed by active emotional abuse and neglect and, finally, active physical abuse and neglect.

Table 1. Distribution of 0-year-old children who have been subjected to one of the four forms of child abuse and neglect. Percentage.

Category of child abuse and neglect	Children aged 0-1 year
Active physical	1
Passive physical	4
Active emotional	2
Passive emotional	4
Number of children	50,151

The nature of child abuse and neglect

Based on the returned questionnaires it is possible to describe which observations or signs are the most common within each of the four categories of child abuse and neglect and, thus, to characterize the most frequently occurring observations within each category.

As for active physical child abuse and neglect, bruises and other signs of beatings or violence are the most commonly observed signs. I.e., signs/symptoms referring to the classical description of maltreatment of children.

Within the category passive physical child abuse and neglect, the most common observations are signs/symptoms of neglect in connection with malnutrition, insufficient clothes, and lack of care in connection with, e.g., routine medical care. In other words, signs/symptoms which resemble misery-marked children of former times. It ought to give rise to reflection that *4 per cent of a generation of 0-year-olds actually show signs of misery.*

Within the category active emotional child abuse and neglect, the most prevalent signs/symptoms indicate that the parents communicate with their children in a very negative way; a physical and verbal form of contact through which the parents communicate a number of negative signals which collectively tell the child that it is not worth anything, that its needs do not count, and that it should not feel too sure that anybody really likes it. I.e., signs/symptoms indicating an emotionally neglected child without proper contact to its surroundings.

The last category is passive emotional child abuse and neglect. Within this category observations indicate that a number of parents are not capable of interpreting their child's verbal and physical signals; nor are they capable of disregarding their own needs for the benefit of the child's needs. Furthermore, they may not be able to distinguish between their own needs and those of the child. That is to say that the child is emotionally neglected and that the environment in which the child grows up does not make it possible for the child to establish a meaningful (verbal or nonverbal) dialogue with its surroundings; a dialogue which may, at least partly, be based on the child's own feelings and/or needs.

Social strain and relief measures

Experience shows that psycho-social strain accumulate in those families where there is reason to be concerned about the child's basic needs and/or welfare. Or, perhaps these families are the most visible. In the survey, questions were asked concerning a number of known psycho-social strains among the parents of the children in need of special care for social reasons.

The survey reveals that, according to the health nurses, the families of children in need of special care for social reasons can be characterized by the fact that they subsist on transfer income and/or their being subjected to such strains as low intelligence, alcohol abuse, physical maltreatment of the mother, mental illness, physical illness, and drug abuse. However, it is important to note that since the strains just mentioned characterize 80 per cent of the parents of children in need of special care for social reasons, there is another 20 per cent of these children whose parents cannot be characterized by such strains.

In other words, it is important to realize that *there is a group of children in need of special care for social reasons and a group of children subjected to abuse and neglect whose families do not immediately appear to be families with economic and psycho-social problems.*

Four fifths of the parents of children in need of special care for social reasons depend on transfer income. Other than that, low intelligence in the case of one of the parents, alcohol abuse in the case of one or both parents, and physical maltreatment of the mother are the most common strains.

As far as relief measures are concerned, it is evident that the aim is for the family to remain together in their familiar environment. Relief measures outside the children's home have been implemented in very few cases only (0.6 per cent of all children). The most common relief measures are orders/recommendations concerning day-care center, assignment of a personal advisor, and counseling/therapy with a psychologist or another qualified person at a counceling clinic.

CONCLUSION AND RECOMMENDATIONS

It is noteworthy that *physical maltreatment* in the form of e.g. beating which leaves bruises or other more violent forms of physical abuse is of relatively rare occurrence. Of course, this may indicate that it actually is the most rare kind of child abuse and neglect as far as children 0-1 years of age are concerned. However, it cannot be ignored that, as a principal rule, it is the kind of abuse and neglect which is easiest for the parents to conceal. If a child has visible bruises from e.g. beating the parents may call off the health nurse's visit and then make a new arrangement with her when the bruises have disappeared.

During the course of the survey, this subresult has been discussed with qualified people from different professional groups who have experience from cases of child abuse. According to their unambiguous reactions, the figures reflect experiences from practical work, namely that, in relative terms, there has presumably been a reduction in the number of children (0-16 years old) subjected to active physical child abuse and neglect in recent years.

Furthermore, it also has to be presumed that inasmuch as child abuse and neglect has been discussed more in recent years, increased attention will be paid to the passive forms which have been the most invisible so far (cf. Heap, 1985). The survey thus advances a hypothesis that *in the next few years the tendency will be for passive forms of child abuse and neglect to gain a steadily increasing significance for children's development and conditions of life*. Consequently, it is important that general preventive work to a larger degree takes these forms of child abuse and neglect into account when the work is organized.

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