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■ Original Article

The evaluation of general knowledge of emergency care providers about child abuse and neglect

Acil sağlık çalışanlarının çocuk istismarı ve ihmali hakkında genel bilgilerinin değerlendirilmesi

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ABSTRACT

Aim: Child abuse and neglect is a public healthcare problem with medical, legal, developmental and psychosocial comprehension, having complex causes and tragic consequences. The incidence of it in societies is not fully detected. We aimed to measure the knowledge levels of doctors and allied healthcare personnel in emergency departments (ED) about child maltreatment, compare with non-healthcare control group and find out the altering factors.

Material and Methods: In our study, a group of 400 consisted of ED doctors, pediatricians and other healthcare providers who were working in Teaching, University and General Hospital ED in Ankara and 105 subjects as a control group were included. A survey consisting of the demographic questions which also had myth part about child abuse and neglect was configured.

Results: Among the demographics and myth beliefs, it was found that the institutions where the doctors and allied staff work affect their belief in myths, the experience duration is a variable between healthcare staff, receiving training about child abuse is an altering factor for success rate and having children of own doesn't affect the accuracy significantly ($P > 0.05$). The success rates of the control group showed similarity with allied personnel to each myth ($P > 0.05$). However, the control group had low accuracy on myths 7, 18, 19, 22, 25, 27, 30, and 35 than doctors.

Conclusion: All the healthcare providers who work in pediatric and emergency medicine clinics where pediatric patients are encountered mostly should know signs and symptoms of child abuse and neglect, in addition have responsibilities for reporting them to the legal departments. Furthermore, regular training programs should be applied both to community and healthcare system to disprove the myths on this topic.

Keywords: Child abuse, neglect, sexual abuse

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ÖZ

Amaç: Çocuk istismarı ve ihmali, karmaşık nedenleri ve trajik sonuçları sebebiyle tıbbi, yasal, gelişimsel ve psikososyal bir halk sağlığı sorunudur. Toplum içindeki gerçek insidansı tam olarak bilinmemektedir. Çalışmamızda acil servislerde çalışan hekimler ve yardımcı sağlık personelinin çocuk istismarı ve ihmali hakkında bilgi düzeylerini ölçmeyi; elde edilen sonuçları sağlık çalışanı olmayan kontrol grubuyla karşılaştırmayı amaçladık.

Gereç ve Yöntemler: Çalışmamıza Ankara İlindeki Eğitim Araştırma, Üniversite ve Devlet hastanelerinde çalışan acil doktorları, pediatri hekimleri ve diğer sağlık çalışanlarından oluşan 400 kişilik bir çalışma grubu ve 105 katılımcıdan oluşan kontrol grubu dahil edilerek yapılmıştır. Katılımcılara hem demografik sorulardan oluşan hem de çocuk istismarı ve ihmali konusunda genel olarak inanılan mitleri içeren birer anket uygulanmıştır.

Bulgular: Demografik sorular ve mitler içeren ankette, doktorlar ve yardımcı sağlık çalışanlarının çalıştıkları kurumların mitlere bakış açısını etkilediği, deneyim süresinin sağlık çalışanları için bir değişken olduğu, çocuk istismarı konusunda eğitim almış olmanın belirleyici olduğu fakat çocuk sahibi olmanın cevaplardaki doğruluğu anlamlı şekilde etkilemediği tespit edilmiştir ($p>0,05$). Kontrol grubunun başarı oranları her mit için yardımcı sağlık personeli ile benzerlik göstermiştir ($p> 0,05$). Ancak kontrol grubunun 7, 18, 19, 22, 25, 27, 30 ve 35 numaralı mitlerde doktorlara göre düşük doğruluk oranları tespit edilmiştir.

Sonuçlar: Acil servislerinde ve çoğunlukla çocuk yaş grubunun bakıldığı pediatrik acil servislerinde çalışan tüm sağlık çalışanlarının çocuk istismarı ve ihmaliine dair belirti ve bulgularını bilmeleri gerekmektedir. Ayrıca yasal birimlere bildirmeye yönelik sorumlulukları mevcuttur. Bu konudaki mitleri çürütmeye yönelik düzenli eğitim programları hem sağlık sisteminde hem de toplum düzeyinde uygulanmalıdır.

Anahtar kelimeler: Çocuk istismarı, ihmal, cinsel istismar

Introduction

Child abuse and neglect is a public healthcare problem with medical, legal, developmental and psychosocial comprehension, having complex causes and tragic consequences. The incidence in societies is not fully detected. The description of child abuses and neglect (sometimes referred to as child maltreatment) by the World Health Organization (WHO) includes all forms of physical and emotional ill-treatment, sexual abuse, neglect and exploitation that results in actual or potential harm to the child's health, development or dignity [1]. According to WHO, it's estimated that 57 thousand children suffered death because of child abuse and neglect in the year 2000. However, it's believed that the data on mortality are incomplete and the true numbers are estimated to be higher than the calculated figures [2].

From the time that human beings came into existence, cases of child abuse have occurred in every different society and culture. Some groups have worked for the prevention of violence against children from the very ancient times. However, for a long time these studies didn't take attention of the public until finally in 1962, the violence and abuse against children gained importance after the publication of "Battered Child", an article by Kempe et al [3]. Since then, the literature dealing with child abuse and neglect has been increasing with high quality work being done and reported on the many dimensions related to the epidemiology, mechanism, treatment, and prognosis of child maltreatment. Efforts are being directed toward developing an evidence-based approach to the prevention of child abuse and neglect but

it's still a fact that the number of abused children is increasing although the efforts to prevent child abuse all over the world with each passing day. Child maltreatment is underreported in all countries mostly despite mandatory reporting policies. Several studies indicated that the main causes are unawareness of legal written protocols regarding reporting of child maltreatment, incorrect reporting knowledge, recognizing deficiency of abuse and interviewing techniques [4-7]. Therefore, there has been lots of studies regarding the level of knowledge and perspectives of different health provider groups to identify and to spot the problematic steps (prehospital providers, physicians, nurses, allied health workers, team directors) [6-13].

In the society in which it is told, a "myth" is a way of mysterious storytelling usually regarded as a true account of the remote past. It consists of excerpt thoughts and stories that are not certain to be true. Although the definition of child maltreatment is constant, still it is considered to be exploited by the socio-cultural beliefs, and myths vary according to the conditions in the affected communities [14]. The real incidence of child abuse is still controversial due to differing social beliefs. The role of health care providers in the detection, treatment and prevention of child abuse is undeniable. They should not be affected by cultural myths and should work toward using scientific definitions to disprove these myths. Emergency medicine physicians, nurses, allied health care staff and social workers have an important role as much as pediatricians in this regard.

In our study, we aimed to investigate the myths and the level of knowledge of the physicians and the other health care staff working in the emergency department regarding child abuse.

Material and Methods

This multicenter and descriptive study was based on a questionnaire distributed in our capital city, Ankara, between April and June 2012. Volunteer physicians and allied health staff working in the emergency departments of our city (nurses and health technicians) were included. The study was carried out with both pediatric and adult emergency department staff due to the management of pediatric trauma patients in many centers by emergency medicine specialist and residents in our country.

The questionnaire forms were sent to 3 universities, 5 teaching and 3 state hospitals. All the filled-in forms were randomly evaluated by 200 physicians and 200 allied healthcare staff. In the control group, a total of 105 people were selected

randomly among at least college graduated non-healthcare professionals with similar demographic status of study group. The questionnaire form consists of 2 parts. In the first section, demographic information of the participants was collected; in the second section, the myths about child abuse were explored using questions about 37 common but incorrect beliefs. Information on previous training of child abuse was also collected. The myths in the form were a collection of the most frequent child abuse and neglect issues and wrong beliefs which confront the medical and health professionals which are investigated and discussed by many national and international organizations like ASCA (Adult Surviving Child Abuse) and UNICEF [15-25]. The participants were asked to answer "right" or "wrong" to the myths (Table 1).

Table 1. The right and wrong survey questions regarding commonly believed myths about child abuse and neglect

1.	Child abuse is rare.
2.	It is only abuse if it is violent.
3.	It is not possible that any nuclear family member abuses his/her own child.
4.	Only bad people abuse their children.
5.	Child abuse doesn't happen in "good" families.
6.	Most child abusers are strangers.
7.	Abused children always grow up to be abusers.
8.	Anyone who would molest a child is seedy-looking or looks suspicious. I'd know them by looking at them.
9.	Child molesters are unsociable and isolated. If I knew any, I'm sure I naturally wouldn't like them.
10.	Married men don't molest children—they have their wives. Besides, a married man would only molest a child if he wasn't getting sex from his wife.
11.	Many child abusers have problems on their sexual life.
12.	He's a pastor (or teacher, or elder, or highly respected businessman) – he would never do that.
13.	He has a Ph.D., she's president of the company—too smart to be doing something that depraved and disgusting.
14.	A real child molester would never talk about the subject.
15.	Children always react to their abusers.
16.	Abusers cannot be the ones who abused children don't resist against hugging or touching them.
17.	Women do not sexually abuse children.
18.	Some cultures believe that child abuse is acceptable.
19.	Children often lie about abuse.
20.	Children are always safe in groups.
21.	Disabled children are less likely to become victims of abuse.
22.	Child abusers have deprived backgrounds and are of below average intelligence.
23.	I do not think abusers have a high level of intelligence.
24.	People lie about child abuse for attention and sympathy.
25.	Many so-called survivors suffer from False Memory Syndrome.
26.	People do not "forget" child abuse, therefore "recovered memories" are false.
27.	People who sexually abuse children are mentally ill.
28.	Sexual abuse victims are "damaged goods" and their lives are ruined forever.
29.	People who sexually abuse children have been sexually abused themselves.
30.	Men and women sexually abuse children equally.
31.	All offenders are male, all victims are female.
32.	Children are very suggestible and they can easy "make up" stories of abuse.
33.	Children can fabricate sexual abuse stories because of their huge imaginations.
34.	Cute and attractive girls, runaway children and neglected children are potential victims of sexual abuse.
35.	Parks, public toilets, deserted streets, dark places, leisure areas and construction sites are the places where abuse often occurs.
36.	Sexual abusers are violent, aggressive, senile or mentally ill.
37.	Children who are being abused would immediately tell their parents.



Results were based on descriptive statistics. During the second part of the survey, an exploration of 37 myth belief items, if the participant chose "right", it was interpreted labeled as "1". Likewise, indication of "wrong" labeled as "2". We chose to calculate a "success score" for each group according to this labeling based on the number of correct answers. The number of groups forming the data among physicians and allied healthcare staff were equal. Therefore, in order to accurately compare success scores, the contribution of the number of data to obtained score was projected. In this way, the contribution of each participant was emphasized in the calculation of the success score. The aim was to be able to have comparable obtained data results with (0, 1) interval.

In the case of all myths being believed by the study group, the lowest obtained group score is equal to data number of the group and this score is referred to as base score. For example, when evaluating a group of 104 male doctors, if a single myth is found to be believed by the whole group, they receive a base score of 104, indicating the worst scenario for this item of evaluation. When the obtained score of a group is greater than the base score, it indicates well-informed disbelief as success using the same ratio. For example, if the male doctor group has obtained a total score of 174, 104 of this score will be the base score. We find the success score by subtracting the base score from the total score; for this example, the success score is 70 (174-104=70). When we are projecting the sample number to the success score, we can formalize it in the way of myth = (Total score-base score)/sample number (m=success score of a group, n=myth score of the group). For example, for the first myth in the male physician group, the success score is calculated by: Myth 1 Male Physician = (174-104) / 104 = 0.67. We have used Microsoft Excel 2010 throughout the study.

Results

Of the 200 participant physicians in our study, 146 (73%) are emergency medicine specialists, 42 (21%) are emergency medicine residents and 12 (6%) general practitioners. The figure of 200 allied healthcare staff includes 162 (81%) adult emergency department nurses and 38 (19%) pediatric emergency department nurses. In the control group, 68 (64.7%) subjects have a university license, 32 (30.4%) have a master license and 5 (4.7%) just have a college education. The professional fields of the control group include university faculty, police, teachers and engineers.

The overall mean age of the participants was 29.54 (min: 18, max 58), the overall mean age of physicians was 30.92 (min

24, max 51) and the average age of allied health staff was 26.85 (min 18, max 58). The control group had an average age of 32.05 (min 19, max 50). Gender subgroups were equally distributed in physician and control group (male/female ratio; 104/96, 48/57) but significant female intention in allied health staff were noticed (46/154). Experience durations were equally distributed for physician and allied staff in year base. Physician reported receiving more professional educational opportunities than and allied staff (Training programs + congress / symposium; 93+20, 85+6). For control group, these numbers were quite low (4+2). All three groups were mainly parents (Having child of own/no child; 133/67 for physicians, 149/51 for allied staff and 68/37 for control group). The demographic data of 200 physicians, 200 allied health staff and 105 control group subjects is summarized in Table 2.

Table 2. Demographic summary of the participants

		Doctor	Nurse	Control
Gender	Male	104	46	48
	Female	96	154	57
Marital status	Married	115	64	49
	Single	85	136	56
Age	≤20	0	30	3
	21-30	129	125	44
	≥31	71	45	58
Child status	Has	133	149	68
	Has Not	67	51	37
Education Source	Education program	93	85	4
	Congress	20	6	2
	Independent Research	27	39	8
	Media	65	78	92
Education about child abuse	Received	93	85	4
	Not received	107	115	101
Work institution	Teaching Hospital	122	124	-
	State Hospital	26	42	-
	University Hospital	52	34	-
	Special	0	0	-
Working duration at emergency department	1 Year	55	58	-
	2 Years	53	46	-
	3 Years	45	31	-
	4 Years or more	47	65	-

A total of 505 participants were asked to complete the questionnaire about child abuse. The questionnaire included 37 myths. The beliefs on these myths were evaluated. The correct answer rates between 80-100% were considered successful. The myths which the physicians, staff and control groups all answered successfully were numbers 3, 5, 8, 10, 12, 13, 16 and 31. In general, all groups failed in number 2, 18, 25, 34, and 35 (Figure 1), widely believing the myths.

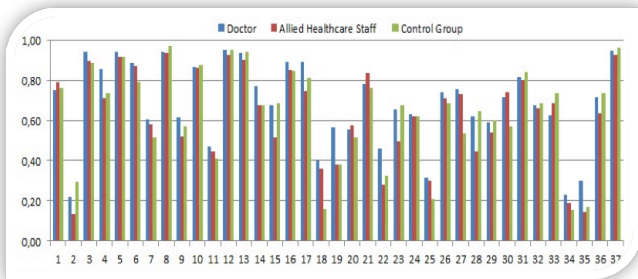


Figure 1: The rates of beliefs in myths by all groups

It is investigated whether the institutions where physicians work affect their belief in myths or not. The results from physicians practicing in Teaching Hospitals and University Hospitals showed similar rates of accuracy, but the results collected from State Hospitals showed the lowest rate of accuracy ($P < 0.05$) (Figure 2). In the results collected from the allied medical staff, the results from State and Teaching hospitals showed similar rates of accuracy but they showed lower success rate compared to University hospitals colleagues ($P < 0.05$) (Figure 3).

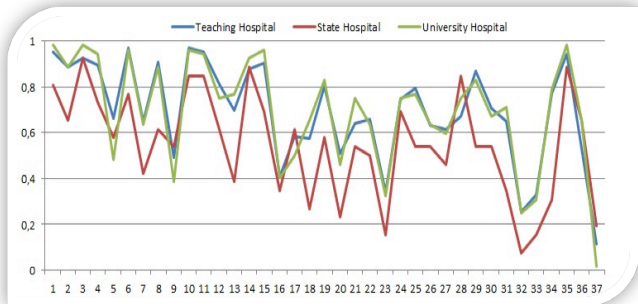


Figure 2: The rates of beliefs among doctors according to their institutions

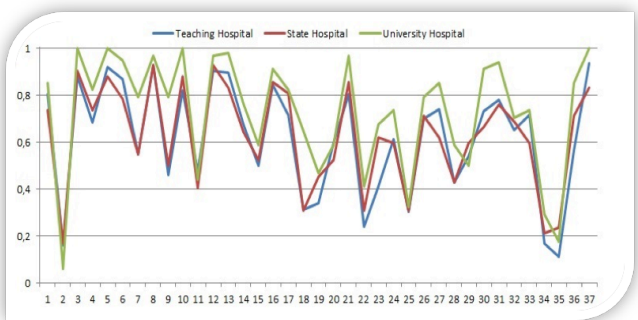


Figure 3: The rates of beliefs among allied healthcare staff according to their institutions

It was evaluated during the study that if the duration of work in emergency departments by participating physicians and allied health staff is a variable factor in beliefs on myths about child abuse. Physicians with less than three years of experience had lower accuracy rate identifying myths about child abuse compared to physicians with more than three years of experience ($P < 0.05$) (Figures 4,5).

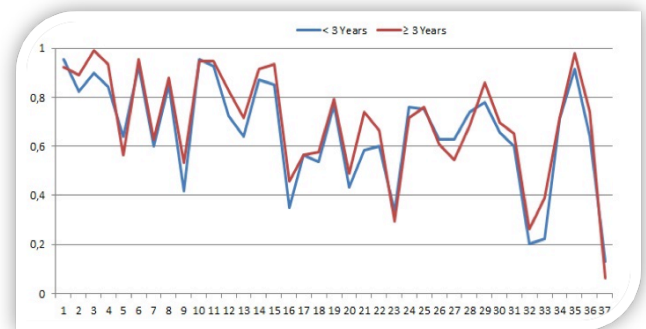


Figure 4: The rates of beliefs among doctors according to their working durations

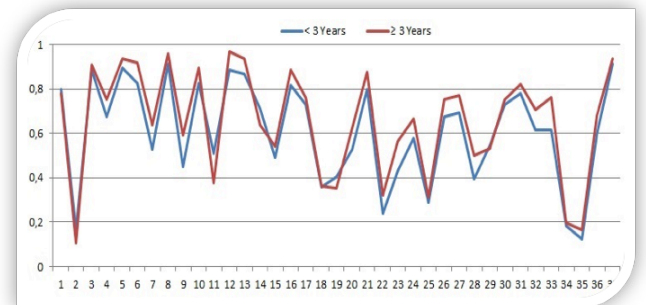


Figure 5: The rates of beliefs among allied healthcare staff according to their working durations

It is also assessed by enquiring about the education history of physicians and allied staff that whether receiving training about child abuse is altering belief in myths or not. It was found that the educated physicians and allied health staff group had higher rates of accuracy to the queried myths ($P < 0.05$).

No significant difference on myth beliefs was detected between physicians and other healthcare staff with children of their own and those without any children ($P > 0.05$). In our study, the difference in beliefs among emergency department medical staff and the control group was examined. The success rates of the control group who were not members of healthcare showed similarity with allied health staff to each myth ($P > 0.05$). However, the control group had higher belief rates on myths 7, 18, 19, 22, 25, 27, 30, and 35 than emergency physicians. It was noticed that the control group had a particularly significant high belief in the wrong myth of “The concept of child abuse varies according to the culture”. The most widely wrong beliefs for each of the three occupational groups were myths number 2, 34 and 35. In our study, more than 90% in all groups stated that they do not believe in 5, 8, 12, 13 and 37 numbered myths (Figure 1).



Discussion

The high rates of incorrect belief in the description of abuse as “physical violence against children” may be explained by incomplete and inadequate information on the true definition. Physical violence is more prevalent than other kinds of abuse, so sexual abuse and neglect are often forgotten when identifying child maltreatment. In terms of knowledge among the participants in our study and all over world, emotional abuse of children is underestimated or disregarded.

In our study, we have investigated physicians from different institutions if the beliefs in the myths about child abuse are changing. The results from the physicians practicing in Teaching Hospitals and University Hospitals showed similar rates of accuracy, but the results collected from State Hospitals showed the lowest rate of accuracy. In the results collected from the allied staff, the results from State and Teaching hospitals showed similarly low rates of accuracy compared to the results of high accuracy collected from University hospitals. It was detected in our study that physicians and allied health staff who had received an education in child maltreatment more frequently answered questions correctly. The difference in the rates of accuracy may come as a result of academic healthcare staff’s opportunity to access more scientific publications, to participate in scientific meetings and the extra attention given to post-graduate education by University and Teaching hospitals.

It was found that among the participant physicians and allied health staff, physicians with less than three years of experience had a lower success score compared to physicians with more than three years of experience. This finding confirms that obtaining education and experience contribute to altering belief in myths.

In our study, the ratios of belief in myths of both men and women in the physicians and allied medical staff were almost parallel with each other, but women had a slightly higher accuracy rate.

It is also detected that physicians and allied staff with children of their own had more accurate answers but it is not statistically significant. In the same way, in a study of Akçay et al conducted in İstanbul University; factors of expertise, gender, state of having kids and duration of training of the physicians do not cause statistically significant difference in approaches to child abuse [26]. The most correct answers were given from the Departments of Emergency Surgery and Trauma and Pediatrics. Physicians with female gender and specialty education duration with more than four years were more successful than most. In the study of Al-Moosa et al, young female physicians were more successful in recognizing child abuse compared to other demographics [7]. Also there was no difference in results due to having children [8-9].

In our study we searched for any difference between healthcare providers and the control group. The ratio of accuracy for the myths in the control group was similar to that of allied healthcare staff, but the control group had more belief in myths than emergency medicine physicians. The control group had a high belief in the myth “the concept of child abuse may vary between cultures”. At the same time, the control group had less belief than physicians and allied staff in the myth that “Abuse is defined as physical violence against children”.

In both diagnosis and treatment of child abuse and neglect, a multidisciplinary approach is necessary. Physicians, especially those in pediatric and emergency care who are commonly faced with cases of abuse, have an unavoidable ethical, moral and legal responsibility to recognize signs and symptoms of child maltreatment and notify legal units. Child abuse has a specific definition and should no longer be tolerated due to outdated cultural mentalities [14]. Regular community education programs should be applied in our society to correct the wrong belief in myths regarding child maltreatment as many studies suggest [27-30].

Limitations of the study: This study may not generalize to all emergency health providers in Turkey, especially considering that most of the centers in Ankara, pediatricians have a more active role on these patients in emergency departments. Probably, pediatricians may have better knowledge about child abuse and better results than the other health allied staff and control group.

As a conclusion, our study shows significant deficiencies in several critical knowledge areas, including identification of child maltreatment. These findings highlight the need for increased education in the realm of emergency care. National legal protocols regarding reporting suspected cases of maltreatment must be well designed and more applicable. Therefore, the inclusion of programs in child abuse mythology in periodic post-graduate training programs and the curriculum of medical and nursing schools should be considered.

More extensive studies to examine child abuse and neglect are needed in our country. Further studies are vital not only for the collection of medical statistical data, but also for the awareness and prevention of child abuse in Turkey.

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