Commentary: Child Maltreatment and Physical Health: A Call to Action

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The preceding section provides new and important information about the link between exposure to one or more types of child maltreatment and impairment that moves the field beyond the association with mental health problems. Despite differences in samples, measurement, and design, the message is consistent across these studies: child maltreatment is associated with a broad range of adverse physical health outcomes, as well as behaviors that increase risk for such outcomes.

Using data from the Chicago Longitudinal Study (CLS), Topitzes, Mersky, and Reynolds (2010) examined the relationship between official reports of child maltreatment collected prospectively and self-report survey data of tobacco smoking by young adults, taking into account a broad range of mediators. In this sample of socially disadvantaged minority participants, official reports of child maltreatment predicted smoking in young adulthood in both genders. This relationship was mediated by several emotional, social, and cognitive factors in adolescence and young adulthood, as well as by school mobility.

The study by Clark, Thatcher, and Martin (2010) surveyed a combined clinical and community sample of adolescents about a range of traumas, substance-use disorders and health-related symptoms, and administered a baseline comprehensive physical examination in addition to laboratory studies. At each assessment, health-related symptoms showed a strong association with trauma severity, a relationship mediated by anxiety. The authors concluded that some physical and laboratory findings in adolescence suggested stress-related responses.

Lanier, Jonson-Reid, Stahlschmidt, Drake, and Constantino (2010) compared the risk of hospital-based care for asthma, cardio-respiratory illness and infections among maltreated and nonmaltreated groups of low-income children. Using longitudinal administrative data from state information systems and controlling for individual, family, and community factors, they found that children reported for maltreatment were at higher risk of hospital care for each of these conditions. Furthermore, recurrent reports of maltreatment were associated with a greater number of hospital care episodes for these illnesses.

The meta-analysis by Irish, Kobayashi, and Delahanty (2010), examined the relationship between exposure to child sexual abuse and physical health outcomes taking into account sampling, measurement, and study design characteristics. A history of sexual abuse in childhood was associated with more physical health symptoms compared with control groups for the majority of outcomes. With one exception, these differences were larger for clinical than community groups.

The overall coherence in findings across these studies is particularly notable, given the differences in approaches to measurement of child maltreatment: Clark et al. (2010) used a structured trauma interview to measure subtypes of abuse but did not include neglect; Irish et al. (2010) focused exclusively on studies of sexual abuse assessed by one or more of self-report questionnaire, interview, or chart review; and the remaining two investigations relied on official reports of maltreatment, although the CLS records did not include cases of emotional abuse. Some might conclude that the approach to measurement of child maltreatment does not matter much—the majority of studies show a link between exposure and impairment; in the case of these four studies, physical health outcomes. Nothing could be further from the truth—especially when
investigating the possible mechanisms and trajectories by which child maltreatment is associated with impairment, as well as assessing the effectiveness of interventions—we need valid and reliable approaches to determine exposure.

The authors are careful to discuss general methodological limitations of their studies, but there is relatively little focus on the potential biases associated with measurement of child maltreatment beyond the well-known “tip of the iceberg” aspect of official reports. What is the reliability and validity of official report data accessed in the CLS and in the state information systems used by Lanier et al. (2010)? Children frequently experience multiple types of maltreatment, yet child-protection agencies often discourage recording of more than one type (Gilbert et al., 2009). Self-report approaches also have limitations. Clark et al. (2010) provided definitions for the child abuse measured with structured questions and then identified “trauma classes;” what is the evidence for this approach? Although Irish et al. (2010) suggested that future research consider the method of sexual abuse assessment as a potential “methodological moderator” in the relationship between exposure and physical health, there is still the important issue of the abuse measure itself and its psychometric properties.

Concerns about the measurement of maltreatment are not specific to these studies. In a recent commentary about the “life course consequences of abuse, neglect and victimization,” despite a generally positive description of the National Comorbidity Study (NCS), Macmillan (2009; no relation) referred to the NCS measurement of child maltreatment as “less than desirable.” Such concerns are not new; a decade ago, Hamby and Finkelhor (2000) made 20 recommendations about the assessment of and instrument development for children’s victimization, including the need to map exposures onto child protection system categories, and measures to include simple, behaviorally specific language. The authors of all four studies emphasized the need to consider subtypes of maltreatment. Although considerable progress has been made in the measurement of physical and sexual abuse, neglect and emotional abuse have received much less attention (Gilbert et al., 2009), and exposure to intimate partner violence has only recently been considered a subtype of child maltreatment.

What are the clinical implications of these findings? Lanier et al. (2010) suggest that “attention should be paid to the health needs of children reported for maltreatment separate from concerns of immediate harm.” Clark et al. (2010) recommend regular screening of “adolescents with child abuse histories.” Topitzes et al. (2010) call for a focus on the developmental processes in promoting resilience among maltreated children. However, the critical question is: how do we make development and evaluation of interventions to prevent maltreatment and associated impairment a priority? Our knowledge about the burden and associated impairment of child maltreatment far exceeds what we know about ways to intervene—just compare two recent reviews on these issues (Gilbert et al., 2009 vs. MacMillan et al., 2009). While it is encouraging that investigators such as Topitzes et al. (2010) consider intervention approaches arising from their study findings, it is essential that we prioritize evaluation of specific approaches and programs aimed at preventing child maltreatment, including public health strategies. It is not sufficient to extrapolate potential approaches from epidemiologic studies; wherever possible, we need to examine the effectiveness of interventions and policies with experimental designs.

What should those of us who are clinicians do in the meantime? Advocate for the implementation of effective programs such as the Nurse Family Partnership (Olds, Sadler, & Kitzman, 2007); recognize and respond to child maltreatment when it occurs (Gilbert et al., 2009); and ensure that children and adolescents who have been victimized have access to the few efficacious interventions that exist, such as cognitive–behavioral therapy for sexually abused children with posttraumatic stress symptoms (Macdonald, Higgins, & Ramchandani, 2006). But especially when it comes to preventing recurrence of maltreatment, we should not assume that a “promising” intervention is effective, as a recent trial of intensive home visiting for families involved with the child welfare system demonstrated (MacMillan et al., 2005).

The results from these four articles add to the ever-expanding evidence about the broad range of problems experienced by children who have been maltreated. While this inquiry should continue, we need to recruit more scientists (and more funding) to the intervention field. Let us hope the emphasis on both mental and physical impairment associated with child maltreatment will provide the “tipping point,” creating a call to action for intervention research.

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References


