J Child Fam Stud (2016) 25:2292–2305
DOI 10.1007/s10826-016-0385-x

ORIGINAL PAPER

Defining Child Maltreatment Among Lay People and Community Professionals: Exploring Consensus in Ratings of Severity

Maria Manuela Calheiros[1] · **Maria Benedicta Monteiro**[1] · **Joana Nunes Patrício**[1] · **Margarida Carmona**[2]

Published online: 26 February 2016

Abstract The way in which laypeople and community professionals define child maltreatment in a family context is essential in decision-making on its referral and assessment. Despite differences found in the perspectives of the two groups, operating definitions are needed, which integrate them. The purpose of this work is to define types of maltreatment, integrating both perspectives (study 1) and to analyse the assessment of the severity of these practices (study 2). In study 1, a consensual qualitative research method was used to analyse 123 interviews of laypeople and 9 annual reports of social and health community services. A joint analysis of 1235 record units allowed us to obtain an integrated definition comprised of 6 types and 20 subtypes of maltreatment. In study 2, with the material gathered in study 1, a scale was created with 4 degrees of severity, based on the Maltreatment Classification System. Next, a sample of 159 interns, from health and social science areas with or without contact with situations of maltreatment, evaluated the severity of the items. An analysis of Kendall's coefficient of concordance showed a lack of consensus in 9 of the 20 subtypes, with physical abuse and sexual abuse being the most consensual types, as opposed to psychological abuse and neglect. These studies underscore the importance of understanding this phenomenon at a community level, and suggest that public awareness may facilitate the referral of these practices, minimizing the over-reporting and under-reporting of cases, and encouraging early and preventive intervention.

Keywords Child maltreatment · Definition · Severity · Community professionals · Laypeople

Introduction

According to the World Health Organization (2014), international estimates on the occurrence and prevalence of child maltreatment in a family context vary, among other factors, according to the definitions of abuse and neglect employed, which play a central role in decision-making on referrals and the remaining assessment process (Arruabarrena and De Paúl 2012; Rodrigues et al. 2015). For this reason, in recent decades, a number of different studies have been done on the definition of maltreatment (e.g., Calheiros 2006; English et al. 2005), with its type (i.e., classification into types and subtypes) and severity being the most commonly studied aspects (Herrenkohl 2005; Litrownik et al. 2005). In general, these studies confirm the lack of social consensus over what forms of parenting are dangerous or unacceptable (Cicchetti and Manly 2001) and which inappropriate parenting behaviours should be considered maltreatment (Wolfe and McIssac 2011). Indeed, although a consensus already exists with regard to the multifaceted definition of maltreatment—physical abuse, sexual abuse, neglect, emotional/psychological abuse—the differentiation between poor parenting and maltreatment within the parental behavior continuum is still a key issue for definition, identification and assessment (Wolfe and McIssac 2011).

There are also differences in the specificity and degrees of severity given to the various subtypes across different

✉ Maria Manuela Calheiros
maria.calheiros@iscte.pt

[1] Instituto Universitário de Lisboa (ISCTE-IUL), CIS-IUL, Edf. ISCTE-IUL, Av. das Forças Armadas, 1649-026 Lisbon, Portugal

[2] Centro de Investigação e Intervenção Social (CIS), Edf. ISCTE-IUL, Av. das Forças Armadas, 1649-026 Lisbon, Portugal

samples of professionals and laypeople (Giovannoni and Becerra 1979; Peterson et al. 1993; Portwood 1999; Runyan et al. 2005; Korbin et al. 2000), underscoring the need for operating definitions integrating the different social conceptions of the problem (National Research Council 1993; Schmid and Benbenishty 2011). This need is particularly important, since laypeople and community professionals are among the primary agents in identifying and referring situations of risk/hazard (e.g., school; police; health or social services, etc.) (CNPCJR 2013; USDHHS 2013). However, with a few exceptions (e.g., Simarra et al. 2002), the search for integration in common-sense and technical definitions has been overlooked in empirical research.

In fact, according to the American agency Children's Bureau, in 2012 (USDHHS 2013), more than half of the referrals were made by community professionals (58.7 %, e.g., educators; authority figures; healthcare workers) and the remainder by unclassified (23.3 %, e.g., anonymous reports) and non-professional sources (18 %, e.g., family members; neighbours), with this referral pattern remaining consistent in the prior 4 years.

In European countries (e.g., Portugal; Spain; United Kingdom), the pattern is similar (CNPCJR 2013; Gilbert et al. 2009). Furthermore, since child maltreatment is a *public crime* in many European countries and American states (i.e., not dependent on the submission of a complaint by the victim, and able to be submitted by anyone, with police entities and public workers obliged to report cases of which they become aware while performing their duties), the reporting systems have been streamlined (e.g., online) to facilitate and encourage community involvement in its detection.

Some authors question the feasibility and effectiveness of the legal obligation for the community to report cases of suspected child maltreatment (Melton 2005), bearing in mind, among other aspects, the negative effects of often unsubstantiated over-reporting to child protection services. Along these lines, others say that, if the community did not play a proactive role, many children would continue to suffer indefinitely without intervention (Mathews and Bross 2008), arguing that over-reporting and under-reporting are two realities that must not be disassociated. If, after investigation, many cases are proven to be unfounded, the circumstances of many children never become known to child protection services due to biased interpretations and assessments (Besharov 2005). As such, a number of studies have shown that the lack of knowledge and ability to recognize cases of maltreatment has, among other aspects, been one of the main barriers to its referral, thus pointing to the need for operating definitions of maltreatment and objective guiding criteria as one of the possible responses to this problem (Alvarez et al. 2005; Gilbert et al. 2009; King and Scott 2014; Pietrantonio et al. 2013).

Some studies show that assessing the severity of abusive practices is among the key variables in recognizing these cases (Egu and Weiss 2003) and in decision-making on the case's eligibility for technical monitoring (Arruabarrena and De Paúl 2012; Molina 2010); as such, the lack of consensus on levels of severity has also been cited among the major problems (Gambrill 2008; Munro 2005). However, according to what we know and with few exceptions (e.g., Smith 2006), there is a lack of studies analysing the assessment of severity in abusive practices at the community level.

Finally, another underlying challenge in the process of defining maltreatment revolves around the cultural and geographic variability in parenting practices and child upbringing (e.g., Fallon et al. 2010). In fact, although the National Research Council pointed in 1993 towards the need for studies in this regard (Barnett et al. 1993; Litrownik et al. 2005), the most relevant research has been done in the United States and Canada (e.g., Herrenkohl 2005), and there are very few studies in Europe differentiating and describing levels of maltreatment severity (e.g., Arruabarrena and De Paúl 2012). In this context, the adoption of definitions from different socio-cultural contexts may result in judgments and interpretations of maltreatment cases that are out of line with their socio-cultural reality.

To minimize these problems, in the present studies, we analysed the conceptions of laypeople and community professionals to seek an operating definition of maltreatment which integrates them, and which distinguishes between various types of abusive practices. We also analysed the severity allocated to the various contents of each subtype to obtain indicators for distinguishing between different degrees of severity. Two studies were carried out for this purpose. In study 1 (qualitative), we sought to define maltreatment in terms of types by jointly analysing the conceptions of laypeople (by analysing interviews) and community professionals (by analysing statistical summary reports). In study 2, a questionnaire was used to assess the allocation of severity to the contents from Study 1, bearing in mind the various descriptors of each subtype of maltreatment, through a quantitative study with interns in the area of social sciences and health, i.e., future community professionals.

Study 1

Method

Participants

We interviewed 123 participants, mostly female (62.6 %) aged 18–68 (28.5 % 25 and under; 35.2 % aged 26–35; 17 % aged 36–45 and 19.3 % 46 and over). Less than half

(32.5 %) of the participants had completed higher education (29.3 % secondary education and 38.2 % basic education). With regard to professional status, based on Portuguese Classification of Occupations (Instituto Nacional de Estatística, 2010), 25.2 % belonged to middle or higher-level staff (e.g., teachers, technicians of electronica), 22 % worked in services (e.g., administrative staff); 9.8 % were specialized workers (e.g., hairdressers, mechanics); 8.1 % were non-specialized workers (e.g., cleaning services, kitchen assistants) and 32.5 % were not actively employed (e.g., students, retired, unemployed). Thirty-nine percent had professional experience with children, but none of the participants were involved in youth and child protection services or had professional contact with child maltreatment.

Procedure

Participants were recruited through convenience and snowball sampling from workplaces and professional training services not related to children and youth protection. Although it was a convenience sample we recruited participants in places where it was possible to have the highest diversity levels regarding age, education and socioeconomic status. Prior to the interview, participants were informed that the objective of the study was to collect their opinions about the meaning of parental maltreatment. It was highlighted that there were no right or wrong answers and that we were interested in the opinions of participants. In order to allow the content analysis, individual interviews, lasting an average of 10 min, were recorded in audio format and subsequently transcribed to text. Confidentiality and anonymity were guaranteed for the data gathered, and informed consent was obtained for participation and recording. Given the sensitivity of the subject and the possibility of people having experienced abuse themselves, in the case participants were distressed by the emotional or social content of the interviews there was a set of measures to respond to any disclosures of abuse. The interviews were conducted by two experienced professionals in the child protection system and family violence (i. e, one clinic psychologist and one social worker) at the participants' workplace or professional training services, in Portugal.

With regard to gathering statistical summary reports, a collection of institutions was chosen according to whether statistical summary reports on the referral of children with signs of abuse existed within their departments. Access and authorization for consulting the reports were obtained through institutional directors, while likewise ensuring the confidentiality and anonymity of the data obtained.

Measures

With regard to the collection of information with laypeople, semi-structured interviews were conducted with a script including direct questions on socio-demographic status (e.g., age, sex, academic background and profession, contact with child maltreatment) and open-ended questions on the definition of abuse and neglect in the parent–child relationship/education (e.g., "What do you consider to be an abuse in the parent–child relationship/education?"; "What do you consider to be a neglect in the parent–child relationship/education?").

With regard to the corpus of analysis for a technical definition, nine annual reports of first-rate community services were analysed, six from hospital institutions and three from community welfare services working with families. The statistical summary reports, describing detailed indicators of maltreatment (e.g., percentage of burns, bruising, malnutrition, abandonment, verbal violence) show the collective situations of maltreatment referred by these institutions to the competent authorities, and were drawn up by social workers (i.e., psychology, social service and sociology) and healthcare workers (i.e., medicine, nursing and speech therapy), and were based on the case records of 516 children being monitored at these institutions (two institutions monitor children aged 0–4; four institutions receive children aged 0–11; and the remaining institutions monitor children aged 0–17).

Data Analyses

To create a categorical conceptual scheme of maltreatment, the corpus of analysis, comprising material obtained from the interviews and described in the statistical summary reports, underwent a consensual qualitative research method (Hill et al. 1997). This consisted of a thematic content analysis (Braun and Clarke 2006), using a bottom-up procedure, with categories and subcategories based on the data semantic content, i.e., in reference and relevant to a single theme. With this criterion, the "keyness" of a certain category or subcategory was not dependent on its frequency, but on whether it captured something important in relation to the definition of maltreatment. Also prevalence was counted at the data level (i.e., a content can appear anywhere in each individual interview or statistical report) and not in terms of the number of different participants/reports who referred that item. Therefore, the set of record units (words or phrases) was organised by the research team into categories (types) and subcategories (subtypes) according to their semantic meaning and a coding system was developed. Through this process 1235 record units were obtained, 1065 from the interviews, and 170 from the statistical summary reports.

Next, to evaluate the categorization system's reliability through inter-rater agreement, around one-fourth of the record units (randomly chosen) were categorized by four independent judges (psychologist, teacher, physician and social worker) with professional experience in the child protection system, using the parameters established in a dictionary created by the researchers for this purpose as a reference. The coding system had good inter-rater agreement indices (Cohen's kappa = .81, $p < .001$).

Finally, given the nature of the corpus of analysis (material obtained from 123 interviews and 9 statistical summary reports) we used quotes to illustrate how each source contributed to this definition issues, and we reported the relevance of the record units within categories.

Results

Definition of types and subtypes of Abuse, Neglect and Sexual Abuse. The 1235 record units obtained were categorized into 6 types and 20 subtypes of abuse—physical abuse (14.9 %; two subtypes); psychological abuse (29.9 %; six subtypes); educational maltreatment (7.4 %; two subtypes); neglect—lack of physical provision (28.7 %; six subtypes); neglect—lack of supervision (16.1 %; four subtypes); and sexual abuse (2.9 %)—bearing in mind parental omissions and behaviours, together with the consequences for the child (see Table 1).

Physical Abuse

This type of abuse refers to the use of violence and physical aggression, and includes two subtypes. The subtype *aggressive physical interaction* (78.3 %) includes violent physical acts by parents as coercive/punitive methods of upbringing (e.g., "beating the child to educate him/her", "spanking, hitting"), as well as observable physical wounds on the child (e.g., "belt marks", "bruises", "fractures"). In turn, the subtype *physical violence methods* (21.7 %) refers to how the abuse was perpetrated ("violently shaking the child", "slaps", "putting in boiling water"). Note that the content of both subtypes was cited in both the interviews (i.e., laypeople) and the statistical summary reports (Table 2), although issues involving serious consequences for the child such as "burnt child," "bruises" "trauma", "injury", "fractures", "retina bleeding" and "perforation of the tympanic" were mostly cited in the statistical summary reports.

Psychological Abuse

This type includes six subtypes, and revolves around parent actions/omissions that may affect the child's emotional needs and harm his/her psychological development. The subtype *conflictual family environment* (8.9 %) refers to the acts of parents prohibiting the child's relationship with other family members (e.g., "the parents do not get along with the grandparents, and do not let them see their grandchildren") and the child's exposure to a disorganized and violent family environment (e.g., "he/she witnesses domestic violence"). The subtype *unresponsive attachment Figs.* (22.5 %) relates to parents' actions showing disinterest and a lack of attention to the child's emotional needs (e.g., "do not stimulate", "lack of contact"), as well as emotional rejection and unpredictability (e.g., "inconsistent and disconnected reactions", "emotional rejection of the child"). The subtype *aggressive verbal interaction* (20.3 %) refers to verbal repression and aggression through insults and threats (e.g., "constant yelling without reason", "belittling", "they do not let them speak"). The subtype *age inappropriate autonomy* (20.1 %) relates to parent expectations that are out of line with the child's responsibilities (e.g., "they do not acknowledge that they are children"), and encouraging the performance of tasks beyond their developmental phase (e.g., "forcing minors to perform tasks unsuited to their age", "not allowing them to play"). All of the above subtypes were described in the interviews as well as in the statistical summary reports (see Table 2). The subtype *coercive discipline methods* (20.3 %) refers to the use of intimidating (e.g., "creating situations of fear") and restrictive disciplinary techniques (e.g., "depriving the child of freedom by locking him/her in rooms or other locations"), and was cited by both sources, although much more in the interviews. The subtype *harsh evaluation patterns* (7.9 %) describes both the parents' disinterest in the child's performance (e.g., "they are not concerned about academic performance"), as well as strict and critical assessments in this regard (e.g., "they are never satisfied with what the child does", "they humiliate the children"), as well as blaming the child for family problems (e.g., "they accuse the child of their divorce") and was less cited by both sources.

Note that the content of all subtypes was similar in both the interviews (i.e., laypeople) and the statistical summary reports.

Educational Maltreatment

This type includes two subtypes, and describes parents' actions that may affect the development of children's citizenship and academic education. The subtype *fostering child deviant behaviours* (55.4 %) includes parent actions promoting children's exposure to and involvement in illegal and inappropriate activities (e.g., "taking drugs in front of them", "begging", "child labour"), and exposure to and reinforcement of deviant models (e.g., "inciting them to violence", "accompanying marginal groups"). All the

Table 1 Categorization system for maltreatment (N = 1235)

Types of abuse and neglect	Subtypes	N	%
Physical abuse N = 184; 14.9 %	Aggressive physical interaction	144	78.3
	Physical violence methods	40	21.7
Psychological abuse N = 369; 29.9 %	Conflictual family environment	33	8.9
	Unresponsive attachment figures	83	22.5
	Harsh evaluation patterns	29	7.9
	Aggressive verbal interaction	75	20.3
	Age inappropriate autonomy	74	20.1
	Coercive discipline methods	75	20.3
Educational maltreatment N = 92; 7.4 %	Fostering child deviant behaviors	51	55.4
	Lack of school monitoring	41	44.6
Neglect—lack of physical provision N = 355; 28.7 %	Inadequate hygiene rules	55	15.5
	Inadequate clothing	30	8.5
	Inadequate housing conditions	59	16.6
	Lack of physical health monitoring	107	30.1
	Lack of mental health monitoring	47	13.2
	Inadequate feeding	57	16.1
Neglect—lack of supervision N = 199; 16.1 %	Unattended developmental needs	32	16.1
	Lack of supervision	75	37.7
	Insecurity in the environment	32	16.1
	Inadequate supplementary supervision	60	30.2
Sexual abuse N = 36; 2.9 %			

contents were cited in the interviews and in statistical summary reports, although issues involving alcohol and drug consumption were cited only in the statistical summary reports (e.g., intoxication due to children's consumption of substances was only referred to in the reports). Finally, the subtype *lack of school monitoring* (44.6 %) describes parent actions showing disinterest for the child's academic involvement and direction (e.g., "they do not control schedules", "they do not keep pace with the child's education"), together with those promoting absence and dropping out from school (e.g., "they do not take the child to school"), and were cited by both sources.

Neglect—Lack of Physical Provision

This type of maltreatment describes shortcomings in basic care involving the child's physical needs, together with the respective damages observed. This type of maltreatment is divided into six subtypes, according to lacking type of care: *inadequate hygiene* (15.5 %) (e.g., "do not bathe", "the child has parasites", "skin diseases caused by dirtiness"), *inadequate clothing* (8.5 %) (e.g., "dirty clothes", "oversized or undersized clothing", "clothing inappropriate for the time of year"); *inadequate housing conditions* (16.6 %) (e.g., "the child lacks an appropriate place to sleep", "the living conditions are so bad that the child has frequent respiratory infections"); *lack of physical health monitoring* (30.1 %) ("no health surveillance", "lack of routine doctor appointments", "inappropriate medications"); *lack of mental health monitoring* (13.2 %) (e.g., "failure to help them when they have some sort of difficulty", "do not take them to services that may help their poor learning and developmental conditions"); and *inadequate feeding* (16.1 %) (e.g., "incomplete meals", "the child is hungry, and the parents do not provide food", "poor nutrition", "failure to provide food to the point that the child becomes sick"). Generally speaking, the content of all subtypes was cited in the interviews as well as in the statistical summary reports, although more frequently in the latter (with the exception of mental health monitoring), which mentioned a collection of specific issues with regard to children's physical health (Table 2). The content cited exclusively in the statistical summary reports, among other things, included: skin lesions due to a lack of hygiene; lack of routine doctor appointments; growth deficiencies; food poisoning and malnutrition due to an inadequate diet.

Neglect—Lack of Supervision

This type of maltreatment includes four subtypes where parent omissions jeopardize the child's safety, given

Table 2 Categorization system for maltreatment by laypeople and professionals

Types of abuse and neglect	Laypeople N (%)	Professional N (%)	Subtypes	Laypeople N (%)	Professional N (%)
Physical abuse N = 184; 14.9 %	172 (93.5 %)	12 (6.5 %)	Aggressive physical interaction	138 (80.2 %)	6 (50.0 %)
			Physical violence methods	34 (19.8 %)	6 (50.0 %)
Psychological abuse N = 369; 29.9 %	326 (88.3 %)	43 (11.7 %)	Conflictual family environment	26 (8 %)	7 (16.3 %)
			Unresponsive attachment figures	67 (20.6 %)	16 (37.2 %)
			Harsh evaluation patterns	28 (8.6 %)	1 (2.3 %)
			Aggressive verbal interaction	70 (21.5 %)	5 (11.6 %)
			Age inappropriate autonomy	63 (19.3 %)	11 (25.6 %)
			Coercive discipline methods	72 (22.1 %)	3 (7 %)
Educational maltreatment N = 92; 7.4 %	80 (87 %)	12 (13 %)	Fostering child deviant behaviors	44 (55.0 %)	7 (58.3 %)
			Lack of school monitoring	36 (45.0 %)	5 (41.7 %)
Neglect—lack of physical provision N = 355; 28.7 %	274 (77.2 %)	81 (22.8 %)	Inadequate hygiene rules	40 (14.6 %)	15 (18.5 %)
			Inadequate clothing	24 (8.8 %)	6 (7.4 %)
			Inadequate housing conditions	51 (18.6 %)	8 (9.9 %)
			Lack of physical health monitoring	86 (31.4 %)	21 (25.9 %)
			Lack of mental health monitoring	44 (16.1 %)	3 (3.7 %)
			Inadequate feeding	29 (10.6 %)	28 (34.6 %)
Neglect—lack of supervision N = 199; 16.1 %	185 (93 %)	14 (7 %)	Unattended developmental needs	27 (14.6 %)	5 (35.7 %)
			Lack of supervision	73 (39.5 %)	2 (14.3 %)
			Insecurity in the environment	27 (14.6 %)	5 (35.7 %)
			Inadequate supplementary supervision	58 (31.4 %)	2 (14.3 %)
Sexual abuse N = 36; 2.9 %	28 (77.8 %)	8 (22.2 %)			

his/her specific developmental needs. The subtype *unattended developmental needs* (16.1 %) refers to a lack of appropriate supervisory measures, particularly in view of the child's development phase and behavioural profile (e.g., "they leave the children with siblings who do not know how to take care of them"). The subtype *lack of supervision* (37.7 %) considers a situation where children are left without reliable adult supervision (e.g., "the children don't go to school, and stay alone at home", "they are out in the street"). *Insecurity in the environment* (16.1 %) refers to a lack of safety assessment where the children spend prolonged periods of time with potential immediate physical hazards (e.g., "leaving drugs or other harmful products in sight", "playing in a hazardous area"). Finally, the subtype *inadequate supplementary supervision* (30.2 %) includes situations with a lack of appropriate care for children, by alternative caregivers, while the parents are absent or physically or mentally impaired. Generally speaking, the content of all of the subtypes was cited in both the interviews and statistical summary reports, although with less relevance of lack of supervision and inadequate supplementary supervision in the latter. With regard to the subtype *insecurity in the environment*, the irreparable consequences of serious accidents were cited exclusively in the statistical summary reports.

Sexual Abuse

This type of abuse (2.9 %) has no subtypes, but does include any sexual attempt and/or contact with children for the purposes of sexual gratification (e.g., "they exploit the child with pleasure") or economic advantage (e.g., "they put the child up for prostitution", "they use the child for pornographic purposes"), with or without physical or psychological coercion (e.g., "rape", "incest"), and exposure to pornographic material or acts (e.g., "abnormal sexual practices"), cited both in the interviews and the statistical summary reports.

Discussion

In general, the definition obtained includes the different types and subtypes of maltreatment referred to in the literature, pointing towards a multifaceted understanding of the constructs, and adapting to the structure suggested by other studies and classification systems (e.g., Barnett et al. 1993; English et al. 2005; Fallon et al. 2010). Furthermore, it includes content related to parent behaviour (i.e., acts and omissions), observed damages (defined primarily by health professionals), and potential danger to the child, similar to other studies (e.g. Barnett et al. 1993; Herrenkohl 2005).

A little bit surprising was the categorization of "fostering child deviant behaviours" and "lack of school monitoring" in the same category. However, the content analysis that made up the subcategory of "lack of school monitoring" indicated that most quotes (21/36) are parental acts related to child education and school attendance, that foster child's deviant behaviour, such as "school dropout", "parents' lack of interest for what children do", "parents do not send child to school", "they do not put the child in school". Another aspect that may have been important in this categorization was the fact that school dropout is an act of parental responsibility that is directly punishable by law in Portugal (unlike other neglect or mistreatment acts).

Along these lines, despite the existing consensus in defining subtypes, this study found a distinct but supplementary contribution in the nature of the content and degree of specificity of the information furnished by each of the sources (i.e., professionals and common sense). In this regard, the main differences are in *educational maltreatment* and *neglect* from the standpoint of *provision* and *supervision*, where the statistical summary reports cite more aspects related to the acts' consequences for the child (e.g., serious accidents, namely irreparable consequences of the lack of safety) and specific issues on the child's and family's physical health (e.g., alcohol and drug consumption; skin lesions due to a lack of hygiene; lack of routine medical visits; and deficient growth, food poisoning and malnutrition) compared to laypeople. In relation to the above aspects, the results thus seem to show also that the content cited describes different levels of severity within each subtype.

Study 2

Method

Participants

The participants were 159 interns in the areas of Education (50.3 %), Psychology (30.2 %) and Health – medicine and nursing—(19.5 %), the majority female (80.5 %), aged 22–56 ($M = 25.22$; $SD = 6.65$). With regard to contact with situations of abuse, 30.2 % of the respondents had previous professional contact with cases in this area, 20.1 % said they had knowledge of close situations and 8.2 % cited personal experience with situations of maltreatment.

Procedure

Participants were recruited through convenience sampling from social and health care institutions related to children and youth protection. The interns were chosen because they had a recent formation in this area, they were being trained in specialized institutions and they would be the future community professionals. Data were collected at Portuguese public institutions in the areas of Medicine, Nursing, Psychology and Education. Before filling out the questionnaires, it was explained to the participants that the objective of the study was to classify different descriptors of maltreatment according to their perceived degree of severity. The questionnaires were answered in person and in group, guaranteeing the confidentiality and anonymity of the data. As in study 1, given the sensitivity of the subject and the possibility of people having experienced abuse themselves, in the case participants were distressed by the emotional or social content of the questionnaire there was a set of measures to respond to any disclosures of abuse.

Measures

To create a scale of severity for abuse based on the record units obtained in Study 1, we followed a top-down procedure, using the proposal of Barnett and collaborators (1993, Maltreatment Classification System—MCS) as a reference. In this system most items are operationally defined by five different levels of severity for each subtype of maltreatment (ranging from inadequate parental act/omission to potential damage, and "observable" consequences of abusive behaviours in children). This scale was translated and adapted based on a discussion panel comprising the principal researcher and four technicians from the Commissions for the Protection of Children and Young People (social worker, attorney, physician and teacher). Therefore, 242 units of analysis obtained in Study 1 (corresponding to around one-fourth of the record units, and distributed over the previously identified types and subtypes of abuse), were categorized by these technicians on a five-level scale (1–5) of increasing severity. The record units obtained in the material under analysis, but not appearing in the categorization system, were categorized by the judges based on their semantic meaning.

The results showed that the majority of subtypes gathered from the material in Study 1 did not present indicators corresponding to the five degrees of severity proposed by the American version (Barnett et al. 1993). In fact, in the categorization process, we were only able to identify a correspondence between the five levels proposed by Barnett and collaborators and the indicators of severity obtained in the subtypes *aggressive physical interaction* and *inadequate feeding*. Three levels of severity were identified in subtypes: *physical violence methods; unresponsive attachment figures; aggressive verbal interaction; lack of school monitoring; inadequate hygiene; inadequate clothing, inadequate housing conditions; lack of physical*

health monitoring and *lack of mental health monitoring*. Four levels of severity were identified in the subtypes: *age inappropriate autonomy; coercive discipline methods; harsh evaluation patterns; fostering child deviant behaviours; insecurity in the environment; sexual abuse*. Finally, only two levels of severity were identified in the subtypes *conflictual family environment* and *lack of supervision,* and just one level in the subtypes *unattended developmental needs* and *inadequate supplementary supervision*. We also found that in the majority of the subtypes, the distribution of record units was concentrated in the lower levels of severity (1 and 2).

Given that the correspondence between the five levels proposed in the Maltreatment Classification System (MCS) only occurred in two of the defined subtypes, in building a scale of severity, four levels of severity were defined (i.e., simple phrases describing the characteristics of each degree of severity). As such, in the subtypes where the record units did not describe content related to four of the five levels of severity proposed by Barnett et al. (1993), MCS indicators were used; in the subtypes where four levels of severity were found, the content was maintained, and in the subtypes where the content analysis resulted in five levels, we chose to combine two of the extreme levels of the MCS.

In this manner, the scale of severity built from the material gathered in Study 1, supplemented with the descriptors of Barnett et al. (1993), differentiated four levels of severity per subtype of maltreatment (example of descriptors of the subtype aggressive physical interaction: (1) They hit the child without touching the neck or head, and without leaving marks, or only leaving small marks; (2) They leave several marks or a highly visible mark on the child's body, without touching the neck or head; (3) They cause small burns, scratches or minor cuts to the body, or leave marks on the head, face or neck; (4) They inflict wounds causing hospital treatment or hospitalization). Similar to Barnett et al. and taking into account the nature of each maltreatment subtype, we intended to create a continuum of severity, whose main criterion was the intensity of the act/omission, which ranged from parental risky acts/omission with potential damage and the consequences for the child.

The four-levels scales, grouped according to the corresponding subtype, were presented randomly to the participants, who were asked to classify them according to their perceived degree of severity on a scale of 1–4 (1 − less serious to 4 − the most serious).

Results

We used Kendall's coefficient of concordance to analyse the consensus between participants in assessing the four levels of severity presented per each subtype of abuse, on the whole and in paired groups (Table 3).

When considering the assessment of the four levels of severity as a whole, most subtypes of abuse have acceptable and good significance values (W between .33 and .92), indicating that participants ranked them in a rather consensual manner. Assessment means ranged approximately from 1 to 4 in all of the subtypes, except in the subtype *age inappropriate autonomy* (psychological abuse), where the mean varies between 2.38 and 2.69, with a non-significant W value ($W = .01$; $\chi^2 = 5.19$; $df = 3$; $p > .05$), showing a lack of consensus between participants. Note that the levels of severity assessed with a lesser degree of consensus involved the subtypes *unresponsive attachment figures* (psychological abuse) ($W = .33$), *aggressive verbal interaction* (psychological abuse) ($W = .40$), and *inadequate hygiene* (neglect—lack of physical provision) ($W = .44$), as opposed to *sexual abuse* ($W = .92$).

When considering the assessment of the different levels of severity in paired groups (levels 1 and 2; levels 2 and 3; levels 3 and 4), the analysis revealed that nine subtypes were not evaluated in a consensual manner. Between levels of severity 2 and 3, there were consensus problems in the subtypes *insecurity in the environment* (neglect—lack of supervision) ($W = .022$; $\chi^2 = 3.45$; $df = 1$; $p > .05$); *inadequate hygiene* (neglect—lack of physical provision) ($W = .009$; $\chi^2 = 1.45$; $df = 1$; $p > .05$); *inadequate feeding* (neglect—lack of physical provision) ($W = .017$; $\chi^2 = 2.59$; $df = 1$; $p > .05$); *unattended developmental needs* (neglect—lack of supervision) ($W = .005$; $\chi^2 = .78$; $df = 1$; $p > .05$) and *physical violence methods* (physical abuse) ($W = .034$; $\chi^2 = 5.02$; $df = 1$; $p > .05$). In turn, between levels of severity 1 and 2, there were problems in the subtypes *lack of physical health monitoring* (neglect—lack of physical provision) ($W = .000$; $\chi^2 = .006$; $df = 1$; $p > .05$) and *aggressive verbal interaction* (psychological abuse) ($W = .000$; $\chi^2 = .000$; $df = 1$; $p > .05$). Finally, between levels of severity 3 and 4, there were agreement problems in the subtypes *unattended developmental needs* (neglect—lack of supervision) ($W = .007$; $\chi^2 = 1.09$; $df = 1$; $p > .05$) and *inadequate housing conditions* (neglect—lack of physical provision) ($W = .015$; $\chi^2 = 2.32$; $df = 1$; $p > .05$).

Discussion

The results showed that, in the public and technical opinions, a consensual evaluation of severity in situations without signs of immediate, clear and observable damages to the child (e.g., *age inappropriate autonomy*) was more difficult, as well as when involving parental domains with less discussion in the public spectrum or in dimensions

Table 3 Description and ranking of descriptors of severity, W values and means

Descriptors	M	W
Aggressive physical interaction (physical abuse)		.78**
They hit the child without touching the neck or head, and without leaving marks, or only leaving small marks (e.g. small bruises on the arm)	1.18	
They leave several marks or a highly visible mark on the child's body, without touching the neck or head (e.g. tooth marks, pinches, punches, kicks)	2.17	
They cause small burns (e.g. cigarette burns), scratches or minor cuts to the body, or leave marks on the head, face or neck of the child (e.g. black eye, marks from slaps)	2.74	
They inflict wounds causing hospital treatment or hospitalization (e.g. serious cuts, second-degree burns, fractures)	3.91	
Physical violence methods (physical abuse)		.56**
They yank or violently shake the child (e.g. pull their hair, ears)	1.72	
They forcefully hit the child with their hand or an object (e.g. lash, belt, ruler, paddle) on the body, without touching the head or neck	2.06	
They kick or punch the child with a closed hand, without touching the head or neck, with a hard-hitting object (e.g. belt buckle, electrical wire) or burn the child with a cigarette	2.31	
They brutally handle the child; they attempt to suffocate the child; they hit the child with an object (e.g. telephone); they throw the child against the wall or down the stairs; they put the child in fire, boiling water or burn the child with an electrical appliance	3.90	
Conflictual family environment (psychological abuse)		.67**
They underestimate the child's relationship with other significant family members (e.g. they make negative comments about the other parent (mother or father); they prohibit contact with grandparents)	1.42	
They expose the child to physically non-violent marital conflicts (e.g. shouting, crying, insults between spouses)	1.78	
They expose the child to physically violent domestic conflicts (e.g. physical aggression)	3.23	
They expose the child to violent outbursts and extremely inappropriate and unpredictable adult behaviour (e.g. alcoholic state) or extreme domestic violence with adult injuries	3.57	
Unresponsive attachment figures (psychological abuse)		.33**
They are disengaged or unable to address the child's emotional needs (e.g. do not have positive and affectionate interactions, their affectionate actions are unpredictable; they are passive, or do not perceive the child's emotional needs; lack stimulating activities with toys, dialogue; the child spends too much time on the computer/TV)	1.76	
They ignore the child's requests for attention (e.g. do not give the necessary attention, do not respond to a baby's cries or an older child's request for some kind of interaction)	2.17	
They leave the child alone for more than 24 h without warning, or the child is abandoned by one of the parents (e.g. one of the parents does not contact the child)	2.57	
Abandonment of the child by the parents (e.g. caregivers have no contact with the child)	3.50	
Harsh evaluation patterns (psychological abuse)		.60**
Show disinterest for the child's academic or other performance	1.46	
Assess the child very strictly, and show little satisfaction in the child's performance (e.g. any evaluation is harsh and critical)	2.14	
Show a negative and hostile standard for assessing the child (e.g. the adult tells the child he/she does nothing right)	2.55	
Assess the child as being at fault for family and/or marital problems (e.g. they tell the child he/she is the reason for their problems); accuse the child unfairly for very serious actions (e.g. theft, aggression, extremely inappropriate behaviour)	3.85	
Aggressive verbal interaction (psychological abuse)		.40**
Yell, insult or ridicule the child (e.g. calling the child "stupid", "moron", "idiot")	1.75	
Prohibit the child, by verbally expressing the inability to give opinions, from expressing ideas and proactively participating in activities	1.99	
Shout, curse and call the child highly offensive names (e.g. "bitch", "whore", "despicable")	2.68	
Verbally threaten the child, terrorize the child and create a climate of fear (e.g. threatening abandonment, giving up for adoption, hurting and injuring the child)	3.58	
Age inappropriate autonomy (psychological abuse)		.01
Force excessive responsibility upon the child (e.g. heavy or dangerous work for the child's age; missing school to care for siblings)	2.38	
Keep the child from having normal social experiences or age-appropriate socialization (e.g. infantilize the child, prohibition from playing with friends, avoiding relationships of friendship)	2.45	
Expect the child to take on a degree of responsibility above his/her age or development (caring for a sibling or home) and deny legitimacy for his/her needs (e.g. do not help, do not recognize his/her problems)	2.48	

Table 3 continued

Descriptors	M	W
Impose levels of performance and expectations so inappropriate (excessive or limited) that negative consequences result for the child, who feels a "failure"	2.69	
Coercive discipline methods (psychological abuse)		.60**
Use fear or intimidation as a primary disciplinary method	1.44	
Lock up and isolate the child for long periods of time (e.g. at home, in his/her room)	2.17	
Give heavy or prolonged punishments (e.g. skipping a meal as punishment, squeezing the child's nose to make him/her eat; not drinking due to bedwetting; not speaking with people he/she likes)	2.56	
Lock up and isolate the child in tiny areas with poor lighting, temperature, ventilation and space. Tie the child's hands/feet to a chair/table or put the child in a box	3.84	
Fostering child deviant behaviours (educational maltreatment)		.47**
They allow the child to be part of adult activities inappropriate for his/her age (e.g. take the child to parties with drinking, adult bars or other non-family situations)	1.50	
Adults behave illegally in the child's presence or with the child's knowledge (e.g. tax fraud, robbery, selling of drugs or stolen items)	2.26	
Know that the child is involved in illegal activities, but do nothing (e.g. even with knowledge, they ignore incidents of vandalism, theft, drinking)	2.60	
Reinforce the child's antisocial behaviour (e.g. violence and/or theft), encourage the child to have destructive behaviour (e.g. alcohol consumption, inappropriate medications or drugs), or involve the child in illegal situations (e.g. child labour or begging)	3.64	
Lack of school monitoring (educational maltreatment)		.60**
Insufficient or inadequate monitoring of the child's daily education (e.g. school materials, learning, schedules, notes, absences, behaviour and habits in a school context)	1.59	
Allow the child to stay home from school, up to 25 % absenteeism	1.82	
Allow the child to stay home from school, from 25 % to 50 % absenteeism	2.82	
Allow the child to be absent most of the time (more than 50 % absenteeism) or drop out of school	3.78	
Inadequate hygiene (neglect—lack of physical provision)		.44**
Keep the child with a dirty appearance (e.g. does not bathe, does not wash hair or brush teeth, bad smell, has lice and/or fleas)	1.44	
Limit the child's normal functioning due to hygiene (e.g. discriminated against or isolated by other children due to appearance, smell or lice)	2.45	
Keep the child in unsanitary bodily hygiene conditions (e.g. problems with chronic lice, prolonged contact with urine), with potential health problems (e.g. rash)	2.59	
Allow the child to have health problems or injuries due to hygiene conditions (e.g. skin diseases, infected skin lesions	3.53	
Inadequate clothing (neglect—lack of physical provision)		.60**
Dress the child in clothing unsuitable for his/her age and/or restricting free movement (e.g. clothing so small that it restricts movement, or so large that the child trips or has difficulties securing it)	1.54	
Dress the child in dirty or unkempt clothing (e.g. does not change interior and/or exterior clothing, little washing, with bad smell or holes)	1.85	
Put the child at risk of illness due to lack of hygiene or clothing unsuited to weather (e.g. uses light clothing, walks barefoot or without a coat in winter; hot clothing in summer; uses wet clothing)	2.89	
Allow the child to get sick due to a lack or excess of clothing or unsanitary clothes (e.g. spots on body or infections due to interior clothing or failure to change diapers)	3.72	
Inadequate housing conditions (neglect—lack of physical provision)		.54**
Keep the house dirty (e.g. garbage, dirty dishes, dirty floor or walls, dirty mattresses)	1.63	
Allow the child to sleep, eat or play in inappropriate conditions (e.g. live in parts of the house; do not have beds or mattresses; do not have electricity, water, heating)	1.74	
Keep the child in a physical environment whose hygiene and/or habitability are unsanitary, potentially causing health problems (e.g. rotten food and mounting trash; infestations; house with mould, humidity or water infiltration)	3.28	
Live in cars, below bridges or without fixed housing, with a lack of hygiene and habitability, causing health problems (e.g. respiratory infections; bitten by mice).	3.36	
Lack of physical health monitoring (neglect—lack of physical provision)		.67**
Follow medical instructions for the child in an irregular or inappropriate manner (e.g. medications are not given for small health problems)	1.66	
Miss routine appointments or have delayed child vaccinations	1.71	

Table 3 continued

Descriptors	M	W
Avoid medical treatment for moderate child health problems (e.g. vision or hearing problems), administer medications which are inappropriate or excessive without consulting the doctor (e.g. giving sedatives to control the child)	2.72	
Avoid medical treatment for serious childhood illnesses or injuries (e.g. tuberculosis, HIV, not taken to the emergency room in serious situations) or consume drugs or alcohol during pregnancy (e.g. child is born with alcohol or drug syndrome)	3.92	
Lack of mental health monitoring (neglect—lack of physical provision)		.70**
Go to technicians (e.g. psychologist, speech therapist, tutor) for minor behavioural or developmental problems, but are irregular or inconsistent in following recommendations (e.g. do not observe the necessary changes in attitude)	1.28	
Remain indifferent to professionals pointing out certain child behavioural or functional characteristics (e.g. do not follow advice given for minor academic and/or social/emotional functioning issues)	2.06	
Ignore treatment for a child behavioural or psychological dysfunction (e.g. dysfunction interferes with the ability to develop relationship with peers and functioning at school)	2.87	
Remain completely indifferent to the diagnosis or treatment of situations where the child has potentially irreversible developmental and behavioural problems if not treated (e.g. severe difficulties in learning, language development, isolation or serious aggression)	3.79	
Inadequate feeding (neglect—lack of physical provision)		.74**
Give small quantities of food to the child, and/or some meals are incomplete	1.17	
Give meals to the child so that he/she does not gain weight or grow as expected for his/her age (e.g. inadequate progression in weight or weight gain), with the risk of malnutrition or gastric problems	2.36	
Allow the child to go without two or more consecutive meals, potentially affecting his/her functioning (e.g. difficulties concentrating at school due to hunger)	2.58	
Give food to the child which is so poor or insufficient that it results in physical consequences such as weight loss, food poisoning or gastroenteritis problems (e.g. diarrhoea), major and serious malnutrition or delayed growth for non-organic reasons	3.89	
Unattended developmental needs (neglect—lack of supervision)		.47**
Inadequate supervision, even though the child has some behavioural problems (e.g. impulsive behaviour, hyperactivity)	1.18	
Inadequate supervision, although the child has physical, cognitive or social development problems (e.g. minor physical or mental disability, learning difficulties)	2.81	
Inadequate supervision, although the child has a problematic history of physical and/or cognitive development (e.g. serious physical or mental disability)	2.92	
Inadequate supervision, although the child has a highly problematic history of social/emotional development (e.g. dangerous actions such as suicide)	3.10	
Lack of supervision (neglect—lack of supervision)		.86**
Leave the child alone for short periods of time	1.11	
Leave the child alone for reasonable periods of time	1.99	
Leave the child alone at night, or during the day for long periods of time	3.05	
Leave the child alone the entire night or for highly extended periods	3.85	
Insecurity in the environment (neglect—lack of supervision)		.57**
Leave the child for short periods of time in an environment with no immediate hazards, but with some potential risks (e.g. cabinets with medications within the child's reach)	1.50	
Leave the child for short periods of time in environment with immediate hazards (e.g. playing in an area which is unsafe because of broken glass)	2.25	
Leave the child for several hours in an unsafe place (e.g. entry and exit of cars)	2.42	
Leave the child in a highly dangerous place (e.g. playing in a street or public road where the child may be run over; playing on a roof or in an old building; falling from a window; being burnt or drowning)	3.83	
Inadequate supplementary supervision (neglect—lack of supervision)		.78**
When gone for short periods of time, leave the child in the care of potentially unsuitable people (e.g. preadolescent, elderly with average debilitation)	1.43	
When gone for several hours, leave the child in the care of people with inadequate monitoring skills (e.g. do not pay attention, do not address child's needs)	1.66	
When gone for long periods of time, leave the child with strangers or someone who is not completely trustworthy (e.g. known for excessive drinking, inattentive or having a known history of violence)	3.11	
Leave the child outside of the home, in the street, on his/her own without an alternative means of accommodation and support (e.g. child runs away from home, and they do not worry about his/her whereabouts or try to resolve the situation)	3.80	

Table 3 continued

Descriptors	M	W
Sexual abuse		.92**
Expose the child to sexual stimuli or activities without the child's direct involvement (e.g. child sees pornographic materials; witnesses sexual activities due to lack of adult prevention; sexual discussions in a non-contextualized manner)	1.10	
Direct verbal proposals to the child for sexual activities, show genitals or masturbate in front of her	2.01	
Provoke physical contact, without penetration, for sexual gratification (e.g. touching, probing or masturbating)	2.89	
Consummate rape, with or without physical violence. Have sexual relations with the child (e.g. intercourse, oral sex, anal sex or other forms of sodomy). Allow or encourage prostitution, abnormal sexual practices or pornography	4.00	

* $p \leq .05$; ** $p \leq .001$

more recently acknowledged as abusive, either academically or socially (e.g., neglect).

Indeed, the fact that the dimensions of physical abuse and sexual abuse portray parental acts whose consequences to the child are more evident, and which enjoy greater public prevalence (i.e., frequent media dissemination of sexual abuse cases), may contribute to increased public awareness of these situations and, as a result, a greater ease in identifying, recognizing and differentiating their severity by the community. Furthermore, psychological abuse and neglect are less consensual areas, suggesting that they may be subject to less community awareness (e.g., Korbin et al. 2000). In fact, bearing out the results of other studies (e.g., Peterson et al. 1993; Portwood 1999), the perceptions of the severity of neglectful practices in supervising children gather less consensus among the participants; as such, it should be noted that identifying inadequate supervision is complex, bearing in mind the difficulty of assessing parent omissions, together with a lack of clear standards for leaving children unsupervised (Peterson et al. 1993). In general, there are no clear, agreed upon standards to differentiate between acceptable parental practices and those that cross the line into child maltreatment (Cicchetti and Manly 2001). This situation has been further complicated regarding acceptable versus maltreating parenting in cases of neglect or psychological abuse (Barnett et al. 1993).

General Discussion

The literature has underscored the need for conceptual schemas structured over the maltreatment of children that streamline the recognition and referral of these cases, since laypeople and community professionals, as those making the referrals, may have biased interpretations of these situations, leading to the under-reporting or over-reporting of cases (Mathews and Bross 2008). The decision to report a case of parental maltreatment has been characterized as complex, ambiguous and full of errors and uncertainty. That is even more the case for instances of parental neglect in which, although the long-term effects may be detrimental (DePanfilis 2006), the physical proofs are hard to obtain (Dickens 2007; Rodrigues et al. 2015). Understanding the decision of reporting neglect cases is particularly pertinent in Portugal, where the concept is absent in the law and institutionally undervalued in comparison with other forms of maltreatment like physical or sexual abuse (Torres et al. 2008).

The results obtained in these two studies highlight the importance of cultural values and social contexts (i.e., professional versus community) in understanding the phenomenon and its conceptualizations regarding child maltreatment (Barnett et al. 1993; Calheiros 2013; Knutson 1995), not only in terms of category content, but also in describing the severity of its different indicators.

The present results show that, although the subtypes are highly similar to those which had been defined in the analysis of the records of American technicians, the content of the majority of the subtypes in study 1 do not have the same degree of specificity, namely *psychological abuse* and *lack of supervision* (in which some subtypes included only two or three descriptors). In fact, except for the area of physical abuse, which is described more specifically when compared with the content proposed by Barnett and collaborators (1993)—the reason for including a new subtype in our version (subtype of physical violence methods)—the majority of the subtypes do not include its descriptive specificity. Also, it can be concluded that participants assessed the increased severity of abusive practices with little consensus in nearly half of the subtypes, with a less consensual evaluation in relation to a subtype of psychological abuse. Finally, we concluded that the main discrepancies are between middle levels of severity (i.e., 2 and 3), especially in the subtypes of maltreatment related to neglect, namely *lack of physical provision* and *lack of supervision.*

Along these lines, an understanding of community standards is essential in optimizing social intervention policies. One of the most important stages of social intervention, on a par with prevention and intervention, is

avoiding the often late detection of situations of children at risk, already under circumstances of serious neglect and abuse. Therefore, clear definitions of abuse and neglect, considering the continuum of inadequate parent practices, enable decision-making on the need for intervention without having to be directly based on the extreme severity of maltreatment episodes.

The observed variability in how primary referral agents define which parent behaviours are abusive, and which constitute more serious practices, underscores the importance of undertaking strategies encouraging social awareness on the characteristics of this phenomenon with a view to avoiding biased interpretations of situations and minimizing the problems of over-reporting, under-reporting and unsubstantiation and, consequently, promoting more effective intervention for protecting children and young people.

A continuation of this work will allow a definition of referral parameters and the scheduling of preventive interventions in situations of risk in Portugal, as well as also allowing the decision-making process on the referral of maltreated children to be based on a clearer and more objective assessment than that which is currently being done.

The next phase of this research will be to make the definitions of child maltreatment obtained in the present studies applicable to the community area by laypeople and professionals. In addition, as the definition framework suggested by this research includes the perceptions of professionals and laypeople, those definitions must be validated over time, since views change and new information emerges.

Some limitations may be cited in relation to these studies. First, on studies 1 and 2 we used a convenience sample. Second, the questioning of the subjects on the ranking of severity was done in relation to the indicators of each subtype, and not in relation to the different subtypes of abuse and neglect. Finally, in both studies, children's age as an indicator of their development has not been included. In proposals for future work, it thus seems essential to pursue research incorporating in the sample different groups of professionals and considerations on the children's age in the definitions and allocation of severity, so as to define what constitutes maltreatment, taking developmental stages of children into account. Other limitation is the lack of information about participants' parenting experience (Portwood 1999). Thus in future studies it should be analysed if the fact of being a parent have influence in the maltreatment types and severity definition.

In addition, although we consider the role of cultural context and community values in defining abuse and neglect especially important, we must not overlook the existence of communities that may display abusive behaviours while not constituting a problem in some specific sociocultural context. In such circumstances, the subjective views of certain groups or community standards and beliefs seem largely invalid as defining criteria. This is yet another reason, along with understanding social norms, for using scientific knowledge on which conditions or circumstances put children at risk and promoting a two-way street in a social construct for the problem: from common sense to scientific and vice versa.

References

Alvarez, K. M., Donohue, B., Kenny, M. C., Cavanagh, N., & Romero, V. (2005). The process and consequences of reporting child maltreatment: A brief overview for professionals in the mental health field. *Aggression and Violent Behavior, 10*, 311–331.

Arruabarrena, I., & De Paúl, J. (2012). Improving accuracy and consistency in child maltreatment severity assessment in child protection services in Spain: New set of criteria to help caseworkers in substantiation decisions. *Children and Youth Services Review, 34*, 666–674.

Barnett, D., Manly, J. T., & Cicchetti, D. (1993). Defining child maltreatment: The interface between policy and research. In D. Cicchetti & S. L. Toth (Eds.), *Child abuse, child development, and social policy* (pp. 7–73). Norwood: Ablex.

Besharov, D. (2005). Overreporting and underreporting of child abuse and neglect are twin problems. In D. Loseke, R. Gelles, & M. Cavanaugh (Eds.), *Current controversies on family violence* (2nd ed., pp. 285–298). Thousand Oaks: Sage.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101.

Calheiros, M. M. (2006). *A construção social do mau trato e negligência: Do senso-comum ao conhecimento científico*. Coimbra: Fundação Calouste Gulbenkian, Imprensa de Coimbra.

Calheiros, M. M. (2013). Parents' beliefs on the causes of child maltreatment. *International Journal of Psychology and Psychological Therapy, 13*(1), 1–14.

Cicchetti, D., & Manly, J. T. (2001). Editorial: Operationalizing child maltreatment: Developmental processes and outcomes. *Development and Psychopathology, 13*(4), 755–757.

CNPCJR (2013). *Relatório Anual de Avaliação da Atividade das Comissões de Proteção de Crianças e Jovens* [Annual Evaluation Report of activities of the Commissions for the Protection of Children and Young People at Risk]. Retrieved from http://www.cnpcjr.pt/Relatorio_Avaliacao_CPCJ_2013.pdf.

DePanfilis, D. (2006). Child neglect: A guide for prevention, assessment, and intervention. Washington, DC: U.S. Department of Health and Human Services, Administration on Children and Families, Administration for Children, Youth, and Families, Children's Bureau, Office on Child Abuse and Neglect.

Dickens, J. (2007). Child neglect and the law: Catapults, thresholds and delay. *Child Abuse Review, 16*, 77–92.

Egu, C. L., & Weiss, D. J. (2003). The role of race and severity of abuse in teachers' recognition or reporting of child abuse. *Journal of Child and Family Studies, 12*, 465–474.

English, D. J., Bangdiwala, S. I., & Runyan, D. K. (2005). The dimensions of maltreatment: Introduction. *Child Abuse and Neglect, 29*, 441–460.

Fallon, B., Trocmé, N., Fluke, J., MacLaurin, B., Tonmyr, L., & Yuan, Y. (2010). Methodological challenges in measuring child maltreatment. *Child Abuse and Neglect, 34*, 70–79.

Gambrill, E. (2008). Decision making in child welfare: Constraints and potentials. In D. Lindsey & A. Shlonsky (Eds.), *Child welfare research: Advances for practice and policy* (pp. 175–193). New York: Oxford University Press.

Gilbert, R., Kemp, A., Thoburn, J., Sidebotham, P., Radford, L., Glaser, D., et al. (2009). Recognizing and responding to child maltreatment. *The Lancet, 373*(9658), 167–180.

Giovannoni, J. M., & Becerra, R. M. (1979). *Defining child abuse*. New York: Free Press.

Herrenkohl, R. C. (2005). The definition of child maltreatment: From case study to construct. *Child Abuse and Neglect, 29*, 413–424.

Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A guide to conducting consensual qualitative research. *Counseling Psychologist, 25*, 517–572.

Instituto Nacional de Estatística (2010). *Classificação Portuguesa das Profissões* 2010. Lisboa: Instituto Nacional de Estatística I.P. (*Portuguese Job Classification*).

King, C. B., & Scott, K. L. (2014). Why are suspected cases of child maltreatment referred by educators so often unsubstantiated? *Child Abuse and Neglect, 38*, 1–10.

Knutson, J. F. (1995). Psychological characteristics of maltreated children: Putative risk factors and consequences. *Annual Review of Psychology, 46*, 401–431.

Korbin, J. E., Coulton, C. J., Lindstrom-Ufuti, H., & Spilsbury, J. (2000). Neighborhood views on the definition and etiology of child maltreatment. *Child Abuse and Neglect, 24*(12), 1509–1527.

Litrownik, A. J., Lau, A., English, D., Briggs, E., Newton, R., Romney, S., et al. (2005). Measuring the severity of child maltreatment. *Child Abuse and Neglect, 29*, 553–573.

Mathews, B., & Bross, D. C. (2008). Mandated reporting is still a policy with reason: Empirical evidence and philosophical grounds. *Child Abuse and Neglect, 32*, 511–516.

Melton, G. B. (2005). Mandated reporting: a policy without reason. *Child Abuse and Neglect, 29*(1), 9–18.

Molina, A. (2010). *La toma de decisiones profesionales en Protección de Menores.* Retrieved from http://www.fapmi.es/imagenes/subsecciones1/MT_01_B_Antonio%20Molina%20Facio_PONENCIA_web.pdf.

Munro, E. (2005). Improving practice: Child protection as a systems problem. *Children and Youth Services Review, 27*, 375–391.

National Research Council (NRC). (1993). *Understanding child abuse and neglect*. Washington DC: National Academies Press.

Peterson, L., Ewigmam, B., & Kivlahan, C. (1993). Judgments regarding appropriate child supervision to prevent injury: The role of environmental risk and child age. *Child Development, 64*, 934–950.

Pietrantonio, A. M., Wright, E., Gibson, K. N., Alldred, T., Jacobson, D., & Niec, A. (2013). Mandatory reporting of child abuse and neglect: Crafting a positive process for health professionals and caregivers. *Child Abuse and Neglect, 37*, 102–109.

Portwood, S. G. (1999). Coming to terms with a consensual definition of child maltreatment. *Child Maltreatment, 1*, 56–68.

Rodrigues, L., Calheiros, M. M., & Pereira, C. (2015). The decision of out-of-home placement after parental neglect: Empirically testing a psychosocial model. *Child Abuse and Neglect, 49*, 35–49.

Runyan, D. K., Cox, C. E., Dubowitz, H., Newton, R. R., Upadhyaya, M., Kotch, J. B., et al. (2005). Describing maltreatment: Do child protective service reports and research definitions agree? *Child Abuse and Neglect, 29*(5), 461–477.

Schmid, H., & Benbenishty, R. (2011). Public attitudes toward child maltreatment in Israel: Implications for policy. *Children and Youth Services Review, 33*, 1181–1188.

Simarra, J., De Pául, J., & San Juan, C. (2002). Child maltreatment: Social representation of the general population and the professionals working with children in the Caribbean area of Colombia. *Child Abuse and Neglect, 26*(8), 815–831.

Smith, M. (2006). What do university students who will work professionally with children know about maltreatment and mandated reporting? *Children and Youth Services Review, 28*(8), 906–926.

Torres, A. (Coord), Pegado, E., Sarmento, M., Hilário, A., Freitas, A., Sousa, I., et al. (2008). Estudo de Diagnóstico e Avaliação das Comissões de Protecção de Crianças e Jovens: Relatório Final. Lisboa. *(Diagnostic and assessment of Commissions for the Protection of Children and Young People: Final report).*

USDHHS—U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2013). *Child maltreatment* 2012. Retrieved from http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf.

Wolfe, D. A., & McIsaac, C. (2011). Distinguishing between poor/dysfunctional parenting and child emotional maltreatment. *Child Abuse and Neglect, 35*, 802–813.

World Health Organization (2014). *WHO Media centre: Fact Sheet n°* 150. Retrieved from http://www.who.int/mediacentre/factsheets/fs150/en.