Family Medicine & Primary Care Review 2018; 20(2): 106–111 https://doi.org/10.5114/fmpcr.2018.76451

ISSN 1734-3402, eISSN 2449-8580

ORIGINAL PAPERS

The phenomenon of domestic violence against children in north-western Poland

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Summary **Background.** Violence against children is a major social problem. The state's task is to provide appropriate mechanisms to prevent violence. An analysis of the phenomenon of violence seems a fundamental step to counteract it.
Objectives. The aim of this study was to analyze the phenomenon of domestic violence against children in north-western Poland.
Material and methods. The materials were European Blue Cards concerning cases of violence in the city of Szczecin in the years 2012 and 2013. The analysis included a total of 1299 Blue Cards, from which 58 cards related to violence against children were selected. The selected method was the document analysis method.
Results. Most frequently, persons using violence against children were ascendants, i.e. parents or grandparents (45; 77.59% of cases). In second place (6; 10.34% of cases) were people around the domestic environment, and then collaterals (3; 5.17%), and strangers (2; 3.45%). Most often, the forms of physical violence were pushing and hitting, which was experienced by 57.63% (34) and 54.24% (32) of children, respectively. The most common forms of psychological violence used against children were insults (experienced by 30; 51.72% of children), humiliation (22; 37.93%), criticism (21; 36.21%), and threats (20; 34.48%).
Conclusions. The analysis of Blue Cards shows that children are not victims of violence as often as adults, which may show imperfections of procedures as a tool that should be used to identify domestic violence. Persons who use domestic violence against children are usually ascendants. Adults use various forms of violence against children, mostly shoving, hitting and name-calling.
Key words: domestic violence, child abuse, public policy.

Bażydło M, Giezek M, Zabielska P, Masna B, Tomczak J, Paszkiewicz M, Ciechowicz J, Safranow K, Karakiewicz B. The phenomenon of domestic violence against children in north-western Poland. *Fam Med Prim Care Rev* 2018; 20(2): 106–111, doi: https://doi.org/10.5114/fmpcr.2018.76451.

Background

Violence against children is a phenomenon that has accompanied society since the dawn of history, and with no doubt it is detrimental to fundamental human rights. Currently, the literature describes it as one of the greatest threats to modern civilization [1]. Violence exposes children not only to adverse health effects, but it also has a negative effect on their physical and psychological development [2]. There is a danger that a child that has not learned proper relationships in its family unit will transfer inappropriate behaviors to social life [1]. It has been shown that the experience of childhood abuse is associated with depression, alcohol addiction, suicide, and sexually transmitted diseases in adult life [3–5], whereas an early-life experience of violence may cause permanent damage to the nervous system, the hormonal system, and the immune system [6, 7]. As for domestic violence, police statistics from 2015 show that it was experienced by 17 392 children [8].

In order to prevent violence, it is essential to identify the risk factors for child maltreatment. In the 80s it was found that violence against children is multifactorially conditioned, and it depends on individual, family, community and societal factors [9]. In the literature the child maltreatment risk factors are generally divided into those related to child, parent and family factors [10]. In the 90s it was shown that various risk factors may be associated with various forms of violence: physical, sexual and with neglect. The physical violence risk factors include: low religious attendance and low father warmth, while neglect risk factors involve: large family size, low income, maternal low self-esteem, parental conflict, paternal psychopathology, sociopathy, early childhood anxiety/withdrawal, and low verbal IQ. Such factors as low maternal education, single parent, welfare dependence, early separation from the mother, maternal dissatisfaction, maternal external locus of control, poor marital quality, serious maternal illness and low paternal involvement are associated both with an increase in physical violence and in neglect. The sexual violence risk factors comprise: parental death, harsh punishment, negative life events, presence of a stepfather, unwanted pregnancy from the parent, child sex and handicap. On the other hand, such variables as young age of the mother and maternal sociopathy increase the risk of all the forms of violence [11].

Further research has confirmed the previously identified risk factors, and some new factors have also been noted. The most noteworthy include: using physical punishment [12], substance use (including smoking), more than one health problem in a child under 3 years of age, parent's unemployment lasting 2 years and more, frequent house moving (at least 10) [10], congenital child defects [13]. The research has also revealed that maltreatment was prevalent among immigrants from non-English speaking countries [10]. The recently identified risk factors for physical neglect were maternal depression in poor families and childhood maltreatment experience of the parent [14]. Importantly, an increase in the number of risk factors is related to an increase in the risk of using violence against the child [10, 11].

The phenomenon of violence is a frequent subject of public discussion, and legal regulations – both national and international (mainly the Convention on the Rights of the Child, adopted by the United Nations General Assembly on 20 November 1989). In Poland, the primary legislative act aimed at fighting violence as a phenomenon that violates basic human rights is the Act of 29 July 2005 on the prevention of domestic violence (*Journal of Laws* 2005, No. 180, item 1493, as amended). The beginning of the Act, starting from the preamble, emphasizes its importance for social life. In the preamble, the legislator emphasises that domestic violence violates fundamental human rights, especially the right to life, the right to health, and respect for personal dignity. The preamble expresses a purpose directive that imposes an obligation on public authorities to provide all citizens with equal treatment and respect for their rights and freedoms. The Act defines domestic violence as a recurring intentional act or omission that violates the rights or personal interests of family members, especially those exposing people to the danger of loss of life or health, and violating their dignity, physical inviolability, freedom, including sexual freedom, causing damage to their physical or mental health, as well as causing suffering and moral damage to people affected by violence.

Among the provisions aimed at increasing the efficiency of domestic violence prevention, Article 9d is worth noting as it discusses the norm that introduced the procedure of Blue Cards. This procedure constitutes the whole of the actions undertaken and implemented by representatives of organizational units of social assistance, municipal committees dealing with alcohol-abuse problems, the police, and education and health care units due to suspicions of domestic violence (Article 9d, Paragraph 2). The procedure is initiated once the "Blue Card" form has been filled in. The form and the procedure are defined in the Regulation of the Council of Ministers of 13 September 2011 on the "Blue Cards" procedure and the "Blue Cards" forms (*Journal of Laws* of 2011, No. 209, item 1245). In the foreign literature it is noted that extended supervision over the use of violence against children is necessary to prevent violence [3]. Therefore, a thorough analysis of the data collected from "Blue Cards" is desirable.

Objectives

The aim of this study was to analyze the phenomenon of domestic violence against children in north-western Poland.

Material and methods

The material comprised Blue Cards concerning cases of violence in the city of Szczecin in the years 2012 and 2013. The analysis was based on a total of 1299 Blue Cards. There were 576 and 723 cards for years 2012 and 2013, respectively. Further analysis included 58 cards documenting violence against children.

The selected method was the document analysis method. The interdisciplinary research team, composed of representatives of social welfare and health care, developed a questionnaire with questions about the information provided in the Blue Cards. During the analysis of the Blue Card forms members of the research team filled in the questionnaires. The sought information primarily related to the age and sex of people experiencing violence and people using violence, the relationships between them, the forms of violence, and undertaken interventions.

Statistical analysis was performed using Statistica 9 PL and Microsoft Excel 2013 software. Logistic regression was used for statistical analysis, which allows the description of the influence of several explanatory variables X on the dichotomous response variable Y, taking the value 1 or 0 (success and failure, respectively). In this regression model, apart from the typical parameters and studying their significance, there is also an odds ratio (OR). The odds ratio of 1 means the risk equivalence of the compared groups. A result higher than 1 indicates that the chance of the occurrence of a given event in group A is higher than in group B. The Wald and Score tests were used to determine the significance of explanatory variables in logistic function. A *p*-value less than 0.005 was considered as significant.

All the researchers have been trained in the protection of personal data, and all the authors obtained consent to the processing of the relevant personal data. The Pomeranian Medical University does not require ethics committee approval for studies similar to the one presented in this paper (the Bioethics Committee, information dated 18 June 2014, KB0012/47/06/2014). The Director of the Municipal Family Help Center in Szczecin gave his consent for access to data for scientific purposes.

Results

Among 1299 cases of violence documented in the Blue Cards, 58 (4.46%) cases concerned violence against children. An analysis of the age structure of children who have experienced violence was made, and two age groups were distinguished: 0–10 years and 11–18 years. The groups contained 13 and 45 children. The age structure of the individuals experiencing domestic violence is presented in Figure 1. While analyzing the number of children who have experienced violence in terms of sex it should be noted that the study group included 40 girls and 18 boys. In 2012, violence was used against 17 children, and in 2013 – 41. Most cases of violence were recorded in October and November, which is shown in Table 1.

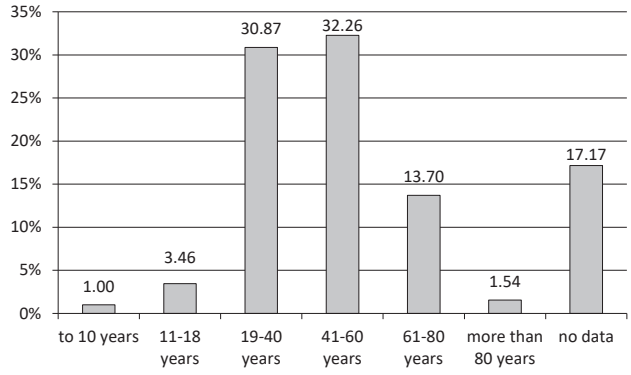

Figure 1. Age structure of people experiencing domestic violence

During the analysis of Blue Cards, attempts were made to answer the question of who uses violence against children most often. According to the results obtained, first place was taken by ascendants, i.e. parents or grandparents (45; 77.59% of cases), next were people around the domestic environment but unrelated to the abused children, e.g. the parent's partner (6; 10.34% of cases), followed by collaterals (3; 5.17 of cases), and strangers, i.e. people from outside the domestic environment (2; 3.45% of cases). Two Blue Cards did not contain information on the perpetrator of violence.

Table 1. The number of Blue Card procedures initiated in particular months

Month	Number of Blue Card procedures		Total
	2012	2013	
I	1	2	3
II	2	1	3
III	2	5	7
IV	2	0	2
V	3	2	5
VI	1	3	4
VII	0	1	1
VIII	1	0	1
IX	0	2	2
X	1	9	10
XI	2	11	13
XII	2	5	7
Total	**17**	**41**	**58**

The analysis of the collected material revealed that in the studied period various forms of violence, including physical, psychological, and other types, were used against children. According to Table 2, the most common forms of physical violence against children were pushing (34; 58.62%) and hitting (32; 55.17%). At the time of the initiation of the Blue Cards procedure, every third child had bruising, and every fifth scratches. The most common forms of psychological violence used against children were insults (experienced by 30; 51.72% of children), humiliation (22; 37.93%), criticism (21; 36.21%), and threats (20; 34.48%). Among other forms of violence most frequent were criminal threats/ /insults (13; 22.41%), and destruction and seizure of property (7; 12.07% and 6; 10.34%, respectively) (Table 2).

Half of the children (31; 53.45%) behaved calmly at the time of initiating the Blue Card procedure; 41.38% (24) were frightened, and the same percentage were crying during the interview. It was difficult to make contact with every fifth child (Table 3). In most cases (38; 65.52%) the persons who initiated the Blue Card procedure could not determine the period of violence. In the case of 13 children, violence against them lasted from 2 up to 12 months, and in 12 individuals – from 1 up to 3 years (Table 4).

Table 2. Forms of violence used against children

Forms of violence		Yes		No		No data	
		n	%	*n*	%	*n*	%
Physical violence	pushing	34	58.62	10	17.24	14	24.14
	hitting	32	55.17	12	20.69	14	24.14
	twisting	14	24.14	24	41.38	20	34.48
	strangling	8	13.79	33	56.90	17	29.31
	kicking	18	31.03	23	39.66	17	29.31
	slapping	23	39.66	18	31.03	17	29.31
	bruising	19	32.76	19	32.76	20	34.48
	scratches	12	20.69	25	43.10	21	36.21
	bleeding	4	6.90	32	55.17	22	37.93
	burns	2	3.45	35	60.34	21	36.21
Psychological violence	isolation	10	17.24	25	43.10	23	39.66
	insults	30	51.72	9	15.52	19	32.76
	ridicule	17	29.31	20	34.48	21	36.21
	threats	20	34.48	19	32.76	19	32.76
	controlling	15	25.86	22	37.93	21	36.21
	limitation of contacts	13	22.41	24	41.38	21	36.21
	criticising	21	36.21	16	27.59	21	36.21
	humiliation	22	37.93	17	29.31	19	32.76
	demoralization	9	15.52	28	48.28	21	36.21
	continuous bothering	17	29.31	19	32.76	22	37.93
Other forms of violence	sexual	2	3.45	38	65.52	18	31.03
	destruction of property	7	12.07	30	51.72	21	36.21
	seizure of property	6	10.34	31	53.45	21	36.21
	criminal threats/insults	13	22.41	23	39.66	22	37.93
	forced alcohol drinking	0	0.0	37	63.79	21	36.21
	forced use of psychoactive substances/ /drugs not prescribed by a doctor	0	0.0	36	62.07	22	37.93
	neglect	2	3.45	0	0	56	96.55

Table 3. Behavior of the child at the time of initiating the Blue Card procedure						
	Yes		No		No data	
Behaviour	*n*	%	*n*	%	*n*	%
Difficulty of establishing contact	12	20.69	35	60.34	11	18.97
Calm	31	53.45	14	24.14	13	22.41
Crying	24	41.38	24	41.38	10	17.24
Frightened	24	41.38	24	41.38	10	17.24
Avoids conversations	9	15.52	35	60.34	14	24.14
Aggressive	7	12.07	39	67.24	12	20.69

Table 4. Period of violence against children		
Period of violence	Number of children	
	n	%
1–4 weeks	3	5.17
2–12 months	13	22.41
1–3 years	12	20.69
4–7 years	5	8.62
8 years and longer	4	6.90
No data	21	36.21

Table 5. Logistic regression of forms of violence and age, gender and behavior of the child																
		Phisical violence			Injury			Psychological violence			Sexual violence			Other forms of violence		
		df	*p*	Wald/ score test	*df*	*p*	Wald/ score test	*df*	*p*	Wald/ score test	*df*	*p*	Wald/ score test	*df*	*p*	Wald/ score test
Age		1	0.85	0.03	1	0.85	0.03	1	0	10.35	1	0	10.35	1	1	0
Gender		1	0	8.34	1	0	8.34	1	0.1	2.65	1	0.1	2.65	1	0.16	2
Behaviour of the child	difficulty of establishing contact	1	0.16	2.01	1	0.16	2.01	1	0.49	0.48	1	0.49	0.48	1	0.16	2
	calm	1	0.49	0.48	1	0.49	0.48	1	0.64	0.21	1	0.64	0.21	1	1	0
	crying	1	0.89	0.02	1	0.89	0.02	1	0.89	0.02	1	0.89	0.02	1	0.16	2
	frightened	1	0.94	0.01	1	0.94	0.01	1	0.85	0.04	1	0.85	0.04	1	0.8	0.07
	avoids co-nversations	1	0.83	0.05	1	0.83	0.05	1	0.54	0.38	1	0.54	0.38	1	1	0
	aggressive	1	0.52	0.41	1	0.52	0.41	1	0.72	0.13	1	0.72	0.13	1	1	0

df – degrees of freedom; *p* – probability.

Table 6. Logistic regression of forms of violence and characteristics of the violent person												
	Phisical violence			Injury			Psychological violence			Other forms of violence		
	df	*p*	Wald/ score test	*df*	*p*	Wald/ score test	*df*	*p*	Wald/ score test	*df*	*p*	Wald/ score test
Age	1	0.934	0.212	1	0.755	0.097	1	0.001	10.881	1	0.711	0.137
Gender	1	0.51	12.216	1	0.825	0.049	1	0.685	0.165	1	0.909	0.013
Relationship with a child	1	0.424	0.392	1	0.139	2.188	1	0.784	0.075	1	0.715	0.133

df – degrees of freedom; p – probability.

It was checked whether there was a relationship between the forms of violence and age, gender, or children's behavior at the time of initiating the Blue Card procedure (Table 5). Physical violence and injures are connected with the gender of a child. Girls experienced physical violence (OR = 3.4) and physical injuries (OR = 8.34) more often than boys. Psychological violence is statistically significantly dependent on the age of the person experiencing violence. Children in the 11–18 age group experienced this form of violence eight times more often (OR = 4.08). Sexual violence and other forms of violence are characterized by a lack of significant dependence on selected independent variables.

It was also examined whether there was a relationship between the forms of violence and the age and gender of the violent person, and their relationship with the child experienc-

ing violence. Psychological violence is statistically significantly correlated with the age of the person suspected of using violence. Twice more often psychological violence occurred in the older age group (41–60) than in the younger (OR = 1.7) (Table 6). Sexual violence in this part of the analysis was excluded because of a large number of data deficiencies.

Discussion

Although the phenomenon of violence is a major social problem, to date the Polish literature has not undertaken an analysis of data contained in the Blue Cards. It should be noted that the Blue Cards are a primary tool used by the police, social workers, and education or health care workers if there is a suspicion of domestic violence. However, it should be remembered that this tool is not perfect – certainly, the Blue Cards procedure has not been initiated in all cases of domestic violence. At the same time, initiation of this procedure does not confirm that domestic violence actually occurred. However, the advantage of the analysis of Blue Cards is the fact that they are a direct source of information on households where violence occurs or is suspected.

The authors' studies revealed that 4.46% (58) of the victims of domestic violence are children. However, a conclusion based on the information that children are not often victims of domestic violence would be too far reaching. In population studies conducted among children and adolescents the percentage of persons affected by domestic violence is considerable. Urban's research showed that 26% of grade six grammar school pupils experienced physical violence [15]. Kasznia-Kocot et al. asked 228 grammar school students if they had suffered domestic violence. As many as 18% of respondents answered this question positively. They were mostly girls, but no statistically significant correlation between sex and answers to the question about domestic violence was observed [2]. The most common forms of violence were physical (20.3%) and psychological (12.1%) violence, while 6.5% of grammar school students indicated neglect as the most common form of violence they had experienced [2]. In the authors' study the most commonly used forms of violence were pushing (34; 58.62%), hitting (32; 55.17%), and insults (30; 51.72%). Neglect was a far less frequently indicated form of violence than reported in the research by Kasznia-Kocot (3.39%) [2]. At this point it should be considered whether in Szczecin, where the authors' research was conducted, neglect does not exist, or whether persons who initiate the Blue Cards procedure (who are usually police officers) are not able to identify this form of violence. Kasznia-Kocot et al. raised an interesting issue as to whether grammar school students feel safe at home. Every fifth person answered in the negative, and statistics have shown that those were mainly girls [2]. The research by Waksmańska et al. conducted in a group of 60 students from grade four primary school to the second year of high school has shown that the most common forms of violence in the family unit were fighting, hitting, and name-calling. Every third child has experienced these forms of violence. Parents were most often the ones to use violence (60%) [1]. In the authors' study, the most common perpetrator was also an ascendant (45; 77.59%).

Attention should be paid to the alarming data obtained in the authors' studies which showed an increase in the number of children affected by domestic violence from 17 in 2012 to 41 in 2013. This growing trend does not necessarily result from a higher prevalence of violence but from a better-established use of the Blue Card procedure [16] and society's increased awareness of violence and of fighting it. The data from the whole of Poland show a systematic decrease in the number of minor victims of violence since 2007 [8]. The international literature also confirms that child exposure to violence has been decreasing [17].

Nevertheless, actions should be carried out to make the society aware that, first of all, violence against children is an ongoing problem which should not be socially accepted and, secondly, awareness raising campaigns addressing children and their environment should be conducted which inform them of what to do should domestic violence occur. This awareness ought to be raised not only through school teachers and social workers or by using government campaigns. In the age of civil society the problem of raising awareness of violence and giving support to its victims should also be undertaken by non-governmental organizations, churches, religious associations, and self-help groups.

In order to counteract violence against children, the World Health Organization (WHO) proposes actions on three levels: 1) societal and community, 2) relationship, and 3) individual [18]. The societal level refers to the legislation and social policy which in Poland is implemented using the Blue Card procedure. However, the problem is the low detection rate of cases of violence against children [19], which hinders the use of this procedure.

Representatives of health care are entitled to initiate the Blue Card procedure if they suspect the occurrence of domestic violence. Therefore, proper preparation of medical personnel to react to risk factors and symptoms of abuse can contribute to the prevention of domestic violence. Family doctors and other primary care workers should be trained in responding to suspected child abuse. Also, the training of medical students should include issues dedicated to preventing domestic violence [20]. The WHO also pays attention to activities aimed at changing awareness of cultural and social norms that support violence against children and adults [18]. These tasks may include social campaigns, the activity of non-governmental organizations raising awareness of violence, but also the activity of religious associations, as low religious attendance is a risk factor for physical violence [11]. These activities are closely linked to the relational level of violence prevention. In the authors' studies these activities seem to be desired as it is the parent who is most often the perpetrator of violence (45; 77.59%). The last prevention level, according to the WHO, is the individual level, which involves making children aware of their rights and the availability of the Blue Card procedure, and recognizing abusive situations [18].

Conclusions

1. The analysis of Blue Cards shows that children are not victims of violence as often as adults, which may show imperfections of procedures as a tool that should be used to identify domestic violence. Therefore, social awareness should be raised of children's rights, the negative consequences of violence, and the Blue Card procedure as a violence counteracting tool.
2. Persons who use domestic violence against children are usually ascendants. Adults use various forms of violence against children, mostly shoving, hitting and name-calling. To ensure appropriate parent-child relationships, parents should be offered support in the form of workshops, open lectures and family counseling.
3. Persons starting new Blue Cards (usually police officers) have pointed out that at the initiation of the procedure they have difficulty in communicating with the child. Therefore, police officers need to be trained in talking to children.

Source of funding: This work was funded by the university's funds (statute-based activity).
Conflict of interest: The authors declare no conflicts of interest.

References

1. Waksmańska W, Grzywna T, Łukasik R. Analiza zjawiska przemocy w rodzinie na podstawie badania ankietowego przeprowadzonego wśród uczniów. *Probl Pielęg* 2007; 15(4): 235–240 (in Polish).
2. Kasznia-Kocot J, Kołodziejska K, Wypych-Ślusarska A, et al. Zjawisko krzywdzenia dzieci na podstawie badań gimnazjalistów. *Med Środow* 2012; 15(1): 51–59 (in Polish).
3. Hillis S, Mercy J, Amobi A, et al. Global prevalence of past-year violence against children: a systematic review and minimum estimates. *Pediatrics* 2016; 137(2): 1–9.
4. Felitti VJR, Anda R, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. *Am J Prev Med* 1998; 14(4): 245–258.
5. Hillis S, Anda RF, Felitti VJ, et al. Adverse childhood experiences and sexually transmitted diseases in men and women: a retrospective study. *Pediatrics* 2000; 106(1): E11.
6. Anda RF, Butchart A, Felitti VJ, et al. Building a framework for global surveillance of the public health implications of adverse childhood experiences. *Am J Prev Med* 2010; 39(1): 93–98.
7. Danese A, McEwen BS. Adverse childhood experiences, allostasis, allostatic load, and age-related disease. *Physiol Behav* 2012; 106(1): 29–39.
8. Statystyki policyjne. Przemoc w rodzinie [cited 04.02.2016]. Available from URL: http://statystyka.policja.pl/st/wybrane-statystyki/przemoc-w-rodzinie/50863,Przemoc-w-rodzinie.html (in Polish).
9. Belsky J. Child maltreatment: an ecological integration. *Am Psychol* 1980; 35(4): 320–335.
10. Doidge JC, Higgins DJ, Delfabbro P, et al. Risk factors for child maltreatment in an Australian population-based birth cohort. *Child Abuse Negl* 2017; 64: 47–60, doi: 10.1016/j.chiabu.2016.12.002.
11. Browna J, Cohena P, Johnsona JG, et al. A longitudinal analysis of risk factors for child maltreatment: findings of a 17-year prospective study of officially recorded and self-reported child abuse and neglect. *Child Abuse Negl* 1998; 22(11): 1065–1078, doi: 10.1016/S0145-2134(98)00087-8.
12. Stoltenborgh M, Bakermans-Kranenburg MJ, Iizendoorn MH, et al. Cultural-geographical differences in the occurrence of child physical abuse? A meta-analysis of global prevalence. *Int J Psychol* 2013; 48(2): 81–94, doi: 10.1080/00207594.2012.697165.
13. O'Donnell M, Nassar N, Leonard H, et al. Characteristics of non-Aboriginal and Aboriginal children and families with substantiated child maltreatment: a population-based study. *Int J Epidemiol* 2010; 39(3): 921–928, doi: 10.1093/ije/dyq005.
14. Meghan E, Shanahan ME, Desmond KR, et al. The within poverty differences in the occurrence of physical neglect. *Child Youth Serv Rev* 2017; 75: 1–6.
15. Urban E. Krzywdzenie dzieci. Ocena skali zjawiska i możliwości interwencji. *Zdr Publ* 2002; 112: 382–390 (in Polish).
16. Giezek M, Bażydło M, Ciechowicz J, et al. The results of the "Blue Cards" questionnaire analysis with respect to the incidence of violence among the elderly. *Fam Med Prim Care Rev* 2017; 19(1): 18–22, doi: 10.5114/fmpcr.2017.65085.
17. Finkelhor D, Shattuck A, Turner HA, et al. Trends in children's exposure to violence, 2003 to 2011. *JAMA Pediatr* 2014; 168(6): 540–546, doi: 10.1001/jamapediatrics.2013.5296.
18. World Health Organization. Preventing Child Maltreatment: a guide to taking action and generating evidence [cited 04.06.2017]. Available from URL: http://apps.who.int/iris/bitstream/10665/43499/1/9241594365_eng.pdf].
19. Horst-Sikorska W, Bryl N. Zespół Dziecka Maltretowanego. *Fam Med Prim Care Rev* 2011; 13(2): 319–321 (in Polish).
20. Topczewska-Cabanek A, Nitsch-Osuch A, Gyrczuk E, et al. Wiedza i opinia studentów IV i VI roku medycyny na temat problemu przemocy w rodzinie – badanie ankietowe. *Fam Med Prim Care Rev* 2010; 12(3): 852–854 (in Polish).

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Received: 27.03.2017
Reviewed: 12.04.2017
Accepted: 20.07.2017

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