

سلسلة الكتاب الإلكتروني

إصدار خاص

الكتاب الإلكتروني لشبكة العلوم النفسية



إهداء بمناسبة

المؤتمر 11 لإتمام الأبحاث النفسية من العرب

أساسيات...

حماية الأطفال من سوء المعاملة والإهمال

... في سوريا

محمد أديب العسالي

عدد 13 (إصدار خاص) - 2008

إصدارات شبكة العلوم النفسية العربية



إصدارات شبكة العلوم النفسية العربية

سلسلة الكتاب الإلكتروني: عدد 13

أساسيات...

حماية الأطفال من سوء المعاملة والإهمال  
... في سورية

محمد أديب العسالي

## الفهرس

6	مقدمة
11	تمهيد
14	المحتويات
15	الفصل الأول: أسس تعامل المجتمع مع حالات سوء معاملة وإهمال الأطفال.
17	خلاصة
18	الفصل الثاني: تعريف سوء معاملة وإهمال الأطفال.
18	1.2.1. التعريف القانوني
19	2.2.2. أنماط سوء المعاملة
20	3.2.3. سوء المعاملة الجسدي
20	4.2.4. سوء المعاملة الجنسي
20	5.2.5. سوء المعاملة النفسي (أو العاطفي)
21	6.2.6. إهمال الأطفال
22	1.6.2. الإهمال الجسدي
22	2.6.2. الإهمال التعليمي
22	3.6.2. الإهمال العاطفي
24	الفصل الثالث: حجم مشكلة سوء معاملة وإهمال الأطفال.
26	الفصل الرابع: أسباب سوء معاملة وإهمال الأطفال.
27	1.4.1. عوامل الأهل أو مقدمي الرعاية
27	1.1.4. الشخصية والصحة النفسية
27	2.1.4. السوابق الوالدية وحلقة سوء المعاملة
27	3.1.4. الإدمان
28	4.1.4. المعارف والمواقف
28	5.1.4. العمر
28	2.4.2. عوامل الأسرة
29	1.2.4.1. بنية الأسرة

- 29 2.2.4. الخلافات الزوجية والعنف المنزلي
- 30 3.4. عوامل الطفل
- 30 1.3.4. العمر
- 30 2.3.4. الإعاقة
- 31 3.3.4. خصائص الطفل الأخرى
- 31 4.4. العوامل البيئية
- 32 1.4.4. الفقر والبطالة
- 32 2.4.4. العزلة الاجتماعية والدعم الاجتماعي
- 32 3.4.4. المجتمعات العنيفة
- 33 4.4.4. العوامل الوقائية
- 34 الفصل الخامس: عواقب سوء معاملة وإهمال الأطفال.
- 35 1.5. العواقب الصحية والجسدية
- 35 1.1.5. العواقب الجسدية عند الرضيع
- 35 2.1.5. التأثير على تطور الدماغ
- 36 3.1.5. عواقب صحية إضافية
- 36 2.5. التطور الاستعرافي والتحصيل الدراسي
- 37 3.5. العواقب الانفعالية والنفسية-الاجتماعية والسلوكية
- 37 1.3.5. العواقب الانفعالية والنفسية
- 38 2.3.5. العنف والإدمان وغيرها من المشكلات السلوكية
- 38 4.5. المقاومة
- 38 5.5. تكلفة سوء معاملة وإهمال الأطفال
- 40 الفصل السادس: الوقاية من سوء معاملة وإهمال الأطفال.
- 40 1.6. الوقاية كاستراتيجية
- 41 2.6. مستويات الوقاية
- 41 1.2.6. الوقاية الأولية أو الشاملة
- 42 2.2.6. الوقاية الثانوية أو الانتقائية
- 42 3.2.6. الوقاية الثالثية أو المستتبة
- 43 3.6. التوعية المجتمعية
- 43 4.6. برامج تثقيف الوالدين
- 44 5.6. مناهج الأطفال المبنية على المهارات
- 44 6.6. برامج الزيارة المنزلية
- 46 الفصل السابع: القوانين والسياسات الناظمة لتدخل الدولة في حالات سوء معاملة وإهمال الأطفال.
- 46 1.7. دور الدولة في التعامل مع حالات سوء معاملة وإهمال الأطفال

48	2.7. وحدة حماية الطفل
51	الفصل الثامن : حدثية حماية الطفل.
51	1.8. تمييز الحالات
52	2.8. التبليغ
52	1.2.8. التبليغ الإلزامي
53	2.2.8. الظروف التي تستوجب التبليغ
53	3.2.8. توقيت وكيفية التبليغ
53	4.2.8. من يتلقى التبليغ
54	5.2.8. محتوى التبليغ
54	6.2.8. مشاكل التبليغ: التفريط والإفراط
55	3.8. تسجيل الحالة (تنظيم الضبط)
56	4.8. التحقيق المبدئي
58	5.8. تقييم الأسرة
59	6.8. تصنيف الحالات
59	7.8. التخطيط لتدبير الحالة
61	8.8. تقديم الخدمات
62	9.8. تقييم تطور الأسرة
63	10.8. إغلاق الحالة
64	الفصل التاسع : الجهات المعنية بالتعامل مع الأطفال في سورية ودور كل منها في الوقاية من سوء المعاملة والإهمال
65	1.9. دور مختلف الجهات المعنية بالوقاية من سوء معاملة وإهمال الأطفال
65	2.9. مقدمو الرعاية الصحية
68	3.9. التقييم النفسي الاجتماعي
69	4.9. المدارس
70	5.9. المنظمات الشعبية
71	6.9. الخدمات الاجتماعية
72	7.9. المؤسسات الدينية
73	8.9. وحدة حماية الطفل
74	9.9. مؤسسات تطبيق القانون
77	الفصل العاشر: مبادئ عمل وحدة حماية الأطفال متعددة الاختصاصات.
77	1.10. بناء الثقة والحفاظة عليها
78	2.10. التوصل إلى اتفاق على القيم الجوهرية
78	3.10. التركيز على الأهداف المشتركة
78	4.10. تطوير لغة مشتركة

79	5.10. إبداء الاحترام لمعارف وخبرة كل فرد
79	6.10. افتراض النوايا الحسنة عند الفرقاء
79	7.10. تمييز نقاط قوة وحدودية الجهات المعنية بالأطفال
79	8.10. تقاسم اتخاذ القرارات وتحمل المسؤولية
79	9.10. القيادة الفعالة
80	10.10. خلاصة
81	المراجع
90	ملحق فصل "سوء معاملة وإهمال الأطفال"

تمهيد

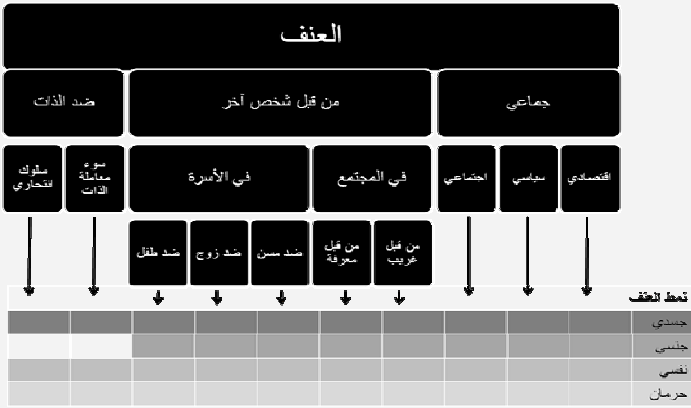
4400

" 1" "

"

(1)

.)



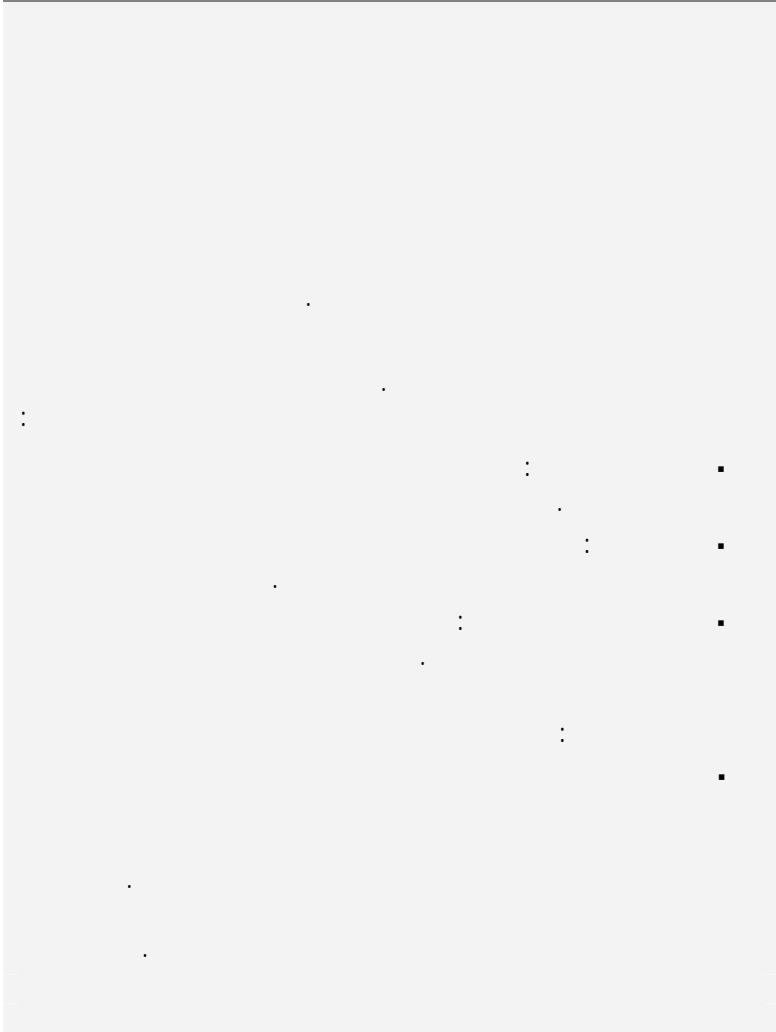
الشكل 1: فئات وأشكال وأماكن وأنماط العنف

- حماية أطفال سورية من سوء المعاملة والإهمال:





## الفصل الأول: أسس تعامل المجتمع مع حالات سوء معاملة وإهمال الأطفال





( )

2

خلاصة

## الفصل الثاني: تعريف سوء معاملة وإهمال الأطفال

### 1.2. التعريف القانوني

## 2.2 أنماط سوء المعاملة

### 3.2. سوء المعاملة الجسدي

4

### 4.2. سوء المعاملة الجنسي

4

( )

( )

( )

5

### 5.2. سوء المعاملة النفسي (أو العاطفي)

"

6"



### 1.6.2. الإهمال الجسدي

- :
- :
- :
- ( ) :
- :
- ) .(

### 2.6.2. الإهمال التعليمي

- :
- :
- :

### 3.6.2. الإهمال العاطفي

- :
- :
- :

)

(

:

:

.( )

9

10

:

" "

:"

"

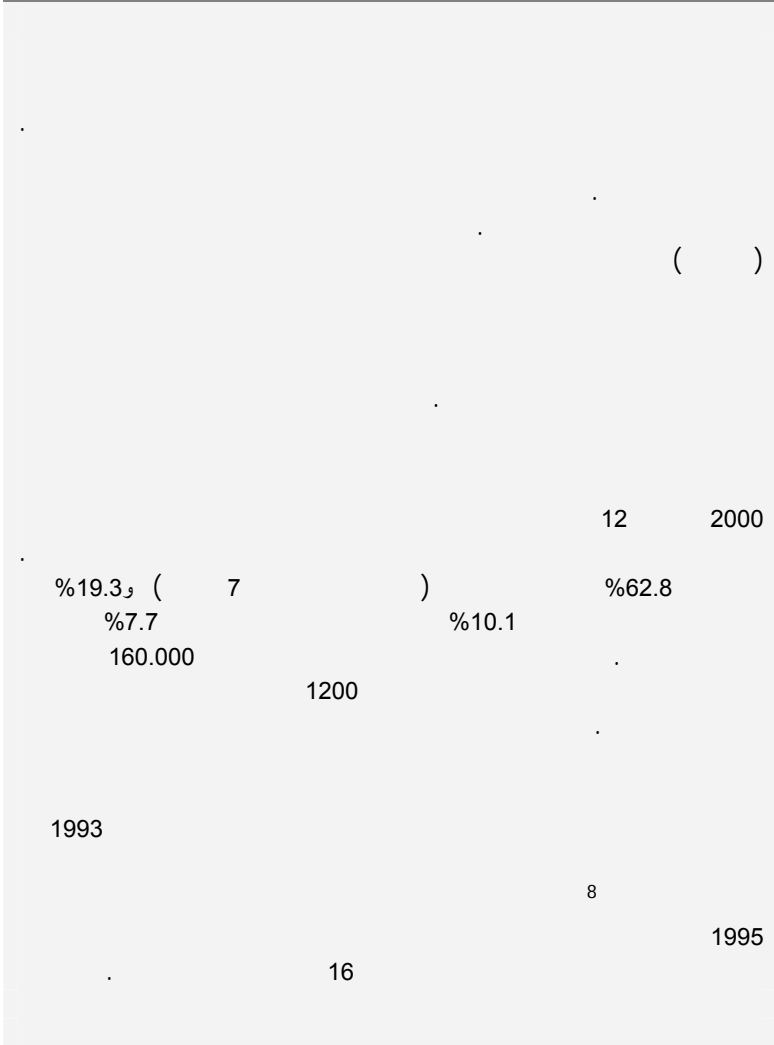
" "

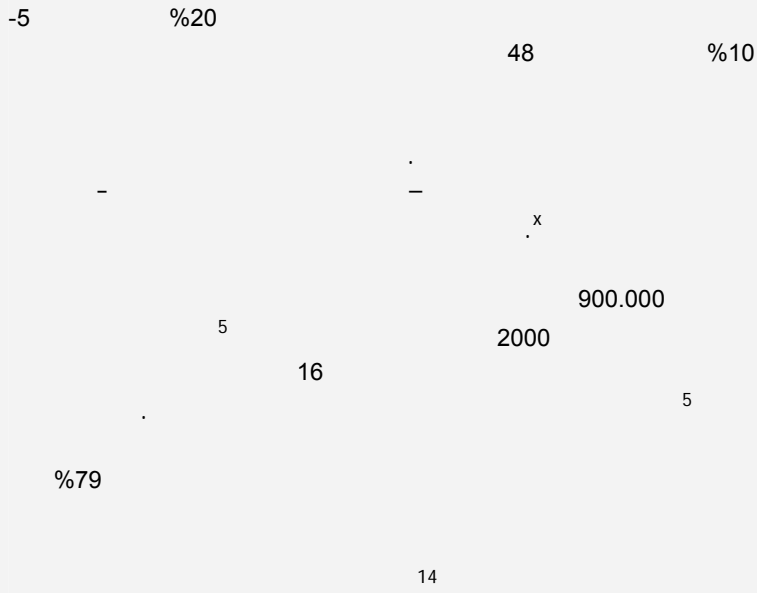
" "

"

11

### الفصل الثالث: حجم مشكلة سوء معاملة وإهمال الأطفال





<sup>x</sup>قدمت بعض الدراسات الاسترجاعية والمسحية الجراة في سورية في عدة مؤتمرات مثل "ملتقى حماية الطفل" الذي انعقد في فندق الشام في دمشق عام 2004. وقد بينت تلك الدراسات أن سوء معاملة وإهمال الأطفال في سورية لا يختلف عنه في باقي الدول، ولكن لم يتم بعد نشر أي من تلك الدراسات بشكل يمكن من توثيقها.

## المراجع

- Krug EG, Dahlberg LL, Mercy JA, et al (2002). World report on violence and health. Geneva: World Health Organization.
- Rycus, J. S., & Hughes, R. C. (1998). Family-centered child protection: An integrated model of child welfare practice assuring children's rights to protection and permanence. Columbus, OH: Institute for Human Services.
- Child Abuse and Prevention Act (1996). 42 U.S.C. 5106g, SEC.111 (6)
- Berliner, L. (2000). What is sexual abuse? In H. Dubowitz & D. DePanfilis (Eds.), Handbook for child protection practice (pp. 18-22). Thousand Oaks, CA: Sage.
- U.S. Department of Health and Human Services, Administration on Children, Youth and Families (2002). Child maltreatment 2000. Washington, DC: U.S. Government Printing Office.
- Hart, S., & Brassard, M. (1995). Psychosocial evaluation of suspected psychological maltreatment in children and adolescents: APSAC practice guidelines. Chicago, IL: American Professional Society on the Abuse of Children (APSAC).
- Hart, S., & Brassard, M. (1991). Psychological maltreatment: Progress achieved. Development and Psychology, 3, 61-70
- Sedlak, A. J., & Broadhurst, D. D. (1996). Third national incidence study of child abuse and neglect (NIS-3). Washington, DC: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect.

- Zuravin, S. J. (1991). Research definitions of child physical abuse and neglect: Current problems. In R. H. Starr & D. A. Wolfe (Eds.), The effects of child abuse and neglect (pp. 100-128). New York, NY: The Guildford Press.
- English, D. (1999). Evaluation and risk assessment of child neglect in public child protection services. In H. Dubowitz (Ed.), Neglected children: Research, practice and policy (pp. 191-210). Thousand Oaks, CA: Sage.
- Egeland, B. (1988). The consequences of physical and emotional neglect on the development of young children. In Child neglect monograph: Proceedings from a symposium (pp. 7-19). Washington, DC: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect.
- Chalk, R., & King, R. A. (1998). Family violence and family violence interventions. Washington, DC: National Academy Press
- National Research Council (1993). Understanding child abuse and neglect. Washington, DC: National Academy Press
- Melnick, B & Hurley, J .R. (1969). Distinctive personality attributes of child-abusing mothers. Journal of Consulting and Clinical Psychology, 33(6), 746-749.
- Kaufman, J., & Zigler, E. (1993). The intergenerational transmission of abuse is overstated. In R. J. Gelles & D. Loseke (Eds.), Current controversies on family violence (pp. 209-221). Newbury Park, CA: Sage
- Gelles, R. J. (1998). The youngest victims: Violence toward children. In R. K. Bergen (Ed.), Issues in intimate violence (pp. 5-24). Thousand Oaks, CA: Sage.
- Hawthorne, NY: Aldine de Gruyter, Zuravin, S. J., McMillen, C., DePanfilis, D., & Risley-Curtiss C. (1996). The intergenerational cycle of maltreatment: Continuity versus discontinuity. Journal of Interpersonal Violence, 11, 315-334.
- Young, N. K., Gardner, S. L., & Dennis, K. (1998). Facing the problem. In Responding to

alcohol and other drug problems in child welfare: Weaving together practice and policy (pp.1-26). Washington, DC: Child Welfare League of America (CWLA) Press.

- Jaudes, P. K., Ekwo, E., & Van Voorhis, J. (1995). Association of drug abuse and child abuse. *Child Abuse and Neglect*, 19(9), 1065-75.

- Zuckerman, B. (1994). Effects on parents and children. In D. J. Besharov (Ed.), *When drug addicts have children: Reorienting child welfare's response* (pp.49-63). Washington, DC: CWLA Press.

- Tarter, R., Blackson, T., Martin, C., Loeber, R & Moss, H. (1993). Characteristics and correlates of child discipline practices in substance abuse and normal families. *American Journal on Addictions*, 2, 18-25

- U.S. Department of Health and Human Services. (1999). *Blending perspectives and building common ground: A report to congress on substance abuse and child protection*. Washington, DC: U.S. Government Printing Office

- Williamson, J. M., Bordin, C. M., & Howe B. A.. (1991). The ecology of adolescent maltreatment: A multilevel examination of adolescent physical abuse, sexual abuse, and neglect. *Journal of Consulting and Clinical Psychology*, 59, 449-457

- Straus, M. A., Hamby, S. L., Finkelhor, D., Moore, D. W., & Runyan, D. (1998). Identification of child maltreatment with the parent-child conflict tactics scales: Development and psychometric data for a national sample of American parents. *Child Abuse and Neglect* 22, 249-270

- Connelly, C. D., & Straus, M. A. (1992). Mother's age and risk for physical abuse. *Child Abuse and Neglect* 16, 709-718.

- Buchholz, E. S., & Korn-Burszty, C. (1993). Children of adolescent mothers: Are they at risk for abuse? *Adolescence*, 28, 361-382.

- Polansky, N. A., Guadin, J. M., Ammons, P.

- W., & Davis, K. B. (1985). The psychological ecology of the neglectful mother. *Child Abuse and Neglect*, 9, 265-275
- Polansky, N. A., Gaudin, J. M., & Kilpatrick, A. C. (1992). Family radicals. *Children and Youth Services Review*, 14, 19-26.
  - Boney-McCoy, S., & Finkelhor, D. (1995). Prior victimization: A risk factor for child sexual abuse and for PTSD-related symptomatology among sexually abused youth. *Child Abuse and Neglect*, 19, 1401-1421.
  - Federal Interagency Forum on Child and Family Statistics. (1999). *America's children: Key national indicators of wellbeing*. Washington, DC: U.S. Government Printing Office.
  - Edelson, J. L. (1999). The overlap between child maltreatment and woman battering. *Violence Against Women*, 5, 134-154.
  - National Clearinghouse on Child Abuse and Neglect Information. (1999). *In harm's way: Domestic violence and child maltreatment*. Washington, DC.
  - Kolbo, J. R. (1996). Risk and resilience among children exposed to family violence. *Violence and Victims*, 11, 113-128.
  - Coohy, C., & Braun, N. (1997). Toward an integrated framework for understanding child physical abuse. *Child Abuse and Neglect*, 21, 1081-1094
  - Gaines, R., Sandgrund, A., Green, A. H., & Power, E. (1978). Etiological factors in child maltreatment: A multivariate study of abusing, neglectful and normal mothers. *Journal of Abnormal Psychology*, 87, 531-540
  - Milner, J. S., & Dopke, C. (1997). Child physical abuse: Review of offender characteristics. In D. A. Wolfe, R. J. McMahon, & R. D. Peters, (Eds.), *Child abuse: New directions in prevention and treatment across the lifespan* (pp.27-53). Thousand Oaks, CA: Sage.
  - Rycus, J. S., & Hughes, R.C. (1998). *Field guide to child welfare: Volume I. Foundations of child protective services*. Washington, DC: CWLA Press.

- Garbarino, J. (1984). What have we learned about child maltreatment? In Perspectives on child maltreatment in the mid '80s. (pp. 6-8). Washington, DC: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect.
- Bousha, D. M., & Twentyman, C. T. (1984). Mother-child interactional style in abuse, neglect, and control groups: Naturalistic observations in the home. *Journal of Abnormal Psychology*, 93, 106-114.
- Trickett, P. K., & Kucynski, L. (1986). Children's misbehaviors and parental discipline strategies in abusive and non-abusive families. *Developmental Psychology*, 22, 115-123.
- Finkelhor, D., Moore, D., Hamby, S. L & Strauss, M. A. (1997). Sexually abused children in a national survey of parents: Methodological issues. *Child Abuse and Neglect*, 21, 1-9.
- Sullivan, P. M., Knutson, J. F. (2000). Maltreatment and disabilities: A population-based epidemiological study. *Child Abuse and Neglect*, 24, 1257-1273.
- Crosse, S. B., Kaye, E., & Ratnofsky, A. C. (n.d.). A report on the maltreatment of children with disabilities. Washington, DC: Department of Health and Human Services, National Center on Child Abuse and Neglect
- Ammerman, R. T., & Patz, R. J. (1996). Determinants of child abuse potential: Contribution of parent and child factors. *Journal of Clinical Child Psychology*, 25, 300-307.
- Steinberg, M. A., & Hylton, J. R., & Wheeler, C. E. (Ed.). (1998). Responding to maltreatment of children with disabilities: A trainer's guide. Portland, OR: Oregon Health Sciences University, Oregon Institute on Disability and Development.
- Zuravin, S. J., Masnyk, K., DiBlasio, F. (1992). Predicting child abuse and neglect by adolescent mothers. In F. L. Parker, R. Robinson, S. Sambrano et al. (Eds.), *New directions in child and family research: Shaping Head Start in the 90's: First national working conference on early childhood and family research* (pp. 246-

247). Washington, DC: Department of Health and Human Services, Administration on Children, Youth and Families.

- Vissing, Y. M., Straus, M. A., Gelles, R. J., & Harrop, J. W. (1991). Verbal aggression by parents and psychosocial problems of children. *Child Abuse and Neglect*, 15, 223-238.

- Drake, B., & Pandey, S. (1996). Understanding the relationship between neighborhood poverty and specific types of child maltreatment. *Child Abuse and Neglect*, 20, 1003-1018.

- National Clearinghouse on Child Abuse and Neglect Information. (2002). National child abuse and neglect data system (NCANDS) summary of key findings for calendar year 2000. Washington, DC.

- Plotnik, R. (2000). Economic security for families with children. In P. J. Pecora, J. K. Whittaker, A. N. Maluccio, & R. P. Barth (Eds.), *The child welfare challenge: Policy, practice, and research* (2nd ed., pp. 95-127). New York, NY: Aldine de Gruyter.

- Polansky, N. A., Guadin, J. M., Ammons, P. W., & Davis, K. B. (1985). The psychological ecology of the neglectful mother. *Child Abuse and Neglect*, 9, 265-275.

- Harrington, D., & Dubowitz, H. (1999). Preventing child maltreatment. In R. L. Hampton (Ed.), *Family violence: Prevention and treatment* (2nd ed., pp. 122-147). Thousand Oaks, CA: Sage.

- Chalk, R., & King, R. A. (Eds.). (1998). *Family violence and family violence interventions. In Violence in families: Assessing prevention and treatment programs*. Washington, DC: National Academy Press

- Cicchetti, D., Lynch, M., & Manly, J. T. (1997). An ecological developmental perspective on the consequences of child maltreatment. Washington, DC: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect.

- Garbarino, J. (1980). What kind of society permits child abuse? *Infant Mental Health Journal*, 1, 270-280.

- Kotch, J. B., Browne, D. C., Ringwalt, C. L., Stewart, P. W., Ruina, E., Holt, K., Lowman, B., & Jung, J. W. (1995). Risk of child abuse or neglect in a cohort of low-income children. *Child Abuse and Neglect*, 19, 1115-1130.
- Egeland, B., Jacobvita, D., & Sroufe, L. A. (1988). Breaking the cycle of abuse. *Child Development*, 59, 1080-1088.
- Stanley, S. M., Markman, H. J., & Jenkins, N. H. (2002). Marriage education and government policy: Helping couples who choose marriage achieve success. Bethesda, MD: National Institute of Mental Health.
- Gelles, R. J. (1998). The youngest victims: Violence toward children. In R. K. Bergen (Ed.), *Issues in intimate violence* (pp. 5-24). Thousand Oaks, CA: Sage.
- Conway, E. E. (1998). Nonaccidental head injury in infants: The shaken baby syndrome revisited. *Pediatric Annals*, 27, 677-690.
- Wallace, H. (1996). *Family violence: Legal, medical, and social perspectives*. Needham Heights, MA: Allyn & Bacon.
- Perry, B. D., Pollard, R., Blakely, T., Baker, W., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation and "use-dependent" development of the brain: How "states" become "traits." *Infant Mental Health Journal*, 16, 271-291.
- Greenough, W. T., Black, J. E., & Wallace, C. S. (1987). Experience and brain development. *Child Development*, 58, 539-559.
- Moeller, T. P., Bachman, G. A., & Moeller, J. R. (1993). The combined effects of physical, sexual, and emotional abuse during childhood: Long-term health consequences for women. *Child Abuse and Neglect*, 17, 623-340
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventative Medicine*, 14, 245-258.

- Perry, M. A., Doran, L. D., & Wells, E. A. (1983). Developmental and behavioral characteristics of the physically abused child. *Journal of Clinical Child Psychology*, 12, 320-324.
- Allen, R. E., & Oliver, J. M. (1982). The effects of child maltreatment on language development. *Child Abuse and Neglect*, 6, 299-305.
- Trickett, P. K., McBride-Chang, C. & Putnam, F. W. (1994). The classroom performance and behavior of sexually abused females. *Development and Psychopathology*, 6, 183-194.
- Egeland, B. (1993). A history of abuse is a major risk factor for abusing the next generation. In R. J. Gelles & D. R. Loseke (Eds.), *Current controversies on family violence*. Newbury Park, CA: Sage.
- Trickett, P. K., & McBride-Chang, C. (1995). The developmental impact of different forms of child abuse and neglect. *Developmental Review*, 15, 311-337.
- Jumper, S. A. (1995). A metaanalysis of the relationship of child sexual abuse to adult psychological adjustment. *Child Abuse and Neglect*, 19, 715-728.
- Maxfield, M., & Widom, C. S. (1996). The cycle of violence: Revisited 6 years later. *Archives of Pediatrics & Adolescent Medicine*, 150, 390-395
- McCauley, J., Kern, D., Kolodner, K., Dill, L., Schroeder, A., DeChant, H., Ryden, J., Derogatis, L., & Bass, E. (1997). Clinical characteristics of women with a history of childhood abuse. *Journal of the American Medical Association*, 277, 1362-1368.
- Heller, S. S., Larrieu, J. A., D'Imperio, R., & Boris, N. W. (1999). Research on resilience to child maltreatment: Empirical considerations. *Child Abuse and Neglect*, 23, 321-338.
- Muller, R. T., Goebel-Fabbri, A. E., Diamond, T & Dinklage, D. (2000). Social support and the relationship between family and community violence exposure and psychopathology among high risk adolescents. *Child Abuse and Neglect*, 24, 449-464.

- Willis, D. J., Holden, E. W., & Rosenberg, M. (Eds.). (1992). Prevention of child maltreatment: Developmental and ecological perspectives (pp. 1-16). New York, NY: John Wiley & Sons.
- McCurdy, K. (2000). What works in nonmedical home visiting: Healthy Families America. In M. P. Kluger, G. Alexander, and P. A. Curtis (Eds.). What works in child welfare (pp. 45-55). Washington, DC: CWLA Press.
- Olds, D., Henderson, C. R., Tatelbaum, R., & Chamberlin, R. (1986). Improving the delivery of prenatal care and outcomes of pregnancy: A randomized trial of nurse home visitation. Pediatrics, 78, 65-78.
- Eckenrode, J. (2000). What works in nurse home visiting programs. In M. P. Kluger, G. Alexander, and P. A. Curtis (Eds.), What works in child welfare (pp. 35-43). Washington, DC: CWLA Press.
- Kalichman, S. C., & Law, C. L. (1993). Practicing psychologists' interpretations of and compliance with child abuse reporting laws. Law and Human Behavior, 17, 83-93.
- Dubowitz, H. (1990). Costs and effectiveness of interventions in child maltreatment. Child Abuse and Neglect, 14, 177-186
- National Clearinghouse on Child Abuse and Neglect Information. (n.d.) Actions for the business community for child abuse prevention. Washington, DC.
- Waldfogel, J. (2000). Reforming child protective services. Child Welfare, 79, 43-57.

## ملحق

2008

Essali, MA (2008). Child Abuse and Neglect. In: Nasir, L (ed) Caring for Arab Patients: A Biopsychosocial Approach. London, UK, Radcliffe

### Introduction

Violence is a major global public health issue. Over 1 million people die every year because of intentional acts of self-directed, interpersonal, or collective violence. Many more are injured or suffer other non-fatal health consequences as a result of being the victim or witness to acts of violence(1). However, in many countries, violence prevention remains a new or emerging field in public health

Existing approaches to violence, which are mainly reactive, may be enhanced by a public health approach which is focused on changing the behavioral, social, and environmental factors that give rise to violence (2).

Public health is committed to aiding communities to solve their own health problems, and to assuring that necessary health services are available in communities. This commitment can be extended to include reducing the severity and duration of the physical or psychological injuries and disabilities caused by violent incidents. Public health can make a significant contribution to the management of violence through its focus on prevention, scientific approaches, potential to coordinate multidisciplinary efforts, and can play a role in assuring the availability of services for victims of violence.

Violence may be defined as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation”(1). This definition

encompasses all types of violence and covers the wide range of acts of commission and omission that constitute violence and outcomes beyond deaths and injuries. Violence may be categorized into self-inflicted, interpersonal, and collective (figure 1), and each category can be subdivided to reflect specific types of violence, settings of violence, and nature of violent acts (physical, sexual, psychological, and deprivation or neglect).

Thus, the spectrum of violence includes child abuse and neglect by caregivers, intimate partner violence, elder abuse, self directed violence and collective violence. While it is important for healthcare workers to be able to deal with all these types of violence, this chapter is limited to dealing with the entity of child abuse and neglect (CAN).

### Definition of CAN

Every child deserves to grow up in a safe and nurturing environment.

Parents have a fundamental right to raise their children as they see fit, and society presumes that parents will act in their children's best interest. When parents do not protect their children from harm and meet their basic needs, as with cases of CAN, society has a responsibility to intervene to protect the health and welfare of these children. Any intervention in family life on behalf of children must be guided by the law and sound professional practice standards.

To prevent and respond to CAN effectively, there needs to be a common understanding of definitions of actions and omissions that constitute child maltreatment. Unfortunately, there is no single, universally applied definition of CAN. However, there are commonalities across definitions, and CAN may be defined as any act or failure to act on the part of a parent or caregiver that results in death, serious physical or emotional harm, sexual abuse or exploitation of a child. This definition refers specifically to parents and other caregivers, and a "child" is any person under the age of 18.

### Types of CAN

There are four commonly recognized forms of child abuse or maltreatment; physical, sexual, neglect and psychological (3).

**Physical Abuse** is inflicting a physical injury upon a child through burning, hitting, punching, shaking, kicking, beating, or otherwise harming a child. It may, sometimes, be the result of over-discipline or culturally accepted practices. While cultural practices are generally respected, healthcare workers should work with parents to discourage harmful behavior and suggest preferable alternatives.

**Child sexual abuse** includes a wide range of behaviors exhibited by a person responsible for the care of a child, and can involve varying degrees of violence and emotional trauma. Child sexual abuse generally refers to sexual acts, sexually motivated behaviors involving children, or sexual exploitation of children. It includes fondling, intercourse, incest, rape, sodomy, exhibitionism, sexual exploitation, or exposure to pornography. The most commonly reported cases involve incest; sexual abuse occurring among family members, including those in biological families, adoptive families, and step-families. Incest most often occurs within a father-daughter relationship; however, sexual abuse may also be committed by other relatives or caretakers.

**Child neglect** is the failure to provide for the child's basic needs. Neglect can be physical, educational, or emotional. Physical neglect can include not providing adequate food or clothing, appropriate medical care, supervision, or proper protection from the weather. Educational neglect includes failure to provide appropriate schooling, special educational needs, or allowing excessive truancies. Psychological neglect includes the lack of emotional support and love, chronic inattention to the child, or exposure to domestic violence or to drug and alcohol abuse.

**Psychological abuse** is a pattern of caregiver behavior that conveys to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value to meeting another's needs. This can include parents or caretakers using extreme or bizarre forms of punishment or threatening or terrorizing a child. The term "psychological abuse" has also been termed emotional abuse, verbal abuse, or mental abuse.

### **Incidence and Prevalence**

Although hundreds of thousands of children are subjected to CAN worldwide, reliable data on the prevalence and incidence of CAN are scarce. Incidence rates are usually drawn from data collected by child protection services, but not all countries have such services and not all CAN cases are reported. Prevalence rates are usually derived from cross-sectional or retrospective surveys.

In countries with well-developed social service agencies, the incidence of CAN seems to be fairly consistent. During the year 2000 in the USA, for example, 12 of every 1,000 were victims of one or more types of CAN; 62.8% suffered neglect (an estimated annual incidence rate of 7 per 1,000 children), 19.3% were physically abused, 10.1% were sexually abused, and 7.7% were victims of psychological maltreatment. About 160,000 child suffer from serious or life-threatening injuries, and approximately 1400 children die from abusive

injuries or neglect, in the USA every year(4). It must be remembered here that these figures reflect the cases that have been reported to child protection agencies. Unknown number of cases may go unnoticed and/or unreported.

Less developed countries underreport CAN, probably because of the lack of social services. However, the widespread nature of CAN is clear. In 48 retrospective population surveys from around the world, the prevalence of sexual abuse during childhood was approximately 20% among women and 5–10% among men(5). In the absence of formal statistics from Arab countries, an impression about the prevalence of CAN may be formed from the number of cases seen in forensic medicine departments and within criminal justice systems(6,7). Available data suggest that the prevalence of CAN in Arab countries may not be much different from the rest of the world(8,9,10).

CAN occurs across socio-economic, religious, cultural, racial, and ethnic groups, and there is no single known cause. Nor is there any single description that captures all families in which children are victims of CAN. Research, however, has identified four groups of risk factors or attributes commonly associated with CAN; parent or caregiver factors (attachment problems, unrealistic expectations of the child, punitive child-rearing styles, parent who were themselves abused as children, psychiatric disorders among parents), family factors (family conflicts, chaotic family structure, abuse of other children in the family), child factors (children who are physically, mentally, or behaviorally difficult), and environmental factors (socioeconomic stressors, social isolation and family secrecy)(11,12,13).

#### **Consequences of CAN:**

Much research has shown that the health consequences of CAN are far broader than just death and injuries. Victims of CAN are at risk of psychological and behavioral problems that may last a lifetime(14). Recent brain research has established a foundation for the neurobiological explanations for many of the physical, cognitive, social, and emotional difficulties exhibited by children who experienced CAN in their early years. Ongoing CAN is typically associated with persistent stress that may drive the child's brain to strengthen the pathways among neurons involved in the fear response(15,16). As a result, the brain may become "wired" to experience the world as hostile and uncaring, thus negatively influencing the child's later interactions, and prompting the child to become anxious, aggressive, or withdrawn(17). CAN may also inhibit the appropriate development of certain regions of the brain. A neglected infant or young child, for example, may not be exposed to

stimuli that would activate important regions of the brain and strengthen cognitive pathways. If the regions responsible for emotional regulation are not activated, the child may have trouble controlling his or her emotions, behavior, or social interaction.

All types of CAN may affect a child's psychological well-being (18). While there is no single set of behaviors that is characteristic of all CAN victims, physically and sexually abused children often exhibit both internalizing and externalizing problems. In addition to obvious sequelae such as death, traumatic brain injury or disfigurement, physical abuse may result in long-term mental health consequences that include violence, criminal behavior, substance abuse, self-injurious and suicidal behavior, depression, anxiety, and other mental health problems(19). While sexual abuse may leave no physical signs, its emotional and psychological consequences may be devastating. Reactions to sexual abuse can include posttraumatic stress disorder, depression, anxiety, anger, impaired sense of self, dissociative phenomena, suicidal behavior, and inappropriate sexual behavior(20,21). Neglect of nutritional and emotional needs of the child may result in significant developmental delays or failure to thrive(22). Motor, fine motor, speech, language, and cognitive delays have been documented. The resultant poor cognitive ability can lead to emotional and behavioral problems.

Moreover, exposure to CAN may affect an individual's health in a number of direct and indirect ways. Victims of sexual abuse, for example, may become infected with sexually transmitted diseases(23). Women who had experienced sexual abuse are more likely to experience ongoing health problems. Adults who were maltreated as children show higher levels of many health problems not typically associated with CAN; heart disease, cancer, chronic lung disease, and liver disease. The link between CAN and these diseases may be depression, which can influence the immune system and may lead to higher risk behaviors such as smoking, alcohol and drug use, and overeating(24).

### **Medical Assessment**

The initial medical treatment of CAN victims should proceed no differently from treatment of accidentally injured children. However, additional attention should be paid to forensic data collection and to ensuring the safety of the child.

Each of the 4 overlapping categories of CAN (physical, psychological, sexual and deprivation) has unique characteristics and requires individual approaches to diagnosis and management. History taking requires a compassionate, yet objective approach to establish how the injury occurred. Information should be gathered from all

available people separately, using open ended, nonleading questions particularly with younger children. Suspicion of CAN may arise from injuries' characteristics unexplained or poorly explained injuries, injuries incompatible with the stated history, changing history, or significant delay in seeking treatment. Munchausen syndrome by proxy, or factitious disorder by proxy, is a covert, potentially lethal, form of CAN that may be difficult to detect and confirm. It describes a psychiatric illness of the mothers or caregivers who induce symptoms and fabricate illnesses in their children(25,26).

The physically abused child typically presents with obvious injuries. It is not uncommon, however, for abused children to present with life-threatening occult head or abdominal trauma without a convincing history or visible external signs. Infants with head injuries may present with nonspecific symptoms such as lethargy, irritability, persistent unexplained vomiting, apnea, coma, or convulsions(27). Abdominal trauma may be manifested by vomiting, pain, tenderness, shock and/or sepsis.

In suspected cases of child sexual abuse, the history should include questions regarding possible behavioral indicators of abuse, such as aggression, depression, suicidal behaviors, withdrawal, low self esteem, nightmares, phobias, regression, school problems, sleep disorders, sexualized behavior, or somatic complaints such as headaches, general fatigue, abdominal pain, constipation, diarrhea, encopresis, genitourinary complaints, or possible pregnancy.

If neglect is suspected, the infant's or child's history should include an evaluation of feeding and nutritional history, growth and developmental progress, environmental and psychosocial history, maternal ( or caregiver) attachment, parents' (or caregivers) perceptions of the problem, and past history of CAN. The caregivers' level of concern may be discordant with the physician's level of concern. Often, a disturbance in bonding may be obvious, but signs of problems with attachment can also be subtle.

The physical examination of physically abused children may reveal a spectrum of injuries ranging from minor bruises and lacerations to severe trauma and death. Although such injuries may be the result of corporal punishment, the intent of the abuser (to inflict injury or not) is not relevant to the medical diagnosis. CAN should be suspected in cases of bruises on a nonambulating infant, injuries in various stages of healing, multiple injuries, injuries with an obvious pattern, such as from a hand or implement, and injuries in locations usually well protected in accidents, such as the trunk, upper arms, upper legs, neck and face, and the perineal area(28). The shape of burns or bruises may suggest a causative factor such as a hot iron or

a cigarette. CAN accounts for about 30% of all childhood fractures, and for 75% of fractures during the first year of life(29). Physical abuse may cause unexplained, severe, and diffuse brain trauma in infants. The shaken baby syndrome is characterized by retinal hemorrhages, intracranial trauma, and cerebral edema.

The physical examination may be normal in most cases of sexual abuse, including most cases of suspected or substantiated sexual abuse of prepubertal girls(30). The most important determinant for sexual abuse is the child's (or a witness') account of the incident. However, questioning the child about the incident should be avoided until appropriate interviewing can be arranged. Physical indicators that may be present are skin bruises caused by the use of force, bruises to the genital area, rectal abnormalities, hymenal abnormalities, and signs of sexually transmitted diseases.

In cases of neglect, the examination most often reveals a rather small and undernourished infant with most developmental milestones either intact or mildly delayed. Signs of severe malnutrition are seen from time to time, however. Failure to thrive should always be considered a possible presentation of child neglect.

### **Psychosocial Evaluation**

A detailed psychosocial evaluation is essential in every suspected case of CAN in order to understand the functioning of the family and the environment in which the abuse occurred. All above mentioned CAN risk factors should be addressed through reviewing the family's current and past social history, finances and resources, living arrangements, background, attitudes and beliefs about child rearing, domestic or interpersonal violence, substance abuse, and mental health disorders including personality disorders and postpartum depression. Understanding the family structure and dynamics is also important to identify sources of support for the child.

If CAN is suspected, the medical history should be completed by appropriate consultations. An interdisciplinary approach is vital in the assessment and care of children subjected to CAN, and in providing support for the caregiver and the child. Whenever possible, nutritionists, developmental specialists, physical or occupational therapists, social workers, psychologists, and/or psychiatrists should be involved. A careful forensic assessment is a necessity, as is reporting the case to child protection services.

### **Management:**

The most important step in the management of CAN cases is ensuring the child's safety. Inpatient care is recommended for acute

traumatic injury, severe malnourishment, and severe mental trauma. Hospitalization may also be necessary if the child's safety is in doubt.

In addition to establishing the diagnosis and providing the appropriate treatment, management of CAN cases also includes documentation of findings(31), and reporting to child protection agencies. Healthcare workers may also be required to make a forensic medical assessment and to give an expert court testimony. Photographic documentation of findings, clearly demonstrating the child's identity and the date of the photograph, is useful for both clinical and legal purposes. Depending on local protocols, the forensic interview may best be performed with the assistance of trained professionals because of its importance in protecting the child and prosecuting the perpetrator. The forensic interview differs from a good medical history in that it is mostly concerned with detailed answers to who, what, where, and when the abuse occurred. The aim of the forensic interview is to convert a medical diagnosis (e.g. intracranial hemorrhage) into a forensic diagnosis (e.g. shaken baby syndrome)(32).

Laboratory and imaging investigations should be tailored to every child. In any child with suspicious bruising, a coagulation profile is helpful in excluding a bleeding diathesis. Hematuria may indicate kidney or urethral trauma. Occult abdominal trauma may be confirmed by liver or pancreatic function tests and CT scan. Complete blood count may indicate internal hemorrhage, or, in other cases, detect chronic anemia in neglected and undernourished children. A full radiographic skeletal survey is indicated in any child aged 2 years or younger with evidence or a strong suspicion of physical abuse. In several studies, The incidence of asymptomatic fractures has been reported to be 15% in these cases(33,34). A brain CT scan or MRI is indicated in any infant with suspicious neurological symptoms or signs, or a history of violent shaking. Dilated eye examination by an ophthalmologist is particularly important if shaken baby syndrome was suspected. Local protocols for sexually transmitted diseases, hepatitis B, and HIV prophylaxis and testing should be followed particularly in cases of sexual abuse.

In addition to the medical follow-up needs (e.g, orthopedic, surgical, neurological), victims of CAN often need child protection and mental health care. Without appropriate social service and mental health intervention, CAN is usually a recurrent and sometimes escalating problem.

Practitioners should report all CAN cases to local child protection agencies before a child is discharged from the hospital. Healthcare workers are among the groups of professionals required to report

suspected CAN to the concerned authorities. Mandated reporting laws for CAN exist in many countries, and every physician should be familiar with local laws. In the USA, for instance, the Child Abuse Prevention and Treatment Act has been established to ensure that victimized children are identified and reported to appropriate authorities. While specific CAN prevention acts may not be present in all countries, most countries, including Arab countries, do have some form of mandatory reporting legislation. The complexity of dealing with CAN cases may be simplified by establishing local institutional protocols specifying the diagnostic and therapeutic steps that are to be taken, who should be consulted, and how to notify child protection agencies.

### **Prevention of CAN**

Healthcare workers are in a unique position to assist in the prevention of CAN because they have routine access to children and families, and because of their interest in the prevention of disease and the promotion of health and well-being. Activities that contribute to the prevention of CAN include prenatal health care, early childhood health care, perinatal coaching that strengthens early attachment between parents and their children, home visits that provide support, education, and community linkages for new parents, and support programs for children with special health and developmental problems. Physicians, nurses, emergency medical technicians, and other medical personnel may identify and report suspected cases of CAN, provide diagnostic and treatment services, provide expert testimony in child protection judicial proceedings, provide information to parents regarding the needs, care, and treatment of children, identify and provide support for families at risk of CAN, develop and conduct primary prevention programs, provide training on medical aspects of CAN, and participate in multidisciplinary CAN prevention teams.

However, prevention of CAN is not the sole responsibility of any single professional group, but a shared community concern. National plans of action need to be developed in collaboration with all relevant governmental and non-governmental agencies in order to jointly develop priorities and objectives, define one another's responsibilities, and work together. Plans should include review and reform of legislation and policy, building data collection and research capacity, strengthening services for victims, and developing and assessing prevention responses. National plans may be modeled on the Guide to UN Resources and Activities for the Prevention of Interpersonal Violence(35), and should concentrate on evidence-based interventions(36). Available empirical evidence supports the efficacy of early childhood interventions, such as home visits, in reducing CAN. Other interventions with promising results include parenting and

family therapy, life-skills and social competency programs, treatment for mental disorders, cognitive behavioral therapy and early detection of at-risk families. Many Arab countries have developed child protection services, usually in the form of child or family protection units, but it seems that only Syria has developed a comprehensive national child protection plan(37).

#### References:

1. Krug E, Dahlberg L, Mercy J, Zwi A, Lozano R, editors. World report on violence and health. Geneva: World Health Organization; 2002.
2. World Health Assembly: Prevention of violence: public health priority. Geneva: World Health Organization, 1996.
3. Dubowitz H, DePanfilis D: Handbook for child protection practice. Thousand Oaks, CA: Sage, 2000.
4. U.S. Department of Health and Human Services, Administration on Children, Youth and Families: Child maltreatment 2000. Washington, DC: U.S. Government Printing Office, 2002.
5. Finkelhor D. The international epidemiology of child sexual abuse. Child Abuse Negl 1994;18(5):409-17.
6. Al-Mahroos FT. Child abuse and neglect in the Arab Peninsula. Saudi Med J 2007;28(2):241-8.
7. Proceedings: Symposium on child protection. Damascus, Syria: Rainbow for a better childhood. 2004.
8. Haj-Yahia MM, Tamish S. The rates of child sexual abuse and its psychological consequences as revealed by a study among Palestinian university students. Child Abuse Negl 2001;25(10):1303-27.
9. Jumaian A. Prevalence and long-term impact of child sexual abuse among a sample of male college students in Jordan. East Mediterr Health J 2001;7(3):435-40.
10. Proceedings: MENA Regional Consultation on Violence Against Children. Cairo, Egypt: National Council of Childhood and Motherhood, 2005.
11. Shalhoub-Kevorkian N. Disclosure of child abuse in conflict areas. Violence Against Women 2005;11(10):1263-91.
12. Cicchetti D, Carlson V: Child maltreatment:

Theory and research on the causes and consequences of child abuse and neglect. New York, NY: Cambridge University Press, 1989.

13. Cooney C, Braun N: Toward an integrated framework for understanding child physical abuse. *Child Abuse Negl* 1997; 21: 1081-1094.

14. Schilling EA, Aseltine RH, Jr., Gore S. Adverse childhood experiences and mental health in young adults: a longitudinal survey. *BMC Public Health* 2007;7:30.

15. Perry BD, Pollard R, Blakely T et al: Childhood trauma, the neurobiology of adaptation and "use-dependent" development of the brain: How "states" become "traits." *Inf Mental Health J* 1995; 16: 271-291.

16. Willis DJ, Holden EW, Rosenberg M: Prevention of child maltreatment: Developmental and ecological perspectives. New York, NY: John Wiley & Sons, 1992.

17. Heide KM, Solomon EP. Biology, childhood trauma, and murder: rethinking justice. *Int J Law Psychiatry* 2006;29(3):220-33.

18. Egeland B, Sroufe LA: Attachment and early maltreatment. *Child Development* 1981; 52: 44-52.

19. Alreshoud A. Child abuse and neglect among delinquents in Saudi Arabia. Pittsburgh: U Pittsburgh; 1997.

20. McCrae JS, Chapman MV, Christ SL. Profile of children investigated for sexual abuse: association with psychopathology symptoms and services. *Am J Orthopsychiatry* 2006;76(4):468-81.

21. Paolucci EO, Genuis ML, Violato C: A meta-analysis of the published research on the effects of child sexual abuse. *J Psychol* 2001; 135:17-36.

22. Block RW, Krebs NF: Failure to thrive as a manifestation of child neglect. *Pediatrics* 2005; 116: 1234-7.

23. Ahmed HJ, Ilardi I, Antognoli A, Leone F, Sebastiani A, Amiconi G. An epidemic of Neisseria gonorrhoeae in a Somali orphanage. *Int J STD AIDS* 1992;3(1):52-3.

24. Felitti VJ, Anda RF, Nordenberg D, et al: Relationship of childhood abuse and household dysfunction to many of the leading causes of death

- in adults. Am J Prev Med 1998; 14: 245-58.
25. Bappal B, George M, Nair R, Khusaiby SA, De Silva V. Factitious hypoglycemia: a tale from the Arab world. Pediatrics 2001;107(1):180-1.
26. Berg B, Jones DP: Outcome of psychiatric intervention in factitious illness by proxy (Munchausen's syndrome by proxy). Arch Dis Child 1999; 81: 465-72.
27. Rubin DM, Christian CW, Bilaniuk LT: Occult head injury in high-risk abused children. Pediatrics 2003; 111: 1382-6.
28. Sugar NF, Taylor JA, Feldman KW: Bruises in infants and toddlers: those who don't cruise rarely bruise. Arch Pediatr Adolesc Med 1999; 153: 399-403.
29. Kocher MS, Kasser JR. Orthopaedic aspects of child abuse. J Am Acad Orthop Surg 2000;8(1):10-20.
30. Adams JA, Harper K, Knudson S, et al: Examination findings in legally confirmed child sexual abuse: it's normal to be normal. Pediatrics 1994; 94: 310-7.
31. Christopher NC, Anderson D, Gaertner L, et al: Childhood injuries and the importance of documentation in the emergency department. Pediatr Emerg Care 1995; 11: 52-7.
32. Conway EE: Nonaccidental head injury in infants: The shaken baby syndrome revisited. Pediatric Annals 1998; 27: 677-690.
33. Belfer RA, Klein BL, Orr L. Use of the skeletal survey in the evaluation of child maltreatment. Am J Emerg Med 2001;19(2):122-4.
34. Lonergan GJ, Baker AM, Morey MK, Boos SC: From the archives of the AFIP. Child abuse: radiologic-pathologic correlation. Radiographics 2003; 23: 811-45.
35. Anon. Guide to United Nations resources and activities for the prevention of interpersonal violence. 2002 [cited 2007 May 3rd]; Available from: [www.who.int/violence\\_injury\\_prevention/media/en/633pdf](http://www.who.int/violence_injury_prevention/media/en/633pdf).
36. Kluger MP, Alexander G, Curtis PA: What works in child welfare. Washington, DC: CWLA Press, 2000.
37. Commission for family affairs. National Child Protection Plan. Damascus, Syria: UNICEF, 2005.

الكتاب الإلكتروني لشبكة العلوم النفسية العربية: العدد 13



---

إصدارات شبكة العلوم النفسية العربية

جميع الحقوق محفوظة للمؤلف 2008

## أ.د. محمد أديب العسالي

**الاختصاص:** الطب النفسي  
**الشهادة:** طبيب بشري، جامعة دمشق (1979)  
**المرتبة العلمية:** دكتوراه فلسفه في العلوم العصبية، جامعة لندن (1990)  
**الاهتمامات العلمية:** الفصام، علم الوبائيات، التجارب السريرية، الطب المسند، حماية الأطفال من سوء المعاملة والإهمال، التعليم الطبي المستمر



▪ **الوظائف والمسؤوليات**  
- مدير مركز الطب النفسي، رئيس لجنة التطوير المهني المستمر (التعليم الطبي المستمر)، رئيس شبكة المهنيين العرب لحماية الأطفال من سوء المعاملة، عضو المجلس التنفيذي لإتحاد الأطباء النفسيين العرب، سكرتير قسم الطب النفسي البيولوجي في الإتحاد العالمي للطب النفسي، عضو الهيئة التعليمية في الجمعية العالمية لحماية الأطفال من سوء المعاملة والإهمال، مؤلف تحالف كوكران العالمي (عضو مؤسس لجماعة الفصام)، رئيس تحرير المركز العربي للطب المسند عضو هيئة تحرير المجلات التالية: الصحة والحياة، المجلة العربية للطب النفسي، ACTA Neuropsychiatrica

▪ **المؤلفات**  
العديد من الأبحاث (عربية، إنكليزية) المنشورة في مجلات محكمة في مجالات الكيمياء العصبية لمرض الفصام، ووبائيات اضطرابات نفسية مثل الفصام والاكثئاب بعد الولادة وإدمان الكحول والمخدرات، والتجارب السريرية لأدوية الفصام، وآليات تأثير الأدوية النفسية، ومراجعات كوكران المنهجية، وحماية الأطفال من سوء المعاملة والإهمال

**الجوائز العلمية**  
- جائزة رابطة بريطانيا العظمى للفصام (1989)  
- جائزة مؤتمر أبحاث الفصام الخامس، النمسا (1990)  
- جائزة مركز آسترا للأبحاث العلمية العصبية (1991)  
- منحة هيوبرت همفري، الولايات المتحدة الأمريكية (1995)  
- جائزة البحث العلمي، وزارة الصحة، دمشق (1997)

**المؤتمرات والندوات العلمية**  
- شارك بتنظيم عشرات المؤتمرات العلمية المحلية والعربية والعالمية،

**تكريم عالمي:** مدرج في

- Who's Who in The World, 15th Ed, Dictionary of International Biography, 27th Ed, Outstanding People of the 20th Century, 1st Ed. IBC, Cambridge, UK

إصدارات شبكة العلوم النفسية العربية

جميع الحقوق محفوظة للمؤلف 2008

