53 - 31.19c Child Maltreatment and Neglect

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maltreatment. Among the CDC's estimates of maltreated children, 9 percent were victims of physical abuse, 1 percent were victims of sexual abuse, 4 percent were victims of neglect, and 12 percent experienced emotional abuse. Estimates of children maltreated in the United States each year are close to 1 million, and the annual number of deaths caused by abuse or neglect is reported to be about 1,500. A majority of child neglect and abuse occurs in infancy and early childhood, negatively impacting overall brain development, and disrupting time-sensitive developmental brain processes. A growing body of research suggests that child maltreatment potentially results in longterm damage in the neuroendocrine system, cell loss, and delays in myelination in the hippocampus and prefrontal cortex, as well as a chronic inflammatory state independent of clinical comorbidities.

The National Longitudinal Study on Adolescent Health investigated the prevalence, risk factors, and health consequences of maltreatment in 12,118 adolescents. Maltreated adolescents retrospectively reported the most common experiences were being left home alone as a child, (reported by 41.5 percent of the sample), physical assault (reported by 28.4 percent), physical neglect (reported by 11.8 percent), and sexual abuse (reported by 4.5 percent). Each type of maltreatment was associated with at least eight of the ten adolescent health risks examined, including self-report of depression, regular alcohol use, binge drinking, marijuana use, overweight status, generally "poor" health, inhalant use, and aggressive behaviors, including fighting and hurting others. Clearly, the effects of self-reported maltreatment had far ranging and long-lasting associations with multiple detrimental consequences. The identification, management, and treatment of child maltreatment require cooperative efforts between professionals, including primary care physicians, emergency room staff, law enforcement, attorneys, social service staff, and mental health professionals. Perpetrators typically deny abuse or neglect and maltreated children often fear disclosure of their abuse or neglect. DEFINITIONS DSM-5 The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) lists Child Maltreatment and Neglect in the section "Other Conditions That May Be a Focus of Clinical Attention." The presence of Child physical abuse, Child sexual abuse, Child neglect, and Child psychological abuse can be coded as confirmed or suspected and as an Initial encounter or a Subsequent encounter. Under a subcategory of "other circumstances related to" each form of child maltreatment or neglect, five "V" coded clinical situations related to maltreatment can be coded. These include the following (1) Encounter for mental health services for victim of child maltreatment by parent, (2) Encounter for mental health services for victim of nonparental child maltreatment, (3) Personal history (past history) of childhood maltreatment, (4) Encounter for mental health services for perpetrator of parental child maltreatment, (5) Encounter for mental health services for perpetrator of nonparental child maltreatment. Federal Law The Child Abuse Prevention and Treatment Act was passed in 1974 and has been amended several times, most recently in 2003. In federal law, child abuse and neglect mean, at a minimum, any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, or sexual abuse or exploitation. It also includes an act or failure to act that presents an imminent risk of serious harm. In federal law, sexual abuse means the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in or to assist any other person to engage in any sexually explicit conduct (or simulation of such conduct for the

purpose of producing a visual depiction of such conduct) or the rape (and in cases of caretaker or interfamilial relationships, statutory rape), molestation, prostitution, or other forms of sexual

exploitation of children or incest with children. State Law A large mass of legal definitions and guidelines exists at the state level. The legal definitions of terms related to the maltreatment of children vary from one jurisdiction to another, so clinicians should be aware of the definitions used in their own locale. The following generic definitions are used in this section. Neglect Neglect, the most prevalent form of child maltreatment, is the failure to provide adequate care and protection for children. Children can be harmed by malicious or ignorant withholding of physical, emotional, and educational necessities. Neglect includes failure to feed children adequately and to protect them from danger. Physical neglect includes abandonment, expulsion from home, disruptive custodial care, inadequate supervision, and reckless disregard for a child's safety and welfare. Medical neglect includes refusal, delay, or failure to provide medical care. Educational neglect includes failure to enroll a child in school and allowing chronic truancy. Physical Abuse Physical abuse can be defined as any act that results in a nonaccidental physical injury, such as beating, punching, kicking, biting, burning, and poisoning. Some physical abuse is the result of unreasonably severe corporal punishment or unjustifiable punishment. Physical abuse can be organized by damage to the site of injury: skin and surface tissue, the head, internal organs, and skeletal. Emotional Abuse Emotional or psychological abuse occurs when a person conveys to children that they are worthless, flawed, unloved, unwanted, or endangered. The perpetrator may spurn, terrorize, ignore, isolate, or berate the child. Emotional abuse includes verbal assaults (e.g., belittling, screaming, threats, blaming, or sarcasm), exposing the child to domestic violence, overpressuring through excessively advanced expectations, and encouraging or instructing the child to engage in antisocial activities. The severity of emotional abuse depends on (1) whether the perpetrator actually intends to inflict harm on the child and (2) whether the abusive behaviors are likely to cause harm to the child. Some authors believe that the terms emotional or psychological abuse should not be used and that verbal abuse more accurately describes the pathological behavior of the caregiver. Sexual Abuse

Sexual abuse of children refers to sexual behavior between a child and an adult or between two children when one of them is significantly older or uses coercion. The perpetrator and the victim may be of the same sex or the opposite sex. The sexual behaviors include touching breasts, buttocks, and genitals, whether the victim is dressed or undressed; exhibitionism; fellatio; cunnilingus; and penetration of the vagina or anus with sexual organs or objects. Sexual abuse can involve behavior over an extended time or a single incident. Developmental factors must be considered in assessing whether sexual activities between two children are abusive or normative. In addition to the forms of inappropriate sexual touching, sexual abuse also refers to sexual exploitation of children, for instance, conduct or activities related to pornography depicting minors and promoting or trafficking in prostitution of minors. Ritual Abuse Cult-based ritual abuse, which includes satanic ritual abuse, is physical, sexual, or psychological abuse that involves bizarre or ceremonial activity that is religiously or spiritually motivated. Typically, multiple perpetrators abuse multiple victims over an extended period. Ritual abuse is a controversial concept; some professionals believed in the 1990s that ritual abuse was a common, horrible phenomenon in society, whereas others were skeptical about most allegations and descriptions of ritual abuse. Perpetrators of Abuse Some lack of consistency is seen in who may be defined as an abuse perpetrator. Usually, a person must be a parent or designated caregiver to be charged with neglect, physical abuse, or emotional abuse. Another adult (e.g., a stranger) who injures a child would be charged with battery, not with child abuse. On the other hand, a caretaker or any other person could be charged with child sexual abuse. State laws vary in this regard. ETIOLOGY Physical

Abuse Although child abuse occurs at all socioeconomic levels, it is highly associated with poverty and psychosocial stress, parental substance abuse, and mental illness. Child maltreatment is strongly correlated with less parental education, underemployment, poor housing, welfare reliance, and single parenting. Child abuse tends to occur more often in families characterized by domestic violence, social isolation, parental mental illness, and drug and alcohol abuse. The probability of maltreatment may be increased by risk factors in the child such as prematurity, intellectual disability, and physical handicap. In addition, the risk of child abuse increases in families with many children. Sexual Abuse Social, cultural, physiological, and psychological factors all contribute to the breakdown

of the incest taboo. Incestuous behavior has been associated with alcohol abuse, overcrowding, increased physical proximity, and rural isolation that prevents adequate extrafamilial contacts. Some communities may be more tolerant of incestuous behavior. Major mental disorders and intellectual deficiency have been described in some perpetrators of incest and sexual abuse. CLINICAL FEATURES Maltreated children manifest a variety of emotional, behavioral, and somatic reactions. These psychological symptoms are neither specific nor pathognomonic: The same symptoms can occur without any history of abuse. The psychological symptoms manifested by abused children and the behaviors of abusive parents can be organized into clinical patterns. Although it may be helpful to note whether a particular case falls into one of these patterns, that in itself is not diagnostic of child abuse. Physically Abused Children In many cases, the physical examination and radiological evaluation show evidence of repeated suspicious injuries. Abused children display behaviors that should arouse the suspicions of the health professional. For example, these children may be unusually fearful, docile, distrustful, and guarded. On the other hand, they may be disruptive and aggressive. They may be wary of physical contact and show no expectation of being comforted by adults, they may be on the alert for danger and continually size up the environment, and they may be afraid to go home. The literature regarding the psychological consequences of physical abuse and neglect indicates a wide range of effects: affect dysregulation, insecure and atypical attachment patterns, impaired peer relationships involving increased aggression or social withdrawal, and academic underachievement. Physically abused children exhibit a range of psychopathology, including depression, conduct disorder, ADHD, oppositional defiant disorder, dissociation, and posttraumatic stress disorder (PTSD). Physically Abusive Parents Abusive parents often feel significant guilt, and may delay seeking help for the child’s injuries, fearful that the child will be taken away. Often the history of how a child sustained injuries given by the parents is implausible or incompatible with the physical findings. Parents may blame a sibling or claim that the children injured themselves. The characteristics of abusive parents often include a history of abuse in their own early lives, a lack of empathy for the child, unrealistic expectations of the child, and an impaired parent–child attachment. Katie, 3 years of age, had been exhibiting new negative and aggressive behavior at preschool beginning 3 months after the birth of her brother. Katie’s teacher observed

her increased irritability and aggression, at times pushing other children, and she had recently hit a classmate with a wooden block, causing a laceration of the child’s lip. When Katie’s teacher took her aside to talk about her behavior, she noticed several bruises on Katie’s arms and face. When her teacher asked Katie how she had gotten the bruises, Katie replied “my mommy’s boyfriend gets mad at me and hits me with his belt.” The teacher reported suspected child abuse to Child Protective Services. Katie’s teacher also called her mother to let her know what was happening,

and suggested that they take Katie for a psychiatric evaluation. Katie's baby brother was colicky and slept only for short periods of time throughout the day and night. He stopped crying only when his mother held him. Her mother, therefore, had little time for Katie, and the mother's boyfriend was left to take care of Katie on evenings after day care and on weekends. He began to drink more than usual and became increasingly irritable. Katie's mother and her boyfriend often argued, and Katie had seen her mother physically pushed and threatened by her boyfriend. Katie, who was a bright, curious, and talkative child, had tried to be helpful by asking to hold the baby. When refused, however, Katie became upset and would lie on the floor and have a tantrum. Katie began to have difficulty falling asleep and awoke repeatedly during the night. Katie's mother's boyfriend would become extremely angry when Katie would wake him up, and often told her to shut up and slapped her when she told him that she couldn't go back to sleep. On many occasions, he responded to her tantrums or repeated demands for attention by hitting her with his belt. Child Protective Services suggested that mother's boyfriend voluntarily move out, and no longer spend time alone with Katie caring for her, which he did begrudgingly, and Katie and her mother began a family therapy program that included parenting training for Katie's mother and, a behavioral program to help Katie with her tantrums. Katie's mother's boyfriend attended Alcoholics Anonymous (AA) meetings and stopped drinking. He was able to control his anger, and was allowed to visit the home, as long as Katie's mother was present. Within the next three months, Katie's aggressive behavior had ceased, and she was less irritable and was no longer having tantrums. She was doing well with peers, was sleeping through the night, and was no longer afraid to be at home. (Adapted from case material from William Bernet, M.D.) Sexually Abused Children A variety of symptoms, behavioral changes, and diagnoses sometimes occur in sexually abused children: anxiety symptoms, dissociative reactions and hysterical symptoms, depression, disturbances in sexual behaviors, and somatic complaints. Anxiety Symptoms. Anxiety symptoms include fearfulness, phobias, insomnia, nightmares that directly portray the abuse, somatic complaints, and PTSD.

Dissociative Reactions and Hysterical Symptoms. The child may exhibit periods of amnesia, daydreaming, trance-like states, hysterical seizures, and symptoms of dissociative identity disorder. Depression. Depression may be manifested by low self-esteem and suicidal and selfmutilative behaviors. Disturbances in Sexual Behaviors. Some sexual behaviors are particularly suggestive of abuse, such as masturbating with an object, imitating intercourse, and inserting objects into the vagina or anus. Sexually abused children may display sexually aggressive behavior toward others. Other sexual behaviors are less specific, such as showing genitals to other children and touching the genitals of others. A younger child may manifest age-inappropriate sexual knowledge. In contrast to these overly sexualized behaviors, the child may avoid sexual stimuli through phobias and inhibitions. Somatic Complaints. Somatic complaints include enuresis, encopresis, anal and vaginal itching, anorexia, bulimia, obesity, headache, and stomachache. These symptoms are not pathognomonic. Nonabused children may exhibit any of these symptoms and behaviors. For example, normal, nonabused children commonly exhibit sexual behaviors, such as masturbating, displaying their genitals, and trying to look at people who are undressing. Approximately one third of sexually abused children have no apparent symptoms. Many adults who were abused as children have no significant abuse-related symptoms. On the other hand, the following factors tend to be associated with more severe symptoms in the victims of sexual abuse: greater frequency and duration of abuse, sexual abuse that involved force or penetration, and sexual abuse perpetrated by the child's father or stepfather. Other factors associated with poorer

prognosis are the child’s perception of not being believed, family dysfunction, and lack of maternal support. Also, multiple investigatory interviews appear to increase symptoms. Intrafamilial Sexual Abuse Incest can be defined strictly as sexual relations between close blood relatives, that is, between a child and the father, uncle, or sibling. Because of increased reporting, sibling incest is an area of growing concern. In its broader sense, incest includes sexual intercourse between a child and a stepparent or stepsibling. Although father–daughter incest is the most common form, incest can also involve father and son, mother and daughter, and mother and son. Intrafamilial sexual abuse and other sexual abuse that occurs over a period of time is characterized by a particular pattern or sequence of steps. Victims of sexual abuse recount a gradual progression of boundary violations by the perpetrator, starting with tiny invasions and escalating to serious, overwhelming intrusions. Healthy, selfconfident children rebuff the intrusions directly (via temper tantrums and verbal disagreements) or indirectly (through silence and distancing maneuvers) or by adopting

any strategy that causes the offender to refrain. Sexual abuse that occurs over a period of time evolves through five phases: engagement, sexual interaction, secrecy, disclosure, and suppression. Engagement Phase. The perpetrator induces the child into a special relationship. The daughter in father–daughter incest has frequently had a close relationship with her father throughout her childhood and may be pleased at first when he approaches her sexually. Sexual Interaction Phase. The sexual behaviors progress from less to more intrusive forms of abuse. As the behavior continues, the abused daughter becomes confused and frightened, because she never knows whether her father will be parental or sexual. If the victim tells her mother about the abuse, the mother may not be supportive. The mother often refuses to believe her daughter’s reports or refuses to confront her husband with her suspicions. Because the father provides special attention to a particular daughter, her brothers and sisters may distance themselves from her. Secrecy Phase. The perpetrator threatens the victim not to tell. The father, fearful that his daughter may expose their relationship and often jealously possessive of her, interferes with the girl’s development of normal peer relationships. Disclosure Phase. The abuse is discovered accidentally (when another person walks into the room and sees it), through the child’s reporting it to a responsible adult, or when the child is brought for medical attention and an alert clinician asks the right questions. Suppression Phase. The child often retracts the statements of the disclosure because of family pressure or because of the child’s own mental processes. That is, the child may perceive that violent or intrusive attention is synonymous with interest or affection. Many incest survivors rally around their perpetrators, seeking to capture any modicum of tenderness or interest. At times, affection for the perpetrator outweighs the facts of abuse, and children recant their statements about sexual assault, regardless of substantiated evidence of molestation. A family with a comfortable financial situation lived in a pleasant, clean house in a nice neighborhood, but they had no friends. Their four teenagers never had visitors. One day, the oldest girl, 17 years of age, went to the police and told them that she had a baby at home and that her own father was the father of the baby. The teen said that her father had been having sexual relations with her for more than 4 years and that he was now doing the same with her younger sisters. The mother admitted suspecting the situation for years, but she had not reported it to the authorities for fear of losing her husband and her children. (Courtesy of William Bernet, M.D.)

Extrafamilial Sexual Abuse Of course, sexual abuse is not limited to incest. Children can be abducted and sexually abused by strangers. A perpetrator may observe a playground and may identify a child who is not closely supervised. A pedophile may molest this child and hundreds of

other children before he or she is apprehended. For the child, this is usually a single, isolated experience. On the other hand, children can be repeatedly abused by trusted adults, such as teachers, counselors, family friends, and clergy. In this scenario, the pedophilic perpetrator grooms the child over a period of time. He or she gains the friendship of children through enjoyable activities and gifts, introduces sexual activities that may seem innocent and even pleasurable, and progresses to more intrusive activities. The pedophile encourages secrecy. A solo sex ring is a form of child sexual abuse that involves one adult perpetrator and multiple child victims, who may know about each other's sexual activities with the perpetrator. A sex ring may also involve multiple perpetrators and multiple victims. Neurobiological and Health Consequences of Child Maltreatment Current data document long-term physical and mental health consequences of child physical abuse, sexual abuse, emotional abuse, and neglect. Severe physical abuse and repeated sexual abuse cause changes in the child's developing brain that persist into adulthood. A review of 20 studies concluded that child maltreatment is associated with future increased levels of inflammatory markers such as increased C-reactive protein (CRP), fibrinogen, and proinflammatory cytokines. The association of child maltreatment with an increased state of inflammatory markers in adulthood is a robust finding. However, it is not clear how this occurs, and how it impacts functioning. According to the CDC, and the Child Maltreatment report, long-term consequences of child maltreatment lead to increased risk of multiple physical illnesses and high risk behaviors such as alcoholism and drug abuse, which in turn can lead to depression, unemployment, and unstable relationships. Physical abuse, emotional abuse, and neglect are strongly related to future depressive disorders, anxiety disorders, eating disorders, suicidal behaviors, drug use, and risky sexual behavior. Child maltreatment is also associated with a host of physical conditions and illnesses, including ischemic heart disease, liver disease, adolescent pregnancy, chronic obstructive pulmonary disease, fetal death, and skeletal fractures. Studies have demonstrated that adults with childhood histories of maltreatment are at higher risk for abnormalities on magnetic resonance imaging (MRI) of the brain that indicate reduced size of the adult hippocampus. These abnormalities are more pronounced on the left side of the brain. Deficient integration exists between the left and right hemispheres, manifested by reduced size of the corpus callosum. These neurobiological effects of child maltreatment probably mediate the behavioral and psychological symptoms that follow abuse, such as increased aggressiveness, heightened autonomic arousal, depression, and memory problems.

EVALUATION PROCESS The evaluation of a child or adolescent who may have been physically or sexually abused depends on its circumstances and context. Practitioners must consider whether they are conducting a forensic evaluation, which has legal implications and may ultimately be used in court, or a clinical evaluation, which is done for a therapeutic purpose. A forensic evaluation emphasizes collecting accurate and complete data to determine—as objectively as possible—what happened to the child. Was the injury an accident, was it self-inflicted, or was it a result of parental abuse? Was the child actually sexually abused, or was he or she indoctrinated to believe that he or she was abused? The data collected in a forensic evaluation must be preserved in a reliable manner through audiotape, videotape, or detailed notes. The results of the forensic evaluation are organized into a report that is read by attorneys, a judge, and others. The emphasis in a therapeutic evaluation is to assess psychological strengths and weaknesses, to make a clinical diagnosis, to develop a treatment plan, and to lay the foundation for continuing psychotherapy. The clinician is also interested in determining what happened to the child, but it is not as essential to distinguish facts from fantasies. Compared with the forensic evaluation, the psychotherapist

does not need to keep such detailed records and ordinarily does not prepare a report for court. In addition to distinguishing a forensic examination from a therapeutic consultation, a number of factors can affect the evaluation of a child who was abused or may have been abused: whether one is a pediatrician in an emergency department or a child psychiatrist in an office, whether a parent or another person is suspected of the abuse, the severity of the abuse and the victim's relationship to the perpetrator, whether physical signs of abuse are obvious or absent, the age and gender of the child, and the degree of anxiety, defensiveness, anger, or mental disorganization that the child exhibits. Often, the examiner must be creative and persistent. From the psychiatric perspective, the interview is usually the primary source of information, and the physical examination is secondary. In practice, children who may have been neglected or sexually abused are interviewed first and are later given a physical examination and other tests. A child who has been physically abused is more likely to have a physical examination that may be followed by a psychiatric interview. When the child is brought to the emergency room, a detailed and spontaneous account of the injury should be obtained promptly from parents or other caregivers before secondary details and rationalizations cloud the information provided. The interviewer should allow the caregiver to explain, to expound, to derail, or to detour the story line. An abuser or codependent parent may claim to have happened on the injured child in a coma or bleeding from some unknown trauma or to have noticed significant bruising, burns, or a crooked extremity while bathing the child. Comparing the parents' histories can provide valuable insight into how power is wielded in the family unit. A one-month-old baby girl was transferred from a rural hospital to a university

medical center because of a reported near sudden infant death syndrome (SIDS). The child was unresponsive and required mechanical ventilation. A nuclear magnetic resonance imaging (MRI) study revealed bilateral subdural hematomas, subarachnoid hemorrhage, and hemorrhage in the parenchyma of the brain. An X-ray skeletal survey showed two posterior rib fractures. An ophthalmologist observed extensive retinal hemorrhages. After the child was admitted to the Pediatric Intensive Care Unit, the child abuse consultant interviewed the parents separately. The mother, 28 years of age, said that she had recently started a new job. The baby was perfectly fine when she left her in the care of her live-in boyfriend, the child's biological father. The father, 24 years of age, said that when he checked on the baby, he found her not breathing, blue, and unresponsive. He ran to report this to a neighbor and then called 911. The child abuse consultant suggested to the father that the baby must have been injured in some way and asked whether the father had any explanation for this injury. The father said, "I shook the baby after I found her not breathing." The consultant concluded that severe child abuse had occurred in the form of shaken baby syndrome. The consultant notified child protective services and the local police department, so that they could initiate and coordinate their investigation. (Courtesy of William Bernet, M.D.) Suspected Sexual Abuse. The examiner should consider the possibility that the parents are not telling the truth. This situation is more complex, however, than suspected physical abuse. For example, the mother may wish to avoid the discovery of father–daughter incest by blaming the child's genital injury on another child or a stranger. In another scenario, the mother may concoct an allegation of incest when the child had never been abused at all. The first version protects a father who is guilty; the second version implicates a father who is innocent. The examiner should determine how the allegation originally arose and what subsequent statements were made. Determine the emotional tone of the first disclosure (e.g., whether the disclosure arose in the context of a high level of suspicion of abuse). Determine the sequence of previous examinations, the techniques used, and what was reported. Try to determine whether the previous interviews

may have distorted the child’s recollections. If possible, review transcripts, audiotapes, and videotapes of earlier interviews. Seek a history of overstimulation, prior abuse, or other traumas. Consider other stressors that could account for the child’s symptoms. The examiner should also ask about exposure to other possible male and female perpetrators. In Either Case. Whether physical or sexual abuse is involved, a pertinent psychosocial history should be collected and organized, including the following:

1. Symptoms and behavioral changes that sometimes occur in abused children
2. Confounding variables, such as psychiatric disorder or cognitive impairment, that may need to be considered
3. Family’s attitude toward discipline, sex, and modesty
4. Developmental history from birth through periods of possible trauma to the present
5. Family history, such as earlier abuse of or by the parents, substance abuse by the parents, spouse abuse, and psychiatric disorder in the parents
6. Underlying motivation and possible psychopathology of adults involved Collateral Information The evaluator should consider requesting collateral information from the following people, after obtaining authorizations: protective services, school personnel, other caregivers (e.g., babysitters), other family members (e.g., siblings), the pediatrician, and police reports. Child Interview Several structured and semistructured interview protocols have been developed that were designed to maximize the amount of accurate information and to minimize mistaken or false information provided by children. These approaches include the Cognitive Interview, which encourages witnesses to search their memories in various ways, such as recalling events forward and then backward. The Step-Wise Interview is a funnel approach that starts with open-ended questions and, if necessary, moves to more specific questions. The interview protocol developed at the National Institute of Child Health and Human Development (NICHD) includes a series of phases and makes use of detailed interview scripts. Although these protocols may be particularly important in a forensic context, experienced clinicians endorse flexibility and consistent good-hearted behavior by the interviewer. As with seeing any patient, the evaluator must size up the situation and use techniques that are likely to help the youngster become comfortable and communicative. One victim might need a favorite object (e.g., a teddy bear or a toy truck); another might need to have a particular person included in the interview. Some children are comfortable talking; others prefer to draw pictures. An unrelated joke, a shared cookie, or a picture on the evaluator’s wall may lead to a disclosure of abuse. Important comments might be made while chatting during the break time, instead of during the structured interviews. GENOTYPE AND MALTREATMENT: RISK AND PROTECTIVE FACTORS Two studies of Caucasian males have provided evidence that particular genotypes with high levels of monoamine oxidase A (MAOA) seem to protect against the malignant impact of childhood maltreatment on the development of conduct disorder and antisocial behavioral patterns. Subjects in a prospective cohort design involving courtsubstantiated cases of child abuse and neglect and matched comparison groups were followed into adulthood. A composite index of violent and antisocial behavior (VASB)

was created based on arrest record, self-report, and diagnostic information. Genotypes associated with high levels of MAOA activity were correlated with less risk of violent and antisocial behavior in

later life for Caucasians, but this effect was not found for non-Caucasians. This result was not replicated in a group of adolescents with respect to the development of adolescent conduct disorder. Further studies are needed to understand the possible links between genotypes of high levels of MAOA and potential behavioral outcomes. TREATMENT AND PREVENTION STRATEGIES The immediate strategic intervention is to ensure the child's safety, which may require the child's removal from an abusive or neglectful home environment. Physicians are among a group of professionals who are mandated by law to report suspected child abuse or neglect to the local protective services agency. Several evidence-based psychotherapies now exist in the treatment of childhood abuse and neglect. These include Multisystemic Therapy for Child Abuse and Neglect (MSTCAN), Parent-Child Interaction Therapy (PCIT), adapted for children who have been physically abused, and Combined Parent-Child Cognitive Behavioral Therapy (CPCCBT). MST-CAN uses a home-based model in which therapists come to the home to involve families in a highly monitored positive interactional approach toward their physically abused children. Parents receive support and guidance to care for their children in a less harsh, nonneglectful manner. This approach has been shown to reduce behavioral problems in the children, while increasing parental understanding of meeting their children's needs in a safe environment. PCIT consists of combined treatment for parents and children in which parenting is coached directly by the therapist and practiced in sessions with parents and children together. Typically, therapists observe parent–child interactions through a one-way mirror and coach parents during the live interaction using a radio earphone. This model is based on the premise that changing parent–child interaction patterns will break the cycle of parent and child behaviors that maintain abusive behavior, and replace it with more nurturing and supportive interactions. Although PCIT has been shown to be effective, additional treatments are likely to be needed for parents with mental health problems such as depression or substance use. CPC-CBT is designed to help parents to develop more positive strategies with their children and to help children to cope more effectively with their past abuse and to learn more positive interactions with parents. Therapeutic techniques used with parents include motivational interviewing, psychoeducation, adaptive coping skills, and better problem solving when difficult situations arise. Therapeutic strategies used with children focus on the development of positive coping, anger management, and gradual exposure through the use of a developmentally appropriate trauma narrative. Parents and children participate together in sessions in which the parent is able to convey complete responsibility for their abusive behavior, and then, the parent and child collaborate on a

new joint family plan that promotes safety and more positive relationships. Therapeutic sessions with the child and parent together appear to add to the effectiveness of treatment. Children who have been maltreated are at increased risk for further maltreatment according to studies of child victims of abuse and maltreatment. Studies have shown that four factors were most consistently identified as predictors of future maltreatment: number of previous episodes of maltreatment; neglect as the form of maltreatment; parental conflict; and parental psychiatric illness. Maltreated children were found to be about six times more likely to experience recurrent maltreatment, and the risk of recurrence was highest within 30 days of the index experience. This underscores the importance of a careful examination of the protective factors in the home environment and the early initiation of therapeutic sessions. REFERENCES Bernet W. Child maltreatment. In: Sadock BJ, Sadock VA, Ruiz P, eds. Kaplan & Sadock's Comprehensive Textbook of Psychiatry. 9th ed. Vol. 2. Philadelphia: Lippincott Williams & Wilkins; 2009:3792. Carr CP, Severei CM, Stingel AM, Lemgruber VB, Juruena MF. The role of early life stress in adult psychiatric disorders. A systematic review according to childhood trauma subtypes. J Nerv Ment Dis. 2013;201:1007–1020. Centers for

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