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Child Abuse and Neglect

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Abstract

Physical, sexual, and emotional abuse and various forms of neglect of children are associated with substantially increased risk for concurrent and subsequent psychopathology and are among the common problems encountered by clinicians in many clinical settings. Such cases pose additional challenges for clinicians because of the many complex family and system forces that engulf these children and their families. Assessing maltreated children generally requires more time than evaluations of children who have not experienced maltreatment. Young children, who experience the highest rates of maltreatment, present especially complex assessments because they are so dependent upon their caregiving environments. Treatment of psychopathology associated with maltreatment, which is often multimodal, requires addressing a variety of external factors that may perpetuate or exacerbate symptoms and impaired functioning. We suggest that the more clinicians understand the different cultures of the legal and child protective services systems will help them advocate more effectively for maltreated children's bests interests so that the complexity of their problems is matched by the comprehensiveness of our efforts to minimize their suffering, enhance their development, and promote their competence.

Keywords

child abuse; child neglect; child maltreatment; child protective services; legal system

Maria, a 12-year-old bilingual undocumented immigrant, disclosed to her school counselor that her stepfather sexually abused her for several years. After an investigation by child protective services (CPS), she was placed in foster care because her mother initially denied that any abuse had occurred. Following this, the stepfather disappeared. Maria was referred by CPS to receive an evaluation for depressed mood.

James, an 8-year-old boy, was flagged by his teacher for cuts and bruising on his forehead. He reported that his father (a single parent) smashed his head into a glass table because he

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had not cleaned his room. The school reported his injuries to CPS who placed him in foster care after investigating. James's father was arrested. James and his father were referred for assessment and treatment as indicated.

Jacqueline, a 22-month-old girl, was found wandering by a police officer several houses away from her home. After Jacqueline waited 30 minutes outside her home with the police, her mother arrived. She was combative towards the police and had a long history of substance-related arrests. Jacqueline was taken into custody and placed with nonrelative foster parents since no relatives were identified by CPS. Her mother was referred to substance abuse intervention and to a parenting intervention. Jacqueline was also referred for evaluation of her status.

Maltreatment of children, comprising various types of abuse and neglect, is a major public health challenge and one of the most powerful risk factors for concurrent and subsequent psychopathology, later health morbidity, and compromised development. In severe cases of maltreatment, children are often placed in foster care, and as a group are at particularly at high risk for negative mental health consequences. Halfon and colleagues[1] found that foster children represented less than 4% of Medicaid eligible children in California but accounted for 41% of all users of mental health services. Costs of the maltreatment that occurred in the United States in 2008 was estimated to be $124 billion, with a per victim lifetime cost estimated to be $210,012 for nonfatal and $1,272,900 for fatal maltreatment.[2]

Clinicians working with children who have experienced maltreatment will be more effective when their approach extends beyond a focus on symptom patterns and functional impairment. In order to do so, they must become knowledgeable about the systems in which maltreated children are entwined. Specifically, the child protection system and the legal system each play an important role in the physical placement and well-being of children who have experienced abuse and neglect. Clinicians may be asked and should be willing to provide input regarding visits, transitions, custody, and related issues. In addition, work in this arena is a potent elicitor of countertransference,[3] and having trusted colleagues with whom to review perceptions and plans is essential.

SCOPE OF THE PROBLEM

In Federal Fiscal Year 2016, approximately 676,000 children in the United States were confirmed as victims of abuse and neglect by child protective service (CPS) systems, an incidence of 0.91%; a much greater number (approximately 3.5 million children) were referred for potential maltreatment.[4] Younger children are more likely to be maltreated and are more likely to die from abuse and neglect. American Indian/Alaskan Native (1.42%) and African American (1.39%) children experience the highest rates of maltreatment. Nevertheless, underreporting of child maltreatment is widely recognized as a problem,[5] and adult retrospective reports of maltreatment are substantially higher[6,7] than substantiated rates of maltreatment in official records. Failure of true cases to be identified by legal authorities, in addition to the challenges of measurement, infantile amnesia, recall bias in retrospective reports, and differing definitions for maltreatment, make ascertaining true prevalence rates challenging.

For the past several years, roughly 250,000 to 275,000 children are taken into foster care each year and a total of 400,000 to 500,000 children are in foster care at any time in the United States.[8] Thus, the majority of child victims who have maltreatment substantiated are maintained with their families and provided with access to services designed to prevent removal. These cases are often referred to as family services, “in home” services, family preservation, or similar terms.

CLASSIFICATION

Types of maltreatment are shown in Table 1.[9] Each of the major headings subsumes many specific types within the broad type. Although neglect is by far the most prevalent type of maltreatment identified by CPS,[4] the important point is that co-occurrence of different types is the rule rather than the exception. In fact, in a recent study of more than 2,200 maltreated school-aged children and adolescents, a minority of children experienced only a single type of maltreatment[10]: only 1% of sexually abused children, 4% of physically abused children, 10% of emotionally maltreated children, and 25% of neglected children had no co-occurrence with one or more other types of maltreatment.[10]

ADVERSE EFFECTS

Maltreatment is associated with compromises in development across virtually every domain (eg, cognitive, language, socioemotional, and neurobiological development.)[11] Mental health problems are among the most salient sequelae of child abuse and neglect. For example, using data from the National Survey of Child and Adolescent Well Being, Burns *et al.*[12] reported that nearly half (48%) of 3,803 children (2 14 years old) who had completed child welfare investigations had clinically significant emotional or behavioral problems. A study of more than 1,000 children 5 to 9 years old who were recruited from pediatric practices determined that those children who had been maltreated were nearly three times more likely to be diagnosed with an internalizing or externalizing disorder.[13] Population estimates attribute that the proportion of childhood psychiatric disorders due to experiences of adversity, including abuse and neglect, is approximately 45%,[7] suggesting that there may be no single greater environmental predictor of mental health difficulties than experiences of maltreatment.

Developmental psychopathologists have highlighted the importance of considering both multifinality and equifinality in the course of adverse experiences and psychopathology.[14] Although many children who have experienced severe neglect in early life develop a psychiatric disorder in childhood and adolescence, a greater proportion do not.[15,16] For some disorders, there is an explicit requirement for the role of environmental circumstances in order to meet diagnostic criteria (eg, trauma is required for posttraumatic stress disorder [PTSD], and inadequate care is a necessary criterion for reactive attachment disorder). For other disorders, although experiences of stress are known risk factors, such experiences are not required for diagnosis (eg, major depressive disorder). Furthermore, even diverse forms of maltreatment that are thought to have different consequences for brain development[17] may result in risk for the same forms of psychopathology[18] (eg, both abuse and neglect are associated with increased risk for externalizing psychopathology). Taken together, we

understand that maltreatment is associated with dramatically increased risk for psychopathology, but that several individual (eg, genetics, temperament) and external factors (eg, consistent and attentive caregivers) may be protective and/or promote resilience in children who have experienced significant adversity.[19] In addition, there is no one-to-one mapping between the severity or type of maltreatment experience and subsequent neurobiological or behavioral consequence. In fact, nearly all psychiatric disorders common in childhood and adolescence (eg, internalizing disorders, externalizing disorders, trauma and stress-related disorders, neurodevelopmental disorders [eg, attention deficit/hyperactivity disorder], and substance use disorders) have been linked to experiences of maltreatment, such that abuse and neglect may play either an etiological role and/or worsen the presentation and course of the disorder. Impairments in functioning, including academic problems, delinquency, and difficulties in social relationships are also associated with maltreatment.

Recent attempts to clarify the potential mechanisms underlying increased risk for psychopathology following maltreatment have examined the processes and constructs that represent intermediate phenotypes (eg, Research Domain Criteria).[20] This approach often focused on the processing and response to emotional content, including rewards, threats, as well as alterations in executive function, among individuals with histories of neglect.[21] These processes are theoretically linked to disorders (eg, threat processing to anxiety disorder and reduced reward sensitivity to depression) and may be useful targets in developing interventions to prevent or treat psychopathology following onset. McCrory and Viding[22] have proposed the theory of latent vulnerability, positing that targeting intermediate phenotypes provides a means of altering risk trajectories following maltreatment but before psychiatric disorders emerge.

In addition to attempts to characterize mechanism, it is important to consider how development might moderate the presentation of symptoms. For example, PTSD presents somewhat differently in preschool age children compared to adolescents,[23] and recent adaptations to the DSM have begun to define developmental differences.[24]

For young children (age 5 years and younger), alternative diagnostic criteria for a number of disorders of early childhood are provided by DC:0–5.[25] Although new and incompletely validated, the criteria for disorders in DC:0–5 were empirically derived in an effort to identify the manifestations of psychopathology in young children. In addition, the approach outlined provides an emphasis on characterizing the relational context of child behavior problems. Furthermore, there is an impetus to identify and treat these children at the youngest possible ages, in order to improve long-term outcomes and reduce the risk for intergenerational transmission of maltreatment.[26]

SYSTEMS ISSUES

In our experience, clinical effectiveness is enhanced greatly if clinicians are knowledgeable about and engage with child protection and legal systems when needed. These systems are best thought of as distinct cultures, each with its own language, values, and priorities.

Understanding how they differ from the values and priorities of the clinical enterprise is an important asset when evaluating and treating maltreated children.

Child Protection System

CPS generally includes distinct divisions responsible for hotline receipt of allegations, investigations of alleged maltreatment, services to families who have a substantiated finding of maltreatment where children are not removed, children placed in foster care, and adopted children following termination of parental rights. It is important to understand which of these divisions is involved with the child, because the roles of the professionals in each are quite different.

CPS is based either at the state or county level. Foster care may be provided by CPS and/or contracted with private entities—some systems (eg, Florida's Community Based Care) are entirely privatized, meaning that foster care and related services are outsourced to local community agencies. When agencies are contracted to provide foster care, understanding their relationship to CPS staff is critical. Staff within CPS are hierarchically arranged; for example, frontline case workers report to supervisors who report to managers who report to directors. Identifying how best to access information and implement leverage within these hierarchies is key to useful collaboration.

Key events in child welfare in the United States are noted in Table 2.[27,28] As directed by the Federal government, child welfare systems in the United States were originally focused on children's physical safety. There is increasing emphasis on permanency in child welfare systems,[29] because many children seemed to be languishing in foster care, which was intended to be a temporary intervention. Throughout the past 100 years, the proverbial pendulum has swung back and forth between a primary emphasis on protecting children and another on preserving families. Still, as Table 2 indicates, there has been a steady broadening of scope of what we mean by child protection over time.

In cases in which there are substantiated reports of maltreatment but parental rights are not immediately terminated, the emphasis has been focused on time-limited opportunities for parents to rehabilitate and resume unencumbered care of their children. Much more recently, child well-being has been made an explicit Federal priority.[30] This provides more impetus for mental health services, although well-being remains a newer and less well integrated emphasis in many settings.

In virtually every case, reunification of children with the parents from whom they have been removed is the goal for CPS. Furthermore, reunification hinges on demonstration of minimal safety and caregiving effectiveness, which typically falls far below the standard approach in clinical treatment. Often, continuing treatment after children are returned to parents is necessary to address a child's symptoms and functional impairment and/or to assist with family stabilization.

Legal System

Courts concerned with child protection are called juvenile court, family court, dependency court, or something similar in different states. Larger jurisdictions may have full-time judges

in these courts, but in smaller jurisdictions, judges may oversee child protection cases as only one of many other roles. Judges are “triers of fact” and make the ultimate decisions regarding most phases of child protection and child custody. There are differences in state-level laws and within individual judges about how to interpret and implement the law. Judges’ perspectives derive from the United States Constitution, especially the due process clause of the 14th Amendment, which has been used to limit government interference in family life. As an initial assumption from a legal perspective, parents are presumed by courts to have their children’s best interest guiding their parenting behavior. Thus, the thrust of most laws pertaining to governmental intervention restricts it to instances in which the child’s physical safety is endangered. Furthermore, at the earliest indication that parents can be minimally safe, many judges are inclined to return children and eliminate the state’s involvement in the family’s life. This inclination runs counter to clinical efforts to delay return until it is clear that parents are sufficiently rehabilitated so that risk of recidivism is minimized.

Nevertheless, courts in all 50 states are required to consider whether their decisions about placement of children, services provided to them, and custody are in the child’s “best interest.”[31] Although the best interests of the child are considered, they do not trump parental rights in cases in which those conflict. Mental health professionals may be called as experts to testify about what is in children’s best interest, providing an opportunity to address current and future needs of the child.

ASSESSMENT

Safety, permanence, and well-being of the child also should inform psychiatric assessments of maltreated children. The most important initial question to address is ensuring that children are physically and psychology safe in their current placements. Second, understanding the timeline and whether the current placement is short-term or long-term and what CPS plans for the child may affect treatment strategies. Finally, child well-being, which encompasses psychiatric symptoms and functional impairment, as well as adequacy of the caregiving environment, form the crux of the assessment.

Assessment of children involved with CPS is complicated by the need for information from multiple sources. Having CPS records available at the time of the evaluation is important. Speaking to the case worker before or during the evaluation provides important supplemental information that may be unavailable from the records, such as information about the legal status and timeline of the case, for example. If the child is in foster care, meeting with foster parents is essential, but biological parents also will provide important history when that is possible. Observing interactions of children with their foster parents as well as with their biological parents will often reveal important differences in children’s behavior. For young children (less than 5 years old), this is essential.

PTSD deserves special mention. It is clearly important to assess for PTSD symptomatology in every child with a history of maltreatment and exposure to violence. In our experience, PTSD may be both over- and underdiagnosed in these children. That is, not every symptomatic child assessed after exposure to a trauma has signs or symptoms of PTSD—

many disorders can result from trauma, although there is some evidence that PTSD serves a gateway function to new-onset disorders following traumatic exposure.[32] Regarding underdiagnosis, PTSD in children can be challenging to identify, especially if children present with re-experiencing and hyperarousal in the form of aggressive behavior. Systematic inquiry about exposure to possible traumatic exposures is key, as well as assessing triggers of challenging behaviors.

Special Issues in Early Childhood

Because the majority of maltreatment cases onset in children less than 5 years old, and because of the developmental vulnerability of the early years, there has been increasing recognition of the importance of bringing insights from developmental science to bear on practice in child welfare.[33] This rationale derives from a convergence of neuroscience documenting the effects of experience on the developing brain, child development data about the centrality of relationships in promoting adaptive relationships, and economic data about the return on investment of early intervention.[34]

From a clinical perspective, we know that young children may be markedly symptomatic with one caregiver and asymptomatic with another caregiver.[35] This is especially likely in the context of young children seen with foster parents and biological parents. In addition to the usual history and developmentally modified mental status examination, a relationship assessment between the young child and all important caregivers is recommended for young children who have been maltreated.[36] Importantly, AACAPPractice Parameters on assessments of infants and toddlers[37] recommends that assessments of young children should typically involve three to five sessions—evaluating young maltreated children will be among the more complex assessments conducted. Formal methods for assessing relationships in young children are available,[38,39] but attending to observed interactions and parents' perceptions of their children in order to understand the relationship are recommended. In addition, Axis II of the *DC:0–5*[25] pro-vides guidelines for comprehensive characterization of the relational context of young children. Although derived from a large body of evidence regarding the importance of primary caregiving relationships and co-parenting for young children's development, the specific *DC:0–5* guidelines about the relational context of young children await explicit validation.

We have argued that foster care is a different intervention for younger children (especially less than 3 years old but generally up to age 5 years) than for older children.[40,41] This derives from our understanding that the quality of the young child's attachment relationships is a foundational component of young children's socioemotional development and an important predictor of subsequent psychosocial functioning, especially within high-risk groups.[42,43] Furthermore, young children develop and sustain attachments through substantial contact with caregiving adults.[44] This means that for young children in foster care, foster parents must function as primary attachment figures for them. The vital role of foster parents is too often under recognized, not only by CPS and the courts, but even by mental health professionals. Recognizing its importance has obvious implications for young children and their relationships with foster parents.

Reports from childcare and preschool teachers are especially valuable to include in the assessment, because they provide data about the child's functioning outside of the family context. This is important for determining which behaviors are pervasive and which are context specific. Given the sometimes contentious relationships between foster and biological parents, teachers can provide a perspective from more objective observers and also from professionals who likely have a keen appreciation of age typical and age-atypical behaviors.

Because of the high rates of cognitive, motor, and language delays in young maltreated children,[45,46] referrals for developmental assessments to address suspected or apparent language and/or motor delays are often indicated.

INTERVENTIONS

One component of treatment of maltreated children is virtually identical to treatment of nonmaltreated children—psychotherapy and/or medication as determined by a thorough assessment. Of course, given that maltreated children are at the extreme of the risk continuum, there are compelling reasons to apply evidenced-based interventions to treat their symptoms and impaired functioning.[47] These treatments are key elements of the therapeutic arsenal for the complex pictures of comorbidity with which maltreated children often present, even though most of the interventions, including medication, have not been studied systematically in maltreated children. Fortunately, there are many evidence-based treatments available for infants through adolescents who have experienced maltreatment (eg, trauma-focused cognitive-behavioral therapy; parent–child interaction therapy; child–parent psychotherapy).

Overuse and misuse of psychotropic medication among foster children has become an increasing concern.[48] Reviewing Medicaid data from one month in 2004 in Texas, for example, Zito *et al.*[49] found that among foster children prescribed psychotropic medication, 41% took three different classes of medication, and 16% took four different classes. Care should be taken about using multiple classes of psychotropic medication in foster children, given the lack of evidence supporting the safety and efficacy of combined pharmacotherapy, particularly for three or more medications. Reduced access to and investment in evidenced-based psychotherapy may contribute to unwarranted psychotropic medication use.

What is different about treatment of maltreated children is that symptom reductions through evidenced-based treatments is rarely sufficient. Comprehensive and multimodal treatments are required, and often over long durations. Myriad factors beyond maltreatment are likely to cause or exacerbate symptoms in maltreated children (eg, maladaptive family interactions, quality of placements, stress of visits, separation inherent in foster placements, separations from siblings, and court and CPS decisions). These challenging stressors require additional clinical efforts to help the child navigate the aftermath of maltreatment.

CASE INTERVENTIONS

Maria had a 5-day inpatient hospitalization for depression with suicidal intent, and completed 4 months of trauma focused cognitive-behavioral therapy (TF-CBT). During this

time, her mother received several months of therapy focused on Maria's stepfather's controlling relationship with her and how this contributed to her failure to protect Maria. She accepted that the abuse had occurred and indicated that initially her fear of the police and CPS had led her to deny her daughter's allegations. In addition, the clinical team intervened to address a conflicted relationship between Maria's family and CPS. Six additional months of family therapy were directed at a role-reversed mother–daughter relationship and the mother's failure to protect Maria from the stepfather. In the midst of these multifaceted intervention efforts, Maria was successfully returned to her mother's care, and treatment continued for another 9 months after her return home.

James was treated with 4 months of TF-CBT. His father was enrolled in a 4-month skill-building group therapy for parents (Effective Black Parenting). Following this, James's father was seen for grief counseling about the loss of James's mother to cancer 2 years earlier. James and his older and younger sister were seen with their father for family therapy, which focused on the father's sensitivity to rejection and angry outbursts. James was returned home after 12 months in foster care.

Jacqueline was overly active, aggressive, and socially indiscriminate when she entered her foster placement. Immediate work with her foster parents focused on restricting her contact with unfamiliar adults and establishing a reward-oriented behavior management plan. The foster mother was coached in using the PRIDE skills (labeled praise, reflections, imitations, descriptions, and enthusiasm) from parent–child interaction therapy. Her symptoms gradually dissipated, and she was able to attend childcare without difficulty. Her biological mother tested positive for substances, did not enroll in an intervention program, and after several months stopped attending scheduled visits with Jacqueline. When Jacqueline was 34 months old, her maternal aunt appeared and requested that she be placed with her. Following a hearing on the matter, including expert testimony about best interest, the judge denied the aunt's request. Jacqueline was adopted by her foster parents after a termination of parental rights trial.

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Key Messages

- Child maltreatment—physical, sexual, and emotional abuse, as well as various forms of neglect—leads to increased risk for psychopathology across development, including internalizing disorders, externalizing disorders, trauma and stress related disorders, neurodevelopmental disorders (eg, attention-deficit/hyperactivity disorder), and substance use disorders, as well as academic problems, delinquency, and difficulties in social relationships.
- Maltreatment is associated with a substantial proportion of the psychiatric morbidity that presents to clinical settings for children and adolescents, so that affected children are overrepresented in these settings.
- Racial and ethnic disparities are apparent. African American and American Indian children have the highest rates of maltreatment, and clinicians should be alert for structural racism affecting decision making.
- More effective care will be provided to maltreated children in need of treatment when clinicians are knowledgeable about the legal and child protection systems, each of which has its own priorities, values, and languages and differs from those of clinical work.
- Assessments of children presenting for evaluation of problems related to maltreatment, especially if they are involved with legal and child protective systems, are necessarily complex and likely require more time than evaluations of children who have not experienced maltreatment.
- Treatment of symptoms and disorders related tomaltreatment should be multimodal and often needs to address external factors that may contribute to their perpetuation and exacerbation.
- Young children, who comprise the majority of maltreatment cases, require careful evaluation of the child’s caregiving contexts, which often includes multiple caregivers, so that both assessments and treatment are comprehensive.

TABLE 1

Longitudinal Studies of Child Abuse and Neglect (LONGSCAN) Modified Maltreatment Classification System

100 Physical Abuse	When a caregiver or responsible adult inflicts physical injury upon a child by other than accidental means. Injury does not include culturally sanctioned physical alterations such as circumcision and ear piercing.
200 Sexual Abuse	When any sexual contact or attempt at sexual contact occurs between a caregiver or other responsible adult and a child, for purposes of the caregiver's sexual gratification or financial benefit. In cases of sexual abuse, caregiver or responsible adult refers to any family member or friend who has a relationship with the child, or is in a position of authority over the child (eg, baby-sitter).
300 Physical Neglect/Failure to Provide	A caregiver or responsible adult fails to exercise a minimum degree of care in meeting the child's physical needs (food, clothing, shelter, hygiene, medical/dental care).
400 Physical Neglect/Lack of Supervision	A caregiver or responsible adult does not take adequate precautions to ensure a child's safety in and out of the home, given the child's particular emotional and developmental needs. This includes adequate supervision, safe environments and adequate substitute care.
500 Emotional Maltreatment	A caregiver persistently or extremely thwarts a child's basic emotional needs. This also includes parental acts that are harmful because they are insensitive to the child's developmental level, including psychological safety and security, acceptance and self-esteem, and age-appropriate autonomy.

Note: Adapted from[9]. Severity ratings 1–5 are included for each type of maltreatment.

TABLE 2

Selected Key Developments in American Child Welfare

Year	Event	Result
1909	First White House Conference on Children	Articulated principles of child welfare, including preference for care in families; most child protection handled by nongovernmental entities at this time
1935	The Social Security Act of 1935	Authorized the first federal grants for child welfare services; these were first federal grants that led states to establish child welfare agencies and to develop local programs to deliver child welfare services
1962	Kempe and colleagues publish Battered Child Syndrome	Led to much greater attention and government-directed child protection efforts
1974	Child Abuse Prevention and Treatment Act (CAPTA; Public Law 93–247)	Mandated that states establish procedures to investigate suspected incidents of child maltreatment, and provided funding to prevent, identify, and treat child maltreatment
1978	Indian Child Welfare Act (ICWA)	Designed to reduce inappropriate removal of Indian children from their homes, ICWA provides that only tribal courts can decide abuse and neglect cases involving children whose permanent residence is a reservation, and the tribe has the right to intervene in cases involving children living outside reservations
1980	Adoption Assistance and Child Welfare Act of 1980 (Public Law 96–272).	Focused on family preservation efforts to help children out of foster care by providing services to prevent the need for removal
1997	Adoption and Safe Families Act (ASFA) (Public Law 105–89).	Shift from reunification efforts to time-limited opportunities for parents to rehabilitate before enacting permanent plans for children
2011	Extension of Child and Family Services Programs (Public Law 112–34)	Focuses on proper use of psychotropic medications and addressing and coordinating services to address trauma
2012	Administration on Children and Families Memorandum on Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services	Child well-being brought on par with safety and permanency as major goals of American Child Welfare practice

Note: Adapted from references[27] and[28].