

The Short- and Long-Term Effects of Child Abuse and Their Implications for the
Suggested Length of Physical and Psychosocial Treatment Regimens

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Abstract

Child abuse is the physical, psychological, or neglectful maltreatment of a child by a caregiver. Intimate partner violence relates closely to child mistreatment. Children are not likely to disclose that their parent or guardian is abusing them. Child abuse may result in short-term consequences, long-term consequences, or death. Some negative outcomes of maltreatment include delinquency, mental health issues, physical problems, educational underachievement, and socioeconomic disparities. The cycle of mistreatment is when a parent who suffered abuse as a child is more likely to maltreat his or her own child. There are factors that protect from the consequences of mistreatment. Research evidence should inform practice as to how to assist victims of child abuse.

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The long-term effects of child abuse, identification of victims of child maltreatment, how survivors cope through adulthood, and what sort of support systems are in place to continue the healing process are all relevant topics in forensic nursing practice. It must be determined if there is evidence that more physical, psychological, emotional, social, or spiritual support would lessen the negative long-term effects of child mistreatment. Assessment should take place over a longer period, such as 30 or 40 years. Goals would include putting an end to the infamous *cycle of abuse* where child abuse victims are at risk of maltreating their own children later in life. Comparing this to short-term support that lasts five years or less would provide evidence for nursing practice in child mistreatment cases. This article is a review of literature relating to this subject to determine what the consequences of abuse, what the cycle of maltreatment looks like, and what mediating factors are already well-established. Discussion of future research efforts will follow.

Definitions of Child Abuse and Maltreatment

Child abuse is any physical maltreatment, emotional ill-treatment, sexual abuse, neglect, or exploitation of children. It results in actual or potential harm to a child's health, survival development, or dignity. There are four types of child abuse: sexual, physical, emotional/psychological, and neglect. Child maltreatment occurs most often in the context of a relationship of responsibility, trust, or power (Norman et al., 2012; Vallone, Addona, D'Elia, & Vicari, 2009).

Another definition is that child mistreatment is any intentional or unintentional act of commission or omission by a parent or caregiver that results in harm, potential for harm, or threat of harm to a juvenile. Physical abuse is the use of physical force or implements against a child that results in, or has the potential to result in, physical injury. This includes hitting, kicking, punching, beating, stabbing, biting, pushing, shoving, throwing, pulling, dragging, shaking, strangling, smothering, burning, scalding, and poisoning (Gilbert et al., 2009). Physical abuse can be any nonaccidental injury a parent or caretaker inflicts or allows another to inflict on a child (Legano, McHugh, & Palusci, 2009).

Sexual maltreatment is any completed or attempted sexual act, sexual contact, or non-contact sexual interaction with a child by a caregiver. Penetration is contact between the mouth, anus, vagina, penis, or vulva of the child and that of another, older individual. Contact involves intentional touching, directly or through clothing, of the child's genitalia, anus, buttocks, or breasts. It excludes contact required for normal care. Non-contact sexual interaction includes exposure to sexual activity, photographing, filming, or prostitution (Gilbert et al., 2009). Sexual abuse includes any exploitation or involvement of a child in a sexual activity that he or she does not fully comprehend, is not able to give informed consent to, is beyond him or her developmentally, or violates the laws or social taboos of society. It may involve the inducement, coercion, or exploitation of a child in unlawful sexual activity, prostitution, or pornographic materials (Legano et al., 2009).

Psychological or emotional mistreatment involves intentional behavior that conveys to the child that he or she is worthless, flawed, unloved, unwanted, endangered, or valued only when he or she meets another's needs. The definition of psychological

abuse could include unintentional actions by the parent, such as constant emotional ill-treatment of child that results in serious and persistent adverse effects on the child's well-being and emotional development. Psychosocial maltreatment can be continual or episodic; substance abuse may be one trigger. It may take the form of belittling, blaming, degrading, intimidating, terrorizing, isolating, or otherwise behaving in a manner that is harmful, potentially harmful, insensitive to the child's emotional/developmental needs, or potentially damaging to the child emotionally/psychologically. Witnessing intimate partner violence may classify as exposure to psychological or emotional abuse (Gilbert et al., 2009). Psychological maltreatment includes spurning, belittling, or shaming a child. It includes terrorizing, threatening, or perpetrating violence against a child. Emotional abuse may involve isolating the child by confining his or her movement or placing unreasonable limitations on his or her interactions with adults or peers. It may involve exploiting, corrupting, modeling antisocial behavior, or encouraging developmentally inappropriate behavior. Psychological mistreatment may mean denying emotional responsiveness, ignoring a child, or failing to express affection to child (Legano et al., 2009).

Child neglect is the most common form of child maltreatment, and is caretaker omissions that result in actual or potential harm to a child (Legano et al., 2009). More specifically, neglect is failure to meet the basic physical, emotional, developmental, medical, dental, or educational needs of a child. It includes failure to provide adequate nutrition, hygiene, shelter, support, or safety. It may involve failure to provide adequate food, clothing, or accommodation. It may take the form of not seeking medical attention when necessary. It might be allowing a child to miss large amounts of school. It may

involve failure to protect a child from violence in the home or community, or from avoidable hazards (Gilbert et al., 2009).

Identification of Victims and Predisposing Factors

The Forensic Nurse Examiner must be able to determine if a child is a potential or actual victim of child abuse. The most common method used is a complete physical examination. Hoytema van Konijnenburg, Teeuw, Sieswerda-Hoogendoorn, Leenders, and van der Lee (2013) reviewed the literature and discovered that there is currently little to no valid evidence that a physical examination alone is capable of reliably detecting maltreatment in children without prior suspicion of abuse. A complete physical examination will only show signs of physical abuse. The interaction between parents and children must also be part of the investigation. Furthermore, there is some bias inherent in a physical examination looking for child abuse. The examiner may see signs of abuse that are the result of other injuries or may misinterpret innocuous signs such as Mongolian spots. They suggested that further study, using a large sample size and reliable methods, is required to determine whether a complete physical examination allows primary care providers and forensic nurse examiners to detect child maltreatment (Hoytema et al., 2013).

In a more specific study, Nash and Sheridan (2009) explained why the discoloration of bruised skin, the skin above and around a contusion, could not validly identify the age of an injury. For example, yellow was most often present in contusions between 24 and 48 hours, but did not always appear in the progression of bruise healing. In addition, interrater reliability is low because two people may see the same color differently. Analysis of three different studies confirmed that dating a bruise or contusion

using only color is unreliable. The nurse must document any injuries as completely as possible, photograph the injuries, and not comment on the age of the injuries (Nash & Sheridan, 2009).

Many environmental and familial factors can lead to child mistreatment. Therefore, screening for these elements should help prevent it. Thompson, Thompson, Black, Esernio-Jensen, Hardt, Das, and Roth (2013) showed that the Healthy Start Prenatal Risk Screen is effective in identifying families at risk for reported child maltreatment. They used a sample of 85,258 women and their second infants to determine that a short interval between pregnancies was significantly associated with reported child maltreatment. The mother's perception of harm to herself and her desire to be pregnant later also correlated with referral due to child abuse. The child maltreatment studied may be the result to having more than one young infant in the household, an unplanned pregnancy after contraception failure, or coercion from a violent partner. Women who are young, are unmarried, or have lower educational levels are also more likely to abuse their children (Thompson et al., 2013).

Knowledge of the characteristics of child abuse victims may help in screening. Girls are more likely to be victims of sexual maltreatment. However, rates of other types of mistreatment are similar for boys and girls. Disability may be a cause or result of child abuse, but certainly correlates. Parents who suffer from poverty, mental health problems, low educational achievement, alcohol overuse, drug misuse, and maltreatment are more likely to mistreat their children. Children of mixed or multiracial heritage are also more likely to become victims of child abuse regardless of socioeconomic status (Gilbert et al., 2009).

In addition to those already listed, there are other factors associated with higher rates of child abuse. Factors that make a caregiver more likely to commit maltreatment include criminal history, inappropriate expectations of children, misconceptions about childcare, and misperceptions about child development. Individual or personal factors that increase a child's risk of mistreatment include behavioral problems, medical fragility, a non-biological relationship with the caregiver, prematurity, and special needs. Family and environmental factors that increase the incidence of abuse include high local unemployment rate, intimate partner violence, poverty, social isolation, and lack of social support (Vallone et al., 2009).

Social support for abuse and social marginalization may contribute to the continuing problem of child abuse. Myths about childhood sexuality, approval of severe forms of corporal punishment, and acceptance of parental authoritarianism may lead to child maltreatment. Socioeconomic deprivation, racism, sexism, and homophobia produce negative effects on children and adults, may intensify the effects of victimization, and increase the likelihood of exposure to violence. Parents stressed by poverty and inadequate social support are more likely to mistreat their children, and children who suffer abuse in such contexts may lack the resources that might provide resilience (Briere & Jordan, 2009).

Evaluation, History, and Physical Examination

Legano, McHugh, and Palusci (2009) suggest that the physician or forensic nurse examiner need to investigate any apparent, inflicted, physical injuries. This is especially true in a family with a history of child abuse. However, suspicion of maltreatment may arise during the course of a routine physical examination. The examiner will need to

complete a history from the parents, a history from the child, a thorough physical examination, laboratory tests, and radiographic studies. The healthcare provider should interview parents and children separately. The examiner should address the history of the present symptoms and events surrounding any physical injuries, prior history of physical trauma, and complete medical history. Suspicious findings in the history include vague or non-existent histories to explain injuries adequately, explanations that change during course of interview, and different histories given to various members of staff. The history may also show different stories of the same episode, no explanations for delay in care, parents indifferent to children's discomfort, parents blame children for the injury, and parental reports that children are "chronic" liars. The medical history should include birth records, past hospitalizations, prior injuries, chronic medical problems, temperament, developmental milestones, and method of discipline. The family history should take account of any genetic tendencies for excessive bleeding, skin disorders, and fractures (Legano et al., 2009).

Legano et al. (2009) suggest that the complete physical examination in physical abuse cases should include appearance, hygiene, behavior, age, and development. The investigator should document any bruises, burns, fractures, and head injuries. The exam may show evidence of major injuries from supposedly minor traumas, specific evidence of inflicted traumas, and injuries inconsistent the developmental ages of the children. The physical exam may also expose injuries located in areas not commonly associated with routine childhood traumas and evidences of healed lesions/scars from previous traumas. Laboratory findings may reveal no medical explanations for the observed injuries, such as evidence of exacerbation of a chronic disease. Radiologic studies may uncover

evidence of physical abuse during routine examination, no evidence of bone disease, and multiple injuries in various stages of healing (Legano et al., 2009).

Legano et al. (2009) state that anogenital examinations after reports of sexual abuse may yield nonspecific results because of normal changes or healed trauma. The investigator must have a working knowledge of forensic interviewing, child development, pre- and post-pubertal anatomy, and the ability to identify and interpret findings that are normal, indicative of trauma, or unclear/uncertain. The examiner should not force the exam, should make it comprehensive, should explain it to the child, and must empower the child. Any injuries to the body, vulva, hymen, perineum, and skeleton necessitate careful documentation, preferably by digital or diagnostic quality photograph (Legano et al., 2009).

Legano et al. (2009) describe indeterminate findings as those where there is insufficient or conflicting data from research studies. These findings support a disclosure of sexual abuse if one is given and are highly suggestive of abuse even in the absence of a disclosure, unless the child or caretaker provides a clear, timely, and plausible description of accidental injury. These include acute laceration or extensive bruising of labia, penis, scrotum, perianal tissues, or perineum; a fresh laceration of the posterior fourchette; and a scar on the posterior fourchette or perianal tissues. They state that specific findings diagnostic of trauma or sexual contact include acute laceration of the hymen, ecchymosis of the hymen, perianal lacerations extending deep to the external sphincter–hymenal transection, missing segment of hymenal tissue, confirmed sexually transmitted infection without congenital or transfusion transmission, pregnancy, or sperm on or in the child's body (Legano et al., 2009).

Legano et al. (2009) found that parental attributes seen in psychological abuse include aggression, poor parenting skills, authoritarian style, and substance abuse. Parents may also have a history of depression, suicide attempts, low self-esteem, and poor social skills. They may exhibit no empathy, excessive stress, domestic violence, and family dysfunction. Children at risk for psychological mistreatment include those with parents undergoing divorce, unwanted or unplanned children, and children who are socially isolated or have a disability. Some signs and symptoms include emotional difficulties, abnormal weight changes, and report of psychological abuse (Legano et al., 2009).

Legano et al. (2009) encourage clinicians to verify that parents are meeting children's basic needs. If they are not, then it is important to determine why. If a child is not receiving adequate nutrition, then he or she may have inadequate growth, failure to thrive, and inadequate weight gain. Clothing that is inappropriate for the weather or poorly fitting may indicate neglect. Inadequate hygiene and protection from environmental hazards may also indicate neglect. Medical neglect includes noncompliance or nonadherence with treatment regimens as well as delay or failure to obtain healthcare. Emotional neglect is the failure to provide adequate affection and nurturing. In educational neglect, parents do not enroll a child in school, they allow a child to miss excessive amounts of school, or they do not ensure that their child receives adequate special education services in school. Assessing resources, access to food, parental risk factors, parental knowledge, and health beliefs is imperative. Neglected children may exhibit developmental delays, poor psychological health, cognitive issues, and language problems. They may also demonstrate poor coping abilities, few positive interactions, insecure attachment, and criminal behavior. Neglected children could have

personality disorder, substance abuse problems, higher catecholamine/cortisol activity, and alterations in the limbic-hypothalamic-pituitary-adrenal axis. Assessment and magnetic resonance imaging might reveal post-traumatic stress disorder, smaller total midsagittal areas of the corpus callosum, and decreased cranial/cerebral volumes (Legano et al., 2009).

Intimate Partner Violence: Cause, Type, or Consequence

Intimate partner violence, domestic violence, and family violence all refer to the same thing. Intimate partner violence is any threatening behavior, harm, psychological abuse, physical maltreatment, sexual mistreatment, financial exploitation, or emotional abuse. By definition, it is between adults who are, or were, intimate partners or family members. Domestic violence is irrespective of gender and sexuality. The most frequent perpetrator is the man in heterosexual couples (Gilbert et al., 2009). Thirty-three percent of women in the United States experience family violence (Legano et al., 2009).

Violence in the home may result in intimate partner violence and child abuse occurring together. Domestic violence and child maltreatment occur in the same household 30% to 60% of the time, and child mistreatment leads to family violence 40% to 60% of the time. The number of intimate partner violence episodes directly correlates with the rate of physical abuse of the child. Risk factors for concurrence of domestic violence and child maltreatment include low socioeconomic status, maternal mental illness, and caretaker substance use (Legano et al., 2009).

Some research includes witnessing intimate partner violence as a type of child abuse. For example, Vallone et al. (2009) consider domestic violence perpetrated by a parent as maltreatment because it affects the child's subsequent development. Children

exposed to family violence experience psychological harm (Gilbert et al., 2009). Children who witness intimate partner violence suffer from behavioral and anxiety disorders, such as oppositional defiant disorder (Vallone et al., 2009). Children may endure harm intentionally or when they try to come between the perpetrator and victim of domestic violence. Family violence adversely affects parents' ability to raise their children and meet their needs (Legano et al., 2009).

Women who experience child abuse are at risk for becoming victims or committers of intimate partner violence. Children living in violent families have a higher tolerance of it in adulthood (Vallone et al., 2009). Children from families who have a high level of family violence who also rate themselves as having a high level of family support report more dating violence. Those from highly violent and highly involved families become insensitive to the violence (Folger & Wright, 2013). Exposure to family violence predicts male abusive behaviors and female victimization in intimate relationships (Legano et al., 2009). In addition to risk of perpetration or victimization, those who witness intimate partner violence and suffer maltreatment have more numerous and severe symptoms (Briere & Jordan, 2009).

Victims of violence turn to substance abuse as a tension reduction behavior. Women in methadone treatment clinics are more likely than women in the community are to have a history of childhood sexual maltreatment or intimate partner violence. Rates of post-traumatic stress disorder among women in treatment also exceed those of the general population. Drug use and financial dependence can limit women's power, sense of options, and use of problem-focused coping. Interventions with victims of domestic

violence should focus on childhood mistreatment history, drug dependence, financial resources, social support, and mental health (Engstrom, El-Bassel, & Gilbert, 2012).

Disclosure, Reporting, and Investigation

Cris Finn (2011) interviewed thirty forensic nurses who attended the International Forensic Nurses Scientific Assembly. He analyzed the participants' stories and experiences of receiving child abuse disclosures. Mr. Finn (2011) stated, "A child's self-disclosure is a critical component in initiating intervention to stop abuse and decrease the likelihood of long-term negative outcomes" (p. 252). He also said that the research consistently indicates that most victims of childhood abuse delay disclosing for significant periods, and that many never disclose until someone discovers their mistreatment through other means. Mr. Finn discovered several themes during his qualitative study: nurses reported that a child-friendly environment, connecting with and building rapport with the children, engaged listening, and believing the children unconditionally were important in supporting disclosure. In addition, many nurses discussed the potential for false disclosures (Finn, 2011).

Uninvestigated child abuse is a common theme in most studies. For example, self-report and parental report levels of child abuse are significantly lower than the number of official investigations by child-protection services and police. Even self-report rates may be low due to forgetting, denial, misunderstanding, and embarrassment. In addition, children may experience more than one type or instance of abuse simultaneously, but investigations tend to focus only the most severe and recent case (Gilbert et al., 2009).

Legano et al. (2009) remind readers that physicians and nurses are among mandated reporters of child abuse, so they need to know how to recognize, assess for, and

report it. General guidelines include the patient meeting the legal definition of a child, an act/omission committed by the parent, a history inconsistent with the injury, or other features of a reported episode fulfill other criteria for maltreatment or neglect. Multiple missed medical appointments, unreasonable delay in seeking medical treatment, abandonment, illnesses preventable by routine medical care, and inadequate care are potential criteria for a neglect report. Statements made by the child or parent disclosing potential mistreatment, physical injuries inconsistent with accident or disease, sexually transmitted infections, and pregnancy are acceptable as a basis for suspected abuse reports. The reporting requirements of mandatory reporting laws supersede the confidentiality of medical records and the patient-provider relationship. Recent federal legislation specifically allows state-mandated child maltreatment reporting and exempts such state reporting laws from federal privacy requirements under the Health Insurance Portability and Accountability Act of 1996. Penalties for not reporting range from fines in some states to criminal charges in others but also include civil penalties so that the child or guardian may litigate to redress financial losses sustained by the failure to report. Most of the legislation describes the need for reasonable suspicion of mistreatment to make a report. A physician does not need to have absolute certainty that abuse occurred (Legano et al., 2009). In addition to mandatory reporting, forensic nurse examiners need to gather forensic evidence, carefully follow the chain of custody, and testify in court cases (Lehman, 2012).

Short-Term Consequences

Death is the most severe immediate consequence of child abuse. Currie and Widom (2010) stated that 1,760 children died because of maltreatment or neglect in the

United States of America in 2007. The number of child mistreatment fatalities is up from 1,530 in 2006 (Legano et al., 2009). The World Health Organization estimates that more than 155,000 deaths in children under the age of 15 occur each year because of child abuse and neglect (Gilbert et al., 2009). If children do survive, then they have increased risks for negative psychiatric, social, behavioral, academic, and interpersonal functioning (Currie and Widom, 2010). For example, child abuse is associated with anxiety, depression, and anger. However, it is hard to generalize as children may suffer multiple types of maltreatment, experience varying numbers of episodes of mistreatment, endure other potentially adverse phenomena, and have a genetic tendency to poor mental health (Briere & Jordan, 2009).

Rogosch, Dackis, and Cicchetti (2011) found that child abuse led to poorer health outcomes and greater behavioral problems. They measured the allostatic load or indicators of the stress response such as cortisol, excess adipose tissue, body mass index, and hypertensive risk of children from low-income families. There was no significant difference in the allostatic load between maltreated and non-maltreated children. The level of stress was the same in both groups, and was most likely due to their socioeconomic level. However, a high allostatic load because of socioeconomic stressors and maltreatment together significantly predicted poor health outcomes. Children from low-income families who also suffer maltreatment are at the highest risk of mental and physical illness. They also had an increased rate of behavioral, delinquent, and social problems (Rogosch et al., 2011).

Vallone, Addona, D'Elia, and Vicari (2009) described the psychological effects on school age children, 6-11 years old, of witnessing abuse and being a victim of sexual or

physical abuse. They found that children who witnessed abuse were more likely to suffer from behavioral disorders, such as attention deficit hyperactivity disorder or oppositional defiant disorder. They discovered that victims of child abuse, sexual or physical, tended to suffer from post-traumatic stress disorder and dissociative disorders. Both groups of children suffered from anxiety disorders, such as separation anxiety disorder. Memory and learning were poorer in mistreated children than those who witnessed violence (Vallone et al., 2009).

Childhood-limited abuse leads more often to stress directed inward such as problem drug misuse, suicidal thoughts, and depressive symptoms. Maltreatment in adolescence leads to criminal behavior, substance abuse, health-risking sexual behavior, and suicidal thoughts. This is why programs need to be effective and developmentally appropriate. Preventing and reporting mistreatment, particularly toward adolescents is important (Thornberry, Henry, Ireland, & Smith, 2010). These are only the short-term consequences of child abuse and maltreatment, but these early negative academic and emotional outcomes may have an effect on the long-term consequences discussed next.

Long-Term Consequences

Child abuse causes a host of long-term physical and mental health issues. Physical child maltreatment increases the risk for depressive disorders, anxiety disorders, eating disorders, childhood behavioral/conduct disorders, suicide attempts, drug use, sexually transmitted infections, and risky sexual behaviors. It may increase the risk of cardiovascular diseases, type two diabetes mellitus, obesity, hypertension, smoking, ulcers, headaches, migraines, arthritis, and alcohol problems. Emotional mistreatment can lead to depressive disorders, anxiety disorders, suicide attempts, drug use, sexually

transmitted infections, and risky sexual behaviors. It may lead to eating disorders, type two diabetes mellitus, obesity, smoking, and alcohol problems. Neglect can cause depressive disorders, anxiety disorders, suicide attempts, drug use, sexually transmitted infections, and risky sexual behaviors. It may cause eating disorders, childhood behavioral/conduct disorders, cardiovascular diseases, type two diabetes mellitus, alcohol problems, and obesity (Norman et al., 2012).

Briere and Jordan (2009) suggest that somatization is bodily distress that arises from psychological phenomena. Children or adult survivors may complain of chronic pelvic pain, genitourinary problems, or gastrointestinal distress because of the trauma of the abuse. Childhood maltreatment may also lead to chronic interpersonal difficulties such as chaotic relationships, abandonment issues, problems trusting others, and ambivalence regarding intimacy. This interpersonal disturbance may result from insecure attachment styles. Dissociation, substance abuse, and tension reduction behaviors are also more common in adult survivors of mistreatment than in their non-abused peers (Briere & Jordan, 2009). More details on some of these effects of maltreatment follow.

The major long-term effect of child abuse and maltreatment is post-traumatic stress disorder (PTSD) or post-trauma syndrome. According to Ackley and Ladwig (2011), PTSD is a sustained maladaptive response to a traumatic or overwhelming event such as abuse. Characteristics of PTSD include aggression, alienation, an altered mood state, anger, anxiety, avoidance, and compulsive behavior. People who suffer from PTSD also may exhibit denial, depression, detachment, difficulty concentrating, enuresis, an exaggerated startle response, and fear. They may have flashbacks, gastric irritability, grieving, guilt, headaches, and hopelessness. Those who suffer PTSD from child abuse

could have hypervigilance, intrusive dreams, intrusive thoughts, irritability, neurosensory irritability, nightmares, and palpitations. They might experience panic attacks, psychogenic amnesia, rage, emotional numbness, repression, and shame. Risk factors for PTSD include diminished ego, displacement from home, chronicity, exaggerated sense of responsibility, inadequate social support, occupation, perception of event, survivor's role in event, and unsupportive environment (Ackley & Ladwig, 2011).

Child abuse increases the risk of internalizing behavior problems, such as anxiety and depression. It also increases the risk of externalizing or aggressive behavior problems. Early and continuous maltreatment lead to more behavioral problems in childhood. Children who suffer mistreatment have an increased risk of depression, which can cascade into other spheres of functioning. Physical or sexual abuse doubles the risk of attempted suicide for young people into their late 20s; this association is dose-dependent, so cumulative adversity increases the risk. Girls who suffer maltreatment are at increased risk for alcohol problems in adolescence and adulthood (Gilbert et al., 2009).

Abused children often suffer from physical as well as psychological consequences. They are more likely to become obese, and may be greater risk for ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. Sexually maltreated children are more likely to have an eating disorder such as bulimia or anorexia. Abnormally overt or intrusive sexual behavior correlates with sexual mistreatment, physical abuse, family adversity, coercive parenting, and modeling of sexual behavior. Children who suffer physical abuse, sexual maltreatment, or neglect are at risk of teenage pregnancy and adult prostitution; this is particularly true for girls. Sexual mistreatment increases a child's risk of earlier onset of sexual activity, greater

number of sexual partners, abortions, and sexually transmitted diseases. Severe or repeated sexual abuse or multiple childhood adversities increases the risk. Exposure to childhood sexual maltreatment may correlate to later sexual orientation; findings suggest that the association relates to sexual adjustment (Gilbert et al., 2009).

In addition to poor physical and psychosocial health, delinquency is also a serious long-term consequence of child abuse. Maltreatment puts juveniles at 55% or 4.8 times higher risk of arrest and 96% or 11 times higher risk of arrest for a violent crime. Baskin and Sommers (2011) found evidence of a similar relationship among childhood maltreatment, foster care placement, and delinquency. On average, a child in foster care has three different placements while in the system. Boys and girls in the foster system are ten times more likely to have a police officer place them under arrest than their peers are. Children receiving in-home services or in foster care households were less likely to become incarcerated. There are differences in whether prior researchers included children who were victims of abuse or neglect, whether it was substantial or reported abuse, what placements were included, the age of the children included, and what defined delinquency (Baskin & Sommers, 2011).

Baskin and Sommers (2011) studied the full array of maltreated children and the full range of arrest offences. They studied abused children who the courts subsequently placed into the foster care system. Foster care and its lack of permanence place young people at a higher risk of delinquency. Their goal was to determine if the type of child abuse, the foster care placement situation, or some combination of factors led to future delinquency. They conducted a prospective study of the official records of children in Los Angeles County from admission to the Department of Child and Family Services (DCFS)

to involvement with the criminal justice system. They included children with new petitions to DCFS, who did not have an arrest prior to entering foster care system, and were from birth to 12 years of age. They discovered that children in the foster care system who had a history of abuse, who were older at the time of placement, and whose placement was unstable with more than one foster home or location were more likely to commit crimes in the future (Baskin & Sommers, 2011).

Topitzes, Mersky, and Reynolds (2011) also found that childhood maltreatment correlated with adult crime for men and women. They discovered that it significantly predicted delinquency in socioeconomically disadvantaged males. Gender alone does not mediate this child abuse and delinquency link. It would appear that for women child abuse has a delayed effect on criminality. The women's relationships with criminally inclined men, misuse of drugs, and abuse of alcohol may lead to this criminal behavior in later life. For men and women, low parental involvement and poor high school graduate rates also increase the incidence of criminal behavior. Men were more likely to engage in illegal activities if they had a tendency toward troublemaking, externalized behavior, were not committed to school, and had impaired social or emotional skills (Topitzes et al., 2011).

Topitzes, Mersky, and Reynolds (2010) found that child abuse and neglect predict cigarette smoking as a young adult. Both men and women who suffered mistreatment in childhood were more likely to smoke later on. Factors influencing this relationship include social maladjustment, poor academic performance, family instability, and criminal involvement. Individual, family, and school dynamics reinforce each other

leading to emotion dysregulation and compensatory smoking. Arrest convictions and disadvantaged status amplifies this effect (Topitzes et al., 2010).

Nikulina and Widom (2013) stated that childhood abuse has significant long-term impacts on adult executive function, nonverbal reasoning, and psychological function even to 41 years of age. Those who suffered neglect as children did poorly on the Trail Making Test – Part B, which measures executive functioning, as adults. They also did worse on the Matrix Reasoning Tests, an assessment of problem solving and nonverbal reasoning, than their peers who did not suffer maltreatment or who suffered other types of mistreatment. Physical and sexual abuse may not affect this type of neuropsychological functioning in adulthood, but neglect certainly does and other types of maltreatment have other cognitive effects (Nikulina & Widom, 2013).

This effect on cognitive functioning may lead to lower educational achievement. Abused children have lower educational achievement than their peers do. They are also more likely to need special education. In addition, children who suffer maltreatment are less likely to complete high school. Mistreatment leads to poor school attendance and performance, and the effects are cumulative. Lower educational attainment, in turn, means that children whose parents or caregivers mistreat them work in menial and semi-skilled occupations and do not remain employed as long as those whose guardians do not (Gilbert et al., 2009).

There is evidence that poor financial health and socioeconomic instability are less obvious problems for adult survivors of child abuse. Zielinski (2009) researched the employment status, income, and health insurance of adult survivors of child abuse and maltreatment. He discovered that victims of child abuse have lower socioeconomic

status, have lower incomes, fall under the poverty line more often, have higher rates of unemployment, and have less health insurance coverage. The lower income held for adult survivors of child abuse after adjusting for childhood socioeconomic status. Victims of physical abuse were less likely to have a lower income, but they were likely to fall below the poverty line and had a much higher risk of unemployment. Victims of child mistreatment, particularly sexual, have lower rates of healthcare coverage and greater reliance on Medicaid (Zielinski, 2009).

In addition to the socioeconomic consequences for the individual, child abuse has long-term costs for society as a whole. Immediate and direct costs include treating maltreatment victims, child welfare services, healthcare costs, and legal services. Later and more indirect costs may include the victim's subsequent impaired physical/mental health, substance abuse, criminality, incarceration, special education, or early pregnancy. Long-term economic results such as unemployment, lost tax revenue, government health care, and other social service expenses place additional burdens on society up to decades later (Zielinski, 2009).

The Cycle of Abuse

The continuation of the cycle of abuse is a multigenerational long-term consequence of child abuse. According to Thornberry and Henry (2013), identifying the causes of child maltreatment perpetration is a prerequisite for developing effective prevention initiatives to reduce its recurrence. Earlier maltreatment victimization is an important cause of subsequent maltreatment perpetration. They tested the hypotheses that being a victim of child abuse is associated with child abuse perpetration and that the timing of the abuse alters this relationship. The authors used data from the Rochester

Youth Development Study, a longitudinal quantitative study based on a stratified random sample. The authors discovered that child abuse victimization limited to childhood, or the age of 11, years did not significantly correlate with child abuse perpetration in adulthood. However, child abuse victimization continuing into or beginning in adolescence, through ages 12-17, did have a strong correlation to child abuse perpetration. The differences between childhood abuse and adolescent abuse in the number of incidents, type of abuse, and severity of abuse suffered are the most likely explanation for the different outcomes in relation to future perpetration of child abuse. They found that 77% of maltreated children do not go on to mistreat their own children. They suggest programs that provide services to adolescent abuse victims should emphasize the advantages of delaying initial childbirth, developing knowledge about normal infant and child development, encouraging effective parenting behaviors including the accurate identification of maltreating behaviors and their negative consequences, and providing therapeutic services to adults who have suffered mistreatment (Thornberry & Henry, 2013).

Parents may or may not be aware of the intergenerational patterns of abuse of which they are a part. Some parents believe that they should do things differently than their parents did. Parents may attempt to do things to improve their relationships with their children, but parents may do things that are destructive to their relationships with their children. McWey, Pazdera, Vennum, & Wojciak (2013) suggest that the majority of parents recognize intergenerational patterns, express a desire to behave differently towards their children, but still engage in destructive behaviors. They suggest that the way a parent sees his or her upbringing, parenting style, and actions should shape his or her therapy (McWey et al., 2013).

Some people suggest that learned violence is a factor in the cycle of abuse, and the above results do show that more exposure increases risk. For example, former abuse victims may assume that dominance and aggression are appropriate methods for getting needs met or raising children. This is particularly true for parents who suffered maltreatment that had psychological ramifications or abuse substances (Briere & Jordan, 2009).

Zielinski (2009) reiterated that low socioeconomic status is a risk factor for the perpetration of abuse and neglect. In addition, parents who are adult survivors of child maltreatment are more likely to abuse their children. Research demonstrates that 25-35% of parents who experienced mistreatment went on to abuse their own children. He suggests that the relationship between mistreatment and socioeconomic outcomes is likely another important mechanism in the intergenerational cycle of family violence (Zielinski, 2009).

Dixon, Browne, & Hamilton-Giachristis (2009) studied families from birth to one year, and placed each family into a group based on parental history of abuse and perpetration of maltreatment. Maintainers had a history of mistreatment and continued the cycle, breakers suffered abuse without maltreating their own children, initiators had no history and still mistreated their children, and controls had no history or accusations of abuse. Risk factors for continuing or initiating a maltreatment cycle included delinquency, young age, living with a violent adult, mental illness, and poor parenting styles. Mental health problems included depression, substance misuse, post-traumatic stress disorder, anxiety, and antisocial personality disorder. As in the other studies, protective factors included financial solvency and social support. For example, women in

intimate, stable, and long-term relationships with a secure home environment were less likely to mistreat their children. They received emotional support and psychotherapy, and they showed fewer signs of stress, depression, and anxiety (Dixon et al., 2009).

Mediating Influences, Protective Factors, and Efficacy of Various Treatments

Topitzes et al. (2011) suggest that working with boys in grades four through six and girls in middle school may help them stay in school and reduce their risk of ending up in the criminal justice system. They also suggest that parental expectations for boys improve their outcome after abuse. For women, parental involvement and school stability mediate the effects of child maltreatment. High school graduation strongly and positively influences men and women, helping them overcome child mistreatment and preventing criminality. The researchers recommend gender specific treatment programs for victims of abuse. Men should receive training in social skills, emotion regulation, and remedial education. Females should have family-based counseling, treatment, and interventions. A synergistic and cross-systems collaboration among mental health, child welfare, school, and juvenile justice services would help both groups, but should be particularly valuable to women (Topitzes et al., 2011).

Topitzes et al. (2010) found that academic success and educational attainment mediated the relationship between child abuse and cigarette smoking. Life satisfaction also positively correlated with a lower risk of adult cigarette smoking. The researchers recommend assisting victims of child abuse with social adjustment, cognitive performance, and school functioning. Engagement and stability of family, school, and peers may also assist this vulnerable group (Topitzes et al., 2010).

Assisting children who suffer abuse with educational attainment, psychological health, and physical health may mediate the long-term consequences of child maltreatment. Child mistreatment leads to impaired cognitive and academic outcomes, such as not completing high school. The association between educational attainment and later socioeconomic status is well established. Education represents a robust mediational pathway for the economic health of adult survivors of child abuse. Specifically, victims of physical or multiple types of maltreatment may benefit from enhanced access to job training programs and vocational counseling. Childhood mistreatment can lead to depression, antisocial behavior, and criminality. These negative psychopathologies may result in lower wages or unemployment. Finally, child abuse increases the risk of chronic health problems, which may jeopardize socioeconomic outcomes (Zielinski, 2009).

Folger and Wright (2013) found that social support from family, and more significantly friends, ameliorates cumulative child maltreatment. For victims of child abuse, social support led to lower levels of depression, anxiety, anger, and hostility. Familial assistance lessened aggression and maladaptive outcomes only in those with lower levels of cumulative child mistreatment; presumably, supportive relationships are not enough in cases of severe child maltreatment. High levels of abuse and support led to increased dating mistreatment in women and decreased self-esteem in men. This suggests that support, particularly from an aggressive or dysfunctional family, is not enough to overcome severely traumatic maltreatment. For young adults, especially those who suffer from higher levels of abuse, friend support is more of a protective factor. A violent family life may lead victims of mistreatment to normalize and accept maltreatment in other relationships, such as dating (Folger & Wright, 2013).

Folger and Wright (2013) found that higher levels of abuse lead to negative outcomes including psychopathology, problematic behaviors, and compromised social support. In other words, one impact of child maltreatment is damage to the trust and safety of interpersonal relationships that compounds the negative effects of the mistreatment. Abuse does affect each gender differently. It leads to depression and anxiety in women, while it results in more anger and hostility in men. The study summarized its findings by saying that social support, particularly from friends, led to decreased depression, anxiety, anger, and hostility (Folger & Wright 2013).

Briere and Jordan (2009) suggest that using simple cause-and-effect clinical formulations as the basis for adult symptomology is misleading. Patients may have suffered more than one type or episode of abuse, and they may have a history of other mediating or exacerbating factors. The etiology of maltreatment outcomes is multivariate. Therefore, numerous events and adverse processes may require therapeutic intervention. In addition to cognitive-behavioral treatment, adult survivors of child mistreatment may need assistance with affect regulation and interpersonal skills (Briere & Jordan, 2009).

Trask, Walsh, and DiLillo (2011) completed a meta-analysis on the efficiency of various therapies in childhood sexual abuse. They found that treatment is generally more effective in reducing the negative consequences of childhood sexual maltreatment than no treatment. Specifically, therapeutic interventions lowered emotional consequences such as post-traumatic stress disorder, internalizing, and externalizing behaviors. These outcomes of psychotherapy apply to children and adults, a variety of problem areas, and various settings. Longer-term interventions yield greater results than shorter-term interventions. Group therapy is just as effective as individual therapy, so completing

therapy in groups may be more efficient (Trask, Walsh, & DiLillo, 2011). Group therapy is financially reasonable and saves time, but it also may provide victims with valuable social interaction.

Conclusion and Recommendations for Practice

Child abuse is the physical, psychological, or neglectful maltreatment of a child by a parent or guardian. A physical examination should not be the only assessment for child mistreatment, but it is an important part of a complete investigation. Intimate partner violence relates closely to child abuse because it can occur in the same family. Children are not likely to disclose that their caregiver is maltreating them, but an inviting milieu may help. Child mistreatment may result in short-term consequences, long-term consequences, or even death. Some additional, potential, negative outcomes of abuse include delinquency, mental health issues, physical problems, educational complications, and socioeconomic disparities. The cycle of maltreatment is when a parent who suffered mistreatment as a child is more likely to abuse his or her own child. There are factors that protect from the negative consequences of maltreatment. Research evidence should inform practice as to how to assist victims of child mistreatment.

The current research findings suggest the need for targeted efforts to intervene over the long-term for neglected and abused children. For example, including family and schools in intervention strategies may help victims of child maltreatment overcome the negative consequences of their circumstances. Assisting victims of child mistreatment to complete their education, obtain good jobs, and become financially independent may help prevent them entering the cycle of abuse and assist them to overcome the usual negative socioeconomic outcomes characteristic of victims. Providing maltreated children with

emotional support, encouraging them to develop a social network, and teaching them interpersonal skills may also help with the negative consequences of mistreatment such as becoming a perpetrator.

Future research should look into what therapies psychiatrists, forensic nurse examiners, and other clinicians are already using. For example, which interventions mentioned are already in place. In addition, future investigators could look further into what results these treatments are getting. For example, which ones are working as well as expected, and which ones require further research into their efficacy. There is some research into the treatment of childhood sexual maltreatment, but very little on other types of mistreatment. Furthermore, upcoming study could explore how long these remedies are continued. Since many consequences are long lasting, it is important to find out if any clinicians sustain rehabilitations over time. Finally, forthcoming research could examine how to maintain the therapeutic relationship and intervene over the long term.

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