CHAPTER 35

PHYSICAL, MENTAL AND EMOTIONAL CONDITION OF CHILD

This chapter covers:

- Child development considerations, including stages, adaptation and attachment.
- Prevalence and nature of neglect.
- Developmental effects of maltreatment by age group, including signs of neglect, physical abuse and sexual abuse, as compared to normal development.
- Risk factors for abuse and neglect, for both parents and children.
- Medical and psychological considerations.
- Importance of timeliness in intervention and treatment.

35.1 Developmental Considerations

35.1.1 Stages of Development

Human beings develop in predictable stages along the life span. Models of child development emphasize different aspects of growth, but all recognize adaptation and attachment as basic principles that guide development. Development is marked by “milestones” that involve mastery of skills, such as learning to walk. Erik Erikson viewed the developmental process as a series of psychosocial stages with specific tasks to be mastered.

- Infancy (0 to 18 months): Trust vs. Mistrust
- Toddlerhood (18 months to 3 years): Autonomy vs. Shame and Doubt
- Preschool (3 to 6 years): Initiative vs. Guilt
- Middle Childhood (6 to 11 years): Industry vs. Inferiority
- Adolescence (11 to 21 years): Identity vs. Role Confusion
- Young Adulthood: Intimacy vs. Isolation
- Adulthood: Generativity vs. Stagnation
- Old Age: Ego Integrity vs. Despair
35.1.2 Adaptation

People are continually adapting to their environment. This process maintains the integrity of the person and allows forward development. Development results from interaction between a person and his or her environment.

Regression refers to a reversion to an earlier or less mature feeling or behavior. In normal development, children may regress when overwhelmed with the demands of a new skill or other form of stress. The temporary loss of skills is a healthy defense that helps the child regroup and move forward. In conditions of unusual stress such as parental maltreatment, the developmental tasks of the stage in which the stress occurs are not completely mastered. Developmental stages may be delayed, distorted, arrested or missed. The infant or child then limps forward in a psychological sense, and may be increasingly handicapped compared to his or her peers.

Early maltreatment and chronic neglect or abuse lead to more permanent changes in attitude and behavior as the child adapts to deviant parenting.

35.1.3 Importance of Attachment

Attachment refers to the psychological bond that develops between the helpless infant and a care-giving adult, normally the mother. Infants have a survival need to attach. Child maltreatment results primarily not from the infant’s failure but from his or her parents’ inability to provide the empathic care that fosters normal attachment.

Attachment is the most important developmental task of the first years of life. Healthy attachment to a reliable and nurturing caregiver lays the foundation for all personality development.

Failure or distortions of attachment constitute a profound early loss, psychologically similar to that experienced with death or other separation. This experience of loss is not a discrete event but a process of adaptation.

Children under five years in age are extremely vulnerable to prolonged separation from the primary attachment figure, the highest risk being between six months and four years in age. All humans respond to loss with characteristic feelings and behaviors. Protest (severe distress and searching behavior) is followed by despair (grieving with little hope of mother’s return, withdrawn, subdued behavior) and then detachment (baby renews interest in the environment). Although this “recovery” serves an obvious adaptive function, the underlying insults are often not relieved.

Loss creates feelings of sadness, rage, fear, shame and guilt. Changes in the self-concept are seen, as the child experiences helplessness and rage at his or her inability to control life events, and a sense of badness and worthlessness develops. This response is seen both in well-attached babies who are separated from attachment figures and in those traumatized by the “psychological absence” resulting from neglect or physical or sexual abuse. It is seen in
all ages when loss occurs.

Attachment patterns, once developed, tend to persist. They are initially the property of the relationship. Later, the pattern of attachment and the personality features that accompany it become a property of the child and resistant to change. The pattern or its derivatives are imposed on other relationships. There is substantial research demonstrating that the quality of attachment is systematically related to the quality of caregiving, that anxious attachment at 12 months remains so at 6 years, and that poor attachment is related to difficulties with learning, peer relationships, mood and behavior at 6 years and beyond. These basic patterns are firmly established by the third year of life.

Patterns change only if experiences change. Factors associated with improvement in attachment are the availability of suitable substitute care; a less chaotic lifestyle; and sometimes, a more robust infant. Studies of resilience have shown that a lasting supportive relationship with one person (friend, teacher, relative, therapist) before the age of 12 may ameliorate the damaging effects of maltreatment. In general, however, for children who remain with parents, early stimulation programs and later efforts to remedy delays are not successful if deviant family relationships are not addressed.

The psychological components of neglect, physical and sexual abuse are the real trauma, causing the most damaging effects of maltreatment. Of these, the parent’s emotional unavailability and the message that the child is worthless, unrewarding, unloved and valuable only in meeting someone else’s needs form the core of psychological harm.

Most maltreated children have some positive attachment to their parents. The terms unhealthy, insecure or anxious attachment do not denote a clinical diagnosis of Reactive Attachment Disorder, which refers to a severe disturbance in social relatedness. In its 2002 position papers, the American Professional Society on the Abuse of Children noted “misuse and overuse” of the Reactive Attachment Disorder diagnosis. The fifth edition of the APA Diagnostic and Statistical Manual is expected to clarify the diagnosis.

35.2 Prevalence and “The Neglect of Neglect”

Although neglect is the most significant and damaging form of child maltreatment it is unaccountably “neglected” in our consideration of harm to children. It is therefore highlighted here and discussed in a broader, more clinical sense than as legally defined. The statistics suffer from various problems of data collection and are provided here as a broad picture of incidence.

35.2.1 Statistics

In the United States, about one-third of reports of maltreatment made each year are substantiated. The incidence of child maltreatment increased substantially and significantly between 1986 and 1996, when the Third National Incidence Study of Abuse and Neglect was published. An estimated 2,800,000 children were maltreated in 1997. Neglect is the most commonly reported and substantiated form of child maltreatment. Nationally, about 56% of
reports involve neglect; 12% sexual abuse; and 25% physical abuse. Neglect is a secondary concern in another 20% of cases.

Neglect kills more children: 55% of child homicide is the result of neglect, 45% the result of physical abuse. In 1997, there were an estimated 1,200 child homicides due to maltreatment nationally, more than 3/4 of the deaths to children under age 4. Sadly, while 50% of slain adults know their murderer, 99% of children do. In one-third of the deaths from neglect, social services had contact with the family, and in an even greater percentage of deaths, a medical professional had seen the family.

35.2.2 Nature of Neglect

Neglect occurs when the child’s basic needs for nurturance, protection and appropriate stimulation go unmet. It is always present in other forms of maltreatment. The child’s caretaker “either deliberately or by extraordinary inattentiveness” allows a child to suffer and/or fails to provide the essential ingredients for developing the child’s physical, intellectual or emotional capacities (Cantwell).

Normal or “good enough” parents provide physical well-being (adequate food, clothing, shelter and heath care) and a sense of being valued and loved (healthy attachment). They provide protection, buffering the infant from excessive noise and discomfort, childproofing the toddler’s environment, and helping older children select appropriate, safe friends and activities. Parents provide appropriate stimulation by talking and playing with their infants, providing developmentally appropriate activities and contact outside the family, and teaching the personal and social skills to function in society.

Neglect can be thought of as an environment of emotional deprivation punctuated by periods of high stimulation. Neglectful parents typically have a poor understanding of developmental needs and unrealistic expectations of their children’s capacity. Parental behavior is inconsistent and unpredictable and the home is often disorganized, if not chaotic. The parent confuses his or her emotional or sexual needs with the child’s and uses the child to satisfy those needs. A parent who feels lonely wakes the infant for company; a parent who is not hungry does not respond to an infant’s cry for food.

When the needs of parent and child coincide, the child may receive wonderful attention and praise. This explains, in part, the desire of abused children to return to their parents’ care. Infants and young children are helpless and dependent on adults and accept their treatment as normal. They may form secure attachments to siblings. Most parents have some positive qualities that provide feelings of worth. Moreover, parents may take excellent physical care of a child who is being sexually exploited or physically abused. They may be responsive to certain needs, such as intellectual curiosity, but unable to tolerate others, such as the child’s independence. These distorting, subtle aspects of neglect and abuse lead to disbelief by adults who might help such children.
It is the cumulative effect of neglect that harms children. Prevention and early intervention are crucial because the earlier and more lasting the maltreatment, the more it is integrated into the child’s personality. Repeated referrals to human services help document chronic neglect and may lead to eventual substantiation.

Substantial research evidence supports the view that even “mild” neglect has devastating long-term effects. For example, neglected children report that the threat of abandonment they experienced was more painful than their physical or sexual abuse. A history of early severe neglect without severe physical abuse may be found in teens or young adults who show violent or criminal behavior.

### 35.3 Developmental Effects of Maltreatment

Children’s experience of maltreatment varies in degree and circumstance. Abuse may occur only occasionally, or daily. It may begin as prenatal neglect or at a later point in childhood when the family is under unusual stress. One severe abusive episode may produce traumatic stress symptoms, while less severe ongoing episodes may be mitigated by the support of one caring parent. A child’s fear and confusion at occasional attack will shift to a more permanent change in the personality when abuse is ongoing and chronic. Positive qualities in the parent may reduce the effects of maltreatment.

Of maltreating perpetrators, 75% are parents and another 10% are relatives. Maximum risk of maltreatment is found in the middle childhood years, 6 - 11, except for sexual abuse, which rises at age 3 and remains constant during childhood. About 80% of perpetrators are under 40 and almost 65% are female. However, men perpetrate most sexual abuse and women most physical neglect. Girls face three times the risk of sexual abuse than boys; boys are at somewhat greater risk of physical injury and significantly greater risk of emotional neglect. Fatalities are about equal by sex. No race differences were found in the national incidence studies.

The following section describes typical responses of children to normal, neglectful, physically abusive and sexually abusive parenting at each developmental stage. These responses are discussed in terms of the effects on the inner life of the child as well as symptoms and behaviors. As noted earlier, most children experience several kinds of maltreatment and many of the sections below apply to all maltreatment. The stages presented are consistent with Greenspan and Erikson’s work.

#### 35.3.1 Birth to 10 Months

**Normal**

The first months of baby’s life are devoted to homeostasis (self-regulation and interest in the world) through a relationship of reciprocal interactions that help the baby differentiate his or her feelings and need states. Through this relationship, the baby develops “basic confidence” (Benedek) that the world is positive.
Through sensitive care, the baby develops an attachment to a primary figure by about 7 months. Trust and the capacity for empathy and intimacy develop out of the “basic confidence” provided in the mother-infant experience. The beginning capacity for love helps the baby manage aggressive impulses (Fraiberg).

The parental figure provides a protective buffer for the helpless infant. The mother is the main representation and interpreter of external reality for the infant. She is the model that the infant imitates and recreates. Thus, parental care provides working internal models of self and other.

In healthy attachment, one expects to see pleasure in reunion; the use of the parent as a secure base for exploration; an active approach to life; active seeking of the parent when separated; and nurturing themes in play. Parent-child interaction is marked by eye contact, spontaneity, affectionate exchanges and contingent responses. Parents are emotionally available and do not severely interfere with, control or ignore the child. Parents have developmentally appropriate expectations. They anticipate danger and appropriately supervise.

**Neglect**

Infants are at special risk for abuse and neglect because of their relative isolation, small size, lack of verbal skills and total dependence on a caretaker.

Lack of empathic caregiving undermines the development of self-regulation and basic trust that allow normal babies to show interest in the world. The neglected baby is not free to observe and learn without worrying about basic necessities. When the parent’s lack of care conveys that the child is unloved and worthless, the child’s sense of self and other is damaged. When there is no protective buffer against the world, the infant is overwhelmed.

Pathological infant defenses appear in the first 18 months. They serve to remove pain from consciousness. These include disorganization (screaming) and an exhausted “cut off” state, freezing, panic states with fighting, transformation of affects (giddy or ghoulish laughter) and turning aggression against the self (hurting self with no evidence of pain).

Failure or distortions of the attachment relationship take characteristic forms, which are apparent by 12 months. These unhealthy or insecure attachment patterns foreshadow later personality characteristics. Three pathological forms of attachment have been identified. Anxious avoidant babies are precociously independent and do not use the mother as a secure base for exploration. Proximity to and contact with her are minimal and they show little reaction to her presence or absence. Anxious ambivalent/resistant babies resist contact in reunion, yet are clingy, unable to be comforted and unable to explore the environment. They have difficulty at separation. Other babies show a disorganized/disoriented pattern, having no organized strategy for managing the distress of separation. They may be apprehensive, helpless, depressed, shift between approach and avoidance, “freeze” and have lowered psychomotor behavior.
Studies of adult attachment patterns suggest that infantile disorganized attachment is the product of severe psychosocial problems in the parent. Furthermore, infantile disorganized attachment appears to be associated with the oppositional, conduct, and other externalizing disorders of childhood, as well as with adult violent attachments.

Infant neglect may cause delays in development, mental retardation, growth failure and death. Delays in cognitive, motor, language and social skills appear early in neglected children. Neglected infants are often listless and unresponsive, or disorganized. For example, infants whose bottles are always propped do not receive the sensory stimulation (being held, regarded, talked to, smiled at) that promotes bonding, hand-eye coordination, perceptual skills and reciprocal communication. Language is the most important accomplishment of the child under 5. The silent infant with normal hearing should alert professionals to possible neglect.

Organic disease accounts for only 10 - 15% of Failure to Thrive (FTT). Non-Organic Failure to Thrive (NO-FTT) signals severe neglect that can cause chronic growth disorders, mental deficiency and death by starvation. Such infants typically recover when hospitalized and fed intravenously, and waste again when returned to their parents. Growth chart curves (height, weight, head circumference, weight-to-height ratio), observation of feeding and careful history establish the diagnosis. Mothers of NO-FTT infants are often depressed, have eating disorders or strange food beliefs and live in chaotic conditions. Their infants may have behavioral and neurological problems that make them difficult to care for.

Growth chart patterns may also signal periods of less severe neglect. For example, the growth chart of one infant whose mother periodically took him to follow a rock band paralleled the concert tours.

Diagnosis of Sudden Infant Death Syndrome (SIDS) should be based on autopsy and a full investigation. It is very difficult to distinguish SIDS from suffocation, strangling or overlying. Multiple SIDS deaths in the family may point to infanticide.

A death scene investigation should be conducted in all child deaths and performed by investigators knowledgeable in causes of nonaccidental injury and death due to parental neglect.

**Physical Abuse**

Physical abuse may cause permanent injury to the maturing central nervous system, resulting in mental retardation, neurological damage, blindness or death. The most common cause of death and maiming in children under 2 is head trauma. This is caused by shaking or shaking and then throwing the child (Shaken Baby Syndrome), or by direct blows to the head. These result in severe injury to the eye, brain and spinal cord. One-third of children with head injury are seen for vomiting and fever. Abuse is not diagnosed and 80% are reinjured. Although perpetrators often claim that they shook the child just a little, the biomechanics of injury indicate that in most cases the baby was shaken with great force in rage, and thrown at the end. Falls rarely cause severe injury or are fatal.
The second most common cause of fatalities is abdominal injuries caused by a penetrating blow by the fist or foot. Half of children with abdominal injuries die. Injuries to the stomach, bowel, liver and pancreas are most likely to be non-accidental.

Other typical physical abuses to infants are skeletal injuries, spinal fractures, bruises, burns, bite marks, genital and anal tears and injuries to the mouth. These are discussed in following sections.

The physical attack often has a precipitating or triggering event, but commonly is the result of a series of stresses that have led to a crisis unrelated to the child. Along with this crisis, the parent was typically abused or neglected in childhood, has little outside support, and perceives the child as unsatisfactory. In infancy and toddlerhood, typical triggers associated with particular kinds of injuries are:

- Inconsolable crying: shaking.
- Toilet accidents and soiled diaper: scalding burns of feet and buttocks.
- Refusing to eat: forced feeding resulting in oral injury and choking to death.

Children perceived as deficient are at higher risk of abuse. Physical deficits such as chronic medical illness, mental deficits such as retardation and developmental delay, and psychosocial deficits such as difficult temperament and hyperactivity place children at risk.

**Sexual Abuse**

Infants are victims of vaginal, anal and oral penetration, and also may be used to satisfy the sexual needs of older people in more subtle ways. Deliberate blows, bites, burns or other trauma to the genitals are sexual abuses.

As with all childhood sexual abuse, physical evidence may be absent. Most abuse is discovered rather than disclosed, by sexually transmitted diseases and other medical symptoms or discovery by a third party. Preverbal children express their pain and fear through nonspecific behaviors, such as crying, and disruption of feeding, toileting and sleep, and sometimes avoidance reactions to the perpetrator or those who resemble him.

**35.3.2 11 to 24 Months**

**Normal**

The baby becomes more organized, interacting in a complex emotionally and socially relevant manner, and forms inner (symbolic) representations. Walking and talking promote the baby’s independence and initiative. She or he becomes able to use symbols to express wishes and thoughts, and to cope with anxiety.
Neglect

Delays are often noticed by the pediatrician or daycare staff. Language is the most common area of delay, probably because it emerges out of the feeling of connection and the wish to communicate.

Parents are responsible for raising children who meet societal expectations for age-appropriate behavior. Neglectful parents provide an inconsistent and often chaotic lack of routine, so that toileting and self-feeding skills are not mastered. In severe neglect the children often have a feral quality.

Maltreating parents typically have a poor understanding of development and inappropriate expectations, and do not provide developmentally appropriate learning experiences. Neglecting parents expect that a child should be able to sit passively or may shut the child away for long periods. A “wall of No!s” discourages activity, exploration and responsiveness on all levels. Gross and fine motor skills may be delayed, as these children often sit or lie quietly for long periods rather than engage in the normal rough-and-tumble, noisy play of agemates. Other children respond with “out-of-control” or erratic behaviors and inattention that may be misdiagnosed as hyperactivity. The complaint that the child “gets into everything” is a clue to over-restriction.

Parents who describe their little ones as “friends” or equals expect the child to use adult judgment and to learn after being told once. Such parents often express pride in raising independent, self-sufficient children and emphasize their precocious maturity and helpfulness.

Proper supervision requires a normal attention span, level of comprehension and sense of responsibility and empathy for the child’s needs. The failure to supervise small children may cause injuries because of the unrealistic expectations of parents and their difficulty learning from experience. They may continue to place the child in dangerous situations despite previous falls from a bed or down the stairs. Working parents may provide inappropriate babysitters or expect children under 12 to supervise little ones for long periods. Neglect of supervision by an at-home parent may be due to substance abuse, chronic mental or physical illness, low intellect, immaturity or lack of empathy.

Some children show disturbance only in certain areas such as curiosity, feeding, aggression or need for affection, reflecting a parent’s difficulty with these feelings and behaviors.

Physical Abuse

Head and abdominal injuries continue to be leading causes of fatalities and serious neurological damage in this age group.

Child abuse fractures include transverse fractures from direct forces, twisting, pulling and compression of the long bones of the arms and legs. Elevation of the membrane lining the bones is pathognomonic of child abuse in infants after 6 months of age. Multiple fractures in
different stages of healing, spiral (or torsion) fractures in a child who is not walking, back and side rib fractures are all suspicious. Unexplained fractures in the long bones warrant investigation for subdural hematoma. Fractures can be dated by their specific stages of healing. Skeletal surveys are essential in children under 2, and recommended for children under 5, to rule out a pattern of past injuries.

About 15-30% of burns are abusive. These have characteristic distribution and appearance such as stocking or glove distribution; immersion burns (child dipped in scalding water); no splash marks; and pattern burns (cigarette). Abusive burns are often reported as “unwitnessed” or caused by siblings, and require more advanced motor skills than the child possesses. They are often associated with toilet training.

Inflicted skin injuries and bruising have recognized patterns. These recognizable injuries and bruises point to inflicted abuses: slap, pinch and grab marks; belt or strap, electric cord and bizarre shaped marks from specific objects; pinnae bruising from brushes; gag and ligature marks from being tied; bite marks; pulled hair; and cleft of mouth bruising from forced feeding. Bruising can be dated inexactly by color.

Parents may explain recurrent injuries and accidents as due to the child’s being “accident prone,” clumsy or hyperactive.

**Sexual Abuse**

Sexual abuse of toddlers may be violent and acute or ongoing.

**35.3.3 2 to 4 Years**

**Normal**

The toddler and preschool child will spend the years until age 4 consolidating skills. The following abilities develop during these years of consolidation:

- Relate to people and things in a balanced manner across a variety of emotions.
- Shift easily between reality and fantasy.
- Regulate mood.
- Accept limits and be self-limiting while feeling good about himself.
- Attend and concentrate.

**Neglect**

These children appear at HeadStart, daycare or preschool unprepared to learn and relate to others. By this age, the effects of early neglect or abuse are compounded by parental difficulties in coping with the child’s assertion of self, growing independence and assertion, and sexual curiosity. Most maltreating parents have problems at the point they had problems in their own childhoods. For many, this occurred in the early years. Moreover, the independence of the 2 - 4 year old creates a crisis of abandonment and rejection for
vulnerable parents who expected the baby to meet their needs for love.

Small children typically present with symptoms that reflect their deviant parenting experiences. These cluster around symptoms of internalization (depression, withdrawal, clingingness, poor self esteem) and externalization (impulsivity, aggression, hyperarousal).

Maltreated children show a diminished “often tragically low self esteem.” Because their own internal sensations, needs and wishes are not validated, they fail to develop an integrated sense of self. They learn to accept whatever care is available and believe it is normal. Often they learn only at school, or when removed to foster care, that other children receive care that does not hurt, frighten or anger.

Such children develop an external orientation, scanning the environment for cues and guidance and disregarding their own sensations and needs. They are often referred to as a great help or a comfort to their parent, and take on unusual responsibilities. The precociously responsible toddler has learned to anticipate mother’s needs for comfort, help with the baby, cleaning or laundry. In this way, he or she hopes to gain mother’s attention and avoid punishment.

The inconsistency, disorganization or frank chaos of their home lives is reflected in their poor self-regulation and difficulty relating to others, and in their play themes and drawings. The hyper-aggressive toddler disorganized by rage mirrors his or her chaotic lifestyle.

**Physical Abuse**

In addition to the signs of neglect, these children may present with symptoms of traumatic stress: hyper-alertness, heightened startle responses and flinching. Scanning helps the battered child anticipate his parents’ moods so as to avoid a blow. Depression may show as irritability or sadness. Aggressiveness, “temper” and defiance are heightened.

Physically abusive parents are overly harsh and hold their children to age-inappropriate standards of self-control with little guidance or instruction. They show little empathy for the child’s pain and fear, just as they received little from their parents. Such parents seem to feel that had they been perfect, they would not have been neglected and abused. They may deny or minimize their own parents’ maltreatment as necessary, having internalized their high standards while resenting parental demands and control.

**Sexual Abuse**

The incidence of molestation rises at age 3 and remains consistent during childhood. The molesting parent distorts his or her responsibility to socialize, protect and nurture his or her child. Incest families are typically socially isolated and abusive, creating multiple distortions in family life. The secrecy of incest and the common failure of the mother to see and protect are especially damaging aspects of incest. Many incest victims harbor greater anger at the nonprotecting mother than at the perpetrator. The normal curiosity of children under 4 about their bodies and gender differences is exploited. Children may begin to be sexually groomed
The definition of love as sexual exploitation creates enormous pain and confusion for the child. Genital and anal regions of prepubertal children are extremely sensitive, and great pain and discomfort are inflicted on the child by digital and penile fondling and penetration. Extremely violent sexual attacks can result in permanent injury and death. Children this age heal quickly from lesser injuries, which may confound the diagnosis of past or chronic molestation.

35.3.4 4 to 6 Years

Normal

Preschool children accelerate motor, language and social skills in an increasingly wider context, building on previous mastery and promoting initiative and confidence. This is a period of egocentrism, expansive fantasy and magical thinking. Awareness of gender differences becomes more apparent, and a clearer gender identity is formed through special interest in the opposite-sexed parent. Relationships with adults and children outside the family increase.

Neglect

The poor self-esteem and confidence of these children worsen as they have more contact with same age peers and other adults and compare themselves to more fortunate children. Delays continue to undermine new learning and achievement. Neglected children are rejected by peers and adults for their unkempt appearance and “wild” unsocialized behaviors.

Physical Abuse

These children show guilt, fear, anger and depression. Physically abused preschoolers, told the abuse was due to their misbehavior or failure to meet expectations, often feel responsible for the abuse. Guilt may be easier to bear than the anxiety of unpredictable and uncontrollable attacks by their caretakers. The egocentric thinking of preschoolers increases guilt and fears of retaliation or abandonment by parents. Anger and aggression are heightened in these children. Depression may be due to poor attachment and the accompanying sense of abandonment and worthlessness. A child may be lethargic and withdrawn, have many aches and pains, or be irritable and agitated in depression. Children this age can be suicidal.

Munchausen’s Disorder by Proxy is a rare disorder with high morbidity and mortality. Recurrent medical symptoms are falsified or induced by the parent, who often is unusually attentive to his or her child, has a medical background and becomes deeply involved with medical staff during his or her child’s hospitalizations. These parents, mostly mothers, seek attention for themselves through the child’s illness. They are often personality disordered and may have been similarly abused as children. A parent may suffocate the child to mimic breathing disorders, put ground glass in the formula to produce blood in the stool, or inject
saliva in the intravenous line to produce infection. Laboratory tests may show suspicious sources of induced illness and hidden video cameras may expose the parent’s actions. The children are often medically ill, fearful and emotionally disturbed.

**Sexual Abuse**

These children also show guilt and fear about their abuse and the results of disclosure. Suppressed anger and depressive equivalents are also seen.

### 35.3.5 6 to 11 Years

**Normal**

This stage is marked by an industrious focus on acquiring broader conceptual, motor, language and social skills. The ability to reason and improved physical skill appear during these years. The child moves more fully into the world beyond the family, and develops a wider variety of relationships with peers and adults. A minority of children may begin puberty at 8 (girls) or 9 (boys).

The child of 8 is able to reason in terms of cause and effect. Expectations for learning, social behavior and conduct are more complex and the mastery of rules becomes important. A rather rigid conscience and morality develops, with a clear sense of right and wrong. The mastery of basic academic skills and the ability to attend and concentrate contribute to these achievements.

**Neglect**

Tragically, for maltreated children, emotional and developmental disturbances both result from and contribute to further maltreatment. By middle childhood impulsiveness, aggressiveness, hyperactivity and learning problems become more prominent, especially in boys. Identification with the aggressor instead of with the helpless victim serves an adaptive --if often malignant--purpose. Some children develop positive strengths in taking an aggressive, assertive stance. These children miss important academic and social experiences that contribute to healthy self-esteem and interest in learning during middle childhood. Their “chip on the shoulder” negativity and inferiority alienate them from others and undermine the later tasks of adolescence.

Some effects may not appear until later developmental stages of adolescence and adulthood, when the emotionally deprived adult revisits his or her own maltreatment on his or her children and partners.

Children with severe symptoms of overarousal, anxiety, depression and impulsive or aggressive behavior may need medication as an adjunct to treatment.

These children show the symptoms of neglect. Battered children may laugh or refuse to cry or admit pain in an effort to master physical abuse. Often, they are unable to cry or really
enjoy themselves and show other constriction of feeling. Deficient empathy for others may make them callous and destructive, especially to smaller children and animals. Sexual attacks on other children, drug and alcohol abuse and other antisocial behaviors may be seen.

It is of note that adult serial killers show a cardinal childhood triad of disturbed behaviors symptomatic of rage, anxiety and lack of empathy: fire-setting, bed-wetting and animal torture.

**Sexual Abuse**

As with other forms of maltreatment, the nature, course and severity of sexual abuse may differ widely. Each child and family must be assessed carefully.

Most children are “traumatically sexualized,” showing both aversive and overvalued feelings about sex, sexualized behaviors as well as avoidance of sex, and sexual identity disturbance. Children feel stigmatized, guilty and responsible for the abuse and/or the consequences of disclosure. These lead to a host of self-destructive behaviors that seem designed to invite punishment. These children feel betrayed and unable to trust. This trauma is expressed in behaviors such as relationships of avoidance, manipulation, reenactment through involvement with exploitative and damaging partners, and angry, acting out behaviors. Finally, powerlessness creates a sense of vulnerability and a desire to control or prevail. Such victims may identify with the perpetrator, acting out aggressively and exploitatively, or may express their vulnerability in avoidant and run away behaviors, anxiety disorders and revictimization.

The secrecy, threat of disclosure, conflict about causing family breakup and disturbed relationships of incest create complex problems. Around age 8, the child may begin to comprehend that the sexual abuse is abnormal and wrong. By this time, she or he is implicated in the abuse, confused about her or his contribution to it and isolated from mother and siblings. At school, the child is increasingly isolated by his or her “secret” and precocious sexual knowledge. Intergenerational incest families are particularly malignant, as the child is exposed to multiple perpetrators in a chaotic, neglectful, and often battering environment.

Sexualized behaviors are a specific symptom of molestation. Victims of sexual abuse may show behavior changes and nonspecific symptoms of fears, regression, social withdrawal, anxiety and panic, unusual anger or aggression, crying, inattention and academic failure, self-destructiveness and sleep problems.

Sexually abused children show associated medical conditions, such as:

- “Generally unhealthy kids.”
- Chronic pain syndromes--headaches, abdominal, leg and hip, genital or anal pain.
- Eating and swallowing difficulties.
- Acute genital or anal pain, bleeding, lesions, redness, discharge, or bruises.
- Recurrent vaginal and urinary tract infection.
- Enuresis.
- Encopresis.
- Sexually transmitted diseases.
- Eating disorders.

As with other forms of maltreatment, protective factors may mitigate the effects of sexual abuse.

### 35.3.6 10 to 21 Years

Adolescence is divided conceptually into early, middle and late stages corresponding approximately to ages 10 - 14, 14 - 18 and 18 - 21. Children may be precocious or delayed in progress through these stages.

**Normal**

Adolescents gradually emancipate from their parents and form an adult identity. One’s sense of self as unique and separate, sexual preference, intellectual concept of the world, lifestyle and choice of work are typically formed by early adulthood.

Early adolescents focus on the changes of puberty and making close friendships with same-sex peers. They compare themselves to agemates and worry about inadequacies. They are able to think more abstractly and begin a symbolic movement away from home.

Middle adolescents have an increasing need for independence and turn to peers for personal standards of behavior. Maturation of cognitive abilities, productive fantasy and altruism mark this period. Sexual and romantic feelings predominate and non-parental role models become important.

Late adolescents complete the final changes of puberty, and the face and body take on an adult form. A secure, acceptable body image, gender role and sexual preference are adopted. Emancipation from the parents is resolved and the adolescent assumes mature relationships and an adult lifestyle.

**Neglect**

By adolescence, signs of developing personality and mood disorders are evident. Early failures or disorders of attachment are associated with later depression, with each subsequent loss triggering unresolved grief. Antisocial, borderline and other personality disorders are highly associated with early maltreatment and loss. Parenting, sexual identity, autonomy and the capacity for intimacy are undermined by these experiences.

Suicide is the second or third most common cause of death among adolescents and young adults. Most childhood suicides point to serious emotional neglect.

The symptoms described in earlier sections are seen in more extreme form in adolescence.
The crisis of the need for love becomes acute in the teen years as peer acceptance, dating and planning for the future become significant. In their search for love, children may be exploited by more powerful peers and adults. Acting out and self-destructive behaviors increase as the adolescent uses his greater strength and physical independence to distance himself from a depriving and painful home.

**Physical Abuse**

In addition to previously described symptoms, battered children may show increased running away, delinquency, substance abuse and violence. These troubled children invite rejection and disapproval from peers and adults.

**Sexual Abuse**

Teens develop eating disorders, weight changes, end up pregnant, engage in prostitution and delinquency, run away, engage in substance abuse, attempt suicide and develop hysteroid symptoms in response to sexual abuse. Self-harming behaviors, such as scratching, cutting and overdosing on medication and drugs, are also related to sexual abuse.

Some proportion of male victims of molestation commit sexual offenses. About 90-95% of sexual abuse is committed by males, and about 20% of all sexual offenses are committed by adolescents. Moreover, 60% of adult male sex offenders report that they began offending in adolescence. Studies of these boys and their parents suggest a high incidence of childhood neglect and abuse. Their mothers tend to be depressed and “psychologically absent,” and ignore, deny and minimize their sons’ offenses.

It is critical to understand that most sexual abuse is not disclosed. Many childhood victims never disclose until adulthood, if then. For this reason, and because of the harm caused by childhood abuses, it is recommended that all mental health interviews include inquiry about childhood sexual abuse and rape.

Recent studies show that disclosure at all ages is piecemeal and prolonged. Children may disclose additional perpetrators only when asked. Often, full disclosure is not obtained until the child has developed a sense of safety and has been able to work through his or her confused feelings and damaged sense of self and others. Children’s silence is typically obtained by direct or indirect threat. Common threats are that the child will be killed, beaten or otherwise physically punished; that the child will be taken to jail or foster care and never see the family again; that the perpetrator will stop loving the child; and that mother or father will leave them, be jailed or have a breakdown. Often times, threats are backed up by ongoing physical abuse and other harsh punishments. Many children are cowed into silence without direct threat simply by the overpowering size of the perpetrator. Although the concrete thinking of young or intellectually deficient children may prevent them from verbally disclosing their abuse because they have been threatened not to tell, these children will often be able to show their abuses in drawings or play.
Retractions are not uncommon, especially in victims of chronic, incestuous or multiple perpetrator abuse. These children are first victimized when they are too young to comprehend the wrongness of the behavior. By the time they disclose or are discovered, they meet disbelief, blaming, rejection and multiple disruptions to themselves and their family. Most face direct or indirect pressure to retract the allegation. Victims with PTSD may have lost memory or detail for the events and present with many symptoms that undermine their credibility.

Childhood victims of sexual abuse are at risk for serious emotional and health problems such as mood and anxiety disorder, difficulty with intimacy, substance abuse and sexual dysfunction. Victims of multiple perpetrators tend to experience even more debilitating symptoms and are two-to-four times more likely to be sexually revictimized as adults.

It is not uncommon for children to be abused by more than one perpetrator. Such children tend to be abused at an earlier age and by a family member when compared with children victimized by one perpetrator. Violence and substance abuse are more common in families with multiple perpetrators. Parental failure to protect exposes children to more perpetrators over time, and the emotional deprivation experienced by children in such families increases vulnerability to manipulation by perpetrators. Research suggests that victims of multiple perpetrators may have more difficulty with psychological recovery because of increased shame and self-blame.

A normal medical examination neither confirms nor rules out sexual abuse. Many forms of sexual abuse such as fondling, oral sex and child pornography do not leave physical evidence. Semen is often absent because of delayed disclosure and the variety of ways perpetrators conceal contact. Young children may heal quickly from penetration injuries with little or no scarring.

35.3.7 Adulthood

Normal

Well-functioning adults are able to form meaningful relationships, work productively and live within the broad constraints of acceptable social conduct. They enjoy pleasures without a crushing sense of guilt and express impulses without being exploitative or violent. They are comfortable with and accepting of themselves.

35.4 Risk Factors for Abuse and Neglect

35.4.1 Parental Risk Factors

It is estimated that about 20% of abused children grow up to be abusive parents, but nearly all abusive parents have a childhood history of maltreatment. Parents who had poor attachments with their parents are unable to develop healthy relationships with their children and to provide empathic care.
A history of maltreatment increases the potential for multiple psychosocial problems. Such parents experience chronic stress, both internally and in their environment. They typically have a history of childhood physical and/or sexual abuse and neglect, inconsistent care, or parental loss. Some may have experienced a non-normative sexual environment or a sexualized mode of relating. Because of their experiences as children, they are prone to substance abuse, depression, isolation, poverty, unemployment, marital discord and adolescent and adult violence and criminal behavior.

Maltreating parents have poor self-esteem, are depressed and apathetic with little capacity for pleasure. They are distrustful and socially isolated with limited support. They are unable to express emotions or tolerate intimacy and although needy, are guarded and superficial in relationships. Thinking and judgment are distorted. They are impulsive, have poor problem solving skills and do not learn from experience or take responsibility for themselves.

Because abusive parents are needy, but unable to reach out for pleasure or support, they look to their children for love. As psychiatrist Brandt Steele points out, the parent brings three disparate attitudes to each parenting task:

- Healthy desire to do something good.
- Longing that the child fill the parent’s emptiness and relieve his or her low self-esteem.
- Punitive demand that the child respond correctly.

Such parents have harsh, authoritarian consciences based on their own experiences of criticism and rejection by their own parents, and later experiences of failure. When the infant or child fails to meet their expectations, resists or does not respond to the parents’ efforts, the vulnerable parent feels criticized and inferior. This stirs up the frustration of his or her need for love, and anger builds. A sense of guilt, helplessness, panic and finally anger precipitate the attack.

### 35.4.2 Child Risk Factors

Children perceived as deficient and unsatisfying are at higher risk of abuse. For example, children are at increased risk if they have physical deficits, such as chronic medical illness; mental deficits, such as retardation and developmental delay; or psychosocial deficits, such as difficult temperament and hyperactivity.

Sometimes children are targeted because they resemble a love partner who abandoned the parent or are perceived as having the bad temper of an abusive father. Distorted and fantasied perceptions of the child may cause blurring of the parent’s boundaries, as hated or feared qualities in themselves or others are attributed to the child.

### 35.5 Medical Considerations

Medical workers have a critical role and opportunity for prevention and early intervention. They see families for pre- and post-natal care and well-baby checks. They observe mother’s
response at birth and in the neonatal period, and treat children for injuries and illnesses. Hospital staff see the more difficult child protective services cases, more physical and sexual abuse and severe neglect, and more moderately or severely injured children.

About 20% of mothers do not bond immediately but do so at a later time. Clues to poor bonding are a lack of interest in the baby, a “stoic” attitude, disappointment with the baby’s gender, disparaging comments (“He looks like an ape”), feeding disturbances (a mother may water down formula to avoid diaper changes) and growth chart discrepancies over time.

When a child has been abused, medical staff need to assess the risk of returning the child home. A child returned home with a minor injury can be severely injured or killed. Careful attention to detail and thorough documentation of all interviews, observations and interventions are critical.

Carole Jenny notes these signs of non-accidental trauma:

- Injury unexplained by the history given.
- Delay in seeking care (several hours to days or longer).
- Changing, evolving or inconsistent history.
- Blaming siblings or small children for the injury.
- Inappropriate affect of caretakers.
- Noncomplaining child with serious injury.
- “Trigger event” precipitating loss of control by caretakers.

Who reports the injury (and who does not) and why they are reporting may be significant. Abusive parents delay seeking help to avoid detection. They may attempt to treat the injury at home or simply ignore the child’s pain. Many such children have learned not to express pain and often are unable to cry.

A careful social history of the parents should be obtained by a skilled social worker. This may provide clues to current stresses and a history of childhood abuse. The parents’ response to the child’s injury, admission to the hospital and involvement of CYFD should be carefully noted.

A history of previous injuries should be taken and the child’s pediatric records obtained. Increasing severity of injury over time from the limbs to the trunk to the head indicates a high risk of future, fatal injury.

Young children, relatives and other involved people should not be used as interpreters during interviews. Children should be interviewed privately away from caretakers. The interviewer should be honest about the purpose, non-leading and calm.

The ability to identify abuse is absolutely dependent upon the belief that it can occur and that anyone can potentially abuse a child. Attention to “gut feelings” and taking time to consider rather than explain away discrepancies are essential. Medical people do not need to prove maltreatment, but simply report suspected abuse and neglect.
Medical workers may fail to recognize abuse and want to avoid involvement in the legal and child protective systems. They may be unfamiliar with the child maltreatment literature and not recognize maltreatment. They may be reluctant to “accuse” especially middle and upper class clients, to lose patients or office time, or be involved with attorneys.

Conclusive statements such as “mother appropriately grieving” or “positive attachment” should be avoided. Abusive parents may cry from guilt for having injured or killed the child or from fear of imprisonment. Many sociopaths test as anxious in jail because they are concerned about prison time, not because they are suffering remorse. Some abusive parents feel remorse immediately after their loss of control and seek immediate help. Abused children may smile and greet their parents and say they want to go home with them, and infants may accept comfort for reasons other than positive attachment. Small children fear abandonment. Children are dependent on their parents and often do not realize that their maltreatment is abnormal. Many abused children receive moments of high, positive stimulation when their parents are feeling good. Some children receive special attention only when they are injured and in pain. Careful evaluation of the relationship needs to be made.

A death scene investigation should be conducted in all child deaths and performed by investigators knowledgeable in causes of nonaccidental injury and death due to parental neglect. An autopsy should be performed in all unexplained child deaths.

### 35.6 Psychological Considerations

Children enter foster care with high rates of emotional problems and developmental delays. Perhaps one-third of these children meet criteria for posttraumatic stress disorder (PTSD) and depression. High proportions of children diagnosed with PTSD have histories of severe neglect.

In children, PTSD develops in response to exposure to extreme stress (acute, episodic or chronic) and becomes persistent. The condition is characterized by feelings of intense fear, helplessness and/or horror; symptoms of re-experiencing the events; avoidance of stimuli associated with the trauma and general numbing; and heightened arousal. Related symptoms include persistent sadness; sleep difficulties and nightmares; poor concentration and forgetfulness; nervousness; fears of dying before adulthood; constant watchfulness; and traumatic reenactment in play.

The instability of foster care and sometimes multiple foster placements repeat the experiences of instability and inconsistent care of the parental home. In addition to the losses and abandonment experienced in maltreatment, foster children lose family and familiar environment (school, neighborhood, friends). They must adapt to a host of new people: social workers, doctors, mental health workers, medical or psychiatric hospital staff, residential treatment staff, attorneys and foster families, as well as new neighborhoods, schools and friends.

Infants may show significant calming and improvement in mood upon removal from their parents, attesting both to their poor care and to the infant’s strong survival need to attach.
The ambivalence about parents felt by older children is very complex, and children need help in sorting through their feelings.

Enormously challenged by severely disturbed maltreated children, some social workers, foster parents and adoptive parents have turned to “holding therapies,” which involve restraint or the purposeful infliction of pain on children as a means of evoking a strong emotional response. The American Professional Society on the Abuse of Children has criticized the use of certain of these therapies, sometimes described as “corrective” or “intensive” “attachment therapies,” noting in its 2002 position papers that such therapies are counter to the attachment theory developed by Bowlby and Ainsworth.

Abused and neglected children benefit most from treatment that helps them meet critical developmental milestones. Most children and adolescents are not capable of grieving the multiple losses of maltreatment, and do not benefit from talking therapy until later developmental stages, when new understanding can be integrated into the sense of self. Instead, they benefit more from efforts to stabilize the family, reduce anxiety and fear, contain antisocial and violent behavior, and improve the child’s ability to learn, make friends, and experience a normal range of feeling. Group counseling for sexually abused children is of benefit, reducing the sense of stigma and improving coping skills.

### 35.7 Importance of Timeliness

Children do not have years to wait for their parents to change. They need and deserve consistent, safe and loving care in order to recover from their maltreatment and develop normally. Many children are not identified until preschool or elementary school after many years of damage. Careful assessment of family needs, prompt adjudication and disposition and speedy resolution of the permanency plan are in children’s best interests.

About 10% of maltreating parents will be unable to ever provide adequate care. These ten percent include the parent with a delusional psychosis about the child, aggressive sociopaths, sadistic parents who torture their children, and fanatics with irrational religious or other justification for their abuses.

Parents who have had earlier children removed or their rights terminated also pose high risk. The capacities of parents with serious mental illness, personality disorder or mental retardation need to be carefully assessed.

Positive qualities in the attachment relationship and motivation to attend visits and otherwise comply with the treatment plan are strengths that suggest a fair or good prognosis. Creative treatment plans can provide needed support and encouragement in the early stages of intervention. Focusing on primary, current problems is more effective than requiring multiple simultaneous therapies for substance abuse, domestic violence, anger management, sexual abuse, parenting and so on. For example, substance dependence or ongoing violence must be addressed before other therapies will have impact. Multiple therapists confound the goal of developing trust, duplicate efforts, and encourage manipulation by savvy clients.
All young children should receive developmental evaluations and recommended therapies, a full medical examination, and indicated treatment. Psychiatric consultation for differential diagnosis of neuropsychiatric disorders and medication may be needed for some children. Psychological evaluation of parents and child provides a comprehensive assessment of functioning, treatment and placement needs. Family assessments examine quality of attachment and may reveal the factors in the parents’ childhoods that led to maltreatment, as well as the specific cause and nature of abusive incidents. Substance abuse should be evaluated when problems with drugs, medication or alcohol are known or suspected. Without primary substance abuse treatment (sobriety or moderation training), other interventions are likely to be of limited effectiveness.

Siblings often go unnoticed, although they may suffer from the same conditions as the target child. Siblings should be interviewed and receive appropriate help. Siblings of sexual abuse victims should have medical examinations, as they are at increased risk for molestation.

It is difficult to engage maltreating parents in treatment. They are typically distrustful, unable to express their feelings and needs verbally, depressed and unmotivated, and extremely needy. Many neglectful mothers feel they need to choose between their child and their partner. Focusing on building trust and coping with current stresses is most helpful. Later, work on childhood issues may be possible. Parenting education alone may be of limited value, as the maltreatment is caused by unconscious or habitual attitudes and behaviors.

Prompt assessment and treatment planning allows CYFD to gauge parental motivation for change. Even resistant parents should be expected to attend all visits, evaluations and treatment sessions scheduled.

35.8 References

This chapter of the Handbook was authored by Elizabeth Dinsmore, Ph.D. Dr. Dinsmore offers the following information about the authors she cites and recommends certain readings and websites.

35.8.1 Authors of Source Material

- Terese Benedek was an analyst who contributed to the understanding of early attachment.
- Hendrika A. Cantwell, M.D. is Clinical Professor Emerita, Department of Pediatrics, School of Medicine, University of Colorado Health Sciences Center, Denver. She has written extensively on neglect.
- Kathleen Coulborn-Faller is Faculty Director of the Civitas Child and Family Program, Director of the Family Assessment Clinic and Principal Investigator for the Interdisciplinary Training Program at the University of Michigan.
- Erik Erikson, M.D. was a psychiatrist and important developmental theorist.
Selma Fraiberg was a child psychoanalyst whose clinical and theoretical insights on early mental representation and work with troubled parents enriched understanding of maltreatment.

Stanley I. Greenspan, M.D. is a founder of the National Center for Clinical Infant Programs. An expert in infancy and early childhood, he is Clinical Professor of Psychiatry and Pediatrics at George Washington University Medical School and a Supervising Child Psychoanalyst at the Washington Psychoanalytic Institute.

Carole Jenny, M.D., M.B.A. is director of the Child Protection Program at Hasbro Children's Hospital in Providence, Rhode Island, and professor of pediatrics at Brown University Medical School. She formerly directed the child abuse program at Children’s Hospital, University of Colorado Medical School, Denver, Colorado.

Brandt F. Steele, M.D., psychiatrist, was with the C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect, Denver. He wrote widely on the intergenerational transmission of child abuse and neglect and work with maltreating parents.

Alan L. Stroufe, Ph.D. is William Harris Professor of Child Development, University of Minnesota.

D.W. Winnicott was a child analyst and Object Relations theorist who contributed to understanding of early development.

35.8.2 Recommended Reading


35.8.3 Other Recommended Sources