3

Child Physical Abuse

LEARNING OBJECTIVES

1. Describe the definition and scope of child physical abuse, including problems inherent in measuring this form of abuse.
2. Identify the various risk factors associated with child physical abuse.
3. Summarize the consequences of child physical abuse, including both short- and long-term outcomes.
4. Discuss the various intervention and prevention efforts that have been developed to address child physical abuse, including evidence of their effectiveness.

Case History: Kevin Fell Off His Razor

Kevin was placed in foster care because his community's Department of Child Protective Services (CPS) determined that his family was in conflict. The placement was made after 10-year-old Kevin was seen at the local hospital's emergency room for bruises, welts, and cuts on his back. According to his mother's report to emergency room personnel, the boy fell off of his Razor (scooter) while riding down a hill near the family home. Kevin was very quiet during the visit, never speaking but occasionally nodding his head in affirmation of his mother's report. The attending physician, however, believed that Kevin's injuries were unlikely to have occurred as the result of such a fall. Rather, they appeared consistent with the kinds of injuries a child might have from being slapped repeatedly or possibly whipped with a belt or other object.

Initially, Kevin's mother persisted in her story that Kevin had fallen from his Razor, but after the doctor told her that the injuries could not have resulted from such an accident, she confessed that her boyfriend, Sam, had some strong opinions about how children should behave and how they should be disciplined. She reported that Sam had a short temper when it came to difficult behavior in children and that he sometimes "lost his cool" in disciplining Kevin. She also mentioned that Sam had been depressed for the past several months because of their difficult financial circumstances. She wondered if these circumstances might have contributed to Sam's violence but also suggested that Kevin's behavior could often be very difficult to control. She said that Kevin had numerous problems, including difficulties in school (e.g., trouble with reading) and with peers (e.g., physically fighting with other children); she described both acting-out behaviors (e.g., setting fire to objects, torturing and killing small animals, stealing) and oppositional behaviors (e.g., skipping school, refusing to do homework, breaking curfew, being noncompliant with requests).

In interviews with a child protective services worker, Kevin revealed that he was, in fact, experiencing physical abuse inflicted by his mother's boyfriend. Kevin reluctantly acknowledged that Sam frequently disciplined him by repeatedly slapping a belt across his back. Kevin reported that on these occasions, he tried hard not to cry but that often the whippings hurt so much that

he couldn't help himself. He also talked about an incident that had taken place when he was several years younger. He had been playing with some baby ducks that lived in the pond in his backyard, trying to teach the ducks to swim underwater. When Sam saw Kevin submerging the ducklings' heads under the water, he became very angry and "taught Kevin a lesson" by holding Kevin's head underwater repeatedly. Kevin was tearful as he told this story and stated that at the time, he thought he was going to drown. Kevin also mentioned that he was worried about Sam's violence toward his mother, reporting that Sam would angrily slap and kick his mother after having been out drinking with his buddies.

After Kevin had been in foster care for several weeks, his foster mother indicated that he was doing very well and described him as a remarkably adaptive child. She said she found him to be a "warm, loving kid," and he had not exhibited "any behavior problems other than what you might expect from a 10-year-old boy." She reported also that Kevin "hoped to go home soon" because he missed his mother and Sam. He believed that he was placed in foster care because he was disobedient toward his mother and her boyfriend and because he hadn't been doing well in school.

The case history presented above describes the violence characteristic of the life of an abused child. Until the 1960s, however, U.S. society was relatively unaware of the violent world of the abused child. Child maltreatment was considered a mythical or rare phenomenon that occurred only in some people's imaginations or in "sick" lower-class families. As is now more widely known, however, child maltreatment is an ugly reality for many children in the United States and worldwide (World Health Organization, 2014).

In this chapter, we focus on one form of child maltreatment—child physical abuse (CPA). We first examine issues related to the definition of the physical abuse of children and the use of official statistics and self-report surveys for determining the magnitude of the problem. We then shift our attention to some of the characteristics that research has found to be typical of physically abused children and the adults who abuse them in an attempt to understand factors that might explain why physical abuse occurs. We also present evidence of the short- and long-term consequences associated with CPA. We conclude the chapter with a discussion of recommendations for addressing the problem.

Scope of the Problem

What Is Child Physical Abuse?

Defining child physical abuse is no easy task. Consider, for example, the following situations. Which of these would you consider child physical abuse?

- Jimmy, a 3-year-old, was playing with his puppy in his backyard when he tried to make the puppy stay near him by pulling roughly on the dog's ear. Jimmy's father saw the child vigorously pulling on the puppy's ear and yelled

at him to stop. When Jimmy did not respond quickly, his father grabbed Jimmy's arm and pulled him away from the dog. The father then began pulling on Jimmy's ear—actually tearing the skin a bit—to teach him a lesson about the appropriate way to treat a dog.

- Angela's baby, Maria, had colic from the day she was born. This meant that from 4:00 in the afternoon until 8:00 in the evening every day, Maria cried inconsolably. No matter what Angela did, she could not get Maria to stop crying. One evening, after 5-month-old Maria had been crying for three hours straight, Angela became so frustrated that she began shaking Maria. The shaking caused Maria to cry more loudly, which in turn caused Angela to shake the infant more vigorously. Angela shook Maria until the baby lost consciousness.
- Ryan and his brother, Matthew, were playing Super Smash Brothers in Ryan's bedroom when they got into a disagreement and began hitting and arguing. Their mother heard the commotion and came running into the room and separated the two boys. She then took each boy, pulled down his trousers, put him over her knee, and spanked him several times.

One way to define physical child abuse is to focus on observable harm. A child who is injured is abused. However, is this definition too restrictive? Is a father who shoots a gun at his child and misses not also guilty of CPA (Gelles & Cornell, 1990)? Beginning in 1988, the National Center on Child Abuse and Neglect began to include an **endangerment standard** in addition to a **harm standard** (U.S. Department of Health and Human Services [U.S. DHHS], 1988, 1996). While the harm standard recognizes children as CPA victims if they have observable injuries that last at least 48 hours, children without observable injuries may also be recognized as abuse victims if they are deemed substantially at risk for injury or endangerment.

This broadened understanding leads us to the following definition: CPA is *the intentional use of physical force against a child that results in or has the potential to result in physical injury*. Behaviors that could be defined as abusive include hitting a child with one's fist or an object such as a belt; kicking, biting, choking, shaking, or burning a child; throwing or knocking down a child; or threatening a child with a weapon. Armed with this definition, we can more effectively evaluate the vignettes above. The behaviors of Jimmy's father as described in the first vignette could qualify as abuse, since pulling on Jimmy's ear results in physical harm. The second vignette describes a mother whose behavior is clearly abusive. Vigorously shaking a child can result in a particularly dangerous type of head injury known as **shaken baby syndrome** or **abusive head trauma (AHT)**, which can result in serious injury or even death (see Box 3.1).

The third vignette illustrates the complicated issue of spanking and corporal punishment. The two boys are spanked but since there is no indication that they were injured, this is not *defined* as CPA. Of course, there is considerable debate about whether it *should* be defined as abusive, or at least unacceptable. The behavior depicted is also complicated by the social context of a family's culture and beliefs with regard to child-rearing. We know, for example, that certain cultural values and

beliefs are associated with greater endorsement and/or use of harsh physical punishment, which in turn is associated with CPA. Several studies indicate that endorsement and use of corporal punishment among U.S. parents is more common among Southerners, African Americans, and Conservative Protestants (Ellison, Musick, & Holden, 2011; Flynn, 1994; Gershoff, Lansford, Sexton, Davis-Kean, & Sameroff, 2012), and that corporal punishment often escalates into CPA (Gershoff, 2013; Gershoff & Grogan-Kaylor, 2016). The controversy about this topic is fueled by disagreement about the sanctity of cultural norms, the impact of harsh physical punishment on children, and the importance of children's rights, all issues we discuss further in Chapter 11.

Box 3.1 Shaken Baby Syndrome

The leading cause of death among physically abused children is death associated with some type of injury to the head, referred to in the medical community as abusive head trauma (AHT; R. Berger & Bell, 2014; Lind et al., 2016). The large majority (81%) of these children are under the age of 4, with 46 percent under the age of 1 at the time of their deaths (U.S. DHHS, 2010). Although the precise mechanisms leading to AHT in cases of CPA have been hotly debated, one common cause of head injury to children is referred to as shaken baby syndrome (SBS).

Shaken baby syndrome results when a caregiver violently shakes a child, causing the child's brain to move within the skull. Such shaking can result in severe injury, coma, or even death. Indeed, of children diagnosed with SBS, approximately 20–25 percent die as a result of their injuries, and only 8–36 percent achieve a "good" recovery (K. Barlow, Thomson, Johnson, & Minns, 2005; Chevignard & Lind, 2014; Lind et al., 2016). The damage can result from any number of causes, such as stretching and tearing blood vessels and brain tissue, disrupting the oxygen supply to the brain, and death of brain cells (Reece, 2011). The children who do survive frequently have lifelong problems such as intellectual disability, cerebral palsy, impaired vision or blindness, seizure disorders, learning disabilities, behavioral difficulties, or physical and emotional growth delays (Lind et al., 2016; Ornstein & Ward, 2012). In addition to permanent neurologic and associated damage, SBS also carries tremendous familial and societal consequences. SBS can result in children being removed from their homes, parents losing their parental rights, and adults being convicted and imprisoned for their actions (C. Christian, Block, & Committee on Child Abuse & Neglect, 2009).

Individuals who confess to shaking a child most commonly report difficulty trying to console a crying baby as the antecedent to the behavior. They often report that they felt frustrated, lost control, or "snapped" at the time the shaking occurred (E. Bell, Shouldice, & Levin, 2011; Reece, 2011; Russell, 2010). Another common reason for abusive shaking of a baby is when a caretaker perceives that a child is misbehaving and the caretaker either cannot stop or cannot tolerate the behavior (Isser & Schwartz, 2006). In one case, a man was accused of assaulting his girlfriend's 3-year-old child (Bell et al., 2011). At the time of the abuse, the man was the only adult in the home and was feeling frustrated because one child under his care was screaming in one room while he was bathing

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the 3-year-old child (who was also upset) in another room. The man began shaking her over and over again for approximately 10–30 seconds. Within that short amount of time, the 3-year-old suffered permanent serious injury including severe mental and physical disability.

Innumerable programs have been launched throughout the country via both public and private organizations to inform and educate the public on the hazards of shaking babies. These programs have been successful, with surveys conducted over the last 10 years showing that over 80 percent of adults report some familiarity with SBS (Dias et al., 2005). Although public awareness is an important first step, it is equally important to equip caregivers with appropriate methods to deal with their frustration and respond to inconsolable infants (B. Russell, 2010). Intervention studies designed to educate about appropriate response methods have been created, such as the Period of Purple Crying program, which helps parents understand and cope with the stress of normal infant crying. The program has a parent education component that includes a 10-minute DVD and 11-page booklet that addresses the risks of shaking a baby and reasons for early infant crying (Barr et al., 2009). In one evaluation study, 4,200 parents participated in a randomized control trial of the program and results indicated that the program not only enhanced mothers' knowledge about infant crying, but mothers who participated in the program were more likely to leave a situation where an infant was crying inconsolably compared to a control group of mothers (Barr et al., 2009). In another study, parents of newborns read a one-page leaflet on SBS and viewed an 11-minute video addressing the dangers of shaking an infant before leaving the hospital with their child. Findings indicated that following implementation of the program, abusive head injuries declined 47–75 percent with no decline in neighboring states during the same time period (Altman et al., 2011; Dias et al., 2005).

Despite the successful outcomes of these programs, prevention efforts must continue. Future research should examine broader audiences as well as how materials might be modified to address parental age, level of literacy, and various risk factors (Ornstein & Ward, 2012). The goal of future prevention efforts is not only to maintain the gains already achieved but to further increase awareness and understanding about SBS and the irreparable damage often associated with this form of child maltreatment.

Legal Perspectives

Federal law defines physical abuse as actions that result in "serious physical or emotional harm" (Child Abuse Prevention and Treatment Reauthorization Act, 2010; 42 U.S.C.A. §5106g). CPA is illegal in all 50 states, districts, and U.S. territories (Child Welfare Information Gateway, 2015), but individual states are left to define the specifics of these guidelines. In general, all U.S. entities acknowledge the harm and endangerment standards discussed above. However, key features of U.S. definitions vary according to the specificity of the acts included as physically abusive. Most emphasize the overt consequences of abuse, such as bruises or broken bones. Parents in all states are permitted to use corporal punishment as long as it is not "injurious," "excessive,"

or "cruel" (Child Welfare Information Gateway, 2015). In California, for example, physical abuse does not include "reasonable and age-appropriate spanking to the buttocks where there is no evidence of serious physical injury" (California Welfare and Institutions Code §§ 300; 300.5).

How Common Is Child Physical Abuse?

According to the most recent figures available from the National Child Abuse and Neglect Data System (NCANDS), approximately 3.2 million children were reported for abuse to CPS in 2014. This number has remained remarkably stable for the last several years. Twenty years ago, for example, 3.14 million suspected cases of abuse were reported to CPS (U.S. DHHS, 2016). Keep in mind that this figure also includes reports of *suspected* cases and includes all forms of abuse (including physical and sexual abuse, neglect, and psychological maltreatment). If we consider only substantiated cases (e.g., upon investigation CPS concluded the children were indeed victimized), include only physical abuse cases, and standardize by population size, rates of physical abuse are approximately 3 per 1,000 children; this is a significant decrease from 20 years ago, when the rate was over 7 per 1,000 children (Finkelhor, Saito, & Jones, 2016; U.S. DHHS, 2016). Approximately 17 percent of all substantiated maltreatment reports were instances of CPA in 2014 and approximately 1,580 children died as a result of child abuse and neglect, with approximately 41 percent of those deaths a result of physical abuse exclusively or physical abuse in combination with some other type of maltreatment (U.S. DHHS, 2016).

The National Incidence Studies (NIS), conducted by the National Center on Child Abuse and Neglect, are a broader measure of the incidence of child abuse and neglect because they are designed to measure not only reports to CPS agencies, but also the number of cases of CPA reported to police and sheriff's departments, schools and day care centers, hospitals, and other mental health and social service agencies. Between the first NIS (known as NIS-1), the results of which were published in 1981, and NIS-3, which was published in 1996, the reporting of CPA steadily increased, from 3.1 to 9.1 per 1,000 children. The most recent National Incidence Study (NIS-4) published in 2010, however, shows an overall decrease in the general incidence of CPA for a rate of 6.5 per 1,000 children (Sedlak, Mettenburg, Basena, Petta, McPherson, Greene, & Li, 2010). These trends are discussed further in Chapter 11.

Probably the most significant self-report perpetration survey, at least from a historical perspective, is the National Family Violence Survey, a telephone survey that used the Conflict Tactics Scales (CTS; Gelles & Straus, 1987, 1988). Parents reported on the conflict techniques they used with their children in the past year, selecting their responses from a scale that ranged from mild forms of violence (e.g., slapped or spanked child) to severe forms of violence (e.g., beat up child, burned or scalded child, used a knife or gun). Some 75 percent of parents admitted to having used at least one violent act while rearing their children. Approximately 2 percent of the parents had engaged in one act of abusive violence (i.e., an act with a high

probability of injuring the child) during the year prior to the survey. The most frequent type of violence in either case was slapping or spanking the child; 39 percent of respondents reported slapping or spanking their children more than 2 times in the previous year.

Recall from Chapter 2 that the original CTS was designed to measure violence between adult intimates. Straus and colleagues (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998) used a redesigned CTS, the Parent–Child Conflict Tactics Scales (CTSPC), to estimate child abuse in a nationally representative sample of 1,000 parents. Two-thirds of the parents surveyed reported using at least one physically violent tactic during the previous year, and three-fourths reported using some method of physical violence during the rearing of their children. Most of the reporting of physical violence by parents involved acts considered minor assaults, such as spanking, slapping, and pinching. As Straus and his colleagues point out, however, although the majority of physical assaults were in the minor assault category and included corporal punishment tactics, *nearly half* of all the parents surveyed said that they had engaged in behaviors from the severe physical assault subscale at some point during their parenting. These behaviors included hitting the child with an object such as a stick or belt, slapping the child on the face, hitting the child with a fist, kicking the child, and throwing or knocking down the child. Each of the very severe physical assault tactics (e.g., beating up or burning the child or threatening the child with a knife or gun) was used by less than 1 percent of the sample.

Self-report victimization surveys ask adults to report on their own childhood experiences with various forms of physical violence from adult caretakers. The National Violence Against Women Survey was conducted from 1995 to 1996 (Tjaden & Thoennes, 2002). In this telephone survey, a random U.S. sample of approximately 16,000 adults (8,000 women and 8,000 men) responded to a modified version of the CTS. The adult respondents were asked to report on the kinds of physical assaults they had experienced as children at the hands of their adult caretakers. Nearly half reported having experienced at least one physical assault by an adult caretaker, with the acts of violence ranging from relatively minor forms of assault (e.g., being slapped or hit) to more severe forms of assault (e.g., being threatened with a knife or gun). Men were at greater risk than women of having experienced these forms of violence.

The second National Survey of Children's Exposure to Violence (NatSCEV II), which used the Juvenile Victimization Questionnaire (see Chapter 2), measured victimization in a nationally representative sample of approximately 4,500 American children from ages 1 month to 17 years (parents or caregivers responded to questions for children under the age of 10) (Finkelhor, Turner, Shattuck, Hamby, & Kracke, 2015). Findings indicated that approximately 14 percent of the youth and parents surveyed reported some experience of child maltreatment (i.e., physical abuse, psychological/emotional abuse, neglect, or sexual abuse) in the previous year and nearly 26 percent reported experiencing child maltreatment at some point during their lifetime. For the oldest children, those 14–17 years old, the lifetime prevalence rates jump to 41 percent. In terms of physical abuse specifically (defined as being hit,

beaten, or kicked), approximately 4 percent of the sample reported such experiences in the past year and about 10 percent reported experiencing physical abuse over their lifetime. The rates of maltreatment in NatSCEV II are slightly higher than in NatSCEV I, but the differences are not statistically significant (Finkelhor, Turner, Shattuck et al., 2015).

Risk Factors Associated With Child Physical Abuse

What specific characteristics and traits are common among physically abused children and the adults who perpetrate violent acts against them? In the sections that follow, we hope to shed some light on the most common characteristics of child victims and adult perpetrators of CPA to help inform our understanding of **risk factors** associated with both physical violence perpetration and victimization. These risk factors are discussed below and summarized in Table 3.1. Research examining these characteristics has demonstrated the heterogeneity of both victim and offender populations, suggesting that although there are some characteristics associated with higher risk, CPA can ultimately occur in any family.

Characteristics of Children Who Are Physically Abused

Data from official reports (U.S. DHHS, 2016), the National Incidence Studies (NIS-4; Sedlak et al., 2010), and self-report surveys such as the NatSCEV II (e.g., Finkelhor, Turner, Shattuck, & Hamby, 2015) indicate that the risk of CPA increases with age. It is hard to know how to interpret these data, however, because we would fully expect significant *underreporting* for very young children. The NIS data, for example, come from mandated reporters. As children grow they become more visible, and their abuse would presumably become more visible to mandated reporters. For self-report surveys, like the NatSCEV, it is actually the parents who provide the information on abuse for children under the age of 10, and they might obviously be reluctant to do so. We become especially suspicious of the data when we examine child fatalities. Recall from earlier discussions that the dark figure for fatalities is small. Most homicides are recorded. When we look at fatalities data, we find that it is *young children* who are at most risk. Almost three-fourths of child fatality victims are under the age of 3 (U.S. DHHS, 2015). This leads us to speculate that, despite what we generally see in the child abuse data, it is actually young children who are most at risk.

In terms of sex, self-report surveys indicate that males are at slightly greater risk for CPA than females. The NatSCEV II, for example, found that boys experienced significantly higher rates of CPA compared to girls both in the past year (4.5% vs. 2.9%) and during their lifetime (11% v. 8.1%) (Finkelhor, Turner, Shattuck, Hamby, & Kracke, 2015).

Official reports suggest that CPA occurs more commonly among some ethnic/racial groups. When considering physical abuse only, the following ethnic and racial

groups have been represented among substantiated CPA victims: Hispanic children (19%), Asian children (16.6%), black children (14%), Pacific Islanders (11.5%), white children (10.3%), and American Indians or Alaska Natives (7.3%) (U.S. DHHS, 2005). Results from the first three NIS, which are generally subject to fewer reporting biases, indicated an absence of race differences in rates of CPA (Sedlak & Broadhurst, 1996; U.S. DHHS, 1981, 1988); however, the most recent NIS-4 found that the incidence of CPA was higher for blacks and Hispanics compared to white children (Sedlak et al., 2010). Furthermore, both black and Hispanic children were at greater risk of suffering serious harm and injury relative to whites. It is difficult to interpret findings related to race and ethnicity because such differences may be related to socioeconomic status (SES), with a disproportionate likelihood of nonwhite children living in poverty.

Many researchers in the field of CPA have argued that special characteristics may put some children at increased risk for abuse and neglect. Several studies, for example, have found an association between CPA and birth complications such as low birth weight and premature birth (J. Brown, Cohen, Johnson, & Salzinger, 1998; DiScala, Sege, Li, & Reece, 2000). Research findings have also implicated physical, cognitive, and developmental disabilities as risk factors for CPA (e.g., Duan et al., 2015; L. Jones et al., 2012; Roberts, Koenen, Lyall, Robinson, & Weisskopf, 2015) (see Chapter 10 for a discussion of abuse in adults with disabilities). Parents of these special needs children may become frustrated by the challenges such children present and therefore become more punitive in their parenting. Such children may be more hyperactive, oppositional, noncompliant, and socially impaired, and parents may not feel that they can either successfully reason with or be understood by such children (Helton & Cross, 2011; Roberts et al., 2015). Although some research has failed to find any evidence that either prematurity or disabilities are risk factors for abuse, or increase a child's risk above and beyond parental characteristics (e.g., parental employment, SES) (e.g., Sedlak et al., 2010), this lack of findings could be due, in part, to the failure of child protection workers to recognize and document disabilities in child abuse cases (Algood, Hong, Gourdine, & Williams, 2011) or to variations in the way states define and collect data on child maltreatment (Child Welfare Information Gateway, 2012b).

Characteristics of Adults Who Physically Abuse Children

Who are the adults who physically abuse children? Official statistics indicate that the maltreated child's parents are the perpetrators of the abuse in the majority of reported cases (78%; U.S. DHHS, 2016). Official statistics are difficult to interpret, however, because many states, by definition, report only those child abuse cases in which perpetrators are in primary caretaking roles. In the NIS-4, a **primary caregiver** was defined as "an adult in charge of the child's care (such as a parent, adult baby-sitter, etc.) or, if the abuser did not meet this requirement, then a parent or caregiver had to permit the abuse of the child" (Sedlak et al., 2010, pp. 6–11). Using this broader NIS-4 definition, 72 percent of perpetrators of CPA were biological parents, 19 percent were nonbiological

Table 3.1 Characteristics of Children Who Are Physically Abused and the Adults Who Abuse Them

Child Characteristics	**Examples**
Demographic factors	Young age
	Male sex
Special characteristics	Birth complications
	Physical, cognitive, and developmental disabilities
Adult Characteristics	**Examples**
Mental health and behavioral difficulties	Self-expressed anger and anger control problems
	Depression
	Low frustration tolerance
	Low self-esteem
	Rigidity
	Deficits in empathy
	Anxiety
	Perceived life stress and personal distress
	Substance abuse/dependence
	Reports of physical health problems and disabilities
Biological factors	Physiological overreactivity
	Neuropsychological deficits and intellectual impairment (e.g., problem solving, conceptual ability)
Parenting deficits	Disregard for children's needs/abilities
	Unrealistic expectations of children
	Deficits in child management skills
	View of parenting role as stressful
	Negative bias/perceptions regarding children
	Poor problem-solving ability with regard to child-rearing
	Intrusive/inconsistent parenting
	High rates of verbal and physical aggression toward children
	Living with a single parent, unmarried parents, in a large family

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Table 3.1 (Continued)

Adult Characteristics	Examples
Economic and family contextual factors	Poverty, low socioeconomic status
	Spousal disagreement, tension, abuse
	Parental history of abuse in childhood
	Deficits in positive interactions with children and other family members
	Verbal and physical conflict among family members
	Deficits in family cohesion and expressiveness
	Isolation from friends and the community

SOURCES: A representative but not exhaustive list of sources for the information displayed in this table includes the following: Berkout & Kolko, 2016; Caselles & Milner, 2000; Chaffin et al., 2004; Crouch, Milner, & Thomsen, 2001; Éthier, Couture, & Lacharite, 2004; S. Graham, Weiner, Cobb, & Henderson, 2001; Hartley, 2012b; T. Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008; Jouriles, McDonald, Smith Slep, Heyman, & Garrido, 2008; Kelleher et al., 2008; Mammen, Kolko, & Pilkonis, 2003; Milner, 2003; Sedlak et al., 2010; Timmer, Borrego, & Urquiza, 2002; U.S. Department of Health and Human Services (DHHS), 2016.

parents, and 9 percent were other individuals (e.g., babysitters, nonparent family members). The severity of injury or harm resulting from the abuse differed significantly depending on the perpetrator of the abuse. Physically abused children were more likely to sustain severe harm when someone other than a parent or parent figure perpetrated the abuse, while they were more likely to sustain moderate harm when either their biological or nonbiological parent physically abused them.

It is important to note that in some cases, siblings have been identified as perpetrators of CPA (L. Jones et al., 2012). Research demonstrates, in fact, that violence between siblings is one of the most common forms of interpersonal violence. Straus, Gelles, and Steinmetz (1980) found that 82 percent of American children with siblings between the ages of 3 and 17 years engaged in at least one violent act toward a sibling during the one-year period preceding the survey. Because sibling violence is so common it is sometimes rationalized as harmless "sibling rivalry." A number of family violence experts, however, strongly disagree, and argue that sibling violence should be recognized as one of the most serious forms of family violence *because* it is so common (Finkelhor, 2008). This issue is discussed further in Chapter 11.

In terms of perpetrator sex, CPS receives slightly more reports of child maltreatment perpetrated by females (54% female and 45% male; U.S. DHHS, 2016). One likely explanation for this is that mothers spend more time with their children than do fathers (U.S. DHHS, 2016). The sex distribution of CPA perpetrators in particular may depend, however, on the specific relationship between perpetrator and child. The NIS-4, for example, found that children who had been physically abused by biological parents were more likely to be abused by mothers (56%) than by fathers (48%),

but the reverse was true when the perpetrators were nonbiological parents or parent substitutes (74% male and 29% female; Sedlak et al., 2010).

Mental Health and Behavioral Difficulties

In the case example that opened the chapter, we saw that part of the mother's explanation for her boyfriend's abusive behavior toward Kevin was attributed to his "short temper," or anger control problems. Studies comparing nonabusive parents with physically abusive parents have identified several mental health and behavioral problems typical of abusive parents, including not only anger control problems, but hostility, low frustration tolerance, depression, low self-esteem, substance abuse or dependence, deficits in empathy, and rigidity (e.g., Berkout & Kolko, 2016; Mammen, Kolko, & Pilkonis, 2003). Many studies have also found that physically abusive adults report more anxiety, life stress, and personal distress than do nonabusive adults (e.g., Chan, 1994; Whipple & Webster-Stratton, 1991). Such negative emotional and behavioral states may increase the risk of CPA by interfering with the ways these parents perceive events, by decreasing their parenting abilities, or by lowering their tolerance for specific child behaviors (Hillson & Kupier, 1994; Lahey Conger, Atkeson, & Treiber, 1984; Milner, 2003). In some cases, the CPA perpetrated by adults with mental health issues is unintentional, as is the case when mothers are suffering from **postpartum depression (PPD)**. In one case a woman with PPD tried to drown her 4-month-old twin babies in a bathtub; she received probation and was required to obtain psychiatric care because the judge recognized that her PPD led to her behavior (Carter, 2016).

Biological and Physical Risk Factors

Research suggests that some physically abusive parents possess a physiological trait that predisposes them to hyperreactive responses (or heightened physiological reactions) to stressful stimuli such as a crying child. Frodi and Lamb (1980), for example, conducted one of the seminal studies in this area by measuring the physical responses of physically abusive mothers and a control group of nonabusive mothers. The two groups of mothers were presented with three videotapes: one showing a crying infant, one showing a quiet but alert infant, and one showing a smiling infant. Comparisons revealed that although both the abusive and the nonabusive mothers responded to the crying infant with increased heart rate, blood pressure, and skin conductance, the abusive mothers displayed greater increases in heart rate. In addition, only the abusive mothers showed increased physiological reactivity in response to the smiling infant, suggesting that abusive parents may view their children as aversive regardless of how the children behave.

These findings have been replicated in studies comparing nonabusive but high-risk participants with low-risk participants and in studies using stressful non-child-related stimuli (e.g., Crowe & Zeskind, 1992; McCanne & Hagstrom, 1996). Although it appears that abusive parents exhibit a general physiological overreactivity, it is unclear exactly how this pattern contributes to parents' physical maltreatment of their children.

It may be that heightened physiological reactivity influences the way a parent cognitively processes or perceives a child's behavior or the way a parent subsequently reacts to a child (Milner, 2003). It is also difficult to determine whether this physiological pattern is the result of a genetic trait or environmental event that predisposes parents toward abusive behavior or whether the physiological pattern develops as a *result* of continuing negative parent–child interactions.

Several studies that have evaluated additional physical risk factors have demonstrated that adults who abuse children report more health problems and physical disabilities than do nonabusing adults (e.g., Lahey et al., 1984). Other research has found evidence that particular neuropsychological factors are characteristic of physically abusive parents. Physically abusive adults demonstrate intellectual impairment and deficits in problem-solving skills (Cantos, Neale, O'Leary, & Gaines, 1997; Éthier, Couture, & Lacharite, 2004). Nayak and Milner (1998) found that mothers at high risk for CPA performed worse than mothers at low risk for CPA on measures of problem-solving ability and conceptual ability as well as on measures of cognitive flexibility. Researchers need to evaluate the variables of physical health and neurological functioning further before they can determine the precise nature of the link between biological risk factors and CPA.

Parenting Deficits

Compared with nonabusive adults, abusive individuals have been found to have unrealistic expectations and negative perceptions regarding their children (Azar, 1997; Milner & Robertson, 1990; Peterson & Gable, 1998). Such parents often regard their children as bad, slow, or difficult to discipline and view their children's behavior as if it were intended to annoy them. An abusive parent may expect a child to be toilet trained at an unreasonably early age, for instance, and so interpret the child's soiling of their diapers as deliberate misbehavior.

Several studies have found that abusive parents tend to view the parenting role as stressful and dissatisfying and that such parents exhibit numerous deficits in child management skills (Berkout & Kolko, 2016; McPherson, Lewis, Lynn, Haskett, & Behrend, 2009). Compared with nonabusive parents, physically abusive parents interact with their children less; when they do interact with their children, they display higher rates of directive, critical, and controlling behavior and a higher frequency of verbal and physical aggression (Chaffin et al., 2004). Tuteur, Ewigman, Peterson, and Hosokawa (1995) observed mother–child dyads at a public health clinic, with each dyad spending 10 minutes in a private room equipped with toys, a table, and paper and crayons. The researchers asked each mother to sit at the table with her child, who was allowed to use the paper and crayons but was not permitted to play with the toys. They found that abusive mothers, compared with nonabusive mothers, used more negative and rigid control (e.g., chased child under the table) rather than positive control (e.g., comfortably directed child) and made requests of their children that were either neutral (e.g., "Keep going") or negative (e.g., "Draw a circle right now") rather than positive (e.g., "Can you please draw a circle for Mommy?").

Economic and Family Contextual Risk Factors

In addition to psychological, biological, and health risk factors, broader contextual conditions serve as risk factors for CPA. According to the NIS-4, children living with two biological parents are significantly less likely to be victims of CPA (2 per 1,000 children) than are children living with a single parent (6 per 1,000 children), with unmarried parents (8 per 1,000), with other married parents such as a biological parent and stepparent or adoptive parent (10 children per 1,000), and with single parents with an unmarried, live-in partner (20 children per 1,000). There is also some evidence that children from larger families are at greater risk (Sedlak et al., 2010). It is difficult to know the causal significance of these various family structures because other relevant factors, such as rates of poverty and stress, are also common in such families.

CPA occurs more often, for example, among economically and socially disadvantaged families (Sedlak et al., 2010; U.S. DHHS, 2016). The NIS-4 found that children living in poverty, defined as those living in households with an income below $15,000 a year, parents' highest education level less than high school, or any member of the household being a participant in a poverty program (e.g., food stamps, public housing, energy assistance, or subsidized school meals), were 3 times more likely to be at risk for CPA by the harm standard as well as the endangerment standard (Sedlak et al., 2010). A clear association between income inequality and substantiated child maltreatment has also been found, suggesting an impact of low income that extends beyond child poverty (Eckenrode, Smith, McCarthy, & Dineen, 2014). Low income also appears to be related to the severity of abuse, with serious or fatal injuries being more likely among families with annual incomes below the poverty level (e.g., Pelton, 1994; Sedlak et al., 2010).

Lack of financial resources, in turn, likely contributes to a number of parental stressors including an inability to provide adequate food, shelter, health care, child care, and education for their children. The mechanisms through which low income and its related stressors increase risk of child maltreatment are not well understood. It may be that these stressors impact the way parents relate to their children, increasing negative forms of parenting (Duva & Metzger, 2010). Another possibility is that low income is associated with other conditions that are associated with increased risk of child maltreatment such as single parenthood, high-crime neighborhoods, poor physical health, and increased risk for substance-use problems and mental health problems (Cancian, Clack, & Yang, 2010; Prinz, 2016; Torquati, 2002). The stress of single parenting, for example, in combination with low income, may lead to child maltreatment.

CPA is also associated with a variety of family struggles and dysfunctions. Risk factors include social isolation from other family members and friends, family conflict and lack of positive interactions, and domestic violence. Perpetrators of CPA, for example, report more social isolation, limited support from friends and family members, and loneliness than do nonperpetrators (e.g., Chan, 1994; Coohey, 2000; Kelleher, Chaffin, Hollenberg, & Fischer, 1994). Abusive and high-risk individuals also report more verbal and physical conflict among family members, higher levels of spousal disagreement and tension, and greater deficits in family cohesion and expressiveness

(e.g., Justice & Calvert, 1990; L. Merrill, Hervig, & Milner, 1996; Mollerstrom, Patchner, & Milner, 1992). In addition, abusive parents engage in fewer positive interactions with their children, such as playing together, providing positive responses to their children, and demonstrating affection (e.g., Alessandri, 1991; Bousha & Twentyman, 1984; Lahey et al., 1984). Indeed, there is evidence of disruption in the parent–child bond, reflecting **insecure attachment style** (e.g., increased avoidance of and resistance to the parent) in infants exposed to CPA (Cicchetti & Toth, 1995) as well as **disorganized attachment** (having no organized strategy to secure safety when frightened) (Barnett, Ganiban, & Cicchetti, 1999). For these children, the parent–child relationship presents an irresolvable paradox, because the caregiver is at once the child's source of safety and protection and the source of danger or harm (Hesse & Main, 2000).

Studies have also demonstrated a significant relationship between the occurrence of CPA and more extreme forms of family conflict such as domestic violence between parents (Hartley, 2012b). Some studies also suggest that abusive parents are more likely to report their own childhood abuse compared to nonabusive parents, suggesting that intergenerational transmission of abuse may occur in some of these families. Kim (2009), for example, analyzed data from the National Longitudinal Study of Adolescent Health and found that parents who reported having been slapped, hit, or kicked by parental figures during childhood were 5 times as likely to report engaging in similar parenting behaviors with their own children than were parents who did not report physically abusing their children. Other studies have failed to find evidence for intergenerational transmission or have found evidence for transmission of neglect and sexual abuse but not CPA (Renner & Slack, 2006; Widom, Czaja, & DuMont, 2015). Findings appear to vary depending on the source of information used to determine maltreatment, such as parents versus their children and CPS records versus self-report (Widom et al., 2015).

Consequences Associated With Child Physical Abuse

Children who experience physical maltreatment are more likely than their nonabused counterparts to exhibit physical, behavioral, and mental impairments. In some cases, the negative consequences associated with abuse continue to affect these individuals well into adulthood. Table 3.2 displays the most frequently reported problems associated with CPA for children as well as adolescents and adults, which are discussed below.

The Negative Effects of Child Physical Abuse

Isolating the effects of CPA is very complicated. As we have discussed, CPA typically accompanies other problems within the family or environment, such as marital violence, alcohol or drug use by family members, parental depression, psychological maltreatment, and low SES. It is therefore difficult to conclude with any certainty that the psychological problems associated with CPA result solely—or even primarily—from violent interactions between parent and child. For example, imagine that you are

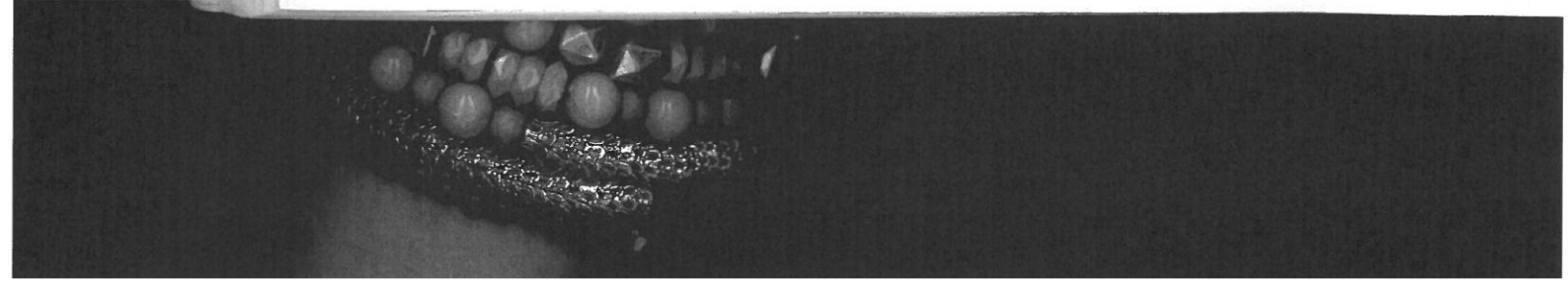


Table 3.2 Possible Effects Associated With Physical Child Abuse for Children and Adolescents and Adults

Age Group	Effects	Examples
Children	Medical and neurobiological complications	Bruises; traumatic brain injury and neurological impairment; chest, throat, and abdominal injuries; bites and burns; fractures; compromised brain development; visual deficits; sleep disorders; alteration of biological stress system
	Cognitive deficits	Decreased intellectual and cognitive functioning; deficits in verbal abilities, memory, problem solving, and perceptual-motor skills; decreased reading and math skills; poor school achievement; increase in need for special education services
	Behavioral problems	Aggression; fighting; noncompliance; defiance; property offenses; arrests; delinquency
	Socioemotional deficits	Delayed play skills; infant attachment problems; poor social interaction skills; peer rejection; deficits in social competence with peers; avoidance of adults; difficulty making friends; deficits in positive social behaviors; hopelessness; anxiety; depressive symptoms; suicidal ideation and behavior; low self-esteem; post-traumatic stress symptoms
	Psychiatric disorders	Major depressive disorder; oppositional defiant disorder; conduct disorder; attention-deficit/hyperactivity disorder (ADHD); borderline personality disorder; post-traumatic stress disorder (PTSD)
Adolescents and adults	Criminal/ antisocial/ violent behavior	Arrests for delinquency; violent and/or criminal behavior; marital violence (for adult males); received and inflicted dating violence; physical abuse of own children; aggression; prostitution
	Substance abuse	Abuse of alcohol; illicit drug use and addiction; polydrug use
	Mental health problems	Self-destructive behavior; suicidal ideation and behavior; anxiety; anger and hostility; dissociation; depression and mania; unusual thoughts; narcissistic vulnerability; shame-proneness; interpersonal difficulties; poor self-concept
	Psychiatric disorders	Antisocial and other personality disorders; ADHD; major depressive disorder; bipolar disorder, PTSD
	Physical health problems	Obesity; chronic pain

SOURCES: A representative but not exhaustive list of sources for information displayed in this table includes the following: Alvarez-Alonso et al., 2016; Baer & Martinez, 2006; R. Berger & Bell, 2014; Currie & Tekin, 2012; Fuller-Thomson & Lewis, 2015; Gilbert, Widom, Browne, Fergusson, Webb, & Janson, 2009; Gold, Sullivan, & Lewis, 2011; Greger, Myhre, Lydersen, & Jozefiak, 2015; Keene & Epps, 2016; Kleinman, 2015; Klika, Herrenkohl, & Lee, 2012; Lee, Herrenkohl, Jung, Skinner, & Klika, 2015; Lind et al., 2016; Miller-Perrin, Perrin, & Kocur, 2009; Nance & Cooper, 2009; Ouyang, Fang, Mercy, Perou, & Grosse, 2008; Reece, 2011; Rouse & Fantuzzo, 2009; Runyon, Deblinger, & Schroeder, 2009; Runyon, Deblinger, & Steer, 2010; Sachs-Ericsson et al., 2010; R. Schneider, Baumrind, & Kimerling, 2007; Thomas, Hyponnen, & Power, 2008.

working with Kevin from the opening case example. In assessing the family, you would find that he is having trouble in school (a possible negative effect of CPA). But Kevin is also from a very poor family and regularly witnesses violence between his mother and her boyfriend when Sam has been drinking heavily. Determining which factors (or combination of factors) are responsible for the school problems is a difficult task. Fortunately, research has become increasingly sophisticated, and as a result we know more than we ever have about the negative effects of CPA (e.g., Font & Maguire-Jack, 2016; Klika, Herrenkohl, & Lee, 2012).

One of the most frequent outcomes associated with CPA in children are *medical and neurobiological problems*. The medical consequences of CPA are numerous and range from minor physical injuries (e.g., bruising) to death (see Box 3.2 on child maltreatment fatalities). Several neurobiological consequences are associated with CPA, including structural and functional brain changes and alterations of systems within the body involved in emotion, executive control, and the stress response (for a review see Hart & Rubia, 2012). In one seminal study, for example, researchers found that a sample of physically and sexually abused children exhibited greater concentrations of urinary dopamine, norepinephrine, and free cortisol than did children in a control group (De Bellis et al., 1999). They also found that a number of specific brain regions were smaller in the abused children. Several other studies are consistent with these results in finding compromised brain development and impairment in the **hypothalamic-pituitary-adrenal (HPA) axis** (a neurobiological system involved in the stress response system of the body) associated with various forms of abuse and neglect (Edmiston et al., 2011; Hart & Rubia, 2012). Changes in neurobiological systems, such as the HPA axis, can have negative impacts on the physical and cognitive development of maltreated children as well as on their ability to regulate both emotional and behavioral responses. Indeed, victims of CPA exhibit deficits in language skills, memory, spatial skills, attention, sensorimotor functioning, cognitive processing, physiological functioning, and overall intelligence (Hart & Rubia, 2012). Research findings also suggest that child abuse might influence the way our genes function, turning on or off the action of some genes, and influencing how susceptible a child is to negative behavioral, psychological, and health outcomes associated with abuse (McCrory, De Brito, & Viding, 2012; Yang et al., 2013).

Box 3.2 What Can Be Done to Prevent Child Fatalities?

NCANDS data indicate that an estimated 1,580 children died in 2014 as a result of child abuse. The two most common causes of death were neglect (72%) and physical abuse (41%). Most of these children were very young (71% under the age of 3) and most were killed by their parents (79%). More than half (54%) of the perpetrators were women (U.S. DHHS, 2016). According to the U.S. Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF, 2016), established by the

Protect Our Kids Act in 2013, although the overall safety of children has increased in the United States, child fatalities are *not* declining and somewhere between 1,500 and 3,000 U.S. children will die each year from maltreatment. In the report, the chairperson of the commission ironically notes that "Child protection is perhaps the only field where some child deaths are assumed to be inevitable, no matter how hard we work to stop them. This is certainly not true in the airline industry, where safety is paramount and commercial airline crashes are never seen as inevitable" (p. 11).

There are few things more tragic than a child who is killed by a parent or caregiver. Inevitably, we must come to grips with the fact that we—society—failed that child. But where and when did we fail the child? At the very least we must acknowledge that we failed to notice what, presumably, would have been warning signs. Children with prior allegations of child maltreatment died from intentional injuries at a rate 5.9 times greater than children not reported for child maltreatment and the risk was greater for victims of CPA compared to neglect (Putnam-Horenstein, 2011; Putnam-Horenstein, Cleves, Licht, & Needell, 2013). An estimated 30–50 percent of children killed by parents or caretakers were killed after they had been identified by child welfare agencies (Wang & Daro, 1996, 1998). In some cases (12% in 2014), the family had received preservation services from CPS in the previous five years. Most troubling of all, 19 children died in 2014 after spending time in foster care and being reunited with their abusive families (U.S. DHHS, 2016). Not every child death, of course, is evidence of a faulty child protection system. But 1,500 child abuse deaths are too many, and must be addressed.

According to the CECANF (2016), the answer to preventing child fatalities lies not in simply improving the current system of child protection, but in requiring fundamental reform such as a national strategy to create a reinvigorated child welfare system. Such reform would include CPS agencies as leaders in the effort to respond quickly but would also include expanding responsibility for child safety to additional community partners who come into contact with families (e.g., health care and public health agencies and professionals). In addition, the commission recommended greater sharing of CPS data on families, both electronically and in real time, to enhance CPS response, as well as increased identification of children and families at greatest risk for child maltreatment fatality by retrospectively reviewing child fatality cases over the past five years.

What else can be done to help prevent fatalities? One response that has been helpful is the establishment of **child fatality review teams** (Krugman & Lane, 2014; Palusci & Covington, 2014). Such teams are typically composed of community professionals representing multiple agencies who retrospectively review the circumstances under which a child died, including interviewing family members, teachers, neighbors, and others, in order to reconstruct the circumstances and events that may have contributed to the death. Although the functions of these teams vary, typically they identify the prevalence of deaths from abuse and neglect, improve the policies and procedures of CPS to prevent future child deaths and serious injuries, protect siblings of children whose causes of death are unexplained, and increase professional and public awareness of child death due to maltreatment (Block, 2002; Durfee, Durfee, & West, 2002). One study found a 9 percent decrease in the number of child deaths associated with child fatality review team activities (Palusci, Yager, Covington, 2010). Other suggestions for preventing child fatalities include parent education during the newborn period (see Box 3.1); support for new, especially high-risk, parents through home visitation programs (see Chapter 5); and community involvement in promoting healthy families (CECANF, 2016; Krugman & Lane, 2014).

Studies have shown that physically abused children exhibit *cognitive problems* such as lower intellectual and cognitive functioning relative to comparison groups of children on general intellectual measures as well as on specific measures of verbal facility, memory, **dissociation** (separation of normally related mental processes), verbal language, communication ability, problem-solving skills, and perceptual-motor skills (e.g., Hart & Rubia, 2012). Physically abused children also perform relatively poorly in school, receive more special education services, score lower on standardized tests, have more learning disabilities, and are more likely to repeat a grade (e.g., Rouse & Fantuzzo, 2009; Stone, 2007). These effects persist even after controlling for potential extraneous variables like socioeconomic disadvantage (Kurtz, Gaudin, Wodarski, & Howing, 1993). The cognitive deficits that have been observed in physically abused children may be the result of direct physical injury (e.g., head injury), environmental factors (e.g., low levels of stimulation and communication), or a combination of both.

Physically abused children also suffer from a variety of *behavioral and socioemotional problems*. Abused youth have been found to show more **externalizing behavior problems** such as aggression and antisocial behavior than nonabused children, even after the researchers have statistically controlled for the poverty, family instability, and spousal abuse that often accompany CPA (e.g., Fantuzzo, 1990). As illustrated in the case example that opened the chapter, Kevin exhibited many externalizing problems including physically fighting with other children and other acting-out behaviors (e.g., setting fire to objects, skipping school, refusing to do homework, etc.). Physically abused youth also exhibit higher levels of **internalizing behavior problems**, such as anxiety and depression (Dube et al., 2001; Fantuzzo, delGaudio, Atkins, Meyers, & Noone, 1998). Finally, social interaction deficits are common, including difficulty in making friends, deficits in positive social behavior (e.g., smiling), peer rejection, and delays in interactive play skills (e.g., Prino & Peyrot, 1994; Rogosch, Cicchetti, & Abre, 1995).

These various cognitive, behavioral, and socioemotional difficulties may sometimes form a constellation of symptoms characteristic of specific *psychiatric disorders*. Kaplan, Pelcovitz, and Labruna (1999) estimated that approximately 40 percent of CPA victims will meet criteria for major depressive disorders during their lifetimes, and at least 30 percent will meet criteria for disruptive behavior disorders, as Kevin in our case example may, such as **oppositional defiant disorder** or **conduct disorder**. **Post-traumatic stress disorder (PTSD)** is also a common outcome for physically abused children; in one study, 36 percent of CPA victims met criteria for PTSD (Famularo, Fenton, Kinscherff, Ayoub, & Barnum, 1994). A history of CPA has also been associated with **attention-deficit/hyperactivity disorder (ADHD)**, and **borderline personality disorder** (Famularo, Kinscherff, & Fenton, 1991; Ouyang, Fang, Mercy, Perou, & Grosse, 2008).

Studies have also empirically examined the *long-term sequelae* associated with CPA, and the evidence suggests that many of the difficulties that emerge in childhood are also evident in adulthood. Various mental health symptoms, such as higher incidence of self-destructive behavior, suicidal thoughts and behavior, anxiety, anger and

hostility, aggression, depression, and mania, have been observed in adults with CPA histories (e.g., Font & Maguire-Jack, 2016; Gilbert, Widom et al., 2009; Keene & Epps, 2016; Miller-Perrin et al., 2009; Sachs-Ericsson et al., 2010). Psychiatric disorders are also common and include ADHD, personality disorders, major depressive disorder, bipolar disorder, substance abuse, and PTSD (Cohen, Brown, & Smailes, 2001; Font & Maguire-Jack, 2016; Fuller-Thomson & Lewis, 2015; Fuller-Thomson, Mehta, & Valeo, 2014; Sugaya et al., 2012). Many of these impairments that began in childhood and persisted into adulthood were discussed previously as adult risk factors for CPA and therefore may contribute to the intergenerational transmission of violence (Currie & Tekin, 2012).

One of the most widely studied long-term outcomes of child maltreatment is *criminal behavior* (see Allwood & Widom, 2013; Currie & Tekin, 2012; Jung, Herrenkohl, Klika, Lee, & Brown, 2015; Klika, Herrenkohl, & Lee, 2012; Lee, Herrenkohl, Jung, Skinner, & Klika, 2015). Many of these studies utilize longitudinal designs, in which validated cases of child maltreatment are followed over time and compared to individuals matched on key characteristics. Currie and Tekin (2012) argue that there is a unique relationship, in particular, between CPA and criminal activity. These researchers examined 13,509 adolescents who were assessed 3 times over a seven-year period, and their findings indicated that having a parent who ever struck, hit, or kicked them increased the probability of criminal activity, and the effect tended to be greater if the parent struck them frequently. In a longitudinal study that compared adults who had been physically abused as children to a control group matched on age, sex, race, and SES, Widom and Maxfield (2001) reached a similar conclusion: adults who were physically abused as children were much more likely to be arrested for a violent crime. Other cross-sectional studies have focused uniquely on CPA and identified specific interpersonally violent behaviors in adults who were victims of CPA, including being more likely to receive and inflict dating violence (L. Marshall & Rose, 1990; D. Riggs, O'Leary, & Breslin, 1990), becoming perpetrators of CPA as adults (Kim, 2009), and inflicting physical abuse on intimate partners (Gil-González, Vives-Cases, Ruiz, Carrasco-Portiño, & Álvarez-Dardet, 2008).

One topic that has increasingly become the focus of research attention is the adult *health risks* associated with child maltreatment. The **Adverse Childhood Experiences (ACE) Study**, supported by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente, is a population-based effort to assess associations between adverse childhood experiences (e.g., child maltreatment, parental divorce, parental drug and alcohol abuse) and health and well-being in later life (CDC, n.d.a). Results from the ACE study, which frequently focuses on child maltreatment generally as opposed to CPA specifically, suggest that child maltreatment is indeed associated with poor health behaviors and outcomes such as self-rated health and number of health problems, depression, tobacco and alcohol use, and obesity (e.g., Anda et al., 2001; Dube et al., 2001; Felitti et al., 1998). Results from ACE research studies that specifically focus on CPA have also identified negative health effects, as has non-ACE research (Chartier, Walker, & Naimark, 2010; Font and Maguire-Jack, 2016; Schneiderman, Negriff, & Trickett, 2016).

Risk and Protective Factors Associated With Abuse Effects

CPA victims do not respond to being abused in consistent or predictable ways. For some, the effects of their victimization may be pervasive and long-standing, but for many others the effects may be minimally negative or disruptive. What factors might contribute to the variability researchers have found in the effects associated with CPA? To date, we know very little about potential factors that might mediate or moderate the pathway from CPA to abuse effects. Exceptions are beginning to appear that examine such factors (e.g., Keene & Epps, 2016; Klika et al., 2012; Lee et al., 2015).

Not surprisingly, the more severe the abuse, the longer it continues, the more frequent, and the greater the number of subtypes of maltreatment experienced (e.g., physical abuse, sexual abuse, neglect), the more negative the outcome for the child (e.g., Currie & Tekin, 2012; Sachs-Ericsson et al., 2010; Sugaya et al., 2012). Research from the ACE studies also confirms the cumulative effects of adverse childhood experience on health problems (e.g., Chartier, Walker, & Naimark, 2010).

The child's *perceptions* of the abuse may also serve an important mediating role. Brown and Kolko (1999), for example, found that children who tended to blame themselves for the abuse exhibited greater internalizing symptoms such as anxiety and depression. Other studies have suggested that various emotional processes, such as poor emotion regulation, narcissistic vulnerability, and shame-proneness, underlie angry and aggressive behavior in CPA victims (Gratz, Paulson, Jakupcak, & Tull, 2009; Keene & Epp, 2016; Stevens et al., 2013; Teisl & Cicchetti, 2008).

The earlier children experience abuse, the greater the negative effects. Keiley, Howe, Dodge, Bates, and Pettit (2001) evaluated internalizing behavior and externalizing behavior problems in three physical maltreatment groups: children maltreated prior to age 5, children maltreated at age 5 or older, and a nonmaltreated control group. Results indicated that the earlier children experienced harsh physical maltreatment by caregivers, the more likely they were to experience adjustment problems in early adolescence. In addition, the children maltreated prior to age 5 demonstrated higher levels of both internalizing and externalizing behavior problems, while the children maltreated at age 5 or older experienced higher levels of externalizing problems.

Reports are also beginning to appear that demonstrate the influence of family and sociocultural variables. Some studies find, for example, that the negative effects of abuse are greatest for children in families in which there are high levels of stress, parent–child conflict, and parental mental health problems such as schizophrenia or depression (E. Herrenkohl, Herrenkohl, Rupert, Egolf, & Lutz, 1995; Kurtz, Gaudin, Howing, & Wodarski, 1993; Walker, Downey, & Bergman, 1989). Lee and colleagues (2015) examined peer and partner influences on the pathway between CPA and adult crime as part of the Lehigh Longitudinal Study, which analyzed data from adult participants who were followed from early childhood. These researchers found that CPA predicted adult crime, although indirectly through child and adolescent antisocial behavior, as well as adult partner and antisocial peer influences. The researchers concluded that CPA leads to adult criminal behavior because such experiences trigger

persistent involvement in antisocial behavior throughout one's lifetime, which includes compromised social networks.

Researchers have also begun to examine the role of various protective factors that affect the resilience of individuals who have experienced CPA. Studies have suggested that certain factors, such as high intellectual functioning in the CPA victim (Klika, Herrenkohl, & Lee, 2012) and the presence of a supportive parent figure (E. Herrenkohl et al., 1995), may have a protective influence. In one study, Sachs-Ericsson and colleagues (2010) conducted an analysis of a population sample of more than 1,000 participants aged 50 years or older, who were assessed at two time points, three years apart. The researchers examined the role of self-esteem in explaining the relationship between anxiety and depression and childhood abuse. Findings indicated that abuse had a more negative impact on those with lower self-esteem than those with higher self-esteem, suggesting that self-esteem may serve as a buffer against the negative impact of abuse.

Intervention and Prevention of Child Physical Abuse

Proposed solutions to the CPA problem include both intervention and prevention strategies. Recall from Chapter 1 that intervention refers to strategies designed to treat the problems of abused children or to modify the behaviors of abusive parents. Prevention refers to strategies designed to prevent abuse from occurring in the first place. Although the conceptual distinction between intervention and prevention is clear, in practice, intervention and prevention are overlapping goals in many approaches that attempt to address CPA. In this final section we briefly contemplate how we, as a society, should respond to CPA. How do we address the needs of abused children and the parents who have abused them? How do we attempt to alleviate the occurrence of CPA altogether in our society? Most experts in the field of child maltreatment agree that in order to be successful, strategies for addressing CPA must be broad, aimed at all levels of society (Child Welfare Information Gateway, 2013b; Oates, 2015). Many strategies have been developed, and below we describe these efforts by focusing on physically abused children, their parents, and the communities in which they live. The discussion here focuses on formal programs and strategies; personal responses to address the problem are included in Chapter 11.

Focusing on Physically Abused Children

First and foremost, children who have been identified as physically abused need child protection services. CPS agencies provide a number of different services to children who have been maltreated as well as to those at risk for abuse. Approximately 1.3 million children substantiated for child maltreatment received services in 2014, including foster care, family support, and family preservation services, representing approximately 64 percent of victims (U.S. DHHS, 2016). The role of CPS in providing services to child maltreatment victims will be discussed further in Chapter 5.

One needed intervention for many physically abused children is treatment to address the many consequences associated with abuse that we discussed earlier, including developmental, psychological, and behavioral problems. In the past, physically abused children were not typically referred for treatment because CPA was viewed as a family problem and the individual impact on children was not recognized (Fitzgerald & Berliner, 2012). Today, however, several interventions have been developed and proven effective in treating this group of children including therapeutic day-treatment programs, individual therapy, and group therapy (R. Culp, Little, Letts, & Lawrence, 1991; Runyon, Deblinger, & Steer, 2010; Swenson & Kolko, 2000). Some newer approaches focus on cognitive skills development such as language stimulation (Manso, Garcia-Baamonde, & Alonso, 2011). There is some evidence that these treatment approaches can be successful in decreasing aggressive and coercive behaviors in CPA victims and in improving social behavior, cognitive development, and self-esteem (Fantuzzo et al., 1996; Oates & Bross, 1995; Wolfe & Wekerle, 1993).

The treatment of choice for children who have experienced traumatic events, including physical abuse, however, is some type of trauma-focused therapy that includes cognitive behavioral components that focus specifically on the abuse experience. As summarized by Fitzgerald and Berliner (2012), **cognitive behavioral therapy (CBT)** for abused children includes five components: (1) providing corrective information about abuse, (2) building coping skills to manage stress and regulate emotional distress, (3) achieving mastery over trauma-related memories through gradual exposure, (4) contextualizing and reframing the abuse experience through cognitive restructuring, and (5) enhancing future safety. **Trauma-focused cognitive behavioral therapy (TF-CBT)** is a specific form of trauma-focused therapy and has the greatest evidence of effectiveness to date for children of all ages and across multiple types of child maltreatment (Silverman et al., 2008). Similarly effective approaches have been developed specifically for adolescents (Briere & Lanktree, 2011).

Focusing on Physically Abusive Adults

In previous sections, we described what we know about who is most likely to be abusive and who is most likely to be abused. When we speak of "correlates," or "risk factors," we often find ourselves imagining the "typical" abusive family. It makes sense that we would engage in this typification process, but we must continually remind ourselves that this process is inherently unfair. Abuse can, and often does, occur in unexpected households. Most high-risk households are not abusive. Yet, as we begin to think about prevention and intervention, it seems reasonable to begin with these risk factors. We know, for example, that abusive parents are more likely to be poor and socially isolated, and experience more life stress than other families. Parents have likely experienced or witnessed violence in their own childhoods and demonstrate significant deficits in their own parenting. We also know that the parents in these families often experience multiple problems including substance abuse, mental health disorders, and domestic violence, like the family in our opening case study, which make them unable or unwilling to take care of their children. Several intervention and

prevention approaches have been developed to target specific populations (e.g., abusive parents, young parents, disadvantaged families) and specific risk factors, and these approaches are described below.

Parent Training and Support Efforts

When and how do parents learn how to parent? Perhaps some have taken a class, or read a parenting book. Hospitals send parents home with a list of dos and don'ts, and many offer parents training and support. Most parents, however, were never taught *how* to parent. Most of what parents know they have learned by observation, with the most salient observations likely stemming from how they themselves were parented. Since the 1970s, both intervention and prevention efforts have attempted to provide parents with education and skills training through parent education and support programs. Programs of this kind focus on educating parents about child development, improving parenting skills, modifying attitudes associated with harsh parenting, reducing negative emotions such as anger and stress, and providing settings where parents can share their concerns and work on problem solving with one another (Daro, 2012; Lundahl, Nimer, & Parsons, 2006). Strategies employed include providing parents with written information, video or live demonstrations, training with child discipline experts on increasing child compliance, and role playing and other techniques designed to teach parenting skills (e.g., Daro, 2012). Although most of these programs are intended for high-risk populations, some experts argue that all parents or prospective parents might benefit from this type of education and training (Krug et al., 2002).

One such program is **Incredible Years (IY)**, which targets children with behavior problems and aims to reduce coercive parent–child interactions by providing parents with information about child development along with strategies to enhance parent–child interactions, such as the use of positive discipline, the reduction of negative affect during parenting interactions, and the reinterpretation of negative cognitive attributions about the parent–child relationship (Webster-Stratton, Reid, & Beauchaine, 2011, 2013). Several randomized control trials of IY have found that it is effective at reducing physical punishment and at enhancing parent–child interactions, which in turn leads to improvements in the behavior of young children with oppositional defiant or conduct disorders (Webster-Stratton & Reid, 2010) and attention-deficit/hyperactivity disorder (Webster-Stratton et al., 2011). Several components of these programs have been identified as particularly effective in enhancing parenting skills, reducing risk of abuse, changing attitudes and emotions, and reducing children's problematic behaviors. In a meta-analysis conducted by the Centers for Disease Control and Prevention (2009a), for example, particularly effective components included teaching parents various skills in emotional communication and positive parent–child interactions, as well as providing parents with the opportunity to demonstrate and practice these skills.

Other empirically evaluated parent education and support approaches target the family as a unit, such as integrated parent–child approaches. These interventions focus on both the child and parent, along with their interaction, and constitute a family-oriented

approach that has been used extensively with physically abusive families. Runyon and Urquiza (2011) argue that a coercive parent–child relationship leads to CPA and, as a result, effective treatment needs to address the following four elements: "(1) parenting skills, (2) distorted cognitions/attributions, (3) development of adaptive and nonviolent coping strategies, and (4) development of greater affective regulation" (p. 197).

Several interventions exist that incorporate all four of these elements and are based on the principles of cognitive behavioral therapy. **Alternatives for Families Cognitive Behavioral Therapy (AF-CBT)** is one approach that has been empirically evaluated that targets both physically abusive parents and their children. Kolko (1996b), for example, randomly assigned physically abused children and their parents to either family therapy or separate individual cognitive behavioral treatments for the child and parent, and then compared these two groups with families who received routine community services. Both family therapy and cognitive-behavioral treatment were found to be superior to routine community services in reducing child-to-parent violence, child behavior problems, and parental distress. AF-CBT has also been shown to be effective in reducing levels of parental anger, abuse risk, and re-abuse (Chalk & King 1998; Kolko, 1996a).

In other studies, the effectiveness of **parent–child interaction therapy (PCIT)** has been examined (Chaffin et al., 2004; Chaffin, Funderbunk, Bard, Valle, & Gurwitch, 2011). This form of therapy involves behavioral parent training whereby the parent is coached in parenting skills during live parent–child interactions. Chaffin and colleagues (2004) assigned parent–child dyads to one of three conditions: PCIT only, PCIT with enhanced services (services targeting additional family problems such as parental depression, substance abuse, and marital or domestic violence), or a community parenting group. Families assigned to the PCIT conditions had fewer reports of CPA and greater improvement in parent–child interactions compared to the community parenting condition. Results of several other studies examining the effectiveness of PCIT have indicated it is effective in decreasing child behavior problems, child post–traumatic stress, parental stress, and risk for future abuse (e.g., Borrego, Timmer, Urquiza, & Follette, 2004; Chaffin et al., 2011; Runyon et al., 2010; Timmer, Urquiza, & Zebell, 2006).

Focusing on Communities

As noted in Chapter 1, primary prevention efforts are designed to prevent child maltreatment from occurring in the first place and are often offered at the community level. These prevention strategies are typically designed to improve the larger community environment of children either through wide-scale training, information dissemination, or changes in public policy. Such approaches address the complex and interactive nature of CPA by targeting multiple systems and integrating complementary services. Both theory and research evidence suggest that prevention programs that focus on multiple levels or systems of the ecological model tend to be more effective than programs that focus on a single ecological level (Child Welfare Information Gateway, 2013b; Daro, 2012).

Improving Community Environments

Although enhancing parenting skills, reducing negative parent–child interactions, and decreasing child behavior problems are important intervention and prevention goals, experts also recognize the value in shifting attention from individual- and family-focused strategies to efforts that additionally focus on creating supportive community environments (Daro, 2012; Daro & Dodge, 2009). The intention of such efforts is to create supportive communities where citizens and professionals alike share the belief that keeping children safe from abuse is a collective responsibility and one that requires expanding and coordinating services and support for parents. According to Daro and Dodge (2009), "It is increasingly recognized that environmental forces can overwhelm even well-intended parents, that communities can support parents in their role, and that public expenditures might be most cost-beneficial if directed toward community strategies" (p. 68).

These prevention strategies are typically designed to improve the larger community environment of children through wide-scale dissemination of information, expansion of service and support for parents, and provision of efficient delivery of services. Daro and Dodge identified four intervention strategies often used by community prevention initiatives including: (1) expanding service capacity and access by either offering a new service or by improving families' ability to access services; (2) improving intervention practices by either training providers to deliver services in a unique way or by improving the relationship between provider and participant; (3) improving agency functionality by either altering institutional culture or interinstitutional communication to foster partnerships; and (4) altering community standards to increase mutual reciprocity among neighbors, collective responsibility for child protection and safety, healthy parent–child interaction, and acceptability of seeking services to resolve personal and parenting difficulties.

One of the most widely researched community prevention strategies is the **Triple P—Positive Parenting Program**. Triple P is a multilevel parenting and family support program that was originally developed by a group of researchers at the University of Queensland in Australia. The primary aim of Triple P is to "promote family harmony and reduce parent–child conflict by helping parents develop a safe, nurturing environment and promote positive, caring relationships with their children and to develop effective, non-violent management strategies for dealing with a variety of childhood behavioral problems and common developmental issues" (Turner & Sanders, 2006, p. 184). The program includes a series of five integrated intervention levels of increasing intensity to meet the varying levels of need among families. The interventions focus on positive parenting principles and practices, ranging from broad public or universal forms of dissemination of parenting information (e.g., newspaper articles, radio spots, websites), to brief parenting sessions offered in various primary care facilities for parents needing parenting advice, to more intensive behavioral family interventions for multiple-risk families (Prinz, Sanders, Shapiro, Whitaker, & Lutzker, 2009; Sanders & Prinz, 2012).

A series of controlled outcome studies has demonstrated the effectiveness of the various levels of intervention among a variety of populations and problem areas in

improving the quality of parenting (Prinz et al., 2009; Sanders & Prinz, 2012). In addition, Triple P has proven effective on community-wide outcomes as well. In one study, Prinz and colleagues (2009) randomly assigned 18 counties in South Carolina to either the Triple P program or a control group who received services as usual. Findings suggested a lack of growth in child maltreatment rates in the counties receiving the Triple P program compared to the control counties, which showed considerable growth in substantiated child maltreatment. Other child maltreatment–related indicators (such as out-of-home placements and hospital admissions for child injuries) showed significant decreases in the intervention counties compared to the control counties.

Other community prevention programs take advantage of school-based interventions for preschoolers and school-age children. One promising school-based program is the **Chicago Child–Parent Center program**, which provides preschool education and a variety of family support services for low-income children aged 3 to 9 years (Reynolds & Robertson, 2003). The preschool education component focuses on basic skills in language arts and math, while the family support component includes home visitation, parenting skills, vocational skills, and social supports but primarily focuses on enhancing parental involvement in their children's education. Research evaluating the effectiveness of the Chicago program indicated a 52 percent reduction in court petitions of child maltreatment for children who participated in the Child–Parent Center program compared with children who participated in alternative kindergarten interventions. Among children who attended a Child–Parent Center program, those enrolled for longer periods (e.g., more than four years) experienced lower rates of child maltreatment than those enrolled for a shorter time. In addition, unlike previous studies, the research of Reynolds and Robertson (2003) found that these benefits were maintained. The greatest difference in child maltreatment rates between children who attended a Child–Parent Center program and those who did not, for example, occurred at least six years after the children attended the Chicago program. Components of the program that appear to be particularly salient include family support processes such as increased parent involvement in school and maternal educational attainment as well as decreased family problems (Mersky, Topitzes, & Reynolds, 2011).

Other community prevention programs, such as the **Durham Family Initiative (DFI)**, attempt to expand universal assessments designed to identify families at risk for child maltreatment and then connect them to appropriate community-based services (Dodge et al., 2004). The aim of the initiative is to enhance community social and professional coordination and cooperation to improve a community's ability not only to provide, but also access, evidence-based resources. The effectiveness of this initiative was supported by findings indicating that the rate of substantiated child maltreatment in Durham County decreased by 49 percent between the year prior to the implementation of the DFI program and five years later, compared to 21 percent in five demographically matched comparison counties (Daro & Dodge, 2009).

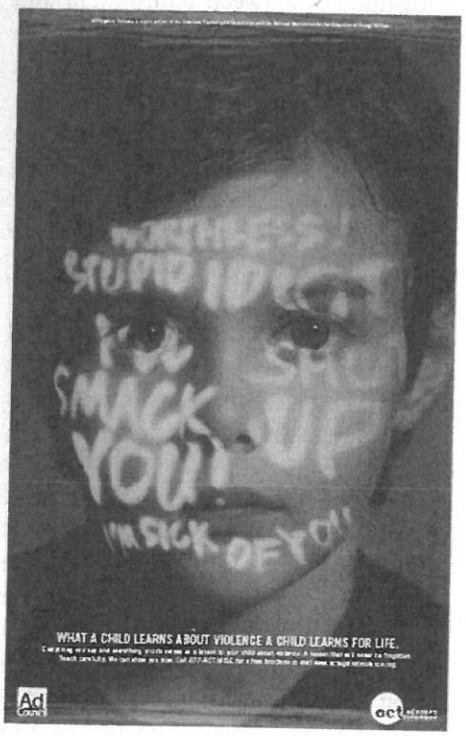
In their review of community child abuse prevention strategies, Daro and Dodge (2009) concluded that these approaches offer reasons for both encouragement and caution. On the one hand, these efforts appear to be promising on both theoretical and

empirical grounds. According to their review, these approaches have been associated with a reduction in reported rates of child maltreatment, injuries to children, and parental stress as well as improvements in parental efficacy and parent–child interactions. On the other hand, this approach requires significant financial resources and it is not yet clear, empirically, that these programs are meeting their goals.

Public Awareness Campaigns

Another approach to the prevention of CPA, and child maltreatment more generally, is that of educating the public about the problem through mass media campaigns. Such campaigns employ public service announcements on radio and television; in newspapers, magazines, and brochures; and on posters and billboards. The rationale behind this approach is that increasing knowledge and awareness about the problem of CPA will result in lower levels of abuse. The reduction of CPA occurs directly, when abusive parents learn that their behavior is inappropriate and take action to change their behavior. Community awareness campaigns may also indirectly reduce rates of abuse as professionals and laypeople begin to recognize the signs and symptoms of CPA and begin reporting suspected abuse to authorities.

Figure 3.1 Example of ACT Media Campaign



SOURCE: Courtesy of the American Psychological Association and the Advertising Council.

The **ACT (Adults and Children Together) Violence Campaign** is an example of a violence prevention media campaign. The goal of the campaign is to raise awareness about adult behaviors that can impact young children for better or worse (ACT Against Violence, n.d.). The media campaign includes public service announcements (see Figure 3.1) that are disseminated via television, radio, and print sources. The message of the campaign is to "teach carefully" because the things that adults say and do in front of children, especially verbally and physically expressing anger and aggression, can affect children's future behavior (ACT Against Violence, n.d.).

Some research evidence indicates that public education campaigns are effective in potentially reducing CPA. Some studies demonstrate evidence, for example, of a link between public education and increased reporting associated with a multimedia campaign conducted in the Netherlands from 1991 to 1992 (Hoefnagels & Baartman, 1997; Hoefnagels & Mudde, 2000). The campaign employed a variety of media and educational efforts, including a televised documentary, televised public service announcements, a radio program, teacher training, and various printed materials (e.g., posters, newspaper articles).

In an evaluation of the campaign, Hoefnagels and Baartman (1997) found that it was effective in increasing awareness of abuse, as shown by the dramatic increase in the number of calls received by a national child abuse hotline in the period after the campaign. Further evidence of the potentially powerful impact of media campaigns comes from universal education programs to prevent shaken baby syndrome, as noted previously (Barr et al., 2009; Dias et al., 2005; see Box 3.1).

Law and Policy

Another strategy in efforts to reduce or eliminate CPA involves criminal justice system responses that target CPA offenders. As noted above, all U.S. states and territories have child abuse statutes that define serious physical abuse as punishable by law (Myers, 2011). Although prosecution of CPA is most often considered to be a tertiary prevention strategy (e.g., it applies after abuse has already occurred), it also has a potential deterrent effect on future acts of abuse and therefore should also be considered a primary prevention strategy. Prosecutors process far more cases of child sexual abuse than cases of CPA (Smith, 1995). This is true due to the significant challenges associated with prosecuting CPA relative to other forms of child maltreatment. Such challenges include the hidden nature of abuse, which makes it difficult to establish proof of what occurred (i.e., who, what, and when), the lack of a clear distinction between punishment and criminal intent to harm a child, difficulties in interpreting medical evidence by both jurors and prosecutors, and lack of experience by prosecutors in handling such cases (Parrish, 2012; Smith, 1995). Since the late 1980s, significant improvements have been made in both the processes of criminal investigation of CPA as well as its prosecution due to increased interdisciplinary training, networking, and professional cross-training among lawyers, social workers, and medical professionals (Parrish, 2012).

In addition to criminal laws that attempt to deter CPA, other policy initiatives have the potential to impact the occurrence of CPA. According to a recent study, for example, paid family leave was associated with reduced risk of abuse-related head injuries in young children (Klevens, Luo, Xu, Peterson, & Latzman, 2016). This study compared data from 1995 through 2011 among California families, where paid family leave was introduced in 2004, with seven states without a paid family leave policy. Not only was there a decline in rates of hospital admission for abuse-related head injuries after 2004, but there was an increase in hospital admission rates for states without paid family leave. In another study, researchers examined the impact of policy associated with child support on likelihood of low-income families being reported for child maltreatment (Slack, Holl, McDaniel, Yoo, & Bolger, 2004). In the experimental group, families were able to receive child support payments with no change in benefits while families in the control group received reduced benefits because of the child support that was required by state policy; thus, the families in the control group experienced modest increases in income. Results indicated that families with modest increases in income were approximately 10 percent less likely to be reported for child maltreatment. The adoption of various policies such as these that enhance income and/or bonding time for parents and infants have the potential to reduce the occurrence of CPA.

Chapter Summary

The physical abuse of children is a complex problem that is not well understood, despite nearly six decades of research. The complexity of CPA is evident in attempts to define what specific circumstances constitute abuse. Although most experts agree that CPA includes a range of behaviors that cause observable harm to children, there is less agreement about the boundary between CPA and normal parenting practices that do not result in observable harm. Despite definitional ambiguities, it is clear that thousands of children are subjected to the harm associated with CPA each year.

Research examining the characteristics of physically abusive adults and physically abused children has demonstrated the heterogeneity of both victim and offender populations, which encompass both sexes and all ages, races, and socioeconomic groups. A number of risk factors, however, have been consistently associated with CPA. Children who are physically abused are often quite young (i.e., 5 years old or younger); children with special needs (e.g., those with physical or mental disabilities) also appear to be at high risk for abuse. Physically abusive adults are found disproportionately among economically disadvantaged groups, and their environments include additional stressors such as having children at a young age and single parenthood. Many adults who inflict violence on children also display other common characteristics, including depression, anger control problems, parenting difficulties, substance abuse problems, family difficulties, and physiological overreactivity.

CPA is associated with a number of negative physical and psychological effects for child victims as well as for adults with childhood histories of CPA. These consequences affect a variety of areas of functioning, including physical, emotional, cognitive, behavioral, and social domains. The experience of CPA, however, does not affect all victims in the same way. Specific factors can mediate the effects of CPA; for example, factors associated with increased negative impact of CPA include the severity of abuse, the duration of the abuse, and the number of forms of abuse experienced.

Proposed solutions to the CPA problem include both intervention and prevention efforts. Because of the complexity of CPA, any single intervention or treatment is unlikely to be successful, particularly with high-risk families. Psychological approaches for children and their families target parenting skills, anger control and stress management, social and developmental skills, and parent–child interactions. Although enhancing parenting skills, reducing negative parent–child interactions, and decreasing child behavior problems are important intervention and prevention goals, experts also recognize the value in shifting attention from individual- and family-focused strategies to efforts that impact society more broadly (through laws and policy initiatives) as well as efforts that additionally focus on creating supportive community environments. The intention of such efforts is to create communities where citizens and professionals alike share the belief that keeping children safe from abuse is a collective responsibility. Public education campaigns have also used the mass media effectively to increase awareness, recognition, and understanding of the CPA problem. Although evaluation studies suggest that many intervention and prevention strategies are promising, additional research is needed to enhance the current state of knowledge about solutions to the CPA problem.

RECOMMENDED RESOURCES

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