CHAPTER

4

Child Physical Abuse

CASE HISTORY Kenny Fell Off of His Razor

Kenny 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 Kenny 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. Kenny 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 Kenny'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.

Initially, Kenny's mother persisted in her story that Kenny 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 of several years, 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 Kenny. She also suggested that Kenny's behavior could often be very difficult to control. She said that Kenny 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 CPS worker, Kenny revealed that he was, in fact, experiencing physical abuse inflicted by his mother's boyfriend. Kenny reluctantly acknowledged that Sam frequently disciplined him by repeatedly slapping a belt across his back. He also talked about an incident when he had been trying to teach the ducks to "swim underwater." When Sam saw Kenny

submerging the ducklings' heads under the water, he became very angry and "taught Kenny a lesson" by holding Kenny's head underwater repeatedly. Kenny was tearful as he told this story and stated that at the time, he thought he was going to drown.

After Kenny 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 Kenny "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 a typical case of child abuse. Until the 1960s, society was relatively unaware of the hellish characteristic of abused children's lives. People considered physical child abuse a mythical or rare phenomenon that occurred only in some people's imaginations or in sick, lower-class families. As it is now more widely known, however, child maltreatment is an ugly reality for millions of children. In 1990, the U.S. Advisory Board on Child Abuse and Neglect described the level of child maltreatment in the United States as a national emergency.

This chapter on child physical abuse (CPA) first offers a discourse on the definition and prevalence of child physical abuse. Following these topics, there is a discussion of short-term and long-term consequences associated with CPA. Next, there is a presentation about the typical characteristics of physically abused children and the adults who abuse them. A dialogue of methodological research problems and explanations of child physical abuse appears next. The chapter concludes with recommendations for addressing the problem.

SCOPE OF THE PROBLEM

What Is Child Physical Abuse?

One of the most significant issues in understanding the problem of CPA is that of defining the term *child physical abuse.* Consider the following situations:

- Ryan and his brother, Matthew, were playing with their Power Rangers in Ryan's bedroom when they got into a disagreement. Both boys began hitting each other and calling each other names. 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.
- 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 3 hours straight, Angela became so frustrated that she began shaking Maria. The shaking caused Maria to cry more loudly, which in turn provoked Angela into shaking the infant more vigorously. Angela shook Maria until the baby lost consciousness.

- 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 tail. Jimmy's father saw the child vigorously pulling on the puppy's tail 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, to "teach him a lesson" about the appropriate way to treat a dog.

These vignettes portray a range of behaviors, from actions that may or may not be considered abusive to those that are clearly abusive. Prior to the 1960s, however, few, if any, of these actions would have been labeled abusive. Society's growing awareness of physical child abuse and researchers' growing understanding helped to evolve more accurate definitions. Furthermore, researchers and practitioners concerned with child physical abuse have also discovered that violence against children may sometimes take an unusual form or be more difficult to recognize.

Definitions of Child Physical Abuse

While recognition of CPA was increasing, the definition continued to be restrictive. The definitions of CPA that first emerged commonly focused on *acts of violence* that cause some form of *observable harm.* In 1988, the National Center on Child Abuse and Neglect broadened the definition of physical abuse to include two standards (U.S. Department of Health & Human Services, 1988).

- **Harm standard:** Recognizes children as CPA victims *if* they have observable injuries that last at least 48 hours
- **Endangerment standard:** Recognizes children as abuse victims if they are deemed to be substantially *at risk* for injury (*endangerment*)

Although some discrepancies exist, many experts include the following signs and symptoms as reflective of physical child abuse (see "Signs of Physical Abuse," n.d.; see also Wiehe, 1997):

Bruises, black eyes, welts, lacerations, or rope marks	A child's report of physical abuse
Physical signs of being punished or signs of being restrained	Bone fractures, broken bones, or skull fractures
Open wounds, cuts, punctures, or untreated injuries in stages of healing	Sprains, dislocations, or internal injuries/bleeding
A sudden change in behavior	

- Child Abuse Prevention and Treatment Act (CAPTA) definition of abuse:

> "Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm." (Child Welfare Information Gateway, 2009, p. 1)

- Centers for Disease Control and Prevention (CDC; 2008, p. 2):

> "The *intentional* use of physical force by a parent or caregiver against a child that results in, or has the potential to result in, physical injury."

Physical Punishment and Child Rearing

Many people consider some of the acts listed (e.g., slapping, paddling, spanking) as *normal* violence. They consider such acts to be acceptable as part of the punishment of children in the course of child rearing. Mainstream Americans use physical punishment as a form of discipline, even with very young children (Watts-English, Fortson, Gibler, Hooper, & De Bellis, 2006). After all, what else can a parent do to manage a noncompliant child? A definition of physical punishment is as follows (Gershoff, 2008, p. 9):

> Physical punishment is the use of physical force with the intention of causing the child to experience bodily pain or discomfort so as to correct or punish the child's behavior.

Protective use of force. Most authorities make a distinction between *physical punishment* and *protective physical restraint.* This distinction occurs because parents frequently *must* use physical force to prevent a child from touching a hot stove or running into the street. Parents might also hold a child's hand down to stop him from hitting a baby.

As Graziano and Namaste (1990, pp. 459–460) state:

> Slapping, spanking, paddling, and, generally hitting children for purposes of discipline are accepted, pervasive, adult behaviors in U.S. families. In these instances, although anger, physical attack, and pain are involved between two people of vastly different size, weight, and strength, such behavior is commonly accepted as a proper exercise of adult authority over children.

Physical Discipline—The Debate

A heated debate about the use of corporal punishment is ongoing. Social scientists and pediatricians, in particular, decry the use of corporal punishment against children. Children are the only group in society that may be hit legally. Even convicted criminals are safeguarded against corporal punishment.

Sociological objections. Perhaps the most significant critic of the cultural acceptance of corporal punishment is Murray Straus, who has attracted considerable attention in recent years for his research and views on spanking. From a *sociological theoretical point of view,* Straus (1991c)

argues that spanking is harmful for two reasons: (a) When authority figures spank, they are, in essence, *condoning the use of violence* as a way of dealing with frustration and settling disputes; and (b) the implicit message of acceptance of this form of *violence contributes to violence* in other aspects of society. Others point out that adults who administer punishment that reduces a behavior (even if temporarily) have *modeled how, when, and why* one uses violence against another (Bandura, Ross, & Ross, 1961).

Learning researchers. Based on laboratory findings, researchers in learning condemn the use of physical punishment on the grounds that it is *ineffective* in achieving the results anticipated by parents, school administrators, prison officials, and others. According to this group of scientists, *a punisher is an event that decreases responses.* By definition, therefore, punishment *cannot* teach *new,* desirable behaviors. Unfortunately, the research in this area is complex and not readily understandable to nonspecialists. Nevertheless, animal research has led to a number of firm conclusions about the use of punishment, a few of which follow (see LaViolette & Barnett, 2000, for a review):

- A punishment can be either *biologically unlearned* (e.g., physical pain) or *learned* (e.g., unpleasantness of *being sworn at*).
- A punishment is *not the opposite of a reward* (reinforcement).
- Mildly punished behavior *will recover* (i.e., occur again).
- To be more effective, punishment must be delivered *immediately* after an unwanted response.
- To be more effective, punishment must be delivered *consistently* after every unwanted response.
- Punishment that *builds up gradually* in intensity is ineffective.

Even this short list of empirical findings demonstrates how faulty assumptions about punishment as an effective tool for managing children's behavior really are. The findings do, however, point out why members of society are disappointed when their use of corporal punishment lacks long-term effectiveness. In particular, the assumption that gradually building up the intensity of spankings is the correct way to deliver punishment is inaccurate.

Neurobiological effects of punishment. Correlational data revealed a significant relationship between harsh childhood physical punishment and the volume of gray matter assessed in adults ages 18 to 25. In this analysis, 1,455 young adults participated in a screening experience for the purpose of subject selection. Among the total, 23 participants had been harshly punished over a minimum of years and 22 had not been harshly punished. Morphometry (neuroimaging of brain anatomy) revealed that harshly punished participants had significantly reduced volumes of gray matter in three brain regions. Correlations between the brain volume measures and IQ scores (WAIS-III) were significant as well. The results suggest that harsh physical punishment has adverse effects on brain development, but correlational data cannot verify causality (Tomoda et al., 2009).

Counter-productiveness of punishment. One element of the debate about corporal punishment is whether it is harmful, neutral, or helpful. One faction holds that corporal punishment does *no harm* (Rosemond, 2005). From the other faction, Straus (2005) maintains that such claims are a myth. Using social science research as a foundation, experts have summarized a list of reasons why punishment may be counterproductive (Gershoff, 2008):

1. It does not help children learn why their behavior is wrong or what they could do alternatively, instead of the punished behavior.
2. The physiological response aroused by the pain of the spanking may prevent the child from learning the lesson that the punishment was supposed to teach.
3. It fails to communicate why refraining from certain behaviors is important. That is, children will learn nothing about morality from a spanking.
4. It demonstrates how using force enables one to control others (modeling).
5. It increases the probability that children will attribute hostile motivations to others.
6. It may cause children to experience fear of their parents, or fear of school if punishment is used at school.
7. Since parents *love* their children, adding punishment to parent-child interactions may increase a child's belief that violence and love are linked.

Spillover effects of spanking. Research also supports Straus's (1991c) viewpoint that spanking is positively correlated with *other forms of family violence,* including sibling abuse and spouse assault. As one illustration, children who had been physically punished during the previous year were three times more likely to have assaulted a sibling during that year. As another illustration, spanking is correlated with crime outside the home, including self-reported delinquency, arrest, and homicide (Straus, 1991c). Other researchers have shown a connection between *spanking* and *antisocial behaviors* such as cheating, telling lies, and disobedience in school (e.g., Dadds & Salmon, 2003; Grogan-Kaylor, 2005). Findings suggest that parents who use spanking to punish antisocial behavior are actually contributing to subsequent antisocial behavior in their children (Straus, Sugarman, & Giles-Sims, 1997).

Despite calls from a large number of social entities and evidence that physical punishment is ineffective and counterproductive, a majority of Americans remain convinced that spanking is not abusive. Indeed, many U.S. states explicitly exclude acts of corporal punishment from their legislative definitions in child abuse statutes.

Children's assessments of punishment. While adults in many spheres of life have voiced their opinions about punishment, social scientists have rarely taken the time to query children about their opinions. To fill this gap, researchers asked 108 children 6 to 10 years old to judge 4 vignettes in which a mother disciplines a child for playing with balls in the living room and breaking a lamp. The types of punishment vary as follows: (a) *time-out,* (b) *withdrawal of a privilege* (e.g., TV viewing), (c) *reasoning/explaining,* and (d) *spanking.*

Effects from exposure to spanking were varied. Some of the results are as follows (Vittrup & Holden, 2010):

- Overall, children judged spanking to be the least fair method of discipline.
- Younger children judged spanking as fairer than older children did.
- Older children judged withdrawal of privileges as fairer than younger children did.
- Older children, relative to younger children, thought recurrence of the punished behavior was less likely in the short term after reasoning.
- Younger children, relative to older children, thought recurrence of the punished behavior was less likely in the short term following time-out.
- The combined group of children thought spanking (or reasoning) would be most effective in the short run.
- The combined group thought that spanking would not reduce recurrence of the punished behavior in the long run, but reasoning would have a longer deterrent effect.
- Although children judged reasoning to be more effective than the other methods in the long run, they did not think reasoning would totally prevent recurrence of the punished behavior.
- The children thought that the spanked children would not misbehave right away because they would be afraid of getting another spanking.
- Neither race nor socioeconomic status (SES) contributed to differences between children.

SECTION SUMMARY

Differentiating Abuse From Punishment

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, or behaviors that do not result in observable harm (e.g., spanking). Currently, the National Incidence Studies (NIS) report abuse using two standards: (a) The harm standard—Children are CPA victims if they have observable injuries that last at least 48 hours; (b) The endangerment standard—Children are abuse victims if they were deemed to be substantially at risk for injury (endangerment).

Controversy especially centers on behaviors that fall somewhere between normal and excessive corporal punishment. Sociologists criticize spanking because it both models and condones violence. Learning experts within the field of psychology criticize punishment in general for many reasons. Primarily, laboratory research has shown how ineffective punishment is unless it is administered "perfectly," and even then punishment seldom eliminates unwanted behaviors permanently. On the other hand, the trauma of harsh punishment is likely to cause permanent neurobiological changes. Both sociologists and psychologists criticize punishment because it is counterproductive. It might temporarily eradicate a behavior, but it teaches nothing—that is, it teaches no acceptable new behaviors. Some experts believe spanking has spillover effects, increasing the probability of violence throughout the family and society. Children do not always perceive punishment as fair.

PREVALENCE/INCIDENCE OF CHILD PHYSICAL ABUSE

Researchers generally use one of two methods of estimation: Official estimates come from government agencies, based on the numbers of cases reported to law enforcement and social service agencies. Other estimates come from self-reports of victims and perpetrators as gathered by survey research. As in other areas of family violence, there are several impediments to reporting. First, medical doctors through inexperience may not recognize child abuse. Second, they may decide to delay or not to report the abuse at all for a host of reasons (court time, belief system, disappointing responses from police or CPS). Other mandated reporters may also decide not to report. The general public may not report for reasons such as lack of certainty (CDC, 2008; Daka, 2009; Sege & Flaherty, 2008). Assessment of recalled CPA among adult samples has suffered from a lack of standardized measurement. Uniformity may improve, however, with the development of a new CPA screening tool crafted using opinions of experts in 28 countries and field tested in 7 countries (Dunne et al., 2009).

Department of Health & Human Services (DHHS; U.S. Department of Health & Human Services, 2008) [CPS records].

The number of substantiated (i.e., found to be true) victims of child maltreatment is 758,289.

Of this number, 16.1% were physically abused.

Official Estimates

Official reporting statistics over the last two decades indicate that reports of child physical abuse from the DHHS have decreased from 1992 to 2004. Presented in the box below are the two major data collections for child abuse.

The U.S. Department of Health & Human Services (2008) identified 758,289 maltreated children. Department of Health & Human Services uses only records from Child Protective Services.

NIS-4 (2005–2006) identified 1,256,600 maltreated children.

National Incidence Study uses data from CPS, professionals, school counselors, and others (Sedlak et al., 2010).

National Incidence Studies (NIS-4, Sedlak et al., 2010) (Data from multiple sources—goes beyond the U.S. DHHS to capture data from individuals such as school counselors and psychologists in private practice)

See Table 4.1 for a summary of statistics for physical abuse.

TABLE 4.1 Numbers of Children Reported for Physical Abuse on the Harm Standard in the National Incidence Studies

Physically Abused Children					
NIS-2 (1986)		*NIS-3 (1993)*		*NIS-4 (2005–2006)*	
269,700	4.3 per 1,000 children	381,700	5.7 per 1,000 children	323,000	4.4 per 1,000 children

Injuries

Some findings about injuries and fatalities are as follows:

Bureau of Justice Statistics—Special Report (Rand, 1997). Many victims of abuse are unwilling or unable to report information about the perpetrators.

- Of children <12 years of age presenting at emergency rooms for treatment.
  - Half of those treated were under 5 years of age.
  - The rate of injury was 1.6 per 1,000 children < 12.
- Relatives inflicted 56% of the injuries, acquaintances inflicted 34.1%, and strangers inflicted 9.7%.

Fatalities by Physical Abuse Only (U.S. Department of Health & Human Services, 2008)

- 22.9% of fatalities were attributed to physical abuse.
- 69.9% of all child fatalities were caused by parents.

National Child Abuse and Neglect Data System (NCANDS; 2008), Victims by Age and Race for 2007. NCANDS describes parents/caregivers only.

- Male infants (18.5%) were more likely than female infants (15.39%) to become a fatality.
- 41.1% of all fatality victims were *White,* 26.1% of victims were *African American,* 16.9% were *Hispanic,* and the remainder was unknown.
- There were 1,400 child fatalities in 2002 (U.S. Department of Health & Human Services, 2002b).

National Violent Death Reporting System (NVDRS): 1,374 deaths in children under 5 with 16 states reporting (Klevens & Leeb, 2010)

- 52% occurred in children under 1 year of age.
- 600 were attributable to child maltreatment.

The Centers for Disease Control and Prevention (CDC; 2008). The Morbidity and Mortality Weekly Report (2008):

- CPS investigated roughly 3.6 million cases of abuse of children less than 18 years of age between October 2005 and September 2006.
- Of these, CPS substantiated the abuse for 905,000 (25.1%) of the cases.
- An investigation of very young children revealed that 3,957 (13.2%) infants <1 week of age were victims of physical abuse.

- 58.9% were male.
- 41.6% of victims were non-Hispanic White, 36.8% were non-Hispanic Black, 18.9% were Hispanic, and 2.7% were other than Hispanic.
- 63% were attributable to abusive head trauma (AHT), 27.5% to other types of physical abuse, and 10% to neglect.
- Fathers/father substitutes were significantly more likely to be perpetrators of AHT and other physical types of abuse; mothers were significantly more likely to be deemed responsible for neglect.

Child Death Review Teams

Sometimes, the recorded causes of children's deaths are inaccurate. Lack of such knowledge impedes interventionists' attempts to reduce child deaths. Communities have inaugurated child *death review teams* to understand better the *real causes* of children's deaths. Teams are made up of community leaders in medicine, child services, religion, law enforcement, and other areas. The expectation is that careful scrutiny of the causes will lead to development of methods to intervene and prevent such deaths. As one illustration, identification of factors involved in *sudden infant death syndrome (SIDS)* and *sudden unexpected infant death (SUID)* contributed to several recommendations. *Preventable* factors involved in these deaths were prenatal smoking, second-hand smoke exposure, alcohol/illicit drug use, and unsafe sleeping practices.

One suggestion triggered by these findings was to explore whether it would be feasible for law enforcement to conduct an *immediate drug and alcohol screen* of parents/caretakers who were on scene prior to an infant's death. Another innovation was to establish *cross-reporting online services between agencies* to enhance alertness among first responders. Knowledge of previous CPS investigations, drug arrests, or previous hospitalizations for a child's injuries would be useful for law enforcement, social services, hospitals, the coroner's office, and other agencies.

Another example of the death review team's activities was the inauguration of *safe sleeping campaigns.* The team noted that unsafe sleeping situations caused the deaths of a number of infants. One type of unsafe sleeping arrangements is *co-sleeping* (allowing the baby to sleep with the parents in the parents' bed). Other types of unsafe sleeping include placing the infant on a couch or in a crib with blankets, pillows, and stuffed toys. One study estimated that 40% of SUIDs resulted from co-sleeping accidents. In these accidents, a parent may overlay the baby causing him or her to suffocate. Such an accident is especially likely if the parent is drunk. In other situations, a baby may suffocate when *sleeping on his stomach* on a soft pillow. He may not be able to turn himself over to breathe. Legislation should mandate hospitals to instruct all new parents about safe-sleeping routines. A brochure is available to help with this task. Another proposal by the infant death review team was to have *universal neonatal home visitations* by public health nurses. Trained nurses are capable of noting potential hazards and of assisting parents in providing a safe living area (Inter-Agency Council on Child Abuse and Neglect [ICAN], 2009).

Neonaticidal Mothers

About 75% of mothers who kill newborns fit a *common profile.* As a group, these women are *not* mentally ill, and they do *not* have a history of arrest. They often *deny their pregnancy*

intermittently. Most manage to *deliver the baby on their own* in secret, and most recover sufficiently to *go right on with their daily routines,* such as going to school or work. Much more research is needed to understand this strange and sad set of circumstances (Beyer, Mack, & Shelton, 2008). The case history below is a typical case.

CASE HISTORY Juliet—A Neonaticidal Mother

Police responded to a call in a middle-class neighborhood when passersby heard screaming coming from the women's restroom in a neighborhood park. When police arrived at 9:30 in the morning, they found 17-year-old Juliet, a high school senior, walking away from a nearby dumpster. Inside the dumpster lay a newborn baby boy wrapped in a plastic trash bag.

Noting blood on Juliet's jacket, the police took her to the hospital where doctors said she had just delivered a baby. The police called Juliet's parents, who had no idea Juliet was pregnant. How could this happen?

When Juliet's best friend asked if she were pregnant, Juliet said, "No." Juliet had confided in the school nurse about the pregnancy, but then refused any medical or social service referrals the nurse gave her. Instead, day after day, Juliet pretended that she was not pregnant. She had told her boyfriend, and his response was the same. The two of them kept pretending she was not pregnant, as if the pregnancy would just disappear.

Juliet was fearful that if her parents knew about her pregnancy, they would be furious with her for having had sex, let alone for getting pregnant. How ashamed of her they would be. Juliet was a B+ student, and she had never been arrested or been in any kind of trouble before. Although she had not been officially tested for any mental health problems, no one had seen any behavior to make them believe that she was mentally ill.

Juliet had given birth over the toilet and then made sure the baby drowned before placing him in the trash bin. At 17, Juliet was a baby killer.

Self-Report Surveys

Surveys of individuals and families across the United States also provide researchers with data they can use to estimate rates of CPA. Usually, researchers ask parents in the general population to report on their use of various kinds of physical violence against their children. Some research is actually able to query children.

Family Violence Survey, 1985. The first National Family Violence Survey–1985 was very influential in revealing the startling amount of self-reported violence toward children (Gelles & Straus, 1987, 1988). In this telephone survey, which used the Conflict Tactics Scale (CTS) to measure abuse, 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). Results disclosed that 75% of the parents acknowledged having used at least one violent act in rearing their children. Approximately 2% 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.

Survey with an improved CTS—1998. To improve upon measurement of child abuse, researchers developed the *Parent-Child Conflict Tactics Scale (CTSPC)*. This inventory specifically assesses violence between parents and children. In addition to its revised physical assault and psychological aggression scales, the CTSPC expands the CTS by including new scales designed to measure *nonviolent discipline, child neglect,* and *sexual abuse* (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998). The CTSPC distinguishes three levels of physical assault: *minor* assault (i.e., corporal punishment), *severe* assault (i.e., physical maltreatment), and *very severe* assault (i.e., severe physical maltreatment). As part of a survey sponsored by the Gallup Organization, Straus and his colleagues administered the CTSPC to a nationally representative sample of 1,000 parents with the following outcomes:

- 75% reported using some method of physical assault during the rearing of their children. Most of the assaults were minor assaults, such as spanking, slapping, and pinching.
- Nearly 50% of parents surveyed said that they had engaged in behaviors from the *severe physical assault subscale* at some point during their parenting. An example of an item from the severe physical assault scale is "hitting the child with an object such as a stick or belt."
- Less than 1% of the parents employed behaviors from the *very severe physical assault* scale. An example of a behavior from this scale is "throwing or knocking down a child."

Office of Juvenile Justice and Delinquency Prevention (OJJDP), First National Survey on Children's Exposure to Violence (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009); *N* = 4,549; Comprehensive national population survey of children:

- 46.3% of all children surveyed had been physically assaulted.
- The peak of assaults occurred between 6 and 9 years of age.
- Of the assaulted children, boys (50.2%) were more likely than girls (42.1%) to be physically assaulted.

National Violence Against Women Survey. In another form of self-report survey, adults in the general population describe their own childhood experiences with various forms of physical violence from adult caretakers. The most significant survey of this type to date is the National Violence Against Women Survey, conducted in 1995–1996 (Tjaden & Thoennes, 2000b). In this telephone survey, a random sample of 16,000 adults (8,000 women and 8,000 men) responded to a modified version of the Conflict Tactics Scale. The respondents reported 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 serious forms (e.g., being threatened with a knife or gun). For both men and women, most of the assaults consisted of pushing, grabbing, shoving, slapping, hitting, or being hit with an object. Men were more likely than women to have experienced these forms of violence.

Trends in Rates of Physical Abuse

What does it mean that the rate of child maltreatment decreased from 1992 to 2004? Is this a true reduction or an artifact? A pair of child maltreatment experts undertook the task of investigating

these questions. For the basis of their comparisons, they used data from the following surveys: (a) National Child Abuse and Neglect Data System (NCANDS), (b) National Crime Victimization Survey (NCVS), (c) Minnesota Student Survey, and (d) Supplementary Homicide Reports. It may be important to acknowledge that they did not use NIS data. NIS abuse data showed a decline of 19% from NIS-3 to NIS-4.

First, they examined the possibility that only one form of maltreatment (e.g., CPA) had decreased, while other forms had not. Inspection of maltreatment trends across maltreatment types, however, did *not* support this possibility. All forms of child maltreatment decreased from 40% to 70%. Inspection of other indicators also showed changes—improvements for *teens.* There were fewer teen pregnancies, teen suicides, and children living in poverty. Hence, they concluded that the downward trend was a valid phenomenon.

Second, they examined a number of possible explanations for the decreases, such as legalization of abortion and improved economic conditions. Their analyses suggested that three explanations appeared more likely than others: (a) *improved economic factors,* (b) *increased agents of social change* (e.g., more social workers), and (c) *psychopharmacological advances,* such as those used to treat sex offenders. Obviously, decreasing trends of such a magnitude must have been related to more than one indicator (Finkelhor & Jones, 2006).

Other related trends. Outcomes of two self-report surveys suggested that the level of child maltreatment was staying about the same, at least not increasing. First, the National Violence Against Women survey, for example, found evidence that childhood physical assaults by caretakers, as reported during adulthood, remained relatively unchanged over time (Tjaden & Thoennes, 2000b). In this survey, younger adults (age 25 or younger at the time of the survey) were just as likely as older adults (age 50 or older) to report having experienced physical assault by caretakers during childhood. Second, Gelles and Straus (1987) found that the estimated rate of violence toward children *declined* from 1975 to 1985. The most *substantial decline* was in the use of *severe and very severe violence* (e.g., kicking, using a knife).

SECTION SUMMARY

Scope of Physical Child Abuse—Prevalence

Several factors impact reports of incidence and prevalence of child physical abuse. Law enforcement and Child Protective Services must abide by legal standards when reporting abuse. Official estimates of abuse ordinarily rely on legally defined acts of CPA. Official estimates suggest that CPA is a problem for 16% to 25% of children. There are some problems of disclosure of abuse among mandated reporters (e.g., pediatricians).

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For various reasons, mandated reporters do not always report, thus decreasing prevalence reports from medical settings. Anonymous self-report surveys of parent-to-child physical abuse reveal very high rates of abuse. In one survey of parents, some 75% reported using at least one violent act toward their children at some point during child rearing.

Records suggest that when children are injured and visit an emergency room, over half of their injuries have been inflicted by relatives including parents. Among fatalities associated with CPA those most common are among the youngest children (those under 1 year of age), and male infants are more likely to be murdered than female infants. Child Death Review teams actively study fatalities in order to understand the causes and make recommendations. Some mothers, especially very young mothers, commit neonaticide. Much more research is needed to understand these events and what might reduce their frequency.

CPS agencies receive hundreds of thousands of reports of CPA each year, and the numbers of reports have increased and decreased during certain time periods. The most current analyses show that the rate of CPA is decreasing.

EFFECTS OF CHILD PHYSICAL ABUSE ON CHILDREN

Children who experience physical maltreatment are more likely than their nonabused counterparts to exhibit *physical, behavioral,* and *emotional impairments.* In some cases, the negative consequences associated with abuse continue to affect individuals well into adulthood (Gershoff, 2008; Sroufe, Coffino, & Carlson, 2010). Until relatively recently, research examining the effects of CPA on children was limited to measures of *physical harm.* Investigators ignored the sometimes subtle, yet significant, social and psychological effects, focusing only on visible signs of trauma, such as physical injuries. Examination of 88 studies uncovered associations between corporal punishment and numerous negative outcomes in childhood on into adulthood, including deficits in moral internalization, poor mental health, and increased aggression, antisocial behavior, and abusive behavior toward others (Gershoff, 2002). Table 4.2 displays the most frequently reported problems associated with CPA for children, adolescents, and adults.

TABLE 4.2 **Effects Associated With Physical Child Abuse for Children, Adolescents, and Adults**

Effects	*Examples*	
Medical and neurobiological complications	Bruises	Head, chest, and abdominal injuries
	Fractures	Compromised brain development
	Burns	Alteration of biological stress system
Cognitive difficulties	Increased need for special education services	Deficits in verbal abilities, memory, problem solving, and perceptual-motor skills
	Decreased reading/math skills	Decreased intellectual and cognitive functioning
	Poor school achievement	

Effects	*Examples*	
Behavioral problems	Aggression	Property offenses
	Fighting	Defiance
	Noncompliance	Arrests
Socioemotional deficits	Delayed play skills	Infant attachment problems
	Peer rejection	Low self-esteem
	Avoidance of adults	Deficits in prosocial behaviors
	Poor social interaction skills	Deficits in social competence with peers
	Difficulty making friends	Hopelessness
	Suicidality	Depressive symptoms
Psychiatric disorders	Major depressive disorder	Oppositional defiant disorder
	Borderline personality disorder	Attention-deficit/hyperactivity disorder
	Conduct disorder	Posttraumatic stress disorder
Aggressive and antisocial behavior	Violent interpersonal behavior	Delinquency; violent and criminal offenses
Deficits in social competence	Increased levels of conflict and negative affect in interpersonal interactions	Decreased levels of social competence
	Low levels of intimacy	
Psychiatric disorders	Major depressive disorder	Disruptive behavior disorders
	Substance abuse	
Other	Attention problems	Sexual risk taking
	Deficient school performance	Increased daily stress
	Suicidal behavior	Low self-esteem
Criminal/violent behavior	Arrests for delinquency	Marital violence (for adult males)
	Physical abuse of own children	Received and inflicted dating violence
	Prostitution	Violent and/or criminal behavior
Substance abuse	Abuse of alcohol and other substances	
Socioemotional problems	Self-destructive behavior	Suicidal ideation and behavior
	Anxiety	Depression and mania
	Dissociation	Unusual thoughts
	Poor self-concept	Interpersonal difficulties
	Hostility	
Psychiatric disorders	Disruptive behavior disorders	Antisocial and other personality disorders
	Posttraumatic stress disorder	Major depressive disorder

SOURCES: A representative but not exhaustive list of sources for information displayed in this table includes Afifi, Brownridge, Cox, & Sareen, 2006; Appleyard, Egeland, van Dulmen, & Sroufe, 2005; English, Widom, & Brandford, 2004; Gershoff, 2008; S. R. Jaffee et al., 2005; D. J. Kolko & Kolko, 2009; Moe, King, & Bailly, 2004; Salzinger, Rosario, & Feldman, 2007; Sedlak et al., 2010; U.S. Department of Health & Human Services, 2008.

LONG-TERM EFFECTS ASSOCIATED WITH CHILD PHYSICAL ABUSE (CPA)

Physical and Mental Health

Abused children, relative to nonabused children, suffer numerous health problems extending on into old age. Some of these problems are observable in kindergarten samples and then stretch across the lifespan (Greenfield, 2010).

Injuries. The effects of CPA-related injuries may follow an individual throughout life. In particular, head injuries, abdominal injuries, and burns are likely to have long-lasting effects (Wharton, Rosenberg, Sheridan, & Ryan, 2000).

Pain. Sadly, victims may experience chronic pain on into old age. Within a sample of 3,381 adults, 14.7% had been physically abused, 5.8% had been sexually abused, and 7.2% suffered both physical and sexual abuse during childhood. Of the abused group, the prevalence of pain was 28.1% (Walsh, Jamieson, MacMillan, & Boyle, 2007).

Specific illnesses. A 32-year prospective study of 1,037 Australians centered on the health records of the participants. The records clearly demonstrated that children exposed to adverse childhood experiences (socioeconomic disadvantage, maltreatment, and social isolation) suffered significantly worse health. In particular, the abused group evidenced (a) *depression,* (b) *high inflammation levels,* and (c) a *clustering of metabolic risk factors.* The metabolic risk factors included being overweight, having high blood pressure, high "bad" cholesterol, high blood sugar, and low oxygen consumption (Danese et al., 2009). Relative to a nonabused group in a different inquiry, adults abused as children had elevated risks for allergies, arthritis, asthma, bronchitis, high blood pressure, and other problems (Reece, 2010).

Criminal and Violent Behavior

One of the most frequently discussed long-term consequences of CPA is criminal and violent behavior (e.g., Lansford et al., 2006).

Criminal behavior of CPA victims. Widom (1989a) compared a sample of validated cases of child abuse and neglect (identified 20 years earlier by social service agencies) to a sample of matched comparisons, evaluating juvenile court and probation department records to establish occurrences of delinquency, criminal behavior, and violent criminal behavior. She found that the subjects in the abused-neglected group had a higher likelihood of arrests for delinquency, adult criminality, and violent criminal behavior than did those in the comparison group (see also Mallett, Dare, & Seck, 2009; Salzinger, Rosario, & Feldman, 2007).

Interpersonal violence. Other research suggests that the interpersonal relationships of adults with childhood histories of physical abuse are more likely than those of nonabused persons to be characterized by violence (Crooks, Scott, Wolfe, Chiodo, & Killip, 2007). Adults with histories of CPA are more likely both to receive and to inflict dating violence (Rapoza & Baker, 2008;

Wolfe, Crooks, Chiodo, & Jaffe, 2003). In addition, adults (primarily males) who were physically abused as children are more likely to inflict physical abuse on their marital partners (McKinney, Caetano, Ramisetty-Mikler, & Nelson, 2009; Weston, Marshall, & Coker, 2007).

Genetic contributions. A team of researchers working in England, New Zealand, and the United States examined the potential role of genetic makeup as a contributor to aggressive, antisocial, or violent behavior in adults who were abused or maltreated as children (Caspi et al., 2002). These researchers speculated that the relationship between childhood maltreatment and violent behavior in adulthood depends on variations in a gene that helps to regulate neurotransmitters in the brain that are implicated in antisocial behavior. They assessed a group of 442 boys in New Zealand for antisocial behavior periodically between the ages of 3 and 28 years and found that maltreated children with a *protective* version of the gene were less likely to develop antisocial problems in adulthood. In contrast, 85% of maltreated children who had the less protective version of the gene later became violent criminal offenders (Jaffee et al., 2005).

Substance Abuse

Researchers have examined the possible association between CPA and later substance abuse among CPA victims. A prospective longitudinal assessment of substance use among the offspring of 585 abusive families detected gender differences in outcomes. CPA was significantly associated with substance abuse for girls at age 12, and then indirectly related to CPA at age 16 and 24. For boys, however, CPA was *not* related to substance abuse at age 12. Instead, substance abuse at age 12 was related to substance abuse at ages 16 and 24. These seemingly unexpected findings for males *are* consistent with previous research by Wilson and Widom (2009). The investigators suggested that CPA among girls led to a use of substances at age 12 which *then* continued onward (Lansford, Dodge, Petit, & Bates, 2010).

Socioemotional Difficulties

Well-conducted studies on the long-term socioemotional consequences of physical maltreatment in childhood are now available. Evidence to date indicates that adults with histories of CPA exhibit more significant emotional problems (e.g., De Bellis & Thomas, 2003; Springer, Sheridan, Kuo, & Carnes, 2007). Some of these disorders are as follows:

Poor self-concept	Attention-deficit disorder	Self-destructive behavior
Anger/hostility	Reactive attachment disorder	Substance abuse disorder
Disruptive disorders	Oppositional defiant disorder	Major depressive disorder
Conduct disorder	Dissociative disorders	Negative feelings about interpersonal interactions
Panic disorder	Personality disorders	PTSD
Anxiety	Mania	Dysthymia

Mediators/Moderators of Abuse Effects

To add to the uncertainty regarding the effects of CPA, it is also true that 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,* whereas for others their abuse experiences may *not be invariably disruptive.*

CPA → **Mediator** → Behavior
or
Moderator

Knowledge of **mediators and moderators** helps to explain the *variability* of effects, why some effects may be pervasive and others not. The following section outlines *some* detected mediators and moderators:

Frequency, severity, and duration of the abuse. More severe and/or chronic maltreatment may have more negative outcomes. Although empirical data on this topic are sparse, some evidence supports this contention (e.g., E. J. Brown, 2003; Wind & Silvern, 1992).

Polyvictimization. The greater the number of subtypes of maltreatment (e.g., physical abuse, sexual abuse, neglect) experienced by a child, the more negative the outcomes will be (e.g., Chartier, Walker, & Naimark, 2010; Fischer, Stojek, & Hartzell, 2010).

Prior involvement with Child Protective Services. Data from a nationally representative, longitudinal survey revealed that prior involvement with CPS influenced the probability of a second determination of abuse (Kahn & Schwalbe, 2010).

Child's attributions. Specific attributions as well as general attributional style were predictive of the level of psychopathology exhibited by CPA victims. Children who tended to blame themselves for the abuse, for example, exhibited greater internalizing symptoms. These findings suggest that the child's *perceptions* of those events may also serve an important mediating role (Kolko & Feiring, 2002; Mash & Wolfe, 2008).

Family stress. The negative effects of abuse are greatest for children in families in which there are high levels of stress and parental psychopathology (e.g., schizophrenia) or depression (Huth-Bocks & Hughes, 2008; Kurtz, Gaudin, Wodarski, & Howing, 1993).

Sociocultural factors. Reports also demonstrate the negative impact of sociocultural and family variables (e.g., SES) on the effects of CPA. The presence of community violence can be a factor influencing the effects of CPA (E. C. Herrenkohl, Herrenkohl, Rupert, Egolf, & Lutz, 1995; Sedlak et al., 2010).

Child's intellectual functioning. Factors such as high *intellectual functioning* and/or the presence of a *supportive parent* figure have a *protective* influence, thus mitigating the effects of CPA (e.g., Lansford et al., 2006).

Relationships between the victim and abuser. The quality of the parent-child interaction may attenuate the negative outcomes of CPA (Collishaw et al., 2007; English, Upadhyaya, et al., 2005). *Parental sensitivity,* for example, has a protective influence (see Haskett, Allaire, Kreig, & Hart, 2008). *Lack of empathy* predicted the appearance of adverse symptoms following CPA victimization (Moor & Silvern, 2006).

Trauma symptoms. Whether a child victim of CPA became an adult CPA abuser (of his/her children) depended on whether the child developed trauma symptoms. Children whose abuse eventuated in the trauma symptom of *avoidance coping* were more likely than those who did not develop the symptoms to abuse their own child (Milner et al., 2010).

Child's temperament. Parenting attempts at socialization were less effective if the child had certain *temperamental features,* such as low fear and low sensitivity to punishment (Edens, Skopp, & Cahill, 2008).

Social support. Egeland (1997) found that mothers who were physically abused but did not abuse their own children were significantly more likely than abusing mothers to have received emotional support from a nonabusive adult during childhood, to have participated in therapy during some period in their lives, and to have been involved in nonabusive, stable, emotionally supportive, and satisfying relationships with mates.

EXPANDED DISCUSSION OF INDIVIDUAL EFFECTS OF CHILD PHYSICAL ABUSE

Medical and Neurobiological Problems

The medical consequences of CPA are numerous and range from minor physical injuries (e.g., bruising) to serious physical disfigurements and disabilities. In extreme cases, CPA can result in death. Bruises are one of the most common types of physical injuries associated with CPA. CPA victims may also have other marks on their bodies as the result of being grabbed or squeezed or of being struck with belts, switches, or cords. When a child has a series of unusual injuries, this is often an indication of CPA (Myers, 1992).

Other common physical injuries associated with CPA include chest and abdominal injuries, burns, and fractures (Myers, 1992; Schmitt, 1987). Victims may incur abdominal injuries by being struck with objects, by being grabbed tightly, or by being punched or kicked in the chest or abdomen, which can result in organ ruptures or compressions. Burns, which are often inflicted as punishment, can result from immersion in scalding water or from contact with objects such as irons, cigarettes, stove burners, and heaters. Finally, fractures of bones in various areas of the body often result from CPA. Any of a number of actions can cause fractures, including punching, kicking, twisting, shaking, and squeezing.

Neurobiological injuries. Negative changes in the brain caused by maltreatment do occur. Several neurobiological consequences are related to CPA head injury including compromised brain development. Victims may exhibit deficits in language skills, memory, spatial skills, attention, sensorimotor functioning, cognitive processing, and overall intelligence. One of the most

dangerous types of CPA injury is *head injury.* Various actions on the part of an abuser can result in head injury and inflict neurotrauma. Some of these actions include a blow to the child's head by an object, punching the head with a fist, compressing the head between two surfaces, throwing the child against a hard surface, and shaken baby syndrome (see Leslie et al., 2005; Reece & Nicholson, 2003).

BOX 4.1 Shaken Baby Syndrome (SBS)

Violently shaking an infant can result in mild to serious *traumatic brain injuries (TBIs*) that are not always readily observable (National Institute of Neurological Disorders and Stroke, 2010). One type of TBI is known as **shaken baby syndrome (SBS).** Shaking a child violently can cause the child's brain to move within the skull, stretching and tearing blood vessels. Damage may include bleeding in the eye or brain, damage to the spinal cord and neck, and rib or bone fractures. For the period 2002–2006, the best estimate of deaths attributable to shaken baby syndrome was 144 (38.4%) of 375 head trauma deaths.

Commonly, parents who bring their children into emergency rooms with nonaccidental head injuries report that the children were hurt when they fell from some item of furniture (e.g., crib, couch, bed). Although 52.2% of TBI hospital deaths were attributed to falls for children age 0 to 14, doctors may be able to determine if such falls were accidental (Jayakumar, Barry, & Ramachandran, 2010).

Brain-injury deaths occurring in emergency rooms (2002–2005) for children 0 to 14 years of age totaled 2,174. Data shed some light on the causes of TBIs, such as motor vehicle deaths and assaults. The estimated average annual death rates associated with TBIs were as follows (Faul, Xu, Wald, & Coronado, 2010):

- 0–4 years of age: 998 deaths, 5.0 per 100,000 children
- 5–9 years of age: 450 deaths, 2.3 per 100,000 children
- 10–14 years of age: 726 deaths, 3.5 per 100,000 children

The estimated annual percentage of TBIs diagnosed in emergency rooms by age and by sex appears in Table 4.3. Note that the preponderance of TBIs occur in male children (Faul et al., 2010).

TABLE 4.3 Percentage of TBIs by Age and Sex

Age	*Number*	*Males*	*Females*
0–4	139,001	55.3%	44.7%
5–9	68,671	65.4%	36.6%
10–14	90,221	76.9%	23.1%

Although medical personnel undertake actions to stop bleeding in the brain, long-term neurological or mental disability may appear (Watts-English et al., 2006)

A Canadian comparison of 11 children who had suffered shaken baby syndrome with 11 matched comparison children found that one long-term consequence was a significant reduction in intelligence scores at 7 to 8 years of age (Stipanicic, Nolin, Fortin, & Gobeil, 2008). To *prevent* SBS, hospitals need to provide information about shaken baby syndrome to new parents in maternity wards (Deyo, Skybo, & Carroll, 2008; Dias et al., 2005).

Cognitive Problems

Studies have shown that physically abused children exhibit 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,** verbal language, communication ability, problem-solving skills, and perceptual motor skills (e.g., Macfie, Cicchetti, & Toth, 2001; see also U.S. Department of Health & Human Services, 2008). The cognitive deficits that have been observed in physically abused children, however, may be the results of *direct physical injury* (e.g., head injury), *environmental factors* (e.g., low levels of stimulation and communication), or a *combination of both*. Additional research is needed to determine the precise nature of the relationship between CPA and the cognitive problems observed in abused children.

Academic performance is another area of substantiated difficulty in physically abused children. Compared with nonabused children, victims of CPA display poor school achievement and adjustment, receive more special education services, score lower on reading and math tests, exhibit more learning disabilities, and are more likely to repeat a grade (e.g., Halambie & Klapper, 2005).

Biological stress reaction. The experience of child maltreatment can also result in alterations of the biological stress systems within the body via disruption of various chemicals in the body, such as *neurotransmitters and hormones* (Cicchetti & Rogosch, in press; Veenema, 2009). In one study, for example, researchers found that a sample of abused children exhibited greater concentrations of urinary dopamine, norepinephrine, and free cortisol than did children in a control group. They also found that a number of specific brain regions were smaller in the abused children relative to the nonabused children. Changes in neurobiological systems can have negative impacts on children's ability to regulate both emotional and behavioral responses (De Bellis & Kuchibhatla, 2006).

Behavioral Problems

Physical aggression and antisocial behavior are among the most common correlates of CPA. In most studies, abused children have exhibited more aggression than nonabused children, even after the researchers have statistically controlled for the poverty, family instability, and wife battering that often accompany abuse (e.g., Springer et al., 2007). In other words, abuse seems to have effects on behavior independent of the potential contribution of other factors. This

negative behavioral pattern has been observed across a wide variety of settings, including *summer camps* (Kaufman & Cicchetti, 1989) and *preschool and day-care programs* (Alessandri, 1991), in which researchers have used a variety of data collection procedures (e.g., R. S. Feldman et al., 1995). Other behavioral difficulties displayed by CPA victims include drinking and drug use, noncompliance, defiance, fighting in and outside of the home, property offenses, and arrests (e.g., Conroy, Degenhardt, Mattick, & Nelson, 2009; Ireland, Smith, & Thornberry, 2002). A type of behavioral problem associated with child abuse that has garnered more and more societal and research attention is bullying.

BOX 4.2 Bullying in Middle School

Bullying is a use of power and aggression to distress a vulnerable person. It can include verbal or physical actions and behaviors such as exclusion and ostracism. Bullying can be conceptualized as the result of the interplay between the child and his or her family, peer group, school, community, and culture.

Bullies and cliques. One interesting observation is that bullying is not confined to a bully-victim dyad. Instead, groups of children victimize individual children (Espelage, 2004).

Children may form cliques in which members influence each other to partake in bullying. Peer groups usually form on the basis of similarity, such as sex, propinquity, and race (see Espelage & Swearer, 2003). The most central member of the clique is often the most aggressive bully (Espelage, 2004). Bullies are often popular and socially dominant (Witvliet et al., 2009).

There are three kinds of bully involvement: (a) *bully only,* (b) *victim only,* and (c) *both victim and bully.* Another group of children are involved as bystanders. Bullies like an audience. There are also different forms of bullying, such as physical, emotional, indirect, verbal, sexual, and relational. Relational bullying is aggression aimed at damaging someone else's relationship (e.g., a rival's dating relationship). (See Espelage & Swearer, 2003, for a review.)

Prevalence of bullying. Bullying occurs almost universally among children and adolescents. Bullying is more prevalent before age 12, and it continues during adolescence. A survey of 15,686 students in Grades 6 to 11 reported a bully involvement rate of 30% (Nansel et al., 2001). A typical trajectory of bullying is beginning in middle school and reaching a peak during the transition from middle school to high school followed by a decline (Pelligrini & Long, 2002). The frequency of bullying varies by the ethnic background of the students and the ethnic composition of the class. Black students report being victimized more than White students (Nansel et al., 2001).

Consequences of bullying. Being the victim of a bully (or clique of bullies) is damaging to one's mental health. A 2-year longitudinal study of 2,232 twins 5 to 7 years old assessed changes via before- and after-test inventories. Of the total, 272 children were bullied by being excluded from school activities, and 137 were involved as

both bullies and victims. Contrasting the bullied groups with the 1,387 children who were not bullied uncovered several significant differences. The bullied group suffered from an escalation of symptoms: depression, anxiety, social withdrawal, and physical complaints (Arseneault et al., 2010; see also Gruber & Fineran, 2007; Poteat & Espelage, 2008).

Characteristics of bullies. Bullies rank high in antisocial behavior and aggression (Solberg & Olweus, 2003). One group of investigators found that increases in bullying over time were associated with *anger, impulsivity,* and *depression* (Espelage, Bosworth, & Simon, 2001). Regardless of sex, masculine traits predicted bullying (Gini & Pozzoli, 2006). Being bullied by a boy was more detrimental to both boy and girl victims than being bullied by a girl (Felix & McMahon, 2006). A newer study has demonstrated that among 105 students (Grades 4, 6, and 8), students with *lower-quality parental attachment* are significantly more likely to bully and to be bullied (Walden & Beran, 2010; see also Eliot & Cornell, 2009).

Characteristics of victims. Students ages 9 to 11 were more likely to be bullied by social exclusion if they were submissive or nonassertive (C. L. Fox & Boulton, 2006). Although any child may become a victim of bullying, the most vulnerable targets are individuals who deviate from the norm, someone who is different because of sexual orientation, race, or disability. Students enrolled in special education classes have a different pattern of bullying than those enrolled in general education. Students in special education reported more bully perpetration, victimization, and physical types of bullying than did general education students. Further, special education students maintained roughly the same level of bullying over the middle school and high school years. General education students who were older, conversely, exhibited less bullying (Rose, Espelage, & Monda-Amaya, 2009).

Victimization is associated with *low self-esteem and depression* (Solberg & Olweus, 2003). Traits of children who do not transition out of victimization indicated that boys were lower in *prosocial behavior* and girls were higher in *impulsivity* compared with those who did transition out of victimization. In addition, a reduction in girls' relational bullying was linked with a cessation of their own victimization (Dempsey, Fireman, & Wang, 2006). Also, some victims react to being bullied with *intensified anxiety and depression.*

Explanations for bullying. *Exposure to parental intimate partner violence (IPV), personal maltreatment, and sibling bullying* are powerful risk factors for future bullying behaviors (Wolfe et al., 2003). A cross-cultural comparison showed a significant relationship between parents' harming a child physically and the child victim's bullying behaviors (Dussich & Maekoya, 2007). Youth from such homes often model the violence and carry out similar abusive patterns of behavior in their own relationships.

Bullies have also witnessed interpersonal aggression at school by peers and some teachers (Twemlow & Fornagy, 2005) and had their own behavior shaped by operant/instrumental learning procedures. Parents or peers may have rewarded (e.g., praised or admired) a child for bullying others or fighting back when insulted. In parallel fashion,

(Continued)

(Continued)

parents/peers may have punished (e.g., ridiculed) a child for not "standing up to a bully" (see Button & Gealt, 2010). From a different point of view, an analysis of the data from the Arseneault et al. (2010) study of twins clearly showed that *genetics* as well as the environment played a role in bullying/bully victimization (Ball et al., 2008).

Treatment/prevention of bullying/victimization. Because bullying occurs most frequently at school, society's expectations are that the school has the responsibility for preventing bullying. The school has to manage a problem that has its roots in physical child abuse in the home (Dussich & Maekoya, 2007; see also Totura et al., 2009). Bullying is not harmless. Teachers, parents, and others should intervene when bullying is observed. A violent childhood does not mean that bullying behavior is inevitable, and interventions can change the way schoolchildren relate to others (Poteat & Espelage, 2008).

Experts studying the problem, taking note of the interrelations between bullying and other parameters, have strongly recommended a research-based, social-ecological program. Interventionists must take into account the impacts of "families, schools, peer groups, teacher-student relationships, neighborhoods, and cultural expectations" (Swearer, Espelage, Vaillancourt, & Hymel, 2010, p. 42).

Difficulties Related to Psychopathology

Additional problems frequently observed in physically abused children are *internalizing behavioral symptom*s that include social and emotional difficulties.

Attachment problems. The quality of the parent-child bond consistently reflects *insecure attachment* in *infants* exposed to CPA. For these children, the parent-child relationship presents an *irresolvable paradox* because the caregiver is both the child's source of safety and protection and the source of danger or harm (Hesse & Main, 2000; Zeanah et al., 2004).

Psychiatric disorders. A number of studies have examined rates of psychiatric disorders in samples of physically abused children and have found that CPA victims are at increased risk for psychiatric problems. The rate of risk for *social dysfunction,* in general, was nine times greater, and *somatization* risk was four times greater in one longitudinal study (Nomura & Chemtob, 2007). Abused (and neglected) children were at elevated risk for experiencing additional traumas (revictimizations) over their lifetime (Widom, Czaja, & Dutton, 2008). CPA has also been associated with *attention-deficit/hyperactivity disorder* and *borderline personality disorder* (e.g., Liu, 2010). Furthermore, there is an increased risk for *bipolar disorder* among physically abused children.

Posttraumatic Stress Disorder (PTSD). Since the late 1980s, researchers have documented **PTSD** in abused children, but the prevalence rates were inconsistent. For children referred to child welfare ($N = 1{,}848$), 11% had clinically significant symptoms of PTSD. For children placed in out-of-home care, 19.2% had PTSD (Hurlburt, Zhang, Barth, Leslie, & Burns, 2010; see also Pollak, Vardi,

Bechner, & Curtain, 2005; B. E. Saunders, Berliner, & Hanson, 2004). One inquiry established that 81% of abused children have partial PTSD symptoms (e.g., Runyon, Deblinger, & Schroeder, 2009).

Depression. One pair of researchers conducted a longitudinal investigation (birth to age 26) on the combined effects of child physical abuse *and* low birth weight among 1,748 children. Analyses showed a 10-fold greater risk of depression among the abused low birth weight children compared with children in a control group (Nomura & Chemtob, 2007; see also Sternberg, Lamb, Guterman, & Abbott, 2006). In another inquiry, harshly parented kindergartners tested with some insolvable puzzle problems revealed **learned helplessness** (similar to hopelessness) (Cole et al., 2007).

Research Issues

It is difficult to be certain that the psychological problems associated with CPA result solely from violent interactions between parent and child. First, child physical abuse often occurs in association with other problems within the family, such as marital violence, alcohol/drug use by parents, and low SES. Determining which factors or combination of factors in the child's environment are responsible for his or her problems is a difficult task. Certainly, it would not be surprising to find that a child who regularly witnesses interparental violence, who is abused by an older sibling, and who is poor might be having problems in school whether or not he or she is being abused by a parent. It would be surprising if such a child were *not* having difficulties. The perennial problems of lack of comparison groups and correlational data are ongoing.

SECTION SUMMARY

Effects of Child Abuse

Society, the government, experts in the social sciences, education, and medicine, those who work in CPS and law enforcement; and many others are extremely concerned about the effects of CPA on children. In fact, there is international concern about the fate of abused children. Researchers examine and categorize the effects of abuse along numerous dimensions: (a) type and severity of outcomes, and (b) duration of the effects, from infancy to old age. 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, severity, duration, frequency, and chronicity of abuse impact the effects of the abuse. Additional research efforts are needed to identify potential mediating variables.

It can be quite challenging to link specific parental abusive behaviors to specific outcomes because behavior has so many causes. Sometimes the effects are subtle or do not show up immediately. The effects of shaken baby syndrome are some of the most damaging and long lasting because of irreversible brain damage. Abused children are likely to have cognitive deficits and behavioral and emotional problems that affect others in the family and community. As one example, bullying one's schoolmates can be directly tied to abusive behaviors in the home.

CHARACTERISTICS OF CHILDREN WHO ARE PHYSICALLY ABUSED

Age

Over the years, evidence has suggested that maltreatment as a whole declines with a child's increasing age. This pattern appears *not* to be true of child physical abuse.

Official estimates.

U.S. Department of Health & Human Services (2008): Age and Percentage of Physically Abused Children

Age	*Percentage*	*Age*	*Percentage*	*Age*	*Percentage*
<1	17.1%	3	12.0%	12–15	19.7%
1	11.0%	4–7	15.7%	16–17	21.0%
2	11.4%	8–11	16.6%	Unknown	20.6%

NIS-4 (Sedlak et al., 2010). NIS-4 reports of ages of physically abused children as follows:

- 2.5 per 1,000 for children 0 to 2
- 3.6 per 1,000 for children 3 to 5
- 5.5 per 1,000 for children 6 to 8
- 4.6 per 1,000 for children 9 to 11
- 5.0 per 1,000 for children 12 to 14
- 4.3 per 1,000 for children 15 to 17

National Child Abuse and Neglect Data System (NCANDS; 2008):

- 13.2% of physically abused children were <1 week old.

National Survey of Children Exposed to Violence (NatSCEV survey of 503 children (Finkelhor et al., 2009)

- 2.1% of children were under 2 years of age.

Self-report surveys. Results of self-report surveys are quite different than those from official estimates. Researchers compared three methods of identifying maltreatment incidents: (a) *retrospectively* (self-report via interview), (b) *prospectively* (case record data), and (c) with a *combination* of both methods. Using a sample of 170 participants tracked from birth to age 19, researchers identified maltreatment occurrences as follows: (a) *retrospective* identification—7.1%, (b) *prospective* identification—20.6%, and (c) *combination* method—22.9% (Shaffer, Huston, & Egeland, 2008).

Gender

NIS-4 (Sedlak et al., 2010) demonstrates that

- *Girls* (8.5 per 1,000 children) are generally more at risk for abuse by the harm standard than are boys (6.5 per 1,000). Inclusion of girls' greater *sexual* victimization appears to account for this overall maltreatment gender differences.
- *Boys* (54%) are generally at slightly greater risk than girls (50%) for child physical abuse.

U.S. Department of Health & Human Services [CPS records] (2008). The number of substantiated (i.e., found to be true) cases of child maltreatment was 758,289 victims (51.3% girls).

Adverse Childhood Experiences (ACE) Study. Data from Kaiser Permanente–San Diego in collaboration with the Centers for Disease Control and Prevention (2006); *N* = 17,337 adult patients reporting on childhood physical abuse.

- *27% of women* (*n* = 9,367) reported having been physically abused.
- *29.9% of men* (*n* = 7,970) reported having been physically abused.

Related Variables

Socioeconomic status. Although child maltreatment occurs in all socioeconomic groups, official statistics have consistently shown that CPA occurs disproportionately more often among economically and socially disadvantaged families (U.S. Department of Health & Human Services, 2008; NIS-4, Sedlak et al., 2010). Economic stress impacts CPA rates in military families as well (Hennessy, 2009).

NIS-4 (Sedlak et al., 2010) presented the following incidence rate of physical abuse among children categorized by SES (see Table 4.4 also):

- 1.5 per 1,000 children were *not* in low SES families.
- 4.4 per 1,000 children were *in* low SES families.

TABLE 4.4 Incidence Rates of Severity of Harm for Maltreated Children Associated With SES Status

Severity of Harm	*Children Not in Low SES Family*	*Children in Low SES Family*
Serious	1.7 per 1,000	9.9 per 1,000
Moderate	2.4 per 1,000	11.7 per 1,000
Inferred	0.2 per 1,000	0.9 per 1,000

Race

NIS-4 incidence rates of physically abused children by race (Sedlak et al., 2010). For the first time, NIS data found a significant racial disparity showing Black children to be the most physically abused:

- 6.6 per 1,000 physically abused children were Black.
- 4.4 per 1,000 physically abused children were Hispanic.
- 3.2 per 1,000 physically abused children were White.

U.S. Department of Health & Human Services (2008) had racial information on 745,962 maltreatment victims of whom 121,137 were physically abused.

African American: 19.1%	Multiple race: 14.1%
American Indian: 10.6%	White: 15.0%
Asian: 19.9%	Unknown/missing: 20.2%
Hispanic: 15.1%	Native Hawaiian/Pacific Islander: 20.8%

The data gathered through national self-report studies of CPA add to the growing body of evidence suggesting that African American families are at the greatest risk for child physical abuse (Wolfner & Gelles, 1993).

Disabled children. The special characteristics of disabled children increase their risk for abuse. Several studies, but not all, have found an association between CPA and *birth complications* such as low birth weight and *premature birth* (Benedict, White, Wulff, & Hall, 1990; J. Brown, Cohen, Johnson, & Salzinger, 1998).

NIS-4 prevalence—2010. Using the NIS-4 harm standard, the incidence rate of *physical abuse* was *lower* for disabled children (3.1 per 1,000) than for nondisabled children (4.2 per 1,000 children). When the incidence rate included neglect *and* abuse, *severity of harm* findings were reversed. The rate for children with disabilities (8.8 per 1,000) was *higher* than the rate for children without disabilities (5.8 per 1,000).

NCCAN—1993. The National Center on Child Abuse and Neglect addressed the incidence of child abuse among children with disabilities (e.g., mental retardation, physical impairments such as deafness and blindness, and serious emotional disturbance) by collecting data from a nationally representative sample of 35 CPS agencies. The results of that analysis indicated that the incidence of child maltreatment was almost twice as high (1.7 times higher) among children with disabilities as it was among children without disabilities. For children who were physically abused, the rate for children with disabilities was 2.1 times the rate for maltreated children without disabilities (versus 1.8 for sexually abused and 1.6 for neglected children). The most common disabilities noted were emotional disturbance, learning disability, physical health problems, and speech or language delay or impairment (U.S. Department of Health & Human Services, 1993).

One difficulty in interpreting these data hinges on the specification of the *sequence* of these events. Were children disabled before the abuse, or did their disabilities result from abuse? CPS caseworkers reported that for 47% of the maltreated children with disabilities, the disabilities directly led to or contributed to child maltreatment; for 37% of the disabled children, abuse presumably caused the maltreatment-related injuries (U.S. Department of Health & Human Services, 1993).

Child Protective Services. One analysis suggested CPS workers may treat abuse of disabled children differently than they treat abuse of nondisabled children. In an evaluation of CPS workers' reaction to vignettes, caseworkers were *less likely to initiate an investigation of disabled children* compared with nondisabled children. Children with *behavioral/emotional disabilities* were the most likely group

among disabled groups to have abuse allegations substantiated. Workers tended to attribute abuse of disabled children to the *added stress of caring for a disabled child.* The workers had empathy for the parents, but they did not condone abuse. The workers were also especially likely to *recommend services for disabled abused children* instead of services for the abusive parents, reflecting their belief in the difficult child model. The researchers suggested that CPS workers need *specialized training* to work with abused disabled children. They also recommended a *team approach* to evaluating cases. The team should include at least one disability expert (Manders & Stoneman, 2008).

American Academy of Pediatrics. In 2001, the American Academy of Pediatrics issued a policy statement on assessing maltreatment of children with disabilities. The organization believes that pediatricians play a significant role in identification, treatment, and prevention of child abuse, especially in cases of maltreatment of disabled children. The group has formulated eight recommendations. As an illustration, "Pediatrician should be actively involved with treatment plans developed for children with disabilities" (Committee on Child Abuse and Neglect and Committee on Children With Disabilities, 2001, p. 511).

CHARACTERISTICS OF ADULTS WHO PHYSICALLY ABUSE CHILDREN

Age

There is some evidence that younger parents are more likely than older parents to maltreat their children physically. NIS-4 reported that only 11% of children were abused by a "perpetrator" under the age of 26. These perpetrators (36%) who were younger, however, were more likely to be *nonparents* than parents by contrast. DHHS records indicate that 69.3% of male child abuse perpetrators and 80.4% of female child abuse perpetrators were younger than age 40 (U.S. Department of Health & Human Services, 2008).

Gender and Parental Type

The gender of the perpetrator varies by the category of abuse according to NIS-4 (Sedlak et al., 2010): More males (62%) *physically* abused children than females (41%). (Sometimes, both a male and a female abuse a child.)

NIS-4 (Sedlak et al., 2010) had information on *types* of 323,000 parental perpetrators of *physical abuse.* See Table 4.5 for a grouping of physically abused children by gender of child and parental type.

TABLE 4.5 Percentages of Physically Abused Children by Gender and Parental Type

Parent Type	*Percentage of Male Children Abused (54%)*	*Percentage of Female Children Abused (50%)*
Biological parent	48%	56%
Nonbiological parent/partner	74%	29%
Other person	56%	43%

Adverse Childhood Experiences (ACE) Study. Data from Kaiser Permanente–San Diego in collaboration with the Centers for Disease Control and Prevention (2006); N = *17,337 adult patients reporting on childhood experiences.* Table 4.6 summarizes differences in household dysfunction reported by gender.

TABLE 4.6 Adverse Childhood Experiences (ACE) of Abuse Reported by Adults

ACE Categories of Household Dysfunction	*Women:* N = *9,367*	*Men:* N = *7,970*
Mother treated violently by male partner	13.7%	11.5%
Household substance abuse	29.5%	23.8%
Household mental illness	23.3%	14.8%
Parental separation/divorce	24.5%	21.8%
Incarcerated household member	5.2%	4.1%

The ACE survey also reported that 15.2% of women and 9.2% of men had experienced four or more adverse events.

Race

U.S. Department of Health & Human Services (2008) had racial information on 121,137 *physically abused child victims* and 891,809 *maltreatment perpetrators.* Racial/ethnicity differences for all *child maltreatment perpetrators* (not just perpetrators of physical abuse) were as follows:

African American: 19.6%	Multiple race: 0.9%
American Indian: 1.3%	White: 47.8%
Asian: 1.0%	Unknown/missing: 9.5%
Hispanic: 19.5%	Native Hawaiian/Pacific Islander: 0.2%

Relationship of Perpetrator to the Abused Child

Official statistics indicate that physically abused children's birth parents are the perpetrators of the abuse in the majority of reported cases. Official statistics are difficult to interpret, however, because many states define as child abuse only those cases in which perpetrators are in caretaking roles.

U.S. Department of Health & Human Services (2008) had information on the type of parental perpetrator for *all maltreatment perpetrators* from 6 states. (More than one parent type may maltreat a child.) Their findings for 658,632 parents were as follows:

Adoptive parent: 0.7%	Stepparent: 4.4%
Biological parent: 90.9%	Unknown parental type: 19.5%

NIS-4 (Sedlak et al., 2010) had information on 323,000 types of parental perpetrators of physical abuse. Among these perpetrators, researchers categorized the perpetrators into three categories as follows:

Biological parent: 72%

Nonbiological parent or partner: 19%

Other person: 9%

NIS-4 (2010) See Table 4.7 for a summary of parental type by severity of harm.

TABLE 4.7 Percentages of Physically Abused Children by Parental Type Using the *Severity of Harm* Standard

Parent Type	*Fatal/Serious Harm*	*Moderate Harm*
Biological parent	22%	78%
Nonbiological parent/partner	17%	83%
Other person	31%	69%

U.S. Department of Health & Human Services (2008) had information on *types* of 658,632 parental perpetrators of child maltreatment (not physical abuse only; 6 states reporting). See Table 4.8 for a categorization of maltreated children by parental type.

TABLE 4.8 Relationship of General Maltreatment Victim to Perpetrator Parental Type

Adoptive Parent	*Biological Parent*	*Stepparent*	*Unknown Parental Type*
4,816	598,815	29,064	26,937

Nontraditional Parenting

Both official data and survey data show that single parents are overrepresented among abusers (J. Brown et al., 1998; Sedlak et al., 2010). NIS-4 found that the highest rates of child abuse occurred among *single parents who had a cohabiting partner.* Children living in these households had a rate of abuse 10 times higher than children living with married biological parents (Sedlak et al., 2010). The U.S. Department of Health & Human Services (2008) reported a rate

of physical abuse at 13.9% for unmarried partners of parents and 9.4% for parents. Grandparents, on the other hand, usually present a safer environment for children. Children cared for by grandparents (3.0 per 1,000) were less apt to be physically abused than children (4.5 per 1,000) cared for by parents (NIS-4, Sedlak et al., 2010).

PSYCHOLOGICAL, INTERPERSONAL, AND BIOLOGICAL CHARACTERISTICS OF ADULTS WHO PHYSICALLY ABUSE CHILDREN

Many studies have attempted to determine whether adults who physically abuse children share any particular characteristics (see Gershoff, 2008). This type of knowledge has the potential for improving treatment. The rationale underlying research on child abusers was the idea that something about the parent caused the abuse, not the child, not the situation, and not the specific parent-child combination. Although suggestive, the correlational nature of the research cannot definitively establish whether certain characteristics *cause* a parent to abuse a child physically. Even if certain traits were contributory to CPA, behavior generally has several causes. See Table 4.9 for a summary of the most common characteristics of adult perpetrators of CPA.

TABLE 4.9 **Psychological, Interpersonal, and Biological Characteristics of Adults Who Physically Abuse Children**

Characteristics	*Examples*	
Emotional and behavioral difficulties	Depression	Deficits in problem-solving skills
	Deficits in empathy	Low frustration tolerance
	Low self-esteem	Anger control problems
	Anxiety	Self-expressed anger
	Rigidity	Substance abuse/dependence
		Perceived life stress and personal distress
Family and interpersonal difficulties	Spousal tension, abuse, disagreement	Verbal and physical conflict among family members
	Parental history of abuse in childhood	Deficits in family cohesion and expressiveness
	Deficits in positive interactions	Isolation from friends and the community
		Abuse of children and other family members
Parenting difficulties	Disregard for children's needs/ abilities	Unrealistic expectations of children
	Deficits in child management skills	Poor problem-solving ability with regard to child rearing
	Negative bias/perceptions regarding children	High rates of verbal and physical aggression toward children

Characteristics	*Examples*	
	View of parenting role as stressful	Low levels of communication, stimulation, and interaction with children
	Intrusive/inconsistent parenting	
Biological factors	Reports of physical health problems and disabilities	Neuropsychological deficits (e.g., problem solving, conceptual ability)
	Physiological overreactivity	

SOURCES: A representative but not exhaustive list of sources for the information displayed in this table includes Borrego, Timmer, Urquiza, & Follette, 2004; Casanueva, Martin, Runyan, Barth, & Bradley, 2008; Estacion & Cherlin, 2010; Francis & Wolfe, 2008; Mammen, Kolko, & Pilkonis, 2003; Milner, 2003; C. M. Rodriguez, 2010; Tajima & Harachi, 2010.

EXPANDED DISCUSSION OF PSYCHOLOGICAL, INTERPERSONAL, AND BIOLOGICAL CHARACTERISTICS OF ADULTS WHO PHYSICALLY ABUSE CHILDREN

Biological Factors

Several researchers have suggested that biological factors may distinguish physically abusive parents from nonabusive parents. Studies have examined physiological reactivity in perpetrators of CPA, and the findings have consistently demonstrated that these individuals are hyperresponsive to child-related stimuli such as crying (e.g., Chen, Hou, & Chuang, 2009; Kagan, 2007; McPherson, Lewis, Lynn, Haskett, & Behrend, 2009).

Emotional and Behavioral Characteristics of Perpetrators

Studies comparing nonabusive parents with physically abusive parents have confirmed several characteristics such as *anger control problems, hostility, low frustration tolerance, depression, low self-esteem, deficits in empathy,* and *rigidity* (e.g., Cicchetti & Rogosch, in press; Sroufe et al., 2010). Such negative emotional and behavioral states may increase the risk of CPA by interfering with the way these parents perceive events, by decreasing their parenting abilities, or by lowering their tolerance for specific child behaviors (Cerezo, Pons-Salvador, & Trenado, 2008). *Substance abuse* problems are significantly related to *recurrence of a CPA report* (Johnson-Reid, Chung, Way, & Jolley, 2010; see also Berger, Slack, Waldfogel, & Bruch, 2010). Along the same lines, some evidence also suggests that abusive parents, relative to nonabusive parents, automatically encode *ambiguous* child behavior in negative ways (Crouch et al., 2010; see also Seng & Prinz, 2008).

Family and Interpersonal Difficulties of Perpetrators

Physically abusive adults are more likely than nonabusive individuals to exhibit family and interpersonal difficulties. Abusive individuals report more verbal and physical conflict among family members, higher levels of spousal disagreement and tension, and greater

deficits in family cohesion and expressiveness. There are several robust linkages between CPA and adult violence:

- Abusive parents report more conflict in their families of origin than nonabusive parents (Henning, Leitenberg, Coffey, Turner, & Bennett, 1996; Messman-Moore & Coates, 2007).
- Abusive parents engage in fewer interactions with their children, such as playing together, providing positive responses to their children, and demonstrating affection (see Boyle et al., 2010).
- Adults with histories of CPA are more likely both to receive and to inflict *dating violence* (Herrenkohl et al., 2004; D. S. Black, Sussman, & Unger, 2010).
- Adults (primarily males) who were physically abused as children are more likely to inflict *physical abuse* on their *marital partners* (Jouriles, McDonald, Slep, Heyman, & Garrido, 2008).
- Adults who were victims of physical abuse as children are more likely to *be perpetrators of CPA as adults* (e.g., Coohey & Braun, 1997; see also Coohey, 2007).

SECTION SUMMARY

Characteristics of Abusive Parents and Abused Children

A relatively large volume of literature describes the characteristics of perpetrators of CPA. Although no single profile exists, research findings indicate that several attributes may represent elevated risk for CPA. The sociodemographic characteristics of the victims of CPA do not suggest that any particular subpopulation of children is the primary target of violence. Both girls and boys are maltreated, and victims are found in all age-groups. CPA victims also come from diverse ethnic backgrounds. Although studies show that CPA usually differs by race of the victim, there is evidence that some characteristics place certain children at more risk than others. Young children, for example (birth to age 5), are at particularly high risk for CPA, as are children who are economically disadvantaged. Children with special needs, such as those with physical or mental disabilities, may be at higher risk for abuse than other children.

High CPA rates are associated with individuals who are young when they have a child. In the overwhelming majority of reported cases, perpetrators are the parents of the victims. Single parenthood is also associated with abuse. The relationship of stepparenting to abuse has been examined, but the findings do not generally indicate that stepparents are as abusive as biological parents. Live-in boyfriends, however, may be particularly abusive. Data regarding perpetrator gender are mixed, although it is clear that CPA is committed by both males and females.

Studies have found numerous psychological characteristics and biological factors that differentiate abusive parents from nonabusive parents, including depression, anger control problems, parenting difficulties, family difficulties, and neurobiological abnormalities.

EXPLAINING CHILD PHYSICAL ABUSE

The Individual Psychopathology Model—Mentally Ill Parent

As CPA has come to be defined more broadly to include greater numbers of adults as perpetrators, it has become increasingly difficult to view child abusers as people who suffer from mental illnesses, personality disorders, alcohol or drug abuse, or any other individual defect. Although research has identified a subgroup of severely disturbed individuals who abuse children, only a small proportion of abusive parents (less than 10%) meet criteria for severe psychiatric disorders (Kempe & Helfer, 1972; Straus, 1980; E. Walker, Downey, & Bergman, 1989). Adults who physically abuse children often do exhibit specific nonpsychiatric psychological, behavioral, and biological characteristics that distinguish them from nonabusive parents, such as anger control problems, depression, parenting difficulties, physiological hyperreactivity, and substance abuse.

Postpartum Depression/Psychosis

The postpartum mental health of a mother is a crucial factor in her child's well-being (Whitaker, Orzoil, & Kahn, 2006). Some mothers with *postpartum depression* experience problems in providing optimal care for their newborns. They have problems in feeding, sleep routines, well-baby clinic visits, vaccinations, and safety practices (Field, 2010). Of interest are findings that the behavior of women with postpartum depression is similar across the globe. Such findings implicate a biological basis for the depression. A small number of mothers with postpartum psychosis may appear to be neglectful, abusive, and even murderous. Although few mothers actually harm their babies because of postpartum depression, many women have recurrent and *disturbing* thoughts of harming their babies (Humenik & Fingerhut, 2007).

Prevalence of postpartum depression. Until recently, the number of women affected by postpartum depression has been largely unknown. Within the United States, about 11% to 16% of women experience depression the first year after childbirth (Logsdon, Wisner, Billings, & Shanahan, 2006; Vesga-López et al., 2008; see also Gaidos, 2010). Within Canada, 11.2% of Canadian-born women experienced postpartum depression in one survey. The percentage among majority group immigrant women was 8.3%, and 24.7% among minority group immigrant women (Mechakra-Tahiri, Zunzunegui, & Sequin, 2007).

A large nationally representative sample of 14,549 women aged 18 to 49 participated in face-to-face interviews as part of the 2001–2002 National Epidemiological Survey on Alcohol and Related Conditions. Epidemiologists were able to contrast women who had been pregnant, women who had been pregnant and suffered postpartum depression, nonpregnant women, and currently pregnant women. Women responded to questions about their alcohol/drug use, their mental health, and their sociodemographic information.

Several findings emerged from the analyses: (a) *Currently pregnant* women had *fewer mood disorders* than nonpregnant women; (b) Pregnancy was not associated with mental disorders; (c) Women who had been *pregnant* during the last 12 months and women currently *pregnant,* relative to nonpregnant women, *consumed less alcohol and drugs* (except for illicit drugs);

(d) Women who had been pregnant during the previous 12 months suffered significantly more depression; (e) Pregnant women with psychiatric conditions received very little treatment; and (f) Risk factors for a major depression included the following: young age, not being married, trauma exposure, exposure to stress, pregnancy complications, and overall poor health. The authors concluded that while pregnancy is *not* related to an increased prevalence of mental disorders, depression is associated with the postpartum period (Vesga-López et al., 2008; see also Gaidos, 2010).

Causes of postpartum depression. The cause of postpartum depression is unknown, but experts refer to it as a *brain-based disorder.* Newer scholarship is finally shedding a glimmer of light on precursors of postpartum depression. One risk is *elevated corticotrophin-releasing hormones* during pregnancy—hormones that help maintain a pregnancy. A second is *childhood sexual abuse* (Lev-Wiesel, Daphna-Tekoah, & Hallak, 2009; Yim et al., 2009). Some women with postpartum depression must also defend themselves against violent husbands (Ulrich et al., 2006). Congress officially widened the number of possible determinants.

Rapid decline in hormones	Previous mental illness	Stressful life events
Lack of social support	Difficulty during labor/ pregnancy	Physical or mental abuse
Marital strife	Premature birth or miscarriage	Family history of mood disorders
Financial problems	Previous bout of postpartum depression	Feeling overwhelmed by one's role as mother

Public reactions. Persons showing signs and symptoms of any mental health condition (e.g., phobia, bipolar disorder, obsessive-compulsive disorder) may receive harsh treatment from society. Without a definitive neurobiological understanding of postpartum depression, society has viewed the abusive behaviors of these mothers as purely criminal. A mother who kills her own baby, regardless of her mental condition, becomes a pariah (Pinto-Foltz & Logsdon, 2008). The general public is also becoming more aware of postpartum depression because of notorious cases in the media and because a few courageous celebrities who have experienced the condition have spoken publicly about their distressing symptoms.

Medical responses. Information is finally making its way into medical journals and hence into doctors' practices. Experts recommend *universal screening* by health care workers for depression during pregnancy and during the postpartum period. In fact, Congress has mandated screening (Tovino, 2010). A first step is to raise awareness among primary care providers (Logsdon et al., 2006). Nevertheless, the stigma attached to any mental illness impedes service delivery (Pinto-Foltz & Logsdon, 2008). Rural women, in particular, face challenges in finding help (Jesse, Dolbier, & Blanchard, 2008).

Legal responses. Quite a few factors that may improve services for postpartum mothers are coalescing. The narrowing gap between medical and mental conditions that must be covered

by insurance companies represents one such factor. The implications of disability law provide another intertwining legal factor affecting women with postpartum depression. Mandated screening is another illustration (Tovino, 2010).

Treatment. Postpartum depression is *underidentified and undertreated*. The most common treatments are psychotherapy and antidepressant medications. Psychosocial interventions may be best for adolescent mothers (Yozwiak, 2010). One effective intervention consisted of an educational element incorporated into postpartum discharge care. The inclusion of information about postpartum depression significantly alleviated depression compared with a comparison group that did not receive the intervention (Ho et al., 2009). Another inquiry found that treatment for postpartum depression resulted in significant stress reduction. A major contributor to stress among postpartum depressed mothers is the perception that their parenting skills are inadequate (Misri, Reebye, Milis, & Shah, 2006).

Another innovative approach for severely depressed women included a 12-week massage therapy component during and after pregnancy administered by a significant male partner. Compared with the nonmassaged depressed women, massaged women were significantly improved: (a) Massaged pregnant and postpartum women had lower cortisol ("stress hormone") levels and less depression; and (b) Massaged pregnant women had fewer preterm births or low birth weight babies. Moreover, the babies had lower cortisol levels and did better on a newborn behavioral assessment test (Field, Diego, Hernandez-Reif, Deeds, & Figuerido, 2009).

Prevention. Fortunately, Congress has done more to reduce problems associated with postpartum depression than it has to diminish several other less serious problems. The House passed the Mom's Opportunity to Access Health, Education, Research, and Support for Postpartum Depression Act (2009). Public awareness campaigns are under way in some locales. The California Assembly Concurrent Resolution proclaimed May 2003 as Postpartum Mood and Anxiety Disorder Awareness Month.

CASE HISTORY Andrea Yates—The Devil Spoke to Her

In 2001, 35-year-old Andrea Yates drowned her five children, ranging in age from 6 months to 7 years, in the bathtub one by one.

During her trial, facts about her mental state came to light. She had suffered postpartum depression after the births of her last two children. Psychiatrists had diagnosed her as suffering from postpartum depression/postpartum psychosis. She would not always take her powerful antipsychotic medication, Haldol; 2 weeks before the drownings, her doctor discontinued its use. Even to the untrained eye, Andrea appeared *mad.* She refused to feed herself and the children from time to time. She hallucinated and frantically read the Bible.

Adding to her torment were the sermons of their church's pastor. He centered on the wickedness of Eve and claimed that any mother who did not rear her children according to the precepts of Jesus Christ would go to hell—so too would her children. Andrea became convinced that she was a *bad* mother. Satan was inside her, and she had to kill her children to save them from hellfire and damnation. Her husband, an ardent member of the congregation, said he did

everything he could to support Andrea. Given Andrea's fragile mental state, her mother-in-law often helped her with the children for hours on end. Despite such support, Andrea remained psychotic, and no one gave her the mental health services she needed.

Strangely, a well-known expert witness for the prosecution said he believed that Andrea was *not* mentally ill and that she was copying a crime she had seen on *Law & Order.* In this episode, a mother who had drowned her children was acquitted on an insanity defense. The jury found Andrea guilty of three of the murders and the judge sentenced her to life in prison. Experts complained about Texas's definition of insanity, and family members blamed the medical community.

Law & Order, however, had never taped such a show! This error became the basis for a second trial, in 2006. This time the jury found Andrea *not guilty by reason of insanity.* Prosecutors took no action against the expert witness for his "honest mistake." The judge sentenced Andrea to a maximum-security mental hospital to remain there until psychiatrists deem her no longer a threat (Associated Press, 2006b; Yardley, 2002).

Munchausen by Proxy

One especially rare and unrecognized type of child abuse is Munchausen syndrome by proxy (MBP). In these strange cases, adult caretakers *falsify* to medical personnel *physical and/or psychological symptoms* in a child to meet their own psychological needs. Typically, children who are victims of MBP are "paraded before the medical profession with a fantastic range of illnesses" (D. A. Rosenberg, 1987, p. 548). The principal routes that caregivers take to produce or feign illness in children include the fabrication of symptoms such as altering laboratory specimens, and the direct production of physical symptoms. For example, caregivers have been known to contaminate children's urine specimens with their own blood and claim that the children have been urinating blood. One mother repeatedly administered laxatives to her child, causing severe diarrhea, blood infection, and dehydration (see D. P. H. Jones, 1994; J. M. Peters, 1989; D. A. Rosenberg, 1987).

An adult's production or feigning of illness in a dependent child is considered *abusive,* primarily because of the serious physical consequences to the child. The procedures that caregivers use to produce illnesses often cause a child physical discomfort or pain (Stirling, 2007). For example, one caregiver administered ipecac to a child to produce recurrent and chronic vomiting and diarrhea (McClung, Murray, & Braden, 1988; see also "Caustic Ingestion," 2010). Such behaviors may result in a child's death. As a case in point, one study of five families with eight children found that all of the victims were poisoned or suffocated by their mothers, and two of the children died (Vennemann et al., 2004). One possible prevention strategy is to place the child in foster care because of the dangerousness of the mother's behavior (Sanders & Bursch, 2002).

The Difficult Child Model

Other theorists have focused on the *behavior* of the child as the major cause of CPA. From this standpoint, children with certain characteristics (such as mental disabilities, aggressiveness,

young age) are at increased risk for abuse (Chen, Hou, & Chuang, 2009). Researchers have also suggested that difficult behavior and specific temperaments in children may contribute to abusive incidents (e.g., Youngblade & Belsky, 1990). Some parents, for example, may lack the skills to manage children who are annoying, defiant, argumentative, or vindictive, and their frustration may lead to child abuse (see J. D. Ford et al., 1999). Children given a psychiatric diagnosis are also at greater risk for abuse than children without psychiatric diagnoses. Furthermore, diagnosed children are at significantly greater risk for **polyvictimization** (Cuevas, Finkelhor, Ormrod, & Turner, 2009).

Regardless of the cause of a child's behavior, CPA is associated with especially demanding and difficult child care. Nonetheless, the behavior of a child should never be accepted as a justification for an adult's violent behavior. Legal statutes governing adult behavior do not grant adults the right to inflict physical injury on children who are difficult. Children cannot be held responsible for their own victimization. In addition, it is important to remember that although characteristics of the child are important, they are only one factor among many that contribute to CPA (Sidebotham & Heron, 2003).

Parent-Child Interaction Model

Parent-child interaction theories suggest that difficult child behaviors interact with specific parental behaviors to result in CPA (Crittenden, 1998; van Bakel & Ricksen-Walraven, 2002). That is, it is the *behavior of both parent and child,* rather than the behavior of either alone, that promotes violence. Studies have repeatedly demonstrated, for instance, that punitive parenting is associated with negative child behavior and outcomes. Researchers in one study contrasted three groups of adults aged 15 to 54 whose retrospective data were available in the National Comorbidity Survey (NCS; Kessler et al., 1994): (a) those who experienced *no physical punishment* (35.5%), (b) those who experienced *physical punishment only* (48.%), and (c) those who experienced *child abuse* (16.5%). Research participants responded to a number of tests of childhood abuse, parental bonding, psychiatric disorders, *and* socioeconomic variables. The physically punished group experienced *less maternal warmth, less paternal warmth,* and *less protective parental bonding*. The punished group also had a greater chance (odds ratio) of manifesting *psychiatric disorders: major depression, alcohol abuse/dependence,* and *externalizing problems.* These results offer very strong support for an association between childhood spanking and adult psychiatric disorders (Afifi et al., 2006).

Some experts have suggested that difficulties in parent-child relations develop during the abused child's infancy, when early *attachments* between parent and child are formed (Erickson & Egeland, 2010; Hennighausen & Lyons-Ruth, 2010). A child may be born with a particular characteristic, such as a difficult temperament or a physical disability, which creates an excessive challenge for a parent and interferes with the development of a secure attachment between the parent and child. This vulnerability may in turn lead to further difficult child behaviors and increased challenges for the parent. Such a pattern may escalate and result in physical abuse when the challenges exceed the parent's tolerance or capability threshold. Research, however, seems to suggest that the temperament of the infant is *not* causal in forming attachments (Sroufe et al., 2010; see also Cerezo et al., 2008). Nevertheless,

these findings do not detract from the many findings of temperamental differences among infants (e.g., Else-Quest, Hyde, Goldsmith, & Van Hulle, 2006).

Social Learning Theory

As noted throughout this text, many retrospective studies have demonstrated that a significant percentage of adults who abuse children were abused themselves as children. In one study, mothers' childhood physical abuse was associated with outcomes for infants: (a) poorer mother-child interaction, (b) increased vigilance, and (c) difficulty recovering from distress among infants (A. J. Lang, Gartstein, Rodgers, & Lebeck, 2010). Abusive adults presumably learned through experiences with their own parents that violence is an acceptable method of child rearing. They also missed the opportunity as children to learn appropriate and nurturing forms of adult-child interaction (e.g., Medley & Sachs-Ericsson, 2009; Milner et al., 2010).

Parenting styles. The findings from prospective studies consistently support the notion that *parenting styles* are passed from one generation to the next (e.g., McKinney et al., 2009; Van Ijzendoorn, 1992). One illustration is the *intergenerational transmission of attachment style* (Belsky, 2005; see also, Doyle, Markiewicz, Brendgen, Lieberman, & Voss, 2000). One investigation identified strong associations between specific types of childhood abuse and adult abuse of one's own children: (a) Parents who had been neglected during their own childhood, relative to those who had not, were 2.6 times more likely to neglect their own children and 2 times more likely to physically abuse their own children, and (b) parents who had been physically abused during childhood, relative to those who had not, were 5 times more likely to physically abuse their own children and 1.4 times more likely to neglect their children (Kim, 2008).

Observational learning. Other opportunities for social learning stem from seeing violence. As one example, children who observe (witness) interparental violence are likely to engage as perpetrator or victim in their own adult intimate relationship (Fehringer & Hindin, 2009; see also A. Flynn & Graham, 2010).

Situational and Societal Conditions

Economic disadvantage. D. G. Gil (1970) was one of the first to point out that a high proportion of abused children come from poor and socially disadvantaged families. Subsequent research has supported these early findings, indicating that CPA is more common among low-income families and families supported by public assistance than among better-off families. Children whose fathers are unemployed or work part-time are also at greater risk for abuse than children whose fathers have full-time employment (Sedlak et al., 2010; Zielinski, 2009).

Social isolation/social support. One group of studies indicates that perpetrators of CPA report more interpersonal problems outside the family—such as social isolation, limited support from friends and family members, and loneliness—than do nonperpetrators (e.g., Coohey, 2007; Staggs, Long, Mason, Krishnan, & Riger, 2007). Abusive parents often lack an extended

family or peer support network. Compared with nonabusive parents, abusive parents have relatively fewer contacts with peer networks as well as with immediate family and other relatives (e.g., Coohey, 2007; Whipple & Webster-Stratton, 1991). As noted previously, children who had grandparents were significantly less likely to be abused than those who did not, suggesting that having an extended family may have functioned to reduce isolation and hence CPA (Sedlak et al., 2010).

Stress

Research indicates that some situational variables, particularly as they affect the levels of stress within families, are associated with child physical abuse. Research evidence has clearly established that parenting stress strongly influences both parenting behaviors and children's behavioral and emotional problems (Huth-Bocks & Hughes, 2008). The importance of a mother's psychological functioning came to light in a comparison of *intolerance for children's misbehavior.* Abusive mothers ($n = 80$) in contrast to nonabusive mothers ($n = 86$) experienced more stress stemming from children's misbehavior (McPherson et al., 2009; see also McKelvey et al., 2008; C. A. Walker & Davies, 2009).

In their review of the literature, D. A. Black, Heyman, and Slep (2001) found that CPA is generally associated with high numbers of *stressful life events* as well as *stress associated with parenting.* Stressful situations that appear to be risk factors for CPA include the presence in the family of a *new baby, illness, death of a family member, poor housing conditions,* and *larger-than-average family size* (e.g., Wolfner & Gelles, 1993). Other situational variables associated with CPA include high levels of stress in the family from *work-related problems* and pressures, marital discord, conflicts over a child's school performance, illness, and a crying or fussy child (Barton & Baglio, 1993).

Military families. Newer research has uncovered strong associations between *stress associated with military service* and physical child abuse and neglect. One inquiry compared military and nonmilitary families on two dimensions derived from *aggregate population data* in Texas: (a) child maltreatment records (from NCANDS), and (b) military deployment records. The research team compared data *before* October 2002 with data from the period *afterward* (October 2002 through June 2003). The rate of substantiated CPA cases per month *doubled during the after period (the deployment period),* and child abuse rates increased both upon deployment *and* upon return from deployment. The rates among nonmilitary families stayed static (Rentz et al., 2007; see also Gibbs, Martin, Kupper, & Johnson, 2007). Other evidence stems from analyses of veterans. An analysis of child physical abuse among *female* military veterans found a prevalence rate of 45% (Sadler, Booth, Mengeling, & Doebbeling, 2004; see also Munsey, 2007a).

Children's behavior during deployment. Another inquiry compared children aged 3 to 5 years of age who had a deployed parent (33% of 233 military families) with children who did not. Children with a deployed parent had significantly *higher externalizing scores* than the comparison group. In addition, parents with a deployed spouse had significantly *elevated depression* when contrasted with their counterparts (Chartrand, Frank, White, & Shope, 2008).

Stress related to intimate partner violence. It is not surprising that mothers who are experiencing male-to-female intimate partner violence would exhibit more stress and hence decreased parenting efficacy. "Living with violence terrorizes children and presents a formidable barrier to women's resources and confidence to meet their children's needs" (P. G. Jaffe & Crooks, 2005, p. 2). A different comparison of abused and nonabused rural mothers indicated that abused mothers sought health care advice significantly more frequently than nonabused mothers (Ellis et al., 2008). If pediatricians and other health workers would routinely screen mothers for spouse abuse, it might lead to helpful referrals and eventually to a reduction in maternal stress and better parenting (see Glowa, Frasier, & Newton, 2002).

Cultural Acceptance of Corporal Punishment

Historically, the view of children and wives as "property" permitted the use of violence against them. Physical chastisement of wives is no longer legal and no longer generally socially acceptable in the United States. Unfortunately, the belief in the legitimacy of physical discipline of children still remains (Garbarino, 2005). So far there are *no federal laws against spanking children,* and only half the states ban spanking in child care settings and/or schools. Parents may still hit children at will in their own homes (Bitensky, 2006). (See www.sagepub.com/barnett3e for a list of possible cultural contributions to CPA.)

Predicting injury from physical punishment. Some injuries and even fatalities are the result of punishment that got out of control (J. E. B. Myers, 2005). A *prediction* of injury (endangerment) forms the basis of CPS workers' decisions to remove the child from the home. In light of the consequences of their decisions, their assumptions about the likelihood of injury deserve evaluation. Beliefs about assaults include the following: (a) Injurious and noninjurious actions are *qualitatively different,* (b) the *determinants* of injurious assault *differ* from the determinants of noninjurious assault, and (c) *caregiving quality* differs during injurious versus noninjurious assaults.

A study examining whether the characteristics of the child, the family, or the social context might provide valid information about risk factors for injury from physical punishment produced *no* significant results. The researchers interpreted the data to mean that *trying to predict injury* from physical punishment may be questionable (Gonzalez, Durrant, Chabot, Trocmé, & Brown, 2008).

Evangelical parenting. Certain *Protestant religious beliefs* (belief in hell, authoritarian parenting) and *sociopolitical conservatism* play a forceful role in the acceptance of physical discipline of children (Ellison & Bradshaw, 2009). Importantly, such beliefs do *not* incorporate acceptance of child physical abuse. In fact, one investigation was able to show that Protestant parents who used corporal punishment were *not* more likely to be guilty of CPA than parents with different beliefs (Dyslin & Thomsen, 2005). A few other findings suggest improved parenting among Protestant religious parents. Evangelical fathers, for instance, were more likely to spend quality time with their children, and Protestant parents were *less* likely to yell at their children (Bartkowski & Wilcox, 2000; Bartkowski & Xu, 2000). The United Methodist Church has now called for a ban on corporal punishment (see Knox, 2010). Another survey noted an association between risk potential for CPA and *extrinsic religiosity* but not for intrinsic religiosity (Rodriguez & Henderson, 2010).

Risk Factors for Child Physical Abuse

There are multiple risk factors implicated in the empirical literature as playing important roles in the physical abuse of children. Evidence continues to accumulate that cultural acceptance of corporal punishment as a method of discipline is a factor that is conducive to CPA (Gershoff, 2008). With a sample of 1,435 parents interviewed by phone, a group of researchers produced empirical evidence for two hypotheses. First, *frequent spanking* is a predictor of child physical abuse. Second, *spanking the buttocks with an object* (may legally be "spanking") is a very strong predictor of CPA (Zolotor, Theodore, Chang, Berkoff, & Runyan, 2008). See Table 4.10 for a more complete summary of risk factors for CPA.

TABLE 4.10 Risk Factors Associated With Physical Child Abuse

Risk Factors Associated With the Parent-Child Relationship		
Characteristics of the child	Young age	Physical and mental disabilities
	Difficult child behaviors	Insufficiently self-protective
Characteristics of the parent	Deficits in parenting skills	View parent role as stressful
	Unrealistic expectations of children	Negatively biased perception of children
	Power-assertive discipline	
Risk Factors Associated With Family Environment		
Characteristics of the family	Abuse of spouses and children	Marital discord
	Few positive interactions	Spank child frequently
	Spank child on bottom with object	
Risk Factors Associated With Situational and Societal Conditions		
Situational conditions	Low socioeconomic status	Large family size
	Single-parent household	Social isolation/lack of social capital
	Receiving public assistance	Situational stress
	Blue-collar employment	Unemployment or part-time work
	Poverty	Family disorganization
	Community violence	
Societal conditions	Cultural approval of violence in society	
	Cultural approval of corporal punishment	
	Power differentials in society and the family	

SOURCES: A representative but not exhaustive list of sources for information displayed in this table includes Annerbäch, Svedin, & Gustafsson, 2010; Cuevas, Finkelhor, Ormrod, & Turner, 2009; de Paúl, Asla, Pérez-Albéniz, & Torres-Gómez de Cádiz, 2006; de Paúl, Pérez-Albéniz, Guibert, Asla, & Ormaechea, 2008; Gershoff, 2008; Leslie et al., 2005; Maker, Shah, & Agha, 2005; C. M. Rodriguez, 2010; Stith et al., 2009; R. Thompson, 2007; H. A. Turner, Finkelhor, & Ormrod, 2010; U.S. Department of Health & Human Services, 2008; Zolotor, Theodore, Chang, Berkoff, & Runyan, 2008.

Polyvictimization/Overlapping Risk Factors

In a retrospective Canadian health study of 9,953 children 15 years old or older, researchers uncovered important facts about neglect and maltreatment. They tallied negative childhood experiences, such as physical abuse, sexual abuse, exposure to marital conflict, poor parent-child relationship, low parental education, and parental psychopathology (Chartier et al., 2010; see also Appleyard et al., 2005; Greenfield, 2010):

- 72% of respondents reported at least one negative childhood experience.
- 37% reported two or more adverse childhood experiences.
- Effects on health from physical or sexual abuse were stronger than for other types of abuse.
- An aggregate measure of abuse revealed increased negative health effects with each additional abuse experience—cumulative effects.
- Adverse experience overlap can increase the likelihood of becoming risk factors for adult health problems.

Protective Factors That Reduce Likelihood of Abuse

The Centers for Disease Control and Prevention (n.d.) has summed up research that has identified factors associated with reduced risks of child maltreatment. See Table 4.11 for a list of these factors.

TABLE 4.11 Factors Associated With Reduced Occurrence of Child Abuse

Family Protective Factors		
Supportive family environment	Child monitoring	Access to health care
Nurturing parenting skills	Parental employment	Access to social services
Household rules	Adequate housing	Extended family support
Family-protective communities		

Contemporary Theories of Child Physical Abuse

In the past decade, experts have formulated several theories of child physical abuse that build on the models just described and take into account the risk factors known to be associated with CPA. Most of these theories focus on the interplay among individual factors, parent-child interaction factors, family environment factors, and situational and societal factors. **Transactional theories,** as one example, emphasize the interactions among **risk factors** and **protective factors** associated with child physical abuse. Unfortunately, both kinds of theories currently have only limited empirical support. Efforts directed toward conceptualizing such theories, however, are a positive first step in understanding the origins of CPA.

Transactional theories. Cicchetti and Lynch (1993) have developed a transactional theory that focuses on the importance of *independent factors* such as characteristics of the

individual, the family, the community, and culture. They suggest that child maltreatment results when potentiating factors that increase the likelihood of maltreatment outweigh various compensatory factors that decrease the risk for maltreatment. Transactional theories are unique in that they not only describe various factors that might contribute to CPA but also emphasize the role of the interaction of these factors in the etiology of child maltreatment. One study found, however, that numerous risk factors identified through bivariate correlational analyses did not uniquely contribute to physical child abuse (Slep & O'Leary, 2007).

SECTION SUMMARY

Explanations for Child Physical Abuse

The causes of CPA are not well understood, and scholars' views on the primary causes of CPA vary widely. Academic logicians have proposed a number of models to explain the behavior. One theory postulated that abusive behavior arises from psychiatric disturbance (e.g., mental illness, personality disorder, substance abuse). Cases of postpartum psychosis and Munchausen syndrome by proxy exemplify the link between parental mental illness and child abuse.

Others suggest that some children are so difficult (e.g., babies who have colic) that they provoke abusive parental behavior. Still others believe that the problem is rooted in stressed parent-child interactions. As a case in point, the deployment of a military spouse/father might make both parties upset, irritable, and depressed. In turn, each party might antagonize the other leading to increased CPA. A third explanation rests on learning theory. Because children learn to model the violent behavior of parents (CPA), they grow up and repeat the intergenerational cycles of violence by abusing their own children.

A significant shift in the conceptualization of CPA occurred with the birth of sociological models. These models emphasize the possible contributions to CPA of the factors of socioeconomic disadvantage, social isolation, situational stressors, and cultural approval of violence. Most likely, more than one theory may help explain CPA. As research progresses, it will be possible to narrow the determinants of CPA and thus clarify the heuristic value of various models.

PRACTICE, POLICY, AND PREVENTION ISSUES

Practice (Treatment) for CPA

Historically, the view that the mental illness of parents caused CPA led to treatment efforts directed primarily at individual parents. Treatment approaches gradually broadened to include not only *adult interventions* but also *child-focused* and *family interventions* (Chaffin et al., 2004; Oliver & Washington, 2009). C*ommunity interventions* address other multiple factors believed to contribute to CPA, such as *social isolation, financial stress,* and *excessive child-care demands.* Many parents are aware of their need for more parenting help. In one survey, 94% of parents

queried said they had unmet needs for either parental guidance or screening by pediatric providers (Bethell, Reuland, Halfon, & Schor, 2004).

Treatment for physically abusive adults. Current maltreatment experts assert that for treatment to be effective it must incorporate four components (Runyon & Urquiza, 2010):

- Parenting skills: For example, remembering to praise a child's desirable behavior—"I like the way you came to dinner right away when I called you."
- Correcting distorted cognitions/attributions: For example, "This toddler is old enough to know better than to run in the street. He is trying to make me mad."
- Coping strategies that are adaptive and nonviolent: For example, "Let me tell you what I need to feel better right now."
- Better emotional regulation: For example, impulse control—"I'll pull this baby's hair right this minute because she pulled my hair. That will teach her!"

A different scheme derived from a meta-analysis of the literature lists three factors essential to effective treatment (Oliver & Washington, 2009): Anger Management, Child Management, and Stress Management.

Parent-Focused Treatment

Although practitioners need more *cultural competence,* the *parent-focused treatment programs* consistently demonstrate improvements in parenting skills as a result of treatment (e.g., D. J. Kolko & Kolko, 2009):

Positive interactions with their children	Decreases in negative interactions
Positive perceptions of their children	Reductions in parenting stress
Effective control of unwanted behavior	Decreases in physically punitive parenting techniques
Enhanced anger control	Decreases in coercive parenting techniques
Improved coping/problem-solving skills	

In-Home Treatments

Several in-home treatments are *effective* for reducing CPA. Project SafeCare exemplifies in-home visitation treatments even though it requires more sessions than other programs. The program extends over 24 weeks and features 5 to 6 in-home visits for each component. Although the sessions are instructive, they do not rely on passive listening by parents. Instead, parents *actively* acquire needed skills through techniques such as completing

homework assignments and demonstrating (modeling) desirable parental behaviors. Some topics addressed by the training staff include *health risks* (safety hazards, proper health care skills) and *psychosocial risks* resulting from poor parent-child interactions. To check on parents' learning (e.g., parent-child interaction skills), the staff conducts assessments of parental skills according to certain protocols (Gershater-Molko, Lutzker, & Wesch, 2003; Edwards & Lutzker, 2008).

Behavior-Based Treatment Programs

There are several empirically tested *effective* programs that use cognitive-behavioral techniques. The focus of the program can be on the *parent's behavior,* the *child's behavior, parent-child interactive behaviors,* or all three. Parent training based on *behavioral (learning)* or *cognitive-behavioral principles* involves educating parents about the following elements:

- The effects of reinforcement and punishment on children's behavior
- The appropriate methods of delivering reinforcement and punishment
- The importance of consistency in discipline
- Identification of events that increase negative emotions
- Changing anger-producing thoughts
- Relaxation techniques
- Methods for coping with stressful interactions with their children

Parent-Child Interaction Therapy (PCIT). PCIT is a program to eliminate parents' physical abuse of their children. As the child and parent interact in one room, a counselor watching behind a window in another room gives the parent instructions via an electronic hearing device ("bug" in the ear). Parents learn specific skills, such as empathic listening and how to communicate the consequences for specific behaviors (see S. N. Hart, Brassard, & Davidson, 2010).

Several outcome evaluations have demonstrated that PCIT programs accomplish most of their goals (e.g., Chaffin et al., 2004; Timmer, Zebell, Culver, & Urquiza, 2010). One study compared 48 Chinese parent-child dyads that received treatment with 62 dyads that did not. Analysis of pre- and post-intervention *questionnaire* data showed that parents who received the treatment reported fewer child behavior problems and experienced less parental stress. Results from pre- and post-intervention *observational data* also demonstrated a decrease in inappropriate child-management skills and an increase in positive parenting practices (C. Leung, Tsang, Heung, & Yiu, 2009). In a second study of 73 parent-child dyads participating in a clinic-based PCIT program, investigators presented an adjunct treatment. They randomly assigned half the dyads to an in-home PCIT series of treatments and the other half to a social support treatment. Dyads who received the PCIT treatment showed a decrease in parental stress, an increase in parental tolerance for child behaviors, but no significant improvement in child behaviors (Timmer et al., 2010).

Alternatives for Families: Cognitive-Behavioral Therapy (AF-CBT)**.** AF-CBT features three phases that focus on psychoeducation, skills training, and application. Embedded within these sections are child-directed, parent-directed, and family-directed components. See Table 4.12 for a summary of the program components.

TABLE 4.12 Program Components of the Alternative for Families: Cognitive-Behavioral Therapy

Child Tasks	*Parent Tasks*	*Family Tasks*
Healthy coping	Becoming engaged in the program	Learn about physical abuse—psychoeducation
Emotion expression	Understanding the reason for the CPS referral	Clarification of abusive behaviors
Emotion recognition, expression, and management	Examining coercive behaviors within the family	Development of safety plans (what to do/ where to go when abuse seems imminent)
Cognitive processing of their experiences of abuse	Examining parental beliefs about coercion and violence	Communication skills training
Social/interpersonal skill learning	Examination of unrealistic expectations of children	Nonviolent problem solving
	Emotion regulation training	
	Parenting skills training	

In one evaluation of the AF-CBT program's efficacy, a researcher compared its results with those of families receiving a *community intervention.* Families receiving AF-CBT manifested less parental distress, risk for child abuse, and family conflict. Results also included better family cohesion and a reduction in children's externalizing behavior (D. J. Kolko & Kolko, 2009).

*The Combined Parent-Child Cognitive Behavioral Treatment (CPC-CBT)***.** CPC-CBT consists of 16 therapy sessions, each 90 minutes long. Within each session, the therapist meets the parent and child separately and together. First, CPC-CBT initiates the program with engagement strategies to motivate the parent to enter and remain in treatment. Second, implementation of a psychoeducational component provides information about different types of abuse and coercive behavior and their impacts on children and parents. Third, parents receive information about child development and setting realistic expectations for children's behavior. Fourth, children learn how to express their feelings.

During the sessions, parents practice *communication skills, positive parenting,* and *behavior management.* First they practice with the therapist and then with their children. The therapist serves as a *coach,* offering positive reinforcement and corrective feedback. Near the end of the session, the whole family develops a *safety plan* and practices how to implement it. A safety plan guides parents and children about specific actions to take, such as going into a different room, if abuse seems imminent. The family also works on communicating about abuse issues. The sessions end with the parent writing a *letter of apology* for being abusive, and the *child writes about the traumatic elements of his abuse.* An outcome evaluation judged the program to be effective (Runyon et al., 2009).

Therapeutic day care. Because abusive parents often find the parenting role challenging and have fewer child care options than other parents, programs that offer *child care* can provide

relief for overly burdened parents who need a break (Hay & Jones, 1994; R. A. Thompson, Laible, & Robbennolt, 1997). Most child interventions, however, involve therapeutic day treatment programs, individual therapy, group therapy, and play sessions. Therapeutic day treatment programs typically provide abused children with *group activities, opportunities for peer interaction*s, and learning experiences to address *developmental delays.* Group therapy may include sharing experiences, anger management, and social skills training. Play sessions include opportunities for informal interaction between abused children and adults and/or peers (e.g., Culp, Little, Letts, & Lawrence, 1991; Swenson & Kolko, 2000).

The Incredible Years. The Incredible Years Teacher Training Series is a program that helps children deal with externalizing behaviors (e.g., noncompliance, poor impulse control). Teachers have access to training modules that can be offered once a week. Children in group settings learn how to empathize and behave in prosocial ways. An evaluation of this program indicated that children become less disruptive at home and in class and also improved their academic performance (Webster-Stratton, 2009). A recent evaluation of the program reported a number of beneficial outcomes. Parent training led to many improvements in the area of disciplining children: less harsh discipline, less physical punishment, more praise/incentive behaviors, more appropriate discipline, and positive verbal discipline (Letarte, Normandeau, & Allard, 2010).

Parental support interventions. Because research has found that many abusive parents are socially isolated, some experts advocate providing them with assistance in developing social support networks made up of personal friends as well as community contacts. The kinds of community contacts that could benefit these families vary depending on their particular needs. One program that has been judged effective relied on a *group therapy format* that centers on identification of stressors common to parenting and how to cope with them. The participants include both abusive and nonabusive parents whose children attend Head Start programs (Fantuzzo, Bulotsky-Shearer, Fusco, & McWayne, 2005; see also Donohue & Van Hasselt, 1999).

Treatment by CPS agencies. Evaluations of *parenting programs* employed by Child Protective Services have shown only weak evidence of effectiveness, apparently because the programs are not necessarily research based (Casanueva et al., 2008). Nevertheless, one element of parental support *infrequently* provided by typical treatment programs is assistance in obtaining services for basic necessities (e.g., Osofsky et al., 2007). Child Protective Services agencies, by contrast, *frequently* provide *assistance in obtaining economic support* (e.g., referral to food banks). CPS also helps parents who need help in completing government forms that will allow them to obtain food stamps and other welfare assistance.

Family preservation and out-of-home care (foster care). Intensive family preservation programs constitute one family-oriented approach that has received a great deal of attention in the literature. In such programs, professionals provide a variety of *short-term intensive and supportive interventions.* Most such programs focus on training parents in child development and parenting skills, as well as in stress reduction techniques and anger management (Wasik & Roberts, 1994). Advocates for family preservation have developed these programs as part of

their efforts to *prevent out-of-home placement* of abused and neglected children. Out-of-home placement may occur when CPS responds to reports of child abuse by removing the child from his or her home. Out-of-home care for child maltreatment victims includes *foster care placement, court placements with relatives* (e.g., kinship care), and placement in *residential treatment centers and institutions*.

The Adoption and Foster Care Analysis and Reporting System estimated that as of September 30, 2008, 463,000 children were living in foster care in the United States (U.S. Department of Health & Human Services, 2009a). The federal Adoption and Safe Families Act of 1997 reaffirms the principle of *family reunification* but also holds paramount the concern for children's safety. This act, which President Bill Clinton signed into law on November 19, 1997, is one of the strongest statements regarding child protection ever produced in this country. It establishes child protection as a national goal and specifies procedures for ensuring that protection.

Despite attempts at reunification, some children must return to foster care. Risk factors for re-entry include the following: (a) *prior foster care placement,* (b) *being younger than 4 years of age,* (c) *prior placement with nonrelatives*, and (d) *being neglected or maltreated physically rather than sexually.* Compared with children in foster care for reasons other than maltreatment, risk for re-entry following physical abuse almost doubled and following neglect was tripled (Connell et al., 2009). It remains unclear to what extent family preservation programs are effective in preventing child abuse (see Dagenais, Briére, Gratton, & Dupont, 2009).

Fathers supporting success. Psychologists have crafted new abuse intervention/prevention programs for fathers. Instead of holding group therapy sessions to teach fathers how to be less abusive, the experts focus on guiding fathers in methods that "help their children." One less-confrontational part of the program is a video presentation depicting parent-child interactions followed by a group discussion. Fathers evaluate the interactions in the videos and eventually bring up their own issues, thus allowing experts to explain effective and nonviolent ways to parent (see Clay, 2010).

Policy Toward Physical Child Abuse

Legal perspectives. There are several problems involved in the development and **operationalization** of state statutes aimed at addressing CPA. Some of these problems include how to define abuse in as objective a manner as possible, how to balance children's rights with parental rights, and how to apply the legal system to such a complex set of human behaviors (Daro, 1988). Until President George W. Bush signed a revision of CAPTA into law in 2003, no national laws defined CPA in a uniform manner. Now, CAPTA provides a bare-bones definition of child abuse and neglect (Child Welfare Information Gateway, 2006).

In addition, each of the 50 states and the District of Columbia has its own legal definition of CPA and corresponding reporting responsibilities. In general, all states acknowledge that CPA is physical injury caused by other than accidental means that results in a substantial risk of physical harm to the child. Other key features of states' definitions vary according to the

specificity of the acts included as physically abusive (e.g., T. J. Stein, 1993). Most emphasize the overt consequences of abuse, such as bruises or broken bones.

Mandatory reporting. During the child abuse prevention movement of the 1960s, all U.S. states adopted *mandatory reporting laws.* These laws require certain professionals to report suspected cases of child maltreatment. Professionals who are mandated to report typically include the following:

- Medical personnel (e.g., physicians, dentists, nurses)
- Educators (e.g., teachers, principals)
- Mental health professionals (e.g., psychologists, counselors)
- Public employees (e.g., law enforcement, probation officers)
- Day care personnel

Many individuals mandated to report suspected abuse encounter challenges in carrying out these requirements. One aspect of the problem is the complexity of reporting. To assist mandated reporters, individual states have prepared booklets specifying detailed guidelines (State of California 2003). With training, some personnel (e.g., nurses) can become the key personnel in recognizing and reporting child abuse (Fraser, Mathews, Walsh, Chen, & Dunne, 2010).

Mandated professionals sometimes have qualms about reporting abuse. Imagine, for example, the nature of the relationship that could develop between a clinical social worker and a troubled mother. After working together for several months, the mother, who has come to trust the social worker, confesses that she sometimes spanks her 3-month-old baby very hard. By law, the social worker is required to report the case to CPS. Experience tells her, however, that given the ambiguity of abuse definitions and the limited physical evidence in this particular case, it is unlikely that the abuse allegation would be substantiated. The family needs help and wants help, and the social worker knows that she is in the best position to provide that help. If the social worker reports the case, she violates the trust she has painstakingly built. In addition, the most likely outcome would be no provision of services and no legal action (Emery & Laumann-Billings, 1998).

Prosecuting individuals who abuse children. Throughout history there have been few legal orsocial costs for child maltreatment. For much of human history, adults have physically and sexually abused children with state endorsement. Child maltreatment offenders are still not uniformly prosecuted for their crimes. Prosecution and conviction rates for child abuse are still very low (Dissanaike, 2010). Myers (2010) explains why this statement is true. He likens the criminal justice system to a funnel that begins with all cases that are officially reported at the broad end and ends with convictions at the narrow end. At every step in the system, fewer cases move forward toward prosecution, that is, toward the smaller end of the funnel:

1. The police receive a report of CPA.
2. The police do not investigate every case.
3. The police arrest only some of the accused and then turn the case over to the prosecutor.
4. The prosecutor decides to prosecute a case only if he has sufficient evidence to convict.
5. The prosecutor takes the case to the grand jury or follows a similar process.
6. The jury usually agrees with the prosecutor and indicts the accused.
7. The accused is arraigned and a defense attorney appointed.
8. The judge holds a preliminary hearing so he can decide whether to compel the accused to be tried.
9. Most cases undergo a plea bargaining process in which the accused pleads guilty to a lesser charge and receives a judgment (e.g., 2 years in jail).
10. Only about 10% of the cases actually go to trial.
11. If convicted, the criminal can appeal his conviction or ask for probation.

The process as outlined above calls attention to the vast number of protections afforded a criminal defendant in the American justice system. Despite the difficulty in prosecuting cases of child maltreatment, there is some evidence that child abuse is treated much like other crimes within the American criminal justice system. The proportion of child maltreatment cases that proceed to trial, for example, is approximately 10%, which is similar to the proportion for criminal cases in general (G. S. Goodman et al., 1992; Tjaden & Thoennes, 1992).

Human rights violations. "Hitting children is a clear violation of children's human rights" (Knox, 2010, p.103). Fortunately, international agencies are making clear progress in ending physical discipline of children. Human rights protections for children clearly state that hitting children is not acceptable. The United Nations proclaims that no violence against children is justifiable. As of 2010, 24 nations have banished corporal punishment of children. All nation members of the U.N. have ratified Human Rights Conventions for the protection of the child except Somalia and the United States. In some countries, hitting a child falls under assault laws (see Knox, 2010).

Cross-cultural responses to CPA. Other countries across the globe are responding to child physical abuse. A sample of these responses follows:

- *Yemeni* authorities have noted the connection between *harsh physical discipline (beatings)* and two outcomes: (a) *school failure,* and (b) *psychological maladjustment.* Yemen urgently needs programs to teach parents behavior modification techniques (Alyahri & Goodman, 2008).

- *Saudi Arabia* has instituted a series of Child Abuse and Neglect protection centers operating within medical centers. The number of reported cases increased during the period between 2000 and 2008 as the work of the protection centers expanded (Al Eissa & Almuneef, 2010).
- *Korean* maltreated children ($N = 357$) ages 9 to 12 participated in a study of maltreatment. Both CPA and emotional abuse were common. Face-to-face interviews with 14 children provided insight into the lives of these children. Typically, alcoholic parents abandoned the children when they were very young. The children went through several cycles of being put into protective care, then reunified with their parents (whom they usually had not seen for a year), only to be mistreated again and put into protective care again. Communities need to develop a holistic approach to the care of these children (Ju & Lee, 2010).

Medical policies. Medical professionals can function as effective sources of support in regard to determinations of physical (and sexual) abuse (Pariset, Feldman, & Paris, 2010). In addition to conducting a medical exam, a doctor needs to understand the context of a child's injuries, the likely biases of any witnesses, and the probability that the injuries he finds could be accidental. He further must receive information about law enforcement's findings, such as where the injury occurred. He must interpret various laboratory tests, take the child's age and developmental status into account, and examine the child's medical history (see Reece, 2010; see also Newman, Holenweg-Gross, Vuillerot, Jeannet, & Roulet-Perez, 2010).

Research Issues

A review of publications on treatment of CPA perpetrators yielded important analyses (Oliver & Washington, 2009):

- Addressing parents' social needs and providing case management are both important elements of treatment.
- High therapy drop-out rates undermine the interpretations of the findings.
- Male caregivers' participation occurs at a very low level.
- Despite exhortations to improve research designs, studies may still fail to include control groups.
- Pretreatment evaluation measurement may lack validity because parents may minimize their parenting problems.
- Most programs are psychoeducational and therefore do not directly address parents' psychological needs.
- Safety screening should occur before all family members receive treatment.
- Treatment failures do not readily appear in the literature.

Prevention of Child Physical Abuse

Most experts in the field of child maltreatment agree that, to be successful, strategies for preventing CPA must be aimed at all levels of society (e.g., family, community, social service institutions). One aspect of prevention involves correct and early recognition (CDC, 2008). Another involves specialized programs for groups, such as teenage parents.

Medical settings. Approximately 84% of pregnant women in the United States receive some prenatal care, and about 99% of infants are born in medical settings (J. A. Martin, Hamilton, et al., 2007). These circumstances provide medical professionals with an opportunity to detect and manage infant abuse (CDC, 2008). Researchers are crafting a screening tool to identify parental risk of harsh punishment of infants and older children for use by medical workers. When available, it will be a useful adjunct to counseling parents (Feigelman et al., 2009).

Anticipatory guidance. An idea forwarded by nursing researchers is to have a concise discussion with parents before any children's major health care problems occur. Information about refraining from hitting, shaking, or spanking their child can be part of the discourse. Other information can include topics such as securing firearms and preventing exposure to violent media (Barkin et al., 2008; Price & Gwin, 2007).

Public awareness. 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. Media can render a service by striving to publicize the danger of *specific disciplinary practices,* such as spanking a child frequently or hitting a child on the buttocks with an object (Zolotor et al., 2008). One evaluation judged a public awareness campaign effective on the basis of the dramatic increase in the number of calls received by a national child abuse hotline in the period after the campaign (Hoefnagels & Baartman, 1997).

Grandparenting

Assistance by grandparents may play a role in preventing abuse. Research on grandparents who raise their grandchildren has only recently begun. One group of studies covers the effects on grandparents of providing care for grandchildren. These assessments find that grandparents may suffer from stress and depression associated with providing care. Sometimes, caring for grandchildren poses an economic burden on grandparents or calls into question their legal rights. Another group of studies examines whether grandchildren are safe in their grandmothers' care and whether they are thriving. Because the research has generally relied on small sample sizes, it is too early to draw any definitive conclusions about grandparenting (e.g., Dolan, Casanueva, Smith, & Bradley, 2008; Dunifon & Kowaleski-Jones, 2007; Letiecq, Bailey, & Porterfield, 2008).

One larger inquiry of 1,051 racially diversified grandmothers is available. It found significant differences attributable to race. Latina grandmothers had the highest scores on life satisfaction. African American grandmothers who had custodial care of their grandchildren were more satisfied than grandmothers who had co-parenting responsibilities with the parent. White grandmothers had the highest negative mood about their roles. They frequently stepped in to care for grandchildren when the parents were incapacitated by drugs (C. C. Goodman & Silverstein, 2006).

Generally, the presence of grandparents is associated with fewer incidents of child abuse and fewer incidents of severe child abuse. Using the harm standard, NIS-4 data for all categories of abuse rates were as follows (Sedlak et al., 2010):

- 6.1 per 1,000 *incidents* of child abuse occurred for children *with* an identified grandparent.
- 7.6 per 1,000 *incidents* of child abuse occurred for children *without* an identified grandparent.
- 3.0 per 1,000 children *with* a grandparent caregiver experienced child physical abuse. Inferred harm was *severe* among 2.3 per 1,000 children.
- 4.5 per 1,000 children *without* an identified grandparent caregiver experienced CPA. Inferred harm was *severe* among 3.2 per 1,000 children.

SECTION SUMMARY

Practice, Policy, and Prevention of Child Physical Abuse

Proposed solutions to the CPA problem include intervention, policy improvements, and prevention efforts. Because of the complexity of CPA, any single intervention or treatment may be insufficient for fostering change. Psychological approaches for children and their families primarily target parenting skills. For example, abusive parents probably do not know how to discipline a child correctly through a system of rewards and punishment (i.e., time-out). They most likely need education about children's social and developmental skills. Parents may not understand why they are angry or stressed and may therefore need counseling in anger control and stress management.

Treatments may be child-centered, parent-centered, or family oriented, and many treatments incorporate all three areas of concern. Some families may need additional treatment interventions that focus on psychiatric disorders, substance abuse problems, or in-home services (e.g., crisis intervention and assertiveness training). Helping parents become economically stable usually helps to reduce CPA as well.

Furthermore, community interventions have expanded to address situational and social factors that might contribute to CPA, such as social isolation and economic stressors. Efforts to prevent CPA have focused primarily on parental competency programs that include home visitation, parent education, and parent support. Such programs operate on the assumption that by enhancing parental support and parents' knowledge about parenting and child development, they can improve family functioning, which will result in lower levels of physical abuse of children.

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.

Among policy initiatives, public education campaigns have effectively increased community awareness, recognition, and understanding of the CPA problem. Head Start and school prevention programs have also contributed to the reduction of abusive parenting. The presence of grandparents in the lives of parents and children usually offers some reduction in CPA.

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Society has not always recognized physical violence directed at children as abusive, but today CPA is illegal in every U.S. state. Most state statutes and experts in the field recognize that CPA includes a range of acts carried out with the intention of harm that puts a child at considerable risk for physical injury. Laws, of course, depend on objective definitions of CPA. Laws also must balance children's rights with parental rights. Examinations of policies regarding legal statutes frequently indicate needed changes.

Fortunately, federal legislators have increased requirements for screening infants and for providing safeguards for their normal development. Medical personnel must become more active in identifying abused children and for screening abused and abusive mothers.

DISCUSSION QUESTIONS

1. Describe the distinction between harm and endangerment standards.
2. Should corporal punishment be outlawed? Is it effective? Why/why not?
3. Describe a *typical* mother who kills her baby. What might her motives be?
4. List five general categories of the effects of CPA on children.
5. Name three mediators of CPA.
6. Discuss the causes and consequences of bullying.
7. Describe a prototypical adult who abuses children.
8. What is postpartum depression and its effects?
9. Describe two different "causal" models of CPA. Which model is most heuristic?
10. Outline two treatment strategies for adults who commit CPA.

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