Chapter 1—Working With Child Abuse and Neglect Issues

Child abuse and neglect pose an increasingly recognized and serious threat to the nation's children. In the last 10 years the reported cases of abused and neglected children more than doubled, from 1.4 million in 1986 to more than 3 million in 1997; substance abuse was involved in more than 70 percent of the cases. A recent survey of State child welfare administrators found that parental substance abuse was a factor in at least 50 percent of substantiated cases of child abuse and neglect. Moreover, 80 percent reported that substance abuse and poverty were the two primary factors contributing to abuse and neglect (U.S. Department of Health and Human Services [DHHS], 1999).

Children whose parents abuse substances are almost three times more likely to be abused and four times more likely to be neglected than other children (National Center on Addiction and Substance Abuse at Columbia University [CASA], 1999). Substance abuse is a contributing factor to the abuse of at least one third of the children in the child welfare system (DHHS, 1999). It is estimated that each day five children die as a result of child abuse or neglect—up from three a day reported in 1994 (CASA, 1999; McCurdy and Daro, 1994). In reported cases, the most pervasive form of child maltreatment is neglect (60 percent), followed by physical abuse (25 percent), sexual abuse (13 percent), and emotional maltreatment (5 percent). More than 50 percent of the victims were 7 years old or younger; slightly more than half of victims were girls (Sedlak and Broadhurst, 1996).

Statistics will vary because of differences in criteria and methodology and because many cases of child maltreatment involve overlapping forms of abuse or neglect. (More details regarding the prevalence of child abuse and neglect are provided later in this chapter, along with specific definitions of what is meant by the terms "child abuse" and "neglect.") For the same reasons, it is difficult to determine if the incidence of child maltreatment is actually continuing to rise or not. However, researchers, counselors, and program administrators agree that the rise in substance abuse disorders as a factor in child abuse and neglect cases has severely complicated efforts by child welfare systems to protect children and rehabilitate families (CASA, 1999; DHHS, 1999).

Parents with substance abuse problems are less educated and less likely to be employed full time; they are much less likely than other parents to be married and much more likely to be involved in the welfare system (DHHS, 1999). However, these statistics may result from a population's reliance on public welfare systems; parents in higher socioeconomic classes can afford private systems where reporting is not mandated.

Many clients in substance abuse treatment have histories of child abuse or neglect that might affect their chances for recovery. There is accumulating research and clinical evidence that physical, sexual, and emotional abuse and neglect during childhood increase a person's risk of developing substance abuse disorders (DHHS, 1999). In addition, relapse and treatment complications may be more likely if issues related to maltreatment are not identified and treated (Brown, 1991; Rose, 1991; Young, 1995). The counselor might have more difficulty engaging clients with abuse histories, and these clients may have a variety of disabling comorbid conditions, such as posttraumatic stress disorder (PTSD) and dissociative disorders.

Given the presence of substance abuse in the majority of child abuse or neglect cases, alcohol and drug counselors may also have reason to suspect, or may discover, that clients are abusing or neglecting their own children. The children of substance-abusing parents will also face an increased risk of developing a substance abuse disorder themselves. A recent study confirms what has long been suspected, that children of alcoholics (whether or not they have been abused) have an altered brain chemistry that may make them more likely to become alcoholics themselves (Wand et al., 1998).

If the cycle of intergenerational substance abuse and child abuse and neglect is to be broken, counselors must address these issues. This is discussed in Chapter 5. Counselors will sometimes find it challenging to maintain the therapeutic alliance with clients that is central to successful treatment while meeting their legal obligations to report suspected or known maltreatment (see Chapter 6).

Substance Abuse and Child Abuse and Neglect

Treatment providers have observed that a large proportion of their clients report being physically, emotionally, or sexually abused as children. This clinical knowledge is increasingly supported by research findings. Most of this
research has focused on one of two questions:

1. Are people with substance abuse disorders more likely to have been abused or neglected as children than are people without substance abuse disorders?
2. Are those who report a history of childhood abuse or neglect more likely than their peers to have a substance abuse disorder?

Specific answers to these questions depend to some extent on gender, and therefore the literature for men and women should be examined separately. Because most of the available information in this area focuses on childhood sexual and physical abuse, this TIP primarily addresses these two forms of maltreatment. As noted above, however, neglect is the most prevalent type of child maltreatment, and witnessing domestic violence is also a common (and potentially damaging) form of childhood trauma. (See TIP 25, Substance Abuse Treatment and Domestic Violence [CSAT, 1997b] for more information on how to deal with this significant problem.)

Rates Among Adolescent Girls and Women

A review of several studies found that women who abuse alcohol reported higher rates of childhood sexual and physical abuse than their peers without such disorders (Langeland and Hartgers, 1998). The likelihood of substance abuse disorders was directly related to the severity of childhood abuse as well. A more exhaustive literature review found that women with substance abuse disorders were nearly two times more likely than women in the general population to report childhood sexual abuse. These women were also more likely to have experienced physical abuse (Simpson and Miller, in press).

Miller and her colleagues found that 70 percent of women in treatment for alcohol use disorders reported some form of childhood sexual abuse, while only 35 percent of the women in the general population did the same (Miller et al., 1993). Twelve percent of the women with alcohol use disorders did not suffer any form of sexual or physical abuse, compared with 41 percent of the control sample. The study concluded that parental alcoholism and child abuse were both independent risk factors for problematic drinking among adults, suggesting that childhood abuse itself contributes uniquely to the genesis of substance abuse disorders.

A 1995 literature review reveals a link between childhood sexual abuse and substance abuse (Polusny and Follette, 1995). In community samples, the authors found that the lifetime diagnosis rate of substance abuse disorders was 14 to 31 percent among women who had been sexually abused and 3 to 12 percent among women who had not been abused. In clinical samples, the rate of lifetime substance abuse diagnoses among sexual abuse survivors ranged from 21 to 57 percent, compared with a range of 2 to 27 percent for women without such histories. Another representative study of young adults found that 43.5 percent of the women who had been sexually abused as children met diagnostic criteria for an alcohol abuse disorder, while the criteria were met by only 8 percent of those who had not been sexually abused (Silverman et al., 1996).

The available research does indicate that women with substance abuse disorders are more likely than other women to report childhood abuse and women with childhood abuse histories are more likely than other women to have substance abuse disorders. Despite these findings, it is unclear to what extent the relationship between childhood abuse and the development of substance abuse is causal. Genetics, for example, might account for the association—child abuse might simply be incidental to the process in which the genetic propensity for drinking is passed from parent to child. Childhood stress from sources other than abuse and neglect might also contribute to substance abuse among adults (Malinosky-Rummell and Hansen, 1993). However, even when parental history of alcohol problems and measures of childhood stress are statistically controlled, childhood sexual and physical abuse still seem to contribute significantly to the alcohol-related problems of women (Bennett and Kemper, 1994; Miller et al., 1993).

Rates Among Adolescent Boys and Men

There are fewer studies of child abuse among boys and men with substance abuse disorders, and findings are less consistent than those generated for girls and women. One group of researchers believes that data are insufficient to determine (1) whether men with alcohol abuse disorders are more likely than their peers to have suffered childhood abuse, or (2) whether men with childhood abuse histories are more likely than other men to have alcohol abuse disorders (Langeland and Hartgers, 1998).

Simpson and Miller found 27 studies that addressed the issue of childhood abuse and neglect among men with substance abuse disorders (Simpson and Miller, in press). Only 10 of these studies found childhood sexual abuse rates higher than the national average of 16 percent (Finkelhor et al., 1990), and only six of these studies found rates above 10 percent. Most studies reveal that men with substance abuse disorders actually suffered less sexual abuse than their peers; however, these men did report unusually high rates of childhood physical abuse.
The few prospective studies of childhood abuse among men suggest that abuse does increase the risk of alcohol abuse (Simpson and Miller, in press). Men who report childhood abuse also may be more likely to have a substance abuse disorder, but this conclusion is not certain. Societal expectations of self-reliance and fear of homosexual stigmatization may prevent these men from disclosing childhood sexual abuse (Briere et al., 1988). Current trends, however, suggest that men are becoming more willing to disclose histories of sexual abuse. Although the incidence of abuse has remained stable for women, far more men are reporting sexual abuse than have done so in the past (Simpson and Miller, in press). Men with substance abuse disorders are also reporting more childhood physical abuse. Current study techniques simply may be more sensitive for sexual abuse among men, but further study is needed.

Most studies that have examined the rates of substance abuse among men with child abuse histories have found elevated rates of substance abuse disorders (Simpson and Miller, in press). One important exception to this pattern is a study that examined the rates of arrest for alcohol- and drug-related offenses among young adults with and without documented histories of childhood abuse or neglect (Ireland and Widom, 1994). This study found no relationship between a history of childhood abuse and neglect and substance abuse problems among men. It should be mentioned, however, that Ireland and Widom did not assess whether the study participants experienced child abuse or neglect that was not officially reported. Some of those who were classified as not having been abused or neglected may have experienced such maltreatment, and the results of this study are therefore difficult to interpret.

Most of the available literature indicates that men with childhood abuse histories are more likely to have substance abuse disorders than men without childhood abuse histories (Simpson and Miller, in press). The rates of childhood physical abuse appear to be higher among men with substance abuse disorders than among men from the general population. However, men with substance abuse disorders do not report more childhood sexual abuse than other men. Holmes and his colleagues uncovered several factors that contribute to the reluctance of men to report sexual abuse (Holmes et al., 1997). The shame, homosexual stigmatization, and perceptions of weakness associated with disclosure are perceived by many men to be more burdensome than the secret of abuse. Also, men are prone to minimize the negative effects that childhood sexual abuse may have, though men who were sexually abused as children are at greater risk than their nonabused peers for later psychological and emotional difficulties. Holmes and colleagues found that when men disclose a history of child abuse to their mental health counselors, its importance is often dismissed. The researchers concluded that the childhood sexual abuse of males is viewed with far less gravity than the childhood abuse of girls and women (Holmes and Slap, 1998; Holmes et al., 1997).

**Implications for Treatment of Clients With Child Abuse Histories**

**Mental Health Issues**

Adults with histories of child abuse and neglect may differ from other clients in a number of ways. Although the research base is still limited, clients with childhood abuse histories have been found to have more severe substance abuse disorders, to have started using at younger ages, and to use substances for reasons that differ from other clients. They are also more likely to have attempted suicide, to have PTSD, and to have personality or relationship problems that make them hesitant to accept help (Felitti et al., 1998), which also makes them more vulnerable to relapse.

Clients who have been sexually or physically abused as children often attribute at least part of their substance abuse to their childhood victimization. Hayek found that more than two thirds of women with incest histories believed that the abuse contributed to their alcoholism (Hayek, 1980). Another study revealed that 25 percent of incest victims in alcohol treatment programs believed their drinking problems were caused by their incest experiences (Janikowski and Glover, 1994). Individuals with alcohol abuse disorders and histories of sexual or physical abuse believe that their trauma was a considerable factor in causing their drinking problems and that it was a moderate factor in precipitating their most recent relapses (Brown et al., 1993).

Researchers who have focused on women and girls have found that those with histories of childhood abuse are likely to have developed their substance abuse problems at a younger age (Edwall and Hoffman, 1987; Jarvis et al., 1998; Paone et al., 1992) and that adolescent girls in this group are more likely than their nonabused peers to use cocaine, amphetamines, sedatives, and tranquilizers (Harrison et al., 1989a). Women in substance abuse treatment programs who were sexually abused as children use alcohol to facilitate sexual encounters more often than do other women (Hayek, 1980; Hurley, 1990; Lammers et al., 1995). They are also more likely than their nonabused peers to use substances to alleviate pain (Jarvis et al., 1998), escape family turmoil, and calm tremors (Harrison et al., 1989a). Women might also use substances to escape memories of sexual abuse (Miller and Downs, 1995; Young, 1995).
Alcohol abuse disorders are more severe among men who were sexually abused as children (Simpson, in press; Simpson et al., 1994) and may include overdoses and substance-related seizures (Krintsley et al., 1994). They are also more likely to have gone on “suicidal drinking” binges (Kroll et al., 1985). Suicide is a major problem among clients who were abused as children. These clients are more likely than their nonabused peers to attempt suicide, according to most studies (Harrison et al., 1989b; Jarvis et al., 1998; Krintsley et al., 1994; Wallen and Berman, 1992; Windle et al., 1995). Moreover, the first attempt increases the risk of others (Linehan, 1993a), so that these clients are more likely to attempt suicide again. Research is inconclusive about whether clients with childhood abuse histories are more depressed than their peers. Some findings suggest they are (Benward and Densen-Gerber, 1975; Boyd et al., 1997; Deykin et al., 1992), although others suggest they are not (Krintsley et al., 1992; Neisen and Sandall, 1990; Windle et al., 1995).

PTSD is relatively common among people who were abused physically or sexually as children (Polusny and Follette, 1995; Rowan and Foy, 1993). Among people with substance abuse problems, those with histories of childhood abuse are more likely to meet diagnostic criteria for PTSD (Brady et al., 1994; Hien and Levin, 1994; Krintsley et al., 1992), and PTSD is associated with less successful treatment outcomes (Brady et al., 1994; Brown et al., 1995; Stewart, 1996).

People abused as children are also prone to dissociative disorders (Polusny and Follette, 1995), but it is unclear whether people who have substance abuse disorders and childhood abuse histories engage in more dissociative behaviors than those without childhood abuse histories. Research on male clients in substance abuse treatment has found that those with childhood abuse histories do not report more dissociation than their nonabused peers (Dunn et al., 1993, 1995), but research on female clients in substance abuse treatment suggests that those who were abused as children use a wider variety of dissociative behaviors than other women in treatment (Jarvis et al., 1998). Ostendorf, however, found that female incest victims with alcohol problems scored lower on an index of dissociation than those without alcohol problems (Ostendorf, 1995). Alcohol, the author suggested, may serve the same functions for some as dissociation does for others. More research is needed in this area to clarify the importance of dissociative disorders among clients with childhood abuse histories.

Clients abused as children also seem to be at higher risk than their peers for other mental health and social problems. These include antisocial personality disorder (Windle et al., 1995), legal problems (Birbant et al., 1997; Krintsley et al., 1994; Kroll et al., 1985; Paone et al., 1992), and paranoia (Jarvis et al., 1998; Krintsley et al., 1992; Kroll et al., 1985). Women with substance abuse disorders and childhood abuse histories are more likely than other women in treatment to report sexual problems and abnormal sexual behaviors (Edwall et al., 1989; Hayek, 1980; Jarvis et al., 1998; Swift et al., 1996; Wallen and Berman, 1992). Clients who were abused as children are also more likely than others in treatment to be assaulted as adults, both physically (Edwall and Hoffman, 1987; Edwall et al., 1989; Haver, 1987; Lammers et al., 1995) and sexually (Wallen and Berman, 1992), and they are more likely to develop PTSD following the attack (Brady et al., 1994).

**Risk for Relapse**

Relapse is common during the treatment of substance abuse, and few clients achieve permanent abstinence on their first attempt. Although clinicians have applied a variety of promising pharmacotherapeutic and psychosocial strategies to prevent relapse (Carroll, 1997), relapse rates remain high (Miller et al., 1995a).

Many in the field believe that recovery from substance abuse is even more difficult for people who were abused as children (Brown, 1991; Rose, 1991; Young, 1995). There is fairly strong evidence that men who were abused as children enter treatment more often than other men (Krintsley et al., 1994; Simpson et al., 1994). This suggests that these men may be at greater risk for posttreatment relapse. Studies that combined males and females have also found poorer treatment compliance and outcomes for those who were victimized as children (Carran et al., 1996; Glover et al., 1996; Palmer et al., 1995). Guiterres and colleagues, however, did not find a connection between childhood abuse and treatment completion among males and females (Guiterres et al., 1994).

Childhood abuse does not seem to affect treatment outcomes among women. Women who were sexually assaulted as children do not relapse any more frequently than other women in the year following treatment (Stephenson, 1990). Childhood sexual abuse is not associated with either the likelihood of a woman attending her first referral appointment following detoxification (Hien and Scheier, 1996) or the likelihood that she will complete subsequent treatment (Wallen and Berman, 1992). Childhood abuse is also unrelated to the number of times a woman enters treatment (Brabant et al., 1997; Simpson et al., 1994).

Incest victims, moreover, do not report having tried more treatment modalities or having had more relapses than other women (Jarvis et al., 1998; Kovach, 1983). However, Haver reported poorer treatment outcomes among women who were physically abused by their mothers (Haver, 1987). In a study of aftercare compliance following childbirth, 67 percent of noncompliant women reported some form of childhood abuse while only 25 percent of
compliant mothers did the same (Killeen et al., 1995).

Implications for Treatment Providers

The Consensus Panel recommends that alcohol and drug counselors be aware of childhood abuse and the issues involved in its treatment for the following five reasons:

1. People who were abused as children are more likely than others to attempt and reattempt suicide, as noted earlier. Alcohol and drug counselors, therefore, must watch for signs of suicidal ideation. Counselors should work to help clients ease the emotional burdens of past abuse in order to diminish the likelihood of suicide.

2. Counselors may need to address childhood sexual and physical abuse in order to reduce clients’ risk of abusing their own children. Most abuse survivors do not abuse their own children (Kaufman and Zigler, 1987), although people with substance abuse disorders are at greater risk of doing so. As reported above, substance abuse contributes to almost three fourths of the incidences of child abuse and neglect (CASA, 1999; Famularo et al., 1992; Finkelhor et al., 1983; McCurdy and Daro, 1994). At least 675,000 children are abused or neglected each year by parents or caretakers with substance abuse disorders, and more than 8 million children (11 percent) in the United States are being raised by substance-abusing parents (Kropenske and Howard, 1994). Although it is not known how many of these parents are struggling with their own abuse histories, counselors should be able to address their clients’ abuse issues in order to break the cycle of addiction and violence.

3. Clients often suspect that childhood abuse contributed to their substance abuse disorders and relapses. Although they are not likely to identify precise clinical syndromes, clients may seek help in overcoming the emotional pain of childhood abuse. Counselors should be able to help these clients so that they do not turn to substances for relief.

4. By addressing child abuse issues, the risk of relapse among clients who were abused as children might actually drop below that of their nonabused peers. Preliminary evidence suggests that people with childhood abuse histories use substances as a means of "chemical dissociation." Once trauma issues are resolved, substance use may clear substantially (Roesler and Dafler, 1993).

5. People who were severely sexually or physically abused as children often develop PTSD (Rowan et al., 1994; Wolfe et al., 1994), and this disorder increases their risk of relapse because it engenders intrusive memories and attempts to avoid those memories through self-medication (Kuyken and Brewin, 1994). Therefore, clients suffering from abuse-related PTSD are likely to have endured the most severe forms of abuse. Counselors should be aware of this and know how to help such clients.

Cultural Considerations

Few researchers have studied the influence of ethnic and racial factors on childhood abuse and substance abuse disorders, but specific populations have been the object of several recent studies. For example, Carol Boyd and her colleagues researched crack cocaine addiction among African-American women (Boyd et al., 1997). Boyd's findings for this group are consistent with the larger body of research described earlier. The limited evidence in community-based samples suggests that there are not significant ethnic or racial differences in the base rate of childhood sexual abuse between African-Americans and Whites and between Hispanics and Whites (Arroyo et al., 1997).

Another study reveals similar rates of emotional, physical, and sexual abuse among Native Americans, Mexican-Americans, and European-Americans in treatment for substance abuse (Gutierres and Todd, 1997). However, Native American women reported substantially more physical abuse than other women, and European-American men reported more sexual abuse than other men. This research, along with Boyd’s work, points to the possibility of problems specific to groups, as well as the likelihood of differences in group reporting.

Treatment providers must be sensitive to the ways in which cultural factors interact with a client’s child abuse or neglect history. In a review on the relationship between racism and mental health, racism was found to be a major contributor to psychopathology among ethnic minorities (Carter, 1994; Landrine and Klonoff, 1996; Thompson, 1996). Sensitivity to such cultural phenomena helps facilitate effective interventions for ethnic minorities who have experienced childhood abuse (Manson, 1997). The Consensus Panel urges alcohol and drug counselors to be aware of how clients’ backgrounds may affect treatment.

Some of the challenges faced by culturally diverse populations seeking treatment are disparities in access and availability of services, and language and literacy differences. It is also important for counselors to be aware that
sensitivity to cultural issues includes avoiding a double standard—being overly tolerant or flexible because of uncertainty about unfamiliar social norms. Cultural differences should not be allowed to excuse abusive or neglectful behavior by parents.

**Incidence of Child Abuse and Neglect**

Child protective services (CPS) agencies received reports of over 3 million suspected cases of child abuse and neglect in 1996. CPS staff investigated 75 percent of these reports and substantiated more than 970,000 cases of child maltreatment in that year alone (DHHS, 1999; Sedlak and Broadhurst, 1996). The reported incidence of child abuse and neglect climbed from 41 children per 1,000 in 1990 to 44 children per 1,000 in 1996. Even more disturbing, researchers agree that most incidents—as many as 70 percent—of child abuse and neglect still go unreported (Briere, 1992a; DHHS, 1999).

It is estimated that 42 of every 1,000 children in the United States (under age 18) have been either abused or neglected. The number of sexually abused girls is three times the number of boys, but boys are more likely than girls to be seriously injured by abuse (Holmes and Slap, 1998). Boys are also more likely to be emotionally neglected. As noted above, there seem to be no significant differences among racial and ethnic groups in the incidence of maltreatment or maltreatment-related injuries (Sedlak and Broadhurst, 1996).

Child maltreatment may not necessarily be on the rise; society may be more informed about reporting procedures, and victims may be more educated on resources, safety in disclosure, and ability to seek help in comparison to the past. Some researchers suspect that the tremendous rise in child abuse rates may be largely due to heightened awareness of the issue by society in general (Van Dam et al., 1985). Some of the increase in reported cases may also stem from greater sensitivity among researchers to the subtle cues of abuse and neglect. However, the rate of serious injuries due to child abuse has risen dramatically (Sedlak and Broadhurst, 1996), and (as noted above) the incidence of abuse and neglect might be underestimated as a result of underreporting. Indeed, in one review of children's death certificates, 85 percent of abuse- and neglect-related deaths had been attributed to other causes (McClain et al., 1993).

**Incidence of Child Abuse and Neglect Histories Among Adults**

Given the high incidence of documented abuse and neglect among children, it is reasonable to assume that a sizable proportion of adults experienced similar childhood trauma. However, the true incidence of childhood abuse and neglect among adults is unknown. Research definitions have not been consistent, and this makes estimations difficult (Wyatt and Peters, 1986a). Inclusive definitions yield substantially higher estimates of abuse and neglect, while narrow definitions yield lower ones. Variations in research methods (e.g., questionnaires versus interviews) and populations studied also affect estimates (Wyatt and Peters, 1986b).

A large national study of randomly identified adults in the United States estimates that 27 percent of women and 16 percent of men were sexually abused as children (Finkelhor et al., 1990). Additional estimates of childhood sexual abuse among women range from approximately 7 percent (Burnam et al., 1988) to 54 percent (Russell, 1983). The actual incidence of childhood sexual abuse is unknown (Trickett and Putnam, 1993). The true incidence among adults of other forms of childhood abuse and neglect is also unclear. Physical maltreatment has been studied less than childhood sexual abuse, and inconsistent methods and definitions have made the results uncertain. The incidence of emotional abuse and neglect among adults has not been significantly studied.

**Long-Term Consequences of Child Abuse and Neglect**

Although a causal relationship has been difficult to establish, investigators report that childhood abuse and neglect are associated with later problems. Sexual abuse, for instance, has been linked to depression, anxiety, and sexual dysfunction as well as eating, personality, dissociative, and substance abuse disorders (Beitchman et al., 1992; Browne and Finkelhor, 1986; Cahill et al., 1991; Polusny and Follette, 1995). People sexually abused as children are more likely than others to have social difficulties, and their risk of physical and sexual assault is greater (Polusny and Follette, 1995). One review of the physical abuse literature found that physically abused boys are more likely to become substance abusers, though the reviewers did not include any studies of the risk of substance abuse among physically abused girls (Malinosky-Rummell and Hansen, 1993). Low self-esteem (Briere and Runtz, 1990b) and depression (Braver et al., 1992) are relatively common among college students who were emotionally abused. In fact, they are more common among those who were emotionally abused than they are among those who were physically abused (Gross and Keller, 1992; Ney et al., 1993).

**Defining Abuse and Neglect**

Alcohol and drug counselors must understand the definitions of abuse and neglect in order to adequately screen...
and assess clients who were exposed to them as children. Counselors must also know the definitions because they, like all clinicians, are required by law to report suspected or known child abuse (see Chapter 6).

Clinicians who understand the definitions of child abuse and neglect can also help clients who might not recognize that they were abused or neglected as children. According to researchers, some adults tend to deny, minimize, or forget experiences of abuse (Brown et al., 1999; Della Femina et al., 1990; Kufeldt and Nimmo, 1987). For example, Williams interviewed a sample of women in the early 1990s who had documented histories of sexual abuse occurring between 1973 and 1975 (Williams, 1994). Forty percent of the women failed to report the documented abuse during their assessments. Many of the women in this subgroup, however, did report other instances of childhood sexual abuse, leading the author to suggest that these women may in fact have traumatically forgotten the documented abuse.

**General Definition**

Both Federal and State legislation define child abuse and neglect. The Federal legislation provides a foundation for States by identifying a minimum set of acts or behaviors that constitute maltreatment. The Child Abuse Prevention and Treatment Act (42 U.S.C., §5106g), enacted in 1974 and reauthorized in 1996, defines child abuse and neglect as, at minimum, any recent act or failure to act that results in "imminent risk of serious harm, death, serious physical or emotional harm, sexual abuse or exploitation" (Courtney, 1998) to a child under the age of 18, or, except in the case of sexual abuse, under the age specified by the child protection law of the State, by a parent or caretaker (including any employee of a residential facility or any staff person providing out-of-home care) who is responsible for the child's welfare. The act defines sexual abuse as

- Employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or to assist any other person to engage in, any sexually explicit conduct or any simulation of such conduct for the purpose of producing any visual depiction of such conduct
- Rape, prostitution, and in cases of caretaker or interfamilial relationships, statutory rape, molestation, or other form of sexual exploitation of children
- Incest with children (although legal definitions may vary from State to State, incest can be broadly defined as the imposition of sexually inappropriate acts, or acts with sexual overtones, by one or more persons who derive authority through ongoing emotional bonding with that child--or any use of a minor child to meet the sexual or emotional needs of such persons)

Each State is responsible for providing definitions of child abuse and neglect within this civil and criminal context. Laws vary widely from State to State, and treatment providers must be familiar with the definitions outlined in their own State's laws. In particular, they must understand reporting laws, which describe the circumstances and conditions under which they are obligated to report known or suspected abuse or neglect. These laws also list the conditions under which counselors are allowed to report known or suspected cases described to them by a third party. Counselors should also be familiar with juvenile/family court acts that dictate when a court is allowed to take custody of a child alleged to have been abused or neglected. The definitions in these acts are often the same as those in the reporting law. Finally, treatment providers should know the criminal law in their State that defines criminally punishable forms of abuse and neglect--such as sexual abuse, severe physical abuse, and child endangerment--and the reporting requirements (see Chapter 6 for further information).

**Types of Abuse and Neglect**

There are four major types of child maltreatment: neglect, physical abuse, sexual abuse, and emotional or psychological abuse.

**Neglect**

Neglect is the failure to provide for a child's basic needs. Neglect can be physical, educational, medical, or emotional. **Physical neglect** is the most common type of neglect, and it includes the failure to meet a child's basic needs for food, shelter, and clothing that is not due to a lack of financial resources. Physical neglect also encompasses inadequate supervision and abandonment of a child, expulsion from home, and rejection of a runaway who wishes to return home. **Educational neglect** is the second most frequent type of neglect and includes failing to enroll a child in school, allowing chronic truancy, and not attending to a child's special educational needs. **Medical neglect** involves the refusal of, noncompliance with, or avoidable delay in seeking health care. **Emotional neglect**, which, like emotional abuse, is difficult to document, includes marked inattention to a child's needs for affection, refusal of or failure to provide needed psychological care, or chronic or extreme spousal abuse in the child's presence.
The assessment of child neglect requires consideration of cultural values and standards of care, as well as recognition of the role of poverty in failure to provide the necessities of life. In substance-abusing families, neglect is a much more common reason than physical abuse for a parent to be reported to CPS agencies. In one study of children in foster care who had substance-abusing parents, neglect or abandonment accounted for 70 percent of placements, whereas physical abuse accounted for only 15 percent. For children placed in foster care from families in which substance abuse was not a factor, neglect or abandonment accounted for 37 percent of the cases and physical abuse accounted for 33 percent (Walker et al., 1994).

Physical abuse

Physical abuse can range from minor bruising to killing a child and may involve a single act or repeated occurrences. It is characterized by physical injury inflicted by punching, beating, kicking, biting, burning, or other actions. Such injuries are not accidental, although caretakers may not believe that they intended to harm the child. Physical abuse includes punishment that is not appropriate to a child's age, size, or physical, mental, or emotional condition. Normal disciplinary measures do not require medical treatment, nor do they leave physical marks, such as welts and bruises. Any punishment that involves hitting with a closed fist or with an instrument, as well as kicking, burning, or throwing the child is considered abuse regardless of the severity of the injury.

Sexual abuse

Sexual abuse or incest involves a range of behaviors—including all forms of oral-genital, genital, or anal contact with the child (such as fondling a child's genitals), or nontouching abuse (e.g., exhibitionism, voyeurism), as well as sexual penetration (e.g., intercourse, rape, sodomy), and commercial exploitation of the child via prostitution or the production of pornography. It involves not only acts committed by the perpetrator but inappropriate actions the child is forced or encouraged to perform on the adult. Child sexual abuse means engaging a child in sexual activities that the child cannot comprehend, for which the child is developmentally unprepared, and for which he cannot give informed consent.

Most State laws distinguish between sexual abuse and sexual assault: An act of abuse is perpetrated by a person who has some responsibility for the child's care, whereas an assault is committed by someone other than a caregiver. However, researchers and survivors of childhood abuse perceive that caregivers or relatives who engage a child in sexual activity by use of force, life threats, and beatings are by definition committing sexual assault. For more information on consequences of sexual abuse and assault, see Funk, 1980; Gomes-Schwartz et al., 1985; Paradise et al., 1994; and Sullivan et al., 1979.

Emotional or psychological abuse

Emotional or psychological abuse includes acts of commission or omission by parents or caregivers that have caused, or could cause, serious behavioral, cognitive, emotional, or mental disorders. Examples include the verbal or emotional assault of a child as well as the child's extreme confinement by ropes or other means. Emotional abuse often coexists with other forms of abuse, and it is the most difficult to identify. Many of its potential consequences, such as learning and speech problems and delays in physical development, can also occur in children who are not being emotionally abused. In addition, the effects of such abuse may not be evident until later in life. In some States, a CPS agency can intervene in cases of emotional or psychological abuse without evidence of harm to the child's behavior or condition. Only proof of an extreme form of psychological punishment, such as confining the child to a closet, is required. CPS agencies in these States will not, however, intervene in cases of excessive rejection, blame, or belittlement without proof of harm.

Factors Affecting Research and Screening

Variations in the definitions of child abuse and neglect have made it difficult to assess the extent of the problem and its prevalence in the histories of adults. Although definitions have not yet been standardized (Briere, 1996; Whipple and Richey, 1997), researchers recognize consistency in definitions as an important goal. At present, researchers debate whether to define child abuse and neglect by their impact on the child's development (Garbarino, 1977; Garbarino et al., 1986) or by community standards for appropriate behavior toward children. These distinctions have been central in trying to define emotional abuse, but they have also helped frame discussions about other forms of abuse and neglect. However, in an effort to discourage overly zealous interventions, policymakers tend to advocate narrow definitions of emotional abuse that require proof that the child was harmed (see McGee and Wolfe, 1991, for a discussion of the issues). Some researchers, however, argue for definitions of emotional abuse that are independent of the apparent effects of the abuse (Barnett et al., 1991; Shaver et al., 1991). Emotional abuse and neglect are often ranked on a continuum, and participants are not typically categorized by the mere occurrence or absence of maltreatment. This continuum approach is becoming
more common in the study of child abuse (Bernstein et al., 1994).

Child sexual abuse is often defined broadly by researchers as any unwanted sexual experience occurring before the age of 18, including genital exposure and verbal propositions (Wyatt and Peters, 1986b). More restricted definitions typically specify that the experience must involve physical contact with someone at least 5 years older than the victim if the victim is under a certain age, usually 15 through 18 years old (Krinsley et al., 1992; Rohsenow et al., 1988). The broader conceptualization of sexual abuse yields substantially higher rates of reporting than do more narrow definitions. Acts of physical violence aimed by a parent or caretaker toward a child are considered by most to be abuse, though many studies also specify that the child must have been physically injured (Straus and Gelles, 1990; Whipple and Richey, 1997).

Simply asking clients if they were abused or neglected as children is no longer considered an adequate evaluation of maltreatment (Briere, 1992b; Miller and Downs, 1995; Wyatt and Peters, 1986b). Instead, clients are provided clear behavioral descriptions of experiences to which participants respond "yes" or "no." For example, MacMillan and colleagues used the following questions to assess physical abuse: "During childhood, did an adult often or sometimes push, grab, or shove you? Throw something at you? Hit you with something? Did an adult often, sometimes, or never kick, bite, or punch you? Choke, burn, or scald you? Physically attack you in any other way?" (MacMillan et al., 1997). The number of and manner in which such questions are asked influence the way they are answered. Also, spurious links between child abuse and other symptoms can sometimes be made. Patients with psychiatric disorders, for example, frequently search their past lives for some explanation of their distress (Pope and Hudson, 1992).

Underreporting of sexual abuse appears to be much more likely than overreporting. A therapeutic alliance may have to exist before a patient will disclose an incest history (Pribor and Dinwiddie, 1992). It may be necessary to pose questions at an intake history and then again later in the therapeutic process. For the same reasons of client reticence, Miller and Downs recommend a self-report questionnaire combined with an interview (Miller and Downs, 1995). Each method has been shown to identify cases of abuse missed by the other. See Chapter 2 for more on this issue.

One of the critical new areas of research on people with substance abuse disorders is the study of "resilience factors" that permit some sexually abused individuals to avoid addiction, while others become addicted. Research demonstrates, for example, that victimized women who become alcoholics experienced prolonged, severe sexual abuse in isolation (Beckman and Ackerman, 1995). The courts' tendency to intervene minimally can perpetuate isolation and make the development of resilient behavior less likely. Another study notes a variety of specific factors that affect resilience against addiction in individuals sexually abused in childhood, including level of self-esteem, quality of adolescent peer group, and extent to which PTSD symptoms are experienced (Miller and Downs, 1995). A client's ability to dissociate may actually promote resilience against addiction. It will be very difficult to do any type of resilience studies if "sexual abuse" is not defined as such unless there has been some measurable negative outcome for the victim.

**Personal Meanings of Abuse**

Counselors must recognize when it is appropriate or necessary to report incidents of clients' maltreatment of their children to government agencies, and for this they must know legal definitions of abuse and neglect. However, a broader approach, especially one that considers the meaning of the experience to the client, may be more useful in treatment. Finkelhor, for example, notes how sexual abuse may alter a child's perception of the world (Finkelhor, 1987). It is this altered perception, he argues, that leads to the devastating consequences of abuse. The sexually abused child might well feel betrayed and, as a result, no longer trust others (Springer, 1997). Stigmatization and shame may compromise the child's self-esteem, as well. People who were traumatized might even question their very right to exist (Greening, 1997).

Clinicians must, therefore, understand how clients interpret their experiences. Not all abuse meets the legal or commonly held criteria for abuse; nor will all clients perceive as abusive those experiences which fit the legal definition. For example, a client might report being spanked every day as a small child and might feel that he deserved the spankings because he disobeyed his mother. He might also explain that his mother loved him and that the spankings occurred within a context of caring. Such a client would deny that he had been abused as a child and would not be well served by therapists who insisted otherwise. In contrast, another client may have accepted chronic belittling and criticism while growing up and may not understand its relationship to career failures and repeated relapses.

**The Difficulty of Distinguishing Poverty From Neglect**

Almost every theoretical model of child abuse and neglect recognizes the contribution of stress to poor outcomes,
and poverty is a major source of family stress. Substandard and overcrowded housing in unsafe neighborhoods strains families, as do unemployment and discrimination. In some cases, impoverished families should not be subjected to accusations of intentional child neglect (Besharov and Laumann, 1997). CPS agencies can help counselors understand which cases truly merit investigation and which should be referred to other agencies. Counselors can contact CPS agencies and discuss confusing cases without identifying individuals and families. Counselors can also refer clients to various agencies to help them secure child care, food stamps, and free family health care as needed. (See "Role of Child Protective Service Agencies" in Chapter 5 for more information on working with the child welfare system.) Child neglect and the conditions of poverty often overlap. Even when there is no intent, physical and emotional injury can still occur. Disenfranchisement may lead to deviance, such as criminal activity, that may have an unintended impact on children, as when a parent is arrested or incarcerated. It is the responsibility of the counselor to report instances of reasonable suspicion of abuse or neglect; however, counselors should use caution when distinguishing cases of class and cultural differences from child abuse and neglect. A comprehensive assessment should be conducted before any conclusions are reached. Many CPS agencies provide training for counselors on mandated reporting requirements, and some CPS agencies have the resources for assisting families. See Chapter 6 for more information on requirements and guidelines for reporting.

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