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Child Abuse: A Review Article

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Abstract. In numerous clinical settings, therapists frequently encounter child maltreatment, including physical, sexual, and emotional abuse, as well as other forms, which are associated with a markedly increased risk for both concurrent and subsequent psychopathology. Assessing children who have experienced abuse typically takes longer than evaluating youngsters who have not. Young children—who experience the highest rates of maltreatment—present especially difficult tests because of their acute reliance on their caregiving environments.

Highlights:

1. Child maltreatment increases risk of psychopathology.
2. Assessment takes longer for abused children.
3. Young children are especially vulnerable due to caregiver dependence.

Keywords: Child Abuse, Review.

Introduction

Child maltreatment, which encompasses various forms of abuse and neglect, is one of the most powerful risk factors for psychopathology, subsequent health illness, and poor development, both now and in the future. Children who experience serious abuse are frequently placed in foster care, where they are especially vulnerable to detrimental effects on their mental health. Because Halfon and colleagues rely so heavily on their caregiving contexts, they present particularly complex assessments (1,2). It discovered that although foster children made up 41% of all mental health care consumers in California, they only made up 4% of Medicaid-eligible children. An estimated $124 billion was spent on maltreatment in the US in 2008, with an estimated lifetime cost per victim of $1,272,900 for fatal abuse and $210,012 for nonfatal abuse (3,4).

When treating abused children, clinicians who pay attention to more than simply symptom patterns and functional impairment will have greater success. To do this, they need to become knowledgeable about the processes that contribute to child abuse. In particular, the legal and child protection systems have a big impact on the overall well-being and physical placement of abused and neglected children. Clinicians may be

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contacted regarding visits, transitions, custody, and other relevant issues, and they must be willing to do so. Additionally, countertransference is strongly induced by labor in this field (5,6).

When child protective service (CPS) systems verified that 676,000 children in the United States had experienced abuse and neglect, representing an incidence of 0.91%, a significantly larger number (approximately 3.5 million children) were referred for potential maltreatment, custody, and related issues in Federal Fiscal Year 2016. Additionally, this line of work is a potent countertransference elicitor (7,8).

Younger children are particularly vulnerable to abuse and neglect, which can lead to maltreatment and death. American Indian/Alaskan Native children (1.42%) and African American children (1.39%) had the greatest rates of abuse (9,10) and there are far more adult retroactive reports of abuse (11-13). In recent years, the number of children put in foster care has ranged from 250,000 to 275,000 every year, with 400,000 to 500,000 children in the United States at any given time (8).

Classification

Within the broad type, each of the primary heads encompasses numerous specific types. Even though CPS has found that neglect is by far the most common form of abuse (14,15). The percentage of children who did not additionally experience one or more other forms of maltreatment was just 1% for children who had undergone sexual abuse, 4% for children who had been physically abused, 10% for children who had been mentally abused, and 25% for neglected children (16,17).

Negative Impacts

Developmental deficiencies in almost every area are linked to maltreatment (18,19). Mental health issues are among the most noticeable aftereffects of maltreatment and neglect of children. Burns et al., for instance, used information from the National Survey of Child and Adolescent Wellbeing (20,21). Showed that almost half (48%) of the 3,803 children between two and fourteen years who had been the subject of child welfare investigations had behavioral or emotional problems that were clinically severe. According to a study that included over 1,000 children aged five to nine who were enrolled in pediatric practices (22,23). According to population estimates, adverse

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experiences, such as abuse and neglect, account for about 45% of childhood mental problems (24,25).

When examining negative experiences and psychopathology, developmental psychopathologists have emphasized the significance of taking into account both multifinality and equifinality (26,27). While a higher percentage of children who have suffered from severe neglect in their early years go on to acquire a mental illness during their infancy and adolescence (28-30). For many diseases, the participation of environmental factors is explicitly necessary to meet diagnostic criteria (for example, posttraumatic stress disorder requires trauma, and reactive attachment disorder requires inadequate care). Stress events are recognized risk factors for certain diseases, such as major depressive disorder, but they are not necessary for diagnosis. Additionally, different types of abuse are believed to have varying effects on brain development (31,32) and may increase the likelihood of developing the same types of psychopathologies (33,34).

For instance, there is a correlation between a higher risk of externalizing psychopathology and both abuse and neglect. All things considered, we know that maltreatment is linked to a significantly higher risk of psychopathology, but that some personal characteristics (like temperament and genetics), as well as environmental factors (like reliable and caring caregivers), may shield and/or foster resilience in kids who have faced severe adversity (35,36). To shed light on the possible mechanisms behind the elevated risk of psychopathology after abuse, recent studies have looked at the procedures and structures that correspond to intermediate phenotypes (such as Research Domain Criteria) (37,38). This method frequently concentrated on how people with histories of neglect processed It reacted to shifts in executive function as well as emotional content like threats and rewards (39,40). Theoretically, these processes are connected to illnesses (e.g., decreased reward sensitivity in depression and threat processing in anxiety disorder), and they could be helpful targets for therapies aimed at preventing or treating psychopathology after it has begun. Both Viding and McCrory (41,42).

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Particular Problems in Early Childhood

There has been a growing understanding of the significance of applying developmental science findings to child welfare practice since most cases of maltreatment begin in children under the age of five and because of the early years' developmental vulnerability (43-45).

Young toddlers may have noticeable symptoms with one caregiver and none at all with another, according to clinical knowledge (46,47). According to clinical knowledge, young toddlers may have significant symptoms with one caregiver and none at all with another (48,49). Importantly, AACAP Practice Guidelines for Evaluations of Infants and Toddlers (50,51). It is advised that evaluations of young children frequently take between 3 to 5 sessions; one of the more difficult evaluations will be evaluating children who have experienced maltreatment. There are formal techniques for evaluating relationships in early children (52-54).

For younger children, foster care is a different kind of intervention than for older children, as we have argued, particularly those under three but usually up to age five (55,56). This stems from our knowledge that the quality of early childhood attachment bonds has a major role in their socioemotional development, which also serves as a significant predictor of their future psychosocial functioning, particularly in high-risk groups (57,58). Additionally, via extensive interaction with individuals who provide care, young children form and maintain relationships

Interventions

One aspect of treating maltreated children is essentially the same as treating non-maltreated children: psychotherapy and/or medication, depending on the results of a comprehensive evaluation. Of course, there are strong arguments for using evidence-based therapies to treat the symptoms and reduced functioning of abused children, as they are at the extremity of the risk continuum (59,60). There is growing worry about foster children's overuse and abuse of psychiatric medications (61,62). Examining Texas Medicaid data, for instance, these studies (63-65).

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