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Child Maltreatment: A Public Health Overview and Prevention Considerations

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Abstract

Child maltreatment (CM) is a significant public health problem, affecting hundreds of millions of children globally. CM has been linked to a variety of short- and long-term health consequences, including poor physical and mental health, changes to brain architecture and development, altered biological factors, reduced cognitive ability and educational achievement, and impaired psychosocial functioning. This article will define and describe the various types of CM and its epidemiology from a public health perspective that considers incidence, prevalence, and consequences. The authors discuss risk and protective factors and approaches for the prevention of CM, including key considerations for nurses to help identify potential victims and provide treatment and/or referrals.

Keywords

child maltreatment; long term health; short term health; brain development; protective factors; risk factors

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Child maltreatment (CM) is a significant public health problem, affecting hundreds of millions of children around the world (Pinheiro, 2006; Runyan, Wattam, Ikeda, Hassan, & Ramiro, 2002). CM has been linked to a variety of short- and long-term health consequences, including poor physical and mental health, changes to brain architecture and development, altered biological factors, reduced cognitive ability and educational achievement, and impaired psychosocial functioning (Felitti et al., 1998; Fortson & Mercy, 2012; Leeb, Lewis, & Zolotor, 2011; Middlebrooks & Audage, 2008; Shonkoff, Boyce, & McEwen, 2009). This article will define and describe the various types of CM and its epidemiology from a public health perspective that considers incidence, prevalence, and consequences. We will discuss approaches for the prevention of CM, including some key considerations for nurses to help identify potential victims and provide treatment and/or referrals.

Child Maltreatment

Addressing the problem of CM from a public health perspective is clearly warranted, given the magnitude of the problem and the burden it places on the health of the public. In the following section, we will review various definitions related to child maltreatment, followed

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by discussion of its incidence and prevalence and consequences that include risks to physical health: cognitive development and academic achievement: and emotional and behavioral health.

Definitions

...often the definition of CM is dependent upon the context in which it is used.

Kempe, Silverman, Steele, Droegemueller, and Silver (1962) first coined the term “battered child syndrome” in the early 1960s, yet defining and operationalizing experiences of child abuse and neglect still challenge researchers and practitioners today. Not only are experiences of CM heterogeneous in nature, with multiple types and subtypes, but often the definition of CM is dependent upon the context in which it is used. In particular, varied definitions employed by the multiple sectors addressing CM (e.g., Child Protective Services [CPS]; law enforcement and legal communities; medical professionals; public health officials; other advocates) often limit effective communication across disciplines and this variation constitutes a major barrier to effective surveillance, treatment, and prevention of child maltreatment (Leeb, Bitsko, Merrick, & Armour, 2012).

In an attempt to aid in the collection and use of public health-based CM data, the Centers for Disease Control and Prevention (CDC) partnered with professionals in CM research, prevention, and surveillance from a variety of settings, including universities, state health departments, hospitals, research firms, and other federal agencies, to develop conceptual definitions of CM and guidelines for use in public health settings. Because the definitions were developed through a collaborative effort, they draw upon definitions already in use in other sectors, complement existing definitions, and have been modified to fit the needs of public health professionals whose mission is to prevent child abuse and neglect before it occurs (Leeb, Paulozzi, Melanson, Simon, & Arias, 2008).

The CDC defines CM as any act or series of acts of commission (abuse) or omission (neglect) by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child (Leeb et al., 2008). Brief CDC definitions for the subtypes of CM (i.e., physical abuse [including abusive head trauma], sexual abuse, psychological abuse, and two forms of neglect: failure to provide and failure to supervise) are presented in the Table. These definitions are aligned with the World Health Organization’s (WHO) definitions and support Article 19 of the United Nations Convention on the Rights of a Child, which specifically protects children from all forms of violence, exploitation, and abuse while in the care of parents and other caregivers (Runyan et al., 2002; UNICEF, n.d.).

The Box below highlights a related area of domestic and international concern: child sexual exploitation. Due to the clandestine nature of child sexual exploitation, it is among the most difficult childhood adversities to measure and study, yet can have some of the most severe physical and mental health consequences. Such types of cases are often likely to present in emergency departments and other medical settings at various points during the victimization experience (IOM and NRC, 2013).

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Incidence and Prevalence

> ...studies relying on data from official sources are likely to vastly underestimate the true magnitude of the problem and may not accurately reflect the groups at highest risk.

The lack of consistent, reliable definitions and related information on CM has contributed to varied conclusions about the number of children and families affected, greatly lessening the ability to accurately gauge and track the magnitude of CM in relation to other public health problems. In addition, because experiences of CM, specifically certain types (e.g., sexual abuse), are often known to the victim and the perpetrator alone, official estimates typically represent a gross underestimate. Despite these limitations, in 2012, United States (US) state and local CPS agencies still received 3.4 million reports of children as victims of CM (78.3% of these reports were due to neglect, followed by 18.3% due to physical abuse, 9.3% due to sexual abuse, and 10.6% due to “other” types of maltreatment). Substantiations were made in 686,000 (9.2 per 1,000 in the population) of these cases (U.S. Department of Health & Human Services USDHHSI, 2013).

However, when children are asked directly about their experiences of CM, the rate in the general U.S. population is substantially higher, affecting approximately 1 in 10 U.S. children (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009; Finkelhor, Turner, Shattuck, & Hamby, 2013). U.S. CPS data indicate that young children are at highest risk for CM (USDHHS, 2013), yet self-report data from a national survey of violence against children indicate that rates of CM are highest among 14- to 17-year-olds (Finkelhor et al., 2009). As such, cases of CM coming to the attention of official agencies may be different in type or nature than those that do not. Data from official sources may also distort descriptions of the type of persons at risk and characteristics of the problem, as these also are often discordant from self-reports (Pinto & Maia, 2012). Consequently, studies relying on data from official sources are likely to vastly underestimate the true magnitude of the problem and may not accurately reflect the groups at highest risk. In general, gathering information on multiple indicators and from multiple sources in the assessment and surveillance of CM can lead to better estimates of the true magnitude of the problem and will allow for more accurate surveillance and monitoring of the scope of CM.

Consequences

> ...consequences of CM can be profound and may endure long after the maltreatment occurs.

The last several decades of research are clear: consequences of CM can be profound and may endure long after the maltreatment occurs. The effects can appear in childhood, adolescence, and/or adulthood, and may impact multiple aspects of an individual’s development (e.g., physical, cognitive, psychological, and behavioral). These effects range in consequence from impaired functioning to brain damage, chronic disease, and death. The following sections will focus on outlining consequences that fall into the following three overlapping areas: physical health; cognitive development and academic achievement; and emotional and behavioral health.

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Physical Health.—CM may impact an individual's physical health in a number of direct and indirect ways. Examples of direct physical effects of physical abuse, sexual abuse, and/or neglect may include bruises, burns, broken bones, and sexually transmitted infections. Infants and young children may be particularly vulnerable to the immediate physical consequences caused by physical abuse. Children less than five years of age (with the greatest risk at age 2 to 3 months) are at highest risk of experiencing abusive head trauma that leads to death or severe nonfatal consequences such as visual impairment (e.g., blindness), motor impairment (e.g., cerebral palsy) and/or cognitive impairments (Parks, Annest, Hill, & Karch, 2012).

> ...the impact of... adverse childhood experiences on adult health status is cumulative,... the greater the number of adverse events (e.g., multiple forms of maltreatment), the greater the likelihood of negative health outcomes.

CM results in not only acute injuries, but also predicts numerous physical health problems perhaps not intuitively associated with abuse and neglect (e.g., Thompson, Arias, Basile, & Desai, 2002). For example, the Adverse Childhood Experiences (ACE) Study has repeatedly demonstrated a strong relationship between abuse exposure and/or household dysfunction during childhood and several of the top risk factors for the major causes of death in adulthood (e.g., ischemic heart disease, cancer, chronic lung disease, skeletal fractures, liver disease; Felitti et al., 1998). The findings of this large scale study also indicated that the impact of these adverse childhood experiences on adult health status is cumulative, such that the greater the number of adverse events (e.g., multiple forms of maltreatment), the greater the likelihood of negative health outcomes.

Recent brain research indicates that many of the negative developmental consequences experienced by victims of maltreatment have, in part, neurobiological explanations; abuse and neglect can cause important regions of the brain to form and function improperly, which in turn has consequences for all areas of development (USDHHS, 2001). For example, the stress of chronic abuse may cause a "hyperarousal" response in certain areas of the brain, which may result in hyperactivity and sleep disturbances (Dallam, 2001; Perry, 2001). This stress may also strengthen the pathway among neurons that are involved in the fear response, and as a result, the brain may become predisposed to experience the world as hostile, which in turn may lead to anxious and aggressive behaviors (Perry, Pollard, Blakely, Baker, & Vigilante, 1995). Recent work also indicates that CM can lead to diminished growth in the left hemisphere, which may increase the risk for depression; this is then related to an increased risk for smoking and alcohol use (Tiecher, 2000).

Cognitive Development and Academic Achievement.—Children who have experienced maltreatment are at greater risk than their peers to evidence difficulties in learning and in school performance (Kerr, Black, & Krishnakumar, 2000; Perez & Widom, 1994). The negative impacts of both abuse and neglect have been found even after controlling for potential individual and familial confounders, such as maternal drug and alcohol use; prematurity and birth weight; and maternal anxiety and depression (Mills et al., 2011). Recent work also indicates that children exposed to family violence (physical abuse, sexual abuse, witnessing domestic violence) evidence poorer executive functioning (e.g.,

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cognitive processes such as working memory, inhibition, auditory attention, and processing speed) relative to their peers, even after controlling for internalizing distress and other environmental stressors (DePrince, Weinzierl, & Combs, 2009).

Emotional and Behavioral Health.—In general, children who have experienced maltreatment are more likely than their non-maltreated peers to evidence internalizing (e.g., depression, anxiety) and externalizing (e.g., aggression, substance use) behaviors (Bolger & Patterson, 2001; Johnson et al., 2002; Rogosch, Cicchetti, & Aber, 1995). Specifically, children with a history of maltreatment are at higher risk for experiencing depressive disorders, anxiety disorders (e.g., posttraumatic stress disorder), and increased bullying behavior, aggression, and juvenile delinquency than their peers without such histories (Briere & Jordan, 2009; Kaplow & Widom, 2007). One longitudinal study indicated that being maltreated as a child increased risk of arrest as a juvenile by 59% (Widom & Maxfield, 2001).

As adults, victims of maltreatment are more likely than their non-maltreated counterparts to struggle with a number of psychiatric disorders and also to evidence higher rates of alcohol and drug abuse, suicidality, and high-risk sexual behaviors (Hankin, 2005; Lo & Cheng, 2007; MacMillian et al., 2001; Runyan et al. 2002). In one longitudinal study, as many as 80% of young adults who had histories of maltreatment met the diagnostic criteria for at least one psychiatric disorder (e.g., major depressive disorder, posttraumatic stress disorder) at age 21 (Silverman, Reinherz, & Giaconia, 1996).

> ...CM can have severe negative consequences on the development and maintenance of other close relationships...

Given the influential nature of children's early relationships with parents, CM can have severe negative consequences on the development and maintenance of other close relationships throughout childhood and into adolescence and adulthood (Muller, Goebel-Fabbri, & Dinklage, 2000). Children exposed to maltreatment are at increased risk of exposure to other types of violence later in life (Holt, Buckley, & Whelan, 2008; Renner & Slack, 2006). These children also are at greater risk for engaging in violent and criminal behavior themselves, including maltreatment of their own children (Berlin, Applevard, & Dodge, 2011; Conger, Schofield, Neppl, & Merrick, 2013; Herrenkohl, Klika, Brown, Herrenkohl, & Leeb, 2013; Jaffee et al., 2013; Thornberry et al., 2013). For example, one group of researchers found that women with a history of sexual abuse were twice as likely to be sexually and physically victimized as adults than were non-abused, comparison females (Barnes, Noll, Putman, & Trickett, 2009).

Risk and Protective Factors related to Child Maltreatment

CM, like other forms of trauma, does not affect children in a predictable or consistent fashion. Heterogeneity in short- and long-term outcomes is the result of multiple, interacting factors, including features of the maltreatment experience itself (e.g., severity, chronicity), as well as characteristics of the child (e.g., age, sex), and the child's family, relationships, and community environment (CDC, 2013a). Some research indicates that nearly one quarter of children who are maltreated evidence no long-term symptoms whatsoever (McGloin

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& Widom, 2001), likely because of the complex interplay of multiple levels of risk and protective factors at any given time in a child's life (Cicchetti & Toth, 2005).

As defined in the Surgeon General's report on youth violence, risk factors are those elements that increase the chances of a person acting violently, or being the victim of a violent act (USDHHS, 2001). In other words, a risk factor for CM is any characteristic or circumstance that, if present for a given child, makes it more likely that he or she will experience maltreatment. A protective factor, in contrast, decreases one's likelihood to experience CM.

> Risk and protective factors are not static and change over time. A factor that increases risk for CM at one life stage may or may not put the same child at risk at a later stage in development.

Risk and protective factors are not static and change over time. A factor that increases risk for CM at one life stage may or may not put the same child at risk at a later stage in development (Cicchetti & Toth, 2005). Researchers have long regarded family-level factors as the most influential in determining child exposure to maltreatment and related outcomes (Cicchetti & Lynch, 1993) in large part because individual and family-level factors were the most often examined variables in research. However, evidence over the last several years has expanded to describe the important contributions that the community and broader environment also play in predicting CM victimization and perpetration (Coulton, Crampton, Irwin, Spilsbury, & Korbin, 2007; Klein, 2011).

Although children are not responsible for the harm inflicted upon them, some individual child characteristics have repeatedly been found to increase risk of being maltreated; these characteristics include age less than four years and having special needs. Parental characteristics, such as a lack of understanding of child development and parenting skills; history of child abuse; substance abuse and/or mental health issues; young age; low education; single parenthood; large number of dependent children; low income; and non-biological, transient caregivers in the home (e.g., mother's male partner), have also been found to increase risk of perpetration of child abuse in the home. Other risk factors for perpetration include poor and/or few social connections and support; other forms of family violence in the home (e.g., intimate partner violence); poor parent-child relationships; parenting stress; community violence; and concentrated neighborhood disadvantage (CDC, 2013a; Jent & Merrick, 2013; Merrick & Jent, 2013).

Of particular note is that, while a history of CM may serve as a risk factor, such a history does not necessarily determine who will go on to perpetrate CM. Thornberry, Knight, and Lovegrove (2012) found that the positive association between a history of CM and subsequent perpetration is based largely on methodologically weak research designs; the more rigorous research studies had mixed results. Among methodologically sound research studies that do find an intergenerational continuity in experiences of CM, safe, stable, nurturing relationships have been found to moderate this relationship. That is, protective factors, such as relationships characterized by warmth, trust, and support, can break the cycle of CM across generations (Conger et al., 2013; Jaffee et al., 2013; Merrick, Lee, & Leeb, 2013; Schofield, Lee, Merrick, 2013; Thornberry et al., 2013). Protective factors, although pivotally important, have garnered far less attention in research than risk factors.

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That said, strong perceived social support, a child having a good relationship with at least one parental figure, and having a familial socioeconomic status above the poverty level have been continually associated with lower risk for CM (Freisthler, Bruce, & Needell, 2007; Muller et al,. 2000).

Considerations for Nurses

> Vigilance by nurses is especially important given that the signs and symptoms of maltreatment can be confused with other health problems.

Given that CM is a significant public health problem with serious negative developmental consequences, it is important that CM and its prevention be understood by all of those who interact with families. Nurses, employed in a wide range of settings and engaged in a variety of roles (e.g., primary care, hospitals, schools, academic research institutions, patient and health advocacy, community agencies), are in a unique position to prevent CM and/or identify victims. For example, nurses who work in maternity, neonatal intensive care (NICU), and other pediatric units are in the position of teaching and observing primary caregivers as they care for their infant or child. Maternity nurses often conduct interventions to prevent abusive head trauma and promote safe sleep, and NICU nurses are responsible for ensuring the parent is capable of providing competent care before the infant is discharged home. Nurses working in the Emergency Department (ED) who see older infants and children admitted for treatment of injuries, ingestions, and acute or chronic conditions are in a key position to assess for suspected maltreatment or identify the potential for maltreatment. In school settings, nurses may assist teachers and other school staff and in providing universal prevention programs for child sexual abuse. School nurses are in a position to first assess students who display signs and symptoms of potential maltreatment. Vigilance by nurses is especially important given that the signs and symptoms of maltreatment can be confused with other health problems.

> It is important to note that the requirement to report overrides professional confidentiality requirements.

Nurses in each of these settings are also subject to mandatory reporting laws. All 50 states have laws that require certain professionals to report suspected CM via child protective services, law enforcement agencies, or a “hotline” telephone number. This often includes nurses, in addition to other professionals such as physicians, psychologists, teachers, and law enforcement personnel. Generally, mandatory reporting statutes require that a report is made when there is “reasonable cause” to believe that a child has been maltreated or exposed to conditions that could result in maltreatment (although it is important to note that statutes do vary from state to state). Child protective service agencies are responsible for making decisions about whether an investigation will take place, but it is often the reports made, such as those made by nurses, that set this process in motion. It is important to note that the requirement to report overrides professional confidentiality requirements. In fact, failing to report can lead to criminal penalties or civil liabilities, as well as professional ethical and malpractice complaints. All states provide criminal and civil immunity from liabilities when reports are made in good faith and without malicious intent.

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> Multiple reports from different sources may mean that child protective services is more likely to investigate or substantiate a referral.

Despite these mandatory reporting statutes, numerous studies indicate that many instances of abuse do not get reported by professionals (Gilbert et al., 2009). Research suggests that a variety of factors can influence reporting, including the perceived severity of the situation; a lack of awareness of the appropriate processes for reporting; fear of misinterpreting cultural practices; or concerns about making the situation worse or disrupting a therapeutic relationship (Gilbert et al., 2009; Greipp, 1997). It is important to always make a report to the appropriate authority when required and to not assume that one has already been made. Multiple reports from different sources may mean that child protective services is more likely to investigate or substantiate a referral (Child Welfare Information Gateway, 2003; Fluke, Shusterman, Hollinshead, & Yuan, 2005). In addition, referrals from professionals are more likely to be substantiated than referrals from family, neighbors, and other community members (Child Welfare Information Gateway, 2003).

A CPS report that is substantiated may prevent more serious and even life-threatening CM from occurring in the future. A CPS report that is unsubstantiated may also prevent CM because of the support and additional services that may be provided to families as a result. For example, most states (72.5%) refer both substantiated and unsubstantiated cases to community agencies for services (USDHHS, 2003).

The Importance of Prevention in Child Maltreatment

CM is a significant public health problem that requires a multi-faceted approach to prevention. It is important that prevention efforts target risk and protective factors at all levels of the social ecology, including individual, relationship, community, and societal levels. Prevention programs often fall into one area of a continuum, based on the target of interest: universal prevention, selected prevention, or indicated prevention. A comprehensive system of care for improving outcomes for children and families includes strategies that coordinate resources across this entire continuum. Each type of prevention is described below, followed by a short description of an example program backed with evidence demonstrating its effectiveness. Many of these programs involve nurses as the primary prevention practitioners.

Universal Prevention Programs

> Universal prevention programs are provided to the general population and often aim to educate the general public.. about the scope and consequences of CM before it ever occurs.

Universal prevention programs are provided to the general population and often aim to educate the general public, all parents, service providers, and others about the scope and consequences of CM before it ever occurs. Universal approaches may include public service announcements that encourage positive parenting, school-based child sexual abuse prevention programs, and hospital-based abusive head trauma (AHT) interventions. In many hospitals, maternity nurses conduct AHT prevention interventions with all mothers and infants prior to being discharged home. The majority of these educational programs require

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nurses to ask parents to read a short booklet and view a brief videotape that discusses the dangers of violent infant shaking and suggests ways to handle infant crying (Barr et al., 2009; Dias et al., 2005). One such program, *Period of Purple Crying,* aims to acknowledge that infant crying can be frustrating but that there are ways to handle the crying aside from shaking the infant. Mothers who participated in this program reported increased knowledge about AHT and infant crying and were more likely to report having shared information about the dangers of shaking and the importance of walking away if frustrated (Barr et al., 2009). Randomized CDC-funded clinical trials of this and another AHT programs are currently underway. This research seeks to provide more comprehensive information about the impact of these programs on population rates of AHT.

Another CDC initiative, *Essentials for Childhood,* offers a framework of primary prevention strategies for *all* forms of maltreatment that state and communities can consider to promote safe, stable, nurturing relationships and environments (SSNRs) for all children. Resources and a toolkit related to CM and creating relationships can be found on the CDC website (CDC, 2013b).

Selected Prevention Programs

> Selected prevention programs are directed toward individuals identified as being at-risk or having one or more risk factors associated with CM...

Selected prevention programs are directed toward individuals identified as being at-risk or having one or more risk factors associated with CM (e.g., poverty, parental substance abuse, young parental age). Programs may also target services for communities or neighborhoods that have a high incidence or clustering of risk. Selected prevention programs may include: education programs located in high schools that focus on teenage parents; parent-child centers that provide comprehensive educational and parent support to economically disadvantaged children and their parents; behavioral-based parent training programs; and home visit programs that provide education and support to expecting and new mothers.

Home visitation programs have been widely used and are supported by many organizations, including the American Academy of Pediatrics. One example of this type of program is the Nurse-Family Partnership (NFP, 2011), an evidence-based preventive intervention that typically enrolls low-income, first-time mothers. NFP home visits always begin during pregnancy and can continue until the child's second birthday. NFP home visitors are registered nurses and they follow a detailed guide to address a number of factors with participating families, including increasing healthy behaviors (e.g., diet); decreasing unhealthy behaviors (e.g., cigarette, alcohol and other drug use); recognizing signs of illness in children; and creating safe households. Rigorous research on NFP suggests the program is effective at preventing CM in low-income, first-time mothers, and the results persist over time (Eckenrode et al., 2000; Olds et al., 1997). The NFP program has also been shown to reduce the number of subsequent pregnancies, use of welfare, and criminal behavior in women who participated in the home visiting program, when compared to women in the comparison group (Olds et al., 1997; Olds et al., 2007).

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Indicated Prevention Activities

Indicated prevention activities focus on families where maltreatment has already occurred.

Indicated prevention activities focus on families where maltreatment has already occurred. These programs seek to reduce the negative consequences of the maltreatment and to prevent its recurrence. Indicated prevention programs may include services such as intensive family preservation services that make a trained mental health counselor available to families and mental health services for children and families affected by maltreatment. Trauma-focused Cognitive Behavioral Therapy (TF-CBT) is an example of a conjoint child and parent psychotherapy approach for children and youth who are experiencing emotional distress related to traumatic life events. Although TF-CBT is not specifically designed to prevent maltreatment, it is designed to prevent and reduce emotional distress following maltreatment. A series of randomized controlled trials have demonstrated that TF-CBT is more effective (and with effects maintained over time) than nondirective play therapy and supportive therapies in reducing internalizing (e.g., depression, anxiety) and externalizing (e.g., behavior problems, sexualized behaviors) symptoms with children who have experienced CM (Deblinger, Mannarino, Cohen, & Steer, 2006; Cohen. Mannarino. & Ivengar. 2011; Mannarino. Cohen. Deblinger. Runvon. & Steer. 2012).

In general, cognitive behavioral strategies for treating victims of CM (thereby reducing psychological and behavioral symptomatology) have received the most empirical support. These are strategies typically address the child's thinking patterns, affective responses, and behavioral reactions to the CM. However, it is important to first assure that the child and/or adolescent is safe from future potential harm from the offender, as well as from nonbelieving or unsupportive family members who can be a hindrance to adaptive psychosocial outcomes for the victim (Everson. Hunter. Runyon, Edelsohn, & Coulter. 1991).

One program of note, *Triple P,* includes programming that covers the prevention continuum, with primary, selected, and indicated prevention programming components. This system developed as a population-level system of parenting and familial support and includes five intervention levels, each of which aim to enhance parental competence and prevent or change dysfunctional parenting strategies (Sanders, 2008). The first level includes a communications campaign designed to utilize a range of materials (e.g., newspaper column, radio interviews, public service announcements) to educate community residents in the principles of positive parenting. Levels 2 through 5 are not universal in their approach and reflect increasing intensity of services for parents who may need more focused, individual assistance. Although not designed as a CM prevention program per se, recent study in South Carolina found that this system of parenting interventions resulted in a 28% reduction in substantiated abuse cases, a 44% reduction in child out-of-home placements, and a 35% reduction in hospitalizations and emergency room visits for child injuries (Prinz et al., 2009).

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Conclusion

Essential to the prevention of CM is a multi-faceted approach that promotes safe, stable, and nurturing relationships and environments for all children and families.

It is clear that CM is a significant public health problem that can lead to lasting negative consequences for individuals, families, and society. However, it is important to note that child maltreatment is preventable. Essential to the prevention of CM is a multi-faceted approach that promotes safe, stable, and nurturing relationships and environments for all children and families.

Nurses are in a critical position to serve as primary prevention practitioners, by promoting these safe, stable, and nurturing relationships and environments with all families with whom they come in contact. In addition, nurses play a key role in the identification of potential victims, and provision of treatment and/or referrals for victims of CM. Research shows that a healthier population begins in childhood, and nurses are on the front line in the effort to achieve this goal.

Biography

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Melissa T. Merrick, PhD, is a Behavioral Scientist with the Surveillance Branch in the Division of Violence Prevention (DVP) at the National Center for Injury Prevention and Control (NCIPC). Her major research interests focus on the etiology, course, and prevention of child maltreatment. In particular, much of her current work examines safe, stable, nurturing relationships and environments as they relate to child maltreatment prevention. Dr. Merrick serves as the Lead Scientist for the Adverse Childhood Experiences (ACE) Study in DVP and as a Subject Matter Expert for Child Maltreatment. She is also a coauthor of the National Intimate Partner and Sexual Violence Survey (NISVS) 2010 Summary Report, interested primarily in violence experienced in childhood and adolescence. Dr. Merrick received her PhD from the San Diego State University/University of California, San Diego Joint Doctoral Program in Clinical Psychology.

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Box: Child Sexual Exploitation (CSE).

CSE can include the coercion of a child to engage in any unlawful or psychologically harmful sexual activity, commercially (e.g., trafficking for sexual purposes) or otherwise; the use of children in prostitution or other unlawful sexual practices; the participation of children in pornographic performances and materials; and the solicitation of children for sexual purposes. The recent Institute of Medicine and National Research Council Report, Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States, highlights that CSE is to the detriment of a child's immediate and long-term mental and physical health, as well as to their education and to their spiritual, moral, and social-emotional development (IOM & NRC, 2013). Victims of CSE are also at increased risk for acquiring sexually transmitted infections and diseases, such as human immunodeficiency virus (HIV), and for having poor reproductive outcomes. Increased surveillance, assessment, and research efforts are needed to better understand the magnitude and epidemiology of the problem of CSE in the United States and around the world and to inform necessary prevention, identification, and treatment efforts.

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Table:

Brief CDC Definitions of CM Subtypes

Subtype of Maltreatment	Definition*
Physical abuse	Intentional use of physical force against a child that results in, or has the potential to result in, physical injury. *Exceptions* Physical injuries to the anal or genital area or surrounding areas (e.g., anal or genital bruising or tearing; internal injuries resulting from penetration by a penis, hand, finger, or other object) that occur during attempted or completed sexual abuse (SA), or other physical injuries that result from attempted or completed SA (e.g., bruises due to restraint, hitting, pushing) are considered SA and do not constitute PA.
Sexual abuse	Any completed or attempted (non-completed) sexual act, sexual contact with, or exploitation (i.e., noncontact sexual interaction) of a child by a caregiver.
Psychological abuse	Intentional caregiver behavior that conveys to a child that he/she is worthless, flawed, unloved, unwanted, endangered, or valued only in meeting another's needs.
Neglect	The failure to provide for a child's basic physical, emotional, or educational needs or to protect a child from harm or potential harm.
Failure to provide	Failure by a caregiver to meet a child's basic physical, emotional, medical/dental, or educational needs, or combination thereof.
Failure to supervise	Failure by the caregiver to ensure a child's safety within and outside the home given the child's emotional and developmental needs.

* For complete definitions, see Leeb et al., 2008.