Child Maltreatment

A Review on Prevention, Intervention, and Impact

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KEYWORDS

- Child maltreatment • Child abuse • Early childhood • Child abuse risk
- Treatment for child abuse

KEY POINTS

- Child maltreatment has a significant impact on mental illness sequelae, short-term and long-term medical consequences, academic achievement, and legal ramifications.
- There are factors associated with the child, family structure, parental style and demographics, and social/cultural norms that put children at increased risk of maltreatment.
- Intervention and prevention strategies vary in effectiveness, but current approaches seek to reduce risk through modifiable risk factors.

INTRODUCTION

Child maltreatment refers to the mistreatment, abuse, or neglect of children under the age of 18 years by caregivers or adults responsible for their welfare.[1] Maltreatment encompasses various forms of harm directly to a child or places a child in imminent danger of harm by failing to exercise the minimum degree of care in providing for the child. Harm may include physical abuse, emotional abuse, sexual abuse, and neglect (failing to provide food, clothing, shelter, education, or medical care when financially able to do so).[2] Maltreatment can also result from abandonment of a child for not providing adequate supervision. Maltreatment occurs within a relationship of responsibility, trust, or power.[1]

According to the US Administration for Children and Families, there were 588,229 reported cases of child abuse and neglect in the United States in 2021, translating to a nationwide rate of 8.1 victims per 1,000 children in the population.[3] Worldwide, about 40,150 children aged under 18 years are murdered annually.[4] However, this

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figure likely underestimates the total number of deaths as many deaths resulting from child maltreatment are classified under causes such as falls, burns, drowning, and others.[4] Children between birth and 2 years old are the most vulnerable as they make up nearly a third (27.8%) of maltreatment victims, and specifically, children between birth and 1 year of age make up 15.1% of victims.[3] Of child fatalities, 45.6% of deaths are of victims younger than 1 year.[3] Victimization based on sex is about equal between girls and boys (52.2% and 47.5%, respectively).[3] Most incidents of maltreatment are perpetrated by one or both parents (90.6%).[3]

While childhood maltreatment is widespread, the majority of survivors do not receive services, and even fewer children receive services if caregivers are involved in the abuse or neglect.[5] According to data gathered from 6 countries across Africa, Latin America, and Asia, between 23% and 54% of children report being exposed to violence by a friend or a family member, with up to 25% seeking assistance and up to 11% receiving formal support.[5]

Child maltreatment can have severe short-term and long-lasting detrimental effects on a child's physical, emotional, and psychological well-being, often leading to consequences throughout their lifespan. Addressing maltreatment through intervention and prevention aids in the protection of children from harm and provides them with a safe and nurturing environment in which to grow and thrive. It also upholds the right of children to grow up in a safe and supportive environment ingrained with dignity, respect, and compassion. It can also break the cyclical and generational nature of childhood maltreatment and the financial and health burden to society at large.

IMPACT OF CHILD MALTREATMENT IN EARLY CHILDHOOD

The Adverse Childhood Experiences (ACEs) study led by Kaiser Permanente San Diego Health was a seminal study that quantified the long-term impact of ACE (which includes abuse, neglect, and household dysfunction) on individuals. Over 17,000 individuals from 1995 to 1997 completed a questionnaire. Around 11% reported emotional abuse as a child, 30.1% reported physical abuse, and 19.9% reported sexual abuse, along with other identified ACEs.[6] This study showed that ACEs are vastly more common than recognized or acknowledged and have a powerful relationship to adult health a half-century later. This study, along with other long-term prospective studies, has shown that childhood maltreatment affects multiple health and well-being domains.[7]

Physical Consequences

The immediate consequences of abuse can be severe and may require immediate medical attention. In some cases, physical abuse can result in life-threatening injuries or death. Additionally, physical abuse can have consequences that extend into adulthood. Prospective longitudinal studies have consistently revealed robust links between physical abuse, neglect, sexual abuse, and obesity.[8] Victims of maltreatment are 60% more likely to be morbidly obese as adults, and these associations persist even after adjusting for family characteristics and individual risk factors, including childhood obesity.[6,8] Cross-sectional studies have documented connections between various childhood adversities, such as child maltreatment, and a spectrum of health outcomes in adulthood. These outcomes include conditions like ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.[6,9]

Psychopathology Sequelae

There is a correlation between maltreatment and the development of mental illnesses and increased mental illness burden on individuals. Maltreated children have a

moderately increased risk of depression in adolescence and adulthood.[10] Around a quarter to a third of abused children meet the criteria for major depressive disorder by their late 20s.[10]

In a prospective study tracking individuals who experienced maltreatment before the age of 12 and were evaluated at 29 year old, findings indicated that 23% of those who endured sexual abuse, 19% who suffered physical abuse, and 17% who experienced neglect currently had a diagnosis of posttraumatic stress disorder (PTSD), compared to 10% of controls.[11] Moreover, the lifetime risk of developing PTSD was significantly higher among maltreated individuals compared to controls.[11] Persistent evidence indicates that both physical abuse and sexual abuse are correlated with a twofold increase in the likelihood of attempted suicide among young individuals tracked into their late twenties.[12,13] Maltreatment is associated with increased adolescent use of alcohol and binge drinking, as well as increased risk of marijuana use.[14] Of note, there is evidence that the increased severity and frequency of maltreatment can increase the risk of future development of mental illness.[6,15] In one study, children who have experienced sexual assault faced an increased risk of developing psychological disorders, mainly when the abuse is more severe, involves a perpetrator who is related to the victim, entails the use of force or threats, and when the victim's disclosure to someone results in disbelief, lack of support, or punishment for speaking out about the abuse.[15]

Economic and Societal Consequences

Studies of the economic effects of middle-aged adults who were abused or neglected as children reveal that adults who have documented histories of childhood abuse and neglect tend to have lower educational attainment, reduced employment rates, diminished earnings, and fewer assets compared to matched control individuals.[16] Child maltreatment is linked to enduring deficiencies in educational attainment, in which longitudinal studies conducted prospectively consistently reveal that children who have experienced maltreatment are more inclined to require special education services and tend to achieve lower educational outcomes compared to their peers. Around 24% of maltreated children received special education at a mean age of 8 years, compared with 14% of children with no maltreatment record.[17] Just 42% of the children who experienced maltreatment successfully finished high school, in contrast to two-thirds of community-matched controls.[18,19] Specifically, there exists a 14% disparity in the likelihood of employment during middle age between those with histories of abuse/neglect and the control group after accounting for background factors.[16] In a prospective study comparing court-documented cases of childhood maltreatment with community-matched controls, a significantly higher proportion of abused and neglected individuals were employed in menial and semi-skilled occupations compared to controls (62% vs 45%) by the age of 29 years.[7] Moreover, fewer maltreated individuals had maintained employment over the past 5 years (41% vs 58%).[7]

Children who have experienced abuse and neglect face heightened risks of displaying aggression and causing harm to others, often leading to involvement in criminal and violent behavior, with physical abuse being most strongly related to youth violence in girls.[20,21] Individuals subjected to physical abuse or neglect during childhood exhibited a greater probability of being arrested as juveniles (31% detained compared to 19% of community-matched controls) and as adults (48% compared to 36%).[22]

Intergenerational Impact

Events of childhood maltreatment also increase the risk of revictimization of individuals by about threefold.[23,24] Exposure to multiple types of abuse, victimization both

in childhood and in young adulthood, and recency of abuse increase the odds of revictimization.[25] Risk factors linking child maltreatment to revictimization are multifaceted, but significant risk factors include trauma-related symptoms, loneliness, and neglect as a form of previous maltreatment.[24,26] Individuals who have experienced childhood maltreatment are also at increased risk of becoming perpetrators of child maltreatment, with 75% of perpetrators of child sexual abuse reported to have been victims of sexual abuse during childhood.[27]

RISK FACTORS FOR CHILD MALTREATMENT

Child Risk Factors

Children bear no responsibility for the harm inflicted upon them. However, certain factors are more likely to be present in cases of child abuse and neglect, including age and special health care needs or disabilities. As previously mentioned, the highest incidence of child maltreatment occurs among children under the age of 1 year and gradually declines with age.[3] Young children are at a heightened risk due to their dependency on, and extended time spent with, caregivers as compared to older children. Additionally, children with special needs face an increased risk of maltreatment, with those having behavioral and mental conditions, such as attention deficit and hyperactivity disorder (ADHD), being 1.95 times more likely to experience maltreatment than children without.[28] The combination of experiencing abuse or neglect before the age of 3 years and being diagnosed with a behavioral health condition makes children 10 times more susceptible to maltreatment.[28] Moreover, children with physical health conditions like Down syndrome, cleft lip, or spina bifida are also at a higher risk of experiencing maltreatment.[29]

Caregiver Risk Factors

Risk factors associated with parents or caregivers can heighten the likelihood of child maltreatment. Offspring of mothers with PTSD or depression, as well as fathers exhibiting depressive symptoms, tend to face increased instances of abuse and exposure to traumatic events.[30,31] As stated previously, caregivers with a history of being maltreated during their childhood are more at risk for mistreating their children. Substance use among parents left untreated is linked to maltreatment of children, alongside instances of maternal exposure to intimate partner violence.[32,33] Family poverty, gauged by annual household income and participation in public benefits programs, as well as material hardship, including challenges in affording basic needs, have long been recognized as significant risk factors for childhood maltreatment and are more likely to prompt Child Protective Services investigations.[34–37] Furthermore, parental social isolation and a lack of social support are correlated with child maltreatment. In contrast to parents who break the cycle of intergenerational abuse, those who perpetuate the cycle tend to experience heightened feelings of loneliness and perceived isolation.[36]

Protective Factors and Resilience

Conversely, there are factors that shield children from maltreatment. Present literature highlights both actual and perceived social support as the foremost protective element, capable of counteracting risk factors such as a parent's history of childhood maltreatment.[37] Enhanced parenting knowledge not only diminishes the risk of child maltreatment but also reduces instances of actual abuse, especially among teen mothers with a background of childhood maltreatment.[38] Furthermore, fostering

age-appropriate expectations for the child and displaying empathy toward them also diminishes the likelihood of child maltreatment.[39]

Not every young child subjected to maltreatment will encounter severe or persistent symptoms resulting in lasting impairment. Resilience is characterized by the ability to function adaptively across various domains over time to meet societal expectations, even in the face of adversity. The variance in resilience is due to several factors, including diverse early life adversities, childhood temperament and personality, and the social capital accessible within the household and community. In a prospective study, researchers examining children aged 4 and 6 years discovered that 48% of maltreated children exhibited resilience, defined by competence across behavioral, social, and developmental domains.[40]

PREVENTION AND INTERVENTION

Research into preventing childhood maltreatment lacks consistency and robustness. Currently, there is no universal tool used to predict an individual child's risk of maltreatment. However, studies are ongoing exploring epidemiologic profiles of risk from birth records including child characteristics (low birth weight), pregnancy characteristics (delayed prenatal care) and maternal/familial characteristics (maternal marriage status, enrollment in Medicaid, maternal education status, maternal age, more than 2 siblings) that put children at greater risk of maltreatment. Newborns identified with 3 or more of these risk factors from birth records made up 15% of California study birth cohort, yet represented over 50% of children in the cohort who were subjected to substantiated official-report maltreatment by age of 5 years.[41] There are efforts to use prospective implementation of this epidemiologic study to engage families in supportive interventions to reduce the occurrence of child maltreatment.[42] Moreover, interventions that reduce risk factors in cases of known abuse are also being explored.

Home Visitation Programs

Review studies examining risk factors for child abuse and neglect consistently highlight parent and family-related factors as paramount.[36] Consequently, these factors frequently serve as the focal point of programs aimed at preventing or mitigating child maltreatment.

Various types of programs exist for preventing maltreatment, with home visitation programs one of the most widely used approaches. These initiatives enhance parenting skills and foster positive parent–child relationships by establishing supportive bonds and attachments, reducing harsh parenting practices, promoting nurturing behaviors, and improving household safety. However, there are distinctions among available home visitation programs in terms of the range of services provided, the type of professionals delivering the services, and the frequency or intensity of home visits. Consequently, systematic reviews and meta-analyses investigating the impact of home visitation programs on maltreatment risk have yielded mixed results, contingent upon the specific program and outcomes evaluated.[43]

The Home Visiting Evidence of Effectiveness (HomVEE) review evaluates current high-quality research findings to determine which home-visiting models meet the criteria for being considered evidence-based by the US Department of Health and Human Services. According to the latest HomVEE update in November 2023, 27 of 69 reviewed models were deemed evidence-based.[44] Studies and meta-analyses have shown favorable results for home visits, demonstrating a reduction in the risk of recurrent maltreatment in families previously affected by maltreatment.[45] One notable evidence-based home visiting program that has reduced maltreatment is the

Nurse–Family Partnership (NFP) program. In this program, trained nurses conduct home visits for low-income first-time mothers, providing support during pregnancy and for 2 years after childbirth. The focus is promoting a safe home environment, enhancing parental caregiving skills, and connecting families with health and social services. Beyond these benefits, the NFP program is associated with improved maternal physical and mental health, maternal employment rates, child behavioral health, and cognitive development. Notably, the NFP group showed significantly fewer instances of verified child abuse and neglect compared to the control group, both at the 2 year follow-up and with a 48% reduction in child maltreatment observed at the 15 year follow-up.[46,47]

Parenting Education Programs

Parenting programs represent another intervention commonly used in preventing initial and recurrent instances of child maltreatment. The Adults and Children Together: Parents Raising Safe Kids program established by the American Psychological Association (APA) targets the prevention of child maltreatment in at-risk yet nonmaltreating families.[48] Parents and caregivers participate in sessions on effective parenting techniques, including nonviolent discipline, child development, anger management, and social problem-solving skills. This program has demonstrated a reduction in the rates of psychologically and physically aggressive behaviors toward children among caregivers who received the intervention, as compared to control groups.[48,49]

Multiple meta-analyses of the efficacy of parenting education programs in preventing or reducing child maltreatment have generally indicated minimal-to-moderate overall effects.[50–55] The effectiveness of parent training programs is influenced by various factors, such as the comparison of at-risk versus maltreating samples,[52] the delivery setting of the program (individual vs group, in-home vs office setting),[51] and the duration of the program.[52] A significant challenge in assessing the comprehensive effectiveness of parenting education classes is the lack of randomized controlled trials (RCTs) in child maltreatment. Consequently, essential information may be missing in reviews solely based on primary studies employing RCT designs. However, analyses using RCT and quasi-experimental designs tend to demonstrate greater effectiveness of parent training programs.[50,51]

Foster Care Interventions

Following identification of maltreatment, many children are placed in protective custody until the courts determine whether to reunite them with their parents. The probability of maltreatment recurrence among children placed in foster care due to abuse or neglect following reunification with their biological parents ranges from 30% to 37%.[56] This period presents a critical opportunity for intervention, given that children who have experienced a single reported incident of maltreatment—without further occurrences—do not exhibit significantly higher rates of mental health care utilization compared to children in the general population. However, in instances of more than 2 official reports of child maltreatment, there exists a dose–response relationship between the number of official reports and adverse psychiatric outcomes.[57]

A novel intervention targeting children in foster care due to documented maltreatment, awaiting potential reunification with their parents, involves a 2 generation psychiatric approach aimed at mitigating the risk of recurrence. The Tulane model in Louisiana is an intervention during a critical juncture in child maltreatment in collaboration with court and social service systems.[58] This model incorporates child psychiatric evaluation, dyadic interventions to foster parent–child attachment, and parental

psychiatric treatment. Results indicate a reduction of over 50% in maltreatment recurrence compared to a matched group of children not receiving the intervention. Similarly, under the SYNCHRONY Project, the Tulane model was quasi-replicated more recently in Saint Louis County, Missouri.[59] This court-based, 2 generation intervention enhances the likelihood of successful reunification and prevents unsafe reunification. Parents participating in the SYNCHRONY Project demonstrated significant improvements from severely abnormal baseline scores through Incredible Years parenting education classes. At the same time, children exhibited substantial improvements from abnormal baseline scores in clinical assessments of adaptive functioning.[59] A 10 year follow-up of SYNCHRONY-enrolled children reported a fivefold reduction in re-referrals for recurrence of substantiated child abuse based on court records (3.4% of guardianship cases compared to 18% "care-as-usual" group and 7.1% of reunification cases compared to 35% in "care-as-usual" group).[60]

Psychological Treatment and Services for Maltreated Children

The primary focus of this study does not extend to the initial medical evaluation of maltreated children. However, subsequent psychological interventions for children within this early childhood age group have garnered substantial research support and endorsement from reputable sources such as the California Evidence-Based Clearinghouse, the National Child Traumatic Stress Network, and the American Academy of Child and Adolescent Psychiatry. These organizations have provided the highest ratings and recommendations for psychotherapeutic approaches tailored to children and adolescents impacted by trauma or violence.

The Incredible Years

The Incredible Years program was originally developed as a parenting intervention rather than a specific trauma treatment. It aims to enhance emotional and social competence to prevent and mitigate behavioral and emotional challenges in young children. This program has been tailored and utilized within child welfare services. Targeted for children aged between 4 and 8 years, it holds a California Evidence-Based Clearinghouse (CEBC) rating 1, signifying strong support for its effectiveness.[61]

Eye Movement Desensitization and Reprocessing

Eye Movement Desensitization and Reprocessing (EMDR) therapy is an effective treatment for trauma-related disorders, including those stemming from childhood maltreatment. Its purpose is to alleviate trauma symptoms by facilitating the processing of traumatic memories and reducing distress through brief, structured sessions. During these sessions, patients engage with their beliefs, emotions, and bodily sensations related to the traumatic event while simultaneously focusing on an external stimulus, such as eye movements or tactile sensations, to aid in processing the trauma. EMDR is approved for children aged 2 to 17 years and has a CEBC rating 1.[62]

Attachment and Biobehavioral Catch-up

Attachment and Biobehavioral Catch-up is a CEBC rating 1 intervention for infants and toddlers aged birth to 2 years who have experienced early traumatic disruptions in caregiving or maltreatment. Its primary objective is reconstructing attachment relationships. This intervention emphasizes nurturing caregivers and addressing the child's dysregulation at both behavioral and biological levels. Parents are instructed on providing a responsive, consistent, and nurturing environment and implementing parenting practices to ameliorate the child's behavioral challenges.[63,64]

Parent-Child Interaction Therapy

Parent–child interaction therapy is an intervention for children aged 2 to 7 years exhibiting disruptive behaviors, including those explicitly resulting from experiences of maltreatment. It is designed to enhance troubled parent or caregiver–child relationships and increase positive behaviors in children. Under the guidance of a therapist, parents engage in targeted play and discipline techniques with their children. This intervention has a CEBC rating 1.[65–67]

Child–Parent Psychotherapy

Child–parent psychotherapy (CPP) is a dyadic psychotherapeutic modality with an emphasis on nurturing caregiver–child attachment in dyads who have experienced domestic violence or maltreatment. The goals of the intervention include safety, affect regulation, reciprocal relational dynamics, and parental comprehension of trauma-induced manifestations and adaptive responses in children aged birth to 5 years. Characterized by its longitudinal nature, CPP entails an extensive treatment trajectory comprising 50 sessions wherein both child and caregiver actively participate in tandem and holds a CEBC rating 2.[67–69]

Trauma-focused Cognitive Behavioral Therapy

Trauma-focused cognitive behavioral therapy (TF-CBT) is designed for youth with substantial emotional or behavioral challenges stemming from one or multiple traumatic life events, such as maltreatment. Children and family members engage collaboratively to foster emotional awareness and facilitate adaptive responses to thoughts, emotions, and behaviors linked to prior traumas. Central to TF-CBT is the structured implementation of graduated exposure to trauma-related stimuli. This intervention is for individuals aged 3 to 18 years and has a CEBC rating 1.[67,70,71]

It should be noted that trauma-specific therapeutic interventions may not universally be warranted in cases of maltreatment. There are basic guidelines to determine whether psychotherapy interventions are needed, including when time has passed after abuse and the child has not returned to their prior level of functioning, when complex/multiple incidents of maltreatment have created problems in succeeding in typical developmental milestones (relational, emotional, or behavioral regulation), when the remaining symptoms of maltreatment are significantly impairing the person's ability to function, when depression, grief, or anxiety is directly related to the maltreatment.

SUMMARY

Child maltreatment includes various forms of mistreatment, abuse, or neglect of children by caregivers or adults responsible for their welfare. These harmful acts can include physical abuse, emotional abuse, sexual abuse, neglect, or abandonment, occurring within the context of a relationship of responsibility, trust, or power. Despite the gravity of this issue, many cases go unreported, with profound consequences on children's physical, emotional, and psychological well-being. In the United States alone, over half a million cases of child abuse and neglect were reported in 2021, with approximately 40,150 children under the age of 18 years tragically murdered annually worldwide. The youngest children, aged birth to 2 years, are particularly vulnerable, accounting for a significant portion of maltreatment victims. Alarmingly, most cases of maltreatment are perpetrated by one or both parents. Childhood maltreatment has severe short-term and long-lasting effects, leading to physical health issues like obesity and chronic diseases, as well as mental health disorders such as depression, PTSD, and increased risk of suicide. The socioeconomic consequences are vast, affecting educational attainment, employment opportunities, and

increasing the likelihood of involvement in criminal behavior. Interventions to prevent and address child maltreatment are critical. Home visitation programs and parenting education initiatives aim to avoid maltreatment and mitigate its effects by enhancing parenting skills and fostering positive parent–child relationships. Therapeutic approaches such as trauma-focused cognitive–behavioral therapy and parent–child psychotherapy help children heal from trauma and develop resilience. Despite the challenges, efforts to prevent and intervene in child maltreatment are essential to protect children from harm and provide them with safe and nurturing environments. By breaking the cycle of maltreatment, society can reduce the financial and health burden associated with childhood trauma and uphold the rights of children to grow up in supportive environments.

CLINICS CARE POINTS

- Child maltreatment has a significant impact on mental illness sequelae, short-term and long-term medical consequences, academic achievement, and legal ramifications.
- There are factors associated with the child, family structure, parental style and demographics, and social/cultural norms that put children at increased risk of maltreatment.
- Intervention and prevention strategies vary in effectiveness, but current approaches seek to reduce risk through modifiable risk factors.

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REFERENCES

1. Definitions of child abuse and maltreatment. Office of children and family services. Available at: https://ocfs.ny.gov/programs/cps/definition.php. Accessed March 20, 2024.
2. Child Maltreatment. World Health Organization. Definitions of Child Abuse and maltreatment. Office of Children and Family Services. Available at: https://www.who.int/news-room/fact-sheets/detail/child-maltreatment#:~:text=It%20includes%20all%20types%20of,of%20responsibility%2C%20trust%20or%20power. Accessed March 20, 2024.
3. Child maltreatment 2021. The administration for children and families. 2023. Available at: https://www.acf.hhs.gov/cb/report/child-maltreatment-2021?utm_medium=email&utm_source=maltreatreport020923. Accessed March 20, 2024.
4. Global Health Estimates. 2020: deaths by cause, age, sex, by country and by region, 2000–2019. Geneva: World Health Organization; 2020. Available at: https://cdn.who.int/media/docs/default-source/gho-documents/global-health-estimates/ghe2019_cod_methods.pdf?sfvrsn=37bcfacc_5. Accessed March 20, 2024.
5. Pereira A, Peterman A, Neijhoft AN, et al. Disclosure, reporting and help seeking among child survivors of violence: a cross-country analysis. BMC Publ Health 2020;20(1):1–23.

6. Felitti VJ, Anda RA, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. Am J Preventive Med 1998;14(4):245–58.
7. Gilbert R, Widom CS, Browne K, et al. Burden and consequences of child maltreatment in high income countries. Lancet 2009;373(9657):68–81.
8. Thomas C, Hypponen E, Power C. Obesity and type 2 diabetes risk in midadult Life: the role of childhood adversity. Pediatrics 2008;121(5):1240–9.
9. Draper B, Pfaff JJ, Pirkis J, et al. Long-term effects of childhood abuse on the quality of life and health of older people: results from the depression and early prevention of suicide in general practice project. J Am Geriatr Soc 2008;56(2):262–71.
10. Fergusson DM, Boden JM, Horwood LJ. Exposure to childhood sexual and physical abuse and adjustment in early adulthood. Child Abuse Negl 2008;32:607–19.
11. Widom CS. Posttraumatic stress disorder in abused and neglected children grown up. Am J of Psychiatry 1999;156(8):1223–9.
12. Evans E, Hawton K, Rodham K. Suicidal phenomena and abuse in adolescents: a review of epidemiological studies. Child Abuse Negl 2005;29:45–58.
13. Widom CS. Childhood victimization: early adversity and subsequent psychopathology. In: Dohrenwend BP, editor. Adversity, stress and psychopathology. Chicago, IL: Oxford University Press; 1998. p. 81–95.
14. Hussey JM, Chang JJ, Kotch JB. Child maltreatment in the United States: prevalence, risk factors, and adolescent health consequences. Pediatrics 2006;118(3):933–42.
15. Bulik CM, Prescott CA, Kendler KS. Features of childhood sexual abuse and the development of psychiatric and substance use disorders. Br J Psychiatry 2021;179(5):444–9.
16. Currie J, Widom CS. Long-term consequences of child abuse and neglect on adult economic well-being. Child Maltreat 2010;15(2):111–20.
17. Jonson-Reid M, Drake B, Kim J, et al. A prospective analysis of the relationship between reported child maltreatment and special education eligibility among poor children. Child Maltreat 2004;9(4):382–94.
18. Perez CM, Widom CS. Childhood victimization and long-term intellectual and academic outcomes. Child Abuse Negl 1994;18(8):617–33.
19. Lansford JE, Dodge KA, Pettit GS, et al. A 12-year prospective study of the long-term effects of early child physical maltreatment on psychological, behavioral, and academic problems in adolescence. Arch Pediatr Adolesc Med 2002;156(8):824–30.
20. Landsford JE, Miller-Johnson S, Pettit GS. Early physical abuse and later violent delinquency: a prospective longitudinal study. Child Maltreat 2007;12(3):233–45.
21. Maas C, Herrenkohl TI, Sousa C. Review of research on child maltreatment and violence in youth. Trauma Viol Abuse 2008;9(1):56–67.
22. Widom CS. The cycle of violence. Science 1989;244(4901):160–6.
23. Walker HE, Wamser-Nanney R. Revictimization risk factors following childhood maltreatment: a literature review. Trauma Viol Abuse 2022;24(4):2319–32.
24. Fereidooni F, Daniels JK, Krause-Utz AD, et al. Childhood maltreatment and adulthood victimization: an evidence-based model. J Psychiatric Research 2023;167:42–62.
25. Stroem IF, Aakvaag HF, Wentzel-Larsen T. Characteristics of different types of childhood violence and risk of revictimization. Viol Against Women 2019;25(14):1696–716.

26. Hindley N, Ramchandani PG, Jones DP. Risk factors for recurrence of maltreatment: a systematic review. Arch Dis Child 2006;91(9):744–52.
27. Romano E, De Luca RV. Exploring the relationship between childhood sexual abuse and adult sexual perpetration. J Fam Violence 1997;12(1):85–98.
28. Van Horne BS, Caughy MO, Canfield M, et al. First-time maltreatment in children ages 2–10 with and without specific birth defects: a population–based study. Child Abuse Negl 2018;84:53–63.
29. Jaudes PK, Mackey-Bilaver L. Do chronic conditions increase young children's risk of being maltreated? Child Abuse Negl 2008;32(7):671–81.
30. Chemtob CM, Gudiño OG, Laraque D. Maternal posttraumatic stress disorder and depression in pediatric primary care: association with child maltreatment and frequency of child exposure to traumatic events. JAMA Pediatr 2013; 167(11):1011–8.
31. Lee SJ, Taylor CA, Bellamy JL. Paternal depression and risk for child neglect in father-involved families of young children. Child Abuse Neglect 2012;36(5): 461–9.
32. Kepple NJ. The complex nature of parental substance use: examining past year and prior use behaviors as correlates of child maltreatment frequency. Subst Use Misuse 2017;52(6):811–21.
33. Taylor CA, Guterman NB, Lee SJ, et al. Intimate partner violence, maternal stress, nativity, and risk for maternal maltreatment of young children. Am J Publ Health 2009;99(1):175–83.
34. Conrad-Hiebner A, Byram E. The temporal impact of economic insecurity on child maltreatment: a systematic review. Trauma Viol Abuse 2020;21(1):157–78.
35. Yang M-Y. The effect of material hardship on child protective service involvement. Child Abuse Neglect 2015;41:113–25.
36. Younas F, Gutman LM. Parental risk and protective factors in child maltreatment: a systemic review of the evidence. Trauma Viol Abuse 2023;24(5):3697–714.
37. Corse SJ, Schmid K, Trickett PK. Social network characteristics of mothers in abusing and non-abusing families and their relationships to parenting beliefs. J Community Psychol 1990;18(1):44–59.
38. Bert CS, Guner BM, Lanzi RG. The influence of maternal history of abuse on parenting knowledge and behaviour. Fam Relat 2009;58(2):176–87.
39. DuMont KA, Ehrhard-Dietzel S, Kirkland K. Averting child maltreatment: individual, economic, social and community resources that promote resilient parenting. In: Ungar M, editor. The social ecology of resilience: a handbook for theory and practice. New York City, NY: Springer; 2012. p. 199–217.
40. Dubowitz H, Thompson R, Proctor L, et al. Adversity, maltreatment, and resilience in young children. Acad Pediatr 2016;16(3):233–9.
41. Putnam-Hornstein E, Needell B. Predictors of child protective service contact between birth and age five: an examination of California's 2002 birth cohort. Child Youth Serv Rev 2011;33(8):1337–44.
42. Tandon M, Jonson-Reid M, Constantino JN. Documenting opportunity for systematic identification and mitigation of risk for child maltreatment. JAACAP 2022; 61(11):1313–6.
43. Gubbels J, van der Put CE, Stams GJ, et al. Components associated with the effect of home visiting programs on child maltreatment: a meta-analytic review. Child Abuse Negl 2021;114:104981.
44. Administration for Children and Families. Home Visiting Evidence of Effectiveness (HomVEE). Early childhood home visiting models: reviewing evidence of effectiveness. U.S. Department of Health and Human Services; 2023. Available at:

https://homvee.acf.hhs.gov/publications/HomVEE-Summary. Accessed March 20, 2023.
45. Han K, Oh S. The effectiveness of home visiting programs for the prevention of child maltreatment recurrence at home: a systematic review and meta-analysis. Child Health Nurs Res 2022;28(1):41–50.
46. Olds DL, Henderon CR, Chamberlin R, et al. Preventing child abuse and neglect: a randomized trial of nurse home visitation. Pediatrics 1985;75(1):65–78.
47. Olds DL, Eckenrode J, Henderson CR, et al. Long-term effects of home visitation on maternal life course and child abuse and neglect: fifteen-year follow-up of a randomized trial. JAMA 1997;278(8):637–43.
48. Portwood SG, Lambert RG, Abrams LP, et al. An evaluation of the adults and children together (ACT) against violence parents raising safe kids program. J Prim Prev 2011;32(3–4):147–60.
49. Knox M, Burkhart K, Cromly A. Supporting positive parenting in community health centers: the ACT raising safe kids program. J Community Psychol 2013;41(4): 395–407.
50. Gubbels J, van der Put CE, Assink M. The effectiveness of parent training programs for child maltreatment and their components: a meta-analysis. Int J Environ Res Public Health 2019;13:2404.
51. Van der Put CE, Assink M, Gubbels J, et al. Identifying effective components of child maltreatment interventions: a meta-analysis. Clin Child Fam Psychol Rev 2018;21(2):171–202.
52. Euser S, Alink LRA, Stoltenborgh M, et al. A gloomy picture: a meta-analysis of randomized controlled trials reveals disappointing effectiveness of programs aiming at preventing child maltreatment. BMC Publ Health 2015;15:1068.
53. MacLeod J, Nelson G. Programs for the promotion of family wellness and prevention of child maltreatment: a meta-analytic review. Child Abuse Negl 2000;24(9): 1127–49.
54. Lundahl BW, Nimer J, Parsons B. Preventing child abuse: a meta-analysis of parent training programs. Res Soc Work Pract 2006;16(3):251–62.
55. Chen M, Chan KL. Effects of parenting programs on child maltreatment prevention: a meta-analysis. Trauma Viol Abuse 2016;17(1):88–104.
56. Jonson-Reid M. Foster care and future risk of maltreatment. Child Youth Serv Rev 2003;25(4):271–94.
57. Bae H, Solomon PL, Gelles RJ. Multiple child maltreatment recurrence relative to single recurrence and no recurrence. Child Youth Serv Rev 2008;31:617–24.
58. Zeanah CH, Larrieu JA, Heller SS, et al. Evaluation of a preventive intervention for maltreated infants and toddlers in foster care. JAACAP 2001;40(2):214–21.
59. Constantino JN, Ben-David V, Navsaria N, et al. Two-generation psychiatric intervention in the prevention of early childhood maltreatment recidivism. Am J Psychiatry 2016;173(6):566–73.
60. Constantino JN, Buchanan G, Tandon M, et al. Reducing abuse and neglect recurrence among young foster children reunified with their families. Pediatrics 2023;152(3). e2022060118.
61. The incredible years. California evidence-based Clearinghouse for child welfare. 2024. Available at: https://www.cebc4cw.org/program/incredible-years/. Accessed April 12, 2024.
62. Eye movement desensitization and reprocessing (EMDR). California evidence-based Clearinghouse for child welfare. 2021. Available at: https://www.cebc4cw.org/program/eye-movement-desensitization-and-reprocessing/. Accessed April 12, 2024.

63. ABC: attachment and biobehavioral catch-up. National child traumatic stress network. 2021. Available at: https://www.nctsn.org/sites/default/files/interventions/abc_fact_sheet_general_2021.pdf. Accessed April 12, 2024.
64. California Evidence-Based Clearinghouse for Child Welfare. Attachment and biobehavioral catch-up (ABC). 2024. Available at: https://www.cebc4cw.org/program/attachment-regulation-and-competency-arc-client/. Accessed April 12, 2024.
65. PCIT: parent-child interaction therapy. National child traumatic stress network. 2019. Available at: https://www.nctsn.org/sites/default/files/interventions/pcit_general_031419.pdf. Accessed April 12, 2024.
66. Parent-child interaction therapy (PCIT). California evidence-based Clearinghouse for child welfare. 2023. Available at: https://www.cebc4cw.org/program/parent-child-interaction-therapy/. Accessed April 12, 2024.
67. Trauma and Child Abuse Resource Center. American Academy of child and adolescent Psychiatry. 2024. Available at: https://www.aacap.org/App_Themes/AACAP/docs/resource_centers/resources/misc/psychotherapies_for_child_and_adolescents_affected_by_trauma_or_violence.pdf. Accessed April 12, 2024.
68. CPP: child-parent psychotherapy. National child traumatic stress network. 2012. Available at: https://www.nctsn.org/sites/default/files/interventions/cpp_fact_sheet.pdf. Accessed April 12, 2024.
69. Child-parent psychotherapy (CPP). California evidence-based Clearinghouse for child welfare. 2022. Available at: https://www.cebc4cw.org/program/child-parent-psychotherapy/. Accessed April 12, 2024.
70. TF-CBT: trauma-focused cognitive behavioral therapy. National Child Traumatic Stress Network 2012. Available at: https://www.nctsn.org/sites/default/files/interventions/tfcbt_fact_sheet.pdf. Accessed April 12, 2024.
71. Trauma-focused cognitive-behavioral therapy (TF-CBT). California evidence-based Clearinghouse for child welfare. 2021. Available at: https://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/. Accessed April 12, 2024.