

Chapter 3: Indicators and Effects of Child Maltreatment

Statistical data in this chapter are primarily taken from the Child Welfare Collaborative Group, National Child Traumatic Stress Network & The California Social Work Education Center, *Child Welfare Trauma Training Toolkit Trainer's Guide*, 1st Edition, 2008.

Chapter 3 Overview

This chapter introduces indicators and effects of child maltreatment – both physical abuse and neglect – on child development. Recall or refer to the maltreatment definitions you learned in Module 4.

As you move through this chapter, it is important to understand that knowledge of child development and the indicators of maltreatment is helpful throughout the life of any case – from intake and screening to case closure.

Physical Abuse

Remember that physical abuse is simply defined as any non-accidental injury to a child. It is important to recognize the physical and behavioral indicators in order to differentiate between accidental and non-accidental – or inflicted – injuries.

Knowledge of injuries helps you screen intakes and complete comprehensive assessments with families. Knowledge also helps you determine whether abuse has occurred and the likelihood of future risk of harm when you conduct Family Investigations.

Mental Injury

Recall that mental injury is a form of physical abuse. Statutory language states that mental injury “means an injury to the psychological capacity of emotional stability of a child as evidenced by an observable or substantial impairment in the child’s ability to function within a normal range of performance and behavior with due regard to the child’s culture.”

For a complete definition, follow the link to Statute 626.556, available on our webpage. Find subdivision 2 and read paragraphs (g) and (m).

Mental injury should be diagnosed by a mental health professional who can directly relate the mental injury to something the alleged offender did or didn’t do, in order for you to make a determination that mental injury occurred in a Family Investigation. In a Family Assessment Response, the diagnosis helps you and the family determine appropriate services.

Physical Indicators of Physical Abuse

To determine whether an injury is accidental or abusive, consider:

- The injury’s physical characteristics
- Location of the injury on the child’s body
- Shape and appearance of the marks
- Whether the injury is consistent with the caregiver’s report of how it occurred
- Number and severity of injuries, including the presence of multiple injuries in different stages of healing that suggests repeated injuries.

The most common forms of physical harm are bruises, burns, head injuries, internal injuries, and skeletal injuries.

Bruises

Generally, bruises progress through a series of color changes as acute inflammation subsides, and the red blood cells and hemoglobin break down. Colors change from red to blue, green, yellow and brown before clearing.

Suspicious bruises in different stages of healing, particularly when bruises are located on the same area of the body, suggest repeated episodes of harm.

Bruises in infants and children who do not yet stand should raise concerns of abuse or an unsafe environment because children this young typically lack strength to move in ways that could cause accidental injury.

Birth marks and Mongolian spots are easily mistaken for injuries; it is important to know what they look like in order to avoid classifying them as bruises. Visit the MedlinePlus website referenced on our webpage for more information.

Burns

There are six categories of burns:

- Flame
- Scald
- Contact
- Electrical
- Chemical
- Ultraviolet (sun).

Abusive burns are generally scalds and contact burns. However, you may receive reports of burns in any of these categories.

Most burns occur in children 1-5 years of age and occur at home.

Burns inflicted by cigarettes are most common, leaving marks that are circular, punched out, and of similar size. They can appear as blisters or deep sores, depending upon how long the cigarette was in contact with the skin.

Head Injuries

The most serious inflicted injury is a subdural hematoma, or blood clot, on the surface of the brain. Bleeding in the back of the eyes, or retinal hemorrhaging, is almost always present when there is subdural hematoma, and helps to establish the diagnosis.

A prime example of this type of injury is Shaken Baby Syndrome (SBS) – repeatedly shaking a baby or young child. This causes brain injury equal to that of a blow to the head. In addition,

bones in the neck and spine can be injured, resulting in a collapse of the vertebrae or spinal cord injury.

Impact injuries typically result from a blow to the head by a hand, fist, foot or other object. These injuries may also occur when a caregiver throws or swings a child so that the head hits a surface.

More than a quarter of children who receive abusive head injuries die, making this the leading cause of death from physical abuse. The majority of those who survive exhibit some degree of mental retardation, blindness, cerebral palsy or seizures.

Because head injuries are usually not observable, it is important to know the symptoms so the child can be immediately examined.

Internal Injuries

Abdominal injuries are less frequent than skeletal or head injuries; however, they produce a 50% mortality rate and rank second only to head trauma as the leading cause of death from child abuse.

Abdominal injuries typically occur after the child is ambulatory – more than 2 years of age. As age increases, a shift usually occurs in the site of fatal injury from the brain to the abdomen.

Accidental injuries usually have specific histories and receive prompt treatment. In abuse cases, the history is more general and the injury is often described as resulting from a fall. Vague symptoms of abdominal injury and lack of accurate history increase morbidity and mortality because essential treatment is delayed.

Symptoms typically include projectile vomiting, extreme abdominal pain, or shock from internal bleeding. External bruising or other indicators of injury may not be present.

Skeletal Injuries

Skeletal injuries are rarely life-threatening but can cause long-term deformity or disability. The most common abuse fractures include the femur (long leg bone), skull and ribs. The humerus (long arm bone between elbow and shoulder) is also fractured relatively frequently in abuse cases.

Classic findings of intentional, inflicted injury are:

- Chip, corner or bucket handle fractures – a chip or corner of the bone is torn off during wrenching or twisting. These fractures occur when the extremity is pulled or twisted with force or with violent shaking
- Spiral fractures – usually caused by an adult twisting a child's limb. A spiral tibial fracture is often indicative of abuse.

In *non-ambulatory* toddlers, suspect abuse when a child presents with a rotational stress fracture. Once ambulatory, toddlers *do* have higher rates of accidental rotational stress fractures.

In infants, suspect abuse when the infant presents with rib fractures, which can occur when the child is forcefully squeezed. Accidental fracture of the rib cage is rare, as the ribs are still pliant. In newborns the birth history should be sought to rule out rib fractures from traumatic birth.

In all cases, physicians should rule out underlying medical causes such as Rickets or bone infections.

Injury History

Many child abuse determinations can be made based on physical observations; however injury history is useful, especially when the child is brought in for medical care and presents with multiple, nondescript bruises. These types of histories should be considered as extremely suspicious for non-accidental trauma.

- When a child readily states that a particular adult hurt him, it is almost always true. It is important to interview any child over the age of three separately from caregivers.
- When one parent accuses the other of hurting a child, it is generally accurate if they are not engaged in a custody dispute.
- Partial parent confessions are not uncommon and are as diagnostic as complete confessions.
- The parent denies awareness of blatant injuries, or can't explain how they occurred. When pressed for details, parents are evasive or offer vague, incriminating explanations; non-abusive parents willingly discuss where, when and how the child was hurt.
- Parents offer implausible explanations that are inconsistent with common sense or medical judgment. Occasionally, parents describe a minor accident for a major injury.
- Parents describe child behavior that is not developmentally possible or probable. Alleged self-inflicted injury in babies is extremely serious; these children can be killed if sent home. In general, infants / non-mobile children are unable to cause self-injury.
- Parents accuse siblings of inflicting the injuries when they can't provide realistic explanations. The number and/or seriousness of the injuries usually contradict the explanation.
- Be alert to delays in seeking medical care; abused children often are not brought in for a considerable length of time even for major injuries. In extreme cases, the child is not brought in until he or she is nearly dead. Non-abusive parents generally seek immediate medical help.
- The adult who was with the child at the time of the injury does not come to the doctor or hospital with the child.

Cultural Considerations

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Culture must be considered when assessing child abuse.

Certain folk remedies or healing practices used to treat illnesses may be reported as abuse. Child welfare responses to these reports vary depending on the seriousness of the resulting injury, potential harm to the child or perceived intent. Consult with your supervisor, law enforcement and county attorney if you receive reports alleging any of these cultural practices.

- Cupping is the practice of burning a small amount of material under a cup or glass placed directly against the skin; first or second degree burns can result. The practice is common in Latin American and Russian cultures.
- Coining or spooning is the practice of rubbing a coin or spoon heated in oil on the ill child's neck, spine and ribs. The practice is common in Southeast Asian cultures.
- Moxibustion is a form of acupuncture in which small circular incense or herb burns are made at therapeutic points. The practice is common to Southeast Asian cultures.
- Maquas is the practice of applying hot metal spits or coals to diseased or draining areas. The practice is common to Arab and Jewish cultures.
- Salting is performed on new infants; the skin is rubbed with oil and salt, and/or salt is placed under the tongue. Salting results in hypernatremia (an abnormally high concentration of sodium - salt - in the blood), jaundice, and dehydration. The practice is thought to decrease sweating, strengthen muscles and bones, improve immunity and wound healing, and to disinfect, soften and protect the skin from allergies. Salting is common to Japanese and Arabic cultures, and is also practiced in India.
- Tattooing is the practice of permanently marking a child's skin and is practiced by many cultures.
- Another cultural practice that raises legal questions is female genital mutilation (FGM). Some states, including Minnesota, and some countries have banned FGM.

Behavioral and Emotional Indicators of Physical Abuse

Physical indicators of abuse may be readily observable to reporters and child welfare workers; behavioral and emotional indicators may be less obvious.

Assessing these indicators requires you to apply your knowledge of normal child development.

Very Young Children

Children abused at an early age may display these indicators of developmental delay and atypical or unhealthy development:

- Remote, withdrawn, lack curiosity
- Whine, whimper, or cry with no expectation of comfort

- State of ‘frozen watchfulness’
- Discomfort or fear of physical contact
- Appear to be autistic
- Clinging dependency
- Depressed, or display flat affect and lack of emotion.

Pre-School Children

Pre-school children who are abused are likely to display these behaviors:

- Timid and easily frightened
- Eager to please, may crave attention, may show indiscriminate attachment
- Role reversal
- Physical signs of stress
- Aggressive with other children

School-Age Children

School age children show many of the same characteristics as pre-school children. Problems in relationships and developmental delays will be more pronounced the longer they have been abused.

Behavioral and emotional indicators include:

- Assume the adult role in their relationship with the parent – parentification
- Difficulty relating to other children and adults
- Hyperactivity
- Fear of parents, or in some cases, absence of fear.

Adolescents

Many adolescent emotional and behavioral problems may be indicators of abuse or neglect:

- Lying or stealing
- Fighting, angry outbursts, belligerence, and behaving aggressively towards other people
- Abuse of alcohol or drugs
- Truancy
- Delinquency, including repeated running away or refusing to go home
- Generalized difficulty with interpersonal relationships
- Emotional and social withdrawal, depression, lack of interest in activities or other people.

This concludes the section on physical abuse.

Neglect

Recall that neglect is failure to provide a child’s basic needs, such as food, shelter, clothing, medical and mental health care, supervision, safety and education, when able to do so. Neglect also includes prenatal exposure to alcohol, chronic and severe use of alcohol or controlled substances, and emotional harm.

Neglect is the most frequent cause of death related to child maltreatment. Furthermore, most allegations of maltreatment involve neglect.

Risks of neglect include serious injury, pervasive developmental delay and disability, and sometimes death.

Indicators of Neglect

Examples of physical indicators of neglect include:

- Abandonment
- Lack of supervision
- Untreated illness or injury
- Malnourishment and dehydration
- Dangerous physical environment
- Lack of basic care or hygiene
- Inadequate clothing
- Lack of education
- Emotional neglect

Just as physical abuse indicators vary by age, so do neglect indicators. Use your knowledge of normal child development to help you assess allegations of neglect.

Let's look physical indicators of neglect in more detail.

Physical Indicators of Neglect

- Abandonment occurs when children are left completely alone, with familiar people who aren't prepared or willing to provide extended care, or with strangers for extended periods without parental support.
- Lack of supervision occurs when children who are unable to care for themselves are left unattended or are supervised by incompetent caretakers and are at risk of injury and death. In Minnesota, there is no law about when children can be left alone or in charge of other children; however, there are screening guidelines for supervision, introduced in Module 7.
- Untreated illness or injury is the failure to provide medical care, which can result in chronic illness and disabling conditions, and exacerbates the negative progress of normal diseases. For example, untreated colds and flu can result in pneumonia, which can be fatal.
- Malnourishment and dehydration occurs when children are not fed or are fed improperly. Severe neglect in infants results in Failure to Thrive (FTT).
- A dangerous physical environment includes unsanitary or dangerous living conditions. While a "dirty house" by itself does not create risk for children, unsanitary conditions

such as exposed garbage, rotting food, and animal and human excrement expose children to disease and illness.

Dangerous conditions such as broken glass, exposed electrical wires, flaking lead paint, the presence of rats or other vermin, unlocked guns and ammunition, and accessibility of drugs create a risk of injury.

- Lack of basic physical care and hygiene can contribute to risk of disease or illness. Examples are ulcerated rashes from unchanged diapers, and localized or systemic bacterial infections from skin abrasions or other injuries.

Inadequate clothing may put a child at risk of illness or injury from exposure.

- Lack of education results from failure to send a child to school and assure that the child receives a basic education.

Emotional Neglect

Emotional neglect consists of chronic emotional deprivation; the child is denied attention and affection, is ignored, made to feel unwanted and unloved, is isolated and denied interactions with other people, or is exposed to the conflict, discord, and often erratic behaviors of a mentally ill parent.

Behavioral and Emotional Indicators of Neglect

Behavioral and emotional indicators can alert you to the presence of neglect in families:

- Developmental delay across domains
- Unresponsive, apathetic, lack curiosity, and uninterested in their surroundings
- Abnormal degree of interest in interpersonal interaction
- Appear to be hungry or always tired
- “Out of control”
- School failure.

Emotional Harm

Emotional harm is a form of neglect. The dynamics of emotional harm are subtle and less evident, but vastly more complex, than physical abuse or neglect.

Emotional harm is a concerted attack on a child’s development of self and social competence. It may or may not be a conscious act on the part of the caregiver. Its pattern of psychologically destructive behavior is either in the form of omission or commission.

An example of omission is ignoring the child – omitting necessary attention.

An example of commission is repeatedly telling the child that he or she is stupid – committing intentional acts that harm the child’s emotional health.

Emotional harm can be one of the most damaging types of maltreatment. The younger the child, and the less developed the child's sense of self and identity, the more serious the physical, social, and emotional consequences.

Emotional harm is manifest in many forms, and can vary in frequency and intensity. The five most common forms of emotional harm are:

- Denying emotional responsiveness or ignoring – the caregiver ignores the child's attempts and needs to interact, and shows no emotion in interactions with the child.
- Spurning, hostile, rejecting or degrading – the caregiver's verbal statements or nonverbal acts reject and degrade the child.
- Isolating – the caregiver acts in ways that consistently deny the child opportunities to meet interaction and communication needs with peers or adults.
- Threatening harm – the caregiver's behavior threatens or is likely to physically hurt, kill, abandon or place the child or the child's loved ones or objects in recognizably dangerous situations.
- Exploiting or corrupting – the caregiver acts in ways that encourage the child to develop inappropriate behaviors, such as self-destructive, anti-social, criminal, deviant, or other maladaptive behaviors.

Difficulty in Assessing Neglect

These factors may contribute to difficulty in assessing and identifying neglect:

- Differences in values, norms, and standards of acceptable child rearing in different cultural groups.
- Marginal child rearing, in which the child is not at immediate risk of harm but is at risk for detrimental outcomes from long-term exposure to marginal care.
- Poverty often prevents parents from meeting their children's basic needs. Families in poverty may have inadequate shelter, food, medical care; and limited emotional energy to attend to their children.

Indicators Summary

Use your observation skills when you meet with children and families to assess indicators of maltreatment. Module 7 provides useful assessment tools and resources.

Effects and Consequences of Child Maltreatment

Now that you have an understanding of behavioral and emotional indicators, let's briefly examine the possible effects and consequences of maltreatment on these age groups:

- Infants and Toddlers
- Pre-School Children
- School-Age Children
- Adolescents.

Infants and Toddlers

Abuse and neglect can adversely affect these developmental areas for infants and toddlers:

- Physical
- Cognitive

- Social
- Emotional
- Toilet Training.

Pre-School Children

Abuse and neglect can adversely affect these developmental areas for pre-school children:

- Physical
- Cognitive
- Social
- Emotional.

School-Age Children

The effects of maltreatment on physical, cognitive, social and emotional development are the same as those of the younger groups, but may be more chronic. Because school-age children are in a different stage of development, look for the effects of abuse and neglect from these perspectives:

- Living in chaos
- Relationships with parents and other adults
- Relationships with peers
- Industriousness
- School performance
- Self-esteem and emotional disturbance.

Adolescents

The effects of maltreatment in adolescents vary because each child manifests individualized symptoms.

Look for effects from these perspectives:

- Alcohol and drug abuse
- Truancy
- Pregnancy
- Relationship problems
- Learning problems
- Delinquent behaviors

Variables that Affect Child Responses to Maltreatment

Several variables affect a child's response to abuse and neglect, and the effects of maltreatment on the child's development. These variables also determine the behavioral indicators of maltreatment for the child.

- Age: The younger a child is when first abused or neglected, the greater the risk of serious developmental problems from the maltreatment.
- Duration: The greater the period of time a child has been abused or neglected, the more severe the developmental outcomes will be.
- Frequency: The more frequently a child is maltreated, the more pervasive the effects of the maltreatment.

- Relationship: The closer the relationship of the abuser to the child, the more likely the child will be negatively affected. Abuse and neglect by a parent have the most serious consequences.
- Maltreatment type: The more severe the pain and the greater the injury inflicted on the child, the more negative the social, emotional and physical outcomes will be.
- Availability of support: The presence of other, non-offending adults who provide proper care and nurturance – inside or outside of the home – can partially mediate the negative effects of maltreatment.
- Constitutional factors: The child's basic personality and temperament can affect the outcomes of maltreatment. Some children are more resilient than others and have unusual coping strengths; other children are more vulnerable.

Effects of Maltreatment Summary

Adults who were maltreated as children are much more likely to suffer from serious life-long mental health problems, such as depression, suicide, alcoholism, drug abuse, and medical problems such as heart disease, cancer, and diabetes, which are more indirect consequences of maltreatment.

For more information, go to our webpage for links to the articles “The Impact of Trauma on Child Development” from the *Juvenile and Family Court Journal* and “The Effects of Childhood Stress on Health Across the Lifespan”.

Other Developmental Influences

In addition to the adverse effects of maltreatment on child development, there are other conditions to be aware of when assessing families.

- Fetal Alcohol Spectrum Disorders – FASD
- Prenatal exposure to cocaine and other controlled substances
- Failure to Thrive – FTT
- Child refugee trauma.

Fetal Alcohol Spectrum Disorders – FASD

Alcohol destroys and damages cells in the central nervous system. Widespread destruction of brain cells in early fetal development results in malformations in the developing brain structures, producing abnormalities in brain function.

The most severe end of the spectrum is called Fetal Alcohol Syndrome; its symptoms are associated with prenatal exposure to a large amount of alcohol.

Typical FASD outcomes include:

- Delays in physical growth and development
- Facial physical features distinct from other children
- Fine motor control problems
- Smaller head, microcephaly
- Irritability in infancy, hyperactivity in childhood
- IQ within mild range of mental retardation.

FASD must be diagnosed by a qualified medical professional.

Prenatal Exposure to Cocaine and Other Controlled Substances

Children exposed to drugs in-utero may experience adverse developmental problems in all domains.

Prenatal exposure to cocaine and other drugs are very concerning to child welfare, and each has its own set of negative outcomes. Research indicates that effects often persist into the toddler and pre-school years, and are evidenced by problems in attention, cognitive organization, affect, socialization, and play.

The potentially devastating life-long effects of prenatal exposure to alcohol and drugs have resulted in laws that specifically address mandatory reporting of these situations.

Legal Mandates to Report

Follow the links to Minnesota Statutes addressing alcohol and other drug use that impacts children:

- Statute 626.5561 requires mandated reporting of a “woman who is pregnant and has used a controlled substance for non-medical purposes during the pregnancy...or has consumed alcoholic beverages during the pregnancy in any way that is habitual or excessive.”
- Statute 253B.065, subdivision 5(c) states “The court may order early intervention treatment if the court finds by clear and convincing evidence that a pregnant woman is a chemically dependent person.”
- Statute 253B.02 defines a “chemically dependent person also means a pregnant woman who has engaged during the pregnancy in habitual or excessive use, for a nonmedical purpose, of any of the following substances or their derivatives: opium, cocaine, heroin, ...methamphetamine, amphetamine, ... or alcohol.”

Follow the links on the webpage to read complete statutory language.

It is important to know that a Family Assessment Response or Family Investigation can't be completed until the child is born. Reports of exposure prior to the child's birth must be handled as child welfare cases.

Consult with your supervisor when these types of reports are received.

Failure to Thrive – FTT

The term “failure to thrive” describes a variety of conditions in which infants fail to achieve age-appropriate weight and height levels. A common characteristic is inadequate caloric intake or absorption resulting in malnutrition and growth retardation.

Children with FTT related to neglect are typically:

- Emaciated, pale, and weak; have decreased muscle mass and tone
- Well below normal weight ranges

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- Listless, apathetic, motionless, and irritable
- Unresponsive or resistant to social involvement
- Asleep for longer periods of time than is age-appropriate
- Immature in posture
- Self-stimulating with rocking, head-banging, or rumination
- Delayed in gross motor skills and social development
- Able to recover rapidly with appropriate care in a hospital or with nurturing caregivers.
- It is important to rule out any medical conditions that could cause FTT.

Treatment approaches must include both medical and environmental management, regardless of the cause of the problem.

Parents of children with FTT often display these characteristics:

- Depression, social isolation and anxiety
- Childhood histories of abuse and neglect, including an absence of attachment
- Failure to interact with their infants in a nurturing manner
- Overwhelmed by chronic stress
- Limited ability to empathize with their infants – miss or ignore infant’s cues
- Expressions of sincere concern about the child’s condition but lack of knowledge and ability to engage with their infants.

FTT Interventions

Recommended treatment or interventions for FTT include:

- Immediate hospitalization of the infant with a prescribed caloric intake far in excess of normal growth needs
- Direct involvement of the parents in all aspects of treatment
- Recognition that the parent’s problems are not simply lack of feeding knowledge
- Parents must experience empathy and nurturing in order to provide it for their infant
- Parent education focused on nurturing
- Foster care if the parents do not appear willing or able to improve their care of the infant

Child Refugee Trauma

Some children and families in the child welfare system are immigrants from war-ravaged countries. The effects of war trauma on children are similar to the effects of maltreatment trauma.

According to the Center for Victims of Torture, war-related trauma for refugee immigrant families can include adverse effects in all domains.

- Physical – injuries, illness, and malnutrition
- Psychological – PTSD, anxiety disorders, phobias, and depression
- Social – parents working two jobs and unavailable to their children; role reversal between children and parents; children acting as interpreters; children raising children; marital strife due to changing roles and past trauma; and family reunification issues.

Refugee children often have chronic pain, psychosomatic symptoms, quick escalation of behavior, fighting, depression, academic and developmental delays.

As you can see, it is important to be familiar with a family's background and history because we can't assume that developmental concerns are the result of child maltreatment.

Safety, Permanency and Well-Being

Now that you have information on maltreatment indicators and possible consequences of maltreatment on normal development, click each segment to understand some of the ways that child trauma affects safety, permanency, and well-being.

Safety

Safety for children is both physical and psychological.

A child's inability to regulate his moods and behavior can adversely impact the caregiver's responses and places the child at increased risk

Trauma may impact the child's ability to describe events, which may adversely affect safety planning and intervention

- The child's lack of trust may affect the information she provides, compromising safety planning and intervention
- The child's emotions may be dulled, compromising her believability
- Self-destructive behavior by the child may jeopardize his safety.

Permanency

The child's reaction to stress can impact stability in the home or in placement:

- Inability to regulate moods may result in behaviors that affect reunification or placement
- Lack of trust may result in rejection of caring adults
- Early attachment issues may reduce the child's natural empathy for others, including caregivers
- Physical safety - in the home, with relatives, or foster care - may not be enough to provide stability.

Lack of psychological safety can interfere with permanency. A child may feel psychologically unsafe because he or she is:

- Unfamiliar with caregivers and surroundings
- Afraid that the abuser may come and get him
- Afraid that the abuser will kill or has killed the non-abusive parent or the family pet
- Afraid for the safety of siblings.

Well-Being

Trauma can adversely impact a child's well-being and result in:

- Mental health, physical health, and life path challenges
- Cognitive disruption that affects learning
- An inability to regulate moods

- Feelings of hopelessness
- Self-isolation from support systems
- Inability to develop positive coping skills, leading to high-risk and destructive behaviors
- Development of post-traumatic stress disorder (PTSD).

Children who exhibit these behaviors should receive a thorough mental health assessment from a qualified practitioner as soon as possible.

Summary

This chapter provided an overview of the most common emotional and behavioral indicators and effects of maltreatment on children. It is important for you to recognize that each child is unique and not all children respond similarly to trauma. There are always variables in the child's life that affect his or her response to abuse or neglect.

Remember that short and long-term outcomes can vary depending on the presence of protective factors. A thorough assessment of all domains of the child's development and environment is crucial for planning and implementing culturally appropriate services to strengthen the family and provide for child safety, permanency and well-being.

Next Steps

The Module 6 Chapter 3 transcript is available on the website along with:

- Head Injury Symptoms
- Cultural Diversity and Child Protection
- Indicators & Effects of Maltreatment on Developmental Stages chart
- Affects & Consequences of Child Maltreatment on:
 - Infants and Toddlers
 - Pre-School Children
 - School-Age Children
 - Adolescents

Refer to the website for the following articles:

The *Juvenile and Family Court Journal*, Winter 2006, "The Impact of Trauma on Child Development"

The CDC article, "The Effects of Childhood Stress on Health Across the Lifespan"

And "What is Trauma", from the Center for Excellence in Children's Mental Health

Consult with your supervisor regarding any questions about the content of this chapter.

Remember to check the website and print the documents labeled for classroom use. You will need to bring those documents to class with you.

When you are ready, begin Chapter 4.