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CHILD SAFETY MATTERS

CHILDHOOD ABUSE: HOW TO RECOGNIZE IT

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1. CHILD ABUSE

The clinical definition of child abuse, also known as child maltreatment, refers to a range of violent, abusive, or neglectful behaviors perpetrated against minors by adults or older minors. These abuses can take the form of physical violence, sexual abuse, emotional or psychological abuse, as well as neglect. The definition of child abuse has been developed to identify and provide classification for the different forms of possible violence.

Although these forms of abuse may have distinctive characteristics, they often coexistand have negative repercussions, sometimes even in the long term, on the well-being and development of children. In fact, it is impossible to think of physical violence towards a child that does not also representa form of psychological violence, while psychological abuse is often accompanied by acts of maltreatment.

In order to develop appropriate interventions and protect children from further harm, it is necessary to have a vast literature and a clear definition that is, as far as possible, shared by numerous stakeholders. Clinical definitions of child abuse are often established by organizations and health authorities, such as the World Health Organization (WHO), as well as national and international laws (Guidetti, 2016). However, it is important to consider that the sociocultural context poses a limitation in this field, as these definitions emphasize that such behaviors are excessive compared to what is culturally accepted.

As for the definition, the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5;APA, 2013), classifies abuse and maltreatment within the chapter on Other Conditions.

That May Be a Focus of Clinical Attention (Guidetti, 2016). This definition refers to the presence of violence perpetrated by a more powerful individual against a more vulnerable individual who, due to their physical or psychological immaturity or role differences, is unable to defend themselves and is dependent from a physical and/or psychological standpoint. Maltreatment of minors can be distinguished as follows:

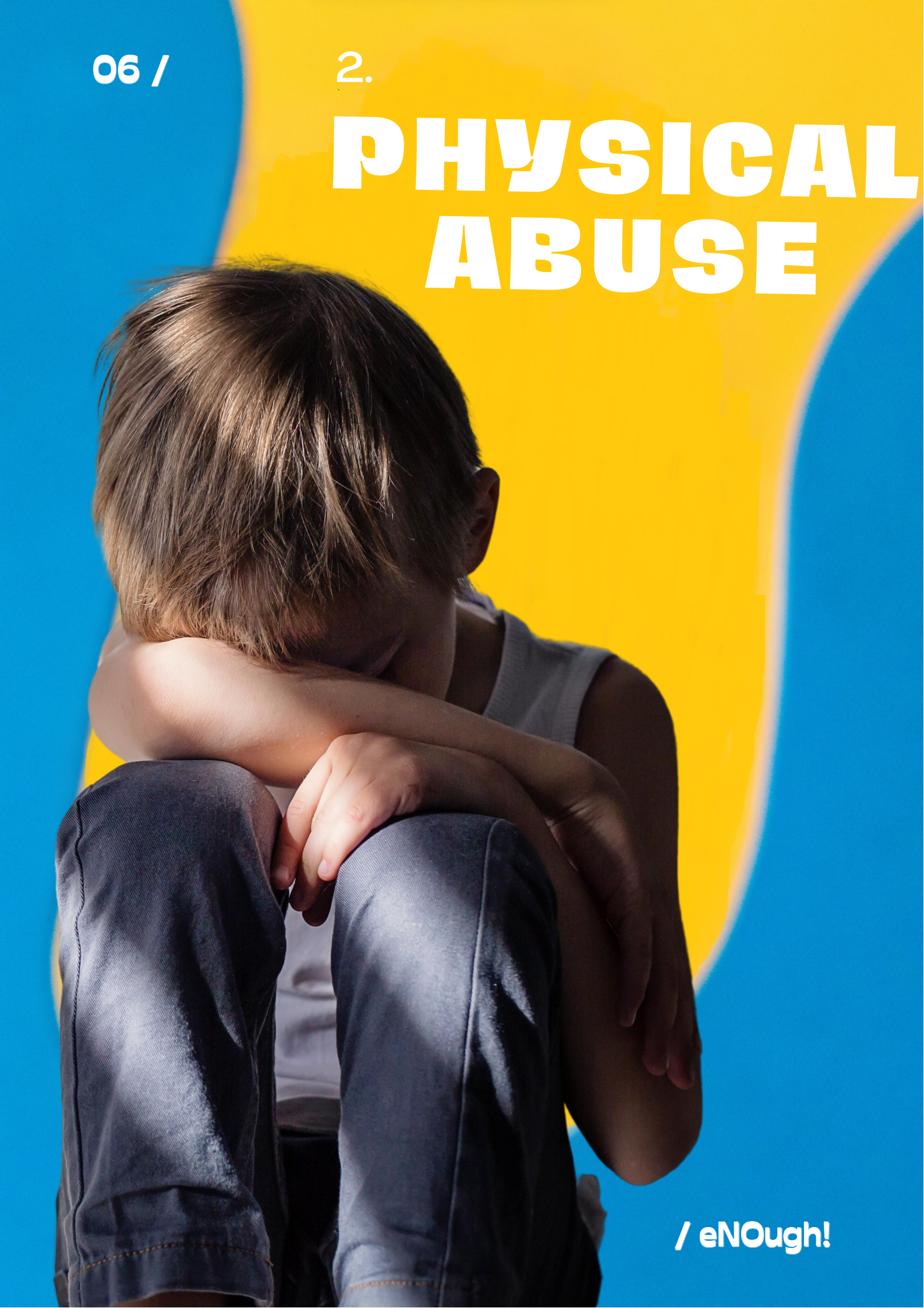
1. Physical abuse;
2. Psychological abuse;
3. Sexual abuse;
4. Caregiver pathology: including discuria, incuria, and ipercuria (such as Munchausen syndrome by proxy).

CHILD ABUSE

In order to comprehensively examine this subject, these types of abuse will now be individually explored, with a particular emphasison recognizing the signs of such forms of violence. Indeed, in order to plan an effective intervention, it is crucial to identify the characteristic indicators of these abuses. Often, children who experience abuse do not openly disclose their experiences due to feelings of shame and guilt, or even because they are too young to fully comprehend what is happening to them. However, these signals can be identified by teachers and school staff, who can then report the abuse and take the necessary actions to safeguard and assist the child.

2.

PHYSICAL ABUSE



Starting with physical abuse, it occurs when there are physical injuries resulting from physical assaults, maltreatment, corporal punishment, or severe violations of physical integrity and life. In terms of epidemiological data, according to a meta-analysis study conducted by Stoltenborgh et al. in 2013, 22.6% of the global population has experienced physical violence during childhood. From a clinical perspective, injuries that are difficult to explain by accidental events can be identified.

These injuries may include bone fractures, bites, multiple and repeated burns or scalds, bruises in areas not typically prone to accidents, twisting or tearing injuries, and hematomas. Such signs can raise suspicions of physical abuse and require a thorough assessment and investigation to determine the underlying cause of the injuries.

The risk indicators associated with physical abuse include the following elements:

- Compromised overall health status.
- The presence of a disproportionate number of injuries, occurring at different times and in various stages of healing.
- Significant delay between the traumatic event and seeking medical attention (lack of promptness in seeking help).

- Hesitation, inconsistency, or contradictions on the part of parents in providing information about the recent trauma, as well as discrepancies between the child's clinical signs (e.g., type of injury) and the version provided by the parents.
- Inappropriate emotional reactions from parents regarding the severity of the injuries.

More specifically, bruises, scientifically known as ecchymosis, appear to be the most common sign in children of all ages who are victims of physical violence (Maguire, 2008). Consequently, they provide an opportunity to intervene and protect the child from further abuse.

PHYSICAL ABUSE

According to Maguire (2008), among children presenting to the Emergency Department or trauma centers, it is estimated that between 7% and 30% have a physical abuse-related injury, with higher figures reported in pediatric hospitals. The highest prevalence of abuse is found in younger children, where up to 40% of injuries in children under 4 years old may be attributed to abuse, while it drops below 10% for adolescents aged 10 to 14 years. Other physical indicators, in addition to bruises, may include scratches, burns, and unexplained fractures or injuries.

Furthermore, children who are victims of physical abuse may exhibit additional nonspecific symptoms that, while not definitive proof of abuse, can serve as warning signs indicating the need for further investigation. Nonspecific symptoms may include behavioral changes such as anxiety, frequent crying, social isolation, self-harming behaviors, difficulties with concentration, and behavioral regression, which involves reverting to behaviors typical of earlier developmental stages. In addition to the aforementioned indicators, according to the scientific literature, additional nonspecific symptoms in the case of a child victim of physical violence may include disturbed object

relations and attachment patterns, aggressive, destructive, or self-destructive behaviors, conduct disorders, academic failures or declining school performance, use of psychoactive substances, and passive, compliant, and submissive behavior (Guidetti, 2016).

It is important to reiterate that these symptoms or signs, on their own, are not indicative of abuse, but they should be regarded as warning signals to be taken into consideration. In the event that suspicions of abuse or maltreatment arise, it is crucial to report and consult with professionals experienced in the field of child welfare in order to obtain a reliable and accurate assessment, as well as appropriate intervention.

Psychological maltreatment, on the other hand, is characterized by an emotional relationship in which repeated and continuous psychological pressures, emotional blackmail, indifference, rejection, denigration, and devaluation occur, causing harm or inhibiting the development of fundamental cognitive and emotional abilities such as intelligence, perception, and memory.

Family indicators of psychological maltreatment include the belittlement of the child, expression of hostility, systematic minimization or blame, attributing the child with responsibility for the difficulties that occur, threats of severe punishment, providing conditional care and affection based on the parents' needs, indifference and lack of emotional availability, failure to recognize and respect the child's individuality, overprotective attitude, and failure to provide age-appropriate cognitive and emotional learning opportunities for the child.

3. PSYCHOLOGICAL ABUSE

Furthermore, the risk indicators associated with psychological maltreatment may vary depending on the context and specificities of each child, but there are common signs that can raise suspicions of psychological abuse. A child's behavior is an external manifestation of their inner stability and security, and the experience of childhood psychological abuse can cause disruptions in behavior and disturbances in psychological development (Odhayani & Watson,2013).
Specifically, children who experience such forms of abuse may exhibit a reactive-hyperarousal symptomatology, characterized by high agitation or hyperactivity, such as psychomotor instability, hostility, and opposition. On the other hand, some children may display an opposite tendency, with adepressive symptomatology, such as reduce dacademic performance, social isolation, sadness, and low self-esteem (Guidetti, 2016). Additionally, emotional abuse of a child can increase the risk of suicidal thoughts and self-harm behaviors, as well as difficulties in forming healthy relationships (NSPCC, 2023).
In this case as well, children who are victims of psychological maltreatment may exhibit the same nonspecific symptoms mentioned in the section on physical maltreatment: anxiety, frequent crying, social isolation, self-harming behaviors, difficulty concentrating, and behavioral regression. Once again, it is important to emphasize that these symptoms or signs, on their own, are not indicative of abuse but should be evaluated as warning signals.

4. SEXUAL ABUSE

Regarding sexual abuse, it can be defined as any sexual act, both physical and non-physical, in which one of the involved individuals is unable to give consent (due to age, incapacity to understand and consent, or due to threats or coercion). According to Finkelhor (1994), sexual abuse can be categorized into forms with physical contactand forms without physical contact:

- With physical contact: it encompasses mild forms of seduction, masked sexual abuse, and severe and overt sexual actions.
- Without physical contact: it includes voyeurism, the use of pornographic images, and exhibitionism.

The specific definitions provided by Finkelhor in 1994 regarding the different forms of sexual abuse are as follows:

- Mild seduction: non-coercive behaviors involving manipulation and persuasion.
- Masked sexual abuse: sexual behaviors that do not involve direct physical contact with the victim's body, such as exploiting the child for the production of pornography.
- Severe overt sexual acts: sexual behaviors involving direct physical contact that can cause severe physical and psychological harm to the victim.
- Voyeurism: secret or hidden observation of others' sexual acts without their consent.
- Pornographic images: use or distribution of visual material depicting explicit sexual acts.
- Exhibitionism: voluntary exposure of one's own genitals in public without the consent of others.

Sexual abuse typically occurs between individuals with a significant age difference, which implies adifference in maturity levels. In the case of child victims of sexual abuse, the perpetrator is usually in a position of authority or a caregiver figure, which creates a greater sense of fear. These dynamics often involve threats, deception, and emotional manipulation towards the child. Due to their immaturity, these children may not fully comprehend the sexual activities carried out by the perpetrator and may lack full awareness of the situation. Various types of events fall under the category of sexual abuse, including instances of pedophilia, rape, cases of incest, and sexual exploitation (Guidetti, 2016).

Sexual abuse can manifest within the family, commonly referred to as "incest," or outside the family. In cases of intrafamilial abuse, the perpetrator is a family member and can involve both males and females. In cases of extrafamilial abuse, the perpetrator is a stranger, and the act can involve both males and females. There is also a third situation where abuse takes on an institutional nature. In such cases, the perpetrator may be a teacher, janitor, caregiver, or coach. Sexual abuse can occur on the street by strangers for profit or can be perpetrated by organized groups such as cults (Guidetti, 2016).
In a study conducted by Stoltenborgh et al. in 2011, involving a sample of over 9 million individuals recruited between 1980 and 2008, a global prevalence rate of 18% among femalesand 7.6% among males for child sexual abuse was estimated (as cited in Guidetti, 2016).
Research on sexual abuse holds significant importance due to the severe and long-lasting effects that have been observed. Short-term consequences include physical symptoms, psychological symptoms, and behavioral changes.

Long-term psychological consequences of sexual abuse include low self-esteem, poor assertiveness, lack of trust in others, difficulties in social relationships, psychological disorders, depersonalization, sexual disorders, engagement in self-destructive behaviors, self-harm, and mutilation. Victims of abuse often attribute blame to themselves, experience problems in their relationships with their own children, and struggle with controlling their thoughts. Browne and Finkelhor (1985, 1988, 1990), for example, identified four emotions that permeate the psyche of child victims of sexual abuse: powerlessness, betrayal, traumatic sexualization, and stigmatization.

In order to provide a specific list of risk indicators associated with sexual abuse, the prestigious Journal of the American Medical Association (JAMA, 1985) compiled a set of behavioral indicators for suspected sexual violence that have been widely disseminated in the scientific literature.

However, the difficulty in interpreting these indicators lies in the fact that the problematic behaviors considered as signs of sexual abuse are actually general indicators of stress in children. Therefore, utilizing this list without adequate caution and information about its limitations can lead to confusion and errors (Legrand, Wakefield & Underwager, 1989). The following is a sample of the indicators includedin this list:

- Displaying excessive withdrawal;
- Exhibiting poor relationships with peers;
- Experiencing low self-esteem;
- Appearing fearful or phobic, especially towards adults;
- Having a deteriorated body image;
- Expressing general feelings of shame or guilt;
- Showing sudden decline in academic performance;
- Engaging in suicidal attempts;
- Displaying regressive behaviors;
- Exhibiting enuresis and/or encopresis;
- Involving oneself in highly sexualized play activities.

5. CAREGIVER PATHOLOGY

John Bowlby, a psychiatrist, psychologist, and psychoanalyst, renowned as the father of Attachment Theory, emphasized the significance of emotional relationships and close bonds among human beings. According to Bowlby, this need is particularly evident in children through their search for parental figures or caregivers and their desire for love and security. Bowlby considered the presence of significant emotional relationships, particularly the mother-child bond, crucial for a child's social and emotional development.

It is within this context that the concept of caregiving pathologies arises, referring to conditions in which parents or caregivers fail to appropriately provide the necessary physical and psychological care to the child, considering their stage of development and age. Due to inadequate caregiving, significant repercussions can occur in the child's development across various aspects such as health, quality of life, nutrition, emotional development, hygiene, and education. Caregiving pathologies encompass situations in which there is a lack of proper care from parents or guardians who fail to adequately meet the child's psychophysical needs according to their age and development.
Caregiving pathologies manifest in three predominant forms:

- Discuria: occurs when the physicaland psychological care provided to the child is insufficient in meeting their actual needs.
- Incuria: manifests when the care provided is distorted and/or inadequate in relation to the child's actual needs.
- Ipercuria: occurs when the care administered is excessive and disproportionate to the child's actual needs (Nuzzolese & Lungo, 2021, pp. 59).

PATHOLOGIES

5.1. Discuria

Discuria manifests through the administration of inadequate care in relation to the child's developmental stage. This concept can be highlighted in two ways: on one hand, there is a lack of supervision over the activities, friendships, and behaviors of a young child; on the other hand, there is an attitude of overprotection and restriction of autonomy by the parent (Guidetti, 2016). In the first case, the lack of supervision exposes the child to numerous risks and dangerous situations.

CAREGIVER PATHOLOGY

In the second case, excessive overprotection hinders the normal development of autonomy and skills in the child, preventing them from exploring the world as a child with a healthy caregiver relationship would. This form of misattunement can prevent the child from acquiring appropriate social, emotional, and cognitive skills, as the parent overprotects the child and denies them the opportunity to face age-appropriate challenges. This can hinder the child's growth and independence. It is essential for parents to create a safe environment that is also suitable for the child's developmental level, promoting a healthy balance between supervision and encouragement of autonomy. This allows the child to explore, learn, and develop appropriately, acquiring the necessary skills to facelife's challenges.

Not infrequently, parents adopt an overprotective attitude and dedicate excessive attention to their child in order to maintain a state of fusion with them, thereby limiting their socialization and openness to the world, and idealizing a relationship that is detached from reality. In these situations, the parent tends to care for the child as if they were still in a previous stage of development, rather than considering their current evolving phases.

As a result, the child tends to exhibit immature behavior relative to their developmental stage. In some cases, the opposite tendency can emerge, where the child adopts a more mature behavior. For instance, this can occur when parents push their daughters to participate in beauty pageants, potentially instilling in them a distorted notion of competition (Nuzzolese & Lungo, 2021, pp. 59).

The risk indicators associated with discuria are as follows:

1. Parents exhibit a lack of empathy that prevents them from adequately perceiving their children's needs.
2. Children are not perceived as autonomous and separate individuals with their own ideas, emotions, and needs distinct from those of the parents.
3. Parents are unaware of the harm they are causing and often believe they are acting in the best interest of the child.
4. The child may experience difficulties in learning and socialization.

The term "incuria" refers to a lack of care that is insufficient to meet the physical and emotional needs of the child. Neglect, for example, represents an extreme case of incuria. In certain situations, such as when painful or toxic treatments are administered to the child, or when there is a threat to their life, we find ourselves in an ethically and culturally contentious area that involvesthe personal beliefsof the adult and the discretionary power of the parent over the child.

Regarding the effects of these "omissive abuses," the traumas caused by varying degrees of caregiver deficiencies can be just as insidious as those resulting from other forms of abuse or violence. Interdisciplinary research informs us that there is a complex and significant etiopathogenic link between disturbed attachment relationships (Fonagy, 1997, as cited in Guidetti, 2016), pathological deviations or alterations, even in early stages of development, in the structures of the brain involved in stress regulation (leading to disturbances in homeostatic mechanisms and subsequent neurophysiological vulnerability), and

5.2. INCURIA

the future development of psychopathology in the child's life (Schore, 2001, as cited in Guidetti, 2016). There are several forms of incuria that can be identified:

- In physical incuria, parents or caregivers fail to adequately provide the child with food, clothing,a safe home, supervision, and protection from potential hazards.
- In emotional incuria, parents or caregivers do not offer adequate affection, love, or emotional support to the child. This can manifest through ignorance, rejection, or hindrance of the child's interaction with other children or adults.
- Medical incuria occurs when parents or caregivers do not

provide the child with appropriate medical care, such as treating physicalor mental injuries or disorders. They may delay healthcare treatments when the child is ill, exposing them to the risk of more severe illnesses or even death.

- Educational incuria occurs when parents or caregivers do not enroll the child in school or ensure that the child attends a conventional school, such as a public or private school, or do not provide adequate homeschooling education.

Neglect differs from abuse because, in the case of neglect, parents and caregivers generally do not have the intention to harm the child entrusted to their care.

Typically, neglect is the result of a combination of factors, including in adequate parenting attitudes, a poor ability to manage stress, unstable family dynamics, and complex life circumstances. It is often found in families facing financial and environmental difficulties, especially when parents have untreated mental health disorders such as depression, bipolar disorder, or schizophrenia, or struggle with

abuse or limited cognitive abilities. Children raised by a single parent may be particularly at risk of neglect due to low income and a lack of available resources. Risk indicators associated with incuria are well represented by the following physical signs in the child: inappropriate clothing for their sex, age, or season; poor hygiene and dermatitis; malnutrition.

5.3. IPERCURIA

In this paragraph, the case is addressed where the child receives excessive or distorted care in relation to their actual physical condition, with excessive medicalization that is inadequate and harmful. This condition is known as ipercuria and is based on an unrealistic idea of the child and their needs. Recognizing this condition is not an easy task, as it is difficult to distinguish between situations of normal concern for the child's health and an excess of attention that can turn into pathological behavior.

Munchausen syndrome by proxy represents the most severe form of overcare. However, this syndrome is no longer included in the DSM-5 as it is difficult to identify and place within a specific diagnostic category. The incidence of this syndrome is 0.4 per 100,000 in the age group between 2 and 16 years, and 2 per 100,000 in children under 1 year of age (Nuzzolese & Lungo, 2021, pp. 61 - 63). There are no gender differences observed among the victims of abuse in Munchausen syndrome by proxy, and typically the mother is the perpetrator of the abuse. The individual with this disorder inflicts serious physical and psychological harm on the child in order to simulate fictitious symptoms, attract the attention of healthcare professionals, and subject the child to unnecessary tests and treatments. The period from the onset of pathological behaviors to the diagnosis of Munchausen syndrome by proxy is 21.8 months (ibidem).

The pathologies inflicted upon a child may vary, but the most commonly reported symptoms include diarrhea, feeding disorders, apnea, cyanosis, convulsive seizures, asthma, allergies, fever, pain, infections, and bleeding. Furthermore, it is frequently observed that the parent possesses medical knowledge, which complicates the recognition of simulation. The parent can manipulate the results of the child's biological tests, induce artificial bleeding from the child's natural orifices to simulate hemorrhages, and may even resort to harmful behaviors such as suffocation. These actions are not driven by aversion towards the child but rather by a desperate desire to draw attention to the child from others. As demonstrated by Bowlby, children yearn for the proximity of their caregiver even in paradoxical situations, which is why a child may be inclined to simulate illness in order to continue receiving attention from or submitting to the mother. The child who is treated in this manner develops a distorted perception of their own body, and this context increases the risk of developing psychotic disorders in the future (Nuzzolese & Lungo,2021, pp. 61-63).

RISK INDICATORS

The following are the typical characteristics of individuals who suffer from Munchausen syndrome by proxy, which are the risk indicators associated with this syndrome:

1. Knowledge or experience in the healthcare field.
2. Typically a married woman, with the husband being a weak or absent figure.
3. Frequent requests for hospitalizations and repeated suggestion of diagnostic tests.
4. Tendency to develop friendly relationships with healthcare professionals.
5. History of psychiatric problems, often related to eating disorders.
6. Difficulty in separating from the child.
7. An abnormal attempt to escape through the abuse of the child.

8. Marital unhappiness or stress in one's own life.
9. Deriving pleasure from manipulating medical staff and certain aspects of medicine.
10. History of parental neglect (Nuzzolese & Lungo, 2021, pp. 61 -63).

Lastly, chemical abuse is another form of hypercare and refers to the inappropriate administration of pharmacological or chemical substances to a child. These substances can be actual medications or seemingly harmless substances such as water or table salt. However, if administered in excessive doses, they can cause harm to the child's physical and psychological health. The chemical abuse syndrome should be considered when symptoms cannot be easily explained by traditional instrumental and laboratory tests and occur every time the mother comes into contact with the child (Nuzzolese & Lungo, 2021, pp. 63).

6. Recognizing at-risk students: an overview

The school environment holds significant importance for children, regardless of their age, as they spend many years and a considerable amount of time within this setting. Teachers, along with the entire faculty, become crucial figures in the lives of these children. Today, schools are no longer seen solely as places where children acquire knowledge through a prescribed curriculum; they are also recognized as essential environments for the psychological development of young individuals. Therefore, teachers must make an effort to identify whether a student's developmental trajectory is typical or atypical.

Within the realm of educational and school services, it is crucial to create conditions in which children feel accepted and supported in expressing their emotions and difficulties to

adults. This can only occur within an environment characterized by affection and empathy, and most importantly, within a relationship of trust that allows the child to open up.

Only by considering these aspects is it possible to utilize observation processes and assessment tools based on indicators that should be correlated with other observable elements, as well as information provided by other professionals, within a comprehensive multidisciplinary evaluation.

In this perspective, the indicators mentioned in the previous paragraphs, associated with various forms of abuse, provide evidence of a significant possibility of harm to the child's life or psychophysical health, disruption in their development, or other pathological outcomes. Teachers play a crucial role in identifying these indicators and providing protection and assistance to children who are victims of abuse. They must be at the forefront of recognizing signs of distress or abnormal behaviors in their students, which may be indicative of an experience of abuse or maltreatment.

When a teacher suspects or receives reports of abuse, it is essential to act promptly and appropriately. The primary priority is to ensure the safety and well-being of the child involved, establishing a safe and supportive environment in which the child feels comfortable sharing their experiences and emotions. This may require careful and respectful listening, as well as creating an atmosphere of trust and confidentiality. Once concerns have been raised, teachers must collaborate with other professionals, such as social workers, school counselors, or healthcare personnel, to assess the situation and plan necessary interventions.

This multidisciplinary collaboration is essential to ensure an accurate evaluation and provide appropriate support to the child and their family. Based on these premises, a general overview will now be provided, not specific to a particular form of abuse, but rather focusing on non-specific warning signs to consider. These signs may indicate the experience of abuse.
Initial and more easily identifiable signals primarily concern physical aspects. Students may have unexplained injuries such as scars, bruises, scratches, and bone fractures. Other signs are less obvious, for example, they may display sudden fear or alertness in unexpected situations. Some students who are victims of abuse may seem afraid to return home and often report symptoms such as stomachaches, abdominal pain, or headaches without an apparent cause. They may also try to conceal obvious signs, such as bruises, by wearing clothing that covers the affected body parts, such as oversized sweaters. Additionally, they may show reluctance to undress in locker rooms before engagingin physical activities.

There are also emotional signs to consider. Children and adolescents who are victims of abuse tend to exhibit sudden behavioral changes, displaying more aggression in the classroom, a noticeable lack of interest, and a sudden decline in academic performance, such as lower grades or increased absences. They may show restlessness and hyperactivity. Additionally, they appear to lose confidence and experience a decrease in self-esteem, often isolating themselves socially. In some cases, they seek greater recognition or affection. Their emotional development may appear inappropriate or delayed compared to typical developmental milestones, and there may be signs of regression in this area. They may also engage in harmful or self-destructive behaviors, such as self-harm, or exhibit signs of substance abuse. Some may display criminal tendencies, such as stealing.
When abuse occurs within the family context, there are additional warning signs to consider. The child may demonstrate poor hygiene, and the parents may show a lack of interest in the child's well-being, using harsh and derogatory language towards them. Unrealistic expectations may be placed on the child. Furthermore, children may be disciplined with strict and severe physical methods.
They may avoid recreational activities with classmates, skip meals, and often lack essential materials for adequate education. The children appear to fear their caregivers and may show reluctance to return home after school.
In conclusion, the sensitivity of teachers, their responsiveness to these warning signs, and their collaboration with other professionals are crucial in ensuring the well-being and protection of the children involved.

Numerous studies provide evidence on the effects of trauma on children's mental health, the development of citoarchitectonic structures, and the functional organization of the nervous system (Cuijpers et al., 2011; Kessler et al., 2010; Dunn & McLaughlin, 2013 cited in Guidetti, 2016).

Specifically, child abuse has negative consequences on developmental trajectories and long-term mental health, with impacts that can persist into adulthood. Significant neurobiological changes, cognitive delays, and dysfunctional behaviors such as aggression, conduct disorder, and substance abuse are observed.

7. In-depth analysis: neuroscience and negative consequences of abuse

Longitudinal studies demonstrate that child abuse is a serious risk factor for the development of various forms of psychopathology in adulthood, influencing more complex aspects of behavior and overall psychobiological and psychological functioning of the victims (Putnam & Trickett, 1997; Busso etal., 2017).

When addressing the issue of abuse, one of the most frequently discussed elements is stress. From a neuroscientific perspective, stress is related to a neuroendocrine system known as the hypothalamic-pituitary-adrenal (HPA) axis.

This axis serves as a central coordinator of neuroendocrine stress response systems. In brief, following exposure to stress, the HPA axis becomes activated and produces a stress hormone called cortisol. Cortisol helps the individual adaptively cope with stressful situations. At the same time, other brain circuits modulate the activity of the HPA axis.

However, in situations of prolonged and repeated stress, such as in the case of chronic abuse, the HPA axis can malfunction. This malfunctioning predisposes individuals to the development of various forms of psychopathology. For example, alterations in the functioning of the HPA axis are observed in patients with depression or Post-Traumatic Stress Disorder.

This represents one of the mechanisms through which abuse predisposes individuals to the development of future forms of psychopathology. In fact, it has been demonstrated that adults who have experienced childhood sexual abuse have an increased risk of Major Depressive Disorder and Post-Traumatic Stress Disorder as a consequence of HPA axis dysfunction (Hulme, 2011).

Furthermore, evidence has also been found for an association between childhood maltreatment and alterations in the immune system, which can lead to an increased incidence of inflammatory states (Danese et al., 2011; Slopen et al., 2010; Moffit et al., 2013 cited in Guidetti, 2016).

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