Child Abuse Recognition and Reporting 2017

Introduction

According to a U.S. Department of Health and Human Services Report issued in 2014, an estimated 702,000 children across the country were victims of abuse or neglect (U.S. Department of Health and Human Services, 2014). Comparing the national estimate of victims from 2010 (698,000) to 2014 (702,000) show an increase of less than 1 percent. Three-quarters (75.0%) of victims were neglected, 17.0 percent were physically abused, and 8.3 percent were sexually abused. Sadly, an estimated 1,580 children died of abuse and neglect at a rate of 2.13 per100,000 children in the national population.

Most mental health professionals have encountered abused children throughout the course of their practice. Psychologists, counselors and social workers are in unique positions to observe and interact with children and elders. They often see individuals struggling with serious emotional problems. In being able to assess the reasons for these problems, mental health professionals are often pivotal in noticing changes in clients that may indicate abuse or neglect. Such professionals are mandated to report suspected child abuse. Most States definitions of mandated reporters include mental health and medical professionals, teachers, clergy, child and foster care workers among those individuals who are required to report child maltreatment.

All 50 states, the District of Columbia, and the U.S. Territories have child abuse and neglect reporting laws that mandate mental health professionals to report suspected maltreatment to a child protective services (CPS) agency. Each state has its own definitions of child abuse and neglect that are based on standards set by federal law. Federal legislation provides a foundation for states by identifying a set of acts or behaviors that define child abuse and neglect. The laws apply to mental health providers working in private practice and institutional settings. In addition to child abuse reporting laws, many states also have laws pertaining to mandatory reporting of elder abuse and sexual exploitation between therapists and clients.

The Child Abuse Prevention and Treatment Act (CAPTA) defines child abuse and neglect as:

Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm.

There are four major categories of child abuse: neglect, physical abuse, psychological or emotional abuse, and sexual abuse.
Despite mandates to report child abuse, many professionals are uncertain when a report is required and practitioners vary in their understanding and opinions of these laws. Unlike the case report, researchers have found a tendency to err on the side of overreporting (Kalichman & Brosig, 1993). Renninger et al. (2002) conducted a survey of licensed psychologists. Although they had knowledge of reporting laws, their performance on a knowledge measure suggested information deficits and a tendency to overreport suspected abuse. Legal considerations were the strongest factor that encouraged reporting. Opinions of the mandatory reporting laws were generally favorable, with some concerns about child protection systems and the impact of reporting on the therapeutic alliance. The latter issue is explored in more detail by Steinberg et al. (1997). There are consequences to both the overreporting and underreporting of abuse.

Once a mandated reporter files a report of suspected abuse, the family often become eligible to receive a variety of services that will improve the family’s ability to care for the child or elder. These services may include parenting classes, counseling, treatment for substance abuse, medical services and anger management classes.

This training will provide an overview of issues related to mandated reporting and support the mental health professional in fulfilling this important role.

Objectives:

After finishing this course, the participant will be able to:

- Define the Child Abuse Prevention and Treatment Act (CAPTA)
- Define the major categories of child abuse (physical abuse, neglect, sexual abuse, emotional abuse) and provide examples of each one
- Define child abuse including characteristics that may lead the practitioner to believe that a child is being abused
- Describe their role as a mandated reporter
- Discuss ethical standards pertaining to confidentiality
- Discuss the concept of a “good faith” report and the consequences of failing to report
- Discuss making a report
- Describe the role of child protective services and the steps in an investigative report
- Discuss the role that culture and ethnicity play in child maltreatment interventions including false positive and negative reporting
Historical Foundations

Prior to looking at the problem of child maltreatment, it is interesting to explore the historical foundations of child abuse reporting, including the enactment of child protection policies.

Many researchers mark the case of Mary Ellen Wilson as the beginning of the American movement to protect children. Mary Ellen was an 8-year-old girl living in New York City. A neighbor noticed evidence of child abuse, including physical beatings, malnourishment, and other deliberate cruelties and deprivations. The neighbor reported this to Etta Wheeler, a member of the Methodist Mission. Etta was frustrated at the lack of authority agencies including the police had in intervening. The only cruelty laws at this time pertained to animals.

According to legend, Henry Berge, founder of the New York SPCA intervened on her behalf, arguing that Mary Ellen was a member of the animal kingdom. She was subsequently removed from the dangerous situation, and her foster mother criminally charged. That same year saw the founding of The New York Society for the Prevention of cruelty to Children.

CAPTA (1974)

By 1963, the United States Children’s Bureau disseminated the first legislation for mandated reporting. The initial legislation prompted similar laws in several states. In 1974, Congress passed the first Child Abuse Prevention and Treatment Act (CAPTA). This landmark legislation:

• Authorized programs and services for child maltreatment programs, including funding for states meeting CAPTA requirements
• Created the National Center on Child Abuse and Neglect and the National Clearinghouse on Child Abuse and Neglect Information (NCCANI).
• Mandates state to provide data on the number and sources of child abuse and neglect reports, investigation dispositions, types of maltreatment and related information.
• Provides for reporting of the National Incidence Study of Child Abuse and Neglect (last published in 2008). This report includes data from more than 5,600 community professionals who have had contact with maltreated children.

Indian Child Welfare Act (ICWA)

In 1978, the Indian Child Welfare Act (ICWA) was added to CAPTA. This act was designed to protect Native American children in the child welfare system. The foundation of the ICWA was based on the observation that Native American
children removed from their homes were often placed in non-Native American homes and that judicial and social work systems were not familiar with traditional Native American value systems. As a result, these systems sometimes mislabeled Native American homes as dysfunctional. Today matters pertaining to Native American children are handled by tribal courts. While this goal was admirable, there has been criticism regarding inadequate funding and implementation (Jones, 1995).

**CAPTA (2010)**

CAPTA has been amended several times and was most recently amended and reauthorized on December 20, 2010, by the CAPTA Reauthorization Act of 2010. In addition to CAPTA, there are a number of other national and local policies that support child welfare. These include:

- Title-IV-B of the Social Security Act
- PROTECT Act (Prosecutorial Remedies and Other Tools to End the Exploitation of Children Today Act of 2003)
- Foster Care Independence Act
- Promoting Safe and Stable Families Act
- Adoption Promotion Act (2003)

**Preventing Sex Trafficking and Strengthening Families Act (2014)**

In 2014, the Preventing Sex Trafficking and Strengthening Families Act was signed. This act ensures that states implement mechanisms for reporting and collecting data on sex trafficking and identifying children who may be at risk of becoming victims of sex trafficking. Additionally the law strengthens existing laws related to adoption incentives and the provision of services to foster parents.

**Defining Child Abuse**

Child abuse definitions vary from state to state, but most of these definitions share some similarities. Child abuse or neglect is defined as “any recent act or failure to act resulting in imminent risk of serious harm, death, serious physical or emotional harm, sexual abuse, or exploitation of a child (usually a person under the age of 18, but a younger age may be specified in cases not involving sexual abuse) by a parent or caretaker who is responsible for the child’s welfare” (CAPTA, 2003; Keeping Children and Families Safe Act, 2003). Such caretakers may include anyone who has direct or regular contact with a child, including school personnel and staff of agencies or organizations. It is important to note that in many states “perpetrators” may commit abuse by acting (commission) or by failing to act (omission).
Minimum standards for defining child abuse are set forth by CAPTA, which categorizes child abuse under four broad types: (a) physical abuse; (b) sexual abuse; (c) emotional abuse; (d) neglect.

All states must meet the minimum standards in defining abuse, however, statutes from state to state. For example, some states include a category of abuse such as child exploitation, which covers incidences that are non-sexual in nature (e.g., child labor). Other states include acts such as withholding a medical treatment or medication. It is advisable to know your state’s statutes.

Consider, for example, the Pennsylvania statutes on child abuse:

**Pennsylvania Definition of Child Abuse**

The term "child abuse" shall mean intentionally, knowingly or recklessly doing any of the following:

1. Causing bodily injury to a child through any recent act or failure to act.
2. Fabricating, feigning or intentionally exaggerating or inducing a medical symptom or disease which results in a potentially harmful medical evaluation or treatment to the child through any recent act.
3. Causing or substantially contributing to serious mental injury to a child through any act or failure to act or a series of such acts or failures to act.
4. Causing sexual abuse or exploitation of a child through any act or failure to act.
5. Creating a reasonable likelihood of bodily injury to a child through any recent act or failure to act.
6. Creating a likelihood of sexual abuse or exploitation of a child through any recent act or failure to act.
7. Causing serious physical neglect of a child.
8. Engaging in any of the following recent acts:
   - (i) Kicking, biting, throwing, burning, stabbing or cutting a child in a manner that endangers the child.
   - (ii) Unreasonably restraining or confining a child, based on consideration of the method, location or the duration of the restraint or confinement.
   - (iii) Forcefully shaking a child under one year of age.
   - (iv) Forcefully slapping or otherwise striking a child under one year of age.
   - (v) Interfering with the breathing of a child.
   - (vi) Causing a child to be present at a location while a violation of relating to operation of methamphetamine laboratory is occurring, provided that the violation is being investigated by law enforcement.
   - (vii) Leaving a child unsupervised with an individual, other than the child's parent, who the actor knows or reasonably should have known:
     - (A) Is required to register as a sexual offender, where the
victim of the sexual offense was under 18 years of age when the crime was committed.
(B) Has been determined to be a sexually violent predator
(C) Has been determined to be a sexually violent delinquent child
(9) Causing the death of the child through any act or failure to act.

While CAPTA defines child abuse within the categories of physical abuse, neglect, sexual abuse, and emotional abuse, it is important to note that child abuse is more typically found in combination than alone. A physically abused child, for example, is often emotionally abused as well, and a sexually abused child also may be neglected.

Risk Factors for Child Maltreatment

What puts a child at risk for maltreatment? Identification of risk factors is an important question, and invaluable in implementing prevention programs. It is a question that mental health professionals have looked at for some time. Initial schemas of risk used the idea of child vulnerability, and attempted to isolate those child risk factors (Action for Child Protection, 2003). These authors recommended conducting a family safety assessment to determine whether a vulnerable child resides in the household. In a nutshell, vulnerability was equated to a child’s ability to defend him or herself. These “child risk factors” are still utilized today (CDC, n.d.) and include:

Young age (especially infants and young children). This is due to their small physical size, early developmental status, and need for constant care are more likely to experience certain forms of maltreatment, such as shaken baby syndrome and non-organic failure to thrive. There also appears to be a connection between premature/low birth weight and child abuse.

Teenagers, are at greater risk for sexual abuse.

Disabilities – Children with physical, cognitive, and emotional disabilities experience higher rates of maltreatment as do children with chronic illnesses. These children are highly dependent on others to meet their basic needs. They may also be at greater risk be due in part of caretaker demands and bonding or attachment issues. Children with cognitive disabilities may have difficulty recognizing danger, knowing who can be trusted, meeting their basic needs and seeking protection. A child’s disability often places increased demands on caregivers, which may outstrip their capacity to meet the child’s needs (i.e., neglect).

“Provocative” Children – A child’s emotional, mental health,
behavioral problems can be such that they irritate and provoke others to act out toward them or to avoid them. Emotional issues such as attention deficit disorder, disruptive behavior disorders, aggression and difficult temperament have thus been found to be risk factors. Thus “difficult temperament” may elicit frustration and stress on the part of caretakers, which may ultimately result in maltreatment.

Non-Assertive/Powerless Children – Regardless of age, a child who is so passive or withdrawn not to be able to make his or her basic needs known is vulnerable. A child who cannot or will not seek help and protection from others is vulnerable.

Gender – girls were sexually abused about three times more frequently than boys. Boys were at somewhat greater risk of serous injury (24% higher), were more likely to be victims of physical abuse, and boys significantly more likely to be emotionally neglected.

Looking at these child factors is important, but it is more likely that a combination of factors contribute to the risk of child maltreatment. These include individual, parent/caregiver factors, and family characteristics. Risk factors are those characteristics associated with child maltreatment—they may or may not be direct causes. The following are risk factors for child maltreatment (CDC, n.d.)

**Parent/Caregiver Factors:**
Personality characteristics – Low self esteem, external locus of control, poor impulse control, depression, anxiety, antisocial behavior

History of abuse or neglect as a child

Substance abuse, leading to parental instability, diversion of money needed for child’s care to habit, inability to maintain employment, interference with parent’s need to provide care and nurturance

Younger maternal age (may be connected to lower economic status, lack of social support, and high stress levels) as is dependency

Lower parental educational attainment

Untreated depression

Adults who were maltreated during childhood
**Family Characteristics:**
Family structure: Single families - primarily with lower income, families with few social supports, large family or many household members (especially indicative for neglect), chaotic homes

Marital conflict and domestic violence

Stress – stressful life events, parenting stress

Parent/Child interaction – lack of parenting skills, harsh discipline, lack of recognition of positive behaviors

Low levels of parent involvement and poor parent–child interactions

Presence of a non-biological caregiver in a single-parent household (especially associated with physical abuse)

Severity of Problems – the severity of a family's problems may predict outcomes

**Environmental Factors** (often in combination with parent, family, and child factors)

Unemployment or inability to provide economically
Poverty (which may lead to increased caregiver strain and mental health problems, along with poorer parenting practices)
Social isolation
Violent communities
Living in area with high population density

**Community Factors**

Community violence
Neighborhood disadvantage (high poverty/residential instability, high unemployment rates, and high density of alcohol outlets), and poor social connections
Racial and ethnic minority status

**Other**
Increased exposure to mandated reporters through participation in social welfare programs

Two recent studies looked more closely at these risk factors (Merskey et al., 2009). The authors analyzed 1,411 participants in an inner-city (Chicago) longitudinal study of families with documented cases of child maltreatment. Receipt of public assistance and single-parent family status were significantly
Mandated Reporting

associated with maltreatment. Among school-age indicators examined, parent participation in school was a mediating factor in maltreatment outcomes. Maternal age at the child’s birth was most strongly associated with physical abuse. Family poverty was also associated with multiple maltreatment outcomes, adding to the evidence linking poverty to child abuse and neglect. Campos et al. (2016) also looked at the effects of socioeconomic status and parental demographics in intentional pediatric burn injuries. These authors found that burns from child maltreatment often result in morbidity and mortality, and most commonly affect children under 3 years of age. More than one third of nonaccidental burns occurred in single-parent homes or have parents with history of mental illness, substance abuse, incarceration, or with families having Department of Children and Family Services (DCFS) involvement.

Another interesting study involved the role of fathers in mediating risk of child physical abuse. Guterman et al. (2009) looked at 1,480 families, conducting in-home and phone interviews. The researchers looked at the mother–father relationship status; father demographic, economic, and psychosocial variables; and other background factors. In looking at fathering factors linked with risk, the researchers found that fathers’ higher educational attainment and their positive involvement with their children most reliably predicted lower maternal physical child abuse risk. They found that Fathers’ economic factors played no observable role in mothers’ risk for physical child maltreatment. The findings of the study suggested that marriage per se does not appear to be a protective factor for maternal physical child abuse and rather it may serve as a proxy for other father-related protective factors.

Physical Abuse

According to the U.S. Department of Health and Human Services (2014), approximately 17% of children reported to social services were victims of physical abuse. Nationally this represents 119,517 children.

The National Center on Child Abuse and Neglect defines child physical abuse as: "The physical injury or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened." The parent or caretaker need not have intended to hurt the child for it to constitute physical abuse. Examples of physical abuse include: beating with a belt, shoe, or other object; burning a child with matches or cigarettes; hitting a child; shaking, shoving, or slapping a child; biting, choking or hair pulling; or inflicting severe physical punishment.

Even forms of physical punishment that do not result in physical injury are considered physical abuse and are outlawed in some states. For example, in Arkansas, Minnesota, and the District of Columbia, hitting a child with a closed fist is considered physical abuse. In Arkansas, hitting a child on the face or head...
is also called physical abuse. For more information on state laws, see www.childwelfare.gov/systemwide/ laws_policies/statutes/defineall.pdf. This is just one of the things that makes it difficult for mental health professionals to determine the lines between physical abuse and “discipline.” And while spanking may not be illegal in all states. Research suggests that even spanking that does not result in serious physical harm, often causes psychological harm, and may be connected to child externalizing behaviors, other forms of family violence and intergenerational violence (MacKenzie, Nicklas, Brooks-Gunn, & Waldfogel, 2014; Zolotor, 2014).

Children of all ages, races, ethnicities, and socioeconomic backgrounds are at risk for physical abuse. Children ages 4–7 and 12–15 are at the greatest risk of being physically abused. Very young children are most susceptible to receiving serious injuries (US Department of Health and Human Services, Administration on Children, Youth and Families, 2009.)

Physical Discipline

It is difficult to accurately estimate what percentage of parents physically discipline children. Some researchers estimate the number to be as high as 70 to 90 percent (Holden, Williamson & Holland, 2014). Holden, Williamson and Holland (2014) looked at the use of corporal punishment in the home. In this small pilot study, the researchers studied 33 mothers as they put children to bed, a time when the likelihood of corporal punishment is great. The researchers used voice recorders, which they wore in sport pouches on their upper arms, to chronicle the family interactions. Forty-five percent of the families in the sample struck their children; many did so more than once over the course of four to six consecutive evenings. Holden’s study found that, on average, parents hit their children just 30 seconds after the start of a conflict, with little warning and often out of anger. Within 10 minutes of the physical discipline, 73 percent of the children misbehaved again.

This study belies the fact that many physically abusive parents and caregivers state that their actions are simply forms of discipline—ways to make children learn to behave. But there is a difference between using physical punishment to discipline and physical abuse.

While physical abuse may be the result of a deliberate attempt to hurt the child, but not always. It can also result from severe discipline. In some instances, the criteria for child abuse may not require that a child have physical injuries. For example, shaking a child under the age of 1 is considered to meet the criteria of child abuse in most states.

Physical abuse vs. Discipline (Helpguide.org)
In physical abuse, unlike physical forms of discipline, the following elements are present:

**Unpredictability.** The child does not know what is going to set the parent off. There are no clear boundaries or rules. Children who have been physically abused often describe this as a feeling “constantly walking on eggshells,” never sure what behavior will trigger a physical assault.

**Lashing out in anger.** Physically abusive parents act out of anger and the desire to assert control, not the motivation to teach the child. The angrier the parent, the more intense the abuse.

**Using fear to control behavior.** Parents who are physically abusive may believe that their children need to fear them in order to behave, so they use physical abuse to “keep their child in line.”

In addition to the factors listed above, McClennen (2010) suggests that various factors should be taken into account when categorizing whether an act is abusive including: 1) age of the child; 2) developmental levels of the child; 3) severity of the action; 4) frequency of the action, and 5) the “contextual” (historical or cultural) perspectives of family and community.

**Case Study**

John, a 15-year-old boy comes to his therapy session, stating that his father had become very angry when he thought John was being disrespectful and John’s father responded by physically picking him up and throwing him against the wall.

**Neglect**

Child neglect is frequently defined as any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm. While physical abuse tends to be episodic, neglect tends to be a more chronic condition. Severe neglect can result in the death of a child. Neglect accounts for over three-quarters of confirmed cases of child maltreatment in the United States—far more than physical or sexual abuse (Child Welfare Information Gateway, 2016).

While States vary with regard to what legally constitutes neglect, Neglect definitions are impacted by the accepted standards of care for children and the role of communities in families’ lives. Some issues that are taken into account when defining neglect and standards of care include:

- Harm to the child
- Parent’s ability or intent
- Family’s concrete resources
• Community norms
• Availability of community resources

Types of Neglect

Physical Neglect

Physical neglect accounts for the majority of cases of maltreatment. Physical neglect generally involves the caregiver not providing the child with basic necessities (e.g., adequate food, clothing and shelter), which in turn endangers the child’s physical health, well being, psychological growth and development. In addition, physical neglect includes child abandonment, inadequate supervision, rejection of a child leading to expulsion from the home and failure to adequately provide for the child’s safety and physical and emotional needs. Physical neglect can severely impact a child’s development by causing failure to thrive; malnutrition; serious illness; physical harm in the form of cuts, bruises, burns or other injuries due to the lack of supervision; and a lifetime of low self-esteem.

Educational Neglect

Educational neglect involves the failure of a caregiver to provide appropriate schooling. This includes the allowance of chronic truancy, failure to enroll a child of mandatory school age in school, and failure to attend to a special educational need. Educational neglect can lead to the child’s failure to acquire basic life skills, dropping out of school or continually displaying disruptive behavior. Educational neglect can threaten the child’s emotional wellbeing, physical health or normal psychological growth and development.

Emotional/Psychological Neglect

Emotional or psychological neglect includes such actions as marked inattention to the child’s needs for affection, refusal of or failure to provide needed psychological care, spousal abuse in the child’s presence, or permission for drug or alcohol use by the child. Parental behaviors considered to be emotional neglect include:

• Ignoring (failure to respond to the child’s need for stimulation, nurturance, encouragement and protection);

• Rejecting (actively refusing to respond to the child’s needs — e.g., refusing to show affection);

• Isolating (preventing the child from having normal social contacts);

Emotional or psychological neglect can lead to poor self-image, alcohol or drug abuse, or child/adolescent destructive behaviors, including suicide.
Medical Neglect

Medical neglect is the failure to provide appropriate health care for a child (although financially able to do so), placing the child at risk. According to NCANDS, in 2014, 2.2 percent of children in the United States were victims of medical neglect (USDHHS, 2014). Medical neglect should be considered warranted when a parent refuses medical care for a child in an emergency or acute illness, and also when a parent ignores medical recommendations for a child with a treatable chronic disease or disability. Medical neglect may also apply in situations in which a psychological illness is present, such as a parent who will not consider hospitalization for a severe eating disorder or suicidal depression. In cases of medical neglect, child protection services agencies may seek a court order for medical treatment to save the child’s life or prevent life-threatening injury.

Neglect and Child Mortality

One of the most tragic consequences of neglect is child mortality (Diaz, Peddle, Reid & Wang, 2002). Neglect causes or contributes to roughly two-thirds of all child maltreatment-related deaths (U.S. Department of Health and Human Services, 2011). Victims of fatal neglect are more likely to be age 7 or younger (U.S. Government Accountability Office, 2011). Even emotional neglect can lead to death, especially in very young children. Neglect of an infant’s need for stimulation and nurturance can result in the infant failing to thrive and even infant death. Emotional neglect is often the most difficult situation to substantiate in a legal context and is often reported secondary to other abuse or neglect concerns.

Intervention

Neglect is a complicated issue that poses significant challenges to treatment clinicians. Gaudin (2013) lists the following recommendations in working with families in which children are maltreated:

• Assume that parents want to improve the quality of care for their children.
• Identify and reinforce hidden strengths and build upon them.
• Be culturally sensitive.
• Do not generalize; each family is unique.
• Build parental feelings of self-esteem, hope, and self-sufficiency.
• Use legal authority as a last resort.
• Set clearly stated, limited, achievable goals that are agreed upon by parents and children.
• Systematically reinforce the parents’ incremental steps.
• Seek out fathers or father figures and engage them in the interventions).
Case Study
Donna Geris is a school social worker that is facilitating a social skills group at the local primary school. During the course of the group, Jenna, a 9-year-old child, states that she is frequently afraid. She describes letting herself and her siblings, ages 6 and 7, into the house after school, and being responsible for preparing meals and doing homework with them. When asked where her mom is she states that she “does not know,” but at times her mom is still not back in time for breakfast.

Emotional Abuse/Serious Mental Injury

Closely related to the concept of emotional/psychological neglect, is the category of emotional abuse. While there is no universally agreed upon definition for emotional abuse, this training material will distinguish emotional or psychological neglect is an act of omission, and emotional abuse is an act of commission. Emotional abuse is one of the most difficult categories of abuse to prove and quantify. Emotional abuse has been linked with disorders of attachment, developmental and educational problems, socialization problems, disruptive behavior, and later psychopathology (Hibbard, Barlow & MacMillian, 2012), because emotional abuse interferes with a child’s normal developmental trajectory. The effects of psychological maltreatment during the first 3 years of life can be particularly profound, because rapid growth of the brain and biological systems takes place during this period, and this is significantly influenced by the child’s early parenting experiences.

The National Center on Child Abuse and Neglect defines emotional abuse as: "acts by the parents or other caregivers that have caused, or could cause, serious behavioral, cognitive, emotional, or mental disorders. In some cases of emotional abuse, the acts of parents or other caregivers alone, without any harm evident in the child's behavior or condition, are sufficient to warrant child protective services (CPS) intervention." For example, making fun of a child, calling a child names, and always finding fault are forms of emotional abuse. Emotional abuse is more than just verbal abuse. It is an attack on a child's emotional and social development, and is a basic threat to healthy human development. Some other examples of emotional abuse are:

Verbally assaulting (belittling, name calling or threatening)
Terrorizing (threatening the child with extreme punishment or creating a climate of terror by playing on childhood fears; Having rigid/unrealistic expectations accompanied by threats if not met)
Corrupting, such as teaching children to engage in antisocial behaviors
Spurning, such as ridiculing a child for showing normal emotions; humiliating a child in public
Extreme inconsistency, such as severely punishing a child for an
Effects of Emotional Abuse

According to a recent study published by the American Psychological Association, children who are emotionally abused or neglected face similar and sometimes worse mental health problems as children who are physically or sexually abused. Researchers used the National Child Traumatic Stress Network Core Data Set to analyze data from 5,616 children with lifetime histories of one or more of three types of abuse: psychological maltreatment (emotional abuse or emotional neglect), physical abuse and sexual abuse. 62 percent had a history of psychological maltreatment, and nearly a quarter (24 percent) of all the cases were exclusively psychological maltreatment, which the study defined as caregiver-inflicted bullying, terrorizing, coercive control, severe insults debasement, threats, and overwhelming demands.

Researchers found that children who were emotionally abused suffered from anxiety, depression, low self-esteem, symptoms of post-traumatic stress and suicidality at the same rate and, in some cases, at a greater rate than children who were physically or sexually abused. Psychological maltreatment was most strongly associated with depression, general anxiety disorder, social anxiety disorder, attachment problems and substance abuse. When emotional abuse occurred concurrently with physical or sexual abuse, it was associated with significantly more severe and far-ranging negative outcomes (American Psychological Association, 2014). Some States definitions of emotional abuse include an indicator of the abuse rendering a child anxious, depressed, or emotionally affected in such a way that it interferes with normal developmental tasks.

Please see Doyle and Timms (2014) for additional information on emotional abuse.

Case Study

Diana is a 16-year-old who has been referred by school counseling staff to Dr. Moore. Diana presents as significantly depressed and expresses suicidal ideation. Diana describes her father as angry, and states that he frequently calls her by obscene and disparaging names. Her mother, who accompanies Diana to the session agrees that her dad “can be hard on Diana at times,” and does not dispute the allegations of name-calling.

Sexual Abuse or Exploitation
The Child Welfare Information Gateway (2016) defines child sexual abuse as the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or interfamilial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children. Simply put, sexual abuse is the adult’s use of a child to achieve any form of sexual gratification.

In response to increased awareness of the sex trafficking of minors in the United States, the Justice for Victims of Trafficking Act of 2015 amended the Federal definition of child abuse with the addition of the following special rule: A child shall be considered a victim of “child abuse and neglect” and of “sexual abuse” if the child is identified, by a State or local agency employee of the State or locality involved, as being a victim of sex trafficking (as defined in the Trafficking Victims Protection Act of 2000).

The most significant feature of child sexual abuse is that the dominant position of an adult allows him or her to coerce the child into sexual activity. Child sexual abuse may include fondling a child’s genitals, masturbation, oral-genital contact, digital penetration, or vaginal and anal intercourse. Child sexual abuse is not solely restricted to physical contact; such abuse could include noncontact abuse, such as making a child watch pornography or look at an adult’s genitals.

Prevalence and Effects of Childhood Sexual Abuse

The prevalence of child sexual abuse is difficult to determine because it is often not reported; experts agree that the incidence is far greater than what is reported to authorities. CSA is also not uniformly defined, so statistics may vary. Statistics below represent some of the research done on child sexual abuse.

The U.S. Department of Health and Human Services' Children’s Bureau report Child Maltreatment 2010 found that 9.2% of victimized children were sexually.

Studies by David Finkelhor, Director of the Crimes Against Children Research Center, show that:

• 1 in 5 girls and 1 in 20 boys is a victim of child sexual abuse;
• Self-report studies show that 20% of adult females and 5-10% of adult males recall a childhood sexual assault or sexual abuse incident;
• During a one-year period in the U.S., 16% of youth ages 14 to 17 had been sexually victimized;
• Over the course of their lifetime, 28% of U.S. youth ages 14 to 17 had been sexually victimized;
Children are most vulnerable to CSA between the ages of 7 and 13.

**Risk Factors**

As with other forms of abuse, there are a number of factors that contribute to the risk of childhood sexual abuse. These include:

- **Child characteristics** – evidence suggests that children who are “passive, troubled or lonely” are often at higher risk of victimization outside the home.

- **Family structure** – Children live with stepparents or a single parent are at greater risk for sexual victimization that those living with married biological parents. Foster children are 10 times more likely to be sexually abused than children that live with both biological parents. Children who live with a single parent that has a live-in partner are at the highest risk: they are 20 times more likely to be victims of child sexual abuse than children living with both biological parents (Sedlack, et al., 2010).

Children are most vulnerable to abuse between the ages of 7 and 13 (Finkelhor, 1994). The median age for reported abuse is 9 years old (Putnam, 2003). However, more than 20% of children are sexually abused before the age of 8 (Snyder, 2010).

African American children have almost twice the risk of sexual abuse than white children. Children of Hispanic ethnicity have a slightly greater risk than non-Hispanic white children (Sedlack, et al., 2010).

The risk for sexual abuse is tripled for children whose parent(s) are not in the labor force (Sedlack, et al., 2010).

Children in low socioeconomic status households are 3 times as likely to be identified as a victim of child abuse (Sedlack, et al., 2010).

Children who witness or are the victim of other crimes are significantly more likely to be sexually abused (Finkelhor, 2010).

**Other Forms of Abuse**

**Sibling abuse**

The physical, emotional or sexual abuse of one sibling by another. Significantly more likely to occur in dysfunctional homes, sibling abuse can lead to lasting consequences.
Munchausen by Proxy Syndrome

The intentional simulation of physical illness by a parent in his or her child, usually for the purpose of attention. This may include fabricating symptoms or actually inducing symptoms (such as causing a child to have a fever, feeding the child things he or she should not ingest, etc.) This is a potentially lethal form of child abuse.

According to the Cleveland Clinic the following characteristics are common in a parent with Munchausen by proxy:

- Often is a parent, usually a mother, but can be the adult child of an elderly patient
- Might be a health care professional
- Is very friendly and cooperative with the health care providers
- Appears quite concerned/overly concerned

Other possible warning signs of Munchausen by proxy syndrome in children include:

- The child has a history of many hospitalizations, often with a strange set of symptoms.
- Worsening of the child’s symptoms reported by the mother and is not witnessed by clinicians
- Child’s reported symptoms do not agree with diagnostic tests.
- More than one unusual illness or death of children in the family.
- The child’s condition improves hospital, but symptoms recur when the child returns home.
- There might be signs of chemicals in the child’s blood, stool, or urine.

Estimates of Munchausen by proxy suggest that about 1,000 of the 2.5 million cases of child abuse reported annually are related to Munchausen by proxy.

Nonorganic failure to thrive

Failure to thrive is defined arrested physical growth and is associated with poor developmental and emotional functioning. Organic failure to thrive occurs when there is an underlying medical cause. Nonorganic failure to thrive occurs in a child who is usually younger than 2 years old and has no known medical condition that causes poor growth. Nonorganic failure to thrive can coexist with child abuse (see for example Rybak, 2015; Larson-Nath, & Goday, 2016).

Parental substance abuse
The caretaker’s use of substances in the presence of a child, or the manufacturing of a controlled substance on the premises occupied by a child are situations included in many State’s definitions of child maltreatment. Additionally some States have criteria that includes prenatal exposure to illegal substances.

**Effects of Child Abuse and Neglect**

Research shows that the child abuse and neglect in this country has serious physical, emotional, and psychological dimensions. Some of the research findings are enlightening:

Cases of child abuse and neglect have been increasing nationwide (Howe 2005). Every day, about four children die in the U.S. because of abuse or neglect, most of them babies or toddlers (11 Facts, 2010).

The trauma of abuse or neglect of a child often lingers into adulthood and even can influence the raising of that victim’s own children (Anda et al. 2005).

Abused children are more likely to abuse alcohol and become addicted to drugs, and one third will later abuse their own children (11 Facts, 2010); People who are abused as children grow up to have many psychological problems, including posttraumatic stress disorder, depression, self-injurious behaviors and chronic suicidal ideation.

About 80% of 21-year-olds who were abused as children met criteria for at least one psychological disorder (11 Facts, 2010).

Of prison inmates, 84% were abused as children (11 Facts, 2010).

In 2003, the total costs of child abuse and neglect were estimated at more than $94 million. These costs included demands on the health care, mental health care, law enforcement, child welfare, and judicial systems. Additionally, indirect costs included special education, juvenile delinquency programs, and adult criminality (Goldman et al. 2003).

**Identifying and Recognizing Signs of Child Abuse**

The information provided thus far details the seriousness of child maltreatment as a concern. A large percentage of treatment professionals,
despite being mandated reporters, fail to report cases of child abuse and neglect. Among the most frequently identified reasons for not reporting are lack of knowledge about child abuse and neglect and lack of familiarity with state reporting laws. Other reasons people don’t report include (American Humane Association, n.d.):

Choosing instead to effectively intervene independent of the formal system.
Fear or unwillingness to get involved
Fear that a report will make matters worse
Reluctance to risk angering the family
Concerns that making a report will negatively impact an existing relationship with the child or others
Belief that someone else will speak up and do something
Concerns about confidentiality issues

In addition to the themes above, some researchers have looked at why medical professionals fail to report child abuse or maltreatment. Borimnejad & Khoshnavay Fomani (2015) conducted qualitative reviews with nurses regarding barriers to reporting child abuse. Five major themes included “knowledge deficit”, “previous unpleasant experiences about child abuse reporting”, “ethical challenges”, “legal challenges” and “cultural beliefs” (about the right of parents, especially fathers, to discipline children in any way they believe necessary). These themes point to areas of opportunity to educate professionals and to support a change in attitudes.

While some communications to mental health providers may be direct, unless there is an obvious reason to doubt the veracity of the client’s report, such disclosures should be considered evidence of child abuse. In other cases, signs may not be so obvious. The presence of a single sign does not prove child abuse, but a closer look is warranted when these signs appear repeatedly or in combination.

The Child Welfare Information Gateway (2007) Factsheet: Recognizing Child Abuse and Neglect: Signs and Symptoms, lists the following signs that may signal the presence of child abuse or neglect. The list below has been adapted for use by mental health professionals

**Signs of Physical Abuse**

<table>
<thead>
<tr>
<th>The Child</th>
<th>The Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has unexplained burns, bites, bruises, broken bones, or black eyes</td>
<td>Offers conflicting, unconvincing, or no explanation for the child's injury</td>
</tr>
<tr>
<td>Frequent injuries that are described as “accidental” or “unexplained”</td>
<td>Describes the child as &quot;evil,&quot; or in some other very negative way</td>
</tr>
<tr>
<td>Has fading bruises or other marks</td>
<td>Uses harsh physical discipline with</td>
</tr>
</tbody>
</table>

---
<table>
<thead>
<tr>
<th>Noticeable after a weekend or absence</th>
<th>the child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has fractured or displaced teeth</td>
<td>Verbalizes unrealistic expectations of child</td>
</tr>
<tr>
<td>Human bite marks</td>
<td></td>
</tr>
<tr>
<td>Seems frightened of parents/protests or cries when it is time to go home</td>
<td></td>
</tr>
<tr>
<td>Shrinks at the approach of adults</td>
<td></td>
</tr>
<tr>
<td>Reports injury by adult caregiver</td>
<td></td>
</tr>
</tbody>
</table>

### Signs of Neglect

#### The Child
- Persistent diaper rash or failure to thrive
- Frequently misses appointments
- Frequently misses school without explanations
- Lacks sufficient clothing for the weather
- States there is no one at home to provide care
- Begs or steals food or money
- Consistently dirty or severe body odor
- Appears malnourished or complains of being hungry
- Frequent absences from school

#### The Parent
- Appears to be indifferent to child
- Seems apathetic or depressed
- Behaves irrationally bizarre manner
- Is abusing alcohol or other drugs
- Is chronically ill
- Has low intellectual functioning

### Signs of Sexual Abuse

#### The Child
- Reports sexual abuse by a parent or other adult caregiver
- Has difficulty walking or sitting
- Torn, stained or bloody underclothing
- Experiences pain or itching in the genital area
- Suddenly refuses to change for gym or physical activities
- Reports nightmares or bedwetting
- Experiences a sudden change in appetite
- Demonstrates bizarre, sophisticated,

#### The Parent
- Is sexual with child
- Buys the child inappropriate clothing or “gifts”
- Comments on child’s body in an inappropriate way
- Is unduly protective of the child or limits child’s contact with other children, especially of the opposite sex
- Is secretive and isolated
- Is jealous and controlling with family members
or unusual sexual knowledge or behavior or acts out sexually
Becomes pregnant or contracts a venereal disease, particularly if under age 14

Signs of Emotional Maltreatment

<table>
<thead>
<tr>
<th>The Child</th>
<th>The Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shows extremes in behavior, such as overly compliant or demanding, extreme passivity, aggression</td>
<td></td>
</tr>
<tr>
<td>Is either inappropriately adult or inappropriately infantile</td>
<td></td>
</tr>
<tr>
<td>Is delayed in physical or emotional development</td>
<td></td>
</tr>
<tr>
<td>Lack of attachment to the parent</td>
<td></td>
</tr>
<tr>
<td>Reacts oddly to persons in authority</td>
<td></td>
</tr>
<tr>
<td>Is fearful or anxious about doing something wrong or making a mistake</td>
<td></td>
</tr>
<tr>
<td>Exhibits delayed physical or emotional development; engages in self-soothing behaviors, thumb sucking, rocking, etc., outgrown by peers</td>
<td></td>
</tr>
<tr>
<td>Constantly blames, belittles, or berates the child</td>
<td></td>
</tr>
<tr>
<td>Is unconcerned about the child and refuses to consider offers of help for the child's problems</td>
<td></td>
</tr>
<tr>
<td>Overtly rejects the child</td>
<td></td>
</tr>
<tr>
<td>Withholds love</td>
<td></td>
</tr>
</tbody>
</table>

Ethical Standards Pertaining to Confidentiality

Reporting suspected child abuse brings with it some weighty issues. Psychologists, social workers and counselors all have ethical guidelines that highlight as a key standard that of confidentiality. For example:

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship (APA Ethical Code, Standard 4.01, Maintaining Confidentiality).

Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. **The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious,**
foresseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed (NASW Ethical Code, 1.07C).

Although the need to maintain client confidentiality is an important standard, no client can be given the guarantee of complete confidentiality. Although child abuse will be defined in more detail in the next section of this text, this is clearly an area in which other ethical standards merit consideration. In discussing this issue Braebeck (as quoted in Ethics Rounds, 2002) states that the principles of nonmaleficence (avoid harm) and beneficence (ensure people's well-being) require that psychologists break confidentiality when a client's actions pose potential harm to self or others that is, that "Psychologists disclose confidential information without the consent...to protect the patient or client or others from harm" (Standard 5.05 [a]). Psychologists must be aware of state mandated limits and inform their clients of the exceptions to confidentiality (Standard 5.02). Thus, privileged communication laws to not apply to mandated reporters.

There has been some discussion as to whether mandated reporting laws hinder confidentiality (Kalichman, 1993, Locke, 1995). For that reason some professionals are reluctant to report suspicions of child abuse. Koocher suggests that when faced with the issue of disclosing suspected abuse, one must be fully aware of the legal requirements but then also consider what the client wants from the therapist. He states: "Most likely, the client wants to process the long-concealed distress and address myriad emotions, including anger, shame, sadness, guilt and a host of other issues commonly experienced by victims of sexual abuse. The client wants and needs to do this in a supportive, safe and reassuring context in order to regain a sense of control and mastery over the frightening events of the past that radiate into her present." Although professionals are mandated to report abuse, the clinical aspects also need careful consideration.

Some guidelines for mandated reporting include:

1) Talk to families about your role as a mandated reporter during the informed consent process
2) If you do have to report child maltreatment, speak to the parent. Reiterate your role, your intentions of ensuring the child’s safety, and your ability to provide continued family support
3) Let the parent know that you have formally made the report
4) Explain the process, including contact you will have with child protective services
5) Support, support, support
Good Faith Reporting

One common question is how certain about clinicians need to be in order to make a report of abuse. Although this will vary from situation to situation, Pass (2007) provides some guidelines that may be helpful. She states that when the professional observes only behavioral symptoms, it is best to document this and continue to assess the situation; that when the professional observes physical symptoms it is best to consult on the situation and also to speak with a parent or guardian; and that when a combination of physical and behavioral symptoms are seen a report is indicated. On a therapeutic level it is important to consider the potential consequences of reporting, and thoroughly assess the situation. There is no timeframe; a 2-3 week assessment is ok if the child is not in immediate danger. Although the clinician should certainly err in favor of the child’s safety it is also important to consider the implications of making a report.

Specific reporting guidelines vary in terms of wording, from state to state. For example some statutes call for reporters to have a "reasonable suspicion" of abuse, while others the reporter to "know or suspect." States also vary in regard to when professionals must report abuse, and it is important to know the specific guidelines in the state in which you practice. Some examples of this are that clinicians must report suspected abuse “when they come into contact with a child in the course of their employment, occupation or practice of a profession,” “are directly responsible for the care of a child,” “a child makes a specific disclosure or is an identifiable victim,” or that a person “makes a disclosure that they have committed child abuse.”

Professionals who are concerned about their responsibility, whether mandatory or voluntary, to report suspected elder abuse often want to know if they may face civil or criminal liability for making such a report. This is often of particular concern if the report is not substantiated. CAPTA requires states to enact legislation that provides for immunity from prosecution arising out of the reporting abuse or neglect. In most states, a person who reports suspected child abuse in "good faith" is immune from criminal and civil liability. There are similar statutes that cover reporting of suspected elder abuse.

If, during the investigation of substantiated child maltreatment, officials determine that a mandated reporter failed to make a report of suspected child abuse, that individual can be liable for civil or criminal charges or a review of their credentials by their licensing agency.

How to Report Suspected Abuse

The procedures for reporting child abuse vary from state to state. All states have a governmental department that investigates suspected child abuse.
The Child Welfare Gateway provides a listing of phone numbers that can be used to report suspicions of abuse. This listing can be found at [http://www.childwelfare.gov/pubs/reslist/rl_dsp.cfm?rs_id=5&rate_chno=11-11172](http://www.childwelfare.gov/pubs/reslist/rl_dsp.cfm?rs_id=5&rate_chno=11-11172)

When reporting suspected abuse the provider should be able to provide the following information:

- child’s name, age, gender, and address
- parent or guardian’s name and address
- nature and extent of the injury or condition observed
- prior injuries and when observed
- actions taken by the reporter (e.g., talking to the child or parent)
- where the act allegedly occurred
- your assessment of current level of safety
- child’s siblings and any related safety concerns
- previous situations of Family involvement with the child welfare system
- reporter’s name, location, and contact information

**Child Protective Services/Investigating Child Maltreatment**

Child Protective Services (CPS) is the name of the governmental agency in that responds to reports of child abuse or neglect. Some states have opted to use other names in an attempt to be more family-centered (as opposed to child-centered such as "Department of Children & Family Services". CPS is also known by the name of "Department of Social Services" (DSS) or simply "Social Services."

Child protective services has the legal authority and obligation to assess, investigate and evaluate reports of child abuse and neglect and to provide services when needed. Child welfare workers are responsible for determining:

- Whether abuse or neglect has occurred
- Whether there is immediate danger or risk to the child
- What the motivation, capacity and intent of the alleged perpetrator
- What the ability of a non-offending caregiver is to protect the child in the immediate future

**Investigatory Stages**

McClennan (2010) identifies the following stages of the CPS investigatory process:

- **Step 1:** Identifying and Reporting: A mandated professional reports suspected child maltreatment to reporting hotline
Step 2: Screening: Caseworkers gather information and determine whether report meets guidelines and whether prior reports have been made. Calls that do not meet guidelines are screened out or referred to other agencies that can better meet a family’s needs. If a report meets guidelines, it is triaged in terms of response time (i.e., within 24 hours) based on severity of abuse/vulnerability of the child.

Step 3: Initial Investigation/Family Assessment: CPS conducts an initial assessment to determine safety and risk. During this time they will generally contact the treatment provider directly, meet with family members at the home, meet with the victim in the home or school setting, and talk with other involved parties, such as the school or agencies. The initial assessment may be extended if there is a determination of risk.

If the initial investigation does not yield safety or risk concerns, the case is then closed, but a record of this contact is kept.

If the child is in immediate danger, the child welfare worker may place him or her under emergency protective services, which may include in-home support and supervision or the temporary removal of the child to a safe alternative environment (e.g., with other family members or in foster care). If the child is removed from the home under these circumstances, the court and family must be notified and an emergency/temporary custody review hearing must be held, typically within 48 to 72 hours.

Step 4: Planning: If the child welfare worker determines that there are safety concerns, but it is safe to leave the child in the home, the worker is responsible for creating a plan to keep the child safe in that environment and for organizing or providing any needed support for the child and the family. Support may come from a variety of sources, including extended family, local community organizations and child protective services.

Step 5: Service Provision: CPS or the agencies involved help the family to implement the plan.

Step 6: Evaluation of Family Progress: The CPS worker continues to evaluate progress.

Step 7: Case Closure: Cases can be closed in various ways. If the child remains in the home and is considered safe, the case will be closed to CPS. If the child was removed from the home and is now
considered safe, reunification (reuniting the child with the parents) can take place.

**Other Services offered by Child Protective Services**

In addition to its role in investigating child abuse, Child Protective Services generally offers other support services. These vary on a state-by-state basis, but may include:

- Parent education groups (designed to promote healthy child development, improve parent-child communication and improve attachment and bonding)
- Groups for parents of children in placements
- Self-esteem groups for parents and teens
- Reunification groups
- Counseling referrals

**In-Home Care Alternatives**

In most States the child welfare system is a collaboration between many different entities. Some in-home alternatives include:

**Family Support Services**: provide prevention and early intervention to families, which may include parent education, school-based services, respite care and early childhood education

**Family preservation services**: short-term, family-focused services to help families cope with stresses. The goal of these services is to maintain children within their families by providing them with assistance. Some examples are food stamps, substance abuse treatment, transportation, housing, and mental health treatment

**Intensive family preservation services (IFPS)**: similar to traditional family preservation services, IFPS involve high levels of face-to-face contact with families and in-home service delivery. Many IFSC programs are specifically designed for situations in which there is a family member or child with a mental illness. Such agencies offer a variety of services including needs assessment, counseling, respite services and psychoeducation.
Cultural Issues in Mandated Reporting

“Children of families in changing cultural contexts are often considered to be at risk for maltreatment. This is because such families may experience sociocultural and socioeconomic change and a loss of their former support networks. Parental acculturation stress and related dysfunction might also affect children. The risk increases when children are exposed to systems with conflicting socialization goals and with contradictory definitions of desirable child-care or supervision frameworks. Conflicts and clashes between parents and socializing agents have been found to have long-term detrimental effects on children and families. Cultural differences may also result in misinterpretation of parental behaviors and misdiagnosis of abuse and neglect. Such conflicts and misinterpretations can be avoided if both parents and social agents learn to understand and to respect their cultural differences, so that together, they can devise ways to bridge them.”

— Strier D. Roer, Reducing Risk for Children in Changing Cultural Contexts

“What does it mean to be “culturally competent” in child maltreatment work? It means we must be sincerely open to all forms of human diversity: ethnic culture, gender, social class, sexual orientation, ability, nationality, language, religion and so on. We must accept this diversity with our minds and our hearts, and learn to work competently to address people’s diverse needs and circumstances.”

— Lisa Aronson Fontes, Child Abuse and Culture

An International Perspective

Unicef estimates that internationally 80% to 98% of children suffer physical punishment, and one in six children is subjected to the most severe forms of corporal punishment. Gender discrimination and inequality contribute to high rates of abuse among women and girls; female genital mutilation FGM/C is a common practice Africa and other area of the world. Other connected problems include ritual servitude, sex trafficking and prostitution. Males are not immune to issues such childhood conscription and child labor. In poorer countries, child neglect may be connected to poverty and other forms of violence may result from political and social instability.

Bridging the Gap in the United States

According to the US Office of Immigration Statistics, as of January 1, 2013, an estimated 13.1 million lawful permanent resident (LPRs) currently reside in the
United States. LPRs, also known as “green card” holders, LPRs are immigrants who have been granted lawful permanent residence in the United States but have not yet become U.S. citizens. Mexico was the leading country of origin, followed by China, the Philippines, the Dominican Republic, Cuba, Viet Nam and El Salvador. California was the leading state of residence with an estimated 3.3 million LPRs in 2013 (Rytina, 2013). These statistics do not take into account the many residents of undocumented status. Many immigrants come from countries where violence was more widespread, and experience economic disparities after immigrating, things that have been connected with child maltreatment.

A trend often observed in the child maltreatment literature is that racial and ethnically diverse families are often overrepresented in reporting of child maltreatment. The following chart (Statistica, 2013) shows child maltreatment rates by race in 2013.

<table>
<thead>
<tr>
<th>Race</th>
<th>Maltreatment Rate/1,000 Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>14.6</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>12.5</td>
</tr>
<tr>
<td>Multiple Race</td>
<td>10.6</td>
</tr>
<tr>
<td>Hispanic</td>
<td>8.5</td>
</tr>
<tr>
<td>White</td>
<td>8.1</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>7.9</td>
</tr>
<tr>
<td>Asian</td>
<td>1.7</td>
</tr>
</tbody>
</table>

**Stresses**

Why are children of color overrepresented in the child welfare system? Not only are there greater incidences of reported maltreatment, but there are also differences in terms of service provision (out of home placement, length of time in foster care, mental health treatment, etc).

Research points to a number of possible reasons for disparate representation of cultural, ethnic, and racial groups in child-welfare systems (Nadan, Spilsbury & Korbin, 2015). One possibility is that mandated reporters may exhibit personal biases in which they view diverse groups through their own, sometimes ethnocentric, cultural lens. There may also be less understanding of what these authors term the “multiple identities” (such as gender, race, and socioeconomic status) that children from these households hold. Overall the point is that cultural factors are complex and that the child welfare system is imperfect. Additionally Dettlaff & Rycraft (2008) point out that the preferable nature of kinship networks rather than foster care placement.

Minority and immigrant families may also be under greater stress; they are more likely to be of lower socioeconomic status, to be unemployed, or to live in single-parent households. These stresses are risk factors for child maltreatment, and it may be more helpful to address the root causes of these problems, when
appropriate, such as providing access to resources (e.g., food and cash assistance) rather than taking more punitive actions.

Why Look At Child Maltreatment Through A Cultural Lens?

While it may seem plausible that child abuse and neglect would be easily identified regardless of cultural boundaries, there is actually considerable variation in child rearing beliefs and behaviors across various cultures and ethnic groups. There is no single standard for child rearing, nor for child abuse and neglect. Labeling behaviors as abusive or neglectful, deciding how to intervene, seeking to understand the causes of problems, and determining what we do to help alleviate the stresses, have much to do with our understanding of the family's culture and what is normal or acceptable within that culture.

False Positive Identifications

Given the ideas discussed above and the disproportionality of ethically diverse groups within child welfare systems, it is important to look at the idea of “false positive” identifications. Fontes (2005) says that a false positive is finding abuse that is not there, and may result from the misidentification of cultural practices as maltreatment. Below are some categories and examples of cultural differences that could result in such misidentification. Some case studies illustrating these categories will follow.

There are a number of categories that could result in false positive identifications:

1) Alternate sleeping arrangements.

Diverse families may engage in practices such as co-sleeping or sleeping on the floor (common in Asian, African and South American families). These practices could be misidentified as neglect or sexual abuse rather than being normative for families of these cultural origins.

2) More flexible boundaries/sharing resources/fluid household composition.

Ethically diverse family members often connect to the idea of the idea of a familial self, in which a sense of self that includes ones’ close relationships. This may be misidentified as a lack of family boundaries or appropriate opportunities for autonomy. There is also the more practical manifestation, such as extended families living in same household, which is not as common in mainstream culture. These practices are common in Latino, Japanese and Indian families.

3) Size norms/Care of Newborns.
Young immigrant children could be seen as experiencing “failure to thrive” when genetically compared to U.S. norms and there may be the misperception of parental neglect. Additionally children who are strictly breastfed may gain weight at a slower rate than their bottle-fed counterparts. Many cultures also restrict others contact with newborns shortly after birth, and thus newer immigrants may be hesitant to bring children outside to their early (2 week) checkups due to fear of something happening to them.

4) Appearance and hygiene differences.

Some cultures have hair/body cutting, restrictions in bathing practices due to religious norms, amulets/protection, body markings, etc. which may be misinterpreted or seen as a lack of caretaking. There may even be practices who are culturally seen as acceptable or necessary, but that could be seen as abusive by those who are unfamiliar with them.

Consider the following case (NRCFCPP Information Packet):

A mother cut the faces of her two young sons with a razor blade and rubbed charcoal into the lacerations. The boys are removed from the household and placed into foster care. The mother is prosecuted for child abuse. The mother was a member of an East African tribe that traditionally practices facial scarring. Her actions were an attempt to assert the cultural identity of her children. Without such markings, her boys would be unable to participate as adults in their culture.

Similar practices may be seen in Afro-Caribbean cultures that practice santería or Brazilian practices in which crosses may be marked on the child’s face when initiated into the religion. Shia Muslims (including male adolescents may participate in ritual self-flagellation (Suzuki & Ponterotto, 2008).

5) Clothing that may differ from peers.

Diverse families may have differing clothing preferences, modest dress, head coverings, etc. Children from these families may not fit neatly into the norm in their peer groups. It is important not to mistake culturally or religiously motivated practices (such as wearing head coverings) as signs of oppression.

6) Responses to authorities/lack of understanding.

Culturally diverse families sometimes defer to authority figures or have a lack of understanding when confronted with demands by child welfare systems. Due to language barriers, requests by authorities may also not be correctly understood. These things may be seen as a lack of cooperation on the part of the family and could result in children being removed incorrectly.
School officials may also mistakenly characterize parents as “uncaring” because they do not attend school meetings when in actuality they do not speak the language well enough to do so. In some cultures, such as Latino cultures teachers may be seen as second parents (“La maestra es la segunda madre”) and parents do not want to interfere with decisions made in the school.

Consider the following case (Chan, as referenced in Fontes):

A Vietnamese mother was reported as being “neglectful” for failing to take her autistic son to early intervention. With sensitive investigation, it was found that the mother did not understand what autism was or the importance of early intervention. This investigation led to the child consistently receiving the services he needed.

7) Unfamiliar disciplinary practices/harsh or overly permissive disciplinary practices.

Diverse cultural groups may employ disciplinary methods that are unfamiliar and could be seen as abusive. Fontes (2005) gives the example of hincar, a practice seen in Latino and Asian groups in which children are forced to kneel on rice as punishment. Mental health professionals may wish to consider several factors in assessing unfamiliar disciplinary practices, including the age of the child, how often the punishment is employed, and whether the punishment is commonplace in a particular ethnic or cultural group.

Some research has found that African American parents use corporal punishment more frequently than white Americans (Gershoff, 2002); this is also common in Caribbean families where flogging is commonly employed for misbehavior. The idea of whether African Americans use physical punishment in a less impulsive way is one that is frequently cited in the literature, and has been studied with mixed results (e.g., Lorber et al., 2011). There is also research supporting the fact that families under high levels of stress will often use more harsh forms of discipline. Asian families expect obedience from children; they may also use physical discipline such as spanking or caning (the latter is seen especially families from Singapore). The Korean proverb mae ga yak ida (translated as "spare the rod and spoil the child") is commonly adhered to by many Korean families.

Some studies have shown that Latino families use less corporal punishment due to the value of familismo, emphasis of the family and sacrificing for the family. In many Native American cultures children are rarely disciplined, instead the goal of discipline is to teach the lessons of life, using stories, and modeling (Bigfoot & Funderburk, 2011).

8) Unfamiliar medical interventions.
Unfamiliar medical interventions can sometimes be seen as abuse. These include:

- **Cupping** - use of skin suction use to mobilize blood flow in order to promote healing through the use of heat or suction. This treatment can leave bruises or other marks.

- **Coining/Coin Rubbing** - traditional Chinese medicine practice in which a coin is repeatedly rubbed against an area of the skin in long flowing moves in order to promote balance. This often leaves physical marks. Coining is widely practiced by Southeast Asians, such as the Vietnamese, Thai, and Lao peoples. The Vietnamese practice of "coin rubbing" in which heated metal coins are pressed forcefully on the child's body leaving bruises is a traditional curing technique that is believed to reduce fevers, chills, and headaches. While bruises are indeed inflicted, in this context it cannot be defined as child abuse.

- **Moxibustion** - traditional Chinese medicine treatment using a Chinese herb called Moxa (Artemisia argyi), which is compressed and rolled into a cigar-shaped herbal stick. Moxa sticks are then lit and held over acupuncture points.

There may also be the belief in Asian cultures that Western medications, such as antibiotics, can promote *yang* and thus should be stopped as soon as a child feels better.

States often have laws that include steps to be taken when a practitioner is concerned about the use of unfamiliar practices. Those that leave physical marks are generally subject to investigation.

**Ways of Showing Affection**

Western cultures often see expressions of affection in hugs, kisses, praise, etc. In other cultures, particularly those that value communal forms of family, affection and love may be expressed in different ways. A recent study by the National Institute of Child Health and Human Development found that families from Sweden often show love by treating children as equals; those from Kenya demonstrate love by being more controlling of their children's behavior; in Hispanic cultures the family's needs before one's own individual needs; and in Italian families show love by being highly involved with their children and through demonstrating a great deal of emotion in their interactions. Fontes (2005) provides the example that families from the Dominican Republic may physically bite their children, sometimes leaving a mark. Fontes notes that this may also be found in Latino and Portuguese families.

**False Negatives, Use of Culture as a Justification**
Just as Fontes (2005) discusses “false positives” in child maltreatment, she also discusses “false negatives” in which professionals fail to recognize child abuse due to attributing behaviors to cultural differences. It is important to be aware of times that caregivers use culture as a justification as abuse (Fontes provides the example of an Italian immigrant father severely beating his daughter due to defiance.) She also cautions that sexual abuse is never justifiable.

**Cultural Sensitivity Best Practice Tips**

- Be aware that differences exist culturally, and consult with others that are most familiar with these differences
- Identifying cultural values and beliefs to be incorporated into assessment and interventions
- Be respectful of the child's cultural heritage, racial ancestry and identity and spiritual or religious faith
- Involve the child's family, including the extended family whenever possible, in the planning and delivery of services for the child
- Using the services of a language and/or cultural interpreter to assist in assessment, planning and service delivery, when necessary and appropriate
- Formulating a plan that promotes an individual’s values and belief systems
- When in doubt, err on the side of protecting the child

Additionally the Jordan Institute for Families suggests the following to incorporate cultural sensitivity into clinical practice:

- If you have questions about a family's culture, ask them in a nonthreatening, honest manner
- Look for opportunities to learn about other cultures, either formally or informally
- Ask the family who should be involved, as this may include extended family members and friends
- Look closely at your own racial and cultural attitudes and values--personal biases often run deep
• Be careful when ascribing certain characteristics to specific groups--every individual is unique

• Consider the role that work, pride, and shame play

**Summary**

As mandated reporters it is important for mental health professionals to be aware of the signs of child abuse as well as the procedures for reporting suspected abuse. All ethical guidelines support the fact that confidentiality is limited when the provider has suspicions that a child is being harmed. Knowing how and when to report abuse can help support efforts to reduce the incidence of child abuse and maltreatment. Mental health professionals perform a vital role in the protection of the children that they serve.
References


American Medical Association, *Diagnostic and treatment guidelines on child sexual abuse*. Chicago: AMA, March, 1992


Campos, J.K. et al. (2016). The Effect of Socioeconomic Status and Parental Demographics on Activation of Department of Child and Family Services in Pediatric Burn Injury. *Journal of Burn Care and Research*.


Larson-Nath, C.M., & Goday, P.S. (2016). Failure to Thrive: A Prospective Study
Mandated Reporting


