Child Abuse Assessment and Reporting

Meets the BBS requirement for 7 CE Hours

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Karlee Ohm, MFT
Rhonda Thomson, MFT
Melissa Wells
CEUCafe.com

Mandated Child Abuse Reporting
California State Guidelines for
Social Workers and Marriage and Family Therapists

Child abuse casts a shadow the length of a lifetime.
– Herbert Ward, Episcopal priest

This course will review California's Child Abuse and Neglect Reporting Act, discuss the requirements of mandated reporters under the law, and examine clinical implications for treating children and adolescents who have been victims of abuse and neglect. Mental health clinicians have a legal and ethical duty to stay informed as to updates in the law that pertains to child abuse reporting. They must learn to recognize signs and symptoms of abuse or neglect, and be sensitive to the psychological needs of the child in the reporting process. Children who have been abused or neglected have already been traumatized by the experience and do not need to be further subjected to psychological harm as a result of the filing of a report of maltreatment. Completing

continuing education in the area of child abuse, maintaining membership in a professional association, and seeking clinical supervision and case consultation in cases of suspected abuse are all ways to ensure that the reporting of suspected abuse and neglect will be handled lawfully, and protect the best interests of the child involved.

Introduction

Protecting children from abuse has a short history in the United States. In 1875, Henry Bergh, who had previously founded the Society to Prevent Cruelty to Animals (SPCA), was instrumental in finding shelter for Mary Ellen Wilson, an 8-year-old illegitimate child in New York City who was maltreated by her stepmother and step-siblings. The city's outrage in response to the newspaper coverage of little Mary Ellen's abuses had its effects. Fueled by favorable opinion in the city, Bergh and his attorney friend Elbridge Gerry then founded the Society for the Prevention of Cruelty to Children (SPCC). Formed to intervene against child neglect and abuse and to advocate for child protection, the SPCC later expanded to Chicago and Philadelphia (Crosson-Tower, 2008).

Sadly, as indicated by the fact that the SPCA existed for a decade prior to the founding of the SPCC, creating public policy to protect youth has not been a top priority. Weak advocacy in this arena has contributed to a barrier in eliminating child abuse. While some progress is being made, even at this time research on child abuse does not receive the financial commitment needed at a federal level to prevent and, more importantly, to end child abuse. According to Vieth (2006),

> Although child abuse and neglect has been appropriately termed a public health epidemic, our nation has not invested money in addressing this ill to the extent we have other epidemics. For example, a study of federal research commitment found we invest one nickel for every $100 of societal cost associated with child abuse, whereas we invest $2 for every $100 of societal cost associated with cancer. This is so, even though the rate of child abuse is 10 times greater than the rate of cancer. (p. 13)

Growing Awareness

While this rampant epidemic of child abuse crumbles the lives of untold numbers of youths and their families, the states of this nation are working toward solutions for diminishing the debacle of child abuse and neglect. Since the founding of the SPCC, other associations have formed to address this problem, including The National Center on Child Abuse and Neglect in Washington, DC; the C. Henry Kempe Center for Prevention and Treatment of Child Abuse and Neglect and the American Humane Association, both in Denver; and the National Committee for Prevention of Child Abuse in Chicago. Additionally, peer-reviewed journals are now publishing research on child abuse and neglect, such as *International Journal of Child Abuse and Neglect, Journal of Child Sexual Abuse,* and *Child Maltreatment* (Crosson-Tower, 2008).

Child Abuse Legislation

Federal legislation to address protection for youth dates back to 1974, when the Child Abuse Prevention and Treatment Act (CAPTA) passed in both houses of Congress. This law established the mandated reporting of child neglect and abuse as well as providing funds for related research. Under CAPTA, all 50 States have passed laws mandating reporting of child abuse and neglect. In California, this section of the penal code is referred to as the Child Abuse and Neglect Reporting Act (CANRA). Originally introduced in 1974, CANRA has since been amended several times, most recently in 1996. The CANRA Task Force continues to recommend changes to help clarify the act to ensure that children receive protection and are not subject to further harm.

The optimal method of assessing for child abuse is through a multidisciplinary approach

A Collaborative Approach to Child Abuse Intervention

The optimal method of assessing for child abuse is through a multidisciplinary approach utilizing medical, law enforcement, mental health, and child protection professionals who perform a forensic evaluation of the whole child. The Children's Justice and Assistance Act and the Child Abuse Prevention and Treatment Act are examples of legislation in place to provide grant money for implementing multidisciplinary investigations in states.

There are a number of models that define the work done collaboratively between CPS and law enforcement. These include multidisciplinary interview centers and child advocacy centers. Multidisciplinary centers are advantageous as they typically have the benefit of more resources, better facilities for conducting investigative interviews, and greater coordination of services. These centers also have specially trained child interviewers. Additionally, many are connected to medical facilities, which enhance the coordination efforts in investigating physical abuse. According to Laraque, DeMattia, and Low,

> In cases of physical abuse, description and photography of the visible external findings (e.g., ecchymoses, lacerations, fractures), radiological findings (e.g., skeletal survey, bone scan, CT/MRI findings of the head), and ophthalmologic findings (e.g., of retinal hemorrhages) are essential …. Assessment of psychological trauma (e.g., anxiety, especially post-traumatic stress and depression) in these settings is part of a comprehensive evaluation. Appropriate disposition, including the possibility of hospitalization for the management of acute injuries and/or safety planning must also be considered. (2006, p. 1138-1139)

Nationwide, 33 states have adopted a multidisciplinary approach to investigating child abuse.

Child advocacy centers are another approach to addressing child abuse. The National Children's Alliance sponsors 280 child advocacy centers in 44 states. The goals for these centers are to reduce trauma to children, increase arrests and prosecution of

perpetrators, and augment services to families through multidisciplinary collaboration. Child advocacy centers feature investigations made available on a 24-hour basis; cross-training between agencies regarding roles, procedures, and responsibilities; and office space for both CPS and law enforcement officials. These officials also have improved access to the district attorney and medical staff (Newman & Dannenfelser, 2005).

Child Protective Services

In many counties, Child Protective Services (CPS) is the county welfare department that handles mandated reports. Child Protective Services, an agency that is part of the Department of Social Services and the Department of Family and Children's Services, has been working on the behalf of youth since the 1960s. While its role has evolved over that time, its functions now include:

- Receiving and screening reports of child abuse initiated by mandated reporters
- Directly intervening in emergency situations
- Determining risk of danger to child and need for service
- Facilitating court interventions, if necessary
- Providing case management and social services for affected families
- Managing out-of-home placement
- Managing efforts to maintain or reunite families (Crosson-Tower, 2008)

With mandated reporters and Child Protective Services working together to address child abuse and neglect, there is a greater chance that youth will be better protected from the emotional and physical harm that would otherwise occur without these interventions. A recent federal study, in fact, found a 26% decrease in the rate of reported sexual, physical, or emotional abuse from 1993, and a 38% drop in sexual

abuse alone (Sedlak, et. al., 2010). Despite this promising trend, the study also found that “[c]hildren with unemployed parents had two to three times higher rates of neglect than those with employed parents.” Children from low-income families were also three times more likely to suffer abuse (Sedlak, et. al., 2010). While this report seems to indicate that policies designed to protect children are having an effect, there is still much work to be done.

California’s Response to Child Welfare

It can be helpful to understand the specific approaches that different states take in addressing the issue of child abuse. The U.S. Department of Health and Human Services reports detailed statistics on child abuse that includes extensive data. Following is the section that specifically pertains to California:

Alicia Sandoval Chief
Child Welfare Data Analysis Bureau
California Department of Social Services
744 P Street, MS 9–13–84
Sacramento, CA 95814
Phone Email
916–653–1812
alicia.sandoval@dss.ca.gov

California’s differential response approach is comprised of three pathways:

Path 1 community response: family problems as indicated by the referral to the child welfare system do not meet statutory definitions of abuse and neglect, and the referral is evaluated out by child welfare with no investigation. Based on the information given at the hotline, however, the family may be referred by child welfare to community services.

Path 2 child welfare services with community response: family problems meet statutory definitions of abuse and neglect but the child is safe and the family has strengths that can meet challenges. The referral of suspected abuse and neglect is accepted for investigation by the child welfare agency, and a community partner goes with the investigator to help engage the family in services. A case may or may not be opened by child welfare, depending on the results of the investigation.

Path 3 child welfare services response: the child is not safe and at moderate to high risk for continuing abuse or neglect. This referral appears to have some rather serious allegations at the hotline. It is investigated, and a child welfare services case is opened. Once an assessment is completed, these families may still be referred to an outside agency for some services, depending on their needs.

Reports

The report count includes both the number of child abuse and neglect reports that require, and receive, an in-person investigation within the timeframe specified by the report response type. Reports are classified as either immediate response or 10-day response. For a report that was coded as requiring an immediate response to be counted in the immediate response measure, the actual visit (or attempted visit) must have occurred within 24 hours of the report receipt date. For a report that was coded as requiring a 10-day response to be counted in the 10-day response measure, the actual visit (or attempted visit) must have occurred within 10-days of the report receipt date.

For the quarter ending September 2015, the immediate response compliance rate was 96.2 percent and the 10-day response compliance rate was 91.4 percent.
The number of staff budgeted for screening, intake, and investigation (emergency response and emergency response assessment) was based on 58 counties for state fiscal year (SFY) 2014.

Fatalities

Fatality data submitted to NCANDS is derived from notifications (SOC 826 forms) submitted to the California Department of Social Services (CDSS) from County Child Welfare Services (CWS) agencies when it has been determined that a child has died as the result of abuse and neglect. The abuse and neglect determinations reported by CWS agencies are made by local coroner/medical examiner of offices, law enforcement agencies, and/ or county CWS/probation agencies. As such, the data collected and reported via SB 39 and used for NCANDS reporting purposes does reflect child death information derived from multiple sources. It does not represent information directly received from either the state's vital statistics agency or local child death review teams.

The data are used to meet the reporting mandates of the federal Child Abuse Prevention and Treatment Act (CAPTA) and for the Title IV-B, Annual Progress and Services Report (APSR). Calendar Year (CY) 2014 is the most recent validated annual data, and is therefore reported for federal fiscal year (FFY) 2015. Counties will continue to determine causes of fatalities to be the result of abuse and/or neglect that occurred in

prior years. Any changes to this number will be reflected in subsequent year's APSR reports.

Prior to CY 2011, the CDSS used data reconciled by the California Department of Public Health (CDPH) for submission to NCANDS. Beginning with the FFY 2010 NCANDS data submission in CY 2011, the CDSS changed the data source to the SB 39 data. Additionally, beginning in CY 2012 CDSS began to receive reports of fatalities determined to be the result of abuse and neglect and caused by an unknown third party. NCANDS submissions beginning in FFY 2013 (CY 2012) to the present, includes these fatalities.

CDSS will continue to look at how it might use other information sources to enrich the data gathered from the SOC 826 reporting process and reported to NCANDS. In September 2012, the CDSS issued a best practices all county information notice to counties encouraging annual reconciliation of CWS child death information with other entities that review child deaths such as local child death review teams, and attendance at local child death review team meetings to participate in discussions regarding deaths which may have been the result of abuse and or neglect. As part of the technical assistance provided to counties regarding SB 39, the CDSS began collecting information regarding county child welfare agencies' roles on local child death review teams and how their participation may lead to further identification and reporting of deaths that are a result of abuse or neglect. Additionally, the CDSS continues to collaborate and share data with the CDPH, for purposes of the reconciliation audit of

child death cases in California. The most recent information shared to date is for CY 2010.

Services

Direct prevention services for children and families include those funded by Community Based Child Abuse Prevention (CBCAP), Promoting Safe and Stable Families (PSSF), Child Abuse Prevention and Treatment Act (CAPTA), and Child Abuse Prevention, Intervention and Treatment (CAPIT, state funds). More than 940,000 parents also received services under these funding streams, including 672 parents participating in a Strategies conference.

There was an overall decrease in the total number of children and families served by CAPTA, CBCAP and PSSF due to several factors. First, Efforts to Outcomes (ETO) gathered data by types of service activity rather than funding stream. Additionally, counties reported staffing issues, implementation of new programs, broad service activity categories which could encompass more than one service activity (e.g. Family Resource Center) and more intensive services as reasons for a decrease in the number of families and children served. However, the number of families served by CAPIT funds increased significantly. This increase was due to some counties reporting an increase of case management and differential response referrals, new services being added to family resource centers and partnerships with other agencies to provide prevention programs.

Also, in FFY 2014, the number of families served with CAPTA funds included families assessed for needs by family service organizations using the Family Development Matrix (FDM). OCAP funded the Family Development Matrix for many years, but chose to not fund FDM in FFY 2015–2016. Using CAPTA funds, OCAP funded Parents Anonymous, the Parents Service Project, and Strategies (three non-pro ts providing training and technical assistance to family service organizations throughout the state). Mandated reporter training was also funded by OCAP, and in FFYs 2015–2016, professionals completed the training. Not all families reported to Child Welfare Services have a case opened, but families referred are offered prevention services that address the reasons they were referred and often “opens the door” to families accessing additional prevention services.

All child victims younger than 3 years are considered eligible for referral for individuals with disabilities education act.

Assessment of Child Abuse

RISK FACTORS

Mental health clinicians are considered to be mandated reporters of suspected child abuse. Under the CANRA section of the penal code, mandated reporters include an extensive list of more than 30 different professional classifications. For the purpose of this course, mandated reporter refers to Licensed Marriage & Family Therapists, Licensed Clinical Social Workers, Marriage & Family Therapist Trainees and Interns,

and Clinical Social Worker Trainees and Interns. This course also refers generally to these professionals as “clinicians” unless specifically noted.

As mandated reporters, it is important that clinicians be aware of risk factors when assessing for child maltreatment. Regarding possible abuse of the child by parents, risk factors include a difficult childhood punctuated with abuse, neglect, family violence, or substance abuse; current substance abuse; and low tolerance for frustration, poor impulse control, external locus of control, depression, or anxiety. Children may be at risk as victims of maltreatment when they display behavioral problems; an aggressive or withdrawn temperament; poor physical development; or difficulty associating with peers and isolation. From a systemic view, families experiencing violence, divorce, and custody battles are at higher risk for child maltreatment. Parents who see their children as a burden and have a conflicted relationship with their children are also at high risk. Any single parents with a limited support system, unemployment and economic distress, and limited access to community resources are also at risk (Crosson-Tower, 2008).

SEXUAL ABUSE

Childhood sexual abuse can happen to any child regardless of race, sex, age, religion, or creed. Perpetrators are, in most cases, familiar with the child. Perpetrators can be a parent, grandparent, sibling, uncle, aunt, step-parent, neighbor, close family friend, teacher, pastor, coach, caregiver, mentor, or stranger.

Signs and Symptoms of Sexual Abuse

The lists below are meant to help mandated reporters identify signs and symptoms that may indicate possible sexual abuse. These lists are not an exhaustive reference, nor will the signs or symptoms always indicate sexual abuse. It is important to consider each sign or symptom as part of a larger clinical picture, not in isolation.

Behavioral Signs of Sexual Abuse

- Children may be sexually precocious. Some children who have been abused may act seductively toward others. They may want to give numerous kisses, initiate inappropriate touch, or constantly request to sit on an adult's lap.
- Pre-adolescents and adolescents who have been sexually abused may be more sexually promiscuous. Adolescents may have an intense desire to be sexually active as a means to gain attention and pseudo comfort.
- Children may wear bulky clothing to hide breasts or other private body parts. They may wear long-sleeved shirts or long pants even on extremely hot days to avoid attention to their body.
- Sexually abused children may attempt to appear unkempt and unattractive. They may not bathe or groom in order to appear less attractive to prospective sexual abusers. Older children may not wear deodorant or may even urinate in their underwear to make themselves repulsive to abusers.
- They may have sexual knowledge beyond what is appropriate for their age and level of development, for example, a five-year-old boy who talks about giving someone a "blow job."
- Children may engage in persistent sexual play with friends, toys, or pets.
- They may display apparent boredom with peers their own age and activities appropriate for their level of development.
- Children may experience a radical change in school performance, for better or worse.

- Along these lines, they may become overachievers. Some children who have been sexually abused attempt to be “extra good” in an effort to diminish the guilt arising from being sexually abused.
- They may become preoccupied with sex. Children who have viewed pornography may be excessively curious about or overly preoccupied with sexuality. Some children may expose their genitals to others or engage in a sudden, unusually high level of masturbation (Monahon, 1993).
- Substance abuse and addiction issues are common with children who have been sexually abused. Adolescents and even children will use alcohol or other drugs in an attempt to feel better and avoid reality.
- These children will display angry, hostile, or aggressive behavior. They have no other way to express themselves and oftentimes act out severe hurt that they have internalized by becoming overly aggressive.
- Sometimes children who have been sexually abused will engage in regressive, babyish behavior.
- They may make intense efforts to gain attention and affection from adults. This may stem from emotional insecurity and low self-esteem as a consequence of sexual abuse.
- Children may spend an inordinate amount of time in game rooms, arcades, etc. These children use games, television, and computers as another way to escape their painful reality.
- Children may engage in self-mutilation, such as sticking themselves with pins, scratching or cutting, or burning themselves. This is another way for adolescents and children to gain attention from others.
- These youths may also kill or torture domesticated animals. This kind of behavior can be a result of severe sexual or emotional abuse. Such children need to act out their fear and pain.
- Children may run away from home in order to avoid further abuse or to gain attention from others.
- They may be unable to concentrate or they may spend a great deal of time daydreaming and “spacing out” in a world of their own.

- These children may engage in excessive or early masturbation.
- They may use coercion to engage in sexual activities with other youths. According to Monahon (1993), children who have been sexually abused make attempts to undress, sexually touch, or engage in intercourse with other children through coercive techniques. For instance, they may try to entice others to come into a room and then coerce them to participate in sexual acts by offering them a reward. They may also get another child to participate in inappropriate sexual acts by threatening to tell an adult or parent about a sexual act in which they had already participated.
- Children may start sucking their thumb or fingers, especially toddlers and younger children. Older children may regress to thumb sucking.
- They may also become a perpetrator, targeting a child, sibling, or friend. It is common for children who are sexually abused to act out with others in an attempt to gain sexual pleasure or to make someone else a victim.
- Young children may engage in inappropriate kissing. They may try to kiss passionately, including the use of their tongue, or they may attempt to kiss others on inappropriate parts of the body, such as the genitals or the breasts.
- Children may not want someone, including a parent, to change their clothes or to give them a bath.
- They may act out sexual activities with toys, such as simulating sex with dolls, or other children by asking friends or siblings to behave sexually.
- Sexually abused children may withdraw from previously enjoyable activities.
- They may ask an unusual amount of questions about human sexuality.

Physical and Medical Signs of Sexual Abuse

- Children who are toilet trained start having bowel movements (encopresis) in their underwear.
- There may be unexplained bruises, redness, or bleeding from the child's genitals, anus, or mouth, as well as pain in these areas. Young children may say things like, "My pee pee hurts."

- Change in eating habits (bulimia, anorexia, or compulsive eating), including a loss of appetite or other eating problems, such as unexplained gagging and swallowing problems.
- Genital sores or milky fluids in the genital area.
- Neurological and verbal expressive delays.
- Complaining of pain while urinating or having a bowel movement; exhibiting symptoms of genital infections, such as offensive odors; or symptoms of a sexually transmitted disease. Girls may get frequent yeast infections.
- Evidence of physical traumas to the genital or anal area.
- Wetting the bed (enuresis). Some children wet the bed so that the perpetrator will not want to visit them during the night.
- Signs of exhaustion due to lack of sleep.
- Memory loss.
- Unexplained pregnancies.
- Complaints of stomach and abdominal pain. Stomach illness all of the time with no identifiable reason.
- Recurrent urinary tract infections.
- Foul odors emanating from genitalia.
- Vaginal or penile discharge, found on underwear, clothing, or bedding.
- Lubricant residue, such as Vaseline or KY Jelly.
- Persistent sore throat.

Emotional Signs of Sexual Abuse

- Sudden mood swings, such as rage, fear, anger, or withdrawal.
- Nightmares, insomnia, sleepwalking, and other sleep disturbances.
- Suicidal ideation, gestures, and attempts.
- Self-hatred and extremely low self-worth.
- Withdrawn, isolated, or excessively worried.
- Fear of the withdrawal of nurturing from parents or caretakers and impaired ability to trust.

- Inability to make age-appropriate friends. A lack of basic social skills for interacting with adults and same-aged peers.
- Fear of certain people or places. For example, a child may not want to be left alone with a babysitter, friend, relative, or some other child or adult. Also, a child who is usually talkative and cheery may become quiet and distant when around a certain person.
- Waking up during the night sweating, screaming, or shaking with nightmares; fear of the dark.
- Fear of monsters, ghosts, evil beings.
- Depression, sadness, and frequent crying.
- Radical mood swings.
- Fear of being photographed.
- A reaction of anxiety toward authority figures.
- Fear of undressing or refusal to undress in gym class.
- Pseudo-mature, overly compliant, accommodating.
- Unexplained periods of panic, which may be flashbacks of the abuse. Oftentimes, children who have been severely sexually abused may have auditory and visual hallucinations or exhibit extreme psychotic behavior.

Psycho-social Signs of Sexual Abuse

- Social or geographic isolation of family that may be the result of incest.
- Daughter/mother role-reversal, in cases of incest. Some mothers may know about ongoing sexual abuse by a spouse. They may have seen it happen or allow it to happen.
- Father doting and lavishing gifts on a select child, in cases of incest.
- Nervous or fearful around adults. Girls who have been sexually abused by a man may have a fear of all men.
- Talking about a new, older friend.

- Suddenly having money. Many perpetrators will offer money and other gifts. Adolescents and children who have excessive amounts of money may be involved in prostitution or pornography.

Age-Inappropriate Sexualized Behavior and Knowledge

Children who are victims of sexual abuse may have sexual knowledge and may display behavior that is not appropriate for their age. These children reenact adult sexual scenarios and behaviors in their play with other children or with their dolls, stuffed toys, or other objects (Monahon, 1993). It can be difficult to distinguish between a child who is displaying normal sexual play or childhood curiosity as opposed to sexual acting out that is inappropriate for the child's level of development. When sexual acting out appears to be more knowledgeable or the child takes the steps for sexual arousal, this is cause for concern.

Age-Appropriate Sexuality in Children

Sexuality is a part of every human regardless of their age. It is important for mandated reporters to understand what constitutes typical, age-appropriate sexual development in children in order to differentiate potential abuse. Below is a partial list of healthy sexual behaviors in children based on their developmental stage (Wurtele & Miller-Perrin, 1992):

Preschool (0-5 years)

Sexual language relating to differences in body parts, bathroom talk, pregnancy, and birth is considered age-appropriate. In addition, age-appropriate behavior may also include masturbation at home and in public, as well as showing and wanting to look at private parts. Children who may have been sexually abused may discuss sexual acts and have sexual contact experiences with other children.

School Age (6-12 years)

Children in this age group may have questions about menstruation, pregnancy, or sexual behavior. They may be curious and experiment sexually with same-aged children, including kissing, fondling, exhibitionism, and role-playing. Age-appropriate behavior may also include masturbation while at home or at other private places. Children who have been sexually abused may discuss explicit sexual acts and participate in sexual acts, such as intercourse or oral sex.

Adolescence (13-16 years)

Appropriate questions to address with this age group regarding sexual topics may include social relationships and sexual customs. Children in this age group may masturbate in private. They may experiment with adolescents of the same age, including open-mouth kissing, fondling, and body rubbing. Sexual intercourse occurs in approximately one third of this age group (Moore, et al., 2006).

Case Example *(Please note that in all case examples the names, ages, and some circumstances have been changed to protect the identity of the child.)*

Rosy, age 12, currently resides with her mother, an older brother who is 18 years of age, and a younger sister, age 9. The Department of Children and Family Services (DCFS) has been to Rosy's home on different occasions due to reports of neglect made by teachers at her school. Based on the information gathered, DCFS found that despite the neglectful conditions of the home, it was more appropriate to work with the family than to place Rosy and her younger sister in foster care.

During a visit with her DCFS Social Worker, Rosy also disclosed sexual abuse by her father. Indeed, he had been having sex with her for the past two years. After a Suspected Child Abuse Report was made and the father was detained and removed from the home, Rosy was referred to Carmen, an MFT, for therapy. She was also referred Lost Daughters United, a global network for fatherless girls www.lostdaughtersunited.org.

Despite ongoing treatment, Rosy's emotional state grew worse. She was not eating, was not completing class work, and she was starting to experience auditory and visual hallucinations. She was afraid to go to sleep at night and reported that evil beings lived in the home. Rosy's declining emotional state alerted Carmen to the possibility that Rosy was still at risk for abuse. Carmen continued to assess Rosy's living environment and relationships, and Rosy eventually told Carmen that she had also been raped by her older brother on several occasions in her current living situation. Rosy said that she was afraid to say anything because her brother helped her mother pay for rent and other household expenses.

Carmen made a report to Child Protective Services, and Rosy and her younger sister were removed from the home and placed in foster care since the mother had not been able to protect Rosy from further sexual abuse. Rosy's younger sister and mother were

angry with her for reporting the abuse and destroying the family. Rosy's mother blamed her for losing her AFDC money and for causing her younger sister's removal from the home.

Case Example

Jake, age 4, is currently in foster care due to neglect by his parents, who also abuse drugs. This is Jake's second foster home placement. His previous caregiver was not able to handle his tantrums or severe mood swings and therefore asked for his removal. Jake shares his foster home with the foster parents' two older daughters and 3-year-old son. When Jake was placed in the home, the foster parents were given his history, which included extreme neglect. Jake's parents left him home alone without the supervision of an adult on many occasions, and he was malnourished.

Jake needed special care and attention to help him heal and build emotional stability. He would often gorge himself, had intense nightmares, and had frequent toileting accidents. In addition, he suffered extreme mood swings and had frequent temper tantrums. On one occasion, the foster mother walked into the room to find her 3-year-old son with his pants down and Jake attempting to kiss the child on the buttocks. The foster mother intervened, and told Jake that this behavior was unacceptable. In addition, she asked him if anyone had ever done this to him. Jake told the foster mother that his mommy had kissed his "pee pee" and touched his "pee pee." The foster mother asked an appropriate question because she knew that while showing and wanting to look at each others' private parts was typically within normal limits, kissing another child on the buttocks was outside of normal sexual play.

The foster mother called Jake's County Social Worker, who agreed that this incident required a mandated report. They agreed that the foster mother would report the incident directly to CPS. The Social Worker followed up to make sure the report was filed. If it had not been, the Social Worker would have made a report.

CHILDHOOD NEGLECT

Childhood neglect is a broad term and is usually defined in terms of severity. CANRA differentiates between “severe” neglect and “general” neglect. Severe neglect is characterized by the failure of the caregiver to prevent the child from suffering severe malnutrition or medically diagnosed nonorganic failure to thrive. It also refers to willfully endangering the person or health of the child by intentionally failing to provide adequate food, clothing, shelter, or medical care.

General neglect also involves a failure on the part of the caregiver to provide adequate food, clothing, shelter, medical care, and/or supervision. However, general neglect does not result in physical injury to the child.

Alcohol and/or drug abuse by a caregiver may contribute to neglect or abuse of a child, but CANRA specifically states that “alcohol or drug abuse, or both alcohol and drug abuse, is not in and of itself a sufficient basis for reporting child abuse or neglect.” (Penal Code Section 11165.7 (B) (38)). Additionally, a positive toxicology screen at birth does not mandate a report of abuse or neglect. However, any indication of maternal substance abuse shall lead to an assessment of the needs of the mother and child pursuant to Section123605 of the Health and Safety Code. If other factors are present that indicate risk to a child, then a report shall be made. However, a report based on risk to a child

> In the case of general neglect, the caregiver does not appear to deliberately want to harm the child.

which relates solely to the inability of the parent to provide the child with regular care due to the parent's substance abuse shall be made only to a county welfare or probation department, and not to a law enforcement agency. (Penal Code Section 11165.13)

Signs and Symptoms of Neglect

The lists below are meant to help mandated reporters identify signs and symptoms that may indicate possible neglect. These lists are not an exhaustive reference, nor will the signs or symptoms always indicate neglect. It is important to consider each sign or symptom as part of a larger clinical picture, not in isolation.

Physical Neglect

- The child begs for money to purchase necessities such as food and clothing.
- The child is seen eating food out of the trash or picking up food or candy from the ground.
- The child shoplifts food in the grocery or convenience store.
- The child is consistently dirty and has severe body odor. The child may have matted hair and chronic infestations of lice or scabies.
- The child lacks sufficient clothing for the weather. This may mean absence of a coat, long pants, or closed shoes in cold weather, or the child may wear sweatshirts and heavy pants during the summer.
- The child abuses alcohol or other drugs. Children of neglect often have parents who abuse alcohol and drugs and therefore follow the example of their parents.
- Parents who neglect their children oftentimes have little knowledge of where their children are or what they are doing.

- The child reports that there is no one at home to provide care and generally lacks adult supervision.
- The child appears to be fatigued or is tired and listless. He or she is falling asleep in class.
- The child shows sudden changes in behavior or school performance.
- The child has learning issues (or difficulty concentrating) that cannot be attributed to specific physical, educational, or psychological causes.
- The child is overly compliant, passive, withdrawn, or depressed.
- The child comes to school or other activities early, stays late, and does not want to go home. Oftentimes children of neglect will want to stay at other people's homes. They will do everything in their power to avoid going home.
- The child has a distended stomach, which is a characteristic of malnutrition, and constant hunger.

Educational Neglect

Frequent absences from school may result in a child's inability to reach educational benchmarks commensurate with the child's age or developmental level. Some of the reasons for frequent absences include:

- Parents who rely on older children to watch younger children during the day while the parents are at work or doing other things.
- Adolescents as well as older children may not want to attend school, and the parents do not have the energy or the parenting skills to ensure that they attend school.
- Parents do not take their children to school because they sleep in or have an early work schedule and must leave their children at home.
- Parents who abuse alcohol or drugs are often away from home or confined to a room and do not make any effort to take their children to school.
- The parent or caretaker fails to enroll a school-age child in school or to provide necessary special education.

Emotional Neglect as Evidenced in the Parent or Caregiver

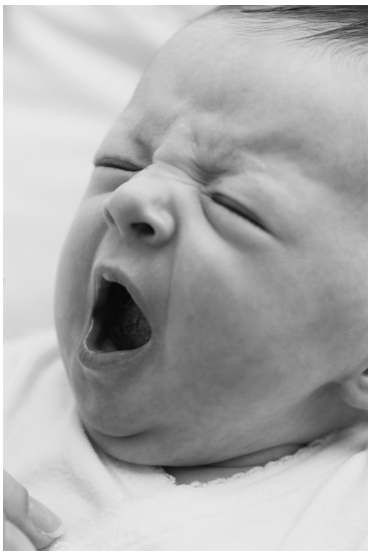
- The parent or caregiver appears to be indifferent to the child. There is little or no attachment to the child.
- The parent fails to provide emotional support, love, and affection. This includes neglect of the child's emotional needs and failure to provide psychological care, as needed.
- The parent or caregiver seems to be depressed or withdrawn.
- The parent or caregiver behaves irrationally or in a bizarre manner.
- The parent is abusing alcohol or other substances, which may include illegal drugs, over-the-counter medications, and prescription drugs.
- The parent blames the child for the child's problems in school or at home.
- The parent or caregiver may ask teachers to use harsh discipline if the child misbehaves.
- The parent or caregiver views the child as entirely bad, worthless, or a burden to the family.
- The parent or caregiver demands a level of physical or academic performance the child cannot achieve. (It should be noted that in foster care, many foster parents may have unrealistic expectations of foster children. The foster parents may believe that foster children should behave as their own children and therefore may constantly belittle them or cut them down).

Emotional Neglect as Evidenced in the Child

- The child exhibits low self-worth and generally doesn't like him- or herself.
- The child constantly and adamantly seeks approval or attention from adults or other children.
- The child can be aggressive or mean to others, including animals and small children.
- The child is frequently fearful and is afraid to make choices. The child does not have the independent skills appropriate for his or her age.

- The child is not attached to the parent or caregiver.
- The child oftentimes isolates him- or herself.
- The child is depressed or extremely passive.

Non-organic Failure to Thrive



Non-organic failure to thrive may describe the child or infant who fails to develop normally; it is not related to a disease or other serious medical condition. Parents can unintentionally fail to give the child the proper care or food due to inexperience with parental responsibilities; lack of knowledge regarding a healthy, age-appropriate diet for children; or as a result of abusing drugs and alcohol and failing to notice the child's needs. Other parents, for reasons of health, may put their young child on a special eating program that is not conducive to physical growth. Some children have poor eating habits, such as eating in front of the television and not having formal meal times.

Also, some parents have hostile feelings toward the child and punish the child by withholding food. There have also been cases of mothers who are going through postpartum depression who fail to feed their infants. Women who neglect their infants due to postpartum depression must be treated immediately for their own safety and for the safety of the infant.

There are also organic causes of failure to thrive that need to be ruled out when making an assessment. Here are some considerations:

- Children who have conditions involving the gastrointestinal system like gastroesophageal reflux, chronic diarrhea, cystic fibrosis, celiac disease, or chronic liver disease. With reflux, the esophagus may become so irritated that the child refuses to eat because it hurts. Cystic fibrosis, chronic liver disease, and celiac disease are conditions that limit the body's ability to absorb nutrients.
- Children who have a chronic illness or medical disorder due to premature birth. The child may not take in enough calories to support normal growth.
- Some infants and children have an intolerance of milk protein or other allergies. A condition such as this can initially lead to difficulty absorbing nutrients until it is recognized. Such sensitivity can also put an entire class of food out of reach, restricting the child's diet and occasionally leading to failure to thrive. Food Protein Induced Enterocolitis Syndrome (FPIES), is one such disorder. FPIES is an immune reaction in the GI system to food proteins that causes inflammation of the intestine and colon, resulting in severe vomiting, diarrhea, and failure to gain weight. It is most commonly seen in very young children, under the age of three. Eosinophilic disorders (often referred to as EE or EOS) are another type of immune disorder that can result in failure to thrive, and are sometimes severe enough to require tube feeding. Clinicians should be aware of these disorders not only to differentiate medical conditions from neglect, but also to help families find appropriate resources for treatment. For more information about the disorders mentioned above, refer to

http://www.kidswithfoodallergies.org/resourcetopic.php?topic=gastrointestinal-disorders.

- Some children may have an infection, including parasites or urinary tract infection, which place great energy demands on the body and force it to use nutrients rapidly. This sometimes brings about short- or long-term failure to thrive.

The above medical conditions are also explained in more detail at www.kidshealth.org. This is not an exhaustive list. When considering failure to thrive in the case of neglect, it is imperative to refer the infant or child to a pediatrician or other specialist. Infants and young children who have been underfed and did not receive appropriate nourishment can be affected for life in terms of physical and emotional development as well as overall health.

Case Example

Tony, age 9, Rob, age 6, and Larry, age 4, were picked up on the streets of Los Angeles when a police officer noticed that they were looking inside a trash bin outside a fast food restaurant. The boys' mother was around the corner looking for food in a dumpster behind the restaurant. The mother was a heroin addict who was spending her AFDC money to support her drug habit. The boys were immediately taken into custody and placed in a foster home. When interviewed, Tony defended his mother and stated that she did the best she could to take care of him and his brothers.

The foster parents noticed that all three boys gorged themselves when they ate and frequently hid food in their pockets and in other hiding places in their bedrooms. When at the park or on a shopping trip, the boys would look on the ground for dropped food or

candy. They would also look for coins to purchase fast foods. After several weeks in foster care, the boys' behavior worsened. They began to act out, and the youngest boy started defecating in closets and other remote areas of the house. The foster parents were discouraged because they thought that if they provided the necessary needs, as well as attention, the boys would improve.

The transition from a highly chaotic environment to a more stable foster home can be extremely stressful to children. Although the boys were in a safer environment, it likely caused a significant level of disequilibrium to their emotional system, as evidenced by the acting out behaviors exhibited after placement. The effects of neglect in this case were far reaching. The boys had been malnourished for several years and required extra nutrition and medical support in order to reach their ideal weight.

Medical Neglect

Medical neglect means that even minimal health care is not being obtained for a child. The lack of medical attention can result in a more severe illness or even death. In some cases, parents do not have the financial means to get the medical care needed for their children. Children who may have severe illnesses, such as cancer, may not be able to obtain insurance. In these cases, the circumstances of the family should be taken into consideration.

Other parents do not seek conventional medical treatment due to religious reasons. In some states, a court order is obtained to authorize medical treatment in order to save a child's life. Swan and Asser (1998) investigated the deaths of 172 children between 1975 and 1995 in which parents used family-healing interventions instead of conventional medical treatments. The study determined that 140 of the deaths could

most likely have been prevented if medical treatment had been used. According to Swan and Asser:

> When faith healing is used to the exclusion of medical treatment, the number of preventable child fatalities and the associated suffering are substantial and warrant public concern. Existing laws may be inadequate to protect children from this form of medical neglect. (1998, p. 629)

Despite the real potential for child harm, caregivers who do not seek medical care for a sick child based on religious belief are not necessarily considered negligent under the law. However, CANRA states that in these cases, "[a]n informed and appropriate medical decision" should be made by the caregiver "after consultation with a physician or physicians who have examined the minor" in order to ensure that the treatment does not constitute neglect. (Penal Code Sections 11165.2, 11165.3)

Signs of Medical Neglect

- The child has an untreated cut that appears to be significantly infected.
- The child has a severe virus or infection and has not been seen by a medical professional.
- The child's teeth are rotting or discolored.
- The child has a severe untreated injury, such as a deep cut or broken bone.

An Ethical Question

Can childhood obesity be considered medical neglect? Rates of childhood obesity are rapidly increasing in the United States. In Great Britain, having an obese child could result in his or her removal from the home. Social workers in Great Britain have been asked to place obese children on the child protection register along with other children who may have experienced abuse or neglect. In some more extreme cases, obese children have been placed in protective custody because the parents have not followed medical advice. Under what circumstances, if any, should childhood obesity constitute neglect? What interventions, if any, would be appropriate in these cases?

- The parent or guardian of the child does not use emergency services for a severe illness or injury.
- When medication is prescribed, the prescription is either not filled or administered to the child according to instructions, resulting in harm to the child.
- Recommended psychological help is not obtained, resulting in pain and suffering to the child.
- The child does not receive required immunizations.
- Treatment plans given by medical professionals for chronic illnesses are not followed.
- The child does not receive glasses or hearing aids when needed.

PHYSICAL ABUSE

Physical abuse constitutes any kind of physical injury, or pain inflicted on a child other than by accidental means.

Examples of Physical Abuse:

The lists below are meant to help mandated reporters identify signs and symptoms that may indicate possible physical abuse. These lists are not an exhaustive reference, nor will the signs or symptoms always indicate physical abuse. It is important to consider each sign or symptom as part of a larger clinical picture, not in isolation.

- Punching
- Striking with a fist or other object
- Pinching
- Pushing
- Pulling
- Kicking
- Strangling

- Biting
- Holding the head under water
- Exposure to extreme water temperatures, such as scalding water or icy cold water
- Burning with boiling water or other hot objects, such as cigarettes or chemicals Electric shock
- Throwing objects to cause harm
- Withholding food or water
- Exposure to a dangerous animal
- Restraining a child by rope, tape, handcuffs, or locking a child in a closet or room
- Forcing a child to drink hot sauce
- Cutting the skin with a sharp object
- Forcing a child to drink alcohol or to ingest illegal or non-necessary medication

Signs and Symptoms of Physical Abuse

Victims of physical abuse, much like victims of neglect and sexual abuse, often protect the perpetrator because they have been threatened by the perpetrator or they do not want to cause trouble for their caregivers. Because of this, it is important to understand and be observant for indicators of physical abuse.

Physical abuse encompasses a broad range of injuries resulting from excessive disciplinary action up to and including physical torture, according to Frederico, Jackson, and Black (2008). According to the Agency for Healthcare Research and Quality (AHRQ), more than 33% of children who are hospitalized for abuse have head injuries, 26% have bruises, 21% have bleeding in eyes, 20% have epileptic convulsions, and 18% have broken limbs (2008). What's more, these children are seven times more likely to die than children hospitalized for reasons other than physical abuse. Nearly 36% of abused children who are hospitalized due to injuries come from the poorest

neighborhoods and 14% live in wealthy communities. Of those admitted for physical abuse, 80% are younger than 5 years old (AHRQ, 2008).

Head trauma is the leading cause of fatalities in child abuse. Retinal hemorrhages appear in 85% of infants or children who are shaken abusively (Horsley, 2008). Ninety percent of abused children have bruises, although non-abused children can have as many as a dozen bruises on their bony prominences and limbs. Also of concern for abuse, however, are genital bruises and facial bruising. It is uncommon for children younger than 9 months to have bruises due to accidents. Bone fractures take considerable force. Research shows that 95% of abusive fractures occur in children less than 3 years old; conversely, 85% of fractures occur in non-abused children older than 5 years. Intentional cigarette burns generally are found on the forehead, upper trunk, and hands (Selby, 2008).

Signs of abuse due to extreme disciplinary actions are generally concealed by clothing, such as on the buttocks or back. Victims or their abusers typically try to explain visible injuries having occurred as the result of an accident. Suspicious explanations of injury include: (1) lack of explanation or unclear explanation for significant injury; (2) an explanation that considerably changes over the course of questioning; (3) an explanation inconsistent with the physical injury; and (4) different explanations for an injury by more than one witness (Horsley, 2008).

Also useful in determining if an injury is intentional is assessing the family's disciplinary patterns, the child's temperament, previous abuse history to the child or his or her parents, substance abuse by those living in the child's home, financial or social stressors in the family, and patterns of violent interaction in the family (Horsley, 2008).

While physical abuse shows more visible signs, much of the time, marks on the body are hidden or the victim makes up stories about the injuries to hide the truth. When talking with a child who may have been abused, it is important to consider the location of the injury. For example, is the type of injury consistent with the explanation? Children who have been abused may have bruises or welts in different stages of healing all over the body, as well as broken teeth, scratches, and other abrasions. It is also important to consider the child's regular activities. For instance, does the child roller skate, ride dirt bikes, skateboard, etc.? Children who are more active may have more frequent injuries, cuts, scrapes, and bruises.

Behavioral Signs of Physical Abuse

- The child is fearful of his or her parents or runs away.
- The child is sad, depressed, or cries frequently.
- The child is extremely angry or aggressive toward pets or other children.
- The child is too eager to please or is overly compliant.
- If touched, the child may flinch or be uneasy.
- The child has extremely low self-esteem.
- The child is absent from school so that the injuries cannot be detected.
- The child seeks no comfort when hurt.
- The child is constantly seeking attention from others.
- Younger children may engage in aggressive pretend play.
- The child may have difficulty sleeping, nightmares, or fear of going to sleep.

- The child may attempt suicide or other destructive behavior to self, such as cutting.
- Drug abuse or alcohol use.
- Difficulty paying attention.

CORPORAL PUNISHMENT

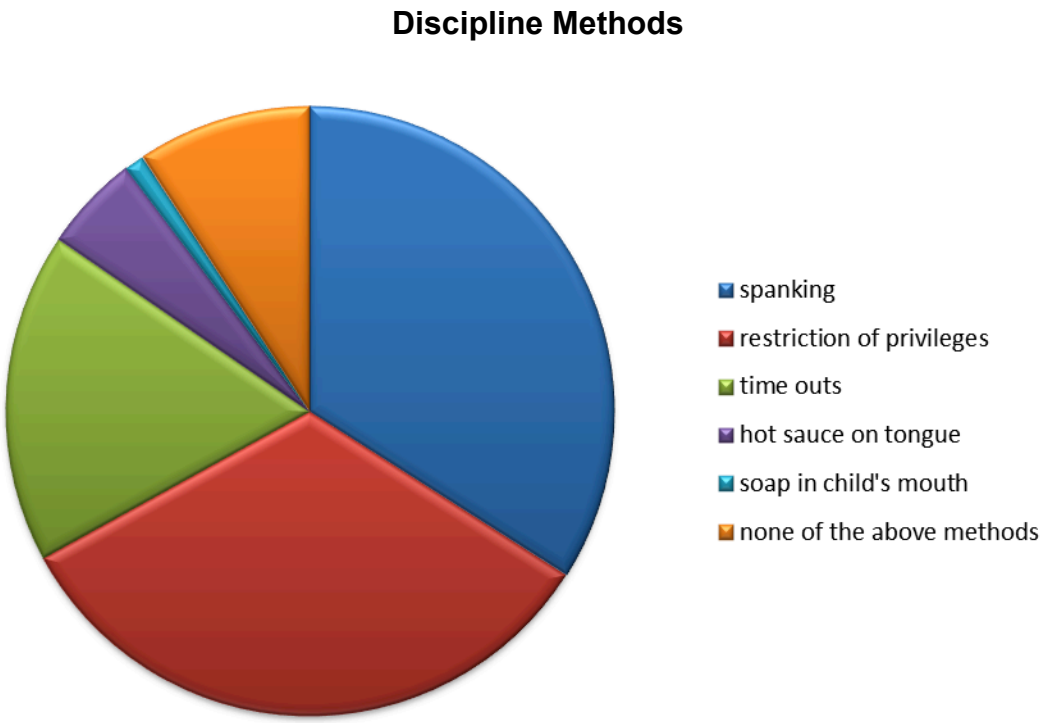
A Mandated Reporting Issue?

Unlawful corporal punishment presents several issues of concern. Many individuals have difficulty determining the definition of corporal punishment. For some parents, spanking and other forms of physical punishment are a daily form of discipline. In the past, schools used many types of corporal punishment, such as spanking a student with a paddle or striking a student on the hand with a ruler. In some states, corporal punishment as a form of discipline in schools is still legal.

Many professionals believe that spanking is not necessary and can cause more harm than good. A California assembly member wants to make it a crime for parents to spank their young children. Many countries already have laws against spanking children. As a professional and a mandated reporter, the choice whether or not to report is made on a case by case basis. If the child is suffering mentally, physically, or socially as a result of corporal punishment, then it is a reportable act. Additionally, whenever a mark is left on the child, such as a bruise, a burn or a cut, a report must be made. To help give further clarification, CANRA describes unlawful corporal punishment as any punishment that is cruel or inhuman or that results in a wound or injury.

If a child is physically out of control, persons working with such a child, such as teachers or administrative staff, may restrain that child in order to protect the child from harm or from hurting others. In these situations, the minimum reasonable amount of restraint should be used to protect the child. This does not give any person working within the school system the right to restrain a child as a form of corporal punishment.

A recent online poll conducted by *LKAS-TV* of Las Vegas, Nevada, found that only one in three parents used spanking as their primary method of discipline. Results were:



Methods of discipline are usually determined by how the parents themselves were disciplined as children.

A Never-Spank Message

Corporal punishment, or spanking, is currently legal throughout the United States, but its use as a means to discipline children is being questioned. Leading the trend away from corporal punishment, Sweden passed legislation in 1979 banning its use by parents in order "to set a national standard for humane treatment of children" (Straus & Douglas, 2008, p. 18). In 2006, the United Nations called for the prohibition and elimination of corporal punishment of children. As of 2007, 19 nations forbid its use and other nations have such legislation pending. In the United States, many of the larger school districts and more than half of the states prohibit use of corporal punishment by teachers (Straus & Douglas, 2008).

While there may be a cultural myth that spanking is effective, a meta-analysis of 88 studies by Gershoff (as cited in Straus & Douglas, 2008) shows the harmful effects of corporal punishment on children, which include increased likelihood of mental health problems, such as depression and anxiety, and the greater probability of antisocial and delinquent behavior. According to Straus & Douglas,

> With over 90% agreement in the research showing that corporal punishment is a risk factor for development problems, we believe the evidence not only permits, but *requires*, a change in policy to one focused on ending corporal punishment …. A large amount of research show that children who are not spanked are, on average, the best behaved and have the lowest rate of psychological problems …. There needs to be an unequivocal *never* spank message. (2008, p. 19-20)

Case Example

Amanda is a 5-year-old girl living with her father Benjamin, who is 25 years old, and his girlfriend Sharon. She attends kindergarten, where she has also been referred to a school-based mental health program, funded by the Healthy Start Initiative, which helps at-risk children develop the social and emotional skills needed to succeed in school. This once-a-week group is run by an MFT Intern, Bruce.

Since Amanda's father works, he leaves the child in the care of his 19-year-old girlfriend after school. Sharon has not been around children much and doesn't know how to handle Amanda. She easily becomes frustrated with Amanda's clamors for attention and help in doing tasks the little girl cannot do for herself, and is resentful of having to care for her.

One evening after work, while giving Amanda her bath, Benjamin noticed that his daughter had marks all over her bottom and legs. He assumed these bruises could only have appeared as a result of a beating with a belt, or some other object, so he confronted Sharon about the marks. Sharon replied that Amanda was a bad girl after school, so she spanked her with a belt. She told Benjamin that she didn't mean to leave marks, and not to worry about it since she won't do it again. Benjamin decided to ignore the situation, and hoped that it wouldn't happen again because he doesn't have another option for child care.

The next day at school, Amanda began her day with the Healthy Start group. The MFT Intern, Bruce, noticed the marks on Amanda's legs. When he inquired, Amanda told him that she got the bruises when she fell off her bicycle. However, her demeanor wasn't congruent with her story. Bruce also didn't think that the marks were consistent with a fall from a bicycle. He suspected physical abuse, and made a report to Child Protective Services.

A CPS investigator interviewed Amanda at school. Amanda told the investigator, who was skilled at interviewing children, that Sharon gave her a beating with a belt while

Daddy was at work. Upon further questioning, the investigator found out that Benjamin knew about the abuse but still decided to let Amanda stay in the care of his girlfriend. Amanda was removed from her home and placed in foster care because of the physical abuse inflicted by her father's girlfriend, and her father's failure to protect her.

Emotional Abuse

Failure of a parent to encourage a child's development through nurturing and love is indicative of emotional abuse. It is a deliberate act of harm as opposed to inadequate parenting. Emotionally abused children typically experience rejection or frightening threats from a caregiver or parent. Such abusiveness fails to provide children with basic emotional necessities, such as consistency and affection (Frederico et al., 2008). Research by Straus and Field (as cited in Hutchinson & Mueller, 2008) shows that 10% to 20% of toddlers and 50% of teens have experienced psychological aggression by parents, which includes cursing, calling the child dumb, threatening to send the child away, or otherwise belittling the child. Indeed, this type of parental maltreatment has been linked with behavioral and emotional problems in abused children, including an increased risk for suicide attempts, depressed affect, sexually transmitted diseases, and alcoholism and smoking. Emotionally abused children typically experience a failure to thrive, are immature, and often have no friends (Selby, 2008). Other research shows that emotionally abused children suffer from psychosocial problems such as fear of being alone, bedwetting, stomach aches, sleep problems, academic failure, distrust of others, low self-esteem, and loneliness (Hutchinson & Mueller, 2008).

Case Example

Stacy is an 8-year-old girl who is a helpful big sister to her 3-year-old brother, Jason. Stacy's mother, Karen, treats Stacy as if she is never good enough, no matter what she does to try to please her mother. Karen continually berates Stacy, even though the young girl packs lunches and helps prepare her younger brother for day care. Karen's lack of empathy extends to her incessant demands for Stacy to rub her feet. Even though Stacy always stops playing to meet her mother's request, Karen tells her, "You're not doing a very good job. If only you were a better daughter, I wouldn't be so depressed all the time."

Eventually Stacy began wetting the bed, which escalated her mother's emotional abuse towards Stacy. Karen screamed at her, "Jesus isn't going to love you anymore. If you're not a perfect daughter, you won't go to heaven. I think Satan must be inside you telling you to make me mad!"

Karen took Stacy to a mental health clinic for counseling for the enuresis. Janine, an LCSW Intern, began family play therapy with Karen and Stacy. Early on in therapy, Janine noticed that Karen would only allow Stacy to play with one toy in the play room and observed demands from Karen that Stacy do things perfectly, as well as incessant criticism. In a subsequent session, Janine met with Stacy individually. It was then that the child disclosed that her mother told her that Satan was inside of her. Stacy reported feeling scared about Satan being inside her, and felt like she was continually being watched. Stacy also said that sometimes she didn't like having to watch her little brother so much because she never did it right and always seemed to make her mother mad at her.

Karen decided that the mother's behavior towards Stacy constituted emotional abuse, and that Stacy was being significantly harmed by the situation. She made a report to Child Protective Services.

Does Emotional Abuse Require a Mandated Report?

CANRA specifically addresses emotional abuse:

> Any mandated reporter who has knowledge of or who reasonably suspects that a child is suffering serious emotional damage or is at a substantial risk of suffering serious emotional damage, evidenced by states of being or behavior, including, but not limited to, severe anxiety, depression, withdrawal, or untoward aggressive behavior toward self or others, may make a report to an agency specified in Section 11165.9. (California Penal Code Section 11166.05)

Notice that the word “may,” gives permission for reporting emotional abuse, but does not mandate it. However, since permission is given, clinicians who report this type of abuse are still protected under the law.

Abuse or Neglect in Out-of-Home Care

Child abuse occurs not only in the home, but also in society’s various institutions including schools, churches, group homes for foster care, residential treatment facilities, psychiatric facilities, and voluntary organizations. Within these settings, the type of abuse that occurs most often is sexual in nature. Adults who work with children in order to indulge in sexually abusive behavior create a dilemma for institutions. Accordingly, the administrators of these institutions are becoming more diligent to create safety networks to protect children and other staff members. Protocols to guide investigations of abuse within these institutions are needed at national and local levels (Sullivan & Beech, 2002).

Some suggested guidelines to help prevent this problem include: (1) establish a threshold of entry that deters committed abusers; (2) foster management that promotes excellence in the institution and vigilance with regard to protecting children from abuse; (3) pursue criminal procedures to effectively deal with offenders; and (4) improve information exchanges between agencies about known abusers. At present barriers within institutions impede exposing child abuse; namely, (1) a lack of policies and procedures to report and investigate institutional abuse, (2) viewing this problem as affecting a staff member rather than the institution as a whole, (3) the closed climate in institutions, and (4) belief systems within institutions. One way to offset these barriers is for institutional administrators to encourage whistle-blowing by staff members (Sullivan & Beech, 2002).

Do priests have the same obligations to report child abuse as other church personnel? Yes. According to Penal Code 11166 subdivision (d), priests are legally obligated to report child abuse and neglect. Over the last decade, many victims have come forward to report that they were sexually abused by their priests when they were children. Unfortunately, when the abuse was reported to different officials within the church, the priests were simply moved to other churches or other positions. As a result, more children were abused. These priests and church officials had a legal obligation to protect children and failed to contact the proper authorities. Sexual abuse cases have occurred in many church settings regardless of the denomination. Many church officials do not understand the law and simply believe that it is best to handle abuse situations without notifying the police and CPS. No matter what the belief system, the church is never above the law.

The only exception to this rule is abuse report during formal confession, also known as the Sacrament of Penance. In this situation, the priest who is receiving the information has a moral responsibility to encourage the abuser to get help. If the abuser is a priest, the person receiving the information has a moral obligation to ensure that the priest is not permitted to be around children.

Children in out-of-home care may under no circumstances be subjected to any type of abuse, including physical, sexual, emotional abuse, and neglect. The investigation of child abuse in an institutional setting is different in several ways from investigating abuse in the family home. Parents have much more discretion in child-rearing practices than employees in institutions. In addition, these facilities are required to provide a harm-free environment to the children placed in their care. According to Barter,

> The scope of culpability is greater in residential placements than in the family context. In residential settings culpability generally extends beyond the immediate abuser(s) to include those directly responsible for managing the facility ….Maltreatment within institutions includes forms of

> abuse unique to residential settings, for example, abusive restraint techniques ...
>
> (1999, p. 398)

It also states that in addition to the state-legislated code, mandated reporters must be aware of guidelines set by individual counties. For example, children in foster care are also under the umbrella of the county agency responsible for licensing foster care homes. Community care licensing agencies do not allow foster parents or staff working in group homes or treatment facilities to use spanking as a form of discipline.
Not only is spanking children in foster care considered a violation of personal rights, but it is also reportable as suspected child abuse because the child is in out-of-home care. When in doubt, contact the community care licensing agency for the specific county in which the facility is licensed. If a child in an out-of-home facility is out of control or is in danger of hurting him- or herself or others, professional staff or foster parents may use reasonable restraint to keep the child or others safe. Beyond this, however, foster parents or professional staff may not use restraint as a form of discipline.

Sadly, child abuse also happens in day-care settings. According to Crosson-Tower (2008), three patterns for child sexual abuse in day-care settings include: (1) an adult associated with the facility abuses one particular child, (2) an adult at the facility abuses various children, or (3) a group of adults abuse multiple children. Although both genders of day-care services have committed abuse, men in this setting are more suspect.

Concerned organizations publish guidelines for selecting a day-care facility. Web sites with this information include:

http://kidshealth.org/parent/positive/family/child_care.html

http://www.nncc.org/Choose.Quality.Care/dc36_choose.care.html

http://www.childcareaware.org/en/child_care_101/5steps.php

http://www.webmd.com/parenting/guide/choosing-child-care-service

Case Example

Billy, age 3, and his two younger siblings were placed in the foster care system due to extreme neglect by their parents, both of whom abused drugs. The foster parents reported that Billy was out of control and aggressive toward his younger siblings. The foster mother said that she needed to watch him constantly so that he wouldn't hurt his siblings. When the social worker, Mario, an LCSW, made his regular visit, he found that the foster mother had clipped Billy into a car seat so that he couldn't move around. The foster mother said that this was justified because he kept hitting his siblings and she didn't know what else to do. She said that Billy had been in the seat for two hours so that she could get stuff done around the house.

Mario made a report to CPS because the child was restrained for such a lengthy period of time. This kind of treatment also constituted a violation of personal rights, according to the community care licensing agency for the county in which Billy resides. The foster mother may have held Billy to stop him from hitting his siblings, but could not restrain him for such a long period of time in this fashion.

Clinicians need to be aware that when a child is out of control or aggressive, he or she may be at risk for inappropriate discipline or abuse. Foster parents can become so frustrated with an out-of-control child that they have been known to lock the child in a bedroom or closet as a means of control and safety. Accordingly, clinicians need to ask questions frequently regarding the method of discipline being used and how the foster parents are coping with the out-of-control child.

Mandated Reporting of Suspected Abuse

Mandated reporters must inform investigative agencies, such as Child Protective Services (CPS), whenever they have reasonable suspicion of alleged abuse of a child. According to the California Attorney General's Office,

> 'reasonable suspicion' means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect. (2006, p. 7)

In order to confirm a reasonable suspicion of child abuse, the therapist will draw upon many factors that include, according to Grosso:

> … (his or her) training, knowledge, and experience, the therapeutic relationship, the credibility of the client, and consultation with other professionals to determine whether a 'reasonable suspicion' exists. If the therapist does not yet have the scope of competence to manage this issue, consultation with a supervisor or objective colleague is necessary before making a final determination. (2009, p. 193)

In California, mandated reporters are protected from civil or criminal actions when they file a report based upon their reasonable suspicions. According to the Attorney General's Office,

> Mandated reporters are provided immunity from civil and criminal liability for making required or authorized reports of known or suspected child

> abuse. This liability shall apply even if the mandated reporter acquired the knowledge or reasonable suspicion of child abuse or neglect outside of his or her professional capacity or outside the scope of his or her employment. (2006, p. 29)

Even with such protection, mandated reporters are cautious about making reports. The severity of abuse and confidence that maltreatment has, in fact, occurred strongly influence the decision to report. While sexual abuse is reported at higher rates for girls than boys, the reporting rates for other types of maltreatment are more equal for both genders. Although poverty and race exert influences on the perception of child abuse, research has shown that Caucasian families have a larger number of allegations and higher rates of substantiation than African American families (VanBergeijk, 2007; Kalichman, 1999).

MAKING A SUSPECTED REPORT OF CHILD ABUSE

Mandated reporters are to contact Child Protective Services (CPS) immediately by telephone if at all possible, and then follow up with a written report on Department of Justice Form SS 8572 (http://ag.ca.gov/childabuse/pdf/ss_8572.pdf) that can be mailed, faxed, or electronically transmitted to CPS within 36 hours of the initial telephone call. Reports may also be made to a police or sheriff's department or a county probation department that is designated by the county to receive reports. These agencies are legally required to take reports, regardless if the report lacks subject matter or it is out of the geographical jurisdiction, unless the caller can immediately be transferred to the proper jurisdiction.

A report must include the following information:

- the name, business address, and telephone number of the mandated reporter
- the capacity that makes the person a mandated reporter
- the information, and source of the information, that caused the reporter to suspect abuse

If known, the report should also include as much of the following information as is known:

- the child's name
- the child's address
- present location of the child
- the child's school, grade, and class (if applicable)
- the names, addresses, and telephone numbers of the child's parents or guardians
- the name, address, telephone number, and other relevant personal information about the person or persons who might have abused or neglected the child (Cal. Penal Code Section 11167(a))

The following link will take you to a form which provides step by step instructions for making a complete report. http://ag.ca.gov/childabuse/pdf/8572_instruct.pdf

What if CPS Won't Take My Report?

Sometimes, a clinician may encounter a CPS or law enforcement official who does not want to take a report because he or she does not consider the report to contain suspected child abuse. In this case, the clinician should still make the report and follow up with a written report to the appropriate agency. The clinician should also remember that his or her mandate is to report suspected abuse, not investigate or substantiate it. If the clinician suspects child abuse, a report is required. It is up to the agency receiving the report to decide what to do with the information once received. The following website provides a list of child abuse reporting hotlines in California, including fax numbers: http://www.childsworld.ca.gov/res/pdf/CPSEmergNumbers.pdf

After a Report Has Been Made

Submitting a report to Child Protective Services (CPS) initiates a chain of events. Although the mandated reporter has a reasonable suspicion, substantiation of the alleged child abuse is investigated by a CPS social worker who determines whether or not abuse or neglect has indeed occurred.

When the mandated reporter notifies CPS by phone of the suspected abuse, the intake social worker may inquire regarding general information of the report. After the report is made, CPS will cross-report to other reporting agencies, and the district attorney (Cal. Penal Code § 11166(j)&(k)). Then, CPS will assess the risk involved in the report, and decide whether an investigation is warranted. If an investigation is conducted, CPS will determine whether the report is "unfounded," "substantiated," or "inconclusive." Once the investigation is complete, the mandated reporter will be informed as to the outcome of the report.

The investigation by CPS and law enforcement may involve talking with the family's parents, children, and other parties who know the child. Assessment with children may occur at school or another neutral setting so that the investigator can interview the child alone. This approach helps minimize the impact that the parent may have on this assessment if it is the parent who is the suspected abuser (Crosson-Tower, 2008).

If a report is deemed unfounded, it means the report of suspected child abuse was determined by the investigator to be either false, inherently improbable, involve an accidental injury, or not meet the criteria of abuse or neglect.

If, during the course of the investigation, the investigator determines there is not enough information to support that abuse or neglect has occurred, the case is regarded as inconclusive, or unsubstantiated, and contact with the family ends. The report is kept on file, however, in case other reports may be made at a later time (Crosson-Tower, 2008).

A substantiated report means the investigator found the circumstances to constitute child abuse or neglect as defined by law, and indicates the need for CPS to intervene in the maltreatment of the child or children. At this point, CPS social workers conduct interviews in the family's home and see involuntary clients, which are typically abusive or neglectful parents. According to Crosson-Tower, "the home is an ideal diagnostic arena. The family drama is played out daily in this setting" (2008, p. 232).

Clinicians who make reports are often mystified and disheartened when they discover that CPS has investigated a report, perhaps substantiating abuse, and yet the child is not always removed from a potentially abusive situation. CPS must balance the potential harm to the child with the disruption and emotional impact that comes with out-of-home placement. CPS is charged by law with making reasonable effort to avoid removal of a child when possible. This is often a difficult balancing act in which it becomes necessary to choose between two imperfect outcomes.

COMMON REPORTING DILEMMAS

Abuse That Took Place a Long Time Ago

Sometimes a clinician will be told by a client of abuse that happened years ago. Under California law, a report is likely still required. If the client is a minor when the abuse is disclosed, a report is required, even if the abuse is no longer occurring. If the client is an adult and the abuse took place when the client was a minor, a report is not mandated. However, if the clinician has reason to suspect that the person who perpetrated the abuse continues to pose a threat, a report would be warranted.

Case Study

Ellen is a 54-year-old woman who is working with Dean, an MFT, to deal with generalized anxiety with agoraphobia. During a recent session while discussing an incident from her childhood, she told Dean that a neighbor had sexually molested her when she was growing up in a small town in Texas. She was 9 years old at the time, and it had happened on a number of occasions when she and her younger brother visited the neighbor's house to help feed his horses. She stated that the neighbor used to give kids sugar cubes and apples to feed the horses, and he molested her while they

were at the stable. She estimated that this neighbor was probably in his 70's now. She stated that on a recent trip home, she asked her parents (whom she had not told of the abuse) what had happened to this neighbor. Her parents told her that the neighbor's son had recently married a young woman with two school-age children, and that they had moved in with him.

Dean decided that a reasonable suspicion existed that this man posed a threat to the children who currently lived in his home. He filed a report with the local CPS office in his local county in California, which was cross-reported to authorities in Texas.

Minors Engaged in Consensual Sex

A minor engaged in sex is another area of considerable confusion to mandated reporters. Some sexual activities between and with minors may not be reportable, depending on factors such as age and consent. The following link clearly delineates the various factors, which are also summarized below:

http://www.cacscc.org/council/reportminors.html

I. Involuntary Sexual Activity: Any type of sexual activity that is involuntary requires a mandated report, regardless of the age of the minors involved.

II. Incest: Always reportable, even if it is consensual, regardless of age.

III. Voluntary Sexual Activity: May or may not be reportable, depending on various factors:

- If both children are under the age of 14, a mandatory report is not required unless there is evidence of coercion, intimidation, bribery, or a disparity in chronological or developmental age.

- If one child is under 14 and the other child is 14-17, a mandatory report is required, regardless of consent. (Penal Code sections 11165.1(a) and 288(a))
- If both children are ages 14-17, no report is required unless there is evidence of coercion or an exploitive relationship, or if the activity involves incest. (see Penal Code § 285, Family Code 2200)
- If the child is 14-17 and the partner is 18 or older, no report is required unless the sexual activity involves the following: **1.** Incest (see Penal Code § 285, Family Code 2200); **2.** Unlawful Sexual Intercourse (also known as "Statutory Rape") involving a person over age 21 with a child age 14 or 15 (see Penal Code § 261.5(d)); and **3.** Lewd and Lascivious Acts involving a child age 14 or 15 and a person who is at least ten years older than the child (i.e. a 14-year-old minor and a person 24 or older; a 15-year-old minor and a person 25 or older) (see Penal Code § 288(c)(1)). While consensual sexual intercourse between a child (a person under age 18) and an adult (a person age 18 or older) is still a crime and thus subject to prosecution, California law only requires that it be *reported* if the child is under age 16 and the adult is over age 21. (See Penal Codes § 11165.1(a), 261.5(a))
- Pregnancy of a minor does not, in and of itself, constitute a reasonable suspicion of child abuse. (see Penal Code § 11166(a)(1))

(http://www.cacscc.org/pdfs/ReportingConsensualSexualActivityTeensRev2006.pdf

Because of the complexity involved in this section of the law, it is advisable to always seek legal consultation with your professional association, as well as seeking consultation with a colleague who is knowledgeable in the area of mandated reporting.

Case Example

Derrick is a 23-year-old college student who is nearing graduation. He is seeing Ken, an MFT Intern in the college counseling center. Derrick is experiencing stress and anxiety because his 17-year-old girlfriend, whom he has been dating for about 3 months, has just told him that she is pregnant. Ken realizes that Derrick's girlfriend is a minor, and is not sure whether a report is mandated in this case. Ken consults with his supervisor, an LCSW, and after discussing the circumstances, determines that a report is not mandated since Derrick's girlfriend is not under 16, the sexual relationship is consensual, and the fact that she is pregnant doesn't necessarily connote child abuse.

Domestic Violence

A child who has been exposed to domestic violence does not automatically trigger a mandated reporting incident. The mandated reporter must ascertain whether or not the child experienced a situation in which his or her physical or emotional health was endangered as a result of the domestic violence. If there is reasonable suspicion that the child is endangered, then a report becomes mandatory. (Mental health professionals are not mandated reporters of domestic violence, and in fact, may be liable for violating a client's right to confidentiality if a report is made.)

Case Example

Tina is a 33-year-old mother to 16-month-old Joey. She has been seeing Alice, an LCSW, for anxiety and low self-esteem related to her abusive relationship with her live-in-boyfriend Carl, who is also Joey's father. Carl had always been controlling of Tina,

but became physically and verbally abusive toward her when she was pregnant with Joey. During her pregnancy he got drunk frequently, and would rage at her, accuse her of getting pregnant with another man, sometimes push her, and also smash items in the house.

Tina reported several abusive episodes to Alice over the course of treatment, but stated that while Joey had heard some of the shouting, and sometimes became agitated and cried, he had never been directly involved. She stated that Joey was usually in his crib, asleep at night, when the abuse occurred. Alice did not report these incidences to CPS. Alice worked with Tina to develop a safety plan, and talked about the need to keep both herself and Joey safe.

During Tina's most recent therapy session, she reported an episode in which Carl threw a glass bottle at Tina while she was holding Joey, nearly hitting Joey in the head. Tina stated that this time Carl was really sorry because he didn't want to hurt Joey, and he promised he would never hurt either one of them again, so she was sure that Joey would be safe. Based on the escalating violence, the threat to Joey's physical safety, and the fact that Tina was unable to recognize the threat, Alice reported the incident to CPS.

Positive Toxicology Screen at the Time of Delivery of an Infant

Abusing substances during pregnancy causes serious complications for newborns and there is often confusion as to whether or not this is classified as child abuse. The effects of prenatal substance abuse are substantial and may include premature birth; infectious diseases, including HIV (human immunodeficiency virus) or AIDS; failure to thrive; fetal alcohol syndrome, SIDS (sudden infant death syndrome); central nervous system disorders, or intrauterine growth retardation. Babies of substance-abusing mothers may exhibit tremors, irritability, high-pitched crying, problems with sucking, diarrhea and

vomiting, seizures, disturbed sleep patterns, and rapid and unusual eye movements (Crosson-Tower, 2008).

Three criteria lead to the diagnosis of fetal alcohol syndrome; namely, an extremely small head, low birth weight, and growth retardation, either prenatally or postnatally. As the affected children grow they may exhibit facial abnormalities, developmental delays, intellectual impairment, and neurological problems. In addition, these children tend to be hyperactive, uncoordinated, and impulsive. They may have difficulty remembering, learning, solving problems, and understanding cause and effect (Crosson-Tower, 2008).

When a mother has HIV or AIDS, the virus can be transmitted to the child prenatally or at delivery or through breast milk. “The prognosis for these infants is poor” (Crosson-Tower, 2008, p. 91).

A positive toxicology screen of a newborn does not automatically call for a mandated report. However, any indication of substance abuse on the part of the mother “shall lead to an assessment of the needs of the mother and child” by a health practitioner or medical social worker. If other factors exist that indicate a risk to the child, a report must be made. However, in this case a report should only be made to a county welfare or probation department, and not to law enforcement. (See Penal Code Section 11165.13 and Health and Safety Code Section 123605)

Underreporting of Suspected Abuse: A Significant Concern

Even though marriage and family therapists and social workers are required by law to report reasonable suspicion of child abuse, many times they choose not to do so. Indeed, underreporting is considered to be a serious problem. Factors that contribute to this reticence to report include lack of sufficient evidence; a perception of negative consequences for the family, child, or therapist; negative previous experiences with staff at Child Protective Services; and fear for loss of the therapeutic alliance (Jankowski & Martin, 2003).

In fact, the impact on the therapeutic relationship is the top reason that professionals may not report child abuse. Research by Steinberg, Levine, and Doueck (as cited in Jankowski & Martin, 2003) indicates that 27% of clinicians believed that the filing of a report of child abuse resulted in clients terminating therapy. Conversely, a strong therapeutic alliance mediates against the client prematurely ending therapy, with as much as 76% of clinicians responding that reporting of child abuse did not negatively impact the alliance. In some cases, this action strengthened the therapeutic relationship (Jankowski & Martin, 2003). While a child abuse report does affect the therapeutic alliance, according to Strozier et al.,

> Studies examining the outcome of treatment after reports are made find that most clients are unaffected, or affected positively. However, one-fourth of reported cases have a negative outcome … a stronger therapeutic alliance, longer time in treatment, and more explicit consent procedures improve outcome. (2005, p. 178-179)

Despite concerns regarding the impact of child abuse reporting on the therapeutic alliance, the number of reports made has steadily increased. Child abuse reports in this nation rose by 158% from the 1970s to the ‘80s, and by an additional 19% of 1.7 million in 1986 to 2.4 million in 1990 (Barrett-Kruse, Martinez, & Carll, 1998). As of 2003, that figure has grown to nearly 3 million (California Attorney General’s Office, 2006).

There is an ethical obligation for the therapist to inform parents and children of the intention to file a report with CPS. The prime determinant in the matter is if such informing could lead to negative consequences for children by their parents, if the parents are suspected as the abusers. According to Kalichman,

> Reactions of parents and children who are informed of an impending report of suspected child abuse are primarily determined by the context within which the information is delivered. Expressing concern and a willingness to get involved by reporting focuses attention on protecting the child and can even increase trust in professional relationships. (1999, p. 196)

Mandated reporters who do not report suspected child abuse not only continue to keep a child in danger, but face serious legal consequences. This is taken directly from the Penal Code 11666:

11166.01. (a) Except as provided in subdivision (b), any supervisor or administrator who violates paragraph (1) of subdivision (i) of Section 11166 shall be punished by not more than six months in a county jail, by a fine of not more than one thousand dollars ($1,000), or by both that fine and imprisonment.
(b) Notwithstanding Section 11162 or subdivision (c) of Section 11166, any mandated reporter who willfully fails to report abuse or neglect, or any person who impedes or inhibits a report of abuse or neglect, in violation of this article, where that abuse or neglect results in death or great bodily injury, shall be punished by not more than one year in a county jail, by a fine of not more than five thousand dollars ($5,000), or by both that fine and imprisonment.

Research shows that several obstacles influence a mandated reporter's decision-making process. One concern is a fear that the abusive parent will retaliate. Other obstacles include not wanting to deal with irate parents or the legal ramifications, such as preparing for court testimony. When a mandated reporter has had a negative experience or has had difficulty communicating with CPS, that individual is less likely to file a report of suspected child abuse (VanBergeijk, 2007; Strozier, Brown, Fennell, Hardee, & Vogel, 2005). Another barrier to reporting is concern about secondary harm by the perpetrator to the child (Chien, 2008).

Failure to report when a reasonable suspicion exists is considered a misdemeanor that carries with it the consequences of a fine or jail term. Professionals who do not act on a reasonable suspicion could also face action from licensing boards (Kalichman, 1999).

CONFIDENTIALITY, MANDATED REPORTING, AND THE THERAPEUTIC ALLIANCE

While a report of suspected child abuse is held in confidentiality, except among various state departments and agencies that may be involved in investigating a case, it is important that a mandated reporter consider the significance of breaching confidentiality with the client when such a report is necessary. The purpose of mandatory reporting law is to, first, eliminate maltreatment; second, to improve the family environment to increase safety of the child; and, third, to provide necessary mental health services for the family in order to assure the child's safety. According to Kalichman,

> The report itself can serve as a catalyst for therapeutic gains by sending a message of protection to a child—showing that adults can protect children by taking actions on their behalf. Reporting can also warn adults that their

> behavior is neither ignored nor condoned. By filing a report of suspected abuse, it is also possible to motivate searches for help, as well as behavior changes in abusive adults. A report of suspected child abuse could open access to social services and place external constraints and contingencies on abusive behavior. (1999, p. 99)

In passing legislation that enacts mandatory reporting of suspected child abuse, lawmakers place greater value on protecting children than on preserving therapeutic confidentiality. While clients may assume that their disclosures in therapy will remain confidential, it is necessary for the therapist to notify clients as part of informed consent of his or her role as a mandated reporter. Studies examining how reporting suspected child abuse affects the therapeutic relationship show that it typically does not destroy the alliance. Indeed, when the client has been informed about mandated reporting beforehand, this helps if a report becomes necessary later (Steinberg, Levine, & Doueck, 1997).

A better outcome follows the making of a child abuse report when a strong therapeutic alliance has been in place. When it is necessary to file such a report, the therapist will more likely be able to repair the relationship with the client. In fact, according to Steinberg et al.,

> The more explicit the therapist was with the client, the more positive was the client's emotional response…. Therapists should provide their clients with sufficient information regarding mandatory reporting, and should do so early enough in the relationship to allow clients to make informed

decisions about whether or not to participate in treatment. (1997, p. 119)

While it is of great concern to the therapist to breach client confidentiality when reporting suspected child abuse, this obstacle is mitigated when the therapist includes a clearly communicated process of informed consent that reviews the limits of confidentiality. Then, the client is more apt to conclude that such a breach in confidentiality is consistent with the therapist's responsibilities. It is also helpful to openly discuss the reporting process with parents and their children. According to Kalichman,

> The after-effects of breached confidentiality are minimized when explanations are tied to previously discussed limits of confidentiality that make clear how the present circumstances fall within these constraints…. Informing families why the report is necessary and what they can expect from an investigation and assuring them that they will receive the reporter's support throughout the investigation can help maintain trust and bring reporting into the context of a therapeutic relationship…. Reporting can send a message of care, concern, and support to families. (1999, p. 91-92)

While the penal code grants immunity to the mandated reporter, it does not protect against malpractice action. A mental health provider who files a report of suspected child abuse may face a lawsuit for slander, for inappropriate breach of confidentiality, for failure to comply with the legally required elements, or for lack of "reasonable" suspicion. If a malpractice action ensues as a result of reporting

child abuse, the law does provide a refund of up to $50,000 for legal fees. To receive the fund, the case must be found in favor of the therapist and the case dismissed. For “absolute” immunity to be granted, the MFT’s attorney must show the court that all legal requirements were completed. (Grosso, 2009, p. 195)

Potential Impact to the Child Following a Report

When children disclose information that leads to a report of abuse and/or neglect, they often feel guilty for talking about this to a helping professional. In many cases, children will go out of their way to protect the abuser, who is frequently a parent or relative. Mandated reporters need to assure children that the abuse is not their fault and that they are not in trouble because the abuse is being reported.

The purpose of reporting abuse is to ensure that the child does not receive further harm. Children feel especially vulnerable after they report abuse and need to feel that they are supported. Children may worry about how they have answered questions related to the abuse. It is extremely important that children realize that there is not a right or a wrong answer. The clinician needs to emphasize the importance of being truthful, while not pressuring the child for information. Additionally, the clinician should avoid leading or closed questions as much as possible, and remember that the clinician’s role is not to investigate abuse, but rather to address the needs of the child within the context of the therapeutic relationship.

A child who is removed from an abusive home is still under significant stress, even if the abuse has stopped. The clinician will need to address many potential issues including, but by no means limited to:

- adjustment to possible foster care placement
- potential change of school
- anger of other family members towards the child
- loss of connection to family members if child is removed from the home
- loss of connection to community (i.e. school, neighbors, church, etc.)
- feelings of tremendous guilt over perceived disloyalty to the family
- potentially abrupt and/or premature termination of therapy due to a geographical move of the child

Even if a child is not removed from the home, the impact of a report is not to be underestimated. The aftermath of a report is a critical moment in the therapeutic relationship, and the clinician must be sensitive and responsive to the singular needs of the child and family at this vulnerable time. Clinicians who work in the field of child abuse often experience the weight of their clients' needs and vulnerabilities acutely, especially in the case of children. These clinicians need to be especially careful of maintaining their own boundaries and self care, in order to avoid harmful countertransference and burnout.

Benefits of Reporting Suspected Child Abuse

The obvious benefit of reporting suspected abuse is the possible cessation of the abuse, at least in each reported incident. According to Kalichman,

> The prospect of stopping abuse is thus a strong motivation for professionals to report…. Reporting abuse can also cause families to face the abusive situation in therapy and work toward a resolution of family conflicts…. Professionals may be conceived as caring and willing to risk getting involved…(and) children can feel protected by professional involvement. (1999, p. 68)

Mandated reporters are obligated by law to make a report if child abuse is suspected. Although the clinical issues are myriad and complex, the imperative to protect children is clear. Ethical clinicians will continually stay updated as to the legal and ethical duties concerning mandated reporting of child abuse, seek legal consultation through a professional association, consult with knowledgeable colleagues, or contact CPS to ask confidential questions regarding the suspected abuse.

Internet resources:

www.stopitnow.com

www.protectkids.com

www.sandf.org

www.helpguide.org

www.nlm.nih.gov/medlineplus/childsexualabuse.html

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