Prevention Handbook

...and intervention guide

Crime and Violence Prevention Center
California Attorney General’s Office

January 1982
revised August 1992 and January 2000
This Handbook provides current information about the subject of child abuse and neglect reporting laws to assist mandated reporters and others in determining their reporting responsibilities. It is not intended to be and should not be considered legal advice. In the event there are questions about reporting responsibilities in a specific case, the advice of legal counsel should be sought.

All revisions to the law in this edition reflect changes through January 2000.
In 1999, the California Department of Social Services estimated that more than 540,577 incidents of child abuse and neglect were reported in our state. Nationally, it is estimated that three children die each day as a result of child abuse and neglect.

New research suggest that a child’s exposure to violence has potentially long term impacts on their emotional and physical well-being. Children’s exposure to violence and maltreatment is significantly associated with increased depression, posttraumatic stress, anger, greater alcohol and drug abuse and lower academic achievement. Studies show that children exposed to violence, either as witnesses or victims, are more likely to become juvenile and adult offenders.

The death or suffering of even one child due to abuse or neglect is a tragedy. Justice and compassion demand that we take action to combat this problem.

Fortunately, California has moved forward aggressively to protect children from abuse. Many communities across the state are becoming more involved in supporting children and families and making child abuse prevention a priority. They have set aside time in their places of worship, schools, local government agencies and in corporate settings to increase awareness of the community’s role in keeping all children safe from abuse. In the long run, strengthening families and communities through prevention efforts will reduce the incidents of child abuse and neglect.

The Department of Justice has consistently taken a proactive role in child abuse prevention. The department developed the Megan’s Law CD-Rom which provides the public with photographs and descriptive information on serious and high-risk sex offenders residing in California. The Child Molester Identification Line is another way to help parents protect their children. The department-administered State Child Death Review Council supports county child death review teams in their efforts to prevent fatal child abuse and neglect. Videos and other materials we produce assist children who witness domestic violence or who are themselves, victims of abuse.

The purpose of the Child Abuse Prevention Handbook is to serve as a practical aid for those who work with children, who are in the field of child abuse prevention and who are mandated to report under the California Child Abuse and Neglect Reporting Act. The handbook provides an overview of the laws, practices and procedures for the prevention, detection, reporting, treatment, investigation and prosecution of child abuse and neglect. It is designed to assist educators, health practitioners, law enforcement officers, child care providers, social workers, religious and youth group workers, probation officers and the general public in understanding their respective duties and responsibilities under state law. It has been updated to reflect the most current changes in the law. As in the past, we hope that you find this handbook useful.

We all bear a responsibility to protect our children, keep them safe and give them a chance to lead happy, fulfilling lives. Together, we can create a California where every child is treated with compassion and dignity.

BILL LOCKYER
Attorney General
“Each of us, whether we have anything to do with children or not, is directly affected by how they are treated.”

— Anonymous
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What is Child Abuse?

To many, child abuse is narrowly defined as having only physical implications. In reality, child abuse includes:

- Physical abuse; unlawful corporal punishment or injury.
- General and severe neglect.
- Sexual abuse; sexual assault; exploitation.
- Willful cruelty or unjustifiable punishment; emotional maltreatment.

Child abuse may involve multiple categories. They include both acts and omissions. Competent interventions must consider evaluating multiple categories of abuse.

The act of inflicting injury or the failure to act so that injury results, rather than the degree of injury, is the basis for making the decision to intervene. A parent or caretaker may begin by inflicting minor injuries, then may increasingly cause more serious harm over a period of time. Therefore, detecting the initial small injuries and intervening with preventive action may save a child from future permanent injury or death.

Physical injuries and severe neglect and malnutrition are more readily detectable than the subtle and less visible injuries that result from emotional maltreatment or sexual abuse. However, all categories of
abuse endanger or impair a child’s physical or emotional health and development and demand attention.

Certain persons, commonly referred to as mandated reporters, are required by law (see Appendix II) to report any known or suspected instance of child abuse. Indicators for suspected child abuse are presented in this publication to assist mandated reporters in meeting their responsibilities under the Child Abuse and Neglect Reporting Act. (See Appendix II for a list of mandated reporters.)

One of the most important indicators for suspecting child abuse is when a child tells someone that he or she has been abused. When a child tells a particular person who is an individual required to report child abuse, the communication is not privileged. That individual, by law, must report what the child has related to him or her. An exception is when the information is relayed during “penitential communication.” A clergy member who acquires knowledge or reasonable suspicion of child abuse during penitential communication is not required to report abuse or neglect. Penitential communication is the communication, intended to be in confidence, including but not limited to, a sacramental confession, made to a clergy member who, in the course of the discipline or practice of his or her church, denomination, or organization, is authorized or accustomed to hear those communications, and under the discipline, tenets, customs, or practices of his or her church, denomination, or organization, has a duty to keep those communications secret. (Pen. Code, § 11166 subd. (c) (2)). Mandated reporters who report suspected child abuse cases have absolute immunity, both civilly and criminally, for making reports. (See “Liability for Failing to Report” page 34.)

The Extent of the Problem

In 1997, the National Committee to Prevent Child Abuse and Neglect released a report indicating that more than 3 million American children are suffering from abuse and neglect. Overall, the number of reported cases of child abuse and neglect have increased 41 percent since 1988. Experts attribute much of the increase to greater public awareness and willingness to report, as well as to changes in how states collect reports of child abuse and neglect. Regardless, the number of substantiated cases has increased at a rate as disturbing as the increase in the number of reported cases. Further, there are reasons to believe that even these figures are just a fraction of the actual incidence of child abuse and neglect. Surveys consistently show that large proportions of cases of suspected child maltreatment remain unreported.

2 National Child Abuse and Neglect Data Systems (NCANDS) Fact Sheet, 1998. NCANDS is funded by the National Center on Child Abuse and Neglect at the Administration of Children, Youth, and Families at the U.S. Department of Health and Human Services.
The probability that child abuse and neglect is a leading cause of childhood deaths seems to be generally accepted. The National Child Abuse and Neglect Data Systems (NCANDS) reported that in 1997 there were an estimated 1,196 child fatalities related to child abuse and neglect. During a five-year period from 1990 to 1994, public child protective services reported that 5,400 children died as a result of child abuse or neglect. In its 1995 report on fatal child abuse, the U.S. Advisory Board on Child Abuse and Neglect reported that a more realistic estimate is about 2,000 annual deaths. Research supports that very young children are the most frequent victims of child fatalities. NCANDS data for 1997 from a subset of states demonstrated that children 3 or younger accounted for 77 percent of fatalities.

Determination of the actual number of child deaths is complicated by official statistics identifying causes of death from abuse and neglect mainly in medical terms (per “International Classification of Diseases” listings). For instance, a child whose death is officially recorded as pneumonia may, in fact, have contracted the illness as a result of being poorly clothed, fed, bedded, or medically neglected. Thus, many child abuse experts feel that abuse or neglect may well be the underlying cause in many cases where the cause is medically described.

Although young children are more “at risk” of abuse than adolescents, the problem of adolescent abuse is often underestimated. Unfortunately, child protective services may discount adolescents because they are considered to be less “at risk” than younger children, and because adolescents are seen as having more options than younger children. Because it is believed that adolescents are able to leave the house until the parent/caretaker “calms down,” they can fight back or, in some cases, take the abuse with only temporary discomfort, they are not considered as helpless as younger children. However, many child prostitutes and youngsters involved in alcohol and drug abuse are victims of physical or sexual abuse and neglect at home. Thus, adolescents may have more options than younger children, but they are not necessarily positive options. Adolescent abuse remains a serious problem that deserves attention and action.

The gathering of accurate information and statistics is recognized as a problem at most levels of government. Efforts have been made to develop systems that will reflect more accurately the scope and degree of child abuse and neglect. The number of suspected child abuse cases reported and investigated in California has steadily risen over the years as a result of the Child Abuse and Neglect Reporting Act and the increased attention paid to the problem by professionals and the public.

In 1999, the California Department of Social Services received 540,577 reports of child abuse incidents. Of these, 26.0 percent were for physical abuse, 40.0

3 Ibid.
percent for general neglect, 13.5 percent for sexual abuse, 8.0 percent for caretaker absence, 3.1 percent for severe neglect, 9.1 percent for emotional abuse, and .3 percent for exploitation. (See charts on page 5.)

The Department of Justice maintains a Child Abuse Central Index which contains data from child abuse investigations submitted by child protective agencies. Between 1994 and 1998, 236,213 child abuse investigation reports were received by the Department of Justice. Of these, 55 percent involved physical abuse, 4 percent severe neglect, 10 percent emotional maltreatment, and 31 percent sexual abuse. (For further information on the Child Abuse Central Index, see page 37.)

Physical Abuse
Physical abuse is any non-accidental act that results in physical injury. Inflicted physical injury most often represents unreasonably severe corporal punishment or unjustifiable punishment. This usually happens when a person is frustrated or angry and strikes, shakes, or throws the child. Intentional, deliberate assault, such as burning, biting, cutting, poking, twisting limbs, or otherwise torturing a child, is also included in this category of child abuse.

Indicators of Physical Abuse
These indicators are used to distinguish accidental injuries from cases of suspected physical abuse:

Location of Injury
The primary area for infliction of injuries is the back surface of the body from the neck to the knees. These injuries constitute the largest percentage of identified abuse. Injuries from abuse are not typically located on the shins, elbows, knees, or on the forehead.

History
The history includes all facts about the child and the injury, including:

- Statements by the child that the injury was caused by abuse.
- Knowledge that a child’s injury is unusual for a specific age group (any fracture in an infant).
- Unexplained injuries (parent, care-taker, or child is unable to explain reason for injury; there are discrepancies in explanation; blame is placed on a third party; explanations are inconsistent with medical diagnosis).
- Parent or caretaker delays seeking care for a child or fails to seek appropriate care.
Reported Child Abuse Incidents in California
1986 - 1999

1999 Child Abuse Incidents by Types of Abuse
(Total Incidents Reported 540,577)

Sexual Abuse
73,153 (13.5%)

Caretaker Absence/Incapacity
43,259 (8.0%)

Exploitation
1,415 (.3%)

Severe Neglect
16,884 (3.1%)

Emotional Abuse
49,581 (9.1%)

General Neglect
216,139 (40.0%)

Source: California Department of Social Services, Statistical Services Branch
* The caseload fall from 1996 to 1999 may be due to transitional issues relating to the implementation of the Child Welfare Services/Case Management System (CWS/CMS)
**Behavioral Indicators**

The following behaviors may result from child abuse, although none is a definitive sign of abuse:

- Child is excessively passive, overly compliant, apathetic, withdrawn, or fearful; or at the other extreme, excessively aggressive, destructive, or physically violent.
- Child and/or parent or caretaker attempts to hide injuries; child wears excessive layers of clothing, especially in hot weather; child is frequently absent from school or physical education classes.
- Child is frightened of parents/caretakers, or, at the other extreme, is overprotective of parents/caretakers.
- Child is frightened of going home.
- Child is clingy and forms indiscriminate attachments.
- Child is apprehensive when other children cry.
- Child is wary of physical contact with adults.
- Child exhibits drastic behavioral changes in and out of parental/caretaker presence.
- Child is hypervigilant.
- Child suffers from seizures or vomiting.
- Adolescent exhibits depression, self-mutilation, suicide attempts, substance abuse, or sleep and eating disorders.

**Types Of Injuries**

**Damage To Skin and Surface Tissue**

**Bruises**

Bruises, also referred to as contusions, resulting from abuse are found on multiple surfaces of the body, particularly the buttocks, back, genitals, and face. They may appear in a characteristic pattern (outline of hand, paired bruises from pinching), or they may clearly resemble an impression of an item of jewelry (a ring), or a disciplinary imprint (a paddle, switch, or coat hanger). Linear bruise marks, strap marks, or loop marks going around a curved body surface are almost always evidence of abuse.

Multiple bruises may all be of the same color, or of different colors if the injuries were sustained at different times. Red, red-blue, violaceous, black-purple, green tint, pale green or yellow bruises, or bruises with crisp or fading margins reflect various stages of healing. When bruises reflect differences in coloration, it is useful to take color photographs of the bruises for investigation of suspected child abuse. Professionals identifying bruises should note their color, shape and size. If photographic documentation is done, it should be done with a 35mm camera using a measurement and color bar.

In cases where bruises are suspected bite marks, investigators should also be prepared to seek the expertise of forensic odontologists.
Blows from a heavy object (a baseball bat or fist) on soft tissue result in deep muscular bruises or hemorrhage. These are rarely discolored and, in time, may be seen on x-rays.

**Abrasions, Lacerations**
As with bruising, the multiplicity and location of the wounds should be considered. For example, lacerations under the tongue or those of a torn frenulum (the small piece of tissue connecting the gum to the lip) could be caused by falling with an object in the mouth or by the use of excessive force during feeding. Both are suspicious injuries when the victim is an infant who is still unable to stand.

Whipping a child with a belt buckle or belts or cords that are looped may cause lacerations resembling a “C” or “U” shape or other wounds with distinctive shapes.

**Bite Marks**
Bite marks may be found on any part of a child’s body. They may appear to be doughnut-shaped, double horseshoe-shaped, or oval in configuration. Individual teeth or a blurry area with varying colorations may be observed, depending on the age of the bite mark lesion. Time is of the essence in recording bite marks through photography and/or video taping because some lesions will become less distinct with time.

Photography, employing non-distorting cameras, with rulers or scales adjacent to the lesion, should be accomplished by forensic dentists, skilled evidence technicians, or other experienced individuals. Salivary swabbings should be collected, because they may be used to determine the blood type of the biter. In penetrating bite marks, services of the individuals listed above should also be obtained in order to secure accurate impressions of the bitten area.

If properly collected and analyzed by experienced forensic dentists, bite mark evidence can point to the guilt or innocence of a perpetrator suspected of involvement in the physical or sexual abuse of a child.

**Burns**
The location of a burn and its characteristics (shape, depth, margins, etc.) may indicate abuse. It is important to keep in mind that children instinctively withdraw from pain. Burns, without some evidence of withdrawal, are highly suspect because a child will usually try to escape—which will result in splashes, uneven burns and sometimes burns on the hands.

Scalding a child with hot liquid is the most common abuse burn. Young infants commonly are scalded by immersion, and older children by having liquids thrown or poured on them.

When children are forcibly held in hot water, there are often sharply demarcated burns. If held in water in a “jackknife” position, only the buttocks and genitalia may be burned. If held down forcibly in a sitting position, the center part of the
buttocks (if pressed tightly against the tub) is spared from burning, thus resulting in a “doughnut-shaped” burn. If the extremities are forcibly immersed in hot water, “glove” or “sock” burns to the hands or feet may result. The burns are often symmetric and an immersion line is readily evident.

“Zebra” burns also indicate abuse. Such burns result when a child is held by his or her hands and legs under a running hot faucet. The tissue on the child’s abdomen and upper legs fold up, preventing burning in the creases. The resulting “zebra stripes” from scalding of exposed tissue are clearly evident.

Abuse may also be suspected when burns are pointed or deeper in the middle. This indicates that hot liquid was poured on, or a hot object (poker, utensil) pressed into the skin.

Another type of burn characteristic of abuse has the shape of a recognizable object evenly burned into the victim’s skin. These burns indicate forced contact or “branding” with, for example, the grill of an electric heater, the element of an electric stove, or an iron.

Cigarette burns are difficult to diagnose, but when inflicted they are often multiple and are usually found on the palms or soles. There is a searing effect, perhaps with charring around the wound.

Rope “burns” appear around wrists or ankles when children are tied to beds or other structures.

**Damage To Brain**

**Head Injuries**

Head injuries are the most common cause of child abuse related deaths and an important cause of chronic neurological disabilities.

Whenever abuse or neglect is suspected, a careful examination of the child’s eyes and nervous system should be performed to look for signs of intracranial injury. For certain groups of suspected victims, a full skeletal trauma series may be necessary as well as a toxicology. Serious intracranial injury can occur without visible evidence of trauma on the face or scalp. Children with any soft tissue injury to the head should be neurologically assessed and have an ophthalmological evaluation to look for retinal hemorrhages. These injuries may cause brain damage or death if undetected and untreated.

When a child is in an unconscious or in an unresponsive state and there is no external evidence of injury and no adequate explanation for the child’s state, head injury from possible abuse should be considered. The caretaker’s explanation for a fall should be carefully documented as to who was present, the distance of the fall, the type of surface hit, and time of the injury.
The medical evaluation is critical but should not stand alone. A complete evaluation, even with severe injury, includes a psychosocial evaluation of the family, caretakers and home. In general, these evaluations should be considered in all cases where child abuse is suspected.

**Shaken Baby Syndrome**

Shaken Baby Syndrome is a term used to describe the constellation of signs and symptoms resulting from violent shaking or shaking and impacting of the head of an infant. The degree of brain damage depends on the amount and duration of the shaking and the forces involved in the impact of the head. Signs and symptoms range on a spectrum of neurological alterations from minor (irritability, lethargy, tremors, vomiting) to major (seizures, coma, stupor, death). These neurological changes are due to destruction of the brain cells secondary to trauma, lack of oxygen to the brain cells, and swelling of the brain. Extensive retinal hemorrhages in one or both eyes are found in the vast majority of these cases. The classic triad of subdural hematoma, brain swelling, and retinal hemorrhages are accompanied in some, but not all, cases by bruising of the part of the body used as a “handle” for shaking. Fractures of the long bones and/or of the ribs may also be seen in some cases. In many cases, however, there is no external evidence of trauma either to the head or the body.

Approximately 20 percent of cases are fatal in the first few days after injury. Survivors suffer from handicaps ranging from mild—learning disorders, behavioral changes—to moderate and severe, such as profound mental and developmental retardation, paralyses, blindness, inability to hear, or a permanent vegetative state.

A careful post-mortem examination is required of all infant deaths in California. These examinations should always include evaluation for signs of intracranial bleeding, retinal hemorrhages, and points of impact on or within the body. Evaluations of potentially suspicious cases also should include forensic lab study by protocol, including toxicology, microscopic tissue examination (including the retina), and a full trauma x-ray series.

**Damage To Other Internal Organs**

**Internal Injuries**

Blunt blows to the body can cause serious internal injuries to the liver, spleen, pancreas, kidneys, and other vital organs and occasionally can cause shock and result in death. Internal injuries are a leading cause of death for victims of child abuse.

Detectable surface evidence of such trauma is present only about half the time. Physical indicators of serious internal injuries may include distension of the abdomen, blood in the urine, vomiting, and abdominal pain.
Damage To Skeleton
Fractures
Any unexplained fracture in an infant or toddler is cause for additional inquiry or investigation. “Spiral” fractures of the long bones (which result from twisting forces) are almost always caused by abuse when they occur before a child begins walking. Rib fractures, especially of back ribs, are the most common fractures found in abused children and are caused from either blunt force (hit) or compression (squeezed).

Fractures are most suspicious for inflicted trauma when there are multiple lesions, they are in different stages of healing, and there are unsuspected lesions. Other fractures that raise suspicion are: “chip” fractures at the end of long bones, which may be fractures from excess traction, jerking, and twisting injuries; multiple rib fractures, especially back rib fractures; and healing or healed fractures without an explanation revealed by x-rays. For young victims, x-ray bone surveys are important tools used to diagnose suspected physical abuse. Radio isotope bone scans may pick up healing fractures, subperiosteal hematomas, etc. A pediatric radiologist should be consulted on all suspicious cases.

Physical Neglect
Neglect is the negligent treatment or maltreatment of a child by a parent or caretaker under circumstances indicating harm or threatened harm to the child’s health or welfare. The term includes both acts and omissions on the part of the responsible person. The California Child Abuse and Neglect Reporting Act defines two categories of physical neglect—severe neglect and general neglect.

Severe neglect means the negligent failure of a parent or caretaker to protect the child from severe malnutrition or medically diagnosed nonorganic failure to thrive. It also means those situations of neglect where the parent or caretaker willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered. This includes the intentional failure to provide adequate food, clothing, shelter, or medical care.

General neglect means the negligent failure of a parent or caretaker to provide adequate food, clothing, shelter, medical care, or supervision where no physical injury to the child has occurred.

An example of inadequate supervision is when parents leave their children unsupervised during the hours when the children are out of school. These parents are often unable to arrange child care services to meet their needs. Although these parents may not regard themselves as child abusers, leaving young children without supervision constitutes general neglect. Children left in these circumstances may also be particularly vulnerable to accidents, injuries, or crime.
Indicators of Neglect

Neglect may be suspected if any of the following conditions exist:

- The child is lacking adequate medical or dental care.
- The child is often sleepy or hungry.
- The child is often dirty, demonstrates poor personal hygiene, or is inadequately dressed for weather conditions.
- The child is depressed, withdrawn or apathetic, exhibits antisocial or destructive behavior, shows exaggerated fearfulness; or suffers from substance abuse, or speech, eating, or habit disorders (biting, rocking, whining).
- There is evidence of poor supervision (repeated falls down stairs; repeated ingestions of harmful substances; a child cared for by another child); the child is left alone in the home, or unsupervised under any circumstances (left in car, street).
- The conditions in the home are unsanitary (garbage, animal, or human excrement); the home lacks heating or plumbing; there are fire hazards or other unsafe home conditions; the sleeping arrangements are cold, dirty, or otherwise inadequate.
- The nutritional quality of food in the home is poor; meals are not prepared; refrigerator or cupboards contain spoiled food.

While some of these conditions may exist in any home environment, it is the extreme or persistent presence of these factors that indicate some degree of neglect. Disarray and an untidy home do not necessarily mean the home is unfit. Extreme conditions resulting in an “unfit home” constitute neglect that may justify protective custody and dependency proceedings under Welfare and Institutions Code section 300 (see Appendix III), as well as criminal neglect charges. (See Appendix IV.)

Psychosocial Failure to Thrive

Infants or young children who are much smaller than would be expected at a particular age can present a difficult diagnostic problem for physicians. After excluding those infants who are small because they were small at birth, there remains a large group of infants with low weights and perhaps short lengths and small head circumferences. Some of these children are small because of a failure to meet their nutritional needs and/or failure to meet their emotional needs. These children may also demonstrate delayed development and abnormal behavior. Some of the small children, however, do have hidden medical problems. Hospitalization may be required to screen for significant medical illness and, more important, to see if the child responds to adequate nutrition and a nurturing environment with a rapid weight gain and more appropriate behavior. Evaluation consists of more than weighing and measuring the baby. The behaviors of the child and the parent should be observed, ideally during feeding, and the action and interaction of the child and adult should be observed by an experienced professional.
If left untreated, the physical and/or emotional health of the child may be endangered, and emotional disorders, school problems, retardation, and other problems may result.

**Emotional Maltreatment**

**Emotional Abuse**

Just as physical injuries can scar and incapacitate a child, emotional maltreatment can cripple and handicap a child emotionally, behaviorally and intellectually. Self-esteem can be damaged. Severe psychological disorders have been traced to excessively distorted parental attitudes and actions. Emotional and behavioral problems may be present, in varying degrees, following chronic and severe emotional abuse, especially when there is little or no nurturing.

This is especially true for neonates, infants and toddlers. These children may become chronically withdrawn and anxious and lose basic social and language skills necessary for intimate relationships. They may become developmentally delayed, socially limited, and, in some cases, antisocial or chronically unable to protect themselves from others.

Verbal assault (belittling, screaming, threats, blaming, sarcasm), unpredictable responses, continual negative moods, constant family discord, and double-message communication are examples of ways parents may subject their children to emotional abuse.

**Behavioral Indicators of Children**

Emotional abuse **may** be suspected if the child:

- Is withdrawn, depressed and apathetic.
- Is clingy and forms indiscriminate attachments.
- “Acts out” and is considered a behavior problem.
- Exhibits exaggerated fearfulness.
- Is overly rigid in conforming to instructions of teachers, doctors, and other adults.
- Suffers from sleep, speech, or eating disorders.
- Displays other signs of emotional turmoil (repetitive, rhythmic movements; rocking, whining, picking at scabs).
- Suffers from enuresis (bed wetting) and fecal soiling.
- Pays inordinate attention to details, or exhibits little or no verbal or physical communication with others.
- Unwittingly makes comments such as, “Mommy/Daddy always tells me I’m bad.”
- Experiences substance abuse problems.

The behavior patterns mentioned may, of course, be due to other causes, but the suspicion of abuse should not be dismissed.
Behavioral Indicators of Parents/Caretakers

A child may become emotionally distressed when:

- Parents or caretakers place demands on the child that are based on unreasonable or impossible expectations or without consideration of the child’s developmental capacity.
- The child is used as a “battle-ground” for marital conflicts.
- The child is used to satisfy the parent’s/caretaker’s own ego needs and the child is neither old enough nor mature enough to understand.
- The child victim is “objectified” by the perpetrator—the child is referred to as “it” (“it” cried, “it” died).
- The child is a witness to domestic violence.

Emotional abuse can be seen as proving a self-fulfilling prophecy. If a child is degraded enough, the child will begin to live up to the image communicated by the abusing parent or caretaker.

Emotional abuse cases can be extremely difficult to prove, and cumulative documentation by witnesses is imperative. Such cases should be referred to treatment as soon as possible.

Suspected cases of emotional abuse that constitute willful cruelty or unjustifiable punishment of a child are required to be reported by mandated reporters. This means a report must be made of any situation where any person willfully causes or permits any child to suffer, or inflicts on any child, unjustifiable mental suffering. (Pen. Code, § 11165.3.) However, mandated reporters may also report any degree of mental suffering. While these cases may not always be prosecuted, reporting provides the opportunity for intervention and/or therapy with the family.

Emotional Deprivation

Emotional deprivation has been defined as “. . . the deprivation suffered by children when their parents do not provide the normal experiences producing feelings of being loved, wanted, secure, and worthy.”

Behavioral Indicators of Emotional Deprivation

Emotional deprivation may be suspected if the child:

- Refuses to eat adequate amounts of food and is therefore very frail.
- Is unable to perform normal learned functions for a given age (walking, talking); exhibits developmental delays, particularly with verbal and nonverbal social skills.
- Displays antisocial behavior (aggression, disruption) or obvious “delinquent” behavior (drug abuse, vandalism); conversely, is abnormally unresponsive, sad, or withdrawn.
- Constantly “seeks out” and “pesters” other adults, such as teachers or neighbors, for attention and affection.
- Displays exaggerated fears.
When parents ignore their children, whether because of drug or alcohol use, psychiatric disturbances, personal problems, outside activities, or other preoccupying situations, serious consequences can occur. However, reporting these situations is not mandated unless they constitute a form of legally defined abuse or neglect.

**Sexual Abuse**

As defined in the Child Abuse and Neglect Reporting Act, sexual abuse is a sexual assault on, or the sexual exploitation of, a minor. Sexual abuse encompasses a broad spectrum of behavior, and it may consist of many acts over a long period of time (chronic molestation) or a single incident. It may progress from less intimate types of sexual activity to active body contact and later to some form of penetration. Victims range in age from younger than one year through adolescence. Specifically, sexual assault includes: rape, rape in concert, incest, sodomy, oral copulation, penetration of genital or anal opening by a foreign object, and child molestation. It also includes lewd or lascivious conduct with a child under the age of 14 years, which may apply to any lewd touching if done with the intent of arousing or gratifying the sexual desires of either the person involved or the child; lewd or lascivious conduct with a child 14 or 15 years of age by a person at least 10 years older than the child; and unlawful sexual intercourse with a minor under 16 years of age by a person over the age of 21 years. Sexual exploitation includes conduct or activities related to pornography depicting minors, and promoting prostitution by minors. (See Appendix IV for a detailed review of these crimes.)

The nature of sexual abuse, the guilt and shame of the child victim, and the possible involvement of parents, stepparents, friends, or other persons in a child caretaker role, make it extremely difficult for children to come forward to report sexual abuse. Yet, despite these problems, reports of sexual abuse made to child protective agencies continue to increase. This increase is usually attributed to the passage of the Child Abuse and Neglect Reporting Act and the public's increased concern for child victims.

Sometimes a child who does seek help is accused of making up stories, because many people cannot believe that the apparently well-adjusted person involved could be capable of sexual abuse. If the matter does come to the attention of authorities, the child may give in to pressure from parents or caretakers and deny that any sexual abuse has occurred. Even if protective attention is gained, the child may feel guilty about “turning in” the abuser or breaking up the family and, consequently, withdraw the complaint. This process leads many to be skeptical of a child's complaint of sexual abuse, and leaves him or her feeling helpless and guilty for causing so much trouble.

The sad reality of sexual abuse is that without third-party reporting, the child often remains trapped in secrecy by shame, fear, and the threats of the abuser.
Indicators of Sexual Abuse

Sexual abuse of a child may surface through a broad range of physical, behavioral and social symptoms. Some of these indicators, taken separately, may not be symptomatic of sexual abuse. They are listed below as a guide, and should be examined in the context of other behavior(s) or situational factors.4

History

• A child reports sexual activities to a friend, classmate, teacher, friend’s mother, or other trusted adult. The disclosure may be direct or indirect (“I know someone . . .”; “What would you do if . . . ?”; “I heard something about somebody.”) It is not uncommon for the disclosure by children experiencing chronic or acute sexual abuse to be delayed.
• Child wears torn, stained, or bloody underclothing.
• A child’s injury/disease (vaginal trauma, sexually transmitted disease) is unusual for the specific age group.
• Child has a history of previous or recurrent injuries/diseases.
• Unexplained injuries/diseases (parent/caretaker unable to explain reason for injury/disease); discrepancies in explanation; blame is placed on a third party; explanations are inconsistent with medical diagnosis.
• A young girl is pregnant or has a sexually transmitted disease. Pregnancy of a minor, regardless of her age, does not

in and of itself constitute the basis of reasonable suspicion of sexual abuse and should not be reported. (Pen. Code, § 11166, subd.(a).) However, other information such as statements by the minor, indication of coercion, or significant age disparity between the minors may lead to a reasonable suspicion of sexual abuse that must be reported.

Behavioral Indicators

Sexual Behaviors of Children

• Detailed and age-inappropriate understanding of sexual behavior (especially by younger children).
• Inappropriate, unusual, or aggressive sexual behavior with peers or toys.
• Compulsive indiscreet masturbation.
• Excessive curiosity about sexual matters or genitalia (self and others).
• Unusually seductive with classmates, teachers and other adults.
• Frightened of parents/caretaker or of going home.

Behavioral Indicators in Younger Children

• Enuresis (bed wetting).
• Fecal soiling.

4 For further information see the State Office of Criminal Justice Planning publication, State Medical Protocol for Examination, Treatment, and Collection of Evidence From Sexual Assault Victims, July 1987.
• Eating disturbances (overeating, undereating).
• Fears or phobias.
• Overly compulsive behavior.
• School problems or significant change in school performance (attitude and grades).
• Inability to make friends.
• Age-inappropriate behavior (pseudo-maturity or regressive behavior such as bed wetting or thumb sucking).
• Inability to concentrate.
• Drastic behavior changes in and out of parent’s/caretaker’s presence.
• Sleep disturbances (nightmares, fearful about falling asleep, fretful sleep pattern, or sleeping long hours).
• Speech disorders.
• Lack of trust.
• Wearing excessive clothing.

Behavioral Indicators in Older Children and Adolescents
• Withdrawal.
• Chronic fatigue.
• Clinical depression, apathy.
• Overly compliant behavior.
• Poor hygiene or excessive bathing.
• Poor peer relations and social skills, inability to make friends.
• Acting out, runaway, aggressive, antisocial, or delinquent behavior.
• Alcohol or drug abuse.
• Prostitution or excessive promiscuity.

• School problems, frequent absences, sudden drop in school performance.
• Refusal to dress for physical education.
• Nonparticipation in sports and social activities.
• Fearful of showers/restrooms.
• Fearful of home life, demonstrated by arriving at school early or leaving late.
• Suddenly fearful of other things (going outside, participating in familiar activities).
• Extraordinary fear of males (in cases of male perpetrator and female victim).
• Self-consciousness of body beyond that expected for age.
• Sudden acquisition of money, new clothes, or gifts with no reasonable explanation.
• Suicide attempt or other self-destructive behavior.
• Crying without provocation.
• Fire setting.

Physical Symptoms
• Sexually transmitted diseases.
• Genital discharge or infection.
• Physical trauma or irritations to the anal/genital area (pain, itching, swelling, bruising, bleeding, lacerations, abrasions, especially if unexplained or inconsistent).
• Pain upon urination/defecation.
• Difficulty in walking or sitting due to genital or anal pain.
• Psychosomatic symptoms (stomachaches, headaches).
**Incestuous/Intrafamilial Abuse**

Sexual abuse of children within the family is the most hidden form of child abuse. In spite of its taboo and the difficulty of detection, some researchers believe this abuse may be even more common than physical abuse.

Incest means sexual activity between certain close relatives (e.g., parents and children, siblings, grandparents and grandchildren); intrafamilial abuse means sexual activity between persons in a family setting (e.g., stepparents, boyfriends).

In most reported cases, the father or another man acting as the parent is the initiator. In some cases, the mother or another woman is the offending adult. Although girls are the most frequent victims, boys are also victims, much more often than previously believed. The embarrassment and shame deter girls and boys alike from reporting the abuse.

The initial sexual abuse may occur at any age, from infancy through adolescence. Sexual abuse may be followed by guilt-provoking demands for secrecy and/or threats of terrible harm or consequences if the secret is revealed. The child may then fear disgrace, hatred, or blame for breaking up the family if the secret is revealed.

**Regardless of how gentle or forceful or how trivial or coincidental the first approach may have been, sexual coercion tends to be repeated and to escalate over a period of years.** The child may eventually accept the blame for tempting and provoking the abuser.

The mother, who would usually be expected to protect the child, may purposely try to stay isolated from a problem of sexual abuse. Sometimes she is distant and uncommunicative, or so disapproving of sexual matters that the child is afraid to speak up. Sometimes she is extremely insecure and the potential loss of her husband or partner, and the economic security he provides, is so threatening that she cannot allow herself to believe or even to suspect that her child is or could be at risk. She may have been a victim herself of child abuse and may not trust her judgment or her right to challenge the male authority. Some mothers actually know their children are sexually abused, but for whatever reason, they “look the other way.”

Until the victim is old enough to realize that incest and intrafamilial abuse are not common occurrences, and/or the victim is strong enough to obtain help outside the family, there is no escape unless the abuse is reported.

**Extrafamilial Sexual Abuse**

Children who are abused by someone outside their family typically know their molester. They meet them at school, youth programs, churches, in their neighborhood, or at other recreational activities. People who molest children fall into all age categories, including pre-teens and the elderly.
Although there are several classifications of child molesters, a pedophile presents the greatest danger to children because a pedophile’s main sexual interest is a child. Pedophiles tend to be well-liked by children and may choose work in professions or volunteer organizations that allow them easy access to children and where they can develop the trust and respect of children and their parents. They sometimes believe sex with children is appropriate and even beneficial. Children may be lured into sexual relationships with love, rewards, promises, and gifts.

Most cases of extrafamilial sexual abuse involve a perpetrator known to the child. However, cases of abuse by strangers do occur. Typically, in these cases the stranger will entice the child (“Will you help me find my puppy?”), convince the child that his or her parent requested the stranger to pick up the child, or simply abduct the child.

**Exploitation/Child Pornography**

Although it is impossible to make an exact assessment of the number of children in California who have been the victims of pornographic exploitation, it is clear that by even the most conservative estimate, the number is alarmingly high.

The difficulty in assessing the number of children used in child pornography is compounded by a number of factors. Evidence indicates that in the vast majority of cases, sexual exploitation is often not discovered, even by the parents of the children. Additionally, the number of juvenile runaways, together with the problem of child prostitution, contribute to the difficulty in making this assessment. The runaway juvenile, alone and without support in a strange city, is a particularly attractive target for pornography or prostitution. Finally, some parents use their own children to produce pornographic material.

Pornographic material is sometimes used by child molesters to desensitize the children, to teach them how to perform sexual activities, or to encourage them to participate in sexual activities with other adults and children. Pictures or videos taken during child exploitation or abuse can include simple nudity, erotic poses, or graphic sexual activity. These pictures and videos have several purposes: they serve as a personal record for the pedophile, are used to blackmail the children into silence, are traded to other pedophiles through child pornography networks, and may be used in commercial child pornography.

In California, law enforcement has expanded their ability to arrest persons suspected of producing and disseminating child pornography. These arrests have resulted in the confiscation of thousands of films, magazines, and still photographs that depict children involved in sexual activity. However, the problem still outweighs the arrests by a large margin.
Internet Exploitation

Computers have traditionally been trusted by both children and adults as reliable and accurate sources of information. The rapid growth of online services and Internet access has added a new dimension to modern computing. Through a computer modem and phone line children now have access to an almost endless supply of information and opportunity for interaction.\(^5\)

The unprecedented growth in child pornography in the United States, largely on the Internet, provides child sexual predators with a virtually undetectable means of sending and receiving illicit images of children (Huycke, 1997). Because of its anonymity, rapid transmission, and unsupervised nature, the Internet has become the venue of choice for predators who transmit and receive child pornography.

Today, the virtual playground of cyberspace affords these child sexual predators the opportunity to engage children in anonymous exchanges that often lead to personal questions designed to assess whether the child can be lured into sexual conversation and sexual contact.

Regardless of law enforcement’s ability to detect and arrest child sexual predators using the Internet, the most effective protection against child victimization is an involved and educated parent. The following is a set of guidelines recommended for parents regarding their children’s use of the Internet:\(^6\)

- **Help children to understand why it is important that they do not give out personal information, even if their new e-mail pal seems to be real friendly, or a “cool” web site offers them a free gift for the information.**
- **Let your children know they can come to you if they are receiving messages that make them feel uncomfortable. Tell them that in such an event, they should save the messages for you to read and handle in an appropriate manner.**
- **Set up guidelines that deal specifically with meeting people on the Internet. Talk to your children about what to do if their new Internet “friend” asks to see them in person, or wants your children to send pictures of themselves.**
- **Teach your children about “netiquette” (etiquette on the Internet), so that they will not accidentally offend anyone, but will still protect themselves.**
- **Keep the computer in a high-traffic part of the house such as the living room. You can then easily monitor your children’s activities without making them feel as if you are watching over their shoulders all the time.**

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• Find web sites you think your children will enjoy and “bookmark” them. This will help direct your children away from using search engines, where they might find inappropriate sites.

• Most importantly, spend time with your children talking about their experiences online. Give them a chance to show you what they have learned or the things they like.7

• Never give out your address.

The National Center for Missing and Exploited Children (NCMEC)’s Cyber Tipline serves as a national resource for tips and leads regarding the sexual exploitation of children. NCMEC is a national clearinghouse for information on cases of abducted, runaway, and sexually exploited youth. NCMEC does not investigate such cases, but receives leads and disseminates them to various investigative law enforcement agencies. In the effort to assist law enforcement, NCMEC offers technical assistance, information dissemination, and advice. NCMEC can be reached through the Internet at www.missingkids.com or by calling their toll-free hotline at 800-843-5678.

All mandated reporters are required to report suspected sexual exploitation. (For further details on these laws, see Appendix IV.)

Abuse of Children With Disabilities

Children with disabilities are abused at more than twice the rate of children in the general population.8 Children may acquire serious and chronic disabilities through abuse, and then become more vulnerable. An estimated 25 percent of children with developmental disabilities acquired the disability as a direct result of abuse.9 Children with developmental disabilities (those that impair the developmental process, such as mental retardation, autism, cerebral palsy and other physical disabilities) receive services from a wide array of professionals, and thus, are vulnerable to a much higher number of trusted individuals who may abuse them. In this population, 99 percent of the perpetrators are known to and trusted by the child and family.10 In many cases when the perpetrator is an approved service provider, the abuse is not reported.

7 National Committee to Prevent Child Abuse, 322 South Michigan Avenue, Suite 1600, Chicago, IL, 60604, 1998.


10 Seattle Rape Relief. Special Education Curriculum on Sexual Exploitation, Seattle, WA; Developmental Disabilities Project 1979.
However, when discovered, the perpetrator is fired and frequently moves to new employment or a volunteer position and continues the abuse.

Emotional and behavioral signs of abuse in children with disabilities may differ from those exhibited by non-disabled children due to differences in the way they function. For example, physical signs are the same, but in some cases, disabled children easily bruise or fracture themselves, so care must be taken to understand the disability when assessing whether abuse has occurred. Communication issues are critical. Children are frequently able to communicate the abuse, but they are often disbelieved due to prejudice against or misunderstanding of individuals with disabilities. Use of assisted communication skills may be required, or the use of an interpreter may be necessary when conducting an interview.

Children with physical disabilities as well as those with psychiatric, sensory (hearing, vision), and communication (non-verbal, language processing impairments) disabilities, have all been victims of abuse. Although statistics indicate that physical assault is most frequently reported, sexual abuse is recognized as grossly under reported. Incest and abuse perpetrated within the family mirrors that which occurs in the general population. Emotional and verbal maltreatment is also a serious problem among this population.

In most cases to date, the perpetrators are male, with the victims nearly equally divided between boys and girls. No single category of persons is identified as perpetrators. However, transporters (bus drivers) do appear to represent a high proportion of those convicted. Some reports indicate that child abuse reporting soars at ages five to six, when many children enter school and come into contact with mandated reporters. Children with disabilities frequently stay within the school system until age 22; however, after 18, their abuse would be reported to Adult Protective Services.

Information about abuse of children with disabilities is not familiar to many in the lay or professional communities, which may leave these children more vulnerable to abuse. The signs of abuse they display may be ignored or mistakenly attributed to the disability. Cases are less likely to be reported, thoroughly investigated, and prosecuted. Lack of serious attention to the needs of disabled children throughout the child abuse response system is unique when compared to any other group of child victims, and must be addressed.

**Cultural Differences**

Our ideas concerning the parenting of children may contrast greatly with other cultures. Cultural definitions of child abuse and neglect are wide and varied. Therefore, the professional must be aware of the discrepancies between our culture and others when assessing children they suspect...
of being abused. There are times when the professional needs to make decisions regarding whether to report child abuse, educate the parents, or simply accept the practice as “different” and not harmful. However, when a professional believes that a practice falls within the definitions of child abuse, it must be reported. Since cultural practices are so diverse, mandated reporters are strongly encouraged to receive cultural competency training to better understand these practices.
Mandated reporters often have questions about situations that may or may not be child abuse. Listed below are situations or circumstances that are not considered child abuse for purposes of the Child Abuse and Neglect Reporting Act:

- **Children fighting.** Injuries caused by children fighting by mutual consent. (Pen. Code, § 11165.6.)

- **Reasonable force.** Injuries caused by reasonable and necessary force used by a peace officer acting within the scope of his or her employment. (Pen. Code, §§ 11165.4, 11165.6.)

Injuries caused by reasonable and necessary force used by public school personnel to stop a disturbance that is threatening physical injury to someone or damage to property, for purposes of self-defense, or to obtain possession of weapons or other dangerous objects within the control of a child. (Pen. Code, §§ 11165.4, 11165.6.)

- **Voluntary sexual activity between children under the age of 14.** Voluntary sexual conduct between children who are both under the age of 14 years and who are of similar age and sophistication is not a crime and need not be reported under the Child Abuse and Neglect Reporting Act. (*People ex rel. Eichenberger v.* ...

- **Pregnancy.** Pregnancy of a minor, regardless of her age, does not, **in and of itself**, constitute the basis of a reasonable suspicion of sexual abuse. (Pen. Code, § 11166, subd. (a).)

- **Past abuse of a child who is an adult at the time of disclosure.** There is no duty to report child abuse unless the victim is a child, meaning a person under the age of 18 years. (Pen. Code, § 11165.) Accordingly, past abuse of a child who is an adult at the time of disclosure or discovery of the abuse need not be reported. However, if a mandated reporter has a reasonable suspicion due to the conversation with this adult that someone still under the age of 18 has been abused, it must be reported.

- **Maternal substance abuse and positive toxicology screen at birth.** A positive toxicology screen at the time an infant is delivered is not, **in and of itself**, a sufficient basis for reporting child 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 Health and Safety Code section 123605. If other factors are present that indicate a risk to the child, a report must be made, but a report based on risk to a child that relates solely to the parent’s inability to provide the child with regular care due to the parent’s substance abuse shall be made only to county welfare departments and not to law enforcement agencies. (Pen. Code, § 11165.13.)

- **Sudden Infant Death Syndrome (SIDS).** SIDS is the sudden and unexpected death of a baby who seems perfectly healthy. Victims are most often between the ages of one month and one year. Every two hours in the United States, a baby dies of SIDS. SIDS happens in families of all social, economic, and ethnic groups. It is a recognized cause of death and is only determined after completing an autopsy, a death scene investigation, and a review of the case history of both the baby and family. Scientists from the United States and around the world are conducting large-scale, ongoing research into deaths from SIDS. These researchers are coming closer to understanding SIDS...but the cause is still unknown. **What is known is that SIDS is not caused by child abuse and it should not be confused with child abuse.** They have identified ways to reduce the incidents of SIDS through certain infant care practices, such as sleep position, breast feeding, and proper infant care.11 “Back to Sleep,” a national educational campaign, recommends that all babies be placed on their backs to sleep, unless otherwise instructed by a health care professional. Some communities have begun “back-to-sleep” campaigns to alert families of this potential risk.

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Who are Child Abusers?

Child abuse occurs in all cultural, ethnic, occupational, and socioeconomic groups. Although many people assume that parents are the only culprits, children can become victims of abuse by persons in nonparental relationships, such as family friends, neighbors, acquaintances, or strangers. Those who abuse children may also be trusted to care for our children, such as teachers, child care providers, or foster parents. They may be male or female; they may be adults, adolescents, or children.

Early identification, reporting, and intervention are essential and vital to protect the child victim because people who abuse typically repeat the abuse and increase its frequency.

Studies indicate that a variety of factors are associated with child abuse. Many of these factors apply to and characterize the general population (such as social isolation, transiency, and other factors discussed in this section). Child abuse is seldom the result of any single factor. Rather, a combination of circumstances and personality types may precipitate an act of abuse. The existence of one or more of the following factors could trigger abusive acts: a predisposition toward maltreatment (perhaps as a result of having been
abused, neglected, or witnessing domestic violence; emotional stress, such as marital or employment problems; substance abuse; a lack of constructive outlets for tension, anger, or aggression; or poor impulse control.

Many people cannot understand how child abuse occurs in a family. Frequently, abusive parents or caretakers themselves have experienced child abuse. Consequently, they may recreate the same destructive environment for their children that their parents provided for them. Without intervention, these negative life patterns can continue for generations.

There are many who believe that all corporal punishment is abusive. There are others who believe it is a useful method of discipline under restrained conditions. Discipline and punishment are not the same; corporal punishment is not legally defined as abuse unless it results in injury.

The combination of physical punishment and rage is ineffective as a disciplinary tool and can be deadly. Many experts agree that while physical punishment and rage have the immediate effect of interrupting the child's behavior, the deterrent effect is not long-term. In addition, the use of excessive corporal punishment may teach a child to resolve conflicts violently and to use physical power rather than reason to obtain results or to express anger.

Abusive parents often reverse roles with their children. That is, they expect and demand love and care from their offspring, but have difficulty in returning these emotional necessities to their children. These parents are either traumatized from child abuse experiences of their own, lack understanding of children's basic needs and capabilities, or choose not to respond appropriately to these needs and capabilities.

Studies have shown that a mother may be more likely to abuse or neglect her child if the early bonding between mother and child immediately after birth is disturbed by separation. This separation can be caused by the prolonged hospitalization of the mother and child and can result when children are born prematurely, or with an illness, or physical abnormality. Also, a child viewed as different or slow may become a scapegoat.

In the intimacy of family life, especially at times of stress or when adult relationships are poor, or where adult needs are unmet, or where abuse happened in childhood, the probability for sexual abuse to occur is high. A child can easily be made to believe that sex is a special game or a normal and necessary part of being loved and accepted. An older child can be convinced that he or she is at fault for seducing the parent or caretaker.

People who abuse may convince themselves that they have a duty to "show the child the facts of life," and that they are more loving and caring than outsiders who might "spoil" or mistreat the child. People who abuse may feel so stressed, neglected, or needy that they feel compelled to exploit the only supporting, loving relationship they can find. Although some adults may believe their
conduct is blameless, the harm done to the child remains the same whenever sexual abuse is committed.

Family stress, created by difficulties in obtaining the basic necessities of life—including food, shelter, clothing, medical care, and education—may cause parents to be less capable of providing adequately for the physical and emotional needs of their children. Depression may play a major role in the inability of the parent to provide appropriate care. In struggling for survival, such a parent may be incapable of resolving difficult situations rationally and child abuse may occur. Such situational stress does not constitute justification or legal defense for child abuse, but must be taken into consideration by agencies that become involved in determining appropriate protective measures against future harm of the child and/or treatment and proper punishment for the child abuser. Neglectful behavior passed down from generation to generation should also be considered.

In its 1990 report, the U.S. Advisory Board on Child Abuse and Neglect outlined conditions causing child abuse that are true today. The report stated:

Child maltreatment is especially likely to occur when families, under stress, lack support from their neighbors. Child maltreatment occurs much more frequently among socially isolated families.

Some parents’ mental health problems can cause them to harm their children or negligently place them in unsafe environments. Among such parents, child maltreatment rarely is the only problem manifested.

Child abuse and neglect associated with substance abuse has experienced an extraordinary increase.

The nation is identifying many babies affected by prenatal substance abuse. Whether from the biological effects of the drugs and alcohol alone, or from the sociological effects of drug abuse on the family, or from both, the risks to these children will continue as they grow older.

The social and personal problems faced by parents and other adults caring for children with special needs are intensified by the special challenges that some of these children present. Moreover, the presence of disabilities renders such children more vulnerable to harm.

The increased complexity of child maltreatment is matched by the complexity of recent, dramatic changes in family and community life: changes in the economic status of families; changes in family structure; and changes in the range of institutions caring for children. While these changes are not necessarily a direct cause of child maltreatment, they create new continuing challenges for the child protection system.12

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Supporting the conditions which lead to abuse outlined by the U.S. Advisory Board on Child Abuse and Neglect, the Third National Incidences Study (NIS) of Child Abuse and Neglect (1996), sponsored by the U.S. Department of Health and Human Services, reported:

“Children of single parents had a 77 percent greater risk of being harmed by physical abuse, an 87 percent greater risk of being harmed by physical neglect, and an 80 percent greater risk of suffering serious injury or harm from abuse or neglect than children living with both parents...” and “...children from [single parent] families with annual income below $15,000 as compared to children from families with annual incomes above $30,000 per year were over 22 times more likely to experience some form of maltreatment.”

The NIS also reported:

“A 1993 study by the U.S. Department of Health and Human Services found that children in alcohol-abusing families were nearly 4 times more likely to be maltreated overall, almost 5 times more likely to be physically neglected, and 10 times more likely to be emotionally neglected than children in non-alcohol-abusing families. Other studies suggest that an estimated 50 to 80 percent of all child abuse cases substantiated by CPS involve some degree of substance abuse by the child’s parents.”

The connection between substance abuse and child abuse has strengthened over the years. In 1997, Wang and Daro reported that 88 percent of respondents named substance abuse as one of the top two problems presented by families reported for maltreatment. This percentage is higher than those reported in previous years, suggesting that after several years of some improvement, substance abuse is again surfacing as a primary contributor to child maltreatment.

These factors, circumstances, and personality types—regardless of culture, ethnicity, occupation, or socioeconomic group—are typical characteristics of people who abuse children. However, our knowledge about the multiple factors involved in child abuse does not permit prediction of future acts with any great accuracy. The knowledge does provide a framework for prevention, intervention and treatment programs. Support must be provided to parents from all sectors of society so that children can grow in the healthiest environment possible.