Violence by Parents Against Their Children

Reporting of Maltreatment Suspicions, Child Protection, and Risk in Mental Illness

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KEYWORDS

• Child abuse • Child maltreatment • Child neglect • Depression • Schizophrenia • Mental illness

KEY POINTS

- Child abuse is not uncommon and has long-term detrimental effects.
- In America, physicians including psychiatrists are legally mandated to report suspicions of child abuse.
- Almost one-half of patients with serious mental illness are parents, and psychiatrists should ask about parenting.
- Studies that purport to demonstrate a higher risk of child maltreatment by parents with mental illness often have methodologic limitations.
- Mental illness should be treated, and should be considered a dynamic risk factor rather than a static risk factor when considering risk toward children.

INTRODUCTION

Psychiatrists often treat parents who are suffering from mental illness. It is often suggested that mental illness leads to child abuse or neglect. However, the risk of violence or neglect is decreased by appropriate treatment of symptoms and support. When there is a reasonable suspicion of child abuse, the psychiatrist is a mandated reporter, like other physicians are. Removing children from their parents is only one option considered by Child Protective Services (CPS) when determining a safe disposition for children they serve.

Disclosures: None.
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Psychiatr Clin N Am 39 (2016) 691–700
http://dx.doi.org/10.1016/j.psc.2016.07.001 **psych.theclinics.com**

Abbreviations

CAPTA	Child Abuse Protection and Treatment Act
CPS	Child Protective Services

DEFINITION OF CHILD ABUSE

According to the Federal Child Abuse Protection and Treatment Act (CAPTA) (42 U.S.C.A. § 5106g), as amended by the CAPTA Reauthorization Act of 2010, child abuse and neglect are a minimum set of acts defined as:

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

Although CAPTA includes specific definitions of sexual abuse and failure to provide appropriate medical treatment, it does not include specific definitions of neglect, physical abuse, or emotional abuse. Each state defines child maltreatment within civil and criminal statutes, with varying tolerance for "corporal punishment." Most states recognize 4 major types of maltreatment: neglect, physical abuse, sexual abuse, and emotional abuse/emotional neglect (Table 1). Witnessing domestic violence is defined as a type of abuse or neglect in some state laws.

Table 1
Types of maltreatment, their definition and prevalence

Type of Maltreatment	Definition[a]	Prevalence
Physical abuse	Intentional use of force against a child that results in, or has the potential to result in, an injury.[1]	*Official:* 119,517 reported cases of physical abuse (including duplicate reports for the same child); 17% of maltreatment victims.[2] 1.6 cases per 1000 children.[2] *Self-report:* 3.5%–16.7% per year.[3]
Neglect	Failure by a caregiver to meet a child's basic physical, emotional, medical/dental or educational needs.[1]	*Official:* 526,744 reported cases; 74% of maltreatment victims[2]; 7 cases per 1000 children. *Self-report:* 1.4% of children per year.[4]
Sexual abuse	Any attempted or completed sexual act, sexual contact with, or sexual exploitation of a child by a caregiver.[1]	*Official:* 58,105 reported cases; 8% of maltreatment victims[2]; 7.8 per 10,000 children. *Self-report:* Childhood prevalence of any sexual abuse 8.7% for boys, 25.3% for girls.[5]
Emotional abuse	Intentional caregiver behavior that conveys to a child that they are worthless, flawed, unloved, or valued only in meeting another's needs.[1]	*Official:* 42,290 reported cases; 6% of maltreatment victims[2]; 5.8 per 10,000 children. *Self-report:* 10.3% of children per year.[4]
Total maltreatment		*Official:* 702,208 individual victims; 9.4 for every 1000 children.[2]

[a] Definitions are based on the Centers for Disease Control and Prevention report, 2014.

During the 2014 financial year, American CPS agencies received 3.6 million referrals regarding 6.6 million children.[2] During this period, there were 702,000 estimated victims of abuse and neglect, a rate of 9.4 victims for every 1000 children.[2] Three-quarters (74%) of these children suffered neglect, 17% physical abuse, and 8.3% were sexually abused.[2] The majority of children (86%) experienced a single category of maltreatment (although they may have experienced that type of maltreatment several times). The remaining 14% were reported with more than 1 type of abuse.[2] One or both parents were the perpetrator in 91% of cases; this included the mother in 40% of cases.[2]

The prevalence of child abuse can be derived from studies using retrospective victim self-reports or survey participation, parental surveys, or statistics from official agencies. Each of these methods has flaws. In general, official rates are one-tenth the rates derived from other methods.[6] One study using latent class methods found that the likely true rate of sexual abuse was twice that which was reported.[7] A review of 66 international studies found that the prevalence of severe parental violence ranged from 3.5% to 16.7% per year.[3] An American study using self-reports found an annual prevalence of emotional abuse of 10.3% and of neglect, 1.4%.[4] A metaanalysis of worldwide studies of sexual abuse estimated a childhood prevalence rate of 8.7% for boys and 25.3% for girls for any type of sexual abuse.[5] In summary, the prevalence of abuse calculated using cases that are reported through official channels tend to underestimate rates of all types of maltreatment significantly, when compared with later self-report.

MANDATORY REPORTING OF SUSPICION OF ABUSE

In 48 states, mental health professionals are one specific group that are mandated to report their suspicion of child maltreatment to an appropriate agency; in New Jersey and Wyoming, all persons are required to report.[8] In America, health professionals contribute to 8% of reports to CPS.[9] The circumstances under which a mandatory reporter must make a report varies between states. Generally, a report must be made if the health professional (in their official capacity) suspects or has reason to believe that a child has been abused or neglected.[8] Another standard is that the reporter has observed or has knowledge of conditions that could reasonably result in harm to the child.[8] In Minnesota, it is mandatory to report any suspected abuse that has happened in the prior 3 years and any threat of abuse.[8] In sum, 28 states require the report of a suspicion including 11 states with wording regarding a reasonable cause to suspect. The other 22 states require reporting of a belief about abuse.[10] All jurisdictions have provisions in their statutes to maintain the confidentiality of abuse and neglect records and to protect the identity of the reporter.[8]

There is an historical shortfall of approximately 10-fold between the prevalence of child maltreatment and reporting to child protection agencies.[6] As noted, retrospective self-report studies of child abuse victimization find substantially higher rates than what is reported by physicians.[10] In 1 prospective study, although doctors attending injured children suspected abuse in 10% of the cases that they saw, only 6% were reported.[11] Clinicians reported 73% of cases that they considered likely or very likely to be abuse, but only 24% of children where they considered abuse "possible."[11] Severe injuries were more likely to be reported, particularly if the injury was not consistent with the given history or the child's developmental level.[11] Indeed, experts may interpret their duty to report differently depending on the severity of injuries, which is a risky practice.[10] Other studies have demonstrated variations in

both whether doctors suspected abuse and how certain about maltreatment doctors feel that they need to be, before reporting to CPS.[10]

A further analysis found that clinicians' likelihood of reporting suspected maltreatment was influenced by: familiarity with the family and their circumstances including knowledge of previous CPS involvement, inconsistencies in the history, mechanism of injury, and delays in seeking treatment.[12] Clinicians who did not report their suspicions of maltreatment described that they had consulted with colleagues or other resources, and were more likely to believe that reporting their suspicions would result in an adverse outcome for the child and their family.[12] Although clinicians may be concerned that their suspicions lack adequate basis, legally they are required to report any reasonable suspicion.[8] Importantly, if a report of abuse is made in good faith, then mandated reporters have immunity from civil or criminal liability under state laws.

The shortfall between the prevalence of maltreatment and report to child protection agencies is compounded by the small proportion of reports which are substantiated. Only one-quarter (26%) of cases reach the threshold for substantiation of maltreatment in the United States.[2] The remaining three-quarters (74%) of cases may have insufficient evidence, poor family cooperation with the investigation, or the service being unable to investigate owing to lack of CPS personnel or resources, or there may have been a lack of maltreatment.[2]

Despite several studies showing higher rates of allegations of maltreatment, a recent review of the literature did not find any study that investigated recognition of child maltreatment as part of the care of parents who were accessing mental health services.[9,13]

PSYCHIATRISTS AS REPORTERS

Psychiatrists are mandated reporters of child abuse, yet are often reluctant to breach confidentiality. Therapists who do not report are most commonly concerned with the loss of the treatment alliance with the potentially abusive parent. However, compliance with mandatory reporting in many cases "contributes positively to the therapeutic process."[14] Despite limited research, in one study, Watson and Levine found that one-half of reports of child abuse were filed during the first 3 months of therapy.[14] In most cases, reporting did not ruin or significantly harm the therapeutic alliance with the parent, although almost one-quarter (24%) did terminate treatment after a report was considered or filed. Watson and Levine considered[14]

> *it is possible … that it is trust, not absolute confidentiality that is essential for the psychotherapeutic relationship. Trust may develop or be maintained even though confidentiality can not be guaranteed or has been breached; clients can accept the disclosure of confidential communications if they feel that the therapist has no choice under the law.*

Reports to CPS are generally made by phone (**Table 2**). CPS have the goals of keeping families together where possible, and ensuring a safe environment for children. CPS investigates reports, may initiate court actions, offers referral to parenting classes and additional supports for families in need. It should generally be discussed with the patient that one is mandated to report, and the benefits of CPS involvement, rather than only potential negative consequences of which they are already likely aware.

Reports should be made to CPS when there is a reasonable suspicion of abuse, neglect, or of significant risk to the child. As well, cases of denial or concealment of pregnancy without prenatal care may be reported for potential concerns of neglect—the mother who may not have even recognized that she is pregnant for

Table 2
Helpful websites regarding child maltreatment and protection

Website	Description
https://www.childwelfare.gov	Gateway for official information produced by the US Department of Health & Human Services, Administration for Children & Families and the Children's Bureau. • Federal and state definitions of maltreatment and requirements for mandatory reporting. • Resources for recognising, preventing, and responding to child abuse and neglect. • Information about supporting and preserving families and services available. • Information about immunity for reporting in good faith.
http://www.cdc.gov/violenceprevention/childmaltreatment/	Administered by the Centers for Disease Control and Prevention. • Focus on child abuse and neglect prevention. • Information about risk and protective factors, prevention strategies. • Data on prevalence of child maltreatment.
http://www.aacap.org/aacap/families_and_youth/resource_centers/Child_Abuse_Resource_Center/Home.aspx	Website of the American Academy of Child & Adolescent Psychiatry, child abuse resource center. • Resources for youth, family and clinicians about abuse and treatment.
https://www.childhelp.org/story-resource-center/child-abuse-education-prevention-resources/	Website run by Childhelp foundation • Resources about child abuse prevention and education. • Online resources and literary resources for children to prevent abuse or help recovery from abuse.
http://www.nccafv.org/child_abuse_reporting_numbers_co.htm	Child abuse reporting numbers by state

9 months suddenly has responsibility for a newborn infant. These mothers frequently retain custody.[15]

In addition to reporting, psychiatric hospitalization should be considered if the risk stems from active symptoms of mental illness. Emergency hospitalization (civil commitment) should be considered in cases where there is serious risk to others (including a child) owing to mental illness. As well, hospitalization should be strongly considered in cases where there is concern about risk of infanticide owing to acute mental illness symptoms—for example, suicidal depression in a loving mother or postpartum psychosis with delusions about the child (for a fuller discussion, see Friedman and Resnick[16]).

PARENTS WITH MENTAL ILLNESS

Mental health professionals do not always ask if their patients are parents.[17,18] A survey of psychiatrists found that 69% asked their female patients if they were mothers 90% to 100% of the time, and 10% asked less than one-third of the time or never.[17] Yet, one-half of women with serious mental illness are parents[19] and 10% to 20% of women with serious mental illness are actively parenting dependent children in their home.[20,21]

Between 5% and 30% of children have a parent afflicted with mental illness, and 3% to 6% have a parent with serious drug misuse.[22]

In the postpartum period, women are at greater risk for new or recurrent serious mental illness, particularly mood disorders. Parents with limited insight into their mental illness are more likely to cause harm to their children.[23] However, symptoms of mental illness are often transient and responsive to treatment and are, therefore, not indicative of overall parenting ability.[24]

About one-half of parents with schizophrenia lose custody of their children.[25] Overall, one-quarter of mothers with serious mental illness lose custody.[26] Fear of custody loss leads to a decrease in disclosure of parenting difficulties in mothers with serious mental illness[27] and may also decrease help-seeking behaviors.

IS MENTAL ILLNESS A RISK FACTOR FOR CHILD MALTREATMENT?

Parental mental illness is often considered a major risk factor for violence against children. In reality, most parents with mental illness do not abuse their children, and most parents who abuse their children are not mentally ill. Despite a dearth of literature, the idea that all persons with mental illness are at risk of child maltreatment is a prevalent view. This implies that, considering the frequency of mental illness (by the various definitions used in the various studies), approximately one-half of the population is considered at increased risk for abusing their children.

A qualitative study of 40 parents with serious mental illness, their children, and social workers involved in their care found no evidence of physical harm or neglect and, although the children had taken on some responsibilities of caring for their parents, this was often seen as positive by both the parent and the child.[28] In this study, it was suggested that there was a lack of parental support from mental health teams and a lack of recognition interventions should be targeted to helping the family work as a unit.[28] One study that measured maternal depression at 2 time points found that a reduction in depression score was associated with better parenting behaviors, better child behavior, and a decrease in child psychopathology.[29]

Mental illness in a woman appears to increase the risk of victimization by intimate partner violence.[30] Since witnessing domestic violence is conceptualized as child abuse in some states, this may contribute to reports of child abuse for mothers with mental illness.

If one considers which symptoms may lead to child maltreatment, it may be the negative symptoms or disorganized thinking of schizophrenia, which leads to neglect, for example. Paranoia or hallucinations could precipitate violence. Low energy and motivation in depression may lead to neglect, similarly to leading to poor self-care. Irritability, impulsivity, poor judgment, and the reckless behaviors of mania may lead to abuse or neglect. Importantly, treatment diminishes symptoms, and one would expect treatment to be protective as it is for other types of violence. Thus, risk of child maltreatment from mental illness should be considered as a dynamic rather than as a static risk.

We suggest that, although symptomatic mental illness may be associated with maltreatment, parents who have been diagnosed with mental illness and treated effectively, in the absence of substance misuse, personality disorder, are not at higher risk of maltreating their children. Although substance abuse and personality disorders may be comorbidities of serious mental illness, they should be considered separately as risk factors among individual parents.

Many studies that purportedly demonstrate that the risk of perpetrating maltreatment is higher among with parents with mental illness have major methodologic

limitations. For example, studies have used varying definitions of mental illness itself, including not only serious mental illness (bipolar disorder, schizophrenia, recurrent major depression) but even including substance use disorders, self-reported depressive symptoms, personality issues, and posttraumatic stress disorder. For example, The National Institute of Mental Health Epidemiologic Catchment Area study found that 58% of those who reported having ever abused a child had been diagnosed with a psychiatric illness during their lifetime; however, excluding antisocial personality disorder, they found that less than 5% of their subjects with mental health disorders had abused or neglected children.[31]

Furthermore, studies may not consider whether the mental illness was treated or untreated, in remission, or whether the parent was acutely unwell. As well, verified child maltreatment is not always an outcome measure. Studies may rely on self-report alone, and retrospective studies may demonstrate recall bias. For example, 1 study found that psychopathology and a personal history of childhood abuse were correlated independently with an increase in child abuse even after controlling for demographics and family of origin characteristics.[32] Both this and the aforementioned National Institute of Mental Health Epidemiologic Catchment Area study assessed the existence and extent of child abuse retrospectively and by self-report, without collateral evidence or documentation. It has been suggested that parents with psychological problems may actually be more likely to report child maltreatment when it occurs, compared with their mentally healthy counterparts, increasing the apparent correlation between parental mental health and child abuse. In addition, the studies used "lifetime diagnosis of a psychiatric disorder" and abuse or neglect of a child at some point during their life. Neither study investigated whether the parent was symptomatic or receiving treatment before or concurrent with the abuse.[31,32]

Even the well-designed Avon Longitudinal Study of Parents and Children[33] demonstrated some of these issues. They found that parental psychiatric history correlated with higher risk. Psychiatric history, however, included psychiatric illness even before pregnancy, and antenatal questionnaires were used to inquire about depression, substance/alcohol abuse and other. As well, however, the measure was of investigation or registration on the child protection register, and thus not necessarily substantiated abuse. Similarly, a recent study of predictors among military parents[34] used the risk of maltreatment as assessed by the Child Abuse Potential Inventory, rather than actual child mistreatment, as an outcome. The Child Abuse Potential Inventory is meant to measure a parent's potential for abuse.[35] Some studies have used this index as a proxy for child maltreatment. However, one of the items on the index is "unhappiness." Therefore, those with depression would be expected to score higher on this index, and of course, will seem to have a higher risk.

In a recent reanalysis of the MacArthur violence risk database, we calculated the prevalence of acts of violence toward children committed by 2 cohorts. We compared those who had been diagnosed with a serious mental illness and were recently discharged from a psychiatric hospital with community controls who were matched for age, gender, and socioeconomic status. Violence was self-reported, but also included interviews of collateral informants and court or police reports. Serious mental illness was defined as including schizophrenia, psychotic disorders, bipolar disorder, and recurrent depression. We found that parents with severe mental illness that was treated were not at an increased risk of violence toward a child, compared with their community counterparts.[13] Psychiatric care thus may be protective against child maltreatment.

SUMMARY

Stigmatizing mental illness may lead to lower rates of help-seeking behavior among parents experiencing symptoms of mental illness, for fear of loss of custody. Rather, the large number of parents with mental illness need support, understanding, and encouragement to continue in their treatment. Substance abuse is a known serious and independent risk factor for all kinds of violence. Yet, often, studies lump together serious mental illness with substance abuse. Studies that purport to demonstrate additional risk of child maltreatment from these parents based on them having mental illness often have serious methodologic issues. Some examples of the methodologic issues found in child abuse/mental illness studies include their often retrospective nature, relying on memories of past abuse; vague definitions of mental illness without consideration of treatment; vague definitions of maltreatment, which may include mere suspicion of abuse rather than verification; and some rely on self-report of maltreatment. When psychiatrists have a reasonable suspicion of child maltreatment, CPS should be contacted, to protect children.

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