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Child Abuse: How Society and Careproviders Should Respond

Edmund G. Howe

Edmund G. Howe, MD, JD, is a Professor of Psychiatry and the Director of Programs in Medical Ethics at the Uniformed Services University of the Health Sciences in Bethesda, Maryland; and is Editor in Chief of *The Journal of Clinical Ethics.*

This special issue of *The Journal of Clinical Ethics* focuses on clinical ethics and domestic violence. In this issue, Mark F. Carr, in "The Spectrum of Religion and Science in Clinical Encounters,"[1] considers what may be the most difficult ethical question careproviders confront: what to do when child abuse or neglect is suspected (hereafter "abuse" will refer to abuse or neglect). Deciding to report a family for abuse can be emotionally bruising: children are powerless, their brains are still developing, and they are exceptionally vulnerable to harm.

At the same time, parents have their own beliefs about how children should be raised, and this warrants respect. To some parents, having the autonomy to raise their children as they deem best may be more important than having autonomy in any other respect. Its loss may seem dearer to them than any other, as parents may equate it with the loss of their children. It is no wonder that some parents respond with rage when careproviders report them to Child Protective Services (CPS). To add complication, there may be a net benefit to allowing some children to remain with parents, and while these children may be at some increased risk, it may be best for them in the long run.

For all of these reasons, it is understandable that careproviders may feel profound doubt in deciding what to do when child abuse is suspected. It is not surprising that decisions may differ. The law requires careproviders to report child abuse when they "reasonably" suspect it, but many don't report abuse, even under these conditions.[2] Careproviders are rarely willing to take on potential legal liability in other circumstances; why would they in these situations? Some careproviders fear that if they report a family, the children will no longer come back for treatment, or they will be less likely to listen to their careprovider due to diminished trust. Careproviders fear that when CPS removes children from their home, they will have less access to adequate healthcare services, and this risk increases when the suspected abuse is less severe. Given these concerns, careproviders may not report, but instead provide better care for the children on their own.

They may be right in this. Children assisted in this way may do better, especially when CPS resources are limited. These decisions are complicated. For example, even though staffs at CPS agencies have greater expertise, when CPS resources are limited, only the children who have been most abused may receive adequate assistance, and children who have been less abused may cumulatively, over time, be more harmed when they are separated from their family, because they are less likely to receive appropriate care. Less-abused children may do better when careproviders don't report to CPS, but treat the children themselves. Given these complexities, is it desirable for society to take stronger measures to increase the degree to which careproviders report child abuse? In the meantime, what should careproviders do? I will address both of

these questions. First I will discuss in more detail the problems summarized above, and then I will discuss solutions for society and for careproviders.

THE PROBLEM

Society and careproviders must protect children. Parents may abuse because of their own problems, such as having been abused, but careproviders have no choice but to assure that children are adequately protected, and to help parents gain access to the help they need, in the hope that they can later be reunited. A greater ethical problem, however, is the one that Carr raises in his article in this issue of *JCE*: how to balance protecting children with respect for parents' values and views? This is a particularly difficult question because there often is an absence of precise criteria that requires careproviders to report abuse.

Children

When a CPS agency has limited resources, only the children and families who are worst-off may receive adequate treatment, and so some careproviders may choose to help less-abused children themselves, rather than report a family to CPS. Understanding why this is not irrational and irresponsible requires an understanding of how children may respond to cumulative harm. Children may be harmed by either abuse or neglect.[3] Abuse is the infliction of harm; neglect, what isn't done. Parents who neglect children may fail to adequately feed them or fail to get them needed medical care. In general, physical abuse or neglect may be easier to detect than emotional abuse or neglect, but the latter may be more harmful — although physical abuse causes emotional harm. Children may become emotionally impaired due to abuse and may lose the capacity to have meaningful relationships with others. For example, typically when non-abused children see another child who is in distress, they will offer comfort. Children who have been abused tend to do this less; they may, in fact, become more aggressive. This may be because the child in distress reminds them of their own distress, and they may feel compelled to do what they can to try to stop it.[4] Another example is that abused children have exceptional difficulties in formal psychological testing — they tend to misinterpret facial expressions when shown pictures of other children's faces; abused children more often misattribute threatening intentions than other children. Abused children may more often respond with inappropriate anger or fear.[5] These tendencies can greatly limit them throughout their adult lives. It should be appreciated that emotional abuse is surprisingly wide-ranging. It may exist even when parents' interactions with their children are "warm."[6]

Given these complexities, when should suspected abuse be reported, particularly emotional abuse? The answer may depend on several factors: What is CPS able to do in the circumstances? What level of expertise does the careprovider have in detecting and treating child abuse, relative to careproviders at CPS — the skills for assessing and treating are different. How much time does a careprovider have to assist a child? How strong was the parent/careprovider relationship prior to the suspicion of abuse? Deciding to report may depend on a careprovider's ability to assess these factors. Regardless, one consideration should remain paramount: when CPS resources are limited, children who are not worst-off may end up worst-off should they be separated from their family.

Parents

Parents may go against their children's best interests for many reasons. Carr provides a paradigmatic example: spanking. The overriding obligation is to protect children from severe abuse, as the law requires, and to help parents who have social and emotional needs. No matter the cause of abuse, most parents believe what they are doing is right. This may be due to deeply held religious, cultural, or idiosyncratic beliefs — or it may be delusional or self-serving rationalization. When parents can recognize their abusive behavior as harmful, the battle is half won, because careproviders can help them pursue the help they need. It is more difficult when parents' values and views differ greatly from those of society or careproviders. Regardless, what careproviders should know about how to best respond is the same.

The basis for conflict may be religious belief, and 44 states in the U.S. have special laws that address how parents can raise their children when the practice in question is based on their religion.[7] A paradigmatic case is that of Jehovah's Witnesses parents who will not allow a child to undergo surgery for severe scoliosis. With surgery, the child may do better and live a longer life. Still, parents might not want the child to undergo the operation because they fear the child may experience excessive bleeding and may need blood or blood products to survive.[8] It is critically important to recognize that the parents are not looking to the child's short-term interests, but to the child's eternal life. From this perspective, if parents truly care, they have no choice. It is broadly recognized that careproviders must know and accept this to have any hope of being able to become parents' allies. Careproviders might say, "I know that you must do what you believe," and "I know that you have no choice but to make this decision." Attempting to become an ally does not mean careproviders can't refer the question to others to make the decision (and how and when this can be done will be explored below). But careproviders must accept that parents' religious views are wholly worthy of respect, and convey this to them. In doing this, careproviders can establish that there is some common ground, and this may allow the parents and child to obtain an optimal result.

This may be common knowledge. Less well known, but important, is that most parents (unless they think they have a problem) believe they are right and can make no other decision, with the same degree of conviction as the parents above, regardless of whether their decisions are based on religion, culture, or idiosyncratic views.[9] The implications for careproviders are profound: in all of these circumstances they should attempt to ally themselves with parents. Doing otherwise will hinder parents in getting the help they need to stop the abuse. Careproviders must be able to create within themselves as close to an unconditional commitment to parents as possible, and to convey this to parents. One way to do this is to understand their perspective.

When parents abuse because they are emotionally impaired, this may be much more difficult. The most experienced in this field suggest that careproviders remind themselves that parents' abusive behavior is most likely the result of abuse they experienced as children.[10] Society, to the degree possible, must try not to marginalize abusive parents, difficult as it is, because harming a child evokes anger and intolerance like nothing else. This is exemplified in how prisoners treat "pedophiles" — prisons often take special measures to protect these inmates from being killed. When parents' autonomy is overridden to protect a child, they may become even more cut off from the rest of society, and it may become clinically and morally important that a careprovider "take their side." As Stephen Bergman, a physician who wrote *The House of God,* stated in another book, "Isolation can be deadly; connection heals."[11]

A case presented in Mark Carr's article in this issue of *JCE* provides an excellent example of this kind of isolation. When Dr. Stapul expresses her concern about spanking to Jimmy's father, he responds, " 'Go right ahead and call the police. I knew we shouldn't have come here today.' " The chief task in most of these situations, when parents believe that what they are doing is right, is not attempt to "trump" or override their belief, but to establish and retain a connection with them.

Criteria for Reporting Abuse

Because the criteria for careproviders to report abuse that they "reasonably suspect" are not specific or fixed, some believe that careproviders should report even when the suspicion of abuse is based on no more than a feeling.[12] Others believe that there should be more objective grounds and that the criteria should be assessed by a team before a report is made.[13] This lack of specific criteria creates inequity: whether a careprovider reports parents or not may depend on the careprovider, not on what parents have done; some have characterized the present system as a lottery, in which the fate of children and parents is determined by which careprovider they see by luck of the draw.[14] Careproviders face a different dilemma: should they report a family, with its attendant problems, or risk that a child may end up dead or maimed? These terrible decisions can harm careproviders' ability to forge a relationship with patients, but it may be possible to counter this harm by sharing these concerns with parents.

Some careproviders will be more affected by such decisions and may have an especially low threshold for this kind of worry. This could be a strength, since they may be more concerned about how a child does, but it may also limit their clinical ability to treat at-risk families. That is, they may lack adequate expertise to deal with their own feelings, and so be less able to respond to possible child abuse in an effective way. These concerns have ethical implications: since excessive worry can make careproviders less effective, perhaps, for moral and clinical reasons, careproviders who feel this way should, when they suspect abuse, report or refer at-risk families to another careprovider who will make these difficult decisions. Given all of these concerns, careproviders should consider how such decisions affect them ahead of time, so they will be prepared when these decisions confront them, so that children will not be placed at additional risk while their careproviders struggle with deciding what to do.

PRINCIPLES

Parents Need a Committed Parent-Careprovider Relationship

Society should accord highest priority to enabling careproviders to establish the most trusting parent-careprovider relationship possible. Careproviders should try to forge relationships of trust to the degree that they can. Social policy may best accomplish this in either of two ways. It may encourage careproviders to refer at-risk families to others who will take over an investigatory role, as this poses a minimal threat to both the careproviders and the families, as early as possible. Alternatively, social policy may permit those with adequate and/or more formally documented expertise to treat at-risk families in a graded series of interventions, according to each family's individual needs — again without potential repercussions for families and careproviders.

The goal is to prevent careproviders from feeling torn between the safety of a child, keeping a family intact, and helping the child and family get the care that they need. To the extent possible, careproviders must be able to avoid deceiving parents by acting as though they are trying to help, when, in fact, they are trying to decide whether to report. In the case described by Carr, Dr. Stapul faces this difficulty when she asks to interview her patient, Jimmy, without his father being present. If Dr. Stapul could report or refer the question of abuse to someone else, her relationship with Jimmy's family and the possibility of their accepting her as an ally would improve. Experts on the ethical problem of careproviders who serve in two roles, note, "the legitimate use of empathy can lead to a quasi-therapeutic interaction that ultimately leaves the evaluated feeling betrayed by the evaluator's report."[15]

The suggested alternative allows careproviders to step out of an investigatory role as soon as they can. They should step out of an investigatory role from the first moment they believe abuse may be an issue, explain to parents what they are doing and why, and hope that doing this with candor will enable parents to accept them as allies. The emotional necessity for this can't be overstated. The costs of CPS finding evidence of child abuse are greater to parents than any they can imagine. There is no sugar coating this.[16] Even when careproviders step out of an investigatory role as soon as they can, it can't help evoking deeply profound fears. With the alternative of having another careprovider investigate, however, it may be more possible for parents to accept careproviders as allies, and to allow careproviders to continue to serve as a guide and advocate until — and after — the presenting problems are resolved.

Parents Want their Children to Stay with Them

The second principle that society and careproviders should consider is that most parents want their children to be with them, regardless of what their actions. There are several possible reasons for this. One is a psychological phenomenon known as "undoing," in which persons try to make up for and offset something "bad" they have done. In this instance, parents' contradictory wish to have their children stay with them may be shown by bringing their children in for care, even though they probably know it could have adverse consequences to themselves. (They also may know that if they don't do this, they may suffer worse consequences.) This core ambivalence may be shown by parents who feel rage in response to being told that their

careprovider might or will report them. It could reflect the intensity of parents' love for their children and their belief that what they are doing for them is right, even if this belief is wholly a rationalization, after the abuse has occurred. The core point for careproviders to recognize is that people can experience two logically contradictory and mutually exclusive feelings at the same time. Thus, even when parents inflict severe abuse, it doesn't necessarily follow that their love for their children doesn't exist at the same time.

Such undoing behavior is not uncommon in people having problems with alcohol. They may say mean things while inebriated, only to apologize later, profusely. They may later literally beg the person they have hurt to give them a second chance. Parents who abuse their children may be like persons addicted to alcohol, in that they may have responses they can't control.[17]

This paradox has two critical implications. First, the task for society and for careproviders is to help these parents acquire adequate control, which may be possible only over an extended period of time. This may mean that social policy should change to better allow time for this to happen. On the other hand, this might increase the risk that if the parents relapse, children could be hurt. Obviously, any new policy must take this into account. Second, parents' desire to keep their children with them may motivate them profoundly to seek the care that they need.

Both of these implications may push society to create new options. These may include options that have previously seemed to be unacceptably coercive, such as allowing parents to continue to meet with and interact with their children, more and more as they heal, even when this takes place over an extended length of time.[18] Parents, if given this option, may want it. And their children may do better than they would otherwise.

Parents Can Change

For these options to work, at-risk children must be sufficiently protected over an extended period of time. There are policies and practices that have not previously been considered that could give them this chance.[19] New living arrangements could, for example, protect children during visits of gradually increasing times, as described above. It may be possible to establish such arrangements, although they previously may have been too coercive to consider. Not withstanding all this, however, why might it be reasonably imagined that parents who have not changed in the past would be more apt to be able to change now?

In addition to better outcomes from improved relationships with careproviders, and new options as discussed, there are some new interventions that may be more effective, to some extent supported by empirical data.[20] There are relatively new programs for parents who lack skills with children; for example, parent trainers coach parents using an ear piece, while watching the parents interact with their children through a one-way mirror.[21] This kind of training might be required when parents want their children to remain with them. This is an example of a kind of coercion not previously allowed, but which some parents might want, in order to keep their children. It would require much increased resources, but may be worth it — to society, and even more to parents (and children).

Ethically, we have traditionally prioritized the needs of children. Due to the unique depth of suffering of parents and children when they are separated, in some cases the need for increased resources for parents may be seen as justified.

SOLUTIONS

Refine Social Policy

Society must give greatest priority to protecting children.[22] Beyond this, the two most critical goals are (1) to free careproviders from dual roles so that they can better treat their patients and be less conflicted, and (2) to give at-risk families access to the best possible care, tailored to provide specifically what they need.

Separate treatment from investigation. A response to the first goal is to separate the roles of treatment and investigation: careproviders would specialize in making protective assessments or in coaching and/or treating.[23] Currently, there are careproviders who focus on conducting forensic evaluations; in these con-

texts, patients feel clearer about which role their own and other careproviders are filling at any given time. Forensic careproviders routinely tell those they evaluate, from the outset, that anything they say may be used against their interests. Similar systems could be created to improve treatment for at-risk families.

Or, as considered above, society could allow careproviders who want to treat at-risk families more time to do this without reporting, or at least allow them to not report *all* at-risk families to CPS. These careproviders might be required to have documented expertise. Either way, careproviders could choose to report or not in a way that allows them to feel less conflicted about dual roles. Ideally, new policies would allow careproviders to treat more parents who need treatment — if they want to — and, when they want to, to be able to treat at-risk families more effectively.

Provide adequate "specialty" expertise. Abuse may involve several different kinds of behavior. Whatever system is adopted to address abuse should provide parents access to careproviders who have the skills to optimally assess and treat them. It is unlikely that one careprovider, even greatly skilled, could effectively assess and treat *all* kinds of abusive parents.

For instance, in some cases bad outcomes are the result of just one instance of neglect. The regret that some parents feel after a bad outcome may have already changed their behavior through what psychologists call "one-time learning." An example is a couple who chose to not bring in their child for an infection: the mother wanted to bring the child in, but the father refused. The child went through a protracted, rocky hospital course as a result. Due to this experience, this will never happen in this family again. Other parents, at the opposite extreme, may be too impaired to be able to give their children the love they need. These parents may need intense help over a longer period of time. Providing different parents different degrees of assessment and help will require much greater resources. Only this may provide enough careproviders, and enable the interventions they can provide to be tailored sufficiently to meet parents' and children's unique needs.[24]

Three new policies. One new approach, especially in light of the above two concerns, is to require stricter reporting via increased enforcement, regardless of the criteria used. This would require that CPS agencies have more adequate resources. When resources are inadequate, careproviders may feel more vulnerable to negative repercussions if they don't report, and this may cause increased reporting of children who are at lower risk, which may lead to fewer children having adequate care, as discussed above.[25] An alternative approach is to free careproviders with special expertise to be more able to treat at-risk families on their own, without reporting, also discussed above. In this scenario, careproviders with special expertise could be required to report only to an "in-house" hospital committee, consisting of experts who monitor families' progress, without reporting to CPS and without more formal assessment.[26] This might cause some parents to be concerned that their careprovider has a conflict. Careproviders would have to decide what to say to parents, and it could have a limiting effect.

A third approach is to leave the system much as it is. Our present system may be characterized as requiring mandatory reporting while providing lax enforcement. One argument for this approach is that some careproviders have greater skills in assessing abuse and treating families, and, under the present system, it may be better for them to treat families than to report them, especially families who are less at risk. As stated above, this may be the case when CPS agencies have funds only to provide adequate assistance to the children who are most seriously at risk.

Ethically, it is inconsistent to require reporting and not enforce it. But allowing the policies and practices to coexist may be optimal, as it may achieve the best net result. Mandatory reporting may move careproviders to report most cases, so that CPS staff, who have the greatest expertise, can assess the maximum number of at-risk families. Not enforcing reporting requirements allows some highly skilled careproviders to treat families at lower risk. Such mutually exclusive policies are carried out by design in some contexts.

Careproviders

The means to assess and treat at-risk families should be improved. It could be that careproviders should refer more — or all — families to specialists in CPS earlier. This looks to the future. What should careproviders do now, and why?

Truth-telling, commitment, and courage. Numerous studies report that how careproviders initially present themselves to patients affects how they are regarded later. Careproviders can form solid relationships with patients by being as honest as possible from the start. How careproviders respond to parents when they first suspect child abuse is all important. This is especially important when careproviders know they may report parents later. Careproviders may quickly sense that they should be looking for additional clues that a child is at risk. They can avoid a role conflict if they report families for initial assessments as early as possible. If they don't, they are implicitly being deceptive with parents, and this may impair their capacity to be effective later.

All patients want to rely on, and take at face value, what careproviders say. This is particularly the case when patients are vulnerable and fearful. It is important for parents to see careproviders as allies in helping their family to thrive and stay together. Careproviders can do this by using three strategies, in this order. First, when abuse may be an issue, careproviders should openly acknowledge that they have dual, possibly conflicting roles. When possible, this should be done before they "reasonably suspect" there is abuse.

Second, careproviders should state explicitly that their dual roles are inescapable, and why. This should extend what parents already (or should already) know. That is, societal and hospital policies regarding child abuse should be entirely transparent, even though it may cause some parents not to seek treatment. This may be ethically preferable, in spite of the fact that it might not protect all children optimally, because other values are given moral weight: having a more open society and showing all parents appropriate respect.

Third, when careproviders first suspect abuse, they should prepare parents by acknowledging that they have bad news. They can say, "I am sorry. You may not have anticipated what I will and must tell you now. I have no choice but to do what I am required to do, to try to best meet your child's needs. Your child's condition is one that parents can create through abuse. Thus, I must refer this question, whether or not this is the case, to others who will explore this." They can add, "You should know that I know this may not be at all what has happened. You should also know that I doubt I can imagine how badly you may feel. You may feel enraged and want to leave the hospital. And perhaps you may never want to see me again — or anyone else. But I do want you to know that if you will accept me, I want to help you now, and always, with this in every way that I can."

Finally, they can say, "There is one more thing I would like to say. I am so glad you brought your child in. Together, we can now do the very best for your child. We couldn't do this unless you brought your child in. I believe that for you to do this, you may have had to have great courage. I imagine that on some level you might have known or suspected this could happen. If you did, you showed great courage and I greatly admire this. If you did not know this could happen, I feel most grateful to you, in any case, because now we can together do our best." And then remain silent.

Thus, careproviders divulge as soon as possible their unavoidable double agency and are truthful. This candor may or may not enhance parents' trust.[27] After making an initial referral, careproviders can devote themselves wholly to the best interests of the parents and children, if parents will allow this, and, to the degree that careproviders can, abandon the role of investigator to the experts to whom they referred the family — unless they become aware of an imminent, severe harm to the child, and then they must protect the child. This is exactly what parents expect. A key aspect is to express unconditional commitment to the best interests of the family. (If careproviders can't make this commitment, they should refer parents to a careprovider who can.)

With the commitment of their careproviders, parents are no longer alone — although they still may feel alone. Careproviders may help parents feel less alone and give them hope. If careproviders can indicate they admire parents' courage in bringing a child for treatment, it may help parents regain equal footing, to the degree that this is possible, it may help parents to move forward. Recognizing and praising their courage may have some added weight, due to the authority that parents may, in spite of themselves, attribute to careproviders. Parents may initially dismiss the praise as meaningless but may find it significant later. It may also help parents regain some self-esteem, which they may most sorely need.

What should careproviders do when parents respond with rage? They can acknowledge the validity of the rage, and hope it will suffice. They can say, "I think I can imagine how you would feel this way. I think that I would, too. I can imagine I might feel as angry as you do, and possibly more so. I wish there was something more for you that I can do. Is there any way now I could help?"

It makes sense that some parents feel rage. The possibility that they may lose their child is enormous. Later, careproviders can tell parents about interventions that could help them do better and keep their child, if parents give them the opportunity. Five of these interventions follow.

Five beneficial interventions. If parents will allow their careprovider to continue to work with them, they should hear about all of the interventions that can help. These interventions work, and may work synergistically.

First, parents may need external support — for example, a single parent of an infant who wakes up a lot needs help so that she or he can get some real sleep. Sleep is a core need, and without it, other interventions may fail. A good model is that of caregivers of patients with dementia. Caregivers may need "respite time," or time to relax, unwind, and "recharge." Much like a single parent who needs sleep, without external help, these careproviders may not succeed.

Second, each parent may need individual assessment and treatment.[28] Factors that can contribute to child abuse include problems such as underlying substance abuse and depression.[29] Unless the underlying problems are recognized and treated, other efforts are likely to fail.

Third, parents may benefit greatly from "couple work."[30] Even if parents are not stressed and have no problems individually, they may have entrenched, destructive patterns of interaction. Unless the patterns are identified and parents can escape them, they may be doomed to fail. For example, one parent may be prone to violence and the other may trigger or perpetuate it by unwittingly "enabling" it to recur. It may be that only with this "enabling reinforcement" that the partner's violence and continuing abuse continues.

Fourth, both parents may do better only when their interactions with their children are specifically addressed. Unless a "family intervention" is made, vicious cycles, similar to those couples show, may continue to exist. For example, a child may be oppositional. The parents may respond, as parents often do, by believing that the remedy is to become more strict, which may make matters worse. The child's misbehavior may escalate, and the parents' strictness, which may come to include retaliation, may worsen. The cycle may continue. Exploring this and identifying a pathological pattern of interactions in family therapy may uniquely enable parents to correct it.[31]

Fifth is individual help for children. Abused children may have, for example, due (or not) to abuse, emotional immaturity or a "developmental delay," that is, the child may be significantly "behind," in some respect or other, children of the same age.[32] A child's immaturity or delay may trigger or contribute to parents' excessive and abusive reactions, and a destructive vicious cycle may ensue.[33] Parents' abusive impulses/responses may be triggered by underlying fear or guilt that they have caused their child to have this problem.[34] They may be right.[35] Getting help for the child may help not only the child but also end the cause of the parents' abuse. The child may be able to become more mature or overcome the developmental delay. Parents may be encouraged and lose their feelings of fear or guilt.

CONCLUSION

There are many reasons that we should provide parents increased access to interventions so they and their children can have the best possible outcome. Perhaps the best reason is provided by Alice Walker in *Possessing the Secret of Joy.* Walker describes female genital mutilation, a practice some see as among the worst examples of child abuse although some cultures practice it. She writes, "there could be no happy community in which there was one unhappy child. Not one! One crying child is the rotten apple in the barrel of his tribe!"[36]

NOTES

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