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APSAC ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

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PERSPECTIVES

Religion-Based Medical Neglect and Corporal Punishment Must Not Be Tolerated

by Rita Swan

Many fundamentalists impose severe corporal punishment on their children in the name of religion. The resulting harm may be even more damaging to children when ascribed to a religious rationale. Many Christian Scientists, following their religious beliefs, fail to provide their children with essential medical care. Author Rita Swan encourages child advocates to argue strongly against statutory religious exemptions from child abuse and neglect charges. 2

FEATURE ARTICLES

Definitional Issues in Munchausen by Proxy

by Catherine C. Ayoub, EdD, and Randell Alexander, MD, PhD

As a first step in developing guidelines for practitioners who may be faced with this complex condition, the APSAC Task Force on Munchausen by Proxy determined a need to clarify definitions. In this article, Drs. Ayoub and Alexander and their colleagues on the Task Force present their working definitions and preliminary recommendations and request feedback from APSAC members. 7

Co-Occurring Spouse and Child Abuse: Implications for CPS Practice

by Anne E. Appel, MA and George W. Holden, PhD

Families in which domestic violence and child abuse occur concurrently present several potentially important implications for CPS workers and the legal system. A better understanding of the dynamics in these families can promote development of more effective prevention and intervention programs. The authors review the available literature and describe models of co-occurrence, treatment issues, and targets for intervention. 11

Case Conference: Sarah's Case

Sarah is a fourth-grader who was referred to child protection authorities after arriving at school with a swollen eye. Sarah had been beaten by Leroy, her mother's live-in partner, who is a deacon in the family's Christian church. Leroy claims that Sarah is possessed by the devil and must learn humility to become closer to God. A social worker, child psychologist and a Christian pastor respond to the difficult issues raised in this case. 15

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APSAC: Ensuring that everyone affected by child abuse and neglect receives the best possible professional response.

Religion-Based Medical Neglect and Corporal Punishment Must Not Be Tolerated

by Rita Swan

Several spokesmen for the Christian Right present corporal punishment as grounded in religion. Several Christian sects refuse medical care on religious grounds. Both religion-based corporal punishment and medical neglect pose difficult challenges to those who work for the protection of children.

The seminal work of scholarship on the first topic is Philip Greven's *Spare the Child: The Religious Roots of Punishment and the Psychological Impact of Physical Abuse.* Greven quotes religious leaders from the seventeenth century to the present who advocate corporal punishment of children on a Biblical basis. He sees the practice as tied to Protestant apocalypticism, the expectation of the imminent end of the world.

His quotations from contemporary fundamentalist spokesmen indicate a perception that the willfulness of children is a primary evil, and that a good Christian has a moral obligation to do "battle" against it and "win." Parents must be obeyed no matter how irrational or sadistic their commands. Children should be hit until they "accept" their punishment. For some, acceptance means that the children cry "tears of a broken will" instead of "tears of anger"; for others, it means the children must stop crying. Children are then expected to express their love in words, hugs, and kisses for the parent who hits them.

God, the Rod, and Your Child's Bod by Larry Tomczak teaches that children should be hit with implements, such as "rods," rather than the hand, so that the children will regard the hand as "an instrument of love."

James Dobson's books recommending corporal punishment have sold millions of copies. His organization, Focus on the Family, has a multi-million dollar budget for its grassroots lobbying and many legislators are sympathetic to its positions.

The religious rationale increases harm to children

Many fundamentalists want to mold their children to represent their religious values. They feel threatened by the mass media's emphasis on consumerism, instant gratification, and sexual freedom; the staggering rise in divorce and births outside of marriage; deteriorating economic status of the working class and unskilled; the necessity for mothers to work full-time to maintain a modest standard of living; and the consequent lack of time and energy to inculcate traditional moral values to children.

A threat mentality, combined with the belief that children are born sinners, may increase the severity of corporal punishment. Also, hitting children with implements rather than the hand means that a parent is less aware of the force being used.

Furthermore, a religious rationale greatly increases the emotional harm done by corporal punishment. The insistence that the physical pain comes because of love may confuse the child. The parent's love is conditioned upon stripping the child of will. Insistence that a supernatural being has ordered the child's pain compounds the assault on the child's sense of self. Religious extremists who claim that the child is possessed by the devil may drive the child to dissociation and other mental illnesses.

Finally, elevating physical assaults on children to the status of a religious practice or ritual may encourage children to provoke beatings. Beatings become a way to get status and love from their parents and God.

Some religious groups see disease as a moral problem. For Christian Scientists, disease is always evidence of man's alienation from God. For several Pentecostal sects, it is a test of faith. For both groups, the only appropriate remedy is ritual argument that sickness is illegitimate because God has redeemed His chosen from it.

Religious exemptions in state statutes

The Christian Science church has enormous power with legislatures and does virtually all of the lobbying for religious exemptions from duties of care. The majority of states have religious exemptions from metabolic testing of newborns; 48 states have religious exemptions from immunizations; 41 states have religious exemptions from civil child abuse or neglect charges; 31 states have religious exemptions (or religious defenses) to one or more criminal charges.

States with a religious defense to the most serious crimes against children include Iowa and Ohio, which offer a religious defense to manslaughter; Delaware and West Virginia, which have religious defenses to murder of a child; Arkansas with a religious defense to capital murder; and Oregon with a religious defense to homicide by abuse.

CAPTA enables religious exemptions

The federal government bears considerable responsibility for the exemptions in state codes. At the request of the Christian Science church, the federal government coerced states to enact religious exemptions to child neglect charges as an eligibility requirement for federal funding. The requirement was dropped in 1983, but in 1996 Congress passed the Child Abuse Prevention and Treatment Act (CAPTA), which does not include "a Federal requirement that a parent or legal guardian provide a child any medical service or treatment against the religious beliefs of the parent or legal guardian."

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Religious-Based Medical Neglect

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CAPTA requires states in the grant program to include failure to provide medical care in their definitions of child neglect, but it also allows these states to have religious exemptions from civil and criminal charges. Furthermore, both the administration and the chairmen of the authorizing House and Senate committees claimed, in support of the bill, that parents have a First Amendment right to withhold medical care from their children on religious grounds.

The Christian Science church is now using the prestige of such federal rhetoric at the state level. In 1997, for example, the church cited it in support of a Maryland bill providing a carte blanche religious exemption to all criminal and civil charges.

The First Amendment does not protect child maltreatment in the name of religious freedom

The US Supreme Court and state courts have consistently ruled that First Amendment guarantees for religious freedom do not include a right to harm or neglect children. Nevertheless, many state legislatures have given parents the right to withhold needed medical care from children on religious grounds. Legislatures are also under continuing pressure to exempt church-run schools and child-care facilities from state education and licensing requirements, from prohibitions of corporal punishment, etc.

A California law offers a good balance between culture and child welfare: "Cultural and religious practices and beliefs which differ from general community standards shall not in themselves create a need for child welfare services unless the practices present a specific danger to the physical or emotional safety of the child." (Calif. Welfare and Institutions Code, Sec. 16509.) Such a law protects minorities from state intrusion motivated by prejudice or suspicion while maintaining an objective definition of abuse and neglect.

What child advocates should do

Child advocates should oppose exemption laws that deprive a class of children of protections enjoyed by other children. Child protection workers should investigate and intervene when children are being harmed even if some argue that the parents' actions are traditional in their culture, religion, or ethnic group. Cultural sensitivity is important, but it should not extend to tolerance of medical neglect or physical abuse of children.

The US Department of Health and Human Services (HHS) is currently drafting regulations to implement CAPTA. HHS expects to publish them in the Federal Register this spring, which will open a period for public comment. Child advocacy organizations should call upon HHS to require the most protective laws possible in the face of CAPTA's unfortunate religious exemption.

What the federal government should do

There is still much that HHS could do. For example, the authorizing congressional committee's report on CAPTA said its religious exemption for parents did not permit a religious exemption from a duty to report medical neglect or from investigation or court-ordered provision of medical care. HHS ought to require states in the grant program to remove religious exemptions from reporting codes.

HHS should also require the states to remove religious exemptions from civil dependency statutes and to repeal statutes that designate prayer as health care, remedial care, or medical care or allow courts to order it in lieu of medical care. Such laws may limit the state's ability to obtain needed medical care for a sick child. HHS has already analyzed congressional intent on this issue and concluded that Congress does not intend for religious means of healing disease to be considered medical care.

Finally, HHS should stop trying to justify the federal government's discrimination with First Amendment claims and should instead advise the states that parents do not have a First Amendment right to withhold medical care from children on religious grounds.

Rita Swan is President of CHILD Inc.

LETTERS

Editors of the *APSAC Advisor* welcome your letters! Appropriate topics for letters include:

- amplification on a point made in an editorial or article,
- disagreements with an author's stated position on a topic,
- disagreements with an author's interpretation of the relevant literature,
- suggestions for new features, or comments on existing ones,
- perspectives on issues in the field that you think are misinterpreted or neglected.

You can write to Debra Whitcomb, the Editor-in-Chief, via e-mail, at debraw@edc.org, or by regular mail, c/o APSAC, 407 S. Dearborn, Suite 1300, Chicago, IL 60605. You can also contact the Editor-in-Chief through APSAC's new web site, at http://www.apsac.org. Letters are typically edited for length, but every effort is made to preserve content. Letters must be typewritten and constructive for consideration for publication.

LETTERS TO THE EDITOR

I am a practicing trial lawyer and an APSAC member for many years. I was very ill last Fall and watched most of the Woodward trial. Your comments in the Winter 1997 *APSAC Advisor* have caused me to write.

I agree with Dr. Lyon's assertion that the very nature of Shake-Impact Syndrome does not lend itself to careful planning and intention. Rather, my experience (as a Social Services Attorney) is that such conduct is sudden, out of control, type of behavior. Such conduct completely negates the intent required to find first degree murder, and may negate the intent required to show second degree murder. It really is more of a sudden emotional behavior which would constitute manslaughter. Of course, neither party to the Woodward case asked the jury to consider manslaughter. The jury then compromised at second degree murder, faced with a dilemma wherein they believed wrongdoing occurred, but probably not what was charged.

The Judge, charged with applying the law, was of the opinion that the evidence presented could not support the conviction. I think he was correct, and saved the system from protracted appeals which almost certainly would have overturned the verdict anyway.

I also agree with Dr. Lyon's assessment of the implications of the Judge's rulings: Most people do not appreciate the seriousness of shaking a baby. If we could say, as a society, that everyone knew that such behavior is practically certain to cause serious bodily harm or death, then the conviction of Louise Woodward, and those similarly situated, would be sustained.

I am especially disturbed at the "see what the media, power, money or influence can do" attitudes of my colleagues at APSAC. This matter is a lot more complicated than that. We are an interdisciplinary group of professionals who ought to examine and understand the legal system before we rush to make emotionally laden criticisms which demonstrate a lack of understanding. I would encourage all APSAC members to review Dr. Lyon's comments, and to discuss them with lawyers in their respective communities. Perhaps we can all learn from each other, and continue in our common goals.

Joe Pickard
Pickard & Waters, P.C.
Denver, CO

NEWS FROM THE FIELD

Child Sexual Behavior Inventory Now Available for Clinical Use

The Child Sexual Behavior Inventory (CSBI) is a 38-item parent report measure assessing the sexual behavior of children ages two to twelve. It was developed by Bill Friedrich, PhD, ABPP, a Professor and Consultant in the Department of Psychiatry and Psychology at the Mayo Clinic in Rochester, MN. The measure was published in November 1997 by PAR (Psychological Assessment Resources) of Odessa, FL.

The published version represents over ten years of research on the sexual behavior of abused and nonabused children. The normative sample numbers 1,114 children (78% Caucasian) and is reasonably well distributed in terms of socioeconomic status. The sexually abused sample numbers 512 children. The CSBI rates the child over the prior six months and measures boundary problems, exhibitionism, gender role behavior, self-stimulation, sexual anxiety, sexual interest, sexual intrusiveness, sexual knowledge, and voyeuristic behavior.

Three subscales have been developed for three age groups of boys and girls: 2-5, 6-9, and 10-12 years of age. These subscales are Total Sexual Behavior, Developmentally Related Sexual Behavior (DRSB), and Sexual Abuse Specific Items (SASI). The DRSB scale includes those items that are endorsed by at least 20 percent of the caregivers in the normative sample for that age group. Elevations on this subscale are more frequent in families undergoing turmoil, or those that have more relaxed attitudes towards family sexuality. The SASI scale includes those items for that age and gender group that significantly differentiate sexually abused from nonabused children. SASI is less affected by family variables other than sexual abuse. Sexually abused children score higher than nonabused children on all three subscales for all age and gender groups, even after controlling for maternal education and family income.

The Professional Manual, which accompanies the test, contains eight well-elaborated case examples that demonstrate how to interpret the results of the test, typically in the context of an interview and other informants. T-Scores for each age-gender group across all three scales are reported as well. The CSBI enables a broad range of mental health professionals to assess a critical dimension of behavior in young children who are thought to have been sexually abused.

The CSBI can be ordered at 1-800-331-TEST. Further information or copies of earlier research articles can be obtained from Bill Friedrich, Ph.D, ABPP, Mayo Clinic, W-11B, Rochester, MN 55905; e-mail friedrich.william@mayo.edu.

A Tribute to Longtime NCCAN Staffer Barbara Bates

Barbara Bates, a longtime staff member of the National Clearinghouse on Child Abuse and Neglect in Washington is stepping down after many years of service and support of research on child maltreatment. Desmond Runyan, MD, DrPH, an APSAC member and researcher at the University of North Carolina, wrote this tribute:

Barbara Bates has left NCCAN after a long and important career shaping and supporting research in the field of child abuse and neglect. She moves to a new role as Grants Review Manager for Educational Services Learning Systems Group in Washington, DC. Among her colleagues in the agency and the investigators she has assisted over the years, there is considerable

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sadness at the departure of such a strong advocate for both maltreated children and for quality research. Barbara's roles at NCCAN included: Research Coordinator for NCCAN; Coordinator for Interagency Work Group on Child Abuse and Neglect Interagency Research Committee; Project Officer for the consortium of Longitudinal Studies in Child Abuse and Neglect (LONGSCAN); and liaison to the American Psychological Association, American Psychological Society, Child Welfare League of America, and The National Council on Research in Child Welfare. Ms. Bates joined NCCAN in 1988 after serving as a program analyst in the Operational Planning Branch and as a Social Science Analyst for DHHS. At NCCAN, Barbara has been an outstanding advocate for improvement of measurement, archiving of data for secondary analysis, and longitudinal studies. She has been a dogged advocate for adequate funding for research within her agency.

HHS Announces Reorganization of the Children's Bureau

Contributed by Emily Cooke, Acting Director, Former NCCAN

The reorganization of the Children's Bureau was announced in the Federal Register on December 8, 1997. The newly restructured Children's Bureau integrates the common functions and activities of the former National Center on Child Abuse and Neglect (NCCAN) with those of the Children's Bureau, while maintaining a visible Office of Child Abuse and Neglect (OCAN).

The reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA) in 1996 eliminated NCCAN, but gave the Secretary the discretionary authority to establish an OCAN within the Department. In response to this legislation, the Department reaffirmed its commitment to the importance of having a unit on child abuse and neglect within the Administration on Children, Youth and Families.

Structuring this unit as part of the Children's Bureau made the most sense, since it provides an opportunity to build better linkages between child welfare (titles IV-B and IV-E of the Social Security Act) and the CAPTA programs. The goal was to make the structure more reflective of the way child protection and child welfare programs are organized in the field, while at the same time retaining a focus on child abuse and neglect.

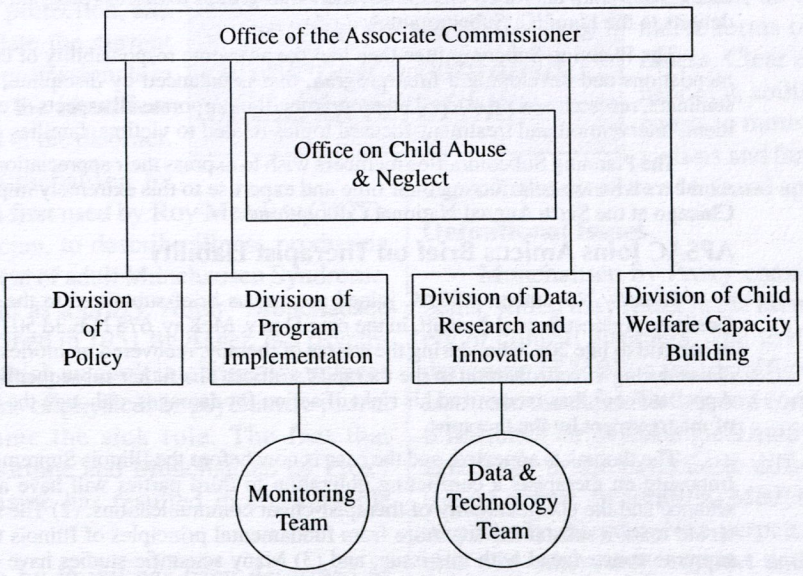
The newly restructured Children's Bureau has five organizational units: the Office of Child Abuse and Neglect, the Division of Policy, the Division of Program Implementation, the Division of Data, Research and Innovation, and the Division of Child Welfare Capacity Building.

The Office of Child Abuse and Neglect provides leadership and direction in the areas of child maltreatment and the prevention of abuse and neglect, and is directly responsible for the management of the Community-Based Family Resource and Support (CBFRS) and the Children's Justice Act (CJA) programs. Like the former NCCAN, the new OCAN is the focal point for collaborative efforts on child abuse and neglect issues within the Department, with other Departments, and with representatives of State and local governments, and national organizations.

The Policy Division is responsible for regulatory and policy development and dissemination for all the Bureau's formula and entitlement grant programs. The Program Implementation Division has oversight responsibility for the operation and review of the Bureau's programs at the State and local level. Program development, innovation and research efforts are carried out by the Division of Data, Research and Innovation. It manages all of the Bureau's information systems and analyzes and disseminates data from the Adoption and Foster Care Analysis and Reporting System (AFCARS) and the National Child Abuse and Neglect Data (NCAND) system and other sources. Training, technical assistance and information dissemination activities are housed under the Division of Child Welfare Capacity Building, which also oversees all Clearinghouse and Resource Center operations and activities.

The staff of the Children's Bureau and the former NCCAN continue the ongoing administration of their programs while the staffing and management decisions are underway to complete the reorganization. Full implementation of the reorganization is expected by the end of June.

The Children's Bureau's Reorganization



ASSOCIATION NEWS

Election for APSAC Board of Directors New Members Nears

During early April, APSAC members will be mailed a ballot for voting for new members to APSAC's Board of Directors. You are encouraged to look for this material in your mail during that time — and, more important, to please vote your choices immediately and return your ballot so it reaches us before the posted deadline. Your vote counts!

1998 Advanced Training Institutes in San Diego Highly Successful

For the sixth consecutive year, APSAC held its annual Advanced Training Institutes in San Diego, California, in conjunction with the "San Diego Conference on Child Maltreatment," sponsored by the San Diego Children's Hospital, Center for Child Protection. We're proud to report that the Institutes were the most successful ever, attracting over 400 registrants!

The program topics for this year's 6-hour intensive skills-building institutes were: "Art and Science of Forensic Interviewing," by Kathleen Coulborn Faller, PhD, Mark Everson, PhD and Tom Lyon, PhD, JD; "The Application of Behavioral Sciences to the Investigation of Sexual Victimization of Children" by Kenneth Lanning, MS; "Advanced Medical Evaluation of Physical Abuse: Radiography, Literature Review, Case Discussion," by Dirk Huyer, MD; "Advanced Medical Evaluation of Sexual Abuse," by Capt. Barbara Craig, MD and Kathleen Dully, MD; "Coordinated Interdisciplinary Approaches to Factitious Disorder by Proxy," by Catherine Ayoub, RN, EdD, Randell Alexander, MD, PhD, Beatrice Yorker, RN, MS, JD, and Herbert Schreier, MD; and "Dyad and Family Therapy in Sibling Abuse," by Mark Chaffin, PhD and Barbara Bonner, PhD.

We extend our deepest appreciation to all our esteemed faculty who so willingly donated their time and expertise to the Institutes, helping to make them the unqualified success they were.

APSAC Staff Changes

There are some staff changes currently taking place at APSAC. First, we want to wish APSAC's enthusiastic Membership Services Manager for the past one and one-half years, Howard Griffin, farewell. Howard's last day was February 18. He is moving into the corporate arena as a computer technology consultant. We wish him well in his new career.

Also, we wish Maureen Kelly, APSAC's stalwart interim Publications Manager, get well wishes. During late January, Maureen fell and broke her leg in several places. She subsequently had surgery and will be home recuperating for eight to 12 weeks! However, Maureen is being pressed into service via telephone.

1998 Annual National Colloquium Planning Well Underway

All members are encouraged to reserve time on their schedules to attend APSAC's 6th Annual National Colloquium, July 8-12, 1998 in Chicago at the Hyatt Regency Riverwalk. APSAC's Annual Colloquium goals are to foster professional excellence in the field of child maltreatment by providing in-discipline and interdisciplinary professional training on various skills levels by offering intensive skills-building programming in best practice and research.

Overall planning for the 1998 Colloquium is being managed by the 1998 Colloquium Planning Subcommittee, which consists of Harry Elias, JD, APSAC President; the Co-Chairs of the Professional Education Committee, Nancy Lamb, JD and Lt. Bill Walsh; the Colloquium Planning Subcommittee Co-Chairs, Catherine Ayoub, RN, EdD, Mike Hertica, and Ben Saunders, PhD; Diane DePanfilis, PhD, MSW, APSAC President-Elect; Delores J. Brooks, Executive Director and Tifanni Sterdivant, Conference Manager.

In an effort to obtain programming recommendations for the colloquium that reflect the needs and interests of the various disciplines represented by APSAC's professional members, focus groups by discipline were appointed to consider and recommend program topics and proposed speakers for their respective discipline. Also, focus groups were organized around the areas of cultural diversity, particularly to offer input on the pre-conference Cultural Diversity Institute day, and on research. Each focus group chair and/or co-chairs convened their groups to discuss program topics, prospective speakers and make recommendations to the Planning Subcommittee.

The Planning Subcommittee then had the awesome responsibility of compiling and considering all focus group recommendations and developing a final program that is balanced by discipline, cultural diversity, invited versus field-generated seminars, research and practice. The program will incorporate all aspects of child maltreatment, addressing prevention, assessment, intervention and treatment-focused topics related to victims, families and perpetrators.

The Planning Subcommittee members wish to express their appreciation to all focus groups chairs, co-chairs, and APSAC members who are contributing their time and expertise to this extremely important process. We look forward to seeing you in Chicago at the Sixth Annual National Colloquium!

APSAC Joins Amicus Brief on Therapist Liability

In early November, APSAC joined an amicus brief submitted to the Illinois Supreme Court on behalf of the Illinois Coalition Against Sexual Assault, in the case Doe v. McKay, 678 N.E.3d 50 (Ill.App.1997). The case involves an adult patient, in her mid to late 20s, who, during the course of therapy, recovered memories of sexual abuse by her father, and accused him of abuse during a confrontation in the therapist's office. The father subsequently sued the therapists for damages, and an Illinois Appellate court has recognized his right of action for damages, although the daughter has not claimed malpractice or any type of mistreatment by the therapist.

The therapists appealed, and the case is now before the Illinois Supreme Court. The amicus brief argued three points: (1) Imposing on therapists a conflicting obligation to third parties will have a serious detrimental effect upon the therapeutic alliance and the confidentiality of therapist-client communications; (2) The imposition of third party liability upon therapists would mark a substantial departure from fundamental principles of Illinois tort law and contradict conclusions of other state supreme courts faced with this issue; and (3) Many scientific studies have documented the existence of repressed and then recovered memories of abuse and the possibility of recovery of accurate, often verifiable memories of such abuse—both in and out of therapy.

The serious impact of such a liability ruling on therapists and the practice of therapy is obvious. APSAC was joined in the amicus brief by a number of other organizations.

Definitional Issues in Munchausen by Proxy

Catherine C. Ayoub, Ed.D., and Randell Alexander, MD, PhD, co-chairs, Munchausen by Proxy Task Force, APSAC

In 1995, an APSAC Taskforce was created and charged with exploring the condition or conditions sometimes known as Munchausen Syndrome by Proxy, other times called Munchausen by Proxy Syndrome and on still other occasions referred to as Factitious Disorder by Proxy. It was clear to the group that before guidelines for practice could be developed, a clinical description of the entities above was imperative. A subgroup of professionals in the field undertook the task of exploring and committing to writing a new and comprehensive definition of these entities described across the pediatric, psychiatric, law enforcement, legal and social work literature. This position paper is the product of the group's work. We hope to use these definition as the basis for future guidelines. We welcome comments from the membership.

Members of the APSAC Taskforce on Munchausen by Proxy, Definitions Working Group are: Catherine Ayoub, RN, EdD, Randell Alexander, MD, PhD; David Beck, MD; Brenda Bursch, PhD; Kenneth Feldman, MD, Judith Libow, PhD; Mary Sanders, PhD; Herbert Schreier, MD; Beatrice Yorker, RN, MS, JD.

Purpose

In order to clarify the constellation of behaviors currently described as Munchausen by Proxy (MBP), a multidisciplinary group of professionals with expertise in the field has developed a composite of the facets of MBP. Our attempt has been to develop a synthesis of the most current thinking in pediatrics, psychiatry, psychology, child protection, and law and to articulate the current consensus among professionals in order to facilitate the identification and treatment of the disorder.

In order to clarify the constellation of behaviors currently described as Munchausen by Proxy (MBP), a multidisciplinary group of professionals with expertise in thefield has developed a composite of the facets of MBP.

The term Munchausen by Proxy (MBP) was first used by Roy Meadow (1977), a British pediatrician, to describe illness producing behavior reminiscent of adult Munchausen Syndrome, but using the child as a proxy. Adult "Munchausen Syndrome," described in 1951 by Asher, is a psychiatric disorder in which an adult intentionally induces or feigns symptoms of physical or psychiatric illness in order to assume the sick role. The fact that Munchausen Syndrome and Munchausen by Proxy share the same name has resulted in considerable confusion.

Munchausen by Proxy has been described as both a pediatric and a psychiatric entity. The term has been used globally to refer to the child's victimization, to the parent's disorder, and to the interactional component of the victimization and the psychological interchange between parent and child. There have been over 300 papers published in the medical and psychological literature on MBP. Although once thought to be quite rare, the disorder may well be more common than previously believed. Using the results of a very careful, but conservative British study (McClure, Davis, Meadow & Sibert, 1996) we estimate that a minimum of 600 new cases a year will present in the United States. Most experts now agree that MBP is not as rare as previously believed and many cases are likely to go undetected due to the covert nature of their presentation, the lack of public awareness, and the many obstacles to the identification of these case by professionals.

Some discrepancies in the use of the term MBP have arisen both within and across disciplines as the use of the term has expanded, limiting the effectiveness of clinicians involved in diagnosis and treatment, child protection systems in appropriate assessment and intervention, and other professionals asked to educate courts or advocate for the parties in the legal arena. In exploring the approaches to and descriptions of MBP within a variety of disciplines, we have concluded that crafting definitions that take into account the multidisciplinary nature of MBP assessment and treatment can significantly reduce the confusion.

It is essential to describe MBP as accurately as possible within a multidisciplinary context. This requires that MBP be differentiated from other forms of child maltreatment, valid pediatric problems, as well as from alternative forms of adult psychiatric illness. Clear definitions will enhance the ability of clinicians and courts to more effectively protect victims and families, as well as to improve the mandate of fair and appropriate services.

Definitional Issues

Munchausen by Proxy consists of two components, which may result in the identification of a variety of clinical disorders. The first component of the definition of MBP is the identification of the victimization to the child. The second component is the identification of the psychological motivation and the characteristics of the psychiatric difficulty in the perpetrating parent. In addition, MBP has been described as a family disorder. Non-perpetrating spouses, parents and others may support and participate in the deception that is at the core of the perpetrating parent's victimization of the child and must be considered in the assessment and treatment process.

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Munchausen by Proxy

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The Child as Victim

Pediatric Condition (illness, impairment, or symptom) **Falsification** (**PCF**) is a form of child maltreatment in which an adult falsifies physical and/or psychological signs and/or symptoms in a victim, causing the victim to be regarded as ill or impaired by others. It is a sub-group of the larger **Abuse by Condition Falsification** category of victimization in which the victim is another individual, adult or child.

Falsification includes but is not limited to the following forms of deception: directly causing conditions, over or under reporting signs or symptoms, creating a false appearance of signs and symptoms and/or coaching the victim or others to misrepresent the victim as ill. Only the imagination and sophistication of the perpetrator limit the number and extent of the presenting symptoms. The presence of valid illness does not preclude exaggeration or falsification.

A child who is subjected to this behavior is a victim of **Pediatric Condition** (illness, impairment, or symptom) **Falsification** and should be coded as such (Child Abuse - 61.1 (when focus is on perpetrator) and Child Abuse - 995.5 (when focus is on victim, see DSM-IV, p. 682) using the Statistical Manual for Mental Disorders – IV (DSM-IV). If the falsified signs and symptoms are physical, it is coded as **physical type**. If the falsified signs or symptoms are emotional, it is coded as **emotional type**. If both physical and emotional signs or symptoms are falsified, it is coded as **combined type**. Codes for child neglect may also be used to designate the type of victimization to the child (V61.21).

The Parent or Caregiver as Perpetrator

Persons who intentionally falsify history, signs or symptoms in a child to meet their own self-serving psychological needs have been diagnosed with **Factitious Disorder by Proxy** (**FDP**) and should be coded as such (Factitious Disorder Not Otherwise Specified - 300.19, see DSM-IV, p. 475). Different kinds of self-serving psychological needs may motivate this behavior. Some individuals appear to need or thrive on the attention or recognition that results from being perceived as the devoted parent of a sick child. A second motivating factor may include the need to covertly manipulate or deceive authority figures or those perceived to be powerful. Typical cases describe doctors and other health care personnel as the targets of such deception, but professionals including but not limited to lawyers, social workers, judges, school psychologists, teachers, law enforcement, and media representatives have also been identified as targets. These motivations and their corollaries may occur simultaneously or at different times in the same individual. External incentives in **FDP** may also be present and do not preclude the diagnosis.

Pediatric Condition (illness, impairment, or symptom) Falsification (PCF) is a form of child maltreatment in which an adult falsifies physical and/or psychological signs and/or symptoms in a victim, causing the victim to be regarded as ill or impaired by others.

Differential Diagnosis

Issues in the Identification of Abuse by Pediatric Condition Falsification

Pediatric Condition Falsification is a distinct form of abuse. Some of the documented physical conditions alleged in these children include but are not limited to neurological problems (seizures and apnea), gastroenterological problems (vomiting, diarrhea, pain, intestinal pseudo-obstruction and failure to thrive) and allergies. Children may be healthy at birth or start life with prematurity and/or a valid illness. There may be a history given by the mother of difficulties with pregnancies and premature births. Children may present with illnesses whose signs and symptoms are not substantiated by physical and/or laboratory findings; illnesses may not conform to the typical presentation of the condition. Other findings may be increased rates of infection and delayed healing. Children with nasogastric or intravenous indwelling lines or reduced immunity to infection are more vulnerable to serious consequences of **PCF**. Failure to thrive is another finding in **PCF**. Non-accidental injuries also may be present.

Child abuse by **Pediatric Condition Falsification** through psychological or developmental symptoms have been documented, but appear to be less common than physical symptoms (Schreier, 1997). Such symptoms in the child may have some basis in truth and conditions such as attention deficit disorder, Tourette syndrome, bipolar disorder, post traumatic stress disorder, and psychosis may be falsified.

False accusations of child sexual abuse have also been attributed to abuse by **Pediatric Condition Falsification** where the mother is diagnosed with **Factitious Disorder by Proxy** (Meadow, 1995). In these situations, the primary motivation is psychological and involves parental attention-seeking behavior in order to gain recognition for herself in the parenting role from professionals seen as powerful (Meadows, 1995; Schreier, 1996). Issues and motives such as the acquisition of custody may be present, but are NOT the primary motivation that precipitates the child's being brought for repeated sexual abuse examinations.

The abuse may involve one child in the family or it may involve several children either simultaneously or serially (Alexander et al, 1990). There is

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Munchausen by Proxy

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an increased likelihood of a history of another child in the family who was ill and/or who died. The initial concern when MBP is suspected is to diagnose and report the presence of maltreatment in the child - herein defined as child abuse by **Pediatric Condition Falsification**. Such findings may be documented by circumstantial evidence (such as a positive toxicology screen, symptoms occurring only when parent is present, child improving with supervision of or separation from parent) or by direct observation including through the use of video surveillance.

Factitious Disorder by Proxy is a psychiatric disorder which is applied to a person who intentionally falsifies signs or symptoms in a victim (usually, but not always a child).

The specific form or physical consequence of the abuse is not necessarily representative of the intensity or potential harm to the child. Pediatric providers should be aware that there is a high recidivism rate in MBP even after the parents have been apprehended. In many cases parents are likely to continue to abuse their children under close scrutiny, under surveillance, after confrontation and psychiatric treatment, and when their children are returned to them (Kinscherff & Famularo, 1991; Bools, Neale & Meadow, 1994). Both safety issues to the child and treatment planning for the family may hinge upon an assessment of motivation of the parent, in conjunction with the extent, lethality, and chronicity of the abuse to the child.

The psychiatric morbidity to the child is often serious in both cases of near-lethal inducement of illness as well as in the chronic false reporting of symptoms. The psychological impact of the parent's deception can be debilitating to the child.(McGuire & Feldman, 1989).

"Doctor shopping" may be a sign of **Pediatric Condition Falsification** when the motivation is not to actually get help for the child but to subject the child to the abuse of repeated investigations and needless procedures by doctors, in order to maintain relationships with health care personnel. In other instances "doctor shopping" is not present; physicians and other health care providers have long-term treating relationships with the children being victimized.

Issues in the Identification of Factitious Disorder by Proxy

Factitious Disorder by Proxy is a psychiatric disorder which is applied to a person who intentionally falsifies signs or symptoms in a victim (usually, but not always a child). In regard to the issue of motivation of the adult perpetrator, the DSM-IV recognizes that in **Factitious Disorder by Proxy (FDP)**, the abuse, which may be physical or psychological, takes place in a situation where external incentives for the behavior, such as economic gain, are absent. However, it is clear from the work of people experienced in the field (Meadow, 1995) that external incentives such as economic gain, escaping difficult life circumstances, and/or wresting attention or custody from an inattentive or abandoning spouse may be present. However, they are NOT primary in the sense that the driving force for the parent is other than these co-existing incentives.

The literature documents considerable variance in the intensity and periodicity in which this disorder is manifested. There may be periods of quiescence in which no abuse takes place. It should be emphasized that there is NO particular psychological profile or checklist of symptoms that definitely confirm or exclude this diagnosis; there are common patterns, which should be examined on a case by case basis.

Between 93% to 98% of parents or caregivers with **Factitious Disorder by Proxy** are women (Rosenberg, 1987), either mothers, nurses, or foster care parents. Personality problems and disturbances are found quite often; however, psychosis is less common. It is important to note that psychotic delusions may be present in someone who has **Factitious Disorder by Proxy** and, alternatively, that someone might appear to have **Factitious Disorder by Proxy** when the appropriate psychiatric diagnosis is actually delusional disorder, somatic type. A third of mothers themselves suffered from factitious disorder either as adolescents or as adults (Rosenberg, 1987). The mothers, while not always in professions involving health care, are themselves often very medically knowledgeable and have a good command of medical language and terminology. They convince others of their deep caring for their children while the opposite, when the facts are verified, is true.

While lying is a critical component of **Factitious Disorder by Proxy**, it is felt that these adults have the ability not only to lie, but to "impostor". They simulate a caring and believable parent and convince others of their cause while simultaneously engaging in behavior harmful both to the child and to the professionals involved. The resulting distorted relationship between mother and child is the consequence of the child's victimization, driven by the mother's psychiatric disorder. Doctors and other professionals are particularly susceptible to the impostering of these parents, and such relationships may be intense and invasive of the usual professional-parent boundaries.

Women with **FDP** are frequently married to men who are passive, although in a percentage of cases the partners may be directly colluding with the mother in the abuse of the child. Spouses may be physically or emotionally abusive to their partners. Some abuse drugs and alcohol. Commonly, it is the husband or non-perpetrating partner who comes to his wife's

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Munchausen by Proxy

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defense after she has been discovered. However, in some cases, the spouse becomes aware of the condition falsification and chooses to protect the child. Cases do not appear to be limited to a given socio-economic class, race, or life style orientation. Families, particularly maternal grandparents, may play a powerful role in maintaining the deception process in a number of families where the mother is diagnosed with **FDP**.

Conditions that are Abuse by Pediatric Condition Falsification but are not Factitious Disorder by Proxy

There are a number of conditions, which are abuse by **Pediatric Condition Falsification (PCF)** but are not **Factitious Disorder by Proxy (FDP).** Such conditions may be equally as grave as **FDP** and should be taken seriously. It is very important to distinguish **Factitious Disorder by Proxy** from other forms of abuse by **Pediatric Condition Falsification**. These include but are not limited to:

1) Parents or caregivers who injure/abuse their children directly and then lie about the circumstances of their illness; children who are presented to hospital overdosed with drugs given to them by harassed parents trying to keep the child quiet. Caregivers with feelings of hatred and violence towards their children which become apparent soon after meeting them; parents who suffocate their children trying to get them to stop crying.

2) Children who are neglected and/or fail to thrive, where parents cannot cope with the child and/or fail to feed them adequately.

3) Parents, often called "help seekers", who are overwhelmed and blatantly falsify symptoms, maybe on only one occasion, in order to get assistance caring for their child (Schreier & Libow, 1986).

4) Parents of children with chronic illness who appear difficult because of psychological issues of their own or because they disagree with the medical staff and who are resistive to treatment. Over-anxious parents who are extremely distressed about their children's behavior or health and may exaggerate their children's problems in order to receive attention for their children who they feel are not receiving proper care.

5) Children who present with illnesses or conditions resulting in missed school time where the primary motivation is the parent's wish to keep the child dependent and at home. The child may participate by making him/herself ill in order to stay home. The ongoing deception and manipulation of doctors and other personnel is absent.

6) Parents who are delusional and present their children with illness are generally not found amongst parents with **Factitious Disorder by Proxy**. However, delusional disorders may co-exist with **FDP**. There are cases of mothers who were psychotic presenting but their psychosis appeared to be independent of the **FDP** behavior. Such parents are more likely to present with older children.

Preliminary Recommendations

Pediatricians and other health care personnel should:

1) be alert to the possibility of **Pediatric Condition Falsification** and familiar with the many possible presentations in the child; 2) engage in a careful review of the past medical history of the child to include all available past records; 3) request assistance from pediatric or other professionals with expertise in diagnosing **Pediatric Condition Falsification** and **Factitious Disorder by Proxy**; 4) be fully versed in the expected presentation, course, treatment efficacy, and prognosis of the child's disorder; 5) obtain external verification of as many items as possible provided in the history by the caregiver.

When psychological evaluations are recommended in these cases the mental health professional involved should:

1) be experienced with the diagnosis of **Factitious Disorder by Proxy**; 2) have access to as much medical information on the child and family as is possible; 3) thoroughly understand the diagnosis of child abuse by **Pediatric Condition Falsification**; 4) obtain external verification of as many items as possible provided in the history by the caregiver.

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Co-occurring Spouse and Child Abuse: Implications for CPS Practice

by Anne E. Appel, MA and George W. Holden, PhD

The question of co-occurring child and spouse abuse holds several potentially important implications for CPS workers and the legal system. To what extent are children in homes where marital violence has occurred at risk of being physically abused themselves? Should witnessing marital violence be considered emotional abuse? A better understanding of the extent and nature of the co-occurrence of child and spousal abuse can lead to the development of more effective intervention and prevention programs.

This article presents information based on the domestic violence and child abuse literature with the goal of enhancing the CPS worker's understanding of rates of co-occurring spouse and child abuse, models of co-occurrence, treatment issues, and targets for intervention.

A better understanding of the extent and nature of the co-occurrence of child and spousal abuse can lead to the development of more effective intervention and prevention programs.

Rates of co-occurrence

Appel, Angelelli, & Holden (revision under review), tried to estimate the rate of co-occurring physical child abuse and spouse abuse based on a review of the research on domestic violence and child abuse[1]:

- Physical child abuse and spouse abuse co-occur in about 6% of the families in two community samples from the National Family Violence Surveys (1975, 1985) (Hotaling, Straus, & Lincoln, 1990).
- Studies using samples of battered women have reported co-occurrence rates that range between 20% and 100% (e.g., Kruttschnitt & Dornfeld, 1992; O'Keefe, 1995).
- Studies using clinical samples of children have reported co-occurrence rates that range between 26% and 59.4% (e.g., McKibben, DeVos, & Newberger, 1989; Sternberg, Lamb, Greenbaum, Cicchetti, Dawud, Cortes, Krispin, & Lorey, 1993).

Limitations in co-occurrence research

The research on co-occurring spouse abuse and physical child abuse has a number of methodological limitations, including:

- Reliance on battered women samples
- Lack of community/comparison samples
- Reliance on a single source of report for abuse
- Lack of agreement on assessment methods and criteria for abuse

The methodological limitations of the existing research on the co-occurrence of spouse abuse and physical child abuse make it difficult to draw conclusions about the exact overlap between the two problems. Despite these limitations, CPS workers know that a sizable number of the families on their caseload experience both domestic violence and child maltreatment problems. These cases are among the most difficult to assess risk and safety, and to make accurate decisions about appropriate intervention and treatment.

Models of co-occurrence

How is the co-occurrence of child and spouse abuse developed and maintained in the family system? To date, no specialized theories have been developed to address the question of why these two forms of abuse occur together. To provide a conceptual framework for understanding the possible relations among the actors in family violence, two types of models of co-occurrence are presented in Figure 1 and Figure 2.

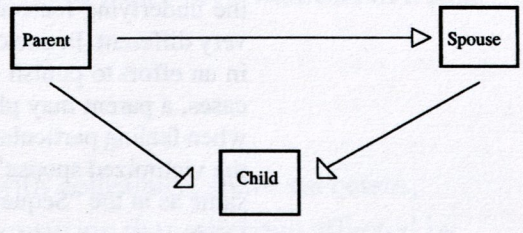
The major distinction between the models is whether they are uni-directional or bi-directional models of co-occurrence. The uni-directional models assume that one spouse and the child are passive recipients of the violence. In contrast, the bi-directional model recognizes that individual members of the family system can interact to develop and maintain the violent behavior patterns. Since it is unlikely that any one model can adequately explain the coexistence of domestic violence and child maltreatment in all cases, it is important that CPS workers understand different explanations so that they can individualize their assessments of families.

Uni-directional Models

The simplest model of co-occurrence is a uni-directional view in which one perpetrator is the sole cause of the violence, and the spouse and child are both passive recipients of the abuse (see Figure 1).

Figure 1

"Dual Perpetrator" model.



[1] *Readers interested in a complete bibliography on studies which contain information regarding the co-occurrence of spouse abuse and physical child abuse can request a copy from the author.*

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Co-occurring Spouse and Child Abuse

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We have conceptualized three types of uni-directional models:

- One Perpetrator Model
- Sequential Perpetrator Model
- Dual Perpetrator Model

In the "One Perpetrator" model, child abuse and spouse abuse originate from one individual, which could be either parent, but it is most often the man. Social learning theory (e.g., Bandura, 1977) predicts that the violence stems from early experiences in the perpetrator's family of origin. The perpetrator observed and now models the use of violence to exert power and control over family members. Individuals who were exposed to family violence in their childhood learned several messages, including: (a) those who love you are also those who hit you, (b)those you love are people you can hit, (c) seeing and experiencing violence in your home establishes the moral rightness of hitting those you love, and (d) if other means of getting your way, dealing with stress, or expressing yourself do not work, then violence is permissible (Straus, Gelles, & Steinmetz, 1980). An alternative theory for this model comes from psychopathology, which suggests that the perpetrator has an antisocial personality that plays itself out in intimate relationships with his partner and his children. In fact, men who have an antisocial behavior disorder are believed to form one of the three major groups of wife batterers (Holtzworth-Munroe & Stuart, 1994).

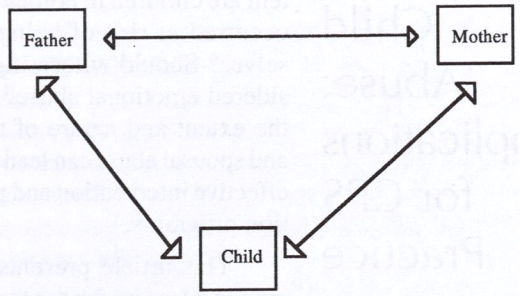
The "Sequential Perpetrator" model implicates the victim of marital abuse as the perpetrator of child abuse. Such a model reflects the situation in which a battered mother might respond to her victimization by physically abusing her child(ren). There are various possible explanations for the abused spouse becoming abusive, including a reaction to the stress of being battered, a modeling of the perpetrator's style of coercive interactions, or simply carrying out the perpetrator's abusive dictates.

Finally, the "Dual Perpetrator" uni-directional model is possible. Here both marital partners physically maltreat the child, although only one parent is the recipient of the marital abuse. It should be pointed out that although the child is abused by both parents, the underlying reasons for the abusive acts may be very different. In one case a parent may abuse a child in an effort to punish or terrorize a partner. In other cases, a parent may physically maltreat a child only when feeling particularly stressed. Thus, the cause of the victimized spouse's abusive behavior may be the same as in the "Sequential Perpetrator" model.

Bi-directional models

A bi-directional model of co-occurring spouse and child abuse would include both child and parent risk factors as contributors to the occurrence of interparental and parent-child violence (see Figure 2).

Figure 2



This "family dysfunction" model predicts that marital violence will result in the development of externalizing behavior problems in the children (Jaffe, Wolfe, & Wilson, 1990; Jouriles & Norwood, 1995). Marital violence can disrupt child rearing in several ways. Battered women, for example, experience increased stress, exhibit greater inconsistency in child rearing, and may become punitive and less warm. This disruption in parenting leads to an increase in coercive interactions with children, which is a risk factor in the development of externalizing behavior problems. Patterson (1986) has suggested that externalizing "acting out" behavior in children elicits coercive behavior from the parent, and the child responds with his or her own coercive behavioral reaction. Witnessing marital violence may also result in the development of externalizing behavior problems in children through social learning. Children who observe and then model their parents' marital violence learn that violence is the preferred method of dealing with family conflict.

Children who observe and then model their parents' marital violence learn that violence is the preferred method of dealing with family conflict.

In addition to the role of social learning and stress in both the uni-directional and bi-directional models, a behavioral genetics explanation cannot be ruled out. Frick and Johnson (1993) proposed a "third variable" model whereby genetic predispositions mediate the relationship between antisocial behavior in a parent and antisocial behavior in a child. In this model, the primary risk factor is the parent's antisocial behavior. That behavior, reflecting an antisocial trait, leads to antisocial behavior in a child through genetic, as well as environmental effects.

Treatment issues

Identifying and assessing co-occurrence

Social service providers who understand the possibility of divergence of family members' reports can utilize protocols that interview family members separately. Research on the divergence of reports from different family members on the occurrence of

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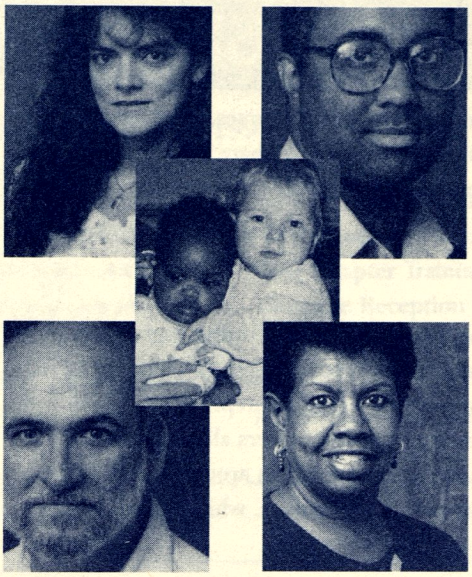

The Sixth National Colloquium of the American Professional Society on the Abuse of Children

July 8 - 12, 1998

Hyatt Regency on the Riverwalk

Chicago, Illinois

Colleagues Connecting for Kids

NETWORK...

Join your colleagues in Chicago for the most stimulating training of your career! APSAC's National Colloquium is more than an excellent source of advanced professional education: It is where members and leaders join forces to advance best practice in the field. Leaders of national committees, task forces, and state chapters meet to plan publications, formulate practice guidelines, and develop strategies for addressing public policy and legislative issues.

LEARN...

APSAC's National Colloquium is a major source of information and research critical for interdisciplinary professionals in the field of child abuse and neglect. Designed for professionals in mental health, medicine, research, academia, education, law, law enforcement, and child protective services, APSAC's seminars--taught by leading experts in their fields--provide the most current thinking and innovations in practice and research. A pre-conference institute examining child maltreatment in African-American families will stimulate discussion and debate on issues of cultural diversity.

TEACH...

In paper presentations, poster sessions, research breakfasts, the Research Symposium, and Open Forums, members and colleagues meet formally and informally to discuss areas of vital interest. Hundreds of professionals report the latest research and practice through poster and paper presentations in a rich mix of stimulating formats.

EMPOWER YOURSELF...

At APSAC's Sixth National Colloquium, you can meet face to face with colleagues, share successes, challenges, and ideas. Lend your energy to the dynamic process of ensuring that everyone affected by child abuse and neglect receives the best possible professional response!

About APSAC

The American Professional Society on the Abuse of Children was incorporated in 1987 and now has more than 5,000 members in 43 state chapters - child protective services workers, law enforcement personnel, psychologists, physicians, nurses, attorneys, teachers, researchers, administrators, clergy, and allied professionals. Diverse as they are, these professionals share a dedication to APSAC's mission of ensuring that everyone affected by child maltreatment receives the best possible professional response.

About the Colloquium

APSAC's National Colloquium offers high quality, interdisciplinary sessions addressing the most critical and cutting edge issues in the field. A volunteer committee of over 50 APSAC members, organized into discipline-specific subcommittees, develops the program, making every effort to ensure that the dominant issues and challenges of this ever-evolving field are represented. Each session offers empirically sound and immediately useful information applicable to practitioners and researchers alike. In addition to an outstanding training opportunity, the Colloquium provides a chance to network with your colleagues from around the country. This year's pre-conference Institute on July 8 focuses on issues of maltreatment in African-American families, while the balance of the Colloquium's diversity programming will concentrate on families of color.

About the Program

The Colloquium program is divided into two major segments:

Invited, intensive seminars -- These three and six-hour skills training seminars are taught by invited faculty who are leading experts in the topic. These intensive, hands-on training seminars are firmly grounded in the latest knowledge and research, and are designed for professionals at all levels of expertise.

Field-generated training and research -- These 90-minute sessions are selected by a process of blind peer review from hundreds of submissions in response to an open call for abstracts. There will be poster presentations, research symposia, open forums, and state chapter, task force and committee meetings.

Chicago in the Summer

Summer is a lively, exciting time in the Windy City, with street fairs, festivals, and the beautiful beaches of Lake Michigan. Taste of Chicago, a 10-day musical and gastronomical feast which annually draws more than two million visitors, will be held the weekend prior to the Colloquium. Chicago's world renowned theater, sports teams, legendary blues clubs, prestigious museums, charming ethnic neighborhoods, shopping on the Magnificent Mile, and five star restaurants make this city a favorite tourist destination.

Hotel Accommodations

The Hyatt Regency Riverwalk is located in the heart of Chicago's downtown area. All Colloquium activities will take place at this hotel, and a block of rooms has been reserved for Colloquium attendees at a rate of $120 (plus tax) for a single or double room for the dates of July 2-15. Reservations must be made by June 16, 1998. Rates thereafter are based on availability. We **urge** you to make hotel reservations early. For reservations, call the hotel directly at 1-800-233-1234, and ask for the APSAC Colloquium rate. For information about alternative hotels in the area, please check the box on the registration form.

Getting There and Getting Around

Chicago is served by two major airports, Midway and O'Hare. Both are easily accessible by public transportation, airport shuttle or taxi cab. Assistance with travel arrangements is available from Genesis Travel at 800-260-6196. Continental Airlines is offering discount fares for the Colloquium - call 800-468-7022, Ref #NQXVRD. Additional discount flights are available through Conventions in America 800-929-4242, Group #538. Hertz and Avis are offering discount car rental rates. For Hertz, call 800-654-2240, meeting code CV#41563. For Avis, call 800-331-1600, discount #J628967. Hotel parking: $26/day for overnight guests.

Cancellation Policy

Cancellations received in writing prior to May 22, 1998 are refundable, less a $50 administrative fee. Cancellations will not be accepted after May 22, 1998. Substitutions may be made. Refunds cannot be processed until after July 12, 1998.

Colloquium Schedule At A Glance

Wednesday, July 8, 1998

8:00 a.m. - 4:00 p.m. Registration
9:00 a.m. - 5:00 p.m. Pre-Conference Institute:
Child Maltreatment in African-American Families
10:00 a.m. - 4:00 p.m. State Chapter Training
6:30 p.m. - 8:00 p.m. Welcome Reception

Daily Thursday - Saturday

7:00 a.m - 5:00 p.m. Registration and Exhibits

Thursday, July 9, 1998

7:15 a.m. - 8:15 a.m. Research Breakfasts
8:30 a.m. - 5:00 p.m. Training Seminars

Friday, July 10, 1998

8:30 a.m. - 10:00 a.m. Plenary Session
10:30 a.m. - 5:00 p.m. Seminars

Saturday, July 11, 1998

8:30 a.m. - 5:00 p.m. Sessions and Research Symposia

Pre-Registration Form

Name & Degree _____ Member ID # _____

Agency _____

Address _____

City, State, Zip _____

Phone _____ Fax _____ Email _____

Registration Fees - Member Rates

- ❑ $335 - APSAC member
- ❑ $275 - APSAC student member
- ❑ $150 - APSAC member one-day attendance

Registration Fees - Non-member Rates

- ❑ $435 - non-member registration *
- ❑ $325 - non-member student *
- ❑ $175 - non-member one-day attendance

* Includes a one year membership in APSAC

For single day registrants, please indicate which day you will attend: _____

Register by May 22, 1998 for the best price!

Registration fees listed above do not include late fees of $50 (full) or $15 (one day) which are required for registrations received after May 22, 1998. Registrations must be accompanied by full payment or purchase order to guarantee early registration rates. Group discounts are available - please call APSAC's Training Department at 312-554-0166 for details.

Method of Payment (please check one)

❑ Visa ❑Mastercard ❑American Express ❑ Check # _____ ❑ Purchase Order # _____

_____ _____ _____
Signature account number exp. date

Total Payment Enclosed $ _____

❑ Please check here if you would like information about alternative hotels in the area.

You will receive confirmation of your registration and a session registration form, with complete program information, in March. You MUST register for specific sessions to complete your registration. To avoid double charges, please do not mail and fax registration forms.

Please help us serve you better -- check one box in each category that best describes you and your practice.

Discipline: ❑ Child protective services ❑ Education ❑ Law enforcement ❑ Medicine ❑ Nursing ❑ Psychiatry ❑ Psychology ❑ Social Work ❑ Sociology ❑ Law

Expertise: ❑ Physical Abuse ❑ Sexual Abuse ❑ Psychological Abuse ❑ Prevention ❑ Neglect

Population Served: ❑ Adolescent victims ❑ Child victims ❑ Adult survivors ❑ Families ❑ Perpetrators

Please return this pre-registration form to:

APSAC, 407 South Dearborn, Suite 1300, Chicago, Illinois 60605 FEIN #93-0940608

fax: 312-554-0919 phone: 312-554-0166 homepage: www.apsac.org

Advance registration deadline June 26, 1998. Registrations thereafter must be on-site.

Colloquium Program Highlights

As this brochure went to press, the Colloquium program was still being finalized. Below are some of the proposed topics which are being considered for inclusion in the final program. The final program will be available in March, and all pre-registered attendees will receive priority registration materials.

Past Years' Colloquium Faculty

Veronica Abney, MSW
Randell Alexander, MD, PhD
Catherine Ayoub RN, EdD
Lucy Berliner, MSW
Robert Block, MD
Barbara Boat, PhD
Barbara Bonner, PhD
John Briere, PhD
Detective Richard Cage, MS
David L. Chadwick, MD
Mark Chaffin, PhD
Jon R. Conte, PhD
Kathleen Coulborn Faller, PhD
Deborah Daro, PhD
Esther Deblinger Sosland, PhD
Diane DePanfilis, PhD, MSW
Howard Dubowitz, MD
The Honorable Harry Elias, JD
Mark Everson, PhD
Jamie Ferrell, BSN
Lisa Fontes, PhD
William Friedrich, PhD
Colleen Friend, MSSA
Ann Haralambie, JD
Sandra Hewitt, PhD
David Kolko, PhD
Kenneth Lanning, MS
Carolyn Levitt, MD
Thomas Lyon, JD, PhD
Kee MacFarlane, MSW
Cheryl McNeil, PhD
John E.B. Myers, JD
Monica Roizner, EdD
Herbert Schreier, MD
Robert Shapiro, MD
Melissa Steinmetz, ACSW
Marvin Ventrell, JD
Lt. Bill Walsh
J.M. Whitworth, MD
Charles Wilson, MSSW
Beatrice Yorker, RN, JD

Child Protective Services

* Engaging Families as Partners to Reduce Risk of Neglect
* Case Planning and Management of Concerning but Unsubstantiated Cases of Alleged Sexual Abuse
* Evaluating Safety to Guide Initial and Reunification Decisions
* Balancing Safety and Family Preservation: When is it safe?
* The Role of CPS in Evaluating the Effect of Parental Substance Abuse

Cultural Diversity

* How Clinical Issues Vary with Cultural Context in Abuse Cases
* Native American CPS Issues
* The Meaning of Culture in Assessing Risk of Maltreatment

Law Enforcement

* Suspect Interrogation in Child Abuse Investigations
* Investigative Techniques for Child Physical Abuse
* Conducting Investigative Interviews in Child Sexual Abuse Cases
* The Link Between Victim's Statement and Perpetrator's Confession
* The Investigation of Child Sexual Exploitation
* Holding Sex Offenders Accountable

Medicine/Nursing

* Lessons Learned from the Louise Woodward Case
* Diagnosis and Treatment of Sexually Transmitted Diseases
* Determining the Timing of Injuries
* Photo Documentation of Abuse
* Update on Sexual Abuse Examinations
* Munchausen Syndrome by Proxy and SIDS
* Forensic Evidence of Burns & Bites
* Abusive Head Trauma

Interdisciplinary

* Enhancing Resilience in Children from Maltreating Families
* Strength Based Approaches to Facilitating Client Change
* Media Control/Preparation
* How Do I Decide to Plan Toward Adoption Rather Than Reunification?
* Hot Topics in Malpractice: Case Analyses
* Interventions with Children Exposed to Domestic Violence
* The Sex Offender Continuum
* Combatting Defense Strategies in Child Sexual Abuse Cases
* Legal, Practical, and Ethical Considerations with One Party Consent Telephone Calls
* Mental Health Malpractice: Professional Self-Preservation
* Domestic Violence and Child Abuse
* Suggestibility Point/Counterpoint

Mental Health

* Evaluating and Treating Parents Whose Children have been Abused
* Sex Offenders: Suggested Typologies and Associated Interventions
* Treating Abused Children
* The Psychological Assessment: An Overview
* Assessment, Triage, and Treatment Selection in a World of Managed Care
* Treating Adult Victims of Abuse in Crisis

Law

* Representing the Non-Offending Parent in Custody Cases
* Challenging Expert Testimony Regarding Children's Suggestibility
* Representing the Child: Advocacy vs. Best Interests
* Jury Selection in Child Abuse Cases
* Pretrial Motion Practice

Co-occurring Spouse and Child Abuse

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domestic violence suggests that:

- Children may underreport acts of parent to child abuse
- Husbands may underreport acts of spouse abuse

Until we have a better understanding of the sources of variability in reports, violence reports from one source are problematic. The best solution appears to be using multiple sources.

McKay (1994) outlines specific indicators that a spouse or child may be a victim of domestic violence and may need to be interviewed separately. Indicators that children may have witnessed domestic violence include fear of leaving abused parent alone, and abusive behavior towards parent. Some of the specific indicators that a mother may be a victim of domestic violence and need to be interviewed separately to assess the possibility of domestic violence as a factor that may also suggest a risk for child maltreatment include:

- Inconsistent explanations for observed injuries
- Accidents during pregnancy
- Substantial delays in seeking medical treatment
- History of repeated accidents and emergency room visits
- Observed embarrassment or evasiveness when questioned about injury or abuse
- Anxiety and fear in presence of partner
- Apologies or explanations for partner's behavior

In addition, McKay (1994) outlines behavioral indicators for screening partners who batter their spouses. Indicators of an abusive partner include:

- Speaking for partner
- Strong resistance to separate interviews
- Derogatory descriptions of, and condescension towards partner
- Minimization of frequency and severity of violence
- Blaming of partner for provoking abuse

Since the presence of domestic violence indicates a higher risk of child maltreatment recurrence (DePanfilis, 1995), CPS workers must increase awareness of these indicators and develop accurate assessments of risk and safety. Most CPS safety evaluation models recognize this and include domestic violence as a factor that increases concern for the safety of maltreated children (DePanfilis and Scannapieco, 1994; Scannapieco and DePanfilis, 1994). CPS workers must further recognize that when mothers are at the point of making a decision to leave the home, legally separate or divorce, the potential danger to the mother and children increases. Therefore, safety planning should consider the need for developing safe alternatives to support mothers when they make these decisions (DePanfilis and Brooks, 1989).

Recognizing that exposure to spouse abuse is emotional abuse

Research suggests that children who witness spousal violence exhibit symptoms that are similar to children who have been emotionally, physically, or sexually abused and are in need of protection (Echlin & Marshall, 1995). The family dysfunction model of co-occurring spouse and child abuse suggests that witnessing marital violence can lead to externalizing behavior in children which disrupts the parent-child relationship, and may escalate into child abuse.

The implications of this research should be considered as CPS workers evaluate the degree to which children are exhibiting symptoms from witnessing violence and whether the conditions observed meet the state's definition of emotional abuse, psychological maltreatment, or mental injury.

Research suggests that children who witness spousal violence exhibit symptoms that are similar to children who have been emotionally, physically, or sexually abused and are in need of protection.

Targets for intervention

Marital relationship: Who gets treatment?

Schechter and Edleson (1994) describe the opposing views of child protective workers and battered women advocates in their interpretations of "the best interest of children." Traditionally, child protective workers approach the problem with the child's safety as the sole priority, while battered women advocates believe that keeping the mother safe from violence is a necessary precursor to keeping the child safe.

There are several important factors to consider when making decisions about the perpetrator's visitation or custody rights or when assessing the most appropriate treatment plan for the family. These factors include the perpetrator's psychological profile, the likelihood of intra-agency collaboration, and the safety of the victims.

Saunders (1994) suggests that efforts to help battered women overcome their psychological trauma and become better parents have a higher likelihood of success than services targeting the perpetrator of violence, whose problems may be more chronic and less amenable to current treatment. Individuals who are violent to their families exhibit a variety of family of origin backgrounds, emotional and personality disorders which are important to assess when deciding if the currently available treatment is recommended. For treatment to be effective, the perpetrator's profile must be one that would allow for long term behavioral change in the perpetrator's family relationships. Many violent perpetrators need a combination of batterer intervention programs and law enforcement sanctions to prevent future violent incidents from occurring in the family. In order for a family approach to treatment to be put into practice, the safety of

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victims of violence must be ensured by collaborating agencies.

Parent-child relationship

The family dysfunction model supports the idea that spouse abuse is a necessary intervention target in the treatment of child abuse, because both forms of abuse are interacting to develop and maintain each other in the family system. However, family systems researchers like Margolin and John (1995) point out that treating the spouse abuse by itself will not have a significant effect on child adjustment because the quality of parenting is such a strong mediator between spouse abuse and child psychological adjustment. In order to have a significant effect on the family system, parenting must also be an intervention target. The family dysfunction model supports the idea that harsh, inconsistent parenting plays a significant role in the emergence of externalizing behavior problems in children who are witnesses to domestic violence.

The parent-child relationship becomes an essential target for intervention when the battered woman is also an abusive parent. This is an especially troublesome situation for child protective workers, because the goals of child safety and family preservation may be in serious conflict. The family dysfunction model suggests that mothers may be aggressive toward their children as a consequence of the stress they are experiencing in the battering relationship. Once the mothers are out of that relationship, they may become less punitive (Holden, Stein, Ritchie, Harris, & Jouriles, in press). Alternatively, if some mothers are chronic abusers, perhaps for reasons apart from their victimization, then it would be important for child protective workers to assess mothers' amenability to current treatment when making decisions about family preservation. Peled & Edleson (1992) suggest that treating battered women in parent groups, concurrently with groups for the children of battered women, may be an effective approach in situations in which battered women are also abusive mothers.

Conclusion

The collaborative approach that is suggested by this model is based on the idea that family violence is a result of a dysfunctional family system. Recognizing that child abuse and spouse abuse are interacting together to develop and maintain each other, professionals who work with families in which child abuse and spouse abuse co-occur need to assess and treat all forms of family violence. Targets for intervention in a family characterized by domestic violence should include the marital relationship and the parent-child relationships. Because the systemic model suggests that intervention targets include both the marital and parent-child relationships, collaboration with other agencies is essential. Child protective workers trained in domestic violence need to take a collaborative approach and work with battered women's advocates and the police and criminal justice system to respond to the family, as opposed to an individualized agency response (Magen et al., 1996). As many researchers have pointed out, there must be coordination of child protective services, battered women's agencies, batterer treatment programs, the police and the criminal justice system for all individuals in the family system to be treated safely and effectively (e.g., Echlin & Marshall, 1995).

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The Case: Sarah

Sarah is a nine year old fourth grader. She has two younger half siblings, George, 6, and Sissy, 3. Her mother, Joanne, was married to Sarah's father but they are currently divorced, and Sarah has limited contact with her father. George and Sissy each have different fathers, who have little contact with the children.

Joanne is very religious and attends a Christian-based church three times a week. The children also attend, and are not allowed to play with friends from outside of the church. Joanne met Leroy, a deacon, through the church. After their first date, Leroy moved into the house with Joanne and the children and reorganized the household, setting bed times and meal times and determining how Joanne's AFDC check would be spent.

Leroy beats the children with his belt, leaving red marks and sometimes bruises. When Joanne complained, he replied, "Spare the rod and spoil the child." During one beating, Sarah was inadvertently struck in the eye by the buckle of the belt, causing her eyelid to swell and obscuring her vision. The two younger children are afraid of Leroy, and try to obey him, although this is difficult as he frequently changes the house rules. Sarah, however, talks back to him and threatens to "tell her daddy on him." Leroy has decided that Sarah is possessed by the devil and is a bad influence on the other children. On one occasion, Sarah talked back to Leroy and he forced her to eat raw horseradish. When she vomited the horseradish, he forced her to eat the vomited horse radish, causing her to vomit again. Leroy forces Sarah to sleep in the basement on a rug instead of in her bed so that she will not roam around at night and poison the minds of the younger children. He made her eat out of a dog dish on the basement floor so she could learn humility and become closer to God.

Leroy has persuaded Joanne that this is the best way to handle Sarah and her insubordination to him and to God. They both have begun to see Sarah as the cause of all the family's problems.

Sarah's teacher noticed Sarah's swollen eye, and that she seemed sad and often fell asleep in class. After an initial reluctance, Sarah told her teacher the situation in her home. The teacher reported Sarah's allegation to the CPS authorities, who removed Sarah from the home, but left the two younger children. Joanne and Leroy have said that the CPS workers are agents of the devil, and are not cooperating with treatment.

Case Response

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University of Maryland

How would CPS intervene? Why?

In any situation where alleged maltreatment is identified, CPS has three responsibilities. Primary is the responsibility to assess the immediate risk to all children in the home. This brief case description identified the factors that placed Sarah in immediate risk of maltreatment, which resulted in her removal. Those factors in summary are: Leroy's perception that Sarah is "possessed by the devil" and that he is self-righteous in his excessively severe "discipline;" the use of a belt to beat the children; Joanne's alignment with Leroy, which leaves her unable to provide protection in the home; and the caretakers' noncooperation with CPS. CPS must continue to assess the immediate safety of the children remaining at home, George and Sissy.

Another responsibility of CPS is to make a finding based on the evidence gathered concerning the allegations of maltreatment. CPS must determine if the situation in this family meets the legal definition of abuse as defined by the state civil law. This is the easiest task in this case situation because the level of evidence needed (a preponderance of the evidence) is met by the following: the children have sustained a physical injury; Sarah is old enough to provide a detailed account of the maltreatment; and Leroy justifies his actions.

Finally, the hardest and most critical task is to assess this family at a deeper level to determine the factors that place all of the children at risk, and then to develop strategies with the family for reducing the risk factors. There is much to further assess in this family now that Sarah's immediate safety has been addressed.

Would you attempt to involve other professionals from other disciplines in the case?

Much has been written on the connotation of the biblical references of "sparing the rod" and the shepherd's use of the rod not to beat sheep but to guide them. It seems that religion plays an important role for Joanne and Leroy. Therefore, it may be beneficial to involve a pastoral counselor who could explore the issue of violence and control with Leroy. I would caution that the CPS worker must be especially knowledgeable of the community resources when making this referral. Religion is identified as an authority and may be utilized to bring about a positive change in this family.

A consultation with a professional who works in the area of domestic violence may assist in an

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Sarah

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assessment of Joanne and her ability to protect her children. I wonder about Joanne's history and her willingness to allow Leroy to take such complete control of her home and children.

What are the key issues?

The key issues identified in this case for CPS are:

The severity of the maltreatment toward all the children, especially Sarah, and the continued need to assess the immediate safety of George and Sissy;

The righteous attitude of Leroy toward violence in the home;

The labeling of "CPS workers as agents of the devil," which makes it difficult to establish a helping working relationship;

Joanne's relationship with Leroy and his control in her home.

Long-range plan for addressing this problem

A more in-depth assessment is necessary to adequately determine the long-term direction for this specific case. In general, CPS needs to assist the caretakers to expand their definition of discipline to include nurturing and guiding of the children's behavior rather than violence. It is encouraging that this situation sounds like a recent development in the life of this family, and therefore, there is a high potential for change. Joanne is a critical piece in this family puzzle—she needs to be supported to examine her relationship and to develop her self-sufficiency as well as her role of primary caretaker.

Case Response

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What are the key issues?

Sadly, most professionals in the field of child abuse have seen similar, though perhaps not as extreme, cases in which distortions of Biblical principles and Christian beliefs are used to perpetuate cruelty against children. If one temporarily sets aside the religious aspects of the case, case formulation is fairly straightforward, involving physical and emotional abuse and neglect of Sarah and probably her two siblings. The abuse is perpetrated by an apparently angry, rigid, controlling man who has used his position of influence to exploit an emotionally dependent, somewhat socially isolated single parent and her young children.

The religious aspects add a challenging wrinkle. Typically, the family's belief system in such a case can play one or more roles: 1) as a cause of child maltreatment (e.g. when critical medical care is withheld because of religious beliefs); 2) as a factor to justify or maintain abusive parenting patterns that have their roots in other individual or family dynamics; or 3) as a possible solution to the problem of child maltreatment.

The shallow and selective nature of Leroy's Christian convictions provides an important clue that role #2 is in effect here. While Leroy is quick to point to Biblical admonitions that parents have primary responsibility for instructing their children in right and wrong behavior, he conveniently ignores equally clear Biblical injunctions against sex outside of marriage. While Leroy offers an extreme (and distorted) interpretation of the "Spare the rod, spoil the child" proverb, he tramples on the crucial, counterbalancing Christian tenets of love and respect for others (e.g., "Do everything out of love," "Love your neighbor (child) as you love yourself," "Regard others as more important than yourself").

Unknown at this juncture of the case—and one of the essential assessment issues—is whether Joanne's religious beliefs and Christian support system can play a significant role, not only in ending the maltreatment of her children, but also in bringing the family to a position of psychological health and well-being.

How would a psychologist intervene?

A psychologist's first contribution in this case would be to aid in the assessment process. A number of issues must be addressed before appropriate intervention and treatment can be planned:

1) Are Sarah's two younger siblings safe? Should the CPS decision to leave them in the care of Leroy and Joanne be reconsidered? Careful and sensitive interviews with Sarah about family life and the care of the children will shed light on this issue, but both younger children should be evaluated for immediate safety as well as longer term treatment needs.
2) What was the mother's role in the abuse and neglect of Sarah and possibly the other children? How workable is she? How committed is she to the relationship with Leroy vs. her children? Is her relationship with Leroy based on love and mutuality? On fear and control? To what degree is her belief system consistent with Leroy's? Is she able to consider other perspectives? What are her own psychological dynamics and needs? What are her strengths and liabilities as a parent? To what degree is she able to empathize with the feelings and needs of her children? What is the nature of her social support system from church and from other sources?
3) How is Sarah functioning psychologically, socially, and academically? Does she exhibit symptoms of depression, anxiety, PTSD, or other signs of psy-

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Sarah

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chological trauma? How was she functioning before Leroy entered her life? What was her relationship with her mother like then? What is it like now? What are her treatment and placement needs?

4) What is Leroy's social, psychiatric, religious, and criminal background? What is his commitment to Joanne? To her children? To reuniting the family? Would he cooperate with a psychological evaluation? Would he be responsive to input from his church pastor or other Christian viewpoints?

What other professionals would you attempt to involve?

I would immediately seek to involve Leroy and Joanne's church pastor. It would be critical to assess his perspective on Leroy and Joanne's relationship, on their abusive and neglectful parenting, and on Leroy's efforts to justify such behavior through appealing to Christian principles. Ideally, the pastor and the rest of the church leadership would be willing not only to communicate a clear, uncompromising message that such treatment of Sarah is intolerable by any Christian perspective, but also to commit to working toward resolution of the problems in the family. If the church pastor were to condone Leroy and Joanne's behavior, hope for an easy resolution would be slim and court action would undoubtedly be necessary to mandate compliance with a treatment plan.

I would also make an effort to ensure that at least one professional who is a committed Christian is included on the assessment/treatment team. Such a person would likely enhance communication and understanding between the various parties and add credibility to the process.

What is the long-range plan?

The long-range plan would include moving Leroy out of the home and Sarah back in. Ideally, this would involve intervention to respectfully challenge and re-construct Joanne's religious belief system so that it could not be used to justify maltreatment of her children. The psychological, social, and economic conditions that contributed to Joanne's decision to engage in a destructive relationship with a man like Leroy would also need to be addressed.

Sarah (and possibly her siblings) will need psychological treatment for the impact of the abuse, neglect, rejection, and abandonment she suffered. These experiences likely will have had a profound effect on her own spiritual and religious beliefs, including instilling in her a view of God as punitive, cruel, and rejecting. Given the possible pervasive influence of this belief system on Sarah's self-concept, moral development, and sense of purpose and meaning throughout life, the spiritual impact of her maltreatment should also be addressed in the treatment plan.

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Case Response

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Presuppositions:

1. As a Christian pastor, I approach situations with the serious attempt to base all decisions upon both the attitudes and directions given in the New Testament.
2. Both my decisions and my resources are backed up by a community of Christians who are committed to living out the practical realities of all that Jesus Christ did and taught.
3. Finally, any responses are not hypothetical but occur frequently in real life situations.

Leroy has violated the most basic Christian commitment to sexual purity as well as his additional commitment to be an example for others to follow (1 Cor. 5:1, 11; 6:9-10; 1 Tim. 3:2-10). As his pastor, I (and one of the elders) would immediately confront Leroy with his moral failure, with his violation of the trust he has held as an officer of the church, and with his sin against Joanne and her children. We would appeal to him in an attitude of gentleness and humility (Gal. 6:1), yet knowing that we do have an authority to command him to repent from his sinful behavior as well. This combination of gentleness and the confidence of authority is backed up by God in the conscience of the man. We would firmly insist that he immediately move out of the house and separate from all contact with the mother and children (1 Tim. 5:20).

At the same time, we would also appeal to Joanne as a Christian to repent to God for her own sin in fornicating and for betraying her children by bringing this man into the home she was charged to protect.

It is not at all unusual in such cases to see one or both of these people experience a genuine sorrow for their sin and change their minds about their conduct in a lasting way. At this point we would assign a mature Christian woman to work with Joanne and a man to work with Leroy. This woman and man would become prayer partners who would help them to experience a deepening commitment to change during this time of vulnerability. Leroy would, of course, be asked to step down from his office as a deacon (elder), and if he refused then his behavior would be discussed with the congregation in a meeting which is not open to the public (1 Tim. 5:20). Should Leroy and Joanne not repent, they would be disfellowshipped according to 1 Cor. 5:11. This is an act which is done

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Sarah

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respectfully with the purpose of communicating to them just how serious their sin is so that they may change their minds.

Leroy's abuse of Scripture in beating the children, claiming that Sarah is possessed by the devil, etc., is not so surprising when you realize that he has already deceived himself by violating so many other Biblical commands already mentioned. I refer to such a man as "having a religious spirit," by which I mean that though he is religious, he is using this to mask a hidden anger, and such a man is dangerous. I certainly deal with such individuals from time to time, but with some basic discernment such a man would never be ordained and placed in a position of authority. If this happened where I was pastoring, I, along with the other pastors and elders, would be asking God to forgive us for allowing such a man to be in this position of trust.

A Christian community is a powerful force to draw upon in such a situation! There would be daily involvement with these two from the prayer-partners who would be able to encourage, exhort, and support them in the process of restoration. The very nature of these relationships involves accountability, and this is so important where such deception has previously worked so deeply in their own hearts. In my own congregation I have many such qualified women and men who have a thorough knowledge of the Scriptures and a deep commitment to living God's way. Usually I choose them based also upon some natural connection or prior relationship with a Leroy or a Joanne.

In my experience I would have heard about Leroy's moving in with Joanne almost immediately, and we would have confronted them long before any abuse could have happened to the children! Such is the nature of the community that it would not be possible for this to happen in secret. In fact, even before I could respond, it is almost certain that a sister would appeal to Joanne and a brother to Leroy to break off this very wrong relationship. Apparently such a community did not exist in this setting so it was fortunate that CPS authorities were able to remove Sarah before even more damage was done.

At this point, my staff would be sitting down with the CPS authorities so that we could work together for the safe return of Sarah to her family. Since my own Christian community has a child psychologist as one of our Home Meeting Leaders, I would ask for his assistance in assessing Sarah's needs as well as those of the other children within the family.

What are the key issues?

1. In a church which is itself living in the integrity of the Scriptures, the child abuse would never have happened because the mother and deacon would have been confronted as soon as Leroy moved in with the family.
2. The second key issue is the abuse of trust by Leroy to take sexual advantage of a vulnerable single mother.
3. Joanne's abdication of her responsibility for the care and protection of her children is the third major violation of principle.
4. The misuse of Christian concepts and terms to justify the abuse of others violates all that the Christian community stands for and the community itself should function to prevent or correct such abuses.

Sixth National Colloquium Call for Volunteers

APSAC is issuing a "call for volunteers" to assist in handling a variety of pre- and on-site assignments for the 1998 National Colloquium in Chicago, July 8-12, 1998. Among the assignments included are: assisting with mailings; handling follow-up telephone calls to registrants; duplicating and collating materials; staffing the registration booth; distributing session materials; collecting evaluation forms; monitoring sessions and other tasks. Based on the time commitment made, it is possible for volunteers — particularly students — to donate enough hours on designated assignments to qualify for Colloquium registration discounts. To sign up for volunteer duty, call APSAC at (312) 554-0166 or e-mail the Conference Manager at APSACEduc@aol.com. See you in Chicago in July!

Edited by Rochelle F. Hanson

JOURNAL HIGHLIGHTS

The purpose of Journal Highlights is to inform readers of current research on various aspects of child maltreatment. APSAC members are invited to contribute to Journal Highlights by sending a copy of current articles (preferably published within the past six months), along with a two or three sentence review to Rochelle F. Hanson, Ph.D., National Crime Victims Research & Treatment Center, Medical University of South Carolina, Charleston, SC 29425 (FAX 803 792-2945).

SEXUAL and/or PHYSICAL ABUSE

Cognitive-Behavioral Therapy Found Superior to Nondirective Supportive Therapy for Sexually Abused Preschoolers

Treatment outcome in sexually abused preschool children was evaluated in 43 sexually abused preschool children and their parents 6 and 12 months after completion of either Cognitive-Behavioral Therapy for Sexually Abused Preschoolers (CBT-SAP) or nondirective supportive therapy (NST). Parents completed questionnaires to measure a variety of symptoms in their children. Analyses indicated that there were significant group by time interactions on several outcome measures from the beginning of the study to the end of the 12-month followup period, with the CBT-SAP group exhibiting significantly more improvement over time than the NST group. Clinical findings also indicate the effectiveness of CBT-SAP over NST in reducing sexually inappropriate behavior. Findings support the superior efficacy of CBT-SAP over NST in maintaining symptom reduction in the year after treatment completion. The importance of using cognitive-behavioral interventions for sexually inappropriate behaviors and including nonoffending parents in the treatment of sexually abused preschool children is discussed.

Cohen, J.A., & Mannarino, A.P. (1997). A treatment study for sexually abused preschool children: Outcome during a one-year follow-up. *Journal of the American Academy of Child & Adolescent Psychiatry Vol 36*(9) 1228-1235.

Relationship Found Between Preschool Abuse History and Adolescent Assaultive Behavior

A 16-year study followed 457 maltreated and nonmaltreated preschool children to identify their involvement in assaultive behavior as adolescents. Subjects were first identified in 1976-77 (at ages 18 months to 6 yrs old) during preschool assessment that examined coping styles and family functioning in abusing and nonabusing families. Assessment of the subjects in late adolescence (1990-92) focused on deviant behavior, including violence. Results indicate that severity of physical discipline, negative quality of the mother's interaction with the child, and the experience of sexual abuse were related to adolescent assaultive behavior.

Herrenkohl, R.C., Egolf, B.P., & Herrenkohl, E.C. (1997). Preschool antecedents of adolescent assaultive behavior: A longitudinal study. *American Journal of Orthopsychiatry Vol 67*(3) 422-432.

Effects of Childhood Abuse Linger Among Adult Women

Results from a study of 1,931 women aged 18+ yrs who attended one of four community-based, primary care practices showed a 22% prevalence rate for childhood physical or sexual abuse. History of childhood abuse was reported more commonly among the youngest subjects, possibly indicating an increasing prevalence, an increasing recognition or redefinition of what constitutes abuse, or a reporting bias in the younger women. Regardless of age, women who reported childhood abuse were less likely to be married. Subjects reporting childhood but not adult abuse also had levels of physical symptoms and psychological problems that were as severe as subjects experiencing current adult abuse. Symptom and complaint levels were highest for subjects reporting both current and past abuse.

McCauley, J., Kern, D E., Kolodner, K., Dill, L., et al. (1997). Clinical characteristics of women with a history of childhood abuse: Unhealed wounds. *JAMA: Journal of the American Medical Association Vol 277*(17) 1362-1368.

New Test Being Developed to Measure Sexual Fantasy

This study examined the preliminary psychometric characteristics of the sexual fantasy questionnaire (SFQ), an instrument designed to measure paraphilic and nonparaphilic fantasies. Aspects of reliability were assessed in a sample of convicted male child molesters (27 inmates and 15 outpatients) and a convenience comparison group of 87 male undergraduates. Results indicate adequate test-retest reliability, acceptable percentage agreement on repeated items, and adequate internal consistency. The convergent validity of the SFQ was supported by the finding that child molesters reported significantly more deviant fantasies involving children than comparison subjects.

O'Donohue, W., Letourneau, E.J; & Dowling, H. (1997). Development and preliminary validation of a paraphilic sexual fantasy questionnaire. *Sexual Abuse: Journal of Research & Treatment Vol 9*(3) 167-178.

OTHER AREAS IN CHILD MALTREATMENT

An Historical Analysis of Child Advocacy Efforts

This article examines the concept of advocacy in child welfare, beginning with definitions of social advocacy and case advocacy. A historical account of advocacy efforts on behalf of abused and neglected children in the US is presented, followed by an analysis of current advocacy efforts, highlighting the potential of court-appointed special advocates. The article concludes with implications and ideas for social workers to assist in case advocacy efforts for children who are part of the child welfare system.

Litzelfelner, P., & Petr, C.G. (1997). Case advocacy in child welfare. *Social Work. Vol 42*(4) 392-402.

Court-Based Mediation Effectively Resolves Child Maltreatment Cases

This article presents the results of an evaluation of 5 California counties (Los Angeles, Santa Clara, Tulare, Contra Costa and Sacramento) utilizing court-based mediation services to process child maltreatment cases filed with the court. The programs employed a variety of different service delivery approaches and targeted cases at a variety of different stages of case processing. Data were generated from the following primary sources: records maintained by mediators expressly for evaluation purposes, file data drawn from juvenile court records, surveys of parents and other lay participants, and interviews with representatives of the primary professional groups participating in mediation and the juvenile court judiciary. The results indicate

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Journal Highlights

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that mediation is an effective method of resolving cases and may offer a number of benefits over adjudication, including more detailed treatment plans and fewer court hearings.

Thoennes, N. (1997). An evaluation of child protection mediation in five California courts. *Family & Conciliation Courts Review Vol 35*(2) 184-195.

The Effect of Childhood Violence on Marital Violence: A Longitudinal Study

This longitudinal study used path analyses to determine whether violence observed and/or experienced in childhood and adolescence had an impact on marital violence as an adult. Male and female subjects, aged 11-15 years, were interviewed each year for four years, and thereafter at 3-yr intervals for 9 yrs. Results support social learning as an important perspective in marital violence; however, males and females are impacted differently. Prior experiences with violence have a more dramatic impact in the lives of females than males, both during adolescence and adulthood, while males appear to be more affected by circumstances occurring concurrently with the marital violence.

Mihalic, S. W., & Elliott, D. (1997). A social learning theory model of marital violence. *Journal of Family Violence, 12,* 21-47.

The Link Between Child Abuse and Date Abuse

Data were collected from female undergraduates on history of abuse (verbal, physical, and sexual) in childhood and dating relationships and psychological adjustment problems. Factors influencing whether people remain in or leave abusive relationships were examined, along with possible mediators of the relationships between child abuse, date abuse, and psychological problems. Verbal, physical, and sexual child abuse were all associated with an increased risk of later date abuse or psychological problems. Abuse by a date was also associated with psychological problems. Data suggest that low self-esteem and general anger problems may serve as mediators for later date abuse or emotional problems.

Sappington, A. A., Pharr, R., Tunstall, A., & Rickert, E. (1997). Relationships among child abuse, date abuse, and psychological problems. *Journal of Clinical Psychology , 53,* 319-329.

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Other Conferences

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April 13-16, 1998. ***24th Annual Critical Care Update.*** Las Vegas, NV. Sponsored by National Professional Education Institute. For more information call 800-573-5575.

April 29-May 2, 1998. ***The Many Faces of Family Support.*** Chicago, IL. Sponsored by the Family Resource Coalition of America. For more information call 888-309-9919.

May 28-31, 1998. ***12th Annual Clinical Meeting.*** Palm Beach, FL. Sponsored by North America Society for Pediatric and Adolescent Gynecology. For information call NASPAG at 215-955-6331.

July 20-24, 1998. ***National Conference of State Legislatures Annual Meeting & Exhibition.*** Las Vegas, NV. For more information call 303-830-2200.

August 4-5, 1998. ***11th Annual Preserving the Innocence of Children Conference.*** Multi- Disciplinary Conference on Child Abuse and Domestic Violence. Weber State University, Ogden, UT. Sponsored by Child Abuse Prevention Center of Ogden. For more information call Marilyn Sandberg at 801-393-3366.

August 16-20, 1998. ***10th Annual Crimes Against Children Conference.*** Dallas, TX. Co-sponsored by Dallas Police Department and Dallas Children's Advocacy Center. For more information, call Jessie Shelburne, Dallas Children's Advocacy Center at 214-818-2600.

September 6-9, 1998. ***Protecting Children: Innovation and Inspiration.*** Auckland, New Zealand. Sponsored by International Society for Prevention of Child Abuse and Neglect. For more information, call 312-644-6410, ext. 3273.

September 13-15, 1998. ***The Second National Conference on Shaken Baby Syndrome.*** Salt Lake City, UT. Sponsored by Child Abuse Prevention Center, Ogden, UT. For more information, call Conference Director, at 719-784-3330.

November 12-14, 1998. ***Northeast Regional Child Maltreatment Conference "Challenging Our Response to Child Maltreatment: Intervention, Prevention or Both?"*** Providence, RI. Sponsored by Massachusetts Society for the Prevention of Cruelty to Children, the Massachusetts Chapter, American Professional Society on the Abuse of Children, and Northeast Regional Children's Advocacy Center and Tufts University School of Medicine. For more information, call Maria Sullivan, 617-636-0945.

November 16-21, 1998. ***12th Annual Conference on Child Abuse and Neglect "Engaging America's Communities."*** Cincinnati, OH. Sponsored by the National Center on Child Abuse and Neglect (NCCAN). For more information, call 301-589-8242.

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The Katie Toth Memorial Education Fund

This special fund was established in memory of Mary Katherine Toth Komie, daughter of long-time APSAC volunteer Patricia Toth. Katie died in April, 1997, at the age of 20 months and her family established the memorial fund, dedicated to the purpose of furthering professional education, in honor and memory of Katie. APSAC and the family of Katie Toth extend deepest thanks to all who support this fund.

Janet Backman (with matching gift from Washington Mutual Foundation)
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