Volume 11 Number 2 Summer 1998

# APSAC ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

## IN THIS ISSUE:



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

# Children are the Silent Victims of Domestic Violence and Chronic Community Violence

by Joy D. Osofsky, Ph.D.

## PERSPECTIVES

We should raise our children as we wish our grandchildren to be raised. Children who live in a violent home or a violent community learn to be violent. Although many people would like to believe that young children are not affected by exposure to violence, the facts reveal a different story. Even the youngest of children show some responses to violence exposure. These responses range from mild changes in behavior and affect in the most benign cases to outright post-traumatic stress responses in the most extreme situations.

Violence too graphic for television is routinely played out in real life in many homes. It is often difficult to protect children from violence that occurs in their own homes. The most recent estimates suggest that between 3 and 10 million children each year are exposed to domestic violence, and almost 1 million reports of child abuse and neglect are confirmed. Although parents may think their children are unaware of domestic violence, the children tell a different story. While it is difficult to obtain accurate statistics, it has been estimated that approximately 75% of children who live in homes where there is domestic violence know about the violence.

Exposure to chronic community violence also takes its toll, often resulting in an increase in behavior control problems or withdrawal, and, over time, a numbing to everyday exposure to violence. Indeed, violence and children's witnessing of violence have been characterized as a public health epidemic in the United States. Violence among youth ages 11-17, including murder, rape, robbery, and aggravated assault, has increased 25% in the last decade. Homicide ranks as the second leading cause of death among males between 15 and 24 years of age, and the rate has more than doubled since 1950. It is even more startling that homicide has become the third leading cause of death for children between the ages of 5 and 14. A recent survey at a public hospital-based pediatric clinic in a major U.S. city found that one in every 10 children under the age of 6 reported having witnessed a shooting or stabbing. Half of these incidents occurred at home and half in the streets. Recent data obtained from approximately 300 children between 6 and 12 years of age indicate that school age children are victims and witnesses to significant amounts of violence. In one moderate sized city, 51% of 5th graders reported that they had been direct victims of violence. Ninety-one percent reported that they had personally witnessed some type of violence.

There is little doubt that such violence exposure has a great impact on how these children experience their world and how they behave and respond. Children exposed to chronic community or domestic violence are at increased risk of becoming violent themselves, without having had the opportunity earlier in their development to internalize a full understanding of the potential results and consequences of such violence.

In some areas of our inner cities, neighborhoods have become like war zones, with children carrying guns and other weapons to school in order to feel safe. Mothers teach their children to watch television lying beneath the window sills in order to avoid random bullets. Even in rural areas that seem tranquil and safe, children may not be totally protected from the random violence that appears to be happening with increased frequency in our society. Unfortunately, in our country, it has become relatively easy for even children to obtain guns if they want them. It should be recognized, however, that much of the violence occurring in neighborhoods is violence that has moved out of the homes and into the street, and children are the innocent, silent witnesses.

It is important to understand what the experience of exposure to violence may mean for a child. The impact will be influenced by the nature of the threat and the damage, the child's relationship with the victim or perpetrator, the severity and duration of the violence exposure, and its proximity to the child. While consistent prospective studies have not yet been done, clinical evidence suggests that different types of violence exposure affects children and families differently. In predicting negative developmental outcomes, it is probable that witnessing domestic violence among people the child knows, and exposure to chronic community violence on a regular basis will have the most significant effects on children.

### What do Children Learn from Witnessing Domestic Violence?

- Violence is an appropriate way to resolve conflict
- Violence is part of family relationships
- The perpetrator of violence in intimate relationships often goes unpunished
- Violence is a way to control other people

(Adapted from *The Children of Domestic Violence,* a report by the Massachusetts Coalition of Battered Women Service Groups and the Children's Working Group, 1995)

Children who are exposed to violence show reactions such as emotional distress, immature behavior, somatic complaints, and regression in toileting and language. In extreme cases, children may show symptoms similar to Post-Traumatic Stress Disorder in adults, such as repeated re-experiencing of the traumatic event, avoidance, numbing of responsiveness, hyper vigilance, and increased arousal. In school-age children, there is frequently an increase in externalizing (aggressive, delinquent) or internalizing (withdrawal and depression) behavior problems.

continued on next page

## The Silent Victims

continued from page 2

Domestic violence may be particularly damaging for young children when they are exposed to assaults between people to whom they are emotionally attached. In such cases, symptoms such as nightmares, disorganized behavior, clinginess, and agitation are common. The child's vulnerability to domestic violence exposure may be compounded by the parent's own response to violence, as witness or victim. The parent-child relationship can be negatively affected when a mother must cope with the physical and mental health aspects of having been battered. She often fears for her own safety as well as that of her children. Parents realize that they may be unable to protect their children from violence, leaving them with feelings of frustration and helplessness. Some parents who are constantly fearful may have difficulty being emotionally available to their children. Other parents may become overprotective or, if extremely traumatized themselves, they may expect their children to protect them. Unfortunately, children raised by such parents may fail to develop the sense of basic trust and security that is the foundation of healthy emotional development. Because domestic violence most often affects mothers, the goal of ending violence against women has important implications for protecting children.

### Public Policy Initiatives for Children Living with Domestic Violence

(from Children who Witness Domestic Violence: The Invisible Victims in *Social Policy Reports,* 1995, Vol IX, No. 3, pp. 1-16).

- Launch a national campaign to change attitudes toward domestic violence
- Foster prevention and intervention approaches that build on family and community strengths
- Provide education to parents, educators, law enforcement officials, and health and mental health professionals about 1) the effects of children's witnessing of domestic violence, and 2) alternative approaches to resolving conflict.
- Promote research that will 1) expand our understanding of domestic violence exposure and 2) contribute to the development of prevention and intervention strategies.

*Joy D. Osofsky, Ph.D. is a psychologist and Professor of Pediatrics and Psychiatry at Louisiana State University Medical Center. She is Director of the Violence Intervention Program for Children and Families in New Orleans, a community-based violence prevention and intervention program linking police, schools, community residents, and mental health professionals. She recently edited the book,* Children in a Violent Society *(New York: Guilford Publishers, 1997).*

# LETTERS

I read with interest Rita Swan's Perspective "Religion-Based Medical Neglect and Corporal Punishment Must Not be Tolerated" (*APSAC Advisor,* Vol 11, n. 1). Although I agree with her that "first amendment guarantees for religious freedom do not include a right to harm or neglect children," how that is applied is far from clear. If Christian Scientists are not allowed to treat their children with prayer, what about naturopaths or herbal remedies (many doctors see naturopathy as quackery)? If all physical punishment is outlawed, what about restraint techniques such as SOLVE? Research on corporal punishment is mixed in its results. Some research is showing that limited corporal punishment is beneficial (note that this is not hitting the child until they "accept" their punishment). Finally, how much freedom does the state give families to raise the child according to the family's beliefs? Do we deny families the right to raise the child according to their standards? The California code is good as long as "specific danger to the physical or emotional safety of the child" is well-defined. If not, it could lead to the slippery slope that all beliefs other than my own are "emotionally unsafe" to the child and therefore demand state intervention.

Gary Rolph, MCS

---

I write in regard to Rita Swan's Perspective in the Spring 1998 issue of the *Advisor*. Ms. Swan appears to paint with a broad brush by advancing that any form of corporal punishment equates to abuse which should be soundly rejected by thinking child advocates, especially if it bears the appearance of religious-based beliefs. Thus her underlying proposition is that those of us who consider ourselves to be child advocates, parents, and Christians must choose between our professional responsibilities and our spiritual commitments to children's health and safety. Ms. Swan fails to account for the numerous state child abuse statutes which exclude the customary parental swat on the bottom that inflicts no abuse, but certainly turns the child's attention to reflect upon their behavior.

While Ms. Swan may want to believe that there is some vast Christian Right conspiracy to legalize abusive beatings to children, she provides scant basis for this: two books by authors Tomczak and Dobson. I have read Dobson's books and cannot find any quote that bears the remotest resemblence to the position Ms. Swan argues. Further, while some may also choose to believe that the fundamentalist-Christian Right movement is so pervasive as to merit such fear, there is no basis for believing that it has infected the state legislative process.

continued on next page

# Letters

continued from page 3

As a former Baptist minister and seminary student, (which would apparently make me, in Ms. Swan's typology, a member of the sadistic Christian Right and an evil fundamentalist) I find it offensive that Ms. Swan should use anecdotal evidence and media caricatures to disparage my professional and theological convictions (which are more in alignment with the protection of children than many others of no theological persuasion). She forces the argument to an either/or proposition, rather than thoughtful and mediated reflection upon what is loving and nurturing discipline and what is abusive treatment. She is correct, however, that I do in fact intend to raise my children within my religious values. She apparently believes this is offensive and abusive, but offers no rationale other than to lump it into the "religious rationale" that "increases harm to children."

Finally, I found Reverend Daley's response to the case conference in this same issue to be the complete antithesis to Ms. Swan's view of how Christians respond to such abusive behavior. Reverend Daley's comments should serve as a reminder that the balance between firmly held religious and child advocacy beliefs among us bad old "fundamentalists" may not be as paradoxical and dangerous as Ms. Swan would lead us to believe.

*Dan Slayton*
*Deputy County Attorney*
*Flagstaff, AZ*

---

To the Editor:

Rita Swan's recent *APSAC Advisor* article is certainly thought provoking, but it is equally provocative. Ms. Swan made no effort to even modulate her anti-Christian rhetoric, and in doing so, distorts the teachings of mainstream Christianity, mocking the sincere convictions of millions of people.

While it is true that there are some people who may abuse or neglect their children in the name of religion, she does not present any data regarding the incidence of this. I am quite sure, however, that the incidence of severe abuse of children is exponentially higher among the morally bankrupt. Indeed, in twenty years as a pediatrician and fifteen with an interest in child abuse, I have seen a mere handful of seriously injured children who have been abused in the name of religion. Some of the most memorable of these cases involved deeply disturbed people whose thinking was psychotic, not religious. Much more common is the child abused by "the mother's boyfriend," a situation which in itself speaks of the moral crisis in which we find ourselves.

Ms. Swan describes my mindset exactly when she says that "They feel threatened by the mass media's emphasis on consumerism, instant gratification, and sexual freedom…" I do indeed feel threatened by these; these are the greatest threats to our society today, as recognized by many Christians. According to Ms. Swan, this "threat mentality" combined with "the belief that children are born sinners, may increase the severity of corporal punishment." One of the fundamental beliefs of all Christians is that we are all born sinners. Thus, Ms. Swan has, without any factual basis, indicted the majority of Christians.

I, too, am an advocate for children, and believe that there can be no exemption from the laws which protect children from abuse and neglect, religious or otherwise. Corporal punishment, however, does not always constitute child abuse, and the vast majority of people on the"Christian Right" love their children and do not abuse them.

While we may not agree with the discipline that certain groups espouse, we must respect their right to use corporal punishment that does not constitute abuse. Granted, there is a fine line between corporal punishment and abuse, and those parents who choose to use corporal punishment must be vigilant to not cross that line. Our role is to protect children when their parents cross that line.

*Stephen Lazoritz, MD*
*Milwaukee, WI*

---

***Rita Swan Responds:***

Slayton and Lazoritz misrepresent my position. I did not say all corporal punishment is abuse. I do not believe that being a child advocate, a responsible parent, and a Christian or a fundamentalist Christian are incompatible. Parents should train children in their religious values, and fundamentalists have many good values to share, which I respect.

Nevertheless, some fundamentalist spokesmen advocate far more corporal punishment than one "swat on the bottom." And severity is only one troublesome aspect. In his *The New Dare to Discipline,* Dr. James Dobson illustrates what disturbs me about his position:

"Nothing brings a parent and child closer together than for the mother or father to win decisively after being defiantly challenged." (p.34)

"[Corporal punishment provides] the opportunity to convey verbal and nonverbal messages to the boy or girl that cannot be expressed at other times…The spanking should be of sufficient magnitude to cause genuine tears." (p.35)

"After emotional ventilation, the child will often want to crumple to the breast of his parent, and he should be welcomed with open, warm, loving arms." (p.35)

continued on next page

continued from page 4

But if the spanked child does not "crumple" soon enough, Dobson recommends more spanking. He says,

"As long as the tears represent a genuine release of emotion, they should be permitted to fall. But crying can quickly change from inner sobbing to an expression of protest aimed at punishing the enemy…I would require him to stop the protest crying, usually by offering him a little more of whatever caused the original tears." (p.70)

Some research indicates a correlation between fundamentalism and child abuse and endorsement of severe physical punishment, including Kathryn Neufeld, "Child-rearing attitudes of child-abusive parents and religiously affiliated parents," master's thesis, California State University Fresno (1978); Vernon Wiehe, "Religious influence of parental attitudes toward the use of corporal punishment," *Journal of Family Violence 5* (1990): 173-86; and Mariann Pokalo, "Caregivers' attitudes toward the severity of punishment for 44 misbehaviors of children in mental retardation institutions," Ph.D. diss., Temple Univ. (1986). I also recommend *For Your Own Good* and other books by Alice Miller which show a connection between authoritarian ideology and child abuse.

Organizations that have spoken out against physical punishment of children as inappropriate and counterproductive include the American Psychological Association, National Association of School Psychologists, EPOCH U.S.A., American Humane Association, National Association of Social Workers, National Committee for the Prevention of Child Abuse, National Foster Parent Association, and American Academy of Pediatrics.

Religious objections to medical care have cost many lives. Pediatrician Seth Asser and I report on 172 deaths in "Child fatalities from religion-motivated medical neglect." (Asser & Swan, 1998.) Since publication, we have learned of dozens of child deaths in Oregon because the Followers of Christ withheld medical care.

In contrast to Rolph, I find the case law and the California statute clear enough. In a nutshell, we have an absolute right to believe our religion and a right to practice our beliefs, until we compromise rights of others. Christian Scientists always have the right to treat their children with prayer, but states should not recognize prayer as a legal substitute for the medical care needed by a sick child. At the point when a reasonable, prudent parent would recognize from the duration or severity of observable symptoms that the child could be seriously ill or injured, the parent should have a legal obligation to obtain medical attention.

Freedom is not absolute. It comes with responsibilities. One of these responsibilities is to safeguard the lives of children.

*Rita Swan, CHILD Inc. Ph. 712-948-3500; e-mail childinc@netins.net*

Asser. S. and Swan, R. (1998). Child fatalities from religion motivated medical neglect. *Pediatrics 101,* 625-9
Dobson, J. (1992). *The New Dare to Discipline.* Wheaton:Tyndale House.
Miller, A. (1983). *For Your Own Good.* New York:Farrar, Straus.

---

I would be interested to know how the respondents were chosen for the "Sarah's Case" case conference in the Spring 1998 issue of the *APSAC Advisor* (V. 11, n. 1 pp 15-18.). Although it may be possible to choose recognized, widely-accepted experts to comment on the social work and psychological aspects of this case, one would be hard pressed to develop a "Christian" response with anything resembling consensus. Reverend Daley's conclusion, for example, that a key issue in the case is "fornication" is a position that would not be shared by many Christian people; not all Christians believe that every partnership must be validated by marriage. Reverend Daley doesn't allow for the possibility that Leroy could be beyond the authority of the church and its leaders. His conclusion that Joanne has abdicated "her responsibility for the care and protection of her children" is blaming another victim caught within a situation approaching spousal abuse, given Leroy's clear need to control every aspect of family life. Only the worldly authority of CPS and the criminal justice system can make Leroy accountable for his actions and protect Joanne and her children. The Christian community has far more to offer Joanne and her children in the way of comfort, healing, and support (social, emotional, and financial).

*John Ratmeyer, MD, Department of Pediatrics*
*Navajo Area Indian Health Services*
*Gallup, NM*

## 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 website, 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.

# ASSOCIATION NEWS

## New Board Elected

The Election for members of APSAC's National Board of Directors for the 1998-99 fiscal year is completed! We are delighted to welcome the following new board members for three year terms:

**Wayne Holder, MSW**, Executive Director of ACTION for Child Protection in Aurora, CO.
**Gloria Le La Cruz-Quiroz, LCSW**, a therapist in private practice in Los Angeles, CA.
**Dirk Huyer, MD**, Hospital for Sick Children Toronto, Ontario, Canada.
**Lavdena Orr, MD**, Director, Child and Adolescent Protection, Children's National Medical Center, Washington, DC.

We also welcome back for a second 3 year term the following re-elected Board members:

David Kolko, PhD
Judith Cohen, MD
Esther Deblinger, PhD
Kathryn McKay-Turman

We extend our deepest appreciation and warm farewells to retiring APSAC Board members Deborah Daro, Martha Erickson, Anthony Urquiza and Robert Pierce.

APSAC's national reputation for excellence is due in large part to the extraordinary contributions of the Board members. In addition to serving on committees, attending meetings and providing continuing leadership, guidance and oversight, Board members donate their teaching services for all APSAC training events. Their dedication and service is greatly appreciated.

## New Publication Scheduled for Release in July

A new APSAC publication entitled "Glossary of Terms and the Interpretation of Findings for Child Sexual Abuse Evidentiary Exams" will be available for pre-publication sale at the Sixth Annual National Colloquium in Chicago in July. This document represents more than two years of work by a committee of medical experts chaired by Dr. John McCann, of the Child Protection Center at the University of California/Davis Medical Center in Sacramento, California. This publication lists commonly accepted definitions for more than 190 medical terms and conditions, as well as the commonly accepted interpretations of the significance of particular findings in sexual abuse examinations. Also included is a reference list of 156 articles and books which support the definitions and interpretations included in this publication. The document will be available for $10 for members, and $20 for nonmembers. To order your copy, please see the ad on page 14 of this issue of the *Advisor.*

## Winner of the Aloha Challenge!

The results are being tabulated, and one lucky APSAC member will soon be enjoying a week in Hawaii as winner of APSAC's Aloha Challenge. At last year's Colloquium, Board President Harry Elias announced that the APSAC member who recruited the most new members in the 1997-98 fiscal year would win a one week stay at a condominium in Kauai, Hawaii. The winner will be announced at APSAC's Membership Luncheon and Awards Ceremony at the Sixth Annual National Colloquium in Chicago. We thank Harry for contributing this wonderful prize, and all the APSAC members who worked so diligently this past year to bring new members into the organization. We encourage members to continue their recruiting efforts in order that we all win the best prize of all: ensuring that everyone affected by child maltreatment continues to receive the best possible professional response.

## Forensic Interview Clinic in Huntsville a Success

APSAC's Second Child Forensic Interview Training Clinic, held in March in conjunction with the Huntsville Symposium on Child Sexual Abuse, was a success. Forty-seven attendees completed the 40-hour course, which provided both didactic and experiential learning on the proper techniques for child interviewing. This was the first time APSAC tried combining the clinic with another training event, enabling the participants to get the most out of their training dollar by participating in two high quality professional education events at the same time. If you would like to be placed on the Clinic Waiting List, please fill out the coupon on page 14 of this issue of the *Advisor.* Previous clinics have filled almost entirely from this list, so we highly recommend you add your name if you are interested in gaining the valuable skills offered through this premier training event.

## APSAC Participates in Adoption 2002 Expert Work Group

In November, 1997, Delores J. Brooks, Executive Director of APSAC, was invited to serve on the Expert Work Group Interagency Initiative convened by the U. S. Department of Health and Human Services, Administration on Children, Youth and Families and the U. S. Department of Justice to develop technical assistance guidelines for the states for implementation of the **Adoption 2002** initiative. The **Adoption 2002** report, prepared by staff of Health and Human Services at the request of President Clinton, is designed to achieve the President's goal of doubling the number of children who are adopted or permanently placed by the year 2002. According to the report, the child welfare system currently places approximately 20,000 children a year. Over the next few years, more than 100,000 children will be in need of permanent placement.

The Guidelines for State Legislation Governing Permanence expert work group is divided into the following subgroups: Court Process; Options for Legal Permanence; Termination of Parental Rights; Non-Adversarial Case Resolution; and Standards for Legal Representation of Children, Parents and the Child Welfare Agency, of which Delores is a member. The role of the work group is to develop a set of technical assistance guidelines in each defined area to help state legislators fashion laws in their respective jurisdictions to enact **Adoption 2002**. The intense meetings of the Work Group, facilitated through several two-day meetings in Washington, D.C., by conference call and in writing, have involved wide-ranging discussions on legislative, policy and practice issues. At the time of its April, 1998, meeting, more than three voluminous draft documents of the Work Group's deliberations had been published and circulated to members for review. At the time the final document is drafted, an even broader group of child welfare representatives will be invited to examine and comment upon the technical assistance recommendations.

Representatives of more than 50 national organizations, including the ABA, state departments of children and family services, municipal and district courts, public and private adoption and foster care agencies, and college and university law schools are among those participating on the Expert Work Group. Official Convener for the Work Group is Carol W. Williams, Associate Commissioner of the Children's Bureau. The next meeting will take place June 29-30.

## Call for Abstracts for APSAC's 7th Annual National Colloquium

Enclosed with this issue of the Advisor are two copies of the Call for Abstracts for the 7th Annual National Colloquium, to be held June 2-6, 1999 in San Antonio, Texas. Don't miss this opportunity to present your work to colleagues from around the country who will be gathering for what has become one of the premier training and networking events in the field. The deadline for submission of abstracts is September 5, 1998.

# Policy Watch

Thomas L. Birch, J.D., Legislative Counsel, National Child Abuse Coalition

# POLICY

## CONGRESSIONAL SPENDING PLANS SHORTCHANGE CHILDREN

Appropriations bills are delayed this year because of disagreements over budget priorities. By law, Congress should have completed a new budget by April 15, but House Budget Committee chair, Rep. John Kasich (R-OH), initially chose to take a confrontational approach which set back the schedule for developing the congressional budget resolution that serves as a spending guideline for the work of the appropriations committees.

With the prospect of a budget surplus and a balanced budget in hand, the crusade for spending cuts is being redefined. Heading into the Memorial Day recess with a budget still held up in the House, Kasich's proposal would have reduced domestic funds by half again as much as required by last year's balanced budget deal, with a sizable share going to pay for newly authorized highway spending. The proposal already passed by the Senate follows the spending cuts outlined in last year's agreement, but rejects President Clinton's spending priorities in education, child care and health care.

House Appropriations Committee chair Rep. Bob Livingston (R-LA) has cautioned against pushing the House to vote for additional cuts in funds for education, health and human services, joining Republican moderates who complain that Kasich hurts domestic programs with disproportionate cuts without looking at ways to save money in the defense budget.

With Congress facing a short legislative session in this election year, appropriations bills were expected to move quickly, but disagreement over drafting a budget outline has held up the legislative process.

Meanwhile, President Clinton's 1999 budget plan sent to Congress in February, the first balanced budget proposed in thirty years, took a stand-pat position on funding for most child welfare services, with a few exceptions.

Funding levels for the Child Abuse Prevention and Treatment Act (CAPTA) programs remain frozen again for another year, as do most other categorical programs of discretionary funding in child welfare. Singled out for an increase is the adoption program which claimed President Clinton's attention a year ago when he announced his Adoption 2002 initiative aimed at doubling the number of foster children placed in adoptive homes.

Funding for family preservation and family support services would go from $255 million this year to $275 million in FY99. Because the program is authorized as a "capped entitlement", Congress is obligated each year to appropriate the full amount authorized by law for the program.

Spending on child care would also increase in the Clinton proposal, in line with the administration's child care initiative unveiled earlier this year by the President. In his budget message, the President indicated his proposal to spend more than $11 billion over the next five years in new money for child care, with $7.5 billion added to the Child Care and Development Block Grant, $3 billion for an Early Learning Fund to improve family support programs, and $900 million for research, enforcing standards, and scholarships.

A major cut in funds is proposed for the Title XX Social Services Block Grant, which goes to states to pay for a range of social services including valuable support for child care, family support, prevention and child protective services. Although the block grant is authorized as a capped entitlement, like the family preservation and support money, Congress and the Administration have chosen to disregard the statutory funding requirements and shift dollars out of the social services pot to pay for budget increases in other programs – a classic form of robbing Peter to pay Paul.

The Administration's budget papers justify reducing the Title XX funding because the block grant supports programs "without statutory performance goals or measures of progress" — the very nature of a block grant! — "in order to help provide funding for other higher priority programs with greater demonstrated outcomes such as Head Start and child care," which are the very kinds of underfunded community services eligible to receive Title XX money. The problem is not a lack of performance measures; the problem is a lack of money, and fiscal shell games do not help the situation.

## NEW FEDERAL CHILD ABUSE AGENCY: OCAN REPLACES NCCAN

The creation of a federal Office of Child Abuse and Neglect (OCAN), replacing the National Center on Child Abuse and Neglect (NCCAN) set up in 1974, was announced on December 8, by Secretary of Health and Human Services (HHS) Donna Shalala. The reorganization implements 1996 amendments to the Child Abuse Prevention and Treatment Act (CAPTA) which eliminated NCCAN as part of an effort to streamline the federal bureaucracy, and gave the HHS Secretary discretionary authority to establish OCAN.

Under the new bureaucratic plan, OCAN will continue NCCAN's role as the lead agency within HHS on issues of child maltreatment and the prevention of abuse and neglect under CAPTA. In that capacity, OCAN will continue to act, as did NCCAN, as the focal point for interagency collaborative efforts, national conferences and special initiatives on child abuse and neglect, and coordinating activities to prevent abuse and neglect and protect children.

continued on next page

## Policy Watch

continued from page 7

At the same time, many of the functions related to issues of child abuse and neglect formerly directed and administered by NCCAN will be integrated with similar functions within the Children's Bureau, with the NCCAN director reporting to the director of the Children's Bureau. Formerly, as the result of a reorganization conducted during the Bush Administration, the director of NCCAN and the head of the Children's Bureau were equals, each reporting directly to the Commissioner of the Administration for Children, Youth and Families (ACYF).

OCAN will continue NCCAN's role administering CAPTA's Community-Based Family Resource and Support Program and the Children's Justice Act grants. The responsibility for CAPTA's two other grant-making programs – basic state grants and the discretionary research and demonstration grants – will be administered by other ACYF divisions, to offer more integration with other programs focused on similar populations of children.

The ACYF Division of Program Implementation will direct CAPTA's basic state grant program, along with the Title IV-B and IV-E child welfare, foster care and adoption assistance support to states. Responsibilities include: developing program instructions; analyzing state plans; monitoring state reviews; and handling financial issues.

ACYF's Policy Division will handle policy development and interpretation of the CAPTA basic state grant program, including regulations and policy interpretations, coordinated with the Title IV-B and IV-E activities.

The CAPTA discretionary grants will be administered by the ACYF Division of Data, Research and Innovation, which will also have responsibility for analyzing and disseminating data from the National Child Abuse and Neglect Data System (NCANDS). The division directs program development, innovation, research and management of all information systems within the jurisdiction of the Children's Bureau.

Training, technical assistance and information dissemination under CAPTA will be consolidated with child welfare, foster care and adoption assistance activities through the ACYF Division of Child Welfare Capacity Building, which will also oversee the National Clearinghouse on Child Abuse and Neglect Information.

### NO RELIGIOUS EXCEPTION IN CHILD PROTECTION LAW

Pressure from child advocates and key Senate staff foiled attempts by Christian Science Church representatives to create a religious exception to the termination of parental rights and reasonable efforts requirements in the Adoption and Safe Families Act of 1997. As drafted by the Senate Finance Committee, a religious exemption amendment was included in legislation this spring making technical amendments to last year's adoption and child protection legislation. Before the measure reached the Senate floor, the amendment had been dropped.

During Senate floor debate on the bill, Sen. Dan Coats (R-IN), who had fought the addition of the religious exception clause, engaged in a colloquy with Finance Committee chair, Sen. William Roth (R-DE), to explain the intention of the original provisions in the 1997 child protection legislation.

Coats pointed out that the 1997 act "makes clear that the health and safety of children must always be of paramount concern in any decision affecting the removal of children from their homes or the reunification of children with their families."

Coats expressed his understanding that "under the new law, the federal government does not require States to make such [reasonable] efforts in cases where a court finds that a parent has killed or assaulted a child or subjected the child to extreme forms of abuse or neglect. At the same time, the new law does not prevent a State from making efforts to preserve or reunify a family in such cases, as long as the child's health and safety are the paramount considerations." Roth responded that the State retains the discretion to make case-by-case determinations regarding whether to seek termination of parental rights.

The exchange on the Senate floor has the effect of emphasizing that the new statute does not intend to offer blanket application for the kind of exemption sought for religious beliefs.

## APSAC Mission

**APSAC's mission is to ensure that everyone affected by child abuse and neglect receives the best possible professional response. APSAC is committed to:**

- Providing interdisciplinary professional education which promotes effective, culturally sensitive approaches to the identification, intervention, treatment, and prevention of child abuse and neglect.
- Promoting research and guidelines to inform professional practice.
- Educating the public about child abuse and neglect.
- Ensuring that America's public policy concerning child maltreatment is well-informed and constructive.

***Every member plays a role in achieving this mission. APSAC's leaders invite members' contributions of time, ideas, energy, and expertise to the wide range of APSAC's activities.***

# Genital Warts in Children

by Lori Frasier, MD

## Introduction

Genital warts or condyloma acuminata are caused by the Human Papilloma Virus (HPV). These warts, described by the ancient Greeks and Romans, have been recognized as having an infectious etiology for nearly a hundred years, with sexual transmission as an etiology demonstrated within the last 50 years. Often described as "epidemic" in adult patients, prior to 1980 there were fewer than 40 pediatric cases reported in the medical literature. Although not a "reportable" infectious disease by Centers for Disease Control standards, in children, HPV is not uncommon. Because of possible sexual transmission, the presence of genital warts raises concern that a child may have been infected by sexual abuse. In the past two decades, advancements in molecular biology and genetics have shed light on this virus and its behavior. Medical providers experienced in both sexual abuse evaluations and in HPV assessments are frequently called upon to sort through conflicting opinions and misinformation regarding HPV infections in children. This article will review some of the most commonly asked questions about HPV and provide answers for the multiple medical and non-medical disciplines involved when allegations of child sexual abuse arise in the context of genital warts.

***Because of possible sexual transmission, the presence of genital warts raises concern that a child may have been infected by sexual abuse.***

## How is the Human Papilloma Virus Transmitted?

HPV is known to be transmitted sexually in adults and in children. It is likely that some type of mucosal or skin damage is necessary to allow the virus to enter epithelial cells for replication. Over 70 subtypes of HPV have been identified, many with an affinity for different parts of the body. For example, the common wart is caused by HPV type 1, and the plantar wart by HPV type 2. The vast majority of genital warts are types 6 and 11. Other subtypes, 16 and 18, also infect the genital tract and are also associated with cervical cancer. In children there are other important modes of transmission to consider. Vertical transmission occurs when an infected mother transmits the virus to her infant. This can occur through the bloodstream prior to birth, or at the time of birth, as the infant passes through the infected cervix and birth canal. Because HPV is a latent virus and can reside in the skin and mucous membranes without causing warts, such lesions may not appear for several months or possibly years following birth. There is some evidence that HPV is transmitted on small water droplets called fomites. Individuals who bathe in public showers have a much higher rate of plantar warts than those who don't.

## Does the absence of warts in the mother during her pregnancy support sexual transmission?

No. HPV can cause subclinical infection, meaning that the virus can be present on the cervix or in the vagina without causing warts. A careful maternal history is essential and must include a history of warts or abnormal PAP smears. If the history is positive for such conditions it may be possible that warts in a young child were transmitted from the mother. However, a negative history and even a negative laboratory examination of the mother only means that the method for testing the mother may not have been sensitive enough to detect subclinical infection. Very sensitive techniques which require amplification of HPV DNA have suggested that HPV may be present in up to 80% of asymptomatic sexually active women.

## Does the age of the child help in determining if warts are sexually transmitted versus vertically transmitted?

It may. However, there are currently no longitudinal studies which clearly define the outside time limits of vertical transmission. Such a study would need to follow infants born to infected mothers for at least 5 years. Additionally, the most sensitive DNA amplification technique, PCR (polymerase chain reaction), would need to be performed on the child at specified intervals. Some professionals have concluded that 2 years is the longest period of time that the virus can lay dormant if transmitted vertically. Beyond two years, it is postulated, children are more likely to have been sexually abused if they develop warts. This presumption is based on adult HPV transmission data, some limited observational data, and one small study following children to 2 and one-half years. On the other hand, it is this author's experience that in many children over age 2, despite a comprehensive evaluation for sexual abuse, it is often impossible to determine the source of infection. The two year cutoff also fails to address the issue that a very young child with warts may have been sexually abused. Certainly, the older the child, the more likely the lesions were sexually transmitted.

## Does viral typing assist in determining if lesions are sexually or vertically transmitted?

No. The most common type of wart found on the genital area of adults and children is HPV type 6, 11. Occasionally types 16, 18, 31, 35 are found in children. All have the same mode of transmission, however these latter types are more strongly associated with cancer. Types 1 and 2 have been found on the anogenital area. Some authors have suggested that

continued on next page

# Genital Warts in Children

continued from page 9

the presence of these types which cause hand, body and foot warts are proof of non-sexual transmission. However, this does not address the issue that sexual abuse of young children often consists of fondling or digital penetration of the vagina or anus. However, such warts may also be transmitted by the child to himself or herself in an innocent manner. Viral typing is costly, time intensive, and, if done by the most sensitive method - PCR, still in the realm of the research laboratory.

***The diagnosis of genital warts in a child should, in most circumstances, raise a concern of sexual abuse.***

**Should all adults be checked?**

A recommendation that all adults be checked without a specific allegation of sexual abuse or a named perpetrator will not be helpful in determining if sexual abuse was the cause. This is due to the high incidence of the virus in the population. Men may have no symptoms. However, adults should be examined as a part of their own health maintenance since some types of HPV may cause anogenital and cervical cancers. On the other hand, if a child with genital warts names a specific individual, the absence of lesions on that individual may not disprove that that individual is the perpetrator. HPV has rates of spontaneous remission that may be as high as 67% without treatment. In one case, an alleged perpetrator tried to prove he could not have been the individual the child named because he had warts and she did not. HPV is not 100% infective. Also, individual immunity may play a role as to whether infection occurs. Immunosuppressed patients such as those with HIV disease or on chemotherapy for cancer or organ transplants can develop extensive, recalcitrant warts. Any child who presents with extensive or aggressive lesions should be evaluated for diseases which cause immune suppression.

**If genital warts are treated and go away, does reappearance indicate reinfection?**

Not necessarily. All known treatments for HPV have a failure rate from 25-50% regardless of whether the lesions are burned, lasered, frozen, or chemically treated. The reason for this is that the virus resides in normal appearing skin around the warts. Therefore, complete eradication of the virus is neither practical nor possible. Topical therapies may cause discomfort and require repeated applications. Laser treatments must be done under a general anesthesia in children and may result in post-operative pain and scarring. Because the spontaneous remission rate is as high as the success rate for treatment, a physician may opt not to treat genital warts.

**Does the location or appearance of the warts aid in determining if they are sexually transmitted?**

Because genital subtypes infect anogenital epithelium, the location of the warts will be similar whether vertically, or sexually transmitted. Tiny, almost indiscernible lesions have been found to have been caused through sexual abuse, and large, aggressive lesions vertically transmitted. The patient's individual immune response seems to play an important role. There may be evidence that warts extending into the anal canal require some type of anal penetration to inoculate the virus internally. Rectal thermometers and suppositories used in young children may serve this function however. Although most anogenital warts are perianal in children, they can and do occur anywhere. The appearance varies greatly from small, flat, flesh-colored lesions, to large cauliflower-like masses on stalks. Lesions on the mucous membranes will appear very different from those on the skin of the labia or penis.

**In light of all this conflicting and confusing information how does one determine if the warts were sexually transmitted or not?**

The diagnosis of genital warts in a child should, in most circumstances raise a concern of sexual abuse. A comprehensive assessment should be performed and include:

1) A comprehensive medical history, including maternal/paternal history of genital lesions or abnormal PAP smears, social history, behavior and developmental history.
2) A non-leading developmentally appropriate interview of the child. Preverbal children are an especially difficult problem. Without a clear history of abuse, normal examination and absence of other STD's, it may be nearly impossible to determine if, when, and by whom such a child was abused.
3) A complete physical exam, including an oral evaluation for warts and an anogenital examination to determine if there are any physical findings to indicate sexual abuse.
4) Laboratory evaluation, including a chlamydia culture and a serologic test for syphilis. If there is any vaginal discharge, a gonorrhea culture should be done also. HIV testing is indicated if warts are aggressive or difficult to treat. Because HPV is sexually transmitted, the presence of another STD will be indicative of sexual abuse. Syphilis is known to cause condyloma lata, a syphilitic genital wart which has been confused with condyloma acuminata. In most cases biopsy of the lesions is not necessary to confirm the diagnosis, but occasionally may be performed if lesions are atypical.

It is important to keep abreast of new developments in understanding HPV disease in children. As recently as 10 years ago, the presence of condyloma acuminata in a child might result in a diagnosis of

continued on next page

## Genital Warts in Children

continued from page 10

sexual abuse and foster placement. Experience has taught us to be cautious in making a determination of sexual abuse in a child. Failure to recognize sexual abuse can have devastating consequences, but so can an incorrect diagnosis of abuse. The presence of genital warts alone is not a diagnostic sign of sexual abuse, but rather directive to obtain a comprehensive medical assessment of the child by an experienced and skilled examiner.

**References:**


American Academy of Pediatrics Committee on Child Abuse and Neglect. (1991). Guidelines for evaluation of sexual abuse in children. *Pediatrics, 87,* 254-260.

Bauer, H.M., Ting, Y., Greer, C.E., et al. (1991). Genital human papillomavirus infection in female university students as determined by a PCR based method. *JAMA, 265,* 472-477.

Boyd, A.S. (1990). Condyloma Acuminate in the pediatric population. *Am J Dis Child, 144,* 817-824.

Cohen, B., Honig, P., & Androphy, E. (1990). Anogenital warts in children. *Arch Dermatol, 126,* 1575-1580.

Davis, A.F. & Emans, S.J. (1989). Human papilloma virus infection in the pediatric and adolescent patient. *J Pediatr, 115,* 1-9.

Ferenczy, A., Mitao, M., Nagai, N, et al. (1985). Latent papillomavirus and recurring genital warts. *N Engl J Med. 313,* 784-788.

Frasier, L.D. (1994). Human papillomavirus infections in children. *Pediatr Ann. 23,* 354-360.

Gutman, L,. St. Claire, K., Herman-Giddens, M.E., et al. (1992). Evaluation of sexually abused and non-abused young girls for intravaginal human papillomavirus infection. *Am J Dis Child 146,* 694-699.

Gutman, L.T., Herman-Giddens, M.E., Phelps, W.C. (1993). Transmission of human genital papillomavirus disease: Comparison of data from adults and children. *Pediatrics, 91,* 31-38.

Kellogg, N.D., Parra, J.M. (1995). The progression of human papillomavirus lesions in sexual assault victims. *Pediatrics, 96,* 1163-1165.

Koutsky, L.A., Galloway, D.A., Holmes, K.K. (1988). Epidemiology of genital human papillomavirus infection. *Epidemiol Rev, 10,* 122-163.

Siegfried, E.C. & Frasier, L.D. (1997). Anogenital warts in children. *Advances in Derm 12,* 141-167.

Smith, E.M., Johnson, S.R., Cripe, T.P. (1991). Perinatal vertical transmission of human papillomavirus and subsequent development of respiratory tract papillomatosis. *Ann Otol Rhino Laryngol, 100,* 479-483, 1991.


# INVESTIGATION

## Investigative Liaison with the Military

by Special Agent Thomas F. Boley
Naval Criminal Investigative Service

### Introduction

What do you do when an ongoing investigation results in the identification of a suspect, victim, or witness who is active duty with the military but has left town since the incident to return to some military assignment hundreds or even thousands of miles from where the incident occurred? Will your agency pay to fly you there to do the interview? What if this military person is now in Japan or on a ship somewhere in the Indian Ocean?

This is a scenario which is not unusual but which may leave local, state, and even federal agencies unsure about how to proceed to get the person interviewed. This article will examine the role of Military Criminal Investigative Organizations, and explain how they can be enlisted to help local agencies.

### The MCIOs

The MCIOs, or the Military Criminal Investigative Organizations, are the Office of Special Investigations (OSI) within the Department of the Air Force, the Criminal Investigation Command (CID) within the Department of the Army, and the Naval Criminal Investigative Service (NCIS) within the Department of the Navy (serving both the Navy and the Marine Corps). Each agency employs trained criminal investigators, known as special agents, who are familiar with interview and interrogation techniques and who understand the military service which they support. Special agents receive training on many aspects of their duties, including the investigation of alleged child sexual and physical abuse.

The MCIOs' investigative jurisdiction covers any criminal offense defined in the Uniform Code of Military Justice (UCMJ), particularly those offenses which are considered felonies within civilian jurisdictions. Even though the term "felony" is not officially used in military justice, it is a common term among both civilian and military law enforcement and criminal investigative agencies. The MCIOs, therefore, may investigate any crime punishable under the UCMJ or by federal law where there is a military interest, as well as provide investigative assistance to local, state, and federal agencies. MCIOs often work with local agencies on joint task forces or on joint investigations in which both agencies have an interest.

In civilian criminal investigations, a need for investigative assistance from the military generally arises when a case requires the interview or interrogation of an active duty person who is assigned to a far-away location.

### Investigators and Their Training

Special agents of OSI, CID, or NCIS may be either civilian or active duty military personnel. They generally have top-secret security clearances and all are professional investigators. Each undergoes initial criminal investigations training and most have specialized training as well. Many are members of APSAC, and attend national child abuse training conferences each year to keep abreast of the latest information regarding child abuse investigations and other issues.

### Coordination with State and Local Agencies

There are many situations which may result in a local or state agency needing to interview a military person. A sailor may have been witness to an aggravated assault while home on leave from his ship in the Indian Ocean. A female Army sergeant may have been raped in a motel while traveling across country during a transfer from one duty station to another, but failed to report it at the time of the incident out of fear for her safety. A recruiter, since transferred overseas, may become a suspect in a child abuse case when allegations are reported by his daughter's friend to a teacher. Military personnel who become victims, witnesses, or suspects may be on ROTC duty, recruiting duty, travel status, or on leave, or for some other reason, present at the scene of a crime or may later learn the details of a crime from someone who was present. The MCIOs are able to locate such persons and interview them on behalf of the civilian agency conducting the investigation.

continued on next page

# Investigative Liaison

continued from page 11

## How MCIOs Can Assist Civilian Agencies

Interviews may be conducted anywhere in the world, within the military community, overseas, aboard ship, in combat zones, or in places which cannot be reached by the investigating detective. Following are some of the leads which the MCIOs can offer.

Records which may be of value are the individual's service record (to determine previous assignments), military training history, or family data. In the case of a homicide caused by Munchausen Syndrome by Proxy, it would be very interesting to see if military records show a history of other children in the family having died. The service record may be the only place where such information could be found. The utility of medical and dental records of the service member as well as family members is well known. From identification of an unidentified body to a medical history which documented but did not recognize child abuse, official military medical records have long been recognized for the valuable information they contain. Family advocacy records and base housing records may also yield valuable investigative information. The Defense Clearance and Investigative Index (DCII) is a Department of Defense (DOD) database through which the investigative records on military personnel and civilians involved with the DOD may be located. This information may be available to a local, state, or federal agency which is conducting a criminal investigation involving a military member, although there are some restrictions on the release of such information to civilian agencies.

Depending on the circumstances of the investigation and the desires of the investigating detective, military suspects may be interviewed, interrogated, photographed, or surveilled on behalf of the investigating agency. As appropriate, the MCIOs may be able to collect and forward evidence, provide office space for the local agency to conduct its own interviews, coordinate simultaneous interviews of witnesses or suspects in different time zones around the world, and other leads as requested. In response, the requesting agency may expect from the MCIO a written report with statements, photographs, official records, and any other investigative information generated during that investigative activity.

Depending on the circumstances, a military suspect may be restricted to the ship or base, may be issued a Military Protective Order (similar to a civilian temporary restraining order), or be required to move into the barracks aboard the base during the conduct of an investigation of child abuse or domestic violence. The MCIOs can assist other agencies in coordinating such actions, as appropriate.

## Restrictions

Because the MCIOs are a part of the Department of Defense, they are bound by certain restrictions within federal law and military regulations which limit their involvement in the enforcing of civilian law and the extent to which they can aid civilian agencies. The MCIOs understand which restrictions may pertain when investigative assistance is requested by civilian agencies, but will provide assistance to the extent possible within the law. Local and state agencies needing assistance should discuss the details of each case with the appropriate MCIO in order to determine what assistance can be provided.

## How to Access the MCIOs

In order to identify and locate the individual to be interviewed, the MCIOs will need his or her name and branch of service at a minimum. If available, the subject's social security number, date of birth, and current military assignment would be of considerable assistance in locating the individual.

Included with this article are the listings of the CID, OSI, and NCIS headquarters phone numbers. If you are seeking investigative assistance from one of the MCIOs, call whichever headquarters number which pertains and someone will refer you to the correct office for your area.

The primary mission of the MCIOs is to provide investigative support and assistance to the military commands which we serve. Part of that mission is conducted through liaison and other investigative contact with local, state, and federal agencies which have developed a military connection of some kind during the conduct of a criminal investigation. If we, the MCIOs, can be of assistance in your investigations, please don't hesitate to ask. We are only a phone call away.

## Contact Information for MCIOs

**US Army Criminal Investigation Command (CID)**
*Normal Working Hours:*
Commander, US Army Criminal Investigation Command
ATTN: CIOP-CO-PE
6010 6th Street, Ft. Belvoir, VA 22060-5506
Phone: (703) 806-0305/6 • Fax: (703) 806-0307
*After Normal Working Hours:*
Staff Duty Officer
(703) 806-0414/5

**Air Force Office of Special Investigations**
*Normal Working Hours:*
AFOSI Criminal Investigations Division
500 Duncan Avenue
Bolling Air Force Base, Washington, DC 20332
(202) 767-5191 • Fax: (202) 767-5196
*After Normal Working Hours:*
Phone: (202) 767-5450 • Fax: (202) 767-5452

**Naval Criminal Investigative Service — Serving both the Navy and the Marine Corps**
*Normal Working Hours:*
WNY Bldg 111 Attn. NCIS Code 23B
716 Sicard Street SE, Washington DC 20388-5380
Phone (202) 433-9250 or (202) 433-9234
Fax: (202) 433-4922
*After Normal Working Hours:*
Phone: (202) 433-9323 • Fax: (202) 433-4922

*Special Agent Tom Boley, a 24-year veteran of NCIS, is currently assigned to NCIS Headquarters where, among other duties, he serves as the Program Manager for the NCIS Victim and Witness Assistance Program. He may be reached by e-mail at boley@ncis.navy.mil*

# Rewards and Challenges of Opening a Children's Advocacy Center

by Robert Block, MD

In 1992, the Tulsa Children's Justice Center was opened to provide medical assessment of cases of alleged abuse, and to serve as the home base for a multidisciplinary team supported by Child Welfare, the Tulsa Police Department, the Office of the District Attorney, the United States Attorney for the Northern District of Oklahoma, the Tulsa Country Sheriff, and the University of Oklahoma Health Sciences Center, Tulsa Campus. The Child Abuse Network, Inc. (CAN Inc) was the agency charged with coordinating all services.

The importance of a multidisciplinary team is demonstrated by a now infamous Oklahoma case where the consequences might have been extraordinarily different had a team been in place. In 1995, two-year-old Ryan Luke was treated at the community hospital for a fractured femur, allegedly due to abuse by his mother or her boyfriend. A judge released the child to the care of his grandfather, following a court hearing at which the mother was represented by a powerful state legislator. Neither a physician nor a representative from child welfare testified at the hearing. The grandfather allowed the child to return to his mother's home, where he was murdered. Had a team been in place more appropriate actions could have occurred and Ryan might be alive today.

In the last six years, the Tulsa Center has experienced successes and challenges which have kept the work stimulating, frustrating, exciting, and rewarding. Challenges have included backlash issues, turf issues between team members, and misperceptions along the way, but the principal challenge has been maintaining the cohesiveness of the interdisciplinary team. Turnover of staff, particularly in the DA's office, law enforcement and Child Welfare has necessitated continual rebuilding of the team, retraining and refocusing of the mission. A written commitment from all agencies and departments involved in the team has been essential to providing stability through times of change.

Establishing permanent operational funding is a challenge familiar to everyone in the field. The Tulsa Center has benefitted from a successful partnership between the Oklahoma University medical college and the Board of Directors of CAN, Inc., which has helped provide private donations. A large endowment drive is underway to secure permanent funding. The CAN Board of Directors includes representatives from all the agencies networked by CAN, Inc, as well as influential members of the community, so funding obtained through Board efforts represents the community's commitment to child abuse and neglect intervention.

Another challenge has been in the area of public policy. Child abuse prevention has become an important focus within Oklahoma, but the investigation of abuse allegations and treatment for abused children have been neglected. It is essential that policymakers understand the importance of secondary and tertiary prevention coupled with assessment and intervention in child abuse cases. Although the OK state legislature passed a bill (named for Ryan Luke) requiring multidisciplinary teams, as so often happens, no money was appropriated to support the teams.

An accounting of the Center's successes must begin with the list of the more than 3,000 children who have received medical evaluations and other services through the Tulsa Children's Justice Center. The most unique feature of the program is the facility and the partnerships it houses. Located on the campus of the University of Oklahoma College of Medicine - Tulsa, the Justice Center houses CAN, Inc., a unit of child protection workers from the state child welfare division, and law enforcement officers. It also houses office space for assistant district attorneys and mental health professionals who work with the children and families, and a medical team consisting of a medical director, a full-time pediatric nurse practitioner, two part time physicians, a medical social worker, nurse and clinic coordinator. As other advocacy centers have learned, locating all services in a single facility has resulted in increased effectiveness of service delivery. The Center has also facilitated the training of medical students and residents.

A variety of challenges lies ahead. Research is helping with issues of the biomechanics of physical injury, as well as questions about what sorts of examinations and tests are necessary in cases of possible sexual abuse. The team is developing a policy to deal with the issue of when to do genital exams on physically abused children, and when to look for occult signs of physical abuse in sexual abuse cases. Differentiating between the need for a forensic, "rape-kit" exam and a standard exam continues to be an issue, linked closely to differentiating between the need for immediate response in the emergency room and a scheduled response at the center.

State reimbursement for medical examinations remains inappropriately low. Telemedicine connections to other sites in mostly rural Oklahoma is a goal not yet realized. Although training physicians in the area of child abuse is accomplished through a formal program in Oklahoma, insuring physician commitment to continuing work in the field is not always successful.

The view from the field in our area of the country is probably not unlike that encountered elsewhere. We continue to see the field of medical assessment of child abuse as clinically important, as well as academically challenging. We must continue to learn how to effectively deal with the media, with politicians and other policymakers, with potential funding sources, and with each other. Sometimes the fire gets pretty hot. But to those who ask, "How can you do this kind of work?", I respond, "How can you not?"

# ORDER YOUR COPY NOW!

## Glossary of Terms and the Interpretations of Findings for Child Sexual Abuse Evidentiary Examinations

*Prepared by APSAC's National Task Force on the Interpretation of Physical Findings in Sexual Abuse, chaired by John McCann, M.D.*

This glossary was prepared to assist professionals who conduct or interpret child sexual abuse medical evaluations, to clarify the terminology currently being used in the field and to assist professionals attempting to determine the significance of ano-genital findings.

Cost for this publication is $10 for members; $20 for nonmembers, plus shipping and handling of $2.50. The form below may be filled out and faxed (with credit card information) to APSAC at 312-554-0919; or mailed with check, or money order to APSAC at 407 S. Dearborn, Suite 1300, Chicago, Illinois 60605. For shipping & handling costs for more than one copy, please call the APSAC office at 312-554-0166, or refer to the publications order form found at APSAC's website, at www.apsac.org.

## Order Form- Glossary of Terms

Name: _____ Member # _____

Agency: _____

Address: _____

City, State, Zip _____

Phone: _____ Fax: _____

E-mail: _____

Credit Card Number _____ Expiration Date _____

Total Amount to be charged _____
*(please include shipping cost)*

Signature _____ # of copies _____

## APSAC's Five Day Child Forensic Interview Clinic

APSAC's comprehensive interview clinic is an intensive forty-hour training experience which provides personal interaction with leading clinicians, researchers, and trainers in the field of child forensic interviewing. Its interview practicum component provides participants with experience interviewing actual children in a supportive environment where constructive feedback is utilized to build and improve specific professional skills.

To add your name to the Forensic Clinic Waiting List, please complete and return this form by fax to 312-554-0919.

Name _____ Title _____

Agency Name _____ Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ E-mail _____

## The Case: Tina

Tina is a five-year-old girl who lives with her mother, Susan, in a major urban city. Susan was the victim of a violent crime perpetrated by Jim, a neighbor that she and Tina knew well. The attack took place during the evening, while Tina was asleep. Jim came into Susan's apartment to use the phone. Once inside her home, he brandished a gun, tied and gagged her, raped her, then severely cut her neck with a knife before shooting her twice in the head. Tina discovered her mother, barely conscious and bleeding on the floor of the living room. After trying unsuccessfully to untie her mother, Tina summoned a neighbor, who called police. The police arrived and Susan was transported to the hospital, without seeing Tina again, who remained at the neighbor's home.

The next day, a clinical social worker from the District Attorney's office went with a detective to interview Tina and assess her safety. This was twelve hours after the shooting. Tina told the social worker that her mom was dead.Tina related that Jim came in the house and "tied mommy up with the telephone cord and cut her neck." When asked how she knew it was Jim, Tina stated "mommy told me and told me to call 911." Tina also told the social worker that her mom had two "bugs" on her head and that blood was coming out of them. Tina was agitated and upset that she could not untie her mom, and she stated several times that she was afraid Jim would come and get her. Tina's grandmother reported that Tina would not sleep in her own bed and would not believe that her mom was indeed alive.

The detective notified the Department of Human Services, but according to DHS, the child was considered safe and the family did not need any intervention since it was not an abuse case. The hospital refused to let the child see her mother because the mother was in intensive care unit. When it was explained to the head nurse that the child believed her mother was dead because of what she witnessed, the hospital staff still refused to let the child visit, stating that it was against hospital policy to allow children into the ICU.

Susan was released from the hospital two weeks after the shooting. Although Susan reported having nightmares repeatedly about the event while in the hospital, she was never seen by a psychiatrist or social worker. The DA's office continued their involvement for several months after the shooting. Both Susan and Tina reported chronic symptoms of PTSD but Susan would not take either to a therapist, stating "we're fine and it's over with." Jim pled guilty to the crime and both Tina and Susan gave Victim Impact Statements eight months after the shooting.

It is now 15 months after the shooting. Tina had to repeat kindergarten due to excessive absences and difficulty paying attention in class. Her teachers report she seemed to "be in another place." Tina complains of stomach aches and headaches, and refuses to go to school. When Susan pushes the issue, Tina tells her mom that she doesn't want to leave her because Jim will come back. The grandmother reports that Susan is unable to keep a job and that she is not sleeping through the night. When asked about therapy, Susan reports "we don't need that, it was a long time ago." Social services have been approached about providing assistance to this family, but since this is not an abuse case, they feel it is not their jurisdiction.

## Case Response

Marilyn Gootman, Ed.D.
Author of *The Caring Teacher's Guide to Discipline,* Corwin Press

**How would you immediately intervene in this situation as a professional in your discipline? Why?**

School must become a safe haven for Tina. The sudden, overwhelming nature of a trauma such as Tina experienced may make her more jumpy and on edge, unable to concentrate, constantly worrying about what will happen next. Clearly established classroom routines can help eliminate some of this tension. A teacher who creates a predictable classroom environment, who explains when activities will deviate from the norm, and who maintains a calm demeanor without sudden outbursts can help not only Tina but all students who come from unstable home environments.

Activities that help Tina identify and label her feelings might help eliminate the stomachaches and headaches. Helping her verbalize her thoughts and feelings can bring them to the surface instead of festering inside her. Charades, card games, and book discussions are among the classroom activities that encourage such verbalization. Tina needs a teacher who is an effective, nonjudgmental listener, who helps her feel comfortable with her feelings but who does not force her to express them.

Pacing is extremely important. Tina must not be rushed or forced to verbalize her thoughts and feelings, but just be made comfortable enough for it to happen. If Tina has a particular interest or hobby, activities that focus on this interest can help engage Tina so that her mind is occupied in a way that will not allow it to be flooded by frightening thoughts. These are sound teaching strategies for all children. The difference between how they are implemented for Tina

continued on page 16

## Case Response

continued from page 15

and her peers is one of degree, not of kind. The classroom teacher must consciously use these strategies to make school a safe haven for Tina.

At the same time, the teacher can also try to make school a safe haven for Tina's mother. If the teacher is supportive and sensitive to both the mother's and the child's fears of being separated, she may be able to ease the separation by verbalizing for the mother how these anxieties are normal for both her and her daughter considering what they have been through. Since Tina's mother is in such a strong state of denial, reaching her will be a challenge which must be approached with the utmost of patience. Being friendly by engaging in small talk and describing what Tina is doing in school might help to break the ice. As the teacher develops a relationship with the mom, she could explain to the mother that, just like a physical wound, Tina's wound needs to be cleaned out and treated lest it get infected. Using this analogy may help the mother feel comfortable obtaining psychological services for her child.

**Would you attempt to involve professionals from any other disciplines in the case? If so, which disciplines how and why?**

Since no other agency has done it, the school should coordinate the case management for this child, just as it does for students with diagnosed special needs. The determination of which students qualify for case management should be broadened beyond the federal mandates to include students such as Tina who live in dire circumstances. Someone in the school, perhaps the school counselor, could convene a team composed of the classroom teacher, the school psychologist, the school social worker, the mother's employment counselor, a medical professional, someone from social services, and even a member of the district attorney's staff, to problem solve together and come up with an individualized plan for Tina. Tina's mother and grandmother could also be included in this team, but initially, her mother may be too fearful to attend such a meeting. If that is the case, after the meeting, the member of the committee who relates best to the mother can share with her the group's plan for helping Tina. Of course, this will place added burdens and stresses on the resources of the school. Providing supplemental financial resources for schools to meet the needs of children in distress is long overdue. Schools are in the best position to coordinate case management and they must be properly funded to do so.

**From your perspective, what are the key issues in this case?**

The biggest issue in this case is the fact that nobody was willing to take the responsibility for helping this family. The CPS authorities stepped out because it was not abuse. The hospital refused to let the child see her mother. The mother was never seen by a psychiatrist or social worker in the hospital. Social services would not provide therapy. The school retained Tina in kindergarten. Someone must take responsibility for helping children like Tina and their families overcome the traumas in their lives. A coordinated team effort focused on developing an individualized plan for the child is essential. If the school must assume this role, then the school must be given sufficient resources to do so.

Another key issue is that educators must be trained to understand Post-Traumatic Stress Disorder, its manifestations in children, and what they can do to help minimize the child's PTSD in the school setting. Many children like Tina are retained, not because of a lack of ability, but because their minds are too filled with frightening thoughts for them to be able to focus on their schoolwork. Altogether too many children are labeled as having Attention Deficit/Hyperactivity Disorder and are put on drugs when it is the trauma in their lives, rather than a neurological disorder, that is causing their symptoms. Jumpiness, inability to concentrate, hypervigilance, and spaciness are all child responses to trauma. Until teachers are trained in the effects of trauma on the lives of children, they will continue to provide counterproductive approaches which often include intolerance, blame, denial, or harsh punishments.

**What would be your long-range plan for addressing this problem?**

Provide teacher training, both in colleges of education and in-service training, on the effects of trauma (abuse, neglect, the death of a loved one, or any sudden overwhelming event such as an accident or an act of violence) on the behavior of students, and what can be done to help these children in the classroom. This training should include recognizing the symptoms of Post-Traumatic Stress Disorder as well as classroom strategies which can enhance the victim's resilience.

Each community should have a mechanism for creating support teams to devise individual plans for children and families who are not functioning well in the aftermath of traumatic life experiences. These teams should include educators, social service workers, medical personnel, and mental health professionals.

continued on page 17

## MOVING?

Please notify the office in plenty of time so you don't miss any issues of the *APSAC Advisor* or *Child Maltreatment*.

Now you can e-mail us your change of address: APSACmems@aol.com

# Case Response

continued from page 16

# Case Response

Esther Deblinger, PhD
Associate Professor of Clinical Psychiatry
University of Medicine and Dentistry of New Jersey - School of Osteopathic Medicine

Based on the case study, there is no question that this mother and child suffered an extremely traumatic experience that would place them at high risk for developing Post-Traumatic Stress Disorder (PTSD). However, as presented it appears that Susan, the child's mother, is not convinced that she and her daughter, Tina, are suffering difficulties stemming from the identified trauma, nor does she believe counseling is warranted for either of them.

Thus, important initial objectives include: (1) understanding and exploring the mother's reasons for feeling that counseling is unwarranted; (2) assessing the child's and the mother's counseling needs; and (3) motivating mother and child to participate in the evaluation and therapy process if necessary.

First, there are several concrete obstacles to counseling, including financial constraints, transportation and scheduling difficulties, which should be addressed directly with Susan. The clinical social worker from the District Attorney's Office may be able to discuss and address some of these with mother, particularly the availability of financial assistance through Violent Crimes Compensation Board.

The above factors, however, may not be central to mother's disinterest in counseling. In fact, it is important to recognize that Susan is not taking an unusual stance concerning counseling. Cultural, familial, educational as well as experiential factors may influence whether one believes counseling is essential in coping with traumatic life experiences. Furthermore, it is common for victims of violence, particularly those suffering PTSD, to minimize symptoms and to avoid any reminder of the trauma in an effort to put the experience behind them. In fact, there is evidence that only a small minority of individuals with PTSD ever seek treatment. Moreover, this mother's minimization of the trauma and its potential psychological impact seems to have been inadvertently reinforced by hospital staff who may have miraculously treated this woman's physical wounds, but who neglected to sensitively address the psychiatric effects of this violent crime. In fact, at the time of the crisis, when individuals tend to be most open to accepting help of a psychological nature, this family's psychological needs do not appear to have been adequately addressed by hospital staff or other professionals. Unfortunately, as time has passed this mother and child may have become less receptive to counseling that would focus on a trauma that, from the mother's perspective, is "over with."

There is, however, some indication that mother is concerned about her daughter's refusal to attend school. Since it appears that this may be the most pressing issue for mom at the current time, I would recruit the assistance of the teacher in recommending that Tina undergo a comprehensive psychological evaluation in order to identify the factors that may be influencing her school difficulties. The teacher may emphasize that the results of such an evaluation will allow the teacher, the mother and the psychologist to collaborate on a plan that will ensure Tina's successful passage into first grade.

It is important that the psychologist evaluating Tina have experience in the assessment and treatment of school phobia as well as Post-Traumatic Stress Disorder. In addition, the evaluation should be comprehensive in nature. The psychologist should show respect for mother's view and not assume that this child's difficulties are solely due to the violent crime she witnessed. In fact, there may be previously undetected learning difficulties, current family stressors, peer difficulties or other factors that may be influencing Tina's current psychosocial functioning both at school and at home.

Throughout the course of the evaluation, it is the psychologist's role to build rapport and establish a trusting relationship with this mother and child. Ideally, in the course of asking questions and exploring issues, Susan may examine her daughter's difficulties and come to different conclusions about the impact of the trauma and the need for counseling. However, regardless of whether or not a natural shift in attitude occurs, if the findings of a comprehensive evaluation indicate that the child is suffering PTSD symptoms that are interfering with her ability to concentrate and even attend school, the psychologist will need to present the evaluation findings and treatment recommendations to mother with a great deal of clarity, detail and empathic support. The psychologist may provide examples that illustrate how she arrived at her conclusions and recommendations, with emphasis on how Tina's symptoms could snowball without effective intervention and how treatment would address her school refusal, concentration difficulties and fearfulness.

Assuming Susan agrees to participate in treatment for her daughter, I would recommend that the counselor providing treatment for Tina broach the subject of Susan's potential PTSD difficulties after she has established a strong supportive relationship with Susan, and Tina has made some significant progress in treatment. At this point, Susan may have a greater appreciation for the benefits of therapy and may be more receptive to the recommendations of a therapist she trusts. With Susan, there will be many issues to explore, including PTSD symtomatology, as well as her relationship with the neighbor, her relationship with her daughter's father, her relationship with her mother and the factors or symptoms that seem to be interfering with her ability to keep a job.

Finally, I would not recommend the involvement

continued on next page

## Case Response

continued from page 17

of child protection at this point in the case. Child protection involvement might exacerbate mother's already negative attitude toward professional intervention. Moreover, there does not appear to be any significant evidence of child abuse or neglect by the mother that would mandate their involvement at this time.

## Case Response

Janet E. Fine, M.S.

Chief, Victim Witness Assistance Program
Suffolk County District Attorney's Office

In our jurisdiction, as in many others, Victim Witness Advocates (VWA) provide critical rights, services, and support for victims of violence—particularly for those involved in the criminal justice system. The services provided by a VWA (whether a clinical social worker, as in this case, or a trained human services professional) include crisis assessment and intervention; safety planning; referrals for mental health, medical, financial and social services; information about victim rights, the court system, and case status; court advocacy; trial preparation; and supportive counseling. The VWA's role is directed at two crucial areas—the crisis needs of victims and witnesses, and their rights and needs as participants in the criminal justice system.

The key issues in this case are, first and foremost, the safety and emotional and physical well-being of Susan, Tina, and Tina's grandmother. Support and services to the neighbor who presumably witnessed a horrifying crime scene, came to Tina's aid, and would likely be involved in the prosecution should also be a focus of care and attention. Another key issue is that of minimizing their criminal justice involvement (including any testimony in preliminary proceedings), and in advocating for their rights and needs throughout the life of the criminal case.

In this case study, the VWA would become involved during the police investigation and upon Jim's arrest and arraignment in court. S/he would immediately begin gathering critical contact and case information from a variety of sources (e.g., police, prosecutor, CPS worker, hospital staff). Immediate focus would be on the primary victims (Susan and Tina), family members (specifically Tina's grandmother), and the neighbor to whom Tina turned for help (a witness and a secondary victim).

In contrast to the strategy employed here of conducting an immediate interview of Tina at her grandmother's home, the VWA would first proceed by discussing a number of primary issues with the prosecutor and police detective. The discussion would include: concerns for Susan and Tina's safety (and that of the grandmother and neighbor), available protection (including bail conditions), and the scheduling of investigative interviews of Tina and other witnesses. The VWA would also ascertain the status of Susan's medical condition and immediately consult with the local specialized treatment program which conducts evaluations and treatment of children who witness serious violence. If Jim had been arrested and arraigned, the VWA and the prosecutor would also discuss the next steps in the court process.

Depending upon Susan's medical condition, the VWA would make direct contact with her in the hospital and/or with key hospital staff to explain the VWA's role and address protection and the most immediate court-related concerns. S/he would also discuss the impact of trauma and the critical need for counseling for both her and Tina. The VWA would follow up by connecting them with specialized trauma services.

The VWA would then make direct contact by phone with Tina's grandmother and arrange to meet her in person. The VWA would support and validate her fears and concerns, and help her understand and prepare for the emotional reactions that she, Susan, and Tina are likely to experience in the aftermath of the violence. The VWA would also assess their safety, emotional, and physical needs.

Immediate court-related concerns and fears of retaliation would be addressed, including discussion of a safety plan and an explanation of bail and the bail notification system (i.e., if Jim were to post bail and be released). In addition, the VWA would discuss referrals for specialized trauma services for the grandmother, Susan and Tina, and evaluate Tina's readiness for an investigative interview. The VWA would also determine whether Tina was attending school and discuss with the grandmother (and separately with Susan) the importance of informing Tina's teachers to further strengthen the network of support and services.

If the need for an interview of Tina was imminent, the VWA would explain the multidisciplinary team (MDT) interview process and its benefits—i.e., minimizing multiple interviews, facilitating and strengthening communication among the professionals involved, and streamlining referrals for services for the grandmother, Tina and Susan. The MDT would be particularly helpful in accessing appropriate trauma services for Susan and Tina. If the VWA had been unsuccessful in gaining Susan's support for mental health evaluation and treatment of Tina, the MDT would strategize methods of intervention to accomplish this, focusing on which team member would be in the best position to evaluate the source(s) of Susan's reluctance. The MDT would benefit from including relevant school personnel in the discussion about Tina's care. If payment for services was an issue, the VWA would seek specialized services from a VOCA-funded agency and/or assist Susan in filing for victim

continued on next page

## Case Response

continued from page 18

compensation for counseling and other expenses (e.g., medical costs, lost wages, crime scene clean-up).

It is unclear from this case study whether CPS was called at the outset to provide temporary care for Tina. Whether they were or not, they could be accessed on a voluntary basis, with Susan's consent, to offer a variety of social services and to provide, if eligible, another source of resources for counseling. All attempts by the MDT and individual members of the team to convince Susan of the need for treatment for Tina would need to be exhausted before considering a neglect report to CPS. This should only be utilized as a last resort.

The long-range plan for this family highlights a key role of the VWA—that of being the center of communication among the various professionals involved in the multidisciplinary intervention. The VWA would maintain frequent contact with the victims and witnesses and other professionals to ensure continuity of services and support. Furthermore, the VWA would provide ongoing information about case status and the court process, assist in trial preparation, the drafting of victim impact statements, and the provision of post-disposition services (e.g., inmate status notification, parole and appeals procedures).

The short-and long-term interventions discussed here will undoubtedly facilitate the victims' recovery from their victimization and help effect a positive prosecution outcome and a meaningful experience with the criminal justice system.

## An Invitation to *Advisor* Readers

Do you have a particularly interesting or challenging case you would like to see featured in The *Advisor's* Case Conference? We invite *Advisor* readers to submit a case summary for feedback from our multidisplinary panel of featured experts. Names and other identifying details should be changed to protect confidentiality, and submission of a case does not guarantee it will be used in the Case Conference section. Case summaries should be limited to one and one-half double spaced pages. Send your case summary to:

**APSAC *Advisor* Case Conference Series**
**407 S. Dearborn, Suite 1300, Chicago, Illinois 60605**
**fax 312-554-0919, email APSACPubls@aol.com**

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) e-mail: hansonrf@musc.edu.*

## SEXUAL and/or PHYSICAL ABUSE

### The Impact of Childhood Sexual Abuse on Parenting

The aim of this study was to examine the impact of a history of child sexual abuse and more general family relationship quality on the parenting of a sample of low-income mothers. This study was a secondary analysis of archived data collected by Zuravin (1996) on 518 low-income mothers. Parenting was assessed using measures such as frequency of worry about child problems, views of self as a parent, and how child discipline problems were handled. Child sexual abuse was associated with more negative views of self as a parent and the greater use of physical punishment strategies even after accounting for differences in family-of-origin relationship quality. Implications for future research and intervention are discussed.

**Banyard, V.L. (1997). The impact of childhood sexual abuse and family functioning on four dimensions of women's later parenting. *Child Abuse & Neglect. 21(11),*1095-107**

### An Overview of the Debate on Repressed Memory

The current debate over repressed memory as well as the prominent theories in this area are discussed. Recent legal developments of repressed memory litigation are discussed along with examples of legal cases that are most relevant to mental health professionals today.

**Corelli, T.B., Hoag, M.J., & Howell, R.J. (1997). Memory, repression, and child sexual abuse: forensic implications for the mental health professional. *Journal of the American Academy of Psychiatry and the Law. 25(1),* 31-47**

### Predicting the Development of PTSD in Childhood Rape Survivors

This study attempted to determine which crime, perpetrator, victim, and aftermath characteristics are related to PTSD status among childhood rape victims. A national representative sample of women (N = 3,220) were interviewed about their history of rape, trauma-related variables, and PTSD status. Consistent with research on crime victims, life threat and physical injury discriminated PTSD status in a sample of childhood rape victims. In addition, two other domains were related to PTSD development: (1) testification about rape and (2) rape types. The present findings are discussed in relation to previous research.

**Epstein, J.N., Saunders, B.E., & Kilpatrick, D.G. (1997). Predicting PTSD in women with a history of childhood rape. *Journal of Traumatic Stress. 10(4),* 573-88**

### Incidence of Physical & Sexual Abuse in a General Population

The purpose of this article was to determine the prevalence of a history of physical and sexual abuse during childhood among the general population. A random sample (N=9953) of residents aged 15 years and older, selected from households in the province of Ontario, Canada, participated in the Ontario Health Supplement. Respondents completed a self-administered questionnaire about a history of physical and sexual abuse in childhood. Prevalence of abuse differed for males and females. Age of the respondent was not significantly associated with childhood abuse within any category for males. However, for females, the reported prevalence in childhood of sexual abuse, co-occurrence of physical and sexual abuse, and both categories of severe abuse decreased with increasing age of the respondent.

**MacMillan, H.L., Fleming, J.E., Trocme, N., Boyle, M.H., Wong, M., Racine, Y.A., Beardslee, W.R., & Offord, D.R.(1997). Prevalence of child physical and sexual abuse in the community. Results from the Ontario Health Supplement. *JAMA. 278(2),* 131-135**

### Studying the Incidence of PTSD

This article reports on the findings of the DSM-IV Posttraumatic Stress Disorder (PTSD) Field Trial. Two hundred thirty four participants who reported sexual and/or physical abuse were evaluated. Participants were categorized according to type of abuse (physical, sexual, both), duration of abuse (acute versus chronic), and onset of abuse (early versus late). Separate logistic regression analyses examined the relationship between age of onset, duration, abuse type, and the complex PTSD (CP) lifetime diagnosis for women and men. Sexually abused women, especially those who also experienced physical abuse, had a higher risk of developing CP, although CP symptoms occurred at a high base rate among physically abused women. The theoretical implications and incremental clinical usefulness of targeting CP symptoms with abused populations are discussed.

**Roth, S., Newman, E. , Pelcovitz, D., van der Kolk, B., & Mandel, F.S. (1997). Complex PTSD in victims exposed to sexual and physical abuse: Results from the DSM-IV Field Trial for Posttraumatic Stress Disorder. *Journal of Traumatic Stress. 10(4),* 539-55**

### Covert Video Surveillance Detects Potentially Lethal Abuse

The purpose of this article was to describe historic markers and clinical observations of life-threatening child abuse as diagnosed by covert video surveillance (CVS). CVS was used to investigate suspicions of induced illness in a sample of 39 children and a control group of 46 children whose illnesses were proven to be attributable to natural medical causes. The use of CVS revealed attempted suffocation or other child abuse in 33 of 39 suspected cases. The authors conclude that detection of this type of abuse requires careful history-taking; thorough examination of the health, social, and police records; and close and focused collaboration between hospital and community child health professionals, child psychiatrists, social workers, and police officers. CVS may help investigate suspicions and ensure that children are protected from additional abuse.

**Southall, D.P., Plunkett, M.C., Banks, M.W., Falkov, A.F., & Samuels, M.P. (1997). Covert video recordings of life-threatening child abuse: lessons for child protection. *Pediatrics. 100(5),* 735-60**

continued on next page

## Journal Highlights

continued from page 21

### Tracking the Clinical Progression of Fatal Head Injuries

The purpose of this article was to determine the normal clinical progression of fatal head injuries in children to aid investigations of nonaccidental trauma. One hundred and thirty-eight accidental fatalities involving head injury were identified by a retrospective chart review. Details of 95 cases were reviewed and cases in which a child either had a Glasgow Coma Scale (GCS) of 14-15 or was described as having a "lucid interval" or as being "conscious" were further studied. Review of head CTs revealed that brain swelling could be detected as early as 1 hour and 17 minutes post injury. The authors discuss clinical implications of their findings.

**Willman, K.Y., Bank, D.E., Senac M. & Chadwick D.L. (1997). Restricting the time of injury in fatal inflicted head injuries. *Child Abuse & Neglect. 21,* 929-40.**

## OTHER ISSUES IN CHILD MALTREATMENT

### Distinguishing Family Violence from Family Maltreatment

The authors of this review argue for the importance of distinguishing between family maltreatment, characterized by minimal physical or sexual harm or endangerment, and family violence, characterized by serious physical injury, profound psychological trauma or sexual violation. The authors provide an empirically based review and discuss the definition and epidemiology of family violence and its causes, its consequences, and appropriate intervention.

**Emery, R.E., & Laumann-Billings (1998). An overview of the nature, causes, and consequences of abusive family relationships: Toward differentiating maltreatment and violence. *American Psychologist, 53,* 121-135.**

## *CHILD MALTREATMENT* SPECIAL SECTIONS CALL FOR PAPERS

*Child Maltreatment,* APSAC's quarterly, peer-reviewed journal, is currently soliciting papers for two upcoming special focus sections. For complete details on these sections and instructions for authors, please visit the *Child Maltreatment* website at http://157.142.136.54/CM/CALLS.HTM. Please send 5 copies and a cover letter indicating which focus section the manuscript is for to:

**Mark Chaffin, Editor in Chief, Center on Child Abuse and Neglect,**
**University of OK Health Sciences Center – CHO 4B138,**
**P.O. Box 26901, Oklahoma City, OK 73190**

## FOCUS SECTION ON REPEAT VICTIMIZATION

**Guest Editor: Dan Smith, Ph.D., University of Arkansas**

A number of studies over the past two decades have reported an association between reports of childhood maltreatment and reports of a variety of victimization experiences later in life, often extending into adulthood. Although this phenomenon has been widely discussed, it is not well understood. *Child Maltreatment* is soliciting manuscripts on topics related to repeat victimization. Manuscripts should be submitted by August 31, 1998.

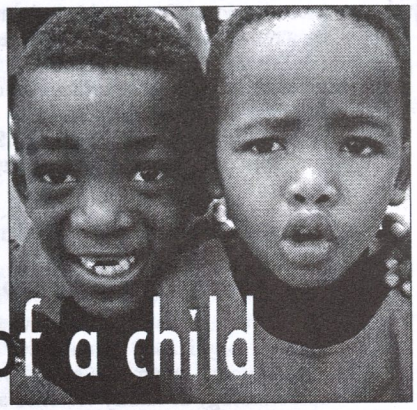
## FOCUS SECTION: CONTROVERSIAL POLICIES AND PRACTICES IN THE FIELD OF CHILD MALTREATMENT

**Editors: Theresa Reid, M.A., and Mark Chaffin, Ph.D.**

*Child Maltreatment* is preparing a focus section for an upcoming issue of the journal on the topic of controversial practices in the field of child abuse and neglect. The section is intended to encourage thoughtful and balanced analysis of practices which are the subject of serious criticism or debate. For example, the section might include contributions related to debated interview techniques, the appropriateness of categorizing infant drug exposure as maltreatment, controversial policies such as time limits for reunification efforts, controversial diagnoses such as dissociative disorders, or controversial treatment approaches such as memory recovery or reattachment therapy. However, the section would be less appropriate for contributions about practices or policies where an accepted negative consensus already exists, including practices which run counter to established law or published guidelines, such as coercive interviewing techniques or failing to report ongoing abuse. All manuscripts for this section are asked to respect a 30 page limit. The deadline for submissions is February 15, 1999.

*Announcing the People to People Ambassador Programs Child Abuse Prevention Delegation, visiting South Africa in November 1998, under the leadership of Joyce Thomas*

# See South Africa through the eyes of a child

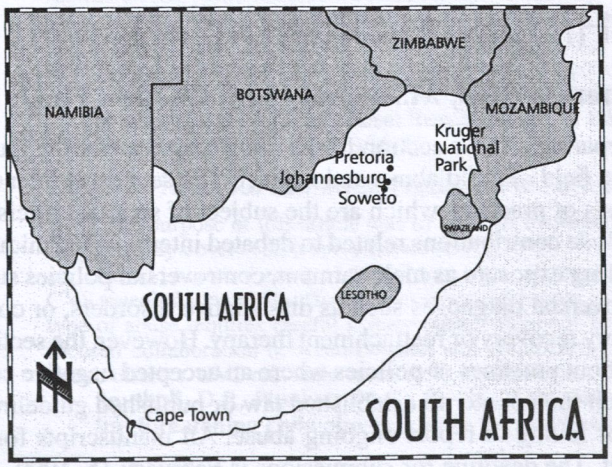


Join fellow child protection specialists on a journey to South Africa, to meet that country's experts in child protection and to exchange information on how each country serves children and families in turmoil. The delegation will enjoy professional exchanges and sightseeing in Johannesburg and Cape Town, as well as a photographic safari in Kruger National Park.

Highlights of the program include meetings with:

- The South African National Council for Child and Family Welfare
- The National Committee for the Prevention of Child Abuse and Neglect, Department of Welfare
- Child Protection Unit of the South African Police, including field visits with unit officers
- University of the Western Cape, Department of Social Welfare
- Staff of several emergency shelters and clinics

The delegation's leader is Joyce Thomas, president and co-founder of the Center for Child Protection and Family Support, Inc., in Washington, DC. Ms. Thomas is a national and international expert on all forms of child maltreatment, domestic violence, and cultural competency. She is also one of the founding members of the American Professional Society on the Abuse of Children, serving as both vice-president and president.




The program is being coordinated by People to People Ambassador Programs, which has over 35 years of experience in arranging international, professional exchanges. Ambassador Programs is a part of People to People International, which was founded by President Dwight D. Eisenhower in 1956. President Eisenhower's vision was that ordinary citizens could be a part of the peace process through "people to people" contact.

## Contact us for details.

For more information on the Child Abuse Prevention Delegation or other professional travel opportunities, please contact:

Jenifer Priest, Program Director
People to People Ambassador Programs
Dwight D. Eisenhower Building
110 S. Ferrall Street
Spokane, WA 99202-4800
Tel: 800-669-7882, ext. 545
Fax: 509-532-3593
E-mail: JeniferP@ambassadors.com

PEOPLE TO PEOPLE
AMBASSADOR
PROGRAMS

## Upcoming Conferences

# CONFERENCES

**July 8-12, 1998.** ***Sixth National Colloquium.*** Hyatt Regency-Chicago, IL. Sponsored by American Professional Society on the Abuse of Children. For more information call (312) 554-0166.

**July 13-17, 1998.** ***Basic Training for Child Abuse Prosecutors and Investigators.*** Boston, Massachusetts. Sponsored by National Center for Prosecution of Child Abuse. For more information call (703) 739-0321.

**July 19-22, 1998.** ***Working with America's Youth National Resource Center for Youth Services.*** Adams Mark Hotel- San Antonio, TX. For more information call (918) 585-2986.

**July 26-29, 1998.** ***Program Evaluation and Family Violence Research: An International Conference.*** Sponsored by The Family Research Laboratory at the University of New Hampshire. Call 603-862-1900.

**August 4-5, 1998.** ***Eleventh Annual Preserving the Innocence of Children Conference.*** Multidisciplinary Conference on Child Abuse and Domestic Violence and How it Affects Children. Weber State University, Ogden, OH. Sponsored by Child Abuse Prevention Center of Ogden. For more information call Marilyn Sandberg at (801) 393-3366.

**August 10-14, 1998.** ***Basic Training for Child Abuse Prosecutors and Investigators.*** Tucson, Arizona. Sponsored by National Center for Prosecution of Child Abuse. For more information call (703) 739-0321.

**August 16-20, 1998.** ***Tenth Annual Crimes Against Children Conference.*** Sponsored by Dallas Police Department and the Dallas Children's Advocacy Center. For more information call (214) 818-2600.

**September 6-9, 1998.** ***Twelfth International Congress on Child Abuse & Neglect.*** Auckland, New Zealand. Sponsored by International Society for Prevention of Child Abuse and Neglect. For more information call (312) 644-6610 ext. 3273.

**September 10-12, 1998.** ***Strengthening Community Cultures One Family At A Time.*** Sponsored by Family Preservation Institute. For more information call 505-646-2143.

**September 13-15, 1998.** ***The Second National Conference on Shaken Baby Syndrome.*** Salt Lake City, Utah. Sponsored by Primary Children's Medical Center, The Child Abuse Prevention Center of Utah, SBS Prevention, and the National Association of Children's Hospitals & Related Institutions (NACHRI). For more information, call 719-784-3330.

**September 17-18, 1998.** ***Child Protection: Our Responsibility.*** Cedar Rapids, IA. Sponsored by St. Luke's Child Protection Center. For more information, call 319-369-8136.

**October 3, 1998.** ***Expanding Visions: The Multi-Dimensional Uses of Sandtray.*** Sponsored by the Sandtray Network. For information, call (415) 342-0760.

**October 21-24, 1998.** ***Forth Internation Conference on Children Exposed to Family Violenece.*** San Diego, CA. Sponsored by Family Fiolence and Sexual Assault Institute and the YWCA Domestic Violence Institute. For more information call, 000-000-0000.

**November 1-3, 1998.** ***Tools That Work: Information Systems to Measure and Improve Services for high-Risk Children, Youth and Their Families.*** Schaumburg, IL. Sponsored by the Child Welfare League of America and the National Court Appointed Special Advocate (CASA) Association.

**November 2-6, 1998.** ***Child Fatalities and Physical Abuse.*** Sponsored by National Center for the Prosecution of Child Abuse. For more information, call (703) 739-0321.

**November 16-21, 1998.** ***Twelfth National Conference on Child Abuse and Neglect.*** Silver Spring, MD. Sponsored by the National Center on Child Abuse and Neglect (NCCAN). For more information call (301) 589-8242.

**June 2-6, 1999.** ***Seventh Annual National Colloquium.*** San Antonio, TX. Sponsored by American Professional Society on the Abuse of Children. For more information call (312) 554-0166.

## In Memoriam

APSAC Staff, Board and volunteers were shocked and saddened to learn of the death of longtime APSAC member and volunteer Thomas R. Curran, JD, MSW, LSW, on May 31, 1998. Tom Curran was an attorney in the Child Advocacy Unit of the Defender Association of Philadelphia, where he represented maltreated children. Curran was also a Clinical Assistant Professor of Psychiatric Mental Health Nursing at the University of Pennsylvania, the former Executive Director of the Philadelphia Advocacy Center, and two-term member of APSAC's National Board of Directors. He also served as faculty for APSAC's Colloquium and was a section editor of the APSAC *Advisor.* Acknowledgments may be sent to Mr. Curran's parents, Paul and Mary Curran, at 415 East Blane Street, McAdoo, PA 19237.

ISSN 1088-3819 

# THANK YOU!

These APSAC members have made generous financial contributions in the last several weeks to support vital work of the organization. Their dontaion have strengthened APSAC's efforts to educate legislators, policymakers, reporters, and editors; to produce additional guidelines for practice; and to encourage promising student research in the field of child maltreatment. We greatly appreciate their generosity and commitment.

**Patron Level ($151 - 500)**
Leonardo Ciambella
Esther Deblinger Sosland, PhD
Joseph Palacios

**Supporter Level ($51 - 150)**
Mark Dennis, Jr.
Raelene Freitag, MSW
Laura Gutman, MD

**Friends Level ($5 - 50)**
H. Crowell Freman, Jr.
Patricia Gurney
Darlene Hall
Michele Lorand, MD
Michaelanne Marie

**Katie Toth Memorial Fund**
Judge Sol Gothard
Helene Blume

**In Honor of Kathleen Coulborn Faller, ACSW, PhD**
1997 Civitas Fellows

## Mark Your Calendars Now!

Join APSAC in San Diego, January 25, 1999 for our Advanced Training Institutes. These six-hour seminars complement the San Diego Conference on Responding to Child Maltreatment by offering in-depth extensive Institutes on selected topics. Taught by nationally recognized leaders in the field of child maltreatment, our six-hour concurrent Institutes offer hands-on, skills-based training grounded in the latest empirical research. For more information about the Institutes or other APSAC training programs, contact our training department at 312-554-0166; Fax: 312-554-0919; E-mail: APSACEduc@aol.com.

APSAC

American Professional Society
on the Abuse of Children
407 South Dearborn Street, Suite 1300
Chicago IL 60605
P 312-554-0166, F 312-554-0919
E-mail: APSACMems@aol.com
http://www.apsac.org

Non-Profit Org.
U.S. Postage
PAID
CHICAGO, IL
Permit No. 4345