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APSAC ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

IN THIS ISSUE:

PERSPECTIVES

Reflections on the Death of A Child
—James Henry, PhD

It's what everyone involved in child maltreatment dreads - the call bringing news that a child on one's caseload has died as a result of abuse or neglect. Professionals in this field live with that possibility and develop coping mechanisms for dealing with stress, but at what cost? Author James Henry explores the intra-personal consequences of living with the life and death pressure associated with work in child protective services. **2**

FEATURE ARTICLES

Child Abuse and Disabilities: A Medical Perspective
—by Ann Botash, MD and Cate Church, PhD

Children with disabilities are often at increased risk of abuse due to a variety of factors, including parental stress, communication difficulties, and unrealistic expectations of the child, given their disability. Screening abused and neglected children for disabilities is not routinely done, even though studies have shown that significant numbers of children served by CPS have developmental disabilities. This article examines the role of medical personnel in screening abused children for disabilities, and disabled children for abuse. **10**

Focused Questions for Interviewing Children Suspected of Maltreatment and Other Traumatic Experiences
—by Kathleen Coulborn Faller, PhD, ACSW

Children are often the primary source of information when conducting investigations about abuse or other traumatic experiences. The importance of conducting an interview without coercing, interrogating, or leading the child has been clearly established by the courts and research. Not only may such practices result in actual inaccuracies or fabrications in the child's responses, these practices can result in legal and ethical challenges to the evaluator's work. This article, by Kathleen Coulborn Faller, PhD, ACSW, will offer guidance for interviewers, and examples of questions that are focused, but are not leading. **14**

CASE CONFERENCE

The Bradley Family

Belinda is the mother of two children, 16-year-old Danny and 3-year-old Bobby. The family comes to the attention of CPS authorities when Danny's high school counselor makes a referral after conducting a home visit and seeing Bobby's condition. At age 3, Bobby is thin and small for his age, is not toilet-trained, and does not appear to respond to his mother or other adults. Belinda admits that she "isn't much of a mother" and that she doesn't "have the energy to give the boys attention." A pediatrician, adult psychologist, and CPS worker respond to the issues in this case. **19**

REGULAR FEATURES

Reflections on the death of a child

By James Henry, PhD

I began a career in child protection 16 years ago, envisioning myself as an impassioned knight rescuing children from the physical and sexual assaults of adults. Since that time, however, my experiences with abused and neglected children have led me on a journey through painful realities that have exposed my own limitations and fears. The tragic stories have left me with haunting inner images of battered bodies and scarred hearts. Ultimately, it has been these children who have changed me. They have challenged me to move beyond theoretical explanations and touch their pain.

Recently, an incident involving a young child has again forced me out of my comfort zone and to the edge of my personal and professional boundaries. It is the outcome that all Child Protective Services workers fear when they make the decision to leave abused/neglected children within their own homes. A four-year-old child died, due to parental neglect, despite years of social service interventions.

Early one morning the call came from the hospital emergency room. My hand took the necessary information, but my mind focused on this little girl I had seen only last week in the newspaper as a success story for family preservation. A knot in my stomach tightened as I faced the harsh reality of senseless death.

And now, weeks later, I still cannot escape the image of the child's stiffened body upon the gurney. I can't seem to erase, despite my frantic efforts to do so, the imprinted pictures of her gray color, matted hair, cold skin, and expressionless face. Remnants of the initial lump within my throat appear spontaneously throughout the day. My mind and body weigh heavy with this unexplainable death.

In the past, time has been an ally to me in burying the pain of such experiences, but this time, the sadness returns daily. I want the memory darkened and covered. I want the feelings to leave. I seek to return to my stoic professionalism that protects me from any psychological aftershocks that shatter my walls of emotional safety.

Cynicism has always been a protector. It rationalizes the cruel realities of life for some children. It speaks bluntly: "Of course it happened!" This death was destined to occur from the moment of conception when these two developmentally delayed and emotionally impaired parents created a new life out of their limitations. Nature demanded abilities far beyond their capabilities! These parents could not even meet their own needs. The energy necessary to care for a child was consumed by their own struggles to personally survive.

I recall how, during the interview at the hospital, I initially was filled with pity for the parents. They were unable to explain any chain of events that could have precipitated the child's death. Their shock, their fear that the system would take away their other child, and their limited cognitive abilities prevented them from being able to remember and/or communicate just how sick the child had been the previous evening. Yet, as their disjointed and contrasting stories unfolded, I became aware of the mother's lack of emotion. Her primary concern appeared to be the potential loss of funds from the termination of the child's Social Security disability check. As the mother launched into a desperate plea for money, my anger surfaced.

My anger has since shifted to the system professionals and their contribution to this senseless death. There had been a series of intensive interventions over the years to provide services to elicit parental change. Numerous agencies and court orders had attempted to alleviate the risk to the child and avoid the tragedy that had now occurred. In retrospect, removal could have prevented death, yet, in an era of preserving the sanctity of the family by leaving abused/neglected children with their parents, a removal was deemed unwarranted.

It was a gamble that ultimately failed. It is not, however, an unusual gamble. It is indicative of the risks that those in the child protection system must take every day. Such risks weigh heavily on those on the front lines, who are saddled with the responsibility of making potentially life and death decisions, often on limited and/or inconclusive information. Perpetual doubt can plague the mind when deciding if a child is safe. There are no certainties, as the unpredictability of risk vacillates between low to high in many abusive/neglectful families, depending on the day's events. The hope is that the children will be resilient enough to overcome significant environmental deprivation and somehow survive. I have come to doubt the wisdom of family preservation policies, given my experience of the subsequent psychological and emotional developmental damage to these children from continuous exposure to harm. There are too many risks that are ignored or minimized when implementing preservation strategies. Family preservation just does not work with some families, as the 43% recidivism rate for previous abuse/neglect reflects. (Michigan Kids Count Report, 1997.) I realize now that advocating for the safety of children demands a willingness to challenge accepted philosophies and resist administrative pressure to maintain children in their own families.

Despite my frustration with the child protection system, I am aware, as time passes, that my anger is just a masquerade for my own sadness and fear. The anger guards my heart, protecting it from the grief that I fear will

continued on page 3

consume me. I am flooded with feelings, as the stiffened child's image within my mind's eye resurrects the tragically familiar faces of other abused and neglected children.

There are blatant societal messages that oppose exploration of pain. It is shunned, stuffed, negated, and deemed unacceptable. Child protection professionals are encouraged to create a hardened persona that keeps the affect protected and preserves a strong inner defense against potentially harmful feelings. There is an unwillingness to let the painful stories of children enter the places of the heart. Attention becomes focused on task accomplishment, with success being determined by external goal achievement rather than attentiveness to the emotional needs of the child victim.

I find it ironic that these same professionals encourage abused/neglected children to express their emotions, the premise being that healing and recovery begin with awareness and attention to one's feelings. We tell children that recognition and acknowledgement of pain are necessary steps for inner resolution of internal and external conflict. Yet, professionals are so reluctant to embrace such a process for themselves for fear of losing control of their emotional life.

There is an old tradition within the Native American culture of a designated "sin-eater" within each tribe. It is the responsibility of the sin-eater to eat the sins of tribal members before their death. This process ensures that the dying member is freed from sin and will be welcomed into the afterlife. The sin-eater thus becomes a key figure within the tribe, yet, is often ostracized because no one wants to associate with him for fear that they themselves will be contaminated by the sins of others. Sin-eaters struggle for ways to participate in the society without accentuating tribal fears, and silence is the primary mechanism for sin-eater survival.

The sin-eater story provides an excellent insight into the expectations brought to bear on child welfare professionals: fulfill the responsibilities of protecting children but do not challenge or expose society's physical and/or psychological practices that contribute to the abuse/neglect or jeopardize the well being of children. Societal ignorance of the emotional and psychological consequences of child abuse/neglect serve to reinforce affect denial amongst professionals, which ensures continuance of the high burnout rate and substantial staff turnover.

Professional survival in child protection demands a strategy for coping with the painful realities that society seeks to ignore. Personal distraction, like one too many beers, or repression, burying the wounds so deeply that nothing is felt, often enable one to sleep at night and come to work another day. Unfortunately, the by-products of these defenses are energy depletion, physical illness, and emotional withdrawal, not only within the professional realm, but in one's personal life as well.

Stress management is considered by many to be a healthy alternative. It provides temporary relief by diverting attention from the pain to a self-care plan with a concentration on relaxation. The goal is to draw boundaries around professional interactions to ensure that one's personal life is protected from unwanted images and thoughts generated by painful encounters. Yet, the emotional intensity experienced in such serious incidents cannot be contained, and it frequently intrudes into the hallowed spaces of personal life. Stress management provides no answers to the haunting questions that surface from senseless tragedies involving children. It functions as a form of benign escape.

Intervening in the lives of abused/neglected children has challenged the very essence of my personal beliefs and worldview. Easy answers from the pulpit, rational explanations, and self-medication deny recognition of the deep grief that swells in the heart. There are no acceptable answers that mitigate the pain.

I return again in my mind's eye to the child's body on the gurney. I no longer can offer her safety. It is too late for her. My many years in Child Protective Services have taught me that life can be unfair and cruel, even to the most undeserving. The death now before me confirms this belief. As the question surfaces, "Why did this happen?" I can answer only "Because it did." No explanations or rationalizations —just gut wrenching honesty.

The author worked as a caseworker and supervisor in child protective services in Michigan for 17 years. He is currently an assistant professor at Western Michigan University, where he teaches classes on child sexual abuse and child welfare, and a therapist in private practice. He may be reached via email at james.henry@wmich.edu.

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

Letters may be directed to Debra Whitcomb, Editor-in-Chief, via email at dwhitcomb@edc.org or by regular mail c/o APSAC, 407 South Dearborn, Suite 1300, Chicago, Illinois 60605, or via fax at 312-554-0919. Letters are typically edited for length, but every effort is made to preserve content. Letters must be typewritten and constructive to be considered for publication.

Letters to the Editor

LETTERS

To The Editor:

In Volume 11, number 3 of the *APSAC Advisor*, there was a case conference discussion about a mother who gave birth prematurely to a child who tested positive for opiates and cocaine exposure. Incredibly, each of the three Case Responses failed to identify the presence of drugs in a child as a form of child abuse. In addition, key points in the case were missed and consultation with medically qualified experts in this field was overlooked.

Tjhin, Cowan and Cronin correctly emphasize safety of the child as the most important factor. The mother in the case, Brenda, had late prenatal care (first at 6 months) and used drugs during her pregnancy, a time when many mothers abstain from substances which may be harmful to their unborn child. Already there should be severe concerns about the mother. Brenda was not willing to go to a treatment program, but now says she is. Brenda has gone to a drug treatment program before (with the birth of her previous drug-exposed child, Lauren, now 18 months old) but evidently that did not completely work. Yet the authors would build upon "Brenda's previous success in caring for Lauren without CPS involvement". The data presented indicate that Brenda was not successful in stopping her drug problem, is not certain she will yet address it, and exposed Lauren to a mother who continues to be a drug user (and possibly exposed Lauren to passive cocaine smoke). This is a questionable base upon which to emphasize "strengths". They also say that the "first priority for other professional involvement would be to obtain a substance abuse assessment to determine which kind of services would be helpful to Brenda." However, the first priority should be a medical evaluation of Lauren to determine if she has been exposed to drugs through passive inhalation, and to see whether she has any other signs of abuse. The delay inherent in the authors' priorities poses a risk for Lauren.

Assessment of the children for health problems and developmental delays (and a history of child abuse) was recommended by Amaro, Roizner, and Nieves. However, a more immediate medical child abuse assessment should be emphasized. Part of the treatment plan not mentioned should be random urine samples, not only of the mother, but the father and any children in the home. Treatment programs for mother and child are desirable, but without father participation or with a return to the same environment the outcome is likely to be poor.

Wilson would reserve dependency action depending upon the occurrence of serious abuse or neglect (a redundancy) or other issues. Drug exposure is serious. Although the outcomes of drug-exposed children are better than originally feared, serious physical problems can occur. The prematurity itself is undoubtedly the result of Brenda's use of cocaine, which can induce premature labor. Already the child has suffered medical risk and the trauma associated with such hospitalization. Thus the standard is already met. Wilson astutely notes that it is unclear how Brenda cared for Lauren while using dangerous drugs with regularity. Perhaps the care was not so good, or perhaps Brenda was not the sole caretaker. However, the use of drugs is an important symptom of the potential environment for her children and should be a focus along with her "quality of care", presumably assessed by professionals when Brenda is not using. Wilson concludes by stating that prior to removal, "the public agency should have to demonstrate a clear connection between the mother's substance use/abuse and child abuse or neglect." Fortunately in some states it has been made clear by law what is known by the public and by medicine, children exposed to toxic substances by the parent equals child abuse.

A more complete discussion of this topic already appeared in the *Advisor* (Alexander and Moskal, 1997). In all instances the exposure to drugs should be considered as child abuse. The American Academy of Pediatrics favors a public health approach, in contrast to criminal prosecution of the mother. This may mean removal of all of Brenda's children to foster care until treatment success has been ensured. Leaving children in the home, even with services, is a plan with a poor prognosis. Recidivism with positive urine screens is the norm, and children's growing up with cocaine in their system through passive exposure is a dangerous undertaking. With the ups and downs of treatment of Brenda's chronic condition (drug abuse), uncertainties abound and any good plan will build in a timeline whereby parental rights may be terminated if proper reunification cannot be achieved within reasonable limits.

Randell Alexander, PhD, MD
Atlanta, GA

Dee Wilson responds:

Dr. Alexander places an unwarranted value on the power of legal definitions of child abuse to resolve difficult assessment issues. Whether or not state laws define prenatal exposure to drugs potentially harmful to a fetus (tobacco? alcohol?) as a form of child abuse, prenatal substance abuse should not be grounds, in and of itself, for involuntary out-of-home placement. This is especially true when older siblings are living in the mother's home and are being adequately parented.

It is dangerous social policy to base placement decisions on assumptions, absent thorough assessments, about women who use cocaine and/or opiates during pregnancy. It is equally rash to assume that prenatal substance abuse, combined with a refusal to participate in drug abuse treatment, equals risk of imminent harm to an infant. Drug/

continued from page 4

alcohol abuse has highly variable effects on parental functioning; similarly, the quality of mother's social support system varies greatly.

A thorough assessment of the mother and her living situation may indicate the need for out-of-home placement, not because this parent was guilty of prenatal substance abuse, but because of a variety of factors, some of which Dr. Alexander identifies in his letter. In short, the legal definition of prenatal substance abuse as child maltreatment provides a clear basis for CPS intervention, but not for involuntary out-of-home placement.

Martha Tjhin responds:

As part of any intensive in-home intervention, a thorough assessment of family and individual family members needs is always conducted. Information would be gathered about when and where Brenda uses substances, what substances are used, and what provisions are made for the care of her children while she uses. Within the Family Preservation model, we do not presume a parent to be incapable of providing adequate care because the parent has substance abuse issues. The focus on strengths is used to engage Brenda in the intervention and to facilitate her willingness to participate in substance abuse treatment, never to minimize the effects of parental substance abuse on children or the care-giving abilities of the substance-abusing parent. The Family Preservation worker would assess all relevant factors impacting the safety of the children, including a review of the children's access to and parent's use of the medical system on behalf of the children.

If indeed the CPS workers determine that a parent cannot safely keep their child at home with him/her while involved in substance abuse treatment, then the least restrictive alternative is the next best option, including relative placement, kinship care, or temporary guardianship. Family Preservation takes an individualized approach, working with the substance affected family based on the strengths each family demonstrates – we do not approach our work with substance-affected families based on generalized views or opinions about what "should be" regarding families with substance use issues. This is a difficult concept for those who practice from a medical model to embrace. However, for those parents who can attend substance abuse treatment and keep their children at home, the prognosis for a positive outcome for both children and parents is maximized.

Hortensia Amaro responds:

Based on the current standard of care, we do not agree with Dr. Alexander's view of the need to place the children in foster care "until treatment success has been ensured". We proposed a residential treatment program for substance abusing mothers and their children as a preferred option over an intervention that can severely disrupt the mother-child bond. These programs can provide an opportunity to identify and respond to the needs of women AND children while keeping the children safe. Studies have shown high rates of success in pregnancy outcomes for pregnant women and good treatment for women when their children can be with them in treatment.

We agree with the authors that treatment for the father would be ideal. However, we find that getting a safe place for the mother and child is the immediate priority in most cases. The father should also be referred to treatment but the first priority should be for the mother since she is the primary caretaker of the children and in such families the mother is highly likely to be subjected to abuse herself. Our recommendation for an assessment of the children included assessment of child abuse history so we are not clear why the authors disregard this recommendation in response to our case response.

Note to readers: In the last issue of the Advisor, (Volume 11, n. 4) David Lloyd commented on a Perspectives piece written by Rita Swan and published in Volume 11, n 1 of the Advisor. This is Ms. Swan's response to that letter.

To The Editor:

I stand by my position presented in v. 11, #1 of the *Advisor*, that the religious exemption in the Child Abuse Prevention and Treatment Act (CAPTA) as reauthorized by Congress in 1996 discriminates against a class of children.

David Lloyd, former director of the National Center on Child Abuse and Neglect, says in a letter to me that a religious exemption from child neglect charges does not compromise protection of children because the state can still intervene and obtain a court order for medical care over the religious objections of parents. However, hundreds of deaths of children in faith-healing sects show that the state often does not receive timely reports on these children. CHILD Inc. believes that parents should have a legal duty to provide children with needed medical care regardless of their religious beliefs.

Please contact us if you are interested in a more detailed response to the letters of Mr. Lloyd and Christian Science lobbyist Brian Talcott.

Rita Swan, President
Children's Healthcare Is a Legal Duty
Phone 712-948-3500, e-mail:childinc@netins.net
web site: http://www.childrenshealthcare.org

APSAC Launches Long Range Plan

By Deborah Daro, PhD

Within any organization, even one as vibrant and focused as APSAC, it is useful to spend time assessing past accomplishments and future opportunities and challenges. APSAC has accomplished much in its first ten years – an established, core membership of 5,000; a system of 34 state chapters; a standard setting organizational newsletter and professional journal; annual colloquia and advanced training institutes; and numerous practice guidelines and professional publications. While we can take pride in our collective efforts, those committed to reducing child maltreatment and mediating the consequences of abuse face a complex and uncertain future. Overburdened child protection systems, insufficient financial support for therapeutic and preventive services, and a sometimes doubting and skeptical general public can combine to make the job of protecting children overwhelming.

If APSAC is going to be successful in insuring that "everyone affected by child maltreatment receives the best possible professional response", it is essential that we spend some time critically assessing the past and planning for the future. The APSAC Long Range Planning Committee (LRPC) has been established to develop a clear set of future organizational objectives and related strategies. Working with APSAC's new Executive Director, the LRPC will spend the next several months gathering information from the APSAC leadership and general membership to determine how to best position APSAC in the future. Our initial conversations suggest a principal organizational challenge is crafting effective membership recruitment and retention strategies involving activities at both the national and state levels. Equally important will be strengthening the organization's internal decision making mechanisms (e.g., board structure, relationship between board and staff, participation by state leaders in decision making) as well as our interactions with other child serving and child advocacy organizations around the country.

As a first step in this process, members of the committee will be contacting each of APSAC's state chapter leaders to learn they see as the organization's strengths and challenges. In addition, the committee will host open forums and discussions for all interested members during the APSAC Colloquium in San Antonio. Included with this issue of the *Advisor* is a brief survey which you can complete if you will be unable to join us for the Open Forum in San Antonio. A two day planning retreat will be held in the summer and we hope to have a draft document available for membership and state leader review in early Fall. The quality of our plan ultimately will be determined by the frank and honest input we receive regarding each member's expectations for APSAC. To this end, I encourage each of you to express your opinions by contacting myself or other members of the committee. The LRPC includes the following APSAC leaders:

Deborah Daro, PhD (Chair)
University of Chicago
Chicago, IL
773-753-2730

Diane DePanfilis, MSW, PhD
University of Maryland School of Social Work
Baltimore, MD
410-706-3609
ddepanfi@ssw.umaryland.edu

Veronica Abney, LCSW, DCSW
Therapist in private practice
Santa Monica, CA
310-576-1878
vabney@msn.com

Harry Elias, JD
Judge, North County Municipal Court
San Diego, CA
760-740-4033
heliasmn@co.san-diego.ca.us

Sandra Wood, MEd
Georgia Council on Child Abuse
Atlanta, GA
SPWOOD@aol.com

David Kolko, PhD
Western Psychiatric Institute & Clinic
Pittsburgh, PA
412-624-2096
kolkodj@msx.upmc.edu

Mike Johnson, BSCJ
Plano Police Department
Plano, TX
972-516-2130
Detmike@aegisconsulting.net

Linda Williams, PhD
Wellesley College
Wellesley, MA
781-283-2834
lwilliams@wellesley.edu

Ben Saunders, PhD
Medical University of South Carolina
Charleston, SC
803-792-2945
saunders@musc.edu

Anne Cohn Donnelley, PhD
Kellogg School of Management,
Northwestern University
Evanston, IL
a-donnelly@nwu.edu
847-467-3000

Lucy Berliner, MSW
Harborview Sexual Assault Center
Seattle, WA
Lucyb@u.washington.edu
206-521-1800

Sandra Rosswork, PhD
Bureau of Navy Personnel
Millington, TN
901-874-4355
p661@persnet.navy.mil

APSAC Institutes Coming to Georgia

This July, APSAC's intensive training institutes will be offered for the first time in conjunction with the Georgia Council on Child Abuse's annual conference, entitled "The Power of Prevention". The conference will be held July 25-28, 1999 in Atlanta, with the APSAC Institutes scheduled for Sunday July 25, 1999. Nine 6-hour seminars will be offered, taught by leading experts in the field. Included with this issue of the Advisor is a brochure with complete details on the Institutes, including how to register. The early registration deadline is June 30, 1999, so don't delay! For more information, please call the APSAC Training Department at 312-554-0166.

APSAC Welcomes New Executive Director

By Diane DePanfilis, PhD, MSW, President - Board of Directors

As President of APSAC and on behalf of the Board of Directors, it is my pleasure to introduce APSAC's new Executive Director, Thomas P. Gauthier, CAE, ACSW who joined APSAC on March 22, 1999.

After screening over 70 applications, reviewing written statements from 16 applicants, and interviewing four candidates, the ten-member search committee led by Dr. Linda Williams found in Thom the VERY BEST match of skills to meet APSAC's needs as we enter our second decade of service.

Thom is a social worker by training with a Master's degree in Social Welfare Policy and Administration, received in 1974 from the University of Chicago School of Social Services Administration. He has relevant professional social work credentials, holds values that mirror APSAC's, is knowledgeable about the complex nature of child maltreatment, and has many contacts with other national organizations with whom we collaborate.

Thom is also an American Society of Association Executives Certified Association Executive (CAE). Many of us are unfamiliar with this designation but it means that he is highly knowledgeable about running membership associations similar to APSAC. Thom brings 22 years of experience with membership associations at the national and state levels.

From 1992 to the present Thom served as the Executive Director of the National Association of Social Workers (NASW) Illinois Chapter in Chicago. Prior to that, from 1985-1992 he served as the Director of Membership, Conferences and Field Services for NASW's national office in Washington, D.C. In this position, he helped develop NASW's state chapter network, working with very diverse chapter capacities and needs. His other experiences were with the American Public Welfare Association and the Illinois Governor's Office, and he continues to serve on the Boards of Directors of a number of community and academic organizations.

We are delighted to have someone of Thom's caliber at the helm of APSAC. The Search Committee was particularly impressed with Thom's experience in working to bring diversity to his other organizational affiliations, his expertise in organizational development and strategic planning, and his keen understanding of the challenges of running a membership organization.

The APSAC Executive Committee, having a brief opportunity to work with Thom in January when he visited with us in San Diego while on vacation from his current position, was particularly impressed with his analytical ability and capacity to keep us on track. We are also very excited about the potential that Thom brings by joining us this year as our Long Range Planning Committee moves forward to extend APSAC's long range plan another three years.

I ask that you join me in welcoming Thomas Gauthier to APSAC and offer him your support, your expertise, and your ideas on how APSAC can most effectively meet our mission to assure that everyone affected by child abuse and neglect receives the best possible professional response.

Board Ballot Enclosed

Enclosed with this issue of the *Advisor* is the ballot for the Board of Directors. As a membership organization, APSAC's Board is elected by the members to represent their interests on a national level. It is vitally important that you take the time to cast your ballot for Board, according to the instructions included on the ballot. All ballots must be postmarked by May 5, 1999. Faxed ballots will not be accepted. If you have any questions, please contact Beverly Bradley at 312-554-0166.

Forensic Clinic Sells Out in Huntsville - Register Now for San Antonio Clinic

APSAC's third Child Forensic Interview Clinic, held March 7-13, in conjunction with the Huntsville Symposium on Child Sexual Abuse, was another sellout success. Fifty registrants had the opportunity to learn from and interact with leading researchers in the field of child forensic interviewing, while receiving individual feedback on their interviewing techniques. The next clinic will be held in conjunction with the 7th National Colloquium. Spaces fill up quickly, and early registration is recommended. First notice of all clinics is given to individuals on the Forensic Clinic Mailing List - to get your name on the list, just complete and return the coupon on page 9 of this issue of the *Advisor.*

APSAC Awards Deadline - April 1, 1999

There is still time to submit nominations for APSAC's annual awards, which are given each year in recognition of the work and dedication of outstanding professionals in the field of child abuse and neglect. The awards will be presented during the membership luncheon at the 7th National Colloquium in San Antonio June 2-5. Six awards will be presented, including Outstanding Professional, Outstanding Service, Research Career Achievement, Outstanding Research Article, Outstanding Doctoral Dissertation and Outstanding Media Coverage. The form which was printed in the last issue of the Advisor listed an incorrect deadline date - the actual deadline is April 1, 1999. Nominations submitted after that date are not guaranteed to be reviewed, but we will do our best to accommodate late entries, due to the incorrect information which was previously published. Please call Maureen Kelly at 312-554-0166 to request a nomination form.

Call for Nominations - Editor in Chief of Child Maltreatment

Child Maltreatment: The Journal of the American Professional Society on the Abuse of Children is seeking nominations for the position of Editor-in-Chief. As directed by APSAC policy, the Editor's term would begin at the end of Volume 5 (on 1/1/2001) and continue for the next five years. The CM Editor is responsible for all aspects of journal operation, including appointing Editorial Board members as scheduled, making all final manuscript decisions, selecting reviewers, directing the anonymous peer review process, guiding the journal's overall direction, chairing Editorial Board meetings, coordinating with the journal's publisher, and operating the journal's editorial office. Enclosed with this issue of the Advisor is a flyer with complete information about the selection process for the new Editor-in-Chief. The deadline for nominations is September 1, 1999. For more information, please call the APSAC Publications Department at 312-554-0166.

POLICY WATCH

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

Clinton Budget For Children

Funding for federal child abuse prevention and treatment programs hardly rates a mention in the fiscal year 2000 spending plan President Clinton sent to Capitol Hill on February 1. The Clinton administration proposes level funding next year in the HHS budget for Child Abuse Prevention and Treatment Act programs: CAPTA state grants - $21 million; discretionary grants - $14 million; community-based resource grants - $33 million. Most child welfare programs, like CAPTA, would be held at current funding next year.

On the plus side of the budget, the President asks Congress to increase spending for the Safe and Stable Families Program (formerly the Family Preservation and Support Grants), which represents an important source of federal dollars for prevention activities. Clinton requests an increase of $20 million to $295 million, as authorized by law for this capped entitlement program.

The President's budget proposes a significant increase — $600 million — for Head Start (from FY99 funding of $4.660 billion to $5.267 billion in FY00), and small increases for runaway youth transitional living — $5 million in new dollars — and adoption opportunities with an extra $2 million. Both programs have attracted special interest from the President and Mrs. Clinton.

Spending issues are bound to bedevil Congress this year, despite the forecast of budget surpluses and a balanced budget from the President.

Over two-thirds of the $9.4 billion discretionary budget request proposed for the Administration for Children and Families goes for child care and Head Start. Funds for foster care and adoption subsidies take the majority of child welfare funds, with increases proposed in spending for both.

In a major policy turn-around, the Clinton administration requests taking the Title XX Social Services Block Grant funds back to $2.38 billion, after pushing for a cut in the program's funds last year to pay the cost of new child care initiatives Clinton proposed.

Spending issues are bound to bedevil Congress this year, despite the forecast of budget surpluses and a balanced budget from the President. A budget agreement signed just a few years ago when the federal deficit was considered an overwhelming problem has left politicians squirming under tight limits on discretionary spending. It is not enough that federal legislators must decide whether their priority is a tax cut, or increased defense spending, or more money for social programs, Congress may find itself this year in the politically hazardous position of debating whether or not to lift the spending caps to relieve some of the pressure – a move no one wants to take first.

Court Blocks Online Protection Enforcement

A preliminary injunction barring the federal government from enforcing the Child Online Protection Act (COPA) was granted by a federal district court judge in Philadelphia on February 1, 1999. In the court's opinion, Judge Lowell A. Reed Jr. explained: "Two diametric interests – the constitutional right of freedom of speech and the interest of Congress, and indeed society, in protecting children from harmful materials – are in tension in this lawsuit."

The 1998 COPA statute was enacted to replace a 1996 measure, the Communications Decency Act, which established a national indecency standard for enforcement of Internet material that the Supreme Court then struck down as unconstitutionally vague and overly broad. The new law makes it a crime for commercial Web site operators to post "material that is harmful to minors" without blocking access to the site through a credit card requirement or other adult verification.

The plaintiffs in the case include the American Civil Liberties Union, the American Booksellers Foundation for Free Expression, the Electronic Frontier Foundation, the Internet Content Coalition, and the Electronic Privacy Information Center, who attacked COPA on the grounds that: 1) it is invalid under the First Amendment for burdening speech that is constitutionally protected for adults; 2) it is invalid for violating First Amendment rights of minors; and 3) it is unconstitutionally vague under the First and Fifth Amendments.

In November 1998, the same federal district court entered a temporary restraining order prohibiting prosecutions under COPA until the court could hear evidence on the requirements for a preliminary injunction. Final adjudication of the constitutional questions raised by the plaintiffs in *ACLU v. Reno*, and the ability of the federal government to enforce COPA will not occur until after a trial on the merits has been completed by the court.

Pryce Introduces Child Abuse Bill

On February 12, 1999, Rep. Deborah Pryce (R-OH) introduced H. R. 764, the Child Abuse Prevention and Enforcement Act which would accomplish three purposes in support of improving child protective services and prevention activities: 1) allow existing criminal justice grant funds to be used by states to help provide child protective services workers and child welfare workers engaged in risk assessment access to criminal conviction records and protection orders; 2) open the use of state criminal justice block grant funds to support CPS investigations, training, etc. and to provide support for prevention pro-

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continued from page 8

grams; and 3) increase the set-aside for Children's Justice Act grants under the Victims of Crime Act from $10 million to $20 million – which comes from forfeited assets, forfeited bail bonds, and fines paid to the government, and can be used by the states for such things as training more child protective services workers and court-appointed special advocates.

H.R. 764, which was referred to the Judiciary Committee, is co-sponsored by Reps. Thomas Ewing (R-IL), Jim Greenwood (R-PA), Tom DeLay (R-TX), and Stephanie Tubbs Jones (D-OH). The bill's provisions, which Pryce introduced into legislation last year, represent a streamlined and noncontroversial version of a bill that had been proposed by former Rep. Susan Molinari (R-NY) during the 105th Congress.

Pryce has said that she intends to make this bill a priority for herself this year. She also has indicated the interest of the House Republican leadership in moving the bill, and wants to work with House Democrats to develop the legislation. On introducing the bill, Pryce said that the measure "provides states and cities with helpful tools to protect children from abuse and neglect without micro-managing their efforts."

Presidential Initiative on Child Violence

Calling for the prevention of violence against children, President Clinton on December 29, 1998, announced a new Children Exposed to Violence Initiative (CEVI) designed to include child abuse offenses in federal homicide laws and improve the way the justice system deals with children who are victims of or witnesses to violence.

The initiative will be led by the Department of Justice, with legislation proposed to amend federal homicide statutes, and activities planned to work with states to develop similar model legislation and put in place reforms to allow children to testify via closed circuit television, limit the number of interviews to which a child can be subjected, and generally improve processes for child witnesses. The child violence initiative will provide approximately $12 million in current Justice Department funding to improve the justice system response to the treatment of child victims and witnesses with training videos, best practice manuals and guides for law enforcement agents, prosecutors, victim and witness coordinators, and court personnel.

The child violence initiative will provide approximately $12 million in current Justice Department funding to improve the justice system response to the treatment of child victims and witnesses.

Appearing with the President at a White House briefing, the initiative was outlined by Deputy Attorney General Eric Holder Jr., who as U.S. Attorney for the District of Columbia had successfully pushed through legislation changing D.C.'s felony murder statute along the lines now proposed for federal law.

In addition, the President will make available $10 million in "Safe Start" grants to help up to 12 cities develop prevention and intervention initiatives focusing on children exposed to violence. The idea for the program is based on initiatives such as the New Haven program, which involves partnerships between law enforcement officers and other community members to provide services and support to children and promote parent education.

In May, 1999, the Justice Department will sponsor a National Summit on Children Exposed to Violence, with the participation of HHS, law enforcement organizations, child advocacy and media organizations, governors, county officials, mayors, legislators and prosecutors, to bring together experts in law enforcement, mental health, child development, domestic violence prevention, and related fields to increase public awareness and discuss additional efforts.

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. The interview practicum component provides participants with experience interviewing actual children in a supportive environment with constructive feedback offered 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.

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Phone _____ Fax _____ E-mail _____

Child Abuse and Disabilities: A Medical Perspective

Ann S. Botash, MD
Associate Professor of Pediatrics
Director, Child Abuse Referral and Evaluation Program
State University of New York, Health Science Center at Syracuse

Cate C. Church, Ph.D.
Assistant Professor of Pediatrics
State University of New York, Health Science Center at Syracuse

Children with disabilities are believed to be maltreated at a higher rate than children in the general population. Rates of abuse and maltreatment in disabled populations have been reported to be between 3 and 61%. Current estimates suggest that children with disabilities are sexually abused at a much greater rate than the general population. When disabilities are identified in abused populations, it is estimated that between 9 and 40% of children served by child protective services have a developmental disability.

In an individual who is older than the age of 5 years, disability refers to a physical or mental impairment that results in functional limitations in one or more of life's major activities. Consistent with the Americans with Disabilities Act, a person has such a disability if the impairment manifested before the age of 22 years, if the person has a history of such an impairment or is regarded as having such an impairment. The term "developmental disability" applies to children from birth to 5 years old who have significant developmental delay or congenital or acquired conditions that may result in a disability if services are not provided. This legal definition provides limited guidance for assessing whether or not a child should be considered to have a disability. Developmental disabilities span a range of diagnoses, including communicative/language disorders, motor delays or conditions, and any combination of functional losses or impairments. Disabilities can be congenital, result from disease states, occur as a result of trauma or can be the result of abusive trauma. Because of the wide range of etiologies there is no one specific treatment or management plan.

Pediatric medical practitioners are an often overlooked resource for screening for disabilities in abused populations and for training other professionals in the child abuse field about developmental disabilities.

The medical provider (physician, nurse practitioner, physician assistant, etc.) who is involved with the direct primary care of a disabled child should monitor the child for signs of abuse. Other medical providers who perform expert child abuse evaluations should consider screening for disabilities. Pediatric medical practitioners are an often overlooked resource for screening for disabilities in abused populations and for training other professionals in the child abuse field about developmental disabilities. In the following review we discuss the medical practitioner's role in developmental assessments of abused children, examine medical literature regarding abuse and disabilities and provide guidance for professionals who must consider abuse in disabled children.

The role of the medical provider in developmental monitoring

The American Academy of Pediatrics recommends routine monitoring of a child's developmental progress as part of preventive heath care. Moreover, Public Law 99-457 (reauthorized as the Individuals with Disabilities Education Act) mandates early identification of and intervention for developmental disabilities. The medical provider is in a critical position to assess children's development because he or she is often the only professional with knowledge of development who has routine contact with the child. This same medical provider is in a unique position to understand the social situation of the family and assess for risk factors of abuse. The medical provider is, therefore, responsible for identifying children at developmental risk, children needing further evaluation, and assisting families in obtaining appropriate services for their child.

Despite the high degree of agreement within the pediatric community about the need for ongoing monitoring of a child's developmental progress, no uniform standard is practiced. Pediatricians use a wide variety of techniques, including the "Aunt Tilly" approach, a combination of careful observation and listening to parents, intuition, and gut response (Cunningham, 1996). Unfortunately, research suggests that less than half the children with mild mental retardation or serious emotional/behavioral disturbances are identified by clinical judgement alone (Scott, Lingaraju, Kilgo & Lazzari, 1993). Relying solely on parent report is another commonly used screening instrument for development. While good reliability has been shown using this method, lack of parental concern about their child's development does not ensure that development is normal (Glascoe, 1996).

Developmental screening is a brief but formal method for sorting out children who probably have developmental problems from children who do not. Several developmental screening tests are available to assist the medical provider in assessing a child; however, these must be used accurately or they fail to be useful. The most widely recognized tool is the Denver Developmental Screening Test-II (Frankenburg & Dodds, 1990). This test was standardized to identify global developmental delay and practitioners are cautioned about making assumptions regarding specific delay in isolated domains of development. Although several questions have been raised regarding the validity of this tool, it remains the sole formal instrument in many pediatric offices. First STEP is a new, popular and easy to use screening tool for the evaluation of preschoolers (Miller, 1995). It takes about fifteen minutes to perform and has excellent sensitivity and speci-

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continued from page 10

ficity. The Bayley Infant Neurodevelopmental Screen (Bayley, 1993) uses directly elicited items to assess neurodevelopmental skills and developmental milestones. The ELM Scale-2 is a very quick and accurate screening tool for language abilities in children under three years of age and has been shown to correlate highly with Bayley Infant Scale of Development mental index scores (Church & Coplan, 1996).

Developmental Surveillance (Glascoe, 1996) is a concept gaining increased attention. In this approach, the medical provider identifies parent concerns and makes regular skilled observations of the child in order to monitor developmental progress. This approach uses formal screening tests and informal observations, repeated measures at different ages, and reports from multiple sources of information, such as parents, teachers, and day care staff. Developmental surveillance is best handled within the context of the routine history and physical examination. This more fluid approach to developmental assessment is undergoing research scrutiny and will likely gain more recognition.

Once the developmental screening or surveillance identifies a child as being either at risk or demonstrating delay, a comprehensive evaluation is in order. This type of evaluation is best performed by a child development specialist, developmental pediatrician, neurologist or team of early intervention therapists who will be able to establish a developmental diagnosis, determine an etiology for the disorder, provide a developmental prognosis, and assist the family in educating themselves about the disorder and establishing appropriate intervention and academic programs. This same approach should be used when child abuse is suspected. The child should be referred to a medical specialist who is familiar with the medical findings of physical and sexual abuse and who is able to work most efficiently with community agencies to provide needed services.

Risk factors for abuse in disabled children

There are many possible causes for increased risk of abuse in developmentally disabled children. These include:

- Enhanced vulnerability as a result of increased demands for care by multiple caregivers
- Chronic stress of child care providers
- Parental attachment problems
- Parental isolation
- Unrealistic expectations of the child's performance
- Aggressive behaviors in the child
- Concurrent risk factors that may be associated with abuse as well as disabilities (such as alcohol and drug abuse)
- Communication limitations resulting in a decreased ability to relay information
- Inability to communicate needs (resulting in neglect)
- Dependency on a large number of caretakers

The relative influence of each of these factors needs further study. There are many limitations to the studies that examine the relationship between abuse and disabilities. These include subject selection biases, disparities between studies on the definitions of disabilities and differing operational definitions of maltreatment. In addition, there is often difficulty in determining the causal relationship between the abuse and disability (within the study population) and sometimes questionable validation of procedures for determining disabilities.

Identifying disabilities in abused children

Recent focus has been directed to the need for child protective services to keep accurate records on maltreated children with disabilities (Bonner, Crow & Hensley, 1997). Bonner et al. conducted a survey of child abuse and neglect state liaison officers which replicated an earlier study by Camblin (Camblin,1982). Bonner et al's prediction of an improvement in training of Child Protective Services personnel and better identification of disabilities among populations of maltreated children in the 12 years between the two studies was not demonstrated. In fact, Bonner et al's study demonstrated that the regular collection of information regarding disabilities in maltreated children had declined since 1982. The authors postulate that children's disabilities are unlikely to be identified as they enter the child protection system, resulting in a lack of provision of necessary services.

A team approach, utilizing child protective workers and pediatric medical practitioners, should help to identify disabled children and therefore enable appropriate referrals for services.

A team approach, utilizing child protective workers and pediatric medical practitioners, should help to identify disabled children and therefore enable appropriate referrals for services. Pediatric medical practitioners who provide ongoing primary care to the child should have significant insight into the child's past developmental issues.

Identifying abuse in disabled children

Evaluating a disabled child for abuse may be much more complicated than evaluating a developmentally normal child. Communication issues may inhibit the elicitation of an accurate history from the child. Resources for home placement may be scarce because of the increased daily caregiver needs The medical professional who is experienced in child abuse evaluations should also be able to perform a brief developmental assessment, as outlined above.

continued on next page

continued from page 11

Ammerman, Herson, and Van Hasselt (1988) prospectively examined factors associated with risk of child maltreatment and assessed maternal and child functioning in 138 hospitalized children and adolescents (aged 3-18 years) with both developmental disabilities and psychiatric disorders. Diagnoses included mental retardation, pervasive developmental disorders, disruptive behavioral disorders and affective disorders. According to the author's rating scales, 61% of the children studied had experienced some form of maltreatment by a care provider during their lifetime. Mothers' use of more severe disciplinary techniques was associated with children who were young, oppositional and higher functioning.

Although this study did not describe the physical findings of the children, the study results indicating that higher functioning children may predispose their mothers to more severe disciplinary techniques may help practitioners focus their screening efforts for abuse in disabled populations. Unrealistic expectations of a child, in terms of their developmental functioning, is a significant risk factor for disabled children. This may be a more significant risk when the child is less physically challenging for the caregiver and more emotionally challenging. For example, a child with behavioral problems due to hearing loss may be more at risk than a child who requires feeding and diaper changes but who has no behavioral problems. Future studies which may help practitioners further focus their screening efforts for child abuse in disabled populations are greatly needed.

Unrealistic expectations of a child, in terms of their developmental functioning, is a significant risk factor for disabled children.

In another study of developmentally disabled children, Jaudes and Diamond examined cases of 37 children with developmental disabilities and child abuse (from a cohort of 162 children diagnosed with cerebral palsy) and reviewed the problems of children whose development was affected by the compounded influences of maltreatment and the presence of a handicapping condition (Jaudes & Diamond,1985). Four areas were identified as crucial to the study of abuse and neglect with respect to the child with developmental disabilities: 1) abuse that causes handicaps; 2) abuse that occurs to the handicapped child; 3) compromises in care that can occur when the handicapped child becomes involved with the medical and legal systems; and 4) arrangements for foster care or other out-of-home placement for the child with handicaps. In 14 of the 37 abused children, the abuse was believed to have caused the cerebral palsy. The abuse in these children involved severe head injuries resulting in brain injury before the age of 1 year. In 23 cases, the abuse followed the diagnosis of cerebral palsy and in 3 children, the abuse both preceded and followed the diagnosis. Most of these children (15 of the 23) suffered from starvation/malnutrition, medical neglect or abandonment. The authors point out that repeated battering of these children was a significant problem, occurring for five of the children. Clearly, there is a need for practitioners to look for signs of abuse in children who are diagnosed with cerebral palsy. Since these children may present to the practitioner often for medical care issues, the practitioner may have the opportunity to search for signs of abuse at multiple intervals.

Amundson, Sherbondy, Van Dyke, and Alexander (1994) review and discuss two case presentations of children with severe malnutrition and growth retardation which complicated the course of medical treatment. Both adolescents had severe mental retardation, cerebral palsy, seizure disorders, scoliosis and growth retardation, and were admitted to hospitals and evaluated for feeding disorders. In the first case, the child suffered from superior mesenteric artery syndrome which may have been precipitated by severe malnutrition. In their discussion, the authors indicate that malnutrition in disabled children may be associated with poor oral intake, gastro-esophageal reflux with aspiration, and chronic constipation. There are few established parameters for defining expectations of growth. People with disabilities may differ from standard norms, and malnutrition is sometimes accepted as part of the disability. Children with disabilities may be at higher risk for serious nutrition problems and practitioners should strive to provide early identification and treatment of protein-energy malnutrition in order to avoid complications. Abnormal growth in a disabled child, just as in a non-disabled child, should trigger a comprehensive evaluation.

Elvik, Berkowitz, Nicholaas, Lipman, and Inkelis (1990) describe their experience of evaluating 35 developmentally disabled females from a residential treatment facility for physical signs of sexual abuse. This study specifically reviewed the medical findings in a group of disabled adults. The task was undertaken after one of the residents became pregnant, resulting in the suspicion of sexual abuse perpetrated at the facility. Patients ranged in age from 13 to 55 years, 69% were categorized as profoundly retarded and no patients were able to provide a history. Two had a prior history of rape and two had a prior history of infection with Chlamydia trachomatis. None of the patients had acute physical findings associated with recent penetrating trauma. The two with prior Chlamydia trachomatis infections had normal examinations. Two patients had a prior history of rape and had normal examination findings. Thirteen had abnormal genital findings which were consistent with healed penetration. In these cases, no perpetrator was identified and the dilemma of determining the significance and implications of the abnormal genital findings was evident. Since it is rare to see abnormal findings in individuals with known

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Child Abuse and Disabilities

continued from page 12

sexual abuse, it is clearly unusual to report so many with physical findings of sexual abuse (Adams, Harper, Knudson, and Revilla, 1994). The authors recommend that pediatric medical practitioners who are longitudinally following a disabled patient perform a complete examination at every visit including an external genital examination of pre-pubertal children, and a pelvic exam, when indicated, for pubertal females.

Data concerning the characteristics of physical and sexual abuse of communicatively handicapped children were collected as part of a longitudinal study of therapeutic efficacy among a group of abused children with documented and verified handicapping conditions (Sullivan, Brookhauser, Scanlan, Knutson, and Schulte, 1991). In 482 children consecutively referred to and evaluated at Boys Town National Research Hospital, identified impairments included hearing problems, mental retardation, visual impairment and others. Comparisons were made between children who were educated in mainstream schooling and those who were part of a residential program. Results indicated that the most prevalent type of maltreatment for both boys and girls was sexual abuse (48%). Mainstreamed boys were somewhat more likely to be physically abused (35%) than sexually abused (30%), but boys in residential facilities were much more likely to be sexually abused (58.8%). Sexual abuse was the single most frequently reported type of maltreatment among each of the described handicap-specific subgroups. Stranger perpetrators accounted for no more than 3% of sexual abuse. Nearly 83% endured multiple episodes of abuse. When considering all types of abuse collectively, the most frequent site at which abuse was perpetrated was the child's home. However, the most common site for cases of isolated sexual abuse was the school (including residential schools) for 39%.

Child protective workers and others involved in the investigation of child abuse cases should work together with medical child abuse professionals to identify disabilities in children.

The authors conclude that sexual and/or physical abuse as well as emotional abuse and/or neglect are significant risks for children with communication disorders and related disabilities. The implication is that the relatively increased risk for sexual abuse in males compared to the general population is due to two factors: 1) education and child care practices and 2) communication barriers. Although this study does not report specific physical findings for abuse, it clearly documents the need for close medical evaluations in this population.

Botash, et al. (1994) reported on 13 children who were referred to a tertiary care outpatient child sexual abuse program in Central New York after facilitated communication revealed disclosures of sexual abuse. These children were examined for physical findings which might indicate sexual abuse. The children, aged 5 to 15 years, had various developmental diagnoses including autistic behavior, mental retardation, cerebral palsy, seizure disorders and Down's syndrome. Four children had corroborating evidence of sexual abuse (one perpetrator confession, one verbal disclosure and

continued on page 18

Focused Questions for Interviewing Children Suspected of Maltreatment and other Traumatic Experiences

Kathleen Coulborn Faller, PhD, ACSW

Introduction

In assessing for child trauma caused by abuse and other insults, a central source of information is the child. Information may derive from the child's verbal and behavioral communications, the child's functioning, and the child's physical condition. The focus of this article is on eliciting verbal communication from the child.

For professionals assessing for child maltreatment, interest in the child as the source of statements about trauma originated in efforts to gather data about sexual abuse, where the evaluator has little to rely upon other than what the child states or demonstrates. However, querying about sexual abuse has taught evaluators important lessons. Evaluators should avoid coercing, interrogating, or leading the child. Not only may such practices result in actual inaccuracies or fabrications in the child's responses, these practices can also result in legal and ethical challenges to the evaluator's work. Accordingly, this article will provide questions that are focused—that is, they may direct the child's attention to a particular topic, but are not leading—that is, they do not suggest responses (Faller, 1993).

It is important for professionals concerned about child protection and well-being to ask questions about a range of caretaker behaviors that might place children at risk.

This article addresses both maltreatment and other inappropriate caretaker behaviors. Caretaker substance abuse, domestic violence, and other endangering behaviors are often associated with child maltreatment, and they can cause secondary trauma to children who witness/experience them. It is important for professionals concerned about child protection and well-being to ask questions about a range of caretaker behaviors that might place children at risk. This article provides general information about strategies for approaching sensitive material and illustrative questions covering several areas of inquiry.

Questions in the context of the child interview

The focus of this article is on one component of child interviews, questioning strategies, and not on all aspects of the child interview. However, some guidance will be provided about the interview as a whole in order to put the questions in context.

The role of the evaluator, the structure of services, logistical considerations, safety issues, and the specifics of the allegation or concerns all impact on whether there will be a single interview or more than one. However, practice and research suggest that for most children disclosure is a process (Elliot & Briere, 1994; Sorenson & Snow, 1991; Summit, 1983) rather than an event. The evaluator must be judicious in juggling competing priorities: the need to know about maltreatment and other trauma, the goal of not re-traumatizing the child, the admonition to avoid leading the child, and the issue of child safety.

It is appropriate at the beginning of the interview to tell the child that you will be asking lots of questions. Some will be easy and some will be harder. You may want to tell the child that he/she doesn't have to answer a question that's too hard. It is also appropriate to tell the child that if he/she doesn't know or doesn't remember the answer, to say so. Finally, it is appropriate to tell the child if he/she doesn't understand the question to say so, and you will try to ask it in a better way. With young and developmentally delayed children, this introduction will be too complicated. However in some cases, the evaluator will be able to modify the introduction to be consistent with the child's comprehension.

Before conducting trauma focused interviewing, assess the child's developmental level so that questioning can be geared to the child's level of functioning. This can be a formal or informal assessment.

Begin the interview by asking questions about positive or neutral topics so that a relationship can be developed before difficult material is introduced (Faller, 1990). This also provides the evaluator an opportunity to assess the child's developmental level.

Questions about sensitive topics can be alternated with less stressful inquiry or with activities, such as games or play. It may also be useful to mediate the stress level of the inquiry by allowing the child to engage in an activity such as drawing or playing with cars during the questioning.

If it is too difficult for the child to talk, offer the child other media with which to communicate, such as drawing, anatomical drawings, anatomical dolls, the dollhouse, or writing. With young children, the media will be limited to those with which the child can demonstrate, such as the dolls or the dollhouse. With older children it may be appropriate to offer them a choice of media.

The evaluator may draw the interview to a close when disclosure is complete, when disclosure is incomplete, but time is up or the child needs to stop, or when concerns have been adequately explored and there is no disclosure. The evaluator needs to reserve time for the child to return to a state of equilibrium if he/she has been stressed by the interview. It is appropriate to apprise the child of what the next steps will be.

Questioning guidelines

Expect to ask numerous questions about the sensitive topics to be addressed. Numerous questions are nec-

continued on next page

Focused Questions

continued from page 14

essary for at least four reasons. First and most obviously, there are many topics you need to learn about. Second, especially with young children, free recall memory is not well developed, and it is necessary to provide cues (Saywitz, Goodman, Nicholas, & Moan, 1991), which may require trial and error questions. For example, the term "touch" may not trigger the child's memory, but the term "hurt" may. Third, children who live in chaotic and abusive environments may not perceive endangering and maltreating experiences as anything out of the ordinary and worth reporting, making numerous questions necessary. Finally, children may be reluctant to disclose these experiences, necessitating numerous questions to overcome this reluctance (Summit, 1983). They may be reluctant either because they have been specifically admonished not to tell, because of attachment to the persons harming them, or because of general lack of trust of adults, including or especially helping professionals.

When you believe the child's response is less than candid, try not to ask the same question again, but to vary the manner in which you pursue the topic. As already noted, you may not have asked the right question to trigger memory. Moreover, you don't want to be perceived either by the child or others reviewing your interview as pressuring the child to provide a specific response.

When interviewing children, use as open-ended questions as is feasible. Maltreated children are particularly sensitive to issues related to compliance and control. Questions that are too pointed can interfere with communication, either by causing "social desirability responses" or by resulting in wariness and denial of actual facts or non-response. However, especially with young children, focused questions, that direct the child to a specific topic are usually needed.

A useful principle when asking about endangering or maltreating behaviors is not to include both the person engaging in the behavior and the behavior in the same sentence (or ***direct*** question). This principle allows for focused but non-leading questions. Examples follow:

- ***A person-focused question***: How does your dad treat you?
- ***A behavior-focused question***: Does anyone at your house ever get spanked?

Each type of question will require follow-up questions. For example, in the case of the behavior-focused question, the interviewer might follow an affirmative response from the child with questions such as:

Who gets spanked?
What do you get spanked with?
What for?
How often?
Does it ever leave a mark?
How long does it hurt?
Do they use other punishments besides spanking?

Another type of focused but non-leading question is one that queries about ***circumstances*** of possible maltreatment or endangerment. Examples are as follows:

- What is it like when grandpa is in charge and your mom is out?
- When your mom's upset, what does she do?
- What do you do when you visit your dad?

In many instances, the child has already come to adult or professional attention because of possible maltreatment. The evaluator usually knows about these circumstances. When other methods to help the child focus on possible maltreatment have been unsuccessful, the interviewer may focus the child on that information. Examples are as follows:

- The doctor said you had an owee. How did you get that?
- Did you tell your foster mom about something that happened before you came to foster care?
- I heard you were really afraid to go home from school today. Can you tell me why?

There will be times when ***multiple choice*** questions are appropriate, for example to inquire about the context of maltreatment or endangerment when the child is non-responsive to a focused question. For example

If the child is non-responsive to "do you remember which house you lived in when your dad started hitting you?", the evaluator could ask "Was it the house in Michigan or Florida?"

Finally, in rare circumstances, the evaluator will resort to ***direct*** questions, when more open-ended questions are not productive and the evaluator remains concerned. Examples are:

- Is your uncle drunk when he hurts you?
- Does your father hit you with a belt?

Substantive areas for questions

It is useful to divide questions into abuse related and endangering related questions. However as already noted, many endangering behaviors do lead directly or indirectly to maltreatment or harm to the child. Clearly the evaluator cannot cover all possible areas in depth. It is useful to plan ahead of time which areas to ask questions about and to have strategies in mind for approaching these topics. It is desirable to generate more than one approach, should the first (or second) be unproductive, but leave you with some worries.

A list of questions for each area is being provided primarily because most mental health professionals do not learn about this type of questioning in their training and may not have thought of ways of asking these sensitive questions. The suggested questions are not exhaustive, but merely illustrative. Moreover, evaluators should tailor their questions to the circumstances of the case and the child's developmental level.

Focused Questions

continued from page 14

Questions about possible maltreatment

1. Care questions
   - Who takes care of you?
     - How do they do it?
     - Are there things you like about how they do this?
     - Are there any things you don't like?
   - Who puts you to bed?
     - What time?
   - Who cooks?
   - What meals do you eat?
   - What do you eat?
   - Are there any times when there's no food?
     - What do you do then?
   - When —— isn't there, who takes care of you?
   - Are there times you baby-sit for/take care of yourself?
     - Is there someone you can call?
     - How long are you alone?
   - Are there any younger kids you look out for?
   - Can you tell me about the last time you took care of yourself?
   - Who helps you get dressed?
   - Who sees that you get to school?
   - Who takes care of you when you're sick?

2. Environment questions

- Who lives at your house?
- Tell me what your house is like.
- Do you like it there?
- Is it cleaner, not as clean, or the same as your foster home?
- Where do you sleep?
- Where do others sleep?
- Do you have a bed?
- Who cleans?
- Where do the animals go to the bathroom?
- Who does the laundry?

3. People questions

- Tell me about ——.
- What is —— like?
- Are there things you and —— do together?
- Do you do things alone with ——?
- Are there things you like about ——?
  - What?
- Are there any things you don't like about ——?
  - What?
- Are there any things —— does to you that you don't like?
- Are there any things —— does to your body you don't like?
  - To what part?
- Does —— ever hurt you in any way?
  - How?

4. Discipline/physical abuse

- What happens when you or(your brother) misbehaves?
  - Are there any other ways they treat you when you misbehave?
- What ways do they punish at your house?
- When they spank, do they use a hand or something else?
- What does that feel like?
  - How long does it hurt?
- About how many times a week do you get whipped?
  - What for?
  - Does it ever leave a mark?
  - What does the mark look like?
  - Usually how long does it take before it goes away?
- Do your parents ever disagree about how you get punished?
- Did you ever have to go to the doctor because of a punishment?

5. Injuries or scars/physical abuse or neglect

If the interviewer notes the child has an injury or scar, the interviewer should ask the child about it.

- How did you get hurt?
- If the explanation does not fit the injury,
- Are you sure that's how it happened?
- What did —— do when you got hurt?
- Did anyone take you to the doctor when you got hurt?
  - What did the doctor say?
  - What did the doctor do?

6. Body parts/sexual abuse

There are lots of ways to ask about sexual abuse. One is by asking about the sexual body parts. This is usually done as part of a general body parts inventory, using anatomical dolls or anatomical drawings.

a. Questions related to the penis, when abuse by a male

- What do you call this part? (using the child's name for the penis in further questioning)
- Who has one?
- What is it for?
  - Is it ever used for anything else besides peeing?
- Did you ever see one?
  - Whose?
  - When?
  - What was he doing?
- Did you ever see it any other time?
- Did you ever have to do anything to one?
- Did anyone ever do anything to you with one?
- How did he do that?
- Do you remember whether the penis was sticking up or hanging down?
- Did anything come out of the end of it?
  - What did the stuff look like?
  - What color was it?
  - What did it taste like?

b. Questions related to the vagina, when victim is a female

- What do you call this part? (use child's term)
- Who has one?

continued on next page

Focused Questions

continued from page 14

Do you have one?
Did anything ever happen to yours?
Did anyone ever hurt you there?
Did anyone ever do anything to your (vagina)?
What did they do?
Who was it?
What did —— use when —— did it?
What part of his body did he use?
Was it on top of your clothing or underneath?
Was it on the outside of your (vagina) or inside?
Do you remember what it felt like?

7. Context questions (most relevant to sexual abuse but may be relevant to other kinds of trauma)

Do you remember the last time this happened?
Can you tell me everything you remember about the last time?
Do you know how old you were when it started?
Can you tell me everything you remember about the first time?
Did it happen one time, two times or lots of times?
Where did it happen?
Where was your mom when it happened?
Where were the other kids?
Did it happen in the daytime or night or both?
Was it on a day when you go to school or not?
Do you remember what time of year it was?
Do you remember what you were wearing?
Did any clothes get taken off?
Who took them off?
What was —— wearing?
Did —— take any clothes off?
Did —— say anything when —— did it?
Did —— say anything about telling or not telling?
Did you tell?
What did you tell?
What did they do?

8. Emotional maltreatment questions

Does anyone ever praise you?
Who?
What for?
How often?
Do you think you are treated the same as other kids in the family or different? Worse or better?
How are you treated?
When you have problems, who can you talk to?
When you are really upset, what do your parents do?
Does anyone ever yell at you or call you names?
Can you tell me about that?
Are there ever times when grown-ups tell you to break the law?
Can you tell me about that?

Questions about endangering behaviors:

1. Family violence

Do your mom and dad have disagreements?
Do they ever have fights?
What do they fight about?
How do they fight?
Do they just yell or do they ever hit?
Does anyone ever get hurt?
Does this happen a lot or has it happened just a few times?
Does anyone ever have to go to the doctor/hospital?
Do any kids ever get hurt when they are fighting?
Does anyone in your family have a gun or knife?
Who?
What can you tell me about (gun or knife)?

2. Substance abuse

Does anyone at your house ever drink alcohol?
Does anyone at your house ever drink beer?
Does anyone at your house ever drink whisky?
How many times a week does —— drink?
Does this happen a lot or every once in a while?
How does —— act when they drink?
Does —— ever fall down?
Can —— take care of you O.K. when she's drinking?
Does she ever just fall asleep?
Does —— ever get mad?
Does —— ever go to the bar?
How often?
Does —— ever hurt anyone when they drink?
Does —— ever drive a car when —— has been drinking?
Did —— ever have an accident?
Did —— ever have to go to the hospital or to a counselor for drinking?
Are there any drugs at your house?
Do you know which ones?
Who uses them?
What happens when they use them?
Do you know how they get them?
Where does the money for them come from?
Do you know?
Did —— ever get sick from drugs?
Then what happened?
Did —— ever have to go to the hospital?
Do you know how old you were when —— started using drugs?
Do you know how many times a day/week —— has to have the drug?

3. Prostitution

Does your mom have boyfriends?
Do you know those men that come to your house?
How do those men treat your mom?
What do you do when they are there?
Does —— ever give your mom money?
What does your mom do when she goes out?
Does anyone baby-sit for you when she's out?

4. Criminal activity

Does — ever get in trouble with the police?
What for?
Did the police ever come to your house?
What for?
Did —— ever get arrested?

continued on next page

Focused Questions

continued from page 17

continued from page 17

Did —— ever have to go to jail?
Did —— ever have to go to court?
Did anybody in your house ever steal anything?
What?
What happened next?
Does —— ever get in fights?
When?
Where?
Who with?

5. Mental illness

Does —— ever act strange/crazy?
What does —— do?
Can she take care of you when she's acting strange?
What do you do when —— is like that?
Did —— ever have to go to the hospital for that?
Does —— take medicine to keep from acting strange?
Does —— ever not take the medicine?
What happens then?

Conclusion

Interviewing children with a possible history of victimization is a challenging task because so much hangs on the evaluator's ability to elicit descriptions of experiences from the child during such interviews. Articles such as this are intended to ease the task of the evaluator and result in accurate and complete disclosures.

REFERENCES

Elliot, D. & Briere, J. (1994). Forensic sexual abuse evaluations of older children: Disclosures and Symptomatology. *Behavioral Sciences and the Law, 12*, 261-277.

Faller, K.C. (1993). *Child Sexual Abuse: Intervention and Treatment Issues.* Wash., D.C. Government Printing Office.

Faller, K.C. (1990). *Understanding Child Sexual Maltreatment.* Newbury Park, CA.: Sage.

Saywitz, K., Goodman, G., Nicholas, E. & Moan. (1991). Children's memory for a genital examination: Implications for child sexual abuse cases. *Journal of Consulting and Clinical psychology*, 59, 682-691.

Sorenson, T. & Snow, B. (1991). How children tell: The process of disclosure in child sexual abuse. *Child Welfare*, 70 (1), 3-15.

Summit, R. (1983). The child sexual abuse accommodation syndrome. *Child Abuse and Neglect*, 7, 177-193.

Child Abuse and Disabilities

continued from page 13

continued from page 13

two with physical examination findings considered suspicious for sexual abuse), and an additional five had other supportive evidence. The authors discuss issues concerning sexual abuse disclosures utilizing facilitated communication and conclude that their results do not support nor refute validation of this communication technique. Since many of these children had other indicators for sexual abuse, the authors recommend that all allegations of abuse in developmentally disabled children be evaluated, including a complete medical examination. This study also implies that sexual abuse may be more common in communicatively impaired children.

In summary, the medical literature provides some useful guidelines to assist the medical practitioner in screening for abuse in disabled populations. Primary care providers should be attentive for signs of abuse in children with higher developmental functioning. All children with disabilities should have complete medical examinations, including a height, weight, and (external) genital examination at every office visit. Abnormal weight loss in children who are severely developmentally disabled should not be overlooked and should be considered a possible sign of neglect. Communicatively impaired children should be considered to be a higher risk for sexual abuse. Child protective workers and others involved in the investigation of child abuse cases should work together with medical child abuse professionals to identify disabilities in children. The primary care medical provider should be able to screen children for developmental problems and to identify risk factors for abuse. Through medical record review, children who are identified by child protective services as suspected of being abused should have records which identify their developmental issues. Child protective workers and others involved in the investigation of child abuse cases should work together with medical professionals to optimize the child's chances for growth and education.

Address correspondence to: Ann S. Botash, MD 90 Presidential Plaza Syracuse, NY 13202 Phone: 315-464-5834 Fax: 315-464-2030 Email: Botasha@hscsyr.edu

REFERENCES

Adams, J.A., Harper, K., Knudson, S., & Revilla, J. (1994). Examination findings in legally confirmed child sexual abuse: It's normal to be normal. *Pediatrics, 94,* 310- 317.

Ammerman, R.T., Hersen, M., Van Hasselt, V.B., Lubetsky, M.J., & Sieck, W.R. (1994). Maltreatment in psychiatrically hospitalized children and adolescents with developmental disabilities: Prevalence and correlates. *J Am Acad of Child & Adol Psychiat, 33* (4), 567-76.

Ammerman, R.T., Herson, M., & Van Hasselt, V.B. (1988). Maltreatment of handicapped children: A critical review. *Journal of Family Violence, 3*: 53-72.

Amundson, J., Sherbondy, A.,Van Dyke, D.C., & Alexander, R.(1994). Early identification and treatment necessary to prevent malnutrition in children and adolescents with severe disabilities. *J Am Diet Assoc, 94,* 880-883.

Bayley, N. (1993) *Manual for Bayley Scales of Infant Development.* San Antonio, TX: The Psychological Corporation Harcourt Brace & Company.

Bonner, B.L., Crow, S.M., & Hensley, L.D. (1997). State efforts to identify children with disabilities: A follow-up study. *Child Maltreatment,* 2(1), 52-60.

Botash, A.S., Babuts, D., Mitchell, N., O'Hara, M., Lynch, L., Manuel, J.(1994). Evaluation of children who have disclosed sexual abuse via facilitated communication. *Arch Pediatrics and Adol Med, 148,* 1282-1297.

Camblin, L.D. (1982). A survey of state efforts in gathering information on child abuse and neglect in handicapped populations. *Child Abuse & Neglect, 6,* 465-472.

Church, C. & Coplan, J. (1994). ELM Scale-2 and Bayley Scale of Infant Development mental index scores. Unpublished manuscript.

Coplan, J. (1993). *Early language milestone scale-second edition examiners manual.* Austin, Texas: Pro-Ed.

Cunningham, A. (Personal communication, January, 1997).

Elvik, S.I., Berkowitz, C.D., Nicholas, E., Lipman, J.L., & Inkelis, S.H. (1990). Sexual abuse in the developmentally disabled: Dilemmas of diagnosis. *Child Abuse & Neglect, 14,* 497-502.

Frankenburg, W. K. & Dodds, J. (1992). *Denver II second edition training manual.* Denver, Colorado: Denver Developmental Materials.

Glascoe, F. (1996). Developmental screening. In M. Wolraich (Ed.), *Disorders of development and learning* (89-128). St. Louis: Mosby-Yearbook

Jaudes, P. & Diamond, J. (1985). The handicapped child and child abuse. *Child Abuse and Neglect, 9,* 341-347.

Miller, L.J. (1995). *First STEP: Screening test for evaluating preschoolers.* San Antonio, TX: The Psychological Corporation Harcourt Brace & Company.

Office on the Americans with Disabilities Act, Civil Rights Division, US Dept. of Justice, PO Box 6618, Washington DC 20035-6118, 202-514-0301/0381, http://www.usdoj.gov/crt/ada/adahom1/htm

Scott, F., Lingaraju, S., Kilgo, J., & Lazzari, A. (1993). A survey of pediatricians on early identification and early intervention services. *Journal of Early Intervention, 17,* 129-138.

Sullivan, P.M., Brookhauser, P.E., Scanlan, J.M., Knutson, J.F., Schulte, L.E. (1991). Patterns of physical and sexual abuse of communicatively handicapped children. *Annal of Otol and Laryng, 100,* 188-194.

The Case- The Bradley Family

Belinda is the mother of two sons. Her 16-year-old son, Danny, was the impetus for the family's referral to Child Protective Services. According to his teachers, Danny appears to be depressed, has been constantly truant from high school, is failing and has engaged in pre-delinquent pranks. The high school counselor attempted numerous times to involve Belinda in Danny's case, but she did not show up for scheduled meetings and did not sign the necessary paperwork for Danny to be evaluated by a psychiatrist. The counselor made a home visit, and upon seeing the condition of the family home and the younger child, made a referral to Child Protective Services.

Belinda's younger son, Bobby, is three years old. When the CPS caseworker visited the home, Bobby was asleep in his crib. The worker woke Bobby and spent approximately 20 minutes with him. He is slightly thinner and shorter than normal. He is, in general, unresponsive, would not play and looked blankly at the worker. He did not cry nor smile, nor reach for his mother. He is not potty trained, and did not speak during the worker's visit. Belinda reported that Bobby is "no trouble" and that he "doesn't really need me very much."

Belinda is 32 years old, medium height and slightly overweight. The CPS caseworker's interview reported that Belinda had rounded shoulders, wore no make-up, her hair was unkempt and her face was expressionless. She was dressed in a disheveled manner, and kept her hands held together, with her eyes on her hands throughout the interview. Belinda stated that she "isn't much of a mother" and that she doesn't "have the energy to give the boys attention." The family's home is messy, though not dirty. Shades were pulled and two small lamps furnished the only light.

The boys' father is a serviceman who went AWOL after Bobby's birth. Belinda has no close relatives in the area, and both her parents and her younger brother died in a fire ten years earlier. When asked about her own childhood, Belinda reported that her mother worked constantly and "never let us kids sit in her lap." She recalled her father as "drunk and mean."

Danny's teachers report that he has done progressively worse during the last two years. Both teachers and the counselor described Danny as "very likeable, although generally shy." Danny is a good-looking boy, who seems to take pains with his appearance. Danny reports that he has no interest in school, saying "My mother doesn't care - why should I?" Danny says his younger brother is "just a baby", and adds that his mother doesn't even get Bobby out of his crib most days, except to feed him or change his diaper. He couldn't remember his mother ever taking Bobby to a doctor since he was born three years ago.

Case Response

Robert F. Perry, MD
Medical Director, the PeeDee Clinic
Child Medical Examiner,
New Hanover County, NC

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

The prime directive of the specialty of pediatrics is to ensure the proper growth and development of the child. Thus, the pediatric professional must assess, and when appropriate, aggressively act upon, any and all variables that potentially impact adversely on the physical and/or emotional health status of the patient. It is with this rationale at the forefront that many practitioners have adopted a family-oriented approach to patient care. In the particular scenario presented in our case study, the most urgent concern from a general pediatrician perspective is the immediate protection and medical assessment of both children. It seems mandatory that these children be removed, at least temporarily, from this deleterious home environment, placed in a protective setting, and comprehensively evaluated.

The history reflects that Bobby, the three-year-old child, is failing to thrive and is seemingly significantly delayed with respect to his cognitive development. A complete physical exam is required to evaluate such parameters as general health status, nutritional status, dental and body hygiene, immune status, and the presence of occult disease and/or neurologic deficit. It is also necessary to search for signs of physical abuse and, hence, a full skeletal survey x-ray should be considered. The child is not walking and it would be important to know if he has any broken bones or evidence of healed fractures in the extremities or elsewhere that might be contributing to this motor delay.

Although it appears that Danny, the 16-year-old, is thriving from a physical standpoint, his behavior clearly places him at increased risk for injury. A comprehensive physical examination is therefore required to rule out occult disease and neurologic and/or cognitive deficit and to determine risk factors for potential injury such as illicit drug use, sexual activity, cigarette smoking, and criminal behaviors.

Finally, it is apparent that the mother, Belinda, is suffering from major depression (and perhaps other more complex co-morbid psychopathologies) and is entirely unable to cope with the caring and nurturing of both her

continued on next page

Case Conference

continued from page 19

children and herself. Given the vicarious physician-patient relationship that can be fostered between the mother and the pediatrician, it would certainly seem appropriate for the doctor to initiate a consult for this troubled parent to a psychiatric professional if such referral had not already been effected by Social Services.

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

Subsequent to an initial assessment to determine the presence of acute and/or readily treatable medical conditions, I would consult with a dietician for the purpose of promptly identifying and correcting any nutritional deficits in the toddler. Stabilization might require a brief period of hospitalization. Likewise, Bobby should be evaluated by physical therapy and, perhaps, occupational therapy, given his delayed motor and functional skills. A thorough assessment of cognitive function to rule out underlying conditions such as mental retardation, autism, pervasive developmental disorder or other neurologic abnormality also seems in order. Hence, a referral to a pediatric neurologist or developmental specialist should be initiated.

Danny clearly requires urgent psychiatric intervention. Certainly, if there is a question of illicit drug or ethanol abuse, then short term inpatient management would be indicated. It is also imperative that this child undergo an educational assessment for the purpose of determining any possible learning or academic deficits and, thereafter, that a comprehensive scholastic plan be designed and implemented.

It is apparent that this mother is a candidate for both medical and psychiatric intervention. Belinda is obviously clinically depressed and entirely unable to effectively manage her life or to care for her children. Since it is probable that she has had little to no meaningful contact with any health care professional for some time, quite possibly since the birth of her second child, a thorough physical examination would be appropriate. Likewise, referral to Gynecology and Psychiatry seems mandatory. Additionally, we must consider the possibility of substance abuse in this mother - especially in light of her strong family history of alcoholism - and referral for therapy as indicated. From the general pediatric standpoint, a healthy and effectively functioning parent is the best guarantee for ensuring the long term health and well being of the children.

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

From a pediatric perspective, the key issue in this case is that there are two patients at different levels of development who are without effective parental input or support. In essence, these children have been chronically neglected and currently manifest the overt symptomatology of such prolonged deprivation. The lack of nurturing to the youngest has resulted in his failure to thrive and his failure to achieve the normal developmental milestones. With respect to the older boy, he has been left to survive essentially on his own resources and, not unexpectedly, he is now manifesting behaviors that place him at increased risk for physical and emotional injury and for potential criminal prosecution. In such setting, if left uncorrected, a tragic outcome for both children seems inevitable.

As significantly, the mother is entirely nonfunctional and without any definable concrete support system. Thus, she is at acute risk for emotional decompensation and, ultimately, for the permanent loss of her family.

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

The pediatric professional is in a unique position to coordinate the various medical, social and community resources available to this mother and her children with the goal of correcting the specific individual problems and, thereafter (if appropriate) of bringing this family back together as an intact and functional unit. This long-range objective of a unified home is clearly in the best interest of both the children and the mother and, ultimately, serves the best interests of the community at large. Had these circumstances not been timely recognized and aggressively intervened upon, the possible consequences would certainly have been catastrophic for all family members.

Case Response

Wayne Holder, MSW
Executive Director
ACTION for Child Protection
Aurora, CO

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

Although a progressive history of this family is not available prior to intervention, it is reasonable to speculate that deterioration in family functioning is likely related to the father's abandonment of the home. This could mean that conditions have continually worsened over a three-year period, making individual and family need acute. The immediate intervention must focus on assessment of individual functioning and need; the nature and quality of interaction and relationships; and how family functioning contributes to or detracts from individual growth, development and need satisfaction. Although Danny provides the entry into this family, it appears as though 3-year-old Bobby's situation is the most critical in the family. The limited information suggests significant delays and conceivably a "Failure to Thrive" situation. This could be a "three alarm" situation with respect to Bobby's safety and even short term survival, given

continued on next page

Case Conference

continued from page 20

Belinda's (mom's) apparent lack of capacity and/or sensitivity and response to the child. Danny's situation may be the best of the three family members. Other professionals are already involved and perhaps may be resources to him. His problems have more energy associated with them, giving some indication of resilience, and he may be processing some positive feedback about his potential that could be giving him strength. Even with these apparent positives, intervention with Danny still must be prompt enough to ward off self-destructive (e.g. delinquent) behavior which would worsen his circumstances and opportunities for change. Belinda's lack of energy, despondency and generally fatalistic outlook on life, though concerning and perhaps defining of the whole family situation, can be understood and addressed in slower and more deliberate ways compared to Bobby or Danny. Since there is so much that is not known or clarified, immediate intervention must stay focused on 1) stabilizing the home situation, particularly with respect to Bobby and 2) assessing individuals and the family unit. Based on those assessments, treatment responses can emerge. Without some further understanding of this family, specific treatment strategies cannot be identified. Immediate intervention could likely involve:

- An immediate physical and developmental evaluation of Bobby.
- A psycho-social assessment with Belinda focusing on history, recent events and circumstances (particularly covering the past 3 years), her capacities and needs, reality testing, etc.
- Depending on my own assessment of Belinda (described above), consideration would be given to acquiring a physical evaluation and/or a psychological or psychiatric evaluation of Belinda.
- A psychological evaluation of Danny, with specific reference to emotions associated with his missing father, relationship to his mother and consideration of his past history.
- A family session to allow for assessment of family interaction, to explore the nature of relationships, and to gain understanding of daily family functioning.
- Based on studying this family, the establishment of a safety plan that assures that Bobby's safety needs are addressed.

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

This family can best be understood and treated through the involvement of various disciplines. Current information, although limited and unqualified, suggests varying degrees of difficulty among all family members. Individual functioning issues are varied by person, age, development and situation, and they appear potentially deep seated and far reaching. Some family conditions, though readily observable, are not obviously explained. For instance, are we to understand Belinda's lethargy as serious depression, a physical condition, or a combination of both? Understanding and treating the family will more likely be successful when the following disciplines are involved:

a pediatrician	Bobby
a child development specialist	Bobby
a psychologist or psychiatrist	Danny
a psychologist or psychiatrist	Belinda (if need is indicated)
a physician	Belinda
a counselor and other school personnel	Danny

These professionals could be woven into a loose team with respect to setting assessment objectives, sharing findings, and providing input into treatment plans. Depending on evaluations of the family, the same or other professionals could be included as treatment providers.

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

- The meaning of Danny's worsening condition/ behavior
- Bobby's development delay
- Bobby's safety
- Belinda's state of mind
- Belinda's capacity as an adult and specifically as a parent
- The apparent depression among all family members
- The meaning of the absence of the father to family members
- The nature of family functioning

What would be your long-range plan?

Since case information is minimal and unqualified prior to necessary assessments, it is impossible to arrive at more than a very general estimation as to the course of action to be taken over the long range. General actions that do seem reasonable include: developmental stimulation for Bobby, energizing and supporting Belinda while re-engaging her in adult and parental responsibilities, re-directing Danny away from self destructive behavior while addressing underlying needs, encouraging family unity while enhancing interactive support and care among family members.

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 multidisciplinary panel of featured experts. Name 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

Case Conference

continued from page 21

Case Response

Bart Trentham, PhD
Psychologist
Family and Children's Services
Tulsa, OK

The Bradley case demonstrates the profound impact that a parent's psychological disorder can have on his/her children's wellbeing. In this case, Belinda's depression has seriously impeded her ability to parent her two sons. Although she apparently parented better in the past, based upon Danny's previous functioning, her depression has depleted her energy and flooded her with apathy and hopelessness. The result - a seriously impaired parent.

Adequately addressing the therapeutic needs of this family requires that the treatment provider(s) consider the needs of each individual family member first, and then consider the needs of the family as a whole. Families who experience child abuse and/or neglect are often multi-problem families with many potentially enduring effects for each individual in the family. Even if the primary treatment modality will be family therapy, each individual's needs must be accurately assessed and addressed. The key treatment issues for Belinda which are evident from this case history are depression, parenting skills and possible adult attachment issues. The key therapeutic issues for Bobby include possible failure to thrive and attachment issues, while Danny's key treatment issues appear to involve depression and rebellious behavior.

The inherent delicacy of treating the Bradley family is complicated by the decisions and actions of the rest of the "helping system." For instance, the case history has identified that a school counselor and a CPS caseworker are already involved with this family. No doubt, many other professionals and paraprofessionals will soon be added. While these professional involvements are critically important, working as an intervention team does require additional effort and cooperation. For example, the initial therapeutic approach should directly follow the findings and/or responses of the CPS caseworker. If one or both children remain with the mother, family therapy should begin immediately and run concurrently with each of their individual therapy regimes. By intervening in this way, the therapist will attempt to mobilize the family interactional pattern toward more adaptive functioning. However, if both children are removed from the home, the initial therapeutic focus should address safety and each of their individual issues, with family therapy to follow. Therefore, the decision making process for when to implement family therapy will not only hinge on the deemed therapeutic usefulness of that approach for this family, but also on the immediate placement decisions and permanency planning decisions which are determined by CPS. The initial focus of therapy for all three clients will be to promote a safe, nurturing family environment.

Bobby exhibits several symptoms which are consistent with Failure to Thrive and he will require specialized intervention approaches. He will need an evaluation by a Developmental Pediatrician, including such components as a nutrition assessment, a psychological evaluation and an audiological report. Even if Bobby is not diagnosed with Failure to Thrive, his symptoms bemoan significant disruptions in his primary attachment process which will require a stable, intensive therapeutic regime. Play therapy will be a critical component of his emotional healing.

Danny could benefit from a medication evaluation regarding his depressive symptoms. He likely feels abandoned by his father for having left the family. Danny's relationship with Bobby is largely unknown and will need to be explored through individual therapy. Furthermore, Danny's therapist should coordinate with his school counselor to effectively promote his personal and academic progress.

Belinda needs individual therapy to address her depressive symptoms. Her therapy should include a conscious effort to expand and effectively utilize her social support network. Belinda also needs to be evaluated as a possible candidate for psychotropic medication therapy. Once her depressive symptoms diminish, training in effective parenting could provide her with new skills to utilize with her children. Parent Child Interaction Training could be extremely helpful in teaching Belinda ways to appropriately interact with Bobby (and Danny) and meet their needs for nurturing. Furthermore, her therapist should coordinate with the CPS caseworker regarding Belinda's vocational interests and potential career training opportunities.

Belinda's depression and subsequent deficits in parenting have had many devastating effects on her children. Remediation of her depressive symptoms is a critical prerequisite for her family's well-being. Both boys should progress much more rapidly in their own therapy if they experience positive changes in their mother during family therapy and visitation. Therefore, Belinda's progress in therapy will be a primary agent of change for the Bradley family.

JOURNAL HIGHLIGHTS

Edited by Rochelle F. Hanson

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.

Study Finds Evidence of PTSD in One-Third of Abused Children

The purpose of this study was to compare the prevalence of Post Traumatic Stress Disorder and other diagnoses in three groups of abused [sexual only (N = 127), physical only (N = 43), and BOTH (N = 34)] children (aged 7-13). The victims and caregivers were separately administered the Diagnostic Interview for Children and Adolescents, Revised Version (DICA). Additionally, caregivers and classroom teachers completed the Child Behavior Checklist (CBCL). Both victims and caregivers endorsed high rates of disorders, with caregivers generally giving higher rates than children, and boys having more externalizing diagnoses than girls. Children in the BOTH group had more diagnoses overall. Concordance between victims and caregivers was modest. PTSD was significantly comorbid with most affective disorders. The authors conclude that children who have been both physically/sexually abused appeared to be at highest risk of psychiatric disturbance. PTSD, though common (circa one-third of victims), was generally comorbid with other affective disorders.

Ackerman, P.T., Newton, J.E., McPherson, W.B., Jones J.G., Dykman, R.A. (1998). Prevalence of post traumatic stress disorder and other psychiatric diagnoses in three groups of abused children (sexual, physical, and both). *Child Abuse & Neglect, 22*(8):759-74.

Severity and Chronicity of Child Abuse Affects Peer Relationships

A prospective longitudinal design was employed to assess risks associated with maltreatment in a representative community sample of 107 maltreated children and an equal number of non-maltreated comparison children. Heightened difficulties in peer relationships and self-esteem were associated with greater severity and chronicity of maltreatment. Type of maltreatment was also related to specific aspects of children's adjustment. Thus, the best predictions of specific aspects of children's adjustment were provided by considering timing, type, and severity of maltreatment.

Bolger, K.E., Patterson, C.J., Kupersmidt, J.B. (1998). Peer relationships and self-esteem among children who have been maltreated. *Child Development, 69*(4):1171-97.

Seventeen Year Study Identifies Risk Factors for Abuse

This study identified demographic, family, parent, and child factors prospectively associated with risk for child abuse and neglect among families in the community. Surveys assessing demographic variables, family relationships, parental behavior, and characteristics of parents and children were administered to 644 families in upstate New York on four occasions between 1975 and 1992. Data on child abuse and neglect were obtained from New York State records and retrospective self-report instruments administered when youths were >= 18 yrs old. Logistic regression analyses indicated that different patterns of risk factors predicted the occurrence of physical abuse, sexual abuse, and neglect, although maternal youth and maternal sociopathy predicted the occurrence of all three forms of child maltreatment. In addition, the prevalence of child abuse or neglect increased from 3% when no risk factors were present to 24% when at least four risk factors were present.

Brown, J., Cohen, P., Johnson, J. G., & Salzinger, S. (1998). A longitudinal analysis of risk factors for child maltreatment: Findings of a 17-year prospective study of officially recorded and self-reported child abuse and neglect. *Child Abuse & Neglect, 22*(11), 1065-1078.

Epidemiology of Child Abuse: A Review of Studies

During the last two decades, epidemiological studies have made important contributions to understanding the problem of sexual abuse of children. This article describes some of the major findings from these epidemiological studies, raises important questions that need to be addressed by future epidemiological studies, and reviews some of the barriers to conducting these studies.

Leventhal, J.M. (1998) Epidemiology of sexual abuse of children: Old problems, new directions. *Child Abuse & Neglect, 22*(6), 481-491.

Study Finds Standard of Proof Does Not Affect CPS Decision Making

This article examined whether standards of proof affect decision making in child protection investigations. Some states use a lower standard of proof of "some credible evidence" (or similar terms) to substantiate cases after investigation. Other state legislatures prescribe a higher standard of "preponderance" of the evidence. It is suggested that a lower rate of substantiation should follow from a higher standard of proof. The Child Maltreatment 1994 report was used to obtain data from each state on child maltreatment reporting, the outcomes of administrative investigation, and characteristics of victims and perpetrators. The percent of substantiation and unsubstantiation for each state was calculated. There was no significant difference in the percent of substantiated and unsubstantiated cases in the two groups (preponderance and lesser standard of proof) of states.

Levine, M. (1998). Do standards of proof affect decision making in child protection investigations? *Law & Human Behavior, 22*(3), 341-347.

Neuropsychological functioning: Comparison of mothers at high- and low-risk for child physical abuse

This study investigated the performance of 20 high- and 20 low-risk mothers for child physical abuse on cognitive measures in a cry (crying infant) and no-cry condition. The degree to which observed risk group differences in cognitive abilities were due to group differences in depression and/or anxiety was explored. All mothers completed a battery of neuropsychological measures as well as measures of depression, and anxiety. Although initial analyses indicated expected risk group differences on most of the neuropsychological measures, controlling for group differences in IQ revealed risk group differences only on measures of conceptual ability, cognitive flexibility, and problem-solving skills. In a third set of analyses that controlled for group differences in IQ, depression, and anxiety, no risk group differences on any of the neuropsychological measures were found. Findings indicate that clinically observed cognitive deficits in high-risk and abusive mothers may be associated with lower levels of intellectual

continued on next page

Journal Highlights

continued from page 23

ability and with higher levels of depression and anxiety.

Nayak, M.B., Milner, J.S. (1998). Neuropsychological functioning: Comparison of mothers at high- and low-risk for child physical abuse. *Child Abuse & Neglect, 22*(7), 687-703.

New Tool for Measuring Psychological and Physical Maltreatment and Neglect

This article describes the development of a new version of the Conflict Tactics Scale (CTS) called the Parent-Child Conflict Tactics Scale (CTSPC). The scale is intended to measure psychological and physical maltreatment and neglect of children by parents, as well as nonviolent modes of discipline. The scale was administered through a telephone survey with the children's parents (mean age 36.8 yrs). The scale provides (1) improved Psychological Aggression and Physical Assault scales, (2) a new Nonviolent Discipline scale, a supplementary scale for Neglect, and supplemental questions on discipline methods and sexual abuse, (3) reliability ranges from low to moderate, and (4) evidence of discriminant and construct validity.

Straus, M., Hamby, S.L., Finkelhor, D., Moore, D. W., Runyan, D. (1998). Identification of child maltreatment with the Parent-Child Conflict Tactics Scales: Development and psychometric data for a national sample of American parents. *Child Abuse & Neglect, 22*(4), 249-270.

Abuse, Accidents or Disease? Causes of Subdural Hematoma

The purpose of this article was to determine the relative frequency of child abuse, accidents and disease as a cause of subdural hematomas in children under 2 years of age, and to determine the main clinical features at presentation that may help to distinguish these groups of patients. A retrospective review was undertaken of the medical records of all children under 2 yrs of age admitted to a children's hospital with the diagnosis of subdural hematoma within a 10-yr period (January 1987 to December 1996). A total of 38 children were identified with subdural hematomas during the study period. The most common cause was nonaccidental injury in 55% of cases; accidents in 39% and nontraumatic causes (6%) made up the remainder. The victims in the nonaccidental injury cases were significantly younger than the accidentally injured children. The most important clinical features were the significantly higher incidence of retinal hemorrhages and associated long bone and rib fractures in the abuse group. Delay in presentation for medical evaluation was also more commonly seen in the abused children.

Tzioumi, D. & Oates, R. K. (1998). Subdural hematomas in children under 2 years: Accidental or inflicted? A 10-year experience. *Child Abuse & Neglect, 22*(11), 1105-1112.

Are Maltreated Children More Prone to Dating Violence?

This study sought to understand how experiences of maltreatment occurring prior to 12 years of age affect adolescent peer and dating relationships. A school-based sample of 15-year-olds was divided into maltreated (n = 132) and non-maltreated (n = 227) subgroups based on self-reported maltreatment. These two groups were then compared on two theoretically determined dimensions of adjustment (i.e., interpersonal sensitivity/hostility; personal resources) and self- and teacher-report measures of peer and dating relationships. Findings supported the hypothesis that maltreated youths significantly differed from nonmaltreated youths in terms of adjustment problems as well as conflict with dating partners and close friends. Maltreated youths reported significantly more verbal and physical abuse both toward and by their dating partners, and were seen by teachers as engaging in more acts of aggression and harassment toward others.

Wolfe, D.A., Wekerle, C., Reitzel-Jaffe, D., & Lefebvre L (1998). Factors associated with abusive relationships among maltreated and nonmaltreated youth. *Development & Psychopathology, 10*(1):61-85.

APSAC Advisor Call for Submissions

The *APSAC Advisor* is inviting submission of manuscripts for possible publication in an upcoming issue. The purpose of the *Advisor* is to serve as a forum for succinct, practice-oriented articles and features that keep interdisciplinary professionals informed of the latest developments in the field of child maltreatment. *Advisor* readers are the more than 4,500 social workers, physicians, attorneys, psychologists, law enforcement officers, researchers, judges, educators, administrators, psychiatrists, counselors, and other professionals who are members or supporters of APSAC.

Appropriate material: *Advisor* editors are interested in articles that focus on particular aspects of practice, detail a common problem or current issue faced by practitioners, review available research from a practice perspective, or, for the Perspectives column, present an opinion on a controversial issue in the field. Articles should be practical and accessible, but also research-based and drawing on the latest empirical studies on a particular topic.

Length: *Advisor* articles should range from four to twelve double-spaced pages in length in manuscript form. Perspectives articles should be 1500-1700 words.

Peer review: All articles submitted for publication in the *APSAC Advisor* undergo peer review, first by the Associate Editor, and then by other professionals with expertise in the article's subject matter.

Submission: All articles should be submitted typed, double-spaced, on white paper, with an accompanying diskette in Microsoft Word or ASCII, or as an attachment via email. Please send manuscripts to: Maureen Kelly, *The APSAC Advisor*, APSAC, 407 S. Dearborn, Suite 1300, Chicago, IL 60605 Phone: 312-554-0166; fax: 312-554-0919 email: APSACPubls@aol.com. For complete Author Guidelines visit our web page at www.apsac.org or call Maureen Kelly.

SEVENTH NATIONAL COLLOQUIUM

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

SAN ANTONIO, TEXAS

JUNE 2-5, 1999

HYATT REGENCY ON THE RIVERWALK

PLAN NOW TO ATTEND:

Bring your family, and enjoy the warmth and hospitality of San Antonio while taking advantage of the excellent professional education and training the Colloquium offers.

Join your colleagues in the city of San Antonio for the most energizing training of your career!

APSAC's National Colloquium is a major source of education and research necessary for professionals in the field of child maltreatment including: mental health, medicine and nursing, law, law enforcement, education, prevention, and child protective services. *Colloquium seminars begin where seminars at other conferences end!*

COLLOQUIUM TOPICS INCLUDE:

- Fatal Child Abuse
- Forensic Evidence Collection
- Medical Evaluation of Child Sexual and Physical Abuse
- Children and the Internet: Investigation, Prosecution and Treatment
- Treating Traumatized Children
- Personal Safety in the Community
- Managing the Therapy Relationship with Adult Survivors
- Sexual Abuse Allegations in Divorce Cases
- Providing Expert Testimony in Child Abuse Litigation
- Cultural Concerns in Mental Health Practice

COLLOQUIUM FEATURES:

- ***Special Event: A Night in Old San Antonio Fiesta***
- ***40-hour Child Forensic Interview Training Clinic***
- ***Intensive, interdisciplinary, skills-based training seminars on all aspects of child maltreatment***
- ***Field generated skills-based training, Research, Poster Presentations, and Symposia***
- ***Networking opportunities with other professionals and APSAC members in your discipline and state***
- ***A faculty of internationally recognized experts***

COLLOQUIUM AT A GLANCE

TUESDAY, JUNE 1, 1999
Professional Group Meeting Day
State Chapter Training
Task Force and Committee Meetings

WEDNESDAY, JUNE 2, 1999
Opening Reception
APSAC Cultural Institute

THURSDAY, JUNE 3, 1999
Research Breakfasts
Intensive Training Seminars
Poster Presentations

FRIDAY, JUNE 4, 1999
Research Breakfasts
Field generated skills-based training
Research Symposium
Awards Ceremony and Luncheon
Event: A Night in Old San Antonio Fiesta

SATURDAY, JUNE 5, 1999
Research Breakfasts
Intensive Training Seminars
Closing Luncheon: Dave Pelzer speaker

Rooms have been reserved for Colloquium attendees at a rate of $119 (single/double), plus tax at the Hyatt Regency on the Riverwalk, located at 123 Losoya Street, San Antonio, Texas 78205. Reservation cut-off date is May 12, 1999. ***We urge you to make hotel reservations early***. For reservations, call the hotel at 210-222-1234 or 1-800-233-1234, and ask for the Colloquium rate.

Registration for APSAC members $425; Non-members registration fees are $475. Registration cut off date is May 10, after that date registration must be on-site.

For more information about APSAC's Seventh National Colloquium please complete and return this form to APSAC's Training Department at 407 South Dearborn Street, Suite 1300, Chicago, Illinois 60605, Phone 312-554-0166, Fax: 312-554-0919 or E-mail: APSACEduc@aol.com. Visit our website at www.apsac.org**.**

Please send me: (Circle)

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OREGON OPPORTUNITY

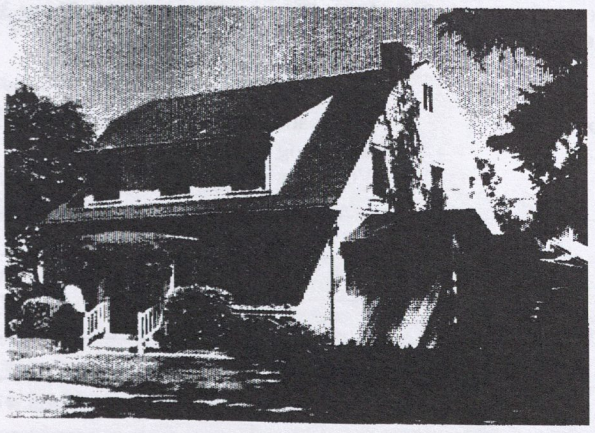
REGIONAL MEDICAL DIRECTOR FOR CHILDREN'S ADVOCACY CENTER

The Jackson County Children's Advocacy Center is seeking a physician who has experience with children's sexual abuse issues for a half time medical directorship.

The Children's Advocacy Center is a community supported Center located in a beautifully restored vintage house in Medford, Oregon. The southern Oregon area is known for its outdoor activities, including fly fishing, skiing, river rafting as well as its cultural attributes. In nearby Ashland, the *Oregon Shakespeare Festival* attracts thousands of national and international theatergoers, and the historic gold mine town of Jacksonville, 10 miles west of Medford, is home each summer to the *Peter Britt Music Festival*. Southern Oregon University is located 13 miles to the south in Ashland, Oregon.

The ideal candidate will be familiar with and able to instruct others in the use of specialized techniques and medical equipment used in child abuse medical assessment. Additionally, the candidate must possess management qualities necessary to oversee medical assessment programs and supportive medical/clerical staff. The candidate should have effective communication and facilitation skills primarily in regards to medical evaluation training, and community advocacy. The position requires administrative duties, court testimony, peer review and education. Additionally, the candidate will be expected to do limited travel throughout the five surrounding counties as a consultant. The successful candidate will work with a professional staff that interacts with local law enforcement, child protection agencies, and the District Attorney's office.

Send all inquiries to: Jane Hamilton, Children's Advocacy Center, 816 W. 10th Street, Medford, OR 97501



CONFERENCES

APSAC Discount

June 2-5, 1999. ***APSAC's 7th National Colloquium.*** Chicago, Illinois. Sponsored by APSAC. Call 312-554-0166. ; fax 312-554-0919; email: apsaceduc@aol.com.

July 25-28, 1999. ***15th Annual Training Symposium: The Power of Prevention.*** Atlanta, GA. Sponsored by the Georgia Council on Child Abuse. Call 404-870-6588.

July 15-20, 2000. ***APSAC's 8th National Colloquium.*** Chicago, Illinois. Sponsored by APSAC. Call 312-554-0166.

Upcoming Conferences

April 7-11, 1999. ***Claiming Our Future.*** San Antonio, Texas. Sponsored by the Association for Childhood Education International. Call (800) 423-3563.

April 9-11, 1999. ***76th Annual Meeting of the American Orthopsychiatric Association.*** Washington, DC. Call 212-564-5930.

April 11-13, 1999. ***20th Annual Statewide Conference on Child Abuse & Neglect.*** Greensboro, NC. Sponsored by Prevent Child Abuse North Carolina & The North Carolina Professional Society on The Abuse of Children. Call 336-716-7663

April 29, 1999. ***Healthy Start, Achieving Children, Successful Futures: the Annual National Conference of the Children's Defense Fund.*** Houston, Texas. Web site: www.childrensdefense.org

April 30-May 2, 1999. ***The Fourth National Clinical Social Work Conference.*** Washington, D.C Sponsored by the Clinical Social Work Federation. Call 703-404-2741.

May 26-29, 1999. ***First Canadian Conference on Shaken Baby Syndrome, Awareness, Prevention & Response; an Integrated Approach.*** Saskatoon, Canada. Hosted by the Saskatchewan Institute on Prevention of Handicaps. Call (306) 655-2512.

June 2-4, 1999. ***Imagine a Brighter Future: Providing Solutions for Children in Crisis.*** Los Angeles, California. Sponsored by Children's Institute International, LA, CA. Call (310) 274-8787, extension 116.

June 3-4, 1999. ***The 4th Biannual Violence Prevention Conference: Voices from the Community: Creating Solutions.*** Long Beach, California. Sponsored by the Violence Prevention Coalition of Greater Los Angeles. Call Anthony Borbon at (213) 240-8279.

October 13-15, 1999. ***4th International Conference on the Child.*** Montreal, Canada. Sponsored by the Organization for the Protection of Children's Rights (O.P.C.R.) Call 514-593-4303.

November 15-17, 1999. ***Challenging Our Response to Child Maltreatment: Intervention, Prevention & More.*** Providence, RI. Sponsored by The Massachusetts Society for The Prevention of Cruelty to Children and The Massachusetts Professional Society on The Abuse of Children. Call 508-580-4691.

December 1-4, 1999. ***13th Annual Empowering Families Conference.*** Baltimore, Maryland. Sponsored by the National Association for Family-Based Services. Call 319-335-3213.

SEEKING SITES FOR RESEARCH STUDY

University of Michigan study on the mothers of sexually abused children seeks sites to participate in research project beginning in summer/fall 1999. We prefer sites with at least ten new clinical cases in a three-month period. Mother must be a nonoffending parent. Sites will receive training in a new model of psychoeducational/support groups for mothers of sexually abused children. For more information, contact Carol A. Plummer, M.S.W., at 734-994-1253 or 734-764-8657 or email at plummerc@umich.edu.

APSAC ADVISOR

Editor-in-Chief
Debra Whitcomb, MA
Education Development Center
Newton, MA
617-969-7100

Executive Editor
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Chicago, IL
312-554-0166

Managing Editor
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312-554-01 66

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Child Protective Services
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Research
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UNH Family Research Laboratory
Durham NH
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THANK YOU!

These APSAC members have made generous financial contributions in the last several weeks to support vital work of the organization. Their donations 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.

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Each year, dozens of national and internationally recognized experts in the field of child maltreatment donate their time and expertise to APSAC as faculty for Advanced Training Institutes, the Child Forensic Interview Clinic, and the Colloquium. This year's Advanced Training Institutes in San Diego (January 25) were better than ever, and feedback was entirely enthusiastic. The contributions of these faculty members in time, travel, and preparation was extraordinary, especially with the many competing demands on their time. We thank them very warmly for making so substantial a commitment to APSAC.

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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