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The Convention on the Rights of the Child and Child Maltreatment: Incompatible Conditions

—Stuart N. Hart & Cynthia Price Cohen

The United Nations Convention on the Rights of the Child is the most widely accepted international human rights treaty in history. It was adopted without dissent by the United Nations General Assembly in November of 1989, and entered into force on September 2, 1990, having received the required twenty ratifications in less than nine months. Nearly ten years later only two of the 193 recognized countries of the world have failed to ratify this international treaty: the United States and Somalia. What's wrong with this picture? Stuart Hart and Cynthia Price Cohen provide an update on efforts to move the U.S. towards ratifying this important Convention. 2

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Screening Young Foster Children for Posttraumatic Stress Disorder and Responding to their Needs for Treatment

— Grady Dale, Jr., EdD., Joshua C. Kendall, M.A., Katherine Im Humber, M.A. and Lisa Sheehan, Ph.D.

Young children who enter foster care often come with a variety of physical and mental health conditions which may go undiagnosed and untreated. Of particular concern is the comparatively high incidence of Posttraumatic Stress Disorder (PTSD) among children in foster care. Research and practice standards have only recently begun to address the different ways that PTSD can manifest in children as opposed to adults. This article reviews the relevant research on children and PTSD, and offers recommendations for treatment. 6

Orofacial Trauma in Child Abuse and the Role of the Dental Profession

— Howard L. Needleman, D.M.D.

Children who are victims of physical or sexual abuse often incur injuries to the face, head and orofacial area of the body. Given this fact, dentists have an important role in screening for signs of non-accidental trauma in the children they serve; yet research has shown that dentists often underreport cases of abuse and neglect due to lack of knowledge and uncertainty about their suspicions. Dr. Howard Needleman, DMD, reviews the history of the dental profession's involvement in screening for and reporting child abuse. 10

ASSOCIATION NEWS – NEW!

To provide APSAC members with extended coverage of the activities of this vibrant association, a new feature debuts with this issue of the *Advisor*. Association News will now be a four-page insert, full of news on APSAC's latest activities, publications and training efforts.

Also in this issue:

PERSPECTIVES

The Convention on the Rights of the Child and Child Maltreatment: Incompatible Conditions

By Stuart N. Hart & Cynthia Price Cohen

State and national leaders repeatedly proclaim that children are our most valuable assets and that their well being is essential to the future of our nation. At the same time, every year large numbers of children in the United States are abused and neglected, while our grossly inadequate systems for prevention and correction of maltreatment are largely ignored. What's wrong with this picture?

Our nation has provided worldwide leadership in setting, promoting, and holding other nations accountable for human rights standards. The United States played a very influential role in the development of the Convention on the Rights of the Child and supported its adoption by the United Nations on November 20, 1989. Nearly ten years later, 191 of the 193 recognized countries of the world, all but the United States and Somalia, have ratified this international treaty. What's wrong with this picture?

It is strongly possible that these two sets of incongruencies are related. It appears that in both situations our national posture and countless political words proclaiming our love for children, their pivotal place in the stream of human progress, and our intentions to assure their protection and healthy development have been rather hollow. In both situations, the view that children are more like property than persons, in both law and practice, seems to have prevailed as national policy. Consequently, children continue to be mistreated and to have their rights ignored.

This failure to live up to national aspirations should not be allowed to stand. Recognition of children's rights and establishment of successful prevention and correction of child maltreatment are strongly related and should be pursued vigorously. In the area of children's rights, the UN Convention presents the best opportunity for advances. In place, as the spirit and law of the land, it can help combat child abuse and neglect.

Why is the UN Convention on the Rights of the Child the proper vehicle for securing children's rights? It is the best representation we have of what Gary Melton termed a "positive ideology" of the child–a shared societal perspective that children are of value as persons in and of themselves, not only for what they can do to benefit others. The Convention is the most widely accepted international human rights treaty in history. It was adopted without dissent by the United Nations General Assembly in November of 1989. It entered into force on September 2, 1990, having received the required twenty ratifications in less than nine months, and reached the status of near universal adoption in just over five years – with more ratifications than any other human rights treaty. The Convention's 41 substantive articles cover all major child issue areas, with standards ranging across basic survival and protection, through nurturance and development, to participation rights. Collectively, these rights require that States Parties (sovereign nations that have ratified the Convention) must assure that children will have their basic needs fulfilled, that they will have support for full development of their potentials, and that they will be prepared for a "responsible life in a free society." The Convention's standards have become the international vision and language for children's rights throughout the world.

What is the Convention's relevance for preventing and overcoming child maltreatment? The treaty in its entirety can be viewed as standing for good treatment and against maltreatment. At the broadest level, it conceives of the child as a person with rights, a person to be respected, protected, and supported toward full and healthy development. Its Article Three, a guiding principle, states "the best interests of the child shall be a primary consideration" in all actions concerning children. These expectations cannot be met in a society that tolerates maltreatment.

Why has the United States not yet committed itself to children's rights by ratifying the Convention on the Rights of the Child? The answer to this question is far from clear. Nearly 300 nongovernmental organizations of some national prominence have formally endorsed the Convention. Included among these are the American Psychological Association, the American Academy of Pediatrics, the American Bar Association, the National Education Association, the American Professional Society on the Abuse of Children (APSAC), and many other professional, advocacy and religious organizations. The U.S. State Department review of the Convention was completed during the Bush administration, but no action was taken. Then, largely because of a death bed plea by James Grant (then head of UNICEF), the United States finally signed the Convention in February of 1995 (Madeline Albright for President Clinton), taking the first step in the ratification process. However, the next step in the ratification process – submission to the U.S. Senate for its constitutionally required "advice and consent" — has not yet been initiated and significant resistance to the Convention has been communicated to the U.S. Congress.

Opposition to ratification of the Convention appears to be based on lack of understanding of international treaties and their implementation processes, and of the specifics of this particular treaty, as well as hostility toward the United Nations and international entanglements, and toward the concept of children's rights. Statements of opposition seem generally to be founded on erroneous thinking about the influence of the UN on the Convention's implementation and about the potential impact of the Convention on the family.

UN focused opposition is grounded in a fear of coercive United Nations intervention if a country doesn't live up

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to its treaty commitments. In truth, the Convention on the Rights of the Child is an international treaty that obliges ratifying sovereign nations (i.e., States Parties) to abide by voluntarily undertaken commitments. Implementation of the Convention is in the hands of its States Parties, who elect the members of the expert oversight body known as the Committee on the Rights of the Child that reviews State Party reports on treaty compliance (see arts. 43 & 44). Public information and international encouragement and persuasion are the Committee's only tools for ensuring that a State Party adequately implements the Convention. Moreover, when a sovereign nation ratifies the Convention it has the right to attach to its instruments of ratification *reservations* indicating those articles with which it will not comply or it may attach *declarations* or *understandings* to explain how the nation will interpret a particular section of the Convention's text. This gives States Parties the possibility of interpreting and implementing the treaty – within the spirit of the treaty's intent – with allowances for the individual nation's values and patterns of life.

Family focused opposition to the Convention is founded on the fear that the Convention will interfere in the parent-child relationship. Opponents claim that: 1) the Convention doesn't respect the rights of parents, 2) it would disallow home-schooling, 3) it would promote abortion or right to life, and 4) it would give children license to do whatever they want regardless of their age or the wishes of parents. These perspectives simply don't match the facts. The Convention strongly respects the family as the primary base for assuring the healthy development of children and directly states this support for parents throughout the Convention (see the Preamble and arts. 5, 3, 7, 9, 10, 18, 22, 23, 27, 29, 37 and 40). Its standards for education (arts. 28 & 29) assure purpose and opportunity but do not restrict the venue for achieving that education. The Convention does support each and every child's right to life, survival and development (art.6) but avoids identifying the point at which life begins and does not deal with the topic of abortion, leaving these issues to be determined by the values of each nation. The Convention does support the rights of children to express their views and be heard; to freedom of thought, conscience and religion; to freedom of association; and access to information (arts. 12, 13, 14, 15, 17). However, all these are clearly modified by the treaty's overriding standard that parents have the responsibility, right and duty to provide appropriate direction and guidance in the exercise of rights by the child "in a manner consistent with the evolving capacities of the child" (see art. 5).

There are some opponents of the Convention who fear it will eliminate corporal punishment and/or the right to apply the death penalty to children. It may very well do that eventually. The Convention makes a clear statement against capital punishment for crimes committed by those under 18 (art. 37). The Convention also appears to oppose corporal punishment, most specifically in schools. It proclaims that "school discipline should be administered in a manner consistent with the child's human dignity" (art. 28). The Convention makes additional statements in support of treatment that promotes the child's sense of dignity and worth (art. 40) and it prohibits torture, cruel, inhuman or degrading punishment (art. 37). With the above articles as a foundation, the Committee on the Rights of the Child has recently been inclined to recommend against corporal punishment in general.

What can be done to encourage United States ratification of the Convention on the Rights of the Child and implementation of its standards?

The Convention is sound in its principles and its system of respectful encouragement and assistance to advance children's rights. Individuals and organizations should educate themselves about its nature and implications and then determine what if anything they will do in its support. Those who are concerned about child maltreatment will find the Convention clearly and strongly in support of ending this societal cancer and of assuring protection and help for its present and potential victims. They will find reason to believe that commitment to and implementation of the full Convention will create a tide of higher standards and moral will sufficient to raise all supports for child welfare and to do so in mutually beneficial ways.

Good information sources for the Convention are available online at Children's Rights Information Network, **www.crin.org**, UNICEF, **www.unicef.org**; United Nations High Commissioner for Human Rights, **www.unhcrh.ch**; and the University of Minnesota Human Rights Library, **www.umn.edu/humanrts/.**

Opposition to the Convention is relatively small in numbers but apparently strong in its efforts to communicate its fears and resistance. So far the opposition seems to have enhanced the longstanding tendency toward inertia on children's issues in national politics. If this is to change, organizations and individuals genuinely concerned about the plight and needs of children in our society will need to do more than sign endorsements. They will need to take action to establish children's rights through support for ratification of the Convention and efforts to implement the spirit of its standards in their work and communities now. State and national political leaders will need to hear from those who want to see our nation commit to children's rights. APSAC has already indicated its intention to help. It's up to individual members to determine the actions they will take in support of APSAC's commitment and in their own personal and professional lives.

Cohen, C. P., & Bitensky, S. (1996). 30 Questions on the United Nations Convention on the Rights of the Child. New York: Childrights International Research Institute.

Bedard, C. (1996). Children's rights handbook: An introductory guide for child protection professionals and agencies. Ithaca, NY: Cornell University & Childhope USA.

POLICY WATCH

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

BUDGET ALLOCATIONS THREATEN SPENDING

With a budget plan for FY2000 putting tight caps on spending in the coming year, the House Appropriations Committee took the next step by handing out reduced allocations to most of the 13 appropriations subcommittees. Only defense, military construction, and transportation spending received more under the allocations scheme approved on May 19 by the committee.

Money for the Labor-HHS-Education Appropriations Subcommittee, which covers all children's services was chopped by 12 percent, from $88.8 billion for FY99 to $78.1 billion for 2000.

The congressional budget resolution is a highly political document in any year. This time around, the stakes are even higher as the Clinton administration and congressional Republicans dance around the issue of raising the spending caps. While no one wants to make the first move, House and Senate appropriations committee members are openly talking about the pressure to release the caps and make more money available for spending.

The 1997 Balanced Budget Agreement was designed to end the growth of budget deficits by 2002, setting spending caps of increasing severity over five years. To many, the caps do not make sense the way they did in 1997. At that time, when a bipartisan agreement set the severe spending limits, deficit, not surplus, was the budget's leitmotif. The agreement made no provision for the annual budget deficits to disappear much earlier due to a strong economy and higher federal tax receipts.

Now, those who draft the money bills seem agreed that the spending caps are unrealistic and have to go. Rep. Bill Young (R-FL), the House Appropriations Committee chair, was quoted by news sources as saying that it would be impossible to stay within spending limits and pass all 13 money bills. Intent on forcing the issue, Young plans to send the military construction, defense, and other noncontroversial spending bills to the floor first. That will leave half a dozen or so appropriations bills, including labor, education, and human services, coming up short later in the year.

Because House Republican leaders, including Rep. John Edward Porter (R-IL), who chairs the HHS appropriations subcommittee, favor doubling funds for the National Institutes of Health over five years, other programs in the bill would have to be slashed even further. Porter has flatly stated that he cannot draft an acceptable bill until the House Republican leadership agrees to allocate more money.

By September, the showdown over scrapping the budget caps is expected to detonate – an event commonly referred to in Washington as "the train wreck". Just before the start of the new fiscal year, October 1 – when an end-of-session deal can be cut with the President, Congress and the White House are expected to face the issue and come to terms with the budget caps.

NIH RESEARCH ON CHILD NEGLECT

Funds to support child neglect research will be available next year for a five-year research grant program announced by the National Institutes of Health (NIH). A total of $3,315,000, pooled from NIH, the Department of Justice's National Institute of Justice and Office of Juvenile Justice and Delinquency Prevention, the HHS Children's Bureau, and the Department of Education's Office of Special Education Programs, will support between 11 and 15 research awards beginning July 1, 2000.

Support for a variety of research activity is anticipated: large scale research grants; exploratory or innovative research; short-term work; studies by less experienced investigators; and feasibility studies testing methods new to child neglect research. Research is encouraged on a variety of topics: the antecedents and consequences of neglect; processes and mediators accounting for or influencing the effects of neglect; and studies on child neglect treatment, preventive intervention, and service delivery.

In addition to the participation of the Departments of HHS, Education and Justice, the funding is supported by several entities in NIH: Office of Behavioral and Social Sciences Research, National Institute on Alcohol Abuse and Alcoholism, National Institute of Child Health and Human Development, National Institute of Dental and Craniofacial Research, National Institute on Drug Abuse, National Institute of Mental Health, and National Institute of Neurological Disorders and Stroke. The need for more research to expand the existing scientific knowledge base on child neglect is the impetus for the funding proposal. In the funding announcement, the NIH expressed the belief that, without special encouragement to the scientific community, the number of studies addressing child neglect will likely continue to lag behind that of studies addressing other forms of childhood trauma. The initiative results from a directive to NIH from the House Appropriations Committee in 1996 to "convene a working group of its component organizations currently supporting research on child abuse and neglect" in order to develop plans for research efforts in child maltreatment.

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POLICY WATCH

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The child neglect research Request for Applications may be found on the NIH Web site at: http://www.nih.gov/grants/guide/rfa-files/RFA-OD-99-006.html For more information, please contact: Cheryl A. Boyce, Ph.D., NIMH, 6001 Executive Boulevard, Room 6200, MSC 9617, Bethesda, MD 20892-9617; Telephone: (301) 443-0848; FAX: (301) 480-4415; Email: cboyce@nih.gov

HHS CHILD ABUSE AND NEGLECT STATISTICS

Almost one million substantiated cases of child abuse and neglect were investigated by child protective service agencies in 1997, according to a report released April 1, 1999, by the U.S. Department of Health and Human Services (HHS). Based on preliminary state-reported child abuse and neglect statistics, HHS estimates that child protective service agencies investigated reports of alleged maltreatment of nearly three million children in 1997. Of those children investigated, states found that 963,870 children were victims of abuse and neglect.

According to HHS, this continues a downward trend in the number of children abused and neglected which started four years ago when substantiated cases reported to CPS agencies totaled a record 1,018,692 in 1993. HHS acknowledges that, while state reports capture much of child abuse and neglect, separate studies (such as the National Incidence Study of Child Abuse and Neglect periodically conducted by HHS) have found that the number of victims may be higher.

The Third National Incidence Study of Child Abuse and Neglect, released by HHS in September, 1996, found that the number of actual child abuse and neglect cases (reported and unreported) nearly doubled between 1986 and 1993 (from 1.4 million to 2.8 million), and the total number of children seriously injured had quadrupled. What's more, the 1996 incidence study found that the actual number of cases investigated by state agencies remained the same, resulting in a decline in the proportion of cases that were investigated from 44 percent in 1986 to 28 percent in 1993.

"Though we're reporting a slight decline in children as victims of abuse and neglect - these numbers nevertheless represent an unacceptable human tragedy we must do more to prevent," said HHS Secretary Donna Shalala.

HOUSE PASSES PREVENTION MONTH RESOLUTION

In recognition of Child Abuse Prevention Month, and the work of individuals and organizations in communities around the country, the House of Representatives unanimously passed House Concurrent Resolution 93 on April 29, 1999. The measure, designed to raise awareness on Capitol Hill, calls on Congress to marshal federal resources "in a manner that maximizes their impact on the prevention of child abuse and neglect" and to allow state and local governments "to use federal law enforcement resources in the fight to prevent child abuse and neglect."

The resolution also expresses the sense that "child protective services agencies, law enforcement agencies, and the judicial system should coordinate their efforts to the maximum extent possible to prevent child abuse and neglect."

CONGRESSIONAL HEARING ON CHILD ABUSE BILL

The Child Abuse Prevention and Enforcement Act, H.R.764, was the focus of a hearing on May 12, 1999, before the House Judiciary Committee's Subcommittee on Crime. Opening the hearing, subcommittee chair, Rep. Bill McCollum (R-FL), spoke in support of the bill's objectives, characterizing the legislation as an example of "how best to accomplish goals with limited public funds." The subcommittee's ranking Democrat, Rep. Bobby Scott (D-VA), said the bill was "a step in the right direction." H.R.764 was intended by its sponsor, Rep. Deborah Pryce (R-OH), as a modest means of accomplishing goals without tapping new appropriated dollars.

The bill, which has been given a high profile by House Majority Whip Rep. Tom DeLay (R-TX), contains three provisions: 1) allow criminal justice funds for video-taping testimony of child victim witnesses testimony to also be used for sharing of criminal and other background record information between law enforcement and CPS; 2) allow states and localities to choose to use criminal justice block grant funds for intervention and prevention of child abuse and neglect; and 3) raise the cap on the share of the Crime Victims Fund to Children's Justice Act (CJA) grants from $10 million to $20 million.

The first panel of witnesses, representing the U.S. Department of Justice, suggested that the bill's purposes were already met under current Justice Department programs. The Clinton administration had not permitted the Justice Department's witnesses to state a position supporting or opposing the legislation.

The second panel included three witnesses testifying in support of the legislation: Deborah Sendek, director, Columbus (OH) Children's Hospital Center for Child Abuse Prevention; Major Lynn Jones, Tulsa Police Department; and Robert Horowitz, American Bar Association Center on Children and the Law.

John Stein, deputy director of the National Organization for Victim Assistance, presented testimony opposing the increase in the share of funds for the Children's Justice Act, advising that NOVA had always resisted attempts to earmark shares of the Crime Victims Fund. Stein proposed that CAPTA be amended to authorize $20 million in appropriations for CJA, with $10 million guaranteed from the Crime Victims Fund.

Screening Young Foster Children for Posttraumatic Stress Disorder and Responding to their Needs for Treatment

Grady Dale, Jr., Ed.D., Joshua C. Kendall, M.A., Katherine Im Humber, M.A. and Lisa Sheehan, Ph.D.

Introduction

For over a generation, researchers have identified high rates of emotional problems in children entering foster care. In their pioneering study, Fanshel and Shinn (1978) described "emotional impairment" in nearly a third of their subjects. Depending on the age group sampled, as many as 80% of these at-risk children show evidence of developmental delays (Halfon, Mendonca, and Berkowitz, 1995; McIntyre and Kessler, 1986; Kendall, Dale and Plakitsis, 1995). In recent years, clinicians and researchers have attempted to pinpoint with greater precision the nature of the psychiatric distress experienced by foster children. Thus, though research findings on the overall level of psychiatric disorders remain unchanged, the diagnostic categories used to describe these at-risk children continue to evolve.

One of the recent advances in understanding foster children involves assessing them for Posttraumatic Stress Disorder (PTSD), which first achieved formal recognition in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, the diagnostic handbook for mental health professionals, in 1980 (American Psychiatric Association, 1980). Two revisions later, the DSM IV (American Psychiatric Association, 1994) includes updated notes to account for the distinct responses of children who experience PTSD. At present, the criteria fail to differentiate adequately between PTSD in adults and children even though children, particularly young children, appear to respond much differently to traumatic stimuli than adults.

At present, the criteria fail to differentiate adequately between PTSD in adults and children even though children, particularly young children, appear to respond much differently to traumatic stimuli than adults.

As opposed to earlier diagnostic labels, Posttraumatic Stress Disorder seems to reflect more directly the experiential world of foster children. As Garbarino (1995) has noted, foster children are often exposed to numerous traumatic stressors in their "socially toxic environments," including physical and sexual abuse, homelessness, neglect, parental substance abuse and abandonment. While these stressors may tend to be chronic, they are also frequently acute and/or episodic in nature. PTSD symptoms overlap with the symptoms of other common psychiatric disorders such as depression and generalized anxiety disorder. In contrast to other diagnoses, however, PTSD captures the overall context of the child's symptoms by identifying these symptoms as a stress reaction to specific traumatic event/s.

Over the past decade an emerging body of research has documented the varying levels of children's exposure to trauma and the symptoms associated with that exposure. Symptoms may increase (Goenjian, Pynoos, and Steinberg, 1995) or decrease (Green, Grace, Vary, Kramer, Gleser, and Leonard, 1994) according to the nature of the trauma, developmental level of the child, and the existence of comorbid conditions. Individual therapy, including play therapy, is important so that children can share their anxieties at a pace consistent with their ability to integrate the experience of the trauma (Gillis, 1993). Group treatment and family therapy are also important modalities, using the insights of significant others as a source for information and coping strategies (Gillis, 1993). While some modalities, including cognitive-behavioral therapy, have produced encouraging results (Deblinger, McLeer, Henry, 1990), there is considerable research work to be done on comparing and treating differing trauma experiences across the spectrum of environments, ages, socioeconomic and cultural factors (Pfefferbaum, 1997).

Researchers are also gathering prevalence data on PTSD in inner-city youth. Burton (1991) found a positive correlation between exposure to community violence and PTSD. Also, Guevera (1991) in his study on gang violence found a positive correlation between the level of exposure to gang violence and PTSD. Inner-city foster children represent a highly vulnerable subset of at-risk children, and their rates of PTSD may be equal to if not higher than other vulnerable child populations.

In a recent study examining 87 children entering foster care aged six to eight, Dale, Kendall, Hessenauer and Humber (1997) found that 33% met criteria for a diagnosis of PTSD. Given the high prevalence rates found in these preliminary investigations, case workers who work with foster children should learn to identify the major signs and symptoms of PTSD. Likewise, clinicians who conduct psychotherapy with foster children should learn how to diagnose and treat this disorder. Early detection and treatment offers the best hope for steering these at-risk children, often victimized both by their families and systems purporting to serve their interest, toward productive, meaningful lives.

Identifying the Signs and Symptoms of PTSD

Posttraumatic Stress Disorder develops over time as the result of exposure to extreme stress. This reaction, which is accompanied by feelings of intense fear, helplessness and/or horror, tends to be chronic. Children with PTSD exhibit symptoms which fall into three general categories: 1) re-experiencing the traumatic events; 2) avoidance of stimuli associated with trauma and general numbing; and 3) heightened arousal.

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Screening Young Foster Children

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Many children entering out-of-home placements are exposed to life-threatening traumatic events. After all, the purpose of out-of-home placements is to protect children seen as "at-risk" for physical or psychological injury. When asked about exposure to traumatic events, a sample of 152 children between the ages of six and eight entering out-of-home placements in Baltimore City report the following stressors:

Traumatic Event	% Endorsement
Fear of being shot or stabbed	72.6%
Hearing gunshots around home or school	66.7%
Fear that something bad might happen	58.1%
Physical abuse/fear of physical abuse	46.2%
Witnessed car accident, fire or injury	46.2%
Know gunshot or stabbing victim	45.3%
Car accident, fire or other injury	27.2%
Verbal threats of physical harm	17.1%
Sexual abuse	3.4%

These 152 children were administered the PTSD Symptom Inventory for Children (PTSD-SIC)(Eisen, 1996). This instrument was part of a screening protocol for children entering the foster care system, through a health clinic specifically designed for emergency out-of-home placement. The PTSD-SIC is a measure which asks questions that directly parallel the criteria outlined in the DSM IV, though there is expansion of the criteria to account for those experiences that are germane to children who live in traumatic communities as well as dysfunctional familial environments. For example, the chronicity of hearing repeated gunshots night after night in one's neighborhood could qualify as a traumatic "re-experience," when coupled with the additional problem of environmental instability resulting from out-of-home placement. These types of reoccurrence (and their impact on children) are not accounted for as "recurring" or "reliving" experiences as defined in DSM IV.

Of the 152 children assessed in the Baltimore study, 33% were found to meet criteria for PTSD, a rate significantly higher than seen in the population at large. In addition, many other children who did not meet criteria for PTSD also reported high levels of distress. Children with PTSD were more likely to report the following: distressing recollections of traumatic events, nightmares, avoidance of thoughts associated with traumatic events, purposeful avoidance of situations which evoke traumatic recollections, difficulty recalling important aspects of trauma, feelings of sadness, worries about premature death, sleep disturbance, poor concentration, hyper vigilance, and exaggerated startle response. Not surprisingly, children with PTSD also tended to exhibit more depressive symptomatology than children without PTSD, highlighting the comorbidity of these two disorders. Symptoms such as sleep disturbance, difficulties with memory and concentration, and feelings of sadness are characteristic of both depression and PTSD.

In light of this evidence, professionals should be aware of the possibility of PTSD in children who exhibit some or all of the following symptoms:

- nightmares and/or difficulty sleeping
- persistent sadness
- poor concentration or forgetfulness
- fears about dying before adulthood
- jumpiness or nervousness
- flashbacks of traumatic event
- play which seems to reenact traumatic event
- refusal to discuss/denial of traumatic event
- avoiding people, places, or things which may remind child of traumatic event
- forgetting important facts about traumatic event
- constant watchfulness and guardedness

Professionals working with at-risk children must also realize that childhood trauma manifests itself in a number of ways besides such overt violence as physical or sexual abuse. Of the 152 foster children in our sample, 44% with PTSD had a history of physical abuse and 11% with PTSD had a history of sexual abuse. Often overlooked by both the research and clinical communities, neglect also has a deleterious impact on children. In the Baltimore City population, an overwhelming majority (71%) of children with PTSD had a history of severe neglect. Although a subset of children had multiple reasons for entering care, many entered care solely due to neglect.

Although childhood PTSD is gaining recognition as a common sequella of neglectful or abusive environments, the standardized measurement of PTSD in children is still in its infancy. Only a handful of instruments have been developed (e.g., Briere, 1996; Eisen, 1996; Saigh, 1989; Pynoos & Eth, 1987).[1] At present, case workers and others who work on behalf of children must familiarize themselves with the behavioral manifestations of PTSD in order to identify children who may be in need of specialized services.

Treating PTSD: Some General Guidelines

As the literature demonstrates, most children placed in foster care are exposed to multiple traumatic events

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Screening Young Foster Children

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and manifest a variety of behavioral and emotional symptoms (Dubowitz, Zuravin, Starr, Feigelman, and Harrington, 1993; Hochstadt, Jaudes, Zimo, and Schachter, 1987; Kendall et al., 1995; McIntyre and Kessler, 1986). As a result of lack of adequate developmental and educational experiences, these children also typically show evidence of cognitive delays and deficits (Hochstadt et al., 1987; Kendall et al., 1995). Tragically, few foster children are referred for the appropriate mental health treatment to address these concerns (Dubowitz et al., 1993; Frank, 1980; Gruber, 1978). Those children who do receive services are generally served in traditional outpatient settings.

Perhaps because no specific symptom profile has emerged for maltreated children in general, no specific treatment protocol has been developed to treat post-traumatic symptoms in foster children. However, because of the ongoing process of emotional and environmental adjustments that result from initial and multiple placements in foster care, these children may re-experience the stressor of continued instability in their lives. Young foster children may therefore exhibit a wide range of problems, depending on the stressors to which they have been exposed. In our opinion, any treatment model for these traumatized children must be both integrated and comprehensive, combining individual, family and community-based interventions. The uniqueness of often chronic environmental instability, fear of abandonment, lack of positive parental bonding, abuse, and neglect should lead to "strategically planned therapy" for the life of the child while in foster care. That is, the therapist should gauge the effects of recovery and additional trauma based on how well the child is making personal adjustments while in placement. Furthermore, because the basic health needs of foster children have often gone unmet (Hochstadt et al., 1987; Chernoff, Combs-Orme, Risley-Curtis and Heisler, 1994) mental health treatment is contingent on addressing any outstanding medical problems.

Case workers and others who work on behalf of children must familiarize themselves with the behavioral manifestations of PTSD in order to identify children who may be in need of specialized services.

Individually-tailored treatment thus encompasses the child's physical, developmental and psychological needs. The abused foster child may need extra supports and opportunities to succeed at age appropriate tasks at school, home and with peers. Success and mastery experiences are crucial to remedying feelings of low self-esteem and helplessness. Such experiences can be achieved through school placement, tutoring, and involvement in structured peer group activities such as sports, scouts and church groups.

Individual therapy should be conducted by a mental health professional familiar with the long-term effects of child maltreatment. Trauma-focused treatment should address both re-experiencing and avoidance symptoms by encouraging the child to work through traumatic events in a safe setting. Dealing with past trauma helps the child gain some feelings of mastery over the event and his[2] feelings related to it.

Individual interventions should also address the distorted belief systems that often develop in response to traumatic stress. The abused child needs to "unlearn" that he was responsible for the precipitating traumas. Abuse also teaches children to expect that close relationships are always fraught with physical, emotional or sexual violation. Likewise, the child needs to change his concept of self and others, giving up the dual role of both protector of parents and helpless victim of abuse. Gone unchallenged, these belief systems may lead the child to reenact his traumatic history in subsequent relationships and environments.

Several coping strategies can address the symptoms related to hyper arousal, such as jumpiness, being on edge, extreme caution and emotional hyper reactivity. Self-comforting strategies such as deep breathing, progressive relaxation and "thought-stopping" may prove useful. A critical component of therapy involves encouraging the child to grieve his deep losses. As a result of abuse and neglect, most foster children have experienced multiple losses including loss of home and neighborhood, loss of family and loss of personal safety. The feelings related to the loss of a parent, even an abusive one, are complex. Therapy should help the child process these painful emotions in order to develop healthy new attachments.

Therapists should attempt to include all available sources of support — within both the family and community — in treatments tailored to the individual child's needs. Without these supports, individual therapy may be severely limited, perhaps even contraindicated. It may be detrimental to begin trauma-focused treatment with a child who does not have an adequate level of safety and stability in his home or community environment. Therapists should thus attempt to enlist the support of the child's immediate and extended family, foster parents, and social workers along with personnel from his school. In practice, rarely are all these individuals available, so therapists must work with whomever is willing and able.

continued on next page

[1] The Child Behavior Checklist (CBCL) by T. M. Achenbach has recently added a section covering posttraumatic stress disorder.

[2] We use the reflexive pronoun "his" to refer to both boys and girls.

Screening Young Foster Children

continued from page 8

Mental health professionals need to educate other professionals involved with a child's care on the profound sequellae of abuse and neglect. Unfortunately, many significant others may not understand the connection between trauma and problematic behaviors, leading to additional blame and rejection for traumatized children. In family therapy, current care givers and biological parents can learn behavioral management strategies for problematic behaviors. Family therapy may also provide a context within which parents can begin to understand how their own childhood experiences, which often included maltreatment, have affected their relationships with their children. Family members may be able to supply essential background information on the child's history and behaviors. Finally, therapists should encourage care givers to reach out to parenting groups such as Parents Anonymous. Foster parents and others entrusted with the care of traumatized children also need support both to develop the skills required to attend to the specialized needs of these children and to replenish their own resources.

Conclusion

An overwhelming number of children entering the child welfare system have been exposed to life-threatening traumas. In our sample of 152 children aged six to eight entering foster care in Baltimore, one-third met DSM IV criteria for a diagnosis of Posttraumatic Stress Disorder (PTSD). These traumatized children urgently require timely clinical interventions. Traumas such as abuse and neglect tend to produce a multitude of confusing and unsettling feelings. Young children, who are still developing a sense of self, do not have the emotional defenses to process these intense feelings on their own.

Case workers and other professionals on the "front lines" must learn both to identify children with PTSD and to arrange for appropriate referrals in the community. We advocate a community treatment model whereby the child's therapist builds bridges with other significant figures in his life such as his foster parents, biological parents, teachers and pediatrician. Ultimately, the healing process involves reconnecting the child both to his own traumatic history and to his community. As a society, we can ill afford to ignore the needs of our traumatized children because they embody our future.

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Orofacial Trauma in Child Abuse and the Role of the Dental Profession

by Howard L. Needleman, D.M.D.

Clinical Professor in Pediatric Dentistry
Associate Dentist-in-Chief
Harvard School of Dental Medicine
Children's Hospital

INTRODUCTION

When an individual is attacked for whatever reason, the head and/or facial areas are commonly involved. This is logical since these areas are exposed and the most accessible to the perpetrator. In addition, the head of the individual is considered representative of the whole being or "self". Therefore, it is not surprising that physical child abuse often involves the head and/or orofacial areas. This article will review the types and prevalence of orofacial trauma in child abuse cases and the role of the dental professional in identifying and treating such cases.

TYPES AND PREVALENCE OF OROFACIAL INJURIES

Some of the common physical features of child abuse were first described in a classic article published by John Caffey in 1946. Caffey described six infants suffering from chronic subdural hematomas who presented with multiple fractures in their long bones. In three of the six cases, orofacial injuries were noted. One child presented with swollen and hemorrhagic gums, petechiae in the oral mucosa and ecchymosis of the face. The other two children both exhibited bruises of the face (Caffey, 1946).

A frenum tear in a very young, non-ambulatory patient (less than one year) should arouse one's suspicion as to the possibility of this injury being non-accidental in origin.

Cameron, Johnson and Camps (1966) also reported on the types of injuries sustained in physically abused children. The authors examined the autopsy findings of 29 fatal cases of abuse seen over a two year period in the Department of Forensic Medicine at the London Hospital Medical College. Half of the children studied (mean age 14.3 months) had obvious bruises of the head, face, and neck. All of the children exhibited soft tissue injuries. The prevalence and location of these injuries were as follows; 79% scalp, 59% neck, 52% forehead, 49% cheek, 48% lower jaw and right leg, and 45% upper lip region. Of the 13 areas described as sustaining soft tissue trauma, the head and neck area were among the most frequently described. Lesions to the jaw and neck were well circumscribed and of a "finger-tip" character suggestive of gripping.

It is important to note that lacerations of the mucosa of the inner aspect of the upper lip near the frenum and/or the occasional tearing of the lip from the alveolar margin of the gums occurred in 45% of Cameron et al.'s cases. In no other study is such a high frequency of frenal lacerations reported, thus torn frenums should not necessarily be considered indicative of inflicted injuries as so often is the case. The age of the child presenting with a frenal laceration is significant in determining the possibility of non-accidental trauma. A frenum tear is not uncommon in the child who is learning to walk (generally between 9 - 18 months) when he/she accidentally falls. However, a frenum tear in a very young, non-ambulatory patient (less than one year) should arouse one's suspicion as to the possibility of this injury being non-accidental in origin. This type of injury may be the result of a blow to the mouth, an effort to silence a screaming child, or the forcing of a spoon or bottle into a baby's mouth by an angry parent who is frustrated at a slow eater. Cameron et al also state that bruises of the cheeks and sides of the head suggest blows or slaps with a fist or open hand. If the lesions are more localized and have underlying severe injuries, they may represent a severe blow or impact with a hard object.

Since Cameron et al's 1966 article, numerous studies have been published investigating the prevalence of orofacial trauma in abused children (Skinner and Castle, 1967; O'Neill, Meacham, Griffin and Sawyers, 1973; Baetz, Sledziewski and Margetts, 1977; Becker, Needleman, and Kotelchuck, 1978; Malcez, 1979; da Fonseca, Feigal, and ten Bensel, 1992; Jessee, 1995.) These studies report the prevalence of trauma to the head and orofacial complex to range between 44% and 86%. Most of the examinations in these studies were performed by physicians, without the involvement of dentists. The study by da Fonseca et al. (1992) had the largest sample of children (1248) and reported a prevalence of trauma to the head and orofacial complex of 75%. Malecz (1979) reported the highest prevalence (86%) presumably because it was the only study to involve dentists in the physical examination.

In reviewing the types of head and orofacial injuries sustained by physically abused children in the above studies, contusions and ecchymoses were the most prevalent injury, occurring in 37% of the cases on the average. This was followed in prevalence by bony fractures (15%), abrasions/lacerations (13%), burns (6%), subdural hematomas (3%), and dental injuries (1%).

Malcez (1979) reported the types of dental injuries seen in the 25 cases of suspected abuse reported by pediatric dentists. Fractured teeth (32%), oral lacerations (14%), fractures of the maxilla or mandible (11%), and oral burns (5%) were the principal dental injuries seen in these cases.

Only four of the large prevalence studies previously cited documented the types of intraoral/dental injuries sustained in the abused cases (Cameron et al, 1966; Becker et al, 1978; da Fonseca et al, 1992; and Jessee, 1995). When the data from these studies were combined,

continued on next page

ASSOCIATION NEWS

From the President

Veronica Abney, LCSW

I am pleased and proud to begin my term as president of APSAC's Board of Directors. It was particularly gratifying to begin my term of office at the 7th Annual Colloquium in San Antonio. This year's Colloquium was an opportunity to experience APSAC at its best. In addition to fabulous programming, the energy, spirit, cohesiveness and commitment of the membership was described by many as inspiring.

I have two goals for the organization as we head into the millennium. First, I want to improve APSAC's response to its membership. This means making sure that member requests and state chapter needs are addressed in a timely fashion. Having an experienced manager like Thom Gauthier on board as Executive Director of the organization is certain to guarantee this. Improving APSAC's response to its membership also means working with state chapters to enhance their efforts to grow and develop by partnering with them in various types of training opportunities. A large part of the success of this year's colloquium is related to collaboration between APSAC national and the Texas State chapter. Lastly, improving APSAC's response to its membership means its leaders and management staff must be more in tune with your needs. APSAC's Long Range Planning Committee has already taken steps to begin this process by hosting an open forum at the colloquium which offered the membership an opportunity to voice their needs and ideas about directions APSAC should take in the future. This same committee has also recently concluded a survey of the state chapter leadership aimed at exploring the needs of the membership.

My second goal for the organization is to increase and diversify the APSAC membership. This goal will be partly accomplished by APSAC improving its response to the membership. A better response to members translates into more members. There are currently two APSAC committees focused on issues of diversity; both will be coming up with plans and activities to make our organization more attractive and accessible to people of color, CPS and law enforcement. To further meet this goal, I will need the help of the membership at large to speak out as ambassadors for APSAC and to actively seek out new members from the disciplines and cultures that are under-represented in the organization.

I look forward to my turn to sit at the helm of the APSAC leadership team. I believe the coming year holds the potential for change and a renewed commitment to our mission to *ensure that all those affected by child maltreatment receive the best possible response.*

1999-2000 Board Elected

Congratulations and a welcome to the newly elected Board members who will serve three year terms beginning June 1, 1999: **Jon R. Conte, PhD; Robert Hugh Farley, MS; Brian K. Holmgren, JD; Robert Kirschner, MD; Cynthia Cupit Swenson, PhD; Tricia D. Williams, JD**. Incumbent Board members who were re-elected for another term include **David Cory, MSSW; Nancy B. Lamb, JD; and Thomas D. Lyon, JD, PhD.** In accordance with APSAC bylaws, the Board of Directors appointed **Terry Hendrix** to fill the final open position on the Board. Thank you to all who ran for election to the Board – APSAC is honored that so many talented and busy professionals were willing to serve.

We want to extend warmest thanks and best wishes to the Board members who rotated off the Board this May – **Catherine Ayoub, RN, EdD; Harry Elias, JD; Sandra Rosswork, PhD; Lieutenant Bill Walsh; and Beatrice Yorker, RN, JD**. We also must extend a very special note of thanks to **Diane DePanfilis, MSW, PhD** who served as President of the Board during this past year. Diane's leadership and dedication guided APSAC through an exceptional year, culminating in our most successful Colloquium to date. Thank you to Diane and all the Board members for their outstanding service to the organization.

7th A Smashing Success

With more than 1200 registrants, 150 nationally renowned faculty and 300+ sessions and poster presentations, the Seventh National Colloquium was APSAC's biggest and most successful to date. Participants worked hard, rising at 7:00am for presentations of cutting edge research at more than two dozen research breakfasts, attending the interdisciplinary training sessions, participating in Open Forums and Task Force meetings, and networking and connecting with colleagues from around the country. There was a little time in the evening for fun, and the Night in Old San Antonio Fiesta drew rave reviews from attendees who partied in lovely Alamo Plaza or wandered along San Antonio's Riverwalk.

Outgoing Board President Diane Depanfilis and David Cory, Colloquium Co-Chair.

Judy Cohen, recipient of the award for best article published in Child Maltreatment. She graciously donated her share of the prize to APSAC.

The Colloquium would not have happened without the tireless work of a group of volunteers who spent the last 13 months preparing and planning for this event. The volunteer leaders for APSAC's 1998-1999 Colloquium were **Diane DePanfilis, PhD, MSW (President), Veronica Abney, MSW (President-elect), Nancy Lamb, JD, Michele Lorand, MD (Colloquium Co-chair),** and **David Cory, MSSW**. These volunteers worked with a 15-member Colloquium planning group to design and implement the program. The members of the **Texas State Chapter** provided invaluable assistance with volunteer recruitment, special events, and on-site logistics, and a number of Texas organizations provided financial and other resources to make the Colloquium possible. Others from Texas who deserve special thanks are **Cecilia McKenzie** and **Grace Davis** from the Office of the Attorney General and **Debbie Davis** from Children's Advocacy Centers of Texas. We also thank **Betty Urbanzyk, Cindy Miller and Diane Martin** for giving so generously of their time to make the logistics of the Colloquium flow as smoothly as they did.

– Please Post –

PLAN NOW TO ATTEND

APSAC

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

Eighth Annual National

COLLOQUIUM

July 10-15, 2000

Chicago Hilton and Towers, Chicago, Illinois

Colleagues Connecting for Kids...

- *Intensive, Interdisciplinary, skills-based training seminars on all aspects of child maltreatment*
- *Field-generated skills training, Research Papers, Poster Presentations, and Symposia*
- *Networking opportunities with other professionals and APSAC members in your discipline and state*
- *A faculty of internationally recognized experts*

APSAC's Annual National Colloquium is a major source of information and research necessary for interdisciplinary professionals in the field of child abuse and neglect.

Learn...

In Paper Presentations, Poster Sessions, the Research Symposium and Open Forums, the most up-to-date and relevant research and practice information is discussed.

Network...

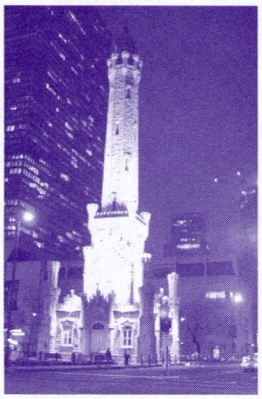
The Colloquium is where interdisciplinary members and other leaders in the field of child maltreatment join forces to advance best practice.

CALL FOR ABSTRACTS INSIDE

Abstract Submission Deadline: October 8, 1999

APSAC's Eighth Annual National Colloquium

July 10-15, 2000 at the Chicago Hilton and Towers, Chicago, Illinois



Join your colleagues in the vibrant city of Chicago for the most energizing professional training of your career!

The exciting city of Chicago is the setting for APSAC's Eighth National Colloquium, to be held when the city is in full swing for summer. The food fair "Taste of Chicago," free concerts in Grant Park, summer waterfront activities, Michigan Avenue's magnificent mile, and special exhibits at the Art Institute, Field Museum, and Shedd Aquarium all are within an easy walk of the conference hotel.

CALL FOR ABSTRACTS:
Submissions must be received by October 8, 1999

APSAC is soliciting abstracts for both training and research presentations at its Eighth Annual National Colloquium, one of the field's premier forums for child maltreatment professionals to offer training presentations and report new research findings concerning legal, medical, mental health, investigative, preventive, and protective services work with abused and neglected children, their families, and perpetrators of abuse. Presentations are encouraged on all aspects of child maltreatment.

Cultural Diversity Institute:

APSAC encourages abstract submissions for its Pre-conference Institute on Cultural Diversity. Training seminars should be designed to help the professional acquire the needed skills to work with diverse populations and to understand the impact of culture on the individual's experience of child maltreatment. Presentations should be geared towards giving participants the opportunity to hear from leaders in the field and to move towards cultural competence. (Be sure to identify your preference to present as part of the Cultural Institute on the Abstract Submission Form)

Types of Presentations:

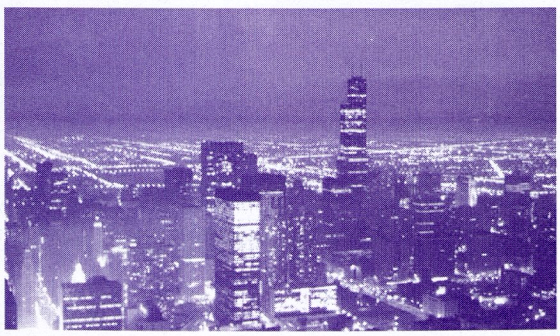
Presentations should be designed for professionals at all levels in the field of child maltreatment and should be based upon the best scientific research, legal research, and practice knowledge available. Presentations can be for either a research or practice audience. Abstracts of training presentations should include adequate descriptions of the content and format of the presentation, its educational objectives, and the proposed teaching methods to be used. Research presentations should include appropriate descriptions of the research questions, methods, and results. For further information, call the training department at 312/554-0166.

TRAINING SEMINAR (Practice only): Skills-building seminars designed to teach professionals innovative and scientifically based practice skills (90 minutes).

SYMPOSIUM (Research or Practice): Related presentations by several speakers on a single topic. Presentations may be reports of research, practice and program innovations, or a combination. Symposium presentations often present diverse points of view (90 minutes).

POSTER PRESENTATION (Research or Practice): Poster display of research, practice, or program innovations providing the opportunity for extended discussion with conference participants.

PAPER PRESENTATION (Research only): Oral presentations of previously unpublished results from an original research study (30 minutes).



Please send me:

- ☐ Information about APSAC's 8th National Colloquium in Chicago, Illinois
- ☐ Information on other training opportunities
- ☐ Information on becoming a member of APSAC
- ☐ APSAC's Professional Publications Catalog
- ☐ Information on Exhibiting at the Colloquium

Name/Degree: _____ Title _____

Affiliation: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

E-mail: _____

Please return this form to APSAC's Training Department, 407 South Dearborn Street, Suite 1300, Chicago, Illinois 60605
Phone: (312) 554-0166 • Fax: (312) 554-0919 • E-mail: APSACEduc@aol.com or visit our website at: www.apsac.org

ABSTRACT SUBMISSION FORM (Side One) SUB ID#_____(Office use only)

Type of presentation: (Circle) Training seminar Symposium Research Paper Poster

If your abstract has been submitted for another type of presentation, are you willing to present as a poster? Yes No

Please consider my abstract for the Pre-conference Institute on Cutural Diversity. (Circle) Yes No

Primary Presentation Format: (Circle) Research Practice Both

For what category is your presentation primarily intended? (Please circle one)

Mental Health	Medicine & Nursing	Cultural Diversity
Law	Law Enforcement	Child Protection/Child Welfare
Prevention	Interdisciplinary	Advocacy/Policy/Management

Title of Presentation: _____

Confine your abstract to the space below, in no smaller than 11-point font. To be considered Abstracts must identify at least four educational objectives guiding the presentation. If cultural issues are relevant, indicate in abstract how they will be addressed.

Educational Objectives (Please specify at least 4):

Do not write below this line

Reviewer's initials:_____

Rating:	Poor				Excellent	Comments:
Importance of subject matter	1	2	3	4	5	
Organization of presentation	1	2	3	4	5	
Rigor	1	2	3	4	5	
Are cultural issues adequately addressed?	Yes		No		Not Applicable	

Not Acceptable (circle)

ABSTRACT INFORMATION FORM (Side Two)

SUB ID#_____(Office use only)

(Please Type or Print)

Title of presentation: _____

Lead Presenter:

First name: _____ Last name: _____ Degree: _____

Academic/Professional/Clinical Title: _____

Affiliation: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

APSAC Member: Yes _____ No _____ Member ID _____

Co-Presenter: (if more than one co-presenter, please use additional sheet)

First name: _____ Last name: _____ Degree: _____

Academic/Professional/Clinical Title: _____

Affiliation: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

APSAC Member: Yes _____ No _____ Member ID _____

***PLEASE NOTE:** Correspondence regarding this abstract submission will be directed to the lead presenter. Lead and co-presenters whose abstracts are accepted will receive a discount on the full conference registration fee. All presenters are expected to attend the Colloquium. APSAC does not pay any conference or travel expenses for presenters. Presenters are responsible for their own travel arrangements.

Submission Requirements: (please submit)

- Six copies of the completed abstract information and submission form (both sides/double-sided). **(Please provide complete and clear contact information for lead and co-presenters.)**
- Six copies of the completed abstract submission form (side one only).
- **One copy of the abstract with title, contact information and educational objectives on plain white paper with 1" margins, in no less than 11 pt. font. (For inclusion in program book, if accepted)**
- One copy of curriculum vitae for all presenters.
- Two self-addressed, stamped envelopes or postcards for acknowledgment of abstract receipt.
- One copy of brief biography (bio should include a listing for all presenters, on one page).
- **Faxed or e-mailed submissions are not acceptable.**

Submissions must be received by October 8, 1999 to be considered.

American Professional Society on the Abuse of Children
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If you have received more than one copy of this announcement, please help us spread the word by giving extras to friends and colleagues!

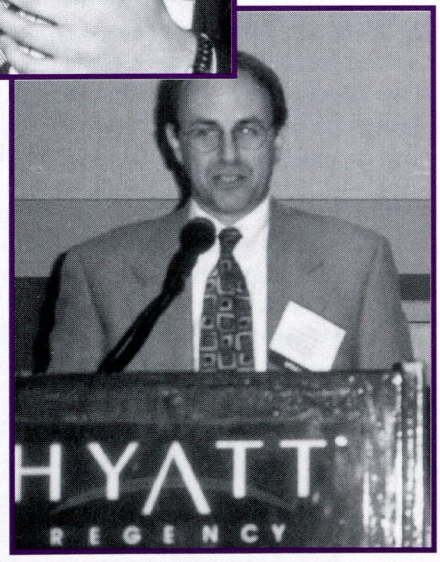
Annual COLLOQUIUM

The media coverage was very positive, with reporters from the local television and radio stations, as well as San Antonio and Austin newspapers covering the Colloquium. We reached across the border as well, with a Mexico-based reporter covering the conference.

It was a very busy week in San Antonio - in addition to the Colloquium, the APSAC's fourth Forensic Interview Clinic was held at Southwest Texas University. The 60+ professionals who completed the clinic gave it very positive reviews. Our deep thanks to Kee MacFarlane, Melissa McDermott, Kathleen Coulborn Faller and all the faculty and volunteers who make this clinic possible.

Diane DePanfilis, Veronica Abney, David Cory and the "Believe In Me" dancers who entertained at the Cultural Institute Luncheon.

Newly elected APSAC Board member Brian Holmgren.



Richard Gelles, PhD, recipient of the 1999 Research Career Achievement Award.

Board member Mike Johnson at the NIOSA Festival.

From the Executive Director

Thomas Gauthier, CAE, ACSW

I am honored and delighted to have been selected as APSAC's Executive Director. As a professionally trained social worker, I hold values that mirror APSAC's and I am strongly committed to APSAC's mission to ensure that everyone affected by child abuse and neglect receives the best possible professional response. I look forward to working in partnership with the Board of Directors, appointed leaders, and members to achieve APSAC's goals.

The challenges presented by the current organizational and resource realities offer a wonderful opportunity to fine-tune the workings of APSAC. The Strategic Planning Committee's work will be critical in this coming year to help sharpen and focus APSAC's focus and priorities. My preliminary longer term vision for APSAC includes a strong National office with the capacity to respond in an efficient, timely, and effective manner to member and chapter needs; a strong network of state chapters, forming the grassroots outreach to members through local programming; a strong public policy/advocacy program supported by the national office and implemented with chapter support, utilizing the research and expertise of members; a highly energized, expanded, and diverse membership; a strong resource development effort contributing major resources to the association, thereby reducing the reliance on membership dues; strong, innovative, and creative partnerships with other national organizations, agencies, and educational institutions leveraging the name, visibility and capacity of APSAC; a large vibrant National Colloquium and expanded training opportunities in partnership with chapters; an expanded publication/non print media program leveraging the expertise of members' research and writing capacities; and a model website serving APSAC members and non members.

Refining APSAC's ability to deliver services to members in order to implement this vision will require a strong partnership amongst staff, members, and elected and appointed leadership. At its recent meeting in conjunction with the Colloquium, the Board of Directors adopted a budget and plan designed to incrementally move APSAC forward. At this meeting, the Board adopted the FY 2000 budget of $1,162,950 in revenues and $1,116,441 in expenses; received the FY 97-98 Audit and requested that the Finance Committee develop and monitor a plan to address the Auditor's recommendations; authorized resources to implement a staff reorganization plan designed to improve services to members and chapters; approved a plan to develop expanded Advanced Institutes in collaboration with state chapters and committed board members' expertise to provide the training. The Board also approved a membership recruitment and retention plan which includes promoting and supporting state chapter recruitment efforts, utilizing board members and advisory board members as individual recruiters, partnering with selected national organizations, reactivating the individual member Ambassador program, and developing a greater presence in Illinois by working more closely with APSAC Illinois. The site for the 2001 Colloquium was also selected – the Colloquium will be held in the Washington DC metro area. Details, including precise location and dates of the conference will follow shortly.

Y2K Bug Bites APSAC's Membership Database

For the last 18 months, APSAC has experienced continuing problems with the database program we use to track our members. After several months of alarming drops in membership numbers, it was discovered that the system we had been using was not Y2K compliant, and therefore any members whose memberships were scheduled to lapse in the year 2000 or beyond were not being recognized as active members. Once the problem was discovered, staff took immediate steps to rectify the situation and provided members with missing copies of the *Advisor and Child Maltreatment*. If you continue to have problems receiving your APSAC materials, please contact Cynthia Steele in the Membership Services department, via phone (312-554-0166), fax (312-554-0919) or email (APSACMems@aol.com). We are committed to providing our members with top quality customer service and we sincerely apologize for any inconvenience these problems have caused. Thank you for your patience.

Board Members, both Chapter and National, provide the leadership to guide APSAC. Special thanks go to this past year's Executive Committee and in particular Diane DePanfilis, outgoing President, who provided extraordinary contributions of time and energy to shepherd APSAC through the staff transitions. Welcome and congratulations to incoming President Veronica Abney and the new and re-elected board members including Jon Conte, Robert Farley, Robert Kirschner, Nancy Lamb, Thomas Lyon, Brian Holmgren, David Cory, Cynthia Swenson, and Tricia Williams.

Questions or comments, contact Thom Gauthier at APSACExec@aol.com

Orofacial Trauma in Child Abuse

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only 2.4% (71/2,910) of the injuries sustained by the 1,774 child were intraoral. Soft tissue trauma to the intraoral tissues (lacerations, ecchymoses) was by far the most common type, with tooth injuries and jaw fractures occurring much less often. Again, in considering this low prevalence of intraoral injuries, it is important to remember that non-dentists were performing the examinations and recording the injuries noted in the physical examination of the children. Therefore, it can be assumed that a higher prevalence of intraoral injuries might actually be present in non-accidental trauma.

The oral cavity is a frequent site of sexual abuse in children (Kenney and Clark, 1992). The presence of oral and perioral gonorrhea or syphilis in a prepubertal child mandates an evaluation for sexual abuse. Unexplained erythema or petechia of the palate, particularly at the junction of the hard and soft palate, may be evidence of forced oral sex. Oral or perioral condylomata acuminata may also be a sign of sexual contact (Seidel, Zonanao and Totten, 1979).

Children who are abused are eight times more likely to have untreated, decayed permanent teeth than are nonabused children (Greene, Cassock, and Aaron, 1994). Therefore, it is important that these children be referred to the proper dental screening as part of their overall case management.

For more than three decades, organized dentistry has been involved in efforts to increase detection and reporting of abused children by dentists, hygienists, dental assistants and other dental support staff.

In summary, these studies demonstrate that 1) trauma to the head and associated areas occur in over half of the cases of physical abuse to children; 2) soft tissue injuries (most frequently bruises) are the most common injury sustained to the head and orofacial complex; and 3) injuries to the upper lip and maxillary labial frenum may be a characteristic lesion in the severely abused non-ambulatory child. Given the large number of children abused every year, it is obvious that dental professionals are in a position to detect substantial numbers of abused children.

THE DENTAL PROFESSION'S INVOLVEMENT

In all 50 states, dentists are required by law to report suspected cases of child abuse and neglect to social service or law enforcement agencies (Mouden and Bross, 1995). For more than three decades, organized dentistry has been involved in efforts to increase detection and reporting of abused children by dentists, hygienists, dental assistants and other dental support staff. Numerous articles have appeared in the dental literature alerting the profession to its moral and legal responsibility as health professionals to recognize and report child abuse.

There are numerous case reports in the dental literature in which the dentist was the professional who initially suspected that injuries involving a child's orofacial structure were the result of physical abuse. Most of these cases involved severe head and orofacial injuries which resulted in hospital admission or death. Therefore, it can be assumed that less severe non-accidental trauma cases appear in medical and/or dental outpatient office settings. These cases may go undetected by the dentist or physician due to their lack of suspicion and/or lack of knowledge of child abuse and neglect.

The first evidence of a lack of reporting of child abuse by dentists appeared in the Journal of the American Dental Association in 1967 ("Child Abuse Reporting Laws," 1967). In this short article, reports of child abuse in the states of New York and Illinois were documented. During 1966 in New York, 416 cases of suspected child abuse were reported; 85% of these reports came from hospitals, 12% from physicians and no reports came from dentists. Illinois records indicate that 934 reports of child abuse were received between 1965 and 1967, only one of which was from a dentist. The first large-scale study investigating the dentist's involvement with child abuse was published by Becker et al in 1978. As a result of this paper the dental profession began to actively address the lack of dentists' involvement in the recognition and reporting of such cases.

Becker et al (1978) sent questionnaires to all pediatric dentists, all oral surgeons and one-third of all general dentists in Massachusetts. Based on 537 responses, the following observations were made:

1) Eight percent of all dentists responding saw suspected cases of child abuse (22% of oral surgeons and 18% of pediatric dentists).

2) Of the 22 suspected cases of child abuse seen, only four cases were actually reported. The main reason cited for non-reporting was that it was difficult to confirm these suspicions.

3) Only 45% of dentists were aware of their legal responsibility to report suspected cases of child abuse (77% of the pediatric dentists and 62% of the oral surgeons).

4) Only 28% of dentists knew the name of the agency to which to report these cases.

5) Although oral surgeons and pediatric dentists represented 15% of the respondents to the questionnaire, they saw 41% of the suspected cases and 59% of the definitive cases of child abuse.

Since that time other studies have been published substantiating the minimal extent to which dentists are involved in reporting cases of child abuse (Davies et al. 1979; Malcez 1979; Blain et al 1979; Blain et al 1982; Ramos-Gomez, Rothman, and Blain, 1998). These sur-

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Orofacial Trauma in Child Abuse

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veys clearly demonstrate that dentists 1) do see cases suspicious for child abuse, 2) often fail to report their suspicions as is legally required, 3) do not have adequate training or knowledge of child abuse and neglect, and 4) if made aware of child abuse and neglect and their responsibility to report, identification and subsequent reporting of these cases by dentists would increase.

Organized dentistry has developed policies and programs to encourage its membership to improve the detection and reporting of child abuse. As early as 1979, the American Dental Association (ADA) developed a policy to encourage its members to be more mindful of their responsibilities in regard to the professional and legal aspects of child abuse. In 1993 the ADA added this responsibility to its *Principles of Conduct and Code of Ethics* stating, "Dentists shall be obliged to become familiar with the perioral signs of child abuse and to report suspected cases to the proper authorities consistent with state law." (American Dental Association, 1995, p. 7) The ADA's Council on Dental Practice has published a booklet for the ADA members entitled "The Dentist's Responsibility in Identifying and Reporting Child Abuse and Neglect", now in its third edition. This document offers guidance for dentists on their role in detecting and reporting child abuse. In addition, it outlines each state's reporting statutes as they relate to dentists, lists each state's reporting agencies, and provides a comprehensive bibliography.

As early as 1979, the American Dental Association (ADA) developed a policy to encourage its members to be more mindful of their responsibilities in regard to the professional and legal aspects of child abuse.

In 1990, Massachusetts become the first state to develop an organized statewide program to educate its dental professionals on the clinical, legal and reporting issues related to child abuse (Needleman, Mac Gregor, and Lynch, 1995). The program was developed and implemented by a coalition of government, private, educational and professional organizations interested and knowledgeable in these issues. This coalition became a model for the successful nationwide program entitled "Prevent Abuse and Neglect through Dental Awareness (PANDA) Coalition" which started in Missouri in 1992. Since that time the program has been established in 34 states in the United States and is now being established in other countries as well. Evidence is slowly mounting documenting the success of these statewide efforts (American Dental Association, 1994). In Missouri, the number of reports by dentists rose by 60% following the year of PANDA's educational and awareness campaign and after four years the reporting rate by dentists had risen by 160% (Mouden, 1998). Most recently, other types of non-accidental trauma such as spousal/partner abuse and elder abuse have been added to the mission of these state coalitions.

SUMMARY

Orofacial trauma is extremely common in cases of child abuse. The dental profession thus has a key role to play in the evaluation and detection of non-accidental trauma to children. Through education and awareness campaigns, dental professionals are increasing their awareness of all types of family violence and their responsibilities to detect and report such cases.

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APSAC AWARDS

Professionals who work on behalf of maltreated children often toil long hours, with low pay and little recognition for the critically important role they play in the lives of children. The annual APSAC awards offers an opportunity for particularly outstanding individuals to receive recognition for their labors from their peers. In addition to recognizing excellence in the field of child maltreatment, the annual awards ceremony thanks those volunteers who give so generously of their time and expertise to the organization and the field, and honors the commitment of all who chose, as their life's work, to care for children.

OUTSTANDING PROFESSIONAL

John Briere, PhD

For outstanding contributions to the field of child maltreatment service and to the advancement of APSAC's goals.

OUTSTANDING SERVICE

Susan Kelley, RN, PhD

For outstanding contributions to APSAC through leadership and to the Society.

RESEARCH CAREER ACHIEVEMENT

Richard Gelles, PhD

For repeated, significant, and outstanding contributions to research on child maltreatment.

OUTSTANDING RESEARCH STUDY

Jocelyn Brown, Patricia Cohen, Jeffrey Johnson and Suzanne Salinger

for their article " 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 and Neglect 22: 1065:1078

DISSERTATION AWARD

Suzanne L. Davis, PhD

"Effect of Social Support on Children's Eyewitness Reports"

Rebecca Bolen, PhD

"Development of an Ecological/Transactional Model of Sexual Victimization and Analysis of its Nomological Classification System"

MEDIA AWARD

Warren Cornwall

Idaho Falls Post Register for the series "Lost Innocents"

PRESIDENT'S HONOR ROLL

The President's Honor Roll was created as a way to thank those APSAC members who have made contributions of time and effort far beyond the call of duty. Only fifteen out of APSAC's more than five thousand members are named to the Honor Roll each year. An organization is only as strong as its members: the extraordinary efforts of these individuals are central to APSAC's success, and are deeply appreciated.

Bette Bottoms, PhD (IL)
Debra Brown, BA (TX)
Grace Davis, LMSW-ACP (TX)
Ron Laney, MA (DC)
Giselle Ferretto Meek, LCSW-C (MD)
Cindy Miller (AL)
Susan Moan-Hardie, RN, PhD (CA)
J. Tom Morgan, JD (GA)
Patricia Myers, LCSW (NJ)
Benjamin Saunders, PhD (SC)
Daniel Smith, PhD (SC)
John Stirling, MD (WA)
Linda Williams, PhD (MA)
Charles Wilson, MSSW (AL)
Joseph Youngblood (RI)

Look for the 2000 Awards nomination form in the January issue of the Advisor!

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 843 792-2945) e-mail: hansonrf@musc.edu.

SEXUAL ABUSE

History of Child Sexual Abuse Affects Coping of Adult Rape Victims

One-hundred-nineteen undergraduate females participated in a study examining the roles of child sexual assault, attributions, and coping on adjustment to rape. Participants completed anonymous questionnaires that assessed for child sexual abuse history, adult victimization history, attributions of blame for the adult assault, coping strategies for the adult rape, and trauma symptoms. Rape victims with a history of child sexual abuse were found to have higher levels of trauma symptoms, made greater use of nervous and cognitive coping strategies, and were more likely to make attributions of blame towards themselves or society. Current symptoms were related to types of coping and attributions of blame, with history of child sexual abuse having an indirect relationship to these variables. The results suggest the importance of attributional and coping variables, as well as child sexual abuse history, as mediators of post-rape adjustment.

Arata, C.M. (1999). Coping with rape: The roles of prior sexual abuse and attributions of blame. *Journal of Interpersonal Violence. 14(1)*, 62-78.

Update to AAP Guidelines for Evaluating Child Sexual Abuse

This statement serves to update guidelines for the evaluation of child sexual abuse first published in 1991. The role of the physician is outlined with respect to obtaining a history, physical examination, and appropriate laboratory data and in determining the need to report sexual abuse.

Guidelines for the evaluation of sexual abuse of children: subject review. American Academy of Pediatrics Committee on Child Abuse and Neglect. *Pediatrics, 103(1)*:186-91.

Effect of Child Sexual Abuse on Adult Attachment Style

This article investigated the nature of the relationship between child sexual abuse, adult attachment style, and psychological adjustment, as measured by the Trauma Symptom Inventory. Participants were 307 female university students, including 85 women with a history of child sexual abuse. Results indicated that a history of child sexual abuse predicted both psychological adjustment and adult attachment style, and that adult attachment style predicted psychological adjustment. In addition, a mediational model in which attachment mediates between child sexual abuse and later psychological adjustment was supported. Results are discussed in terms of implications for conducting therapy with child sexual abuse survivors.

Roche, D.N. Runtz, M.G., Hunter, M.A. (1999). Adult attachment: A mediator between child sexual abuse and later psychological adjustment. *Journal of Interpersonal Violence, 14(2)*, 184-207.

Incidence and Characteristics of Child Sexual Abuse in African-American and European Women

This paper examined the prevalence of child sexual abuse of African-American and European-American women living in Los Angeles and compared the circumstances of these incidents to data collected a decade ago. Incidents of contact abuse were obtained from women aged 18-36 years in 1994 and compared to women with those demographic characteristics from a comparable 1984 data set. The prevalence of abuse, characteristics of the victim, assault, alleged perpetrator, disclosure, and long-term effects by ethnic group affiliation were assessed. Of the total sample, 34% reported at least one incident of sexual abuse prior to age 18. Results show that European-American women had a higher prevalence of abuse, reported being abused more in public environments, and reported more incidents of attempted or completed rape than did African-Americans. While comparisons made with the 1984 data set revealed no significant difference in prevalence rates over the 10-yr period, changes in circumstances (e.g., location of abuse, severity of incidents, and length of time in which abuse occurred) were noted. How these differences can help better tailor prevention messages to different communities is discussed.

Wyatt, G.E., Loeb, T.B., Solis, B., Carmona, J.V. & Romero, G. (1999). The prevalence and circumstances of child sexual abuse: Changes across a decade. *Child Abuse & Neglect, 23(1)*, 45-60.

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Journal Highlights

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PHYSICAL ABUSE

Parental Attitudes and Discipline Practices Link to Physical Abuse

This paper examined factors that place parents at risk of abusing their children by predicting parents' use of discipline practices and attitudes that may bias parents towards abusive behaviors. A telephone interview was administered by the Gallup Organization to a nationally representative sample of 1,000 parents (aged 18-72 years). Using a set of theoretically relevant risk factors, multiple regression was used to predict variations in parental attitudes and parental discipline practices. Results confirm the importance of examining elements of parental attitudes, history, personality characteristics, child age, religion, and ideology in predicting abuse proneness.

Jackson, S., Thompson, R.A., Christiansen, E.H., Colman, R.A., Wyatt, J., Buckendahl, C.W., Wilcox, B.L., & Peterson, R. (1999). Predicting abuse-prone parental attitudes and discipline practices in a nationally representative sample. ***Child Abuse & Neglect, 23(1)*****, 15-29.**

Abusive Head Trauma Often Missed: A Review of 173 Cases

This study involved a retrospective chart review of cases of abusive head trauma (AHT) in children younger than 3 years evaluated at a children's hospital during a 6-year period. At the time of injury, children were evaluated by the hospital's interdisciplinary Child Advocacy and Protection Team (CAP Team). During the retrospective review, charts were examined to determine what factors were associated with a missed versus a recognized diagnosis. The study sample included 173 abused children with head injuries. Of the 173 subjects with AHT, 54 cases (31.2%) were classified as missed. For these 54 cases, the mean number of physician visits before the trauma was recognized was 2.8 (range 2-9 visits). Compared to children whose diagnosis was recognized on the first visit, misdiagnosed cases were much younger, more often white, and more often living with both parents. The more severely symptomatic children were more likely to be recognized as having AHT at first visit to the physician. Using a multivariate logistic model, 4 independent variables predicted the correct diagnosis of AHT at the 1st visit: abnormal respiratory status, seizures present, facial and/or scalp injury, and parents not living together. Suggestions for facilitating the correct diagnosis of AHT are included.

Jenny, C., Hymel, K. P., Ritzen, A., Reinert, S.E., & Hay, T.C. (1999). Analysis of missed cases of abusive head trauma. ***JAMA: Journal of the American Medical Association, 281(7)*****, 621-626.**

OTHER ISSUES IN CHILD MALTREATMENT

Addressing the Traumatic Memory Controversy

Perhaps no other topic in recent history has generated such emotion as the ongoing traumatic memory debate involving alleged reports of physical and sexual abuse. The literature on this topic is replete with reliance on anecdotal statements, unwarranted and grossly overstated generalizations, emotionally laden conclusions, attacks and counter-attacks. This state of affairs has resulted in polarization between cognitive memory researchers and clinical researchers who are attempting to resolve the debate through scientific inquiry. The purpose of this article is to highlight the key issues at the center of this debate in an attempt to move the debate forward. It is argued that resolution of this debate can only be achieved by conducting appropriately designed clinical research with a population of traumatically abused subjects.

Levis, D.J. (1999). The traumatic memory debate: A failure in scientific communication and cooperation. ***Applied & Preventive Psychology, 8(1)*****, 71-76.**

Child Maltreatment Linked to Higher Likelihood of Adult Sexual Victimization

A sample of 30 female college students who reported unwanted sexual experiences judged to constitute date rape was compared with 133 controls who reported no rape. Compared to controls, the date-rape group had significantly higher scores on a measure of overall childhood stress and maltreatment and scored significantly higher on the principal subscale of that measure, which assesses negative home environment/neglect. Date rape participants were also more likely to have experienced sexual abuse in childhood; however the relationship between date rape and other negative childhood experiences remained significant after sexual abuse was partialled out. Thus, forms of maltreatment that are not specifically sexual are also associated with an increased likelihood of sexual victimization later in life. Maltreatment was significantly associated with dissociation, depression, and other psychological symptoms of trauma. Findings are consistent with a model in which the psychological consequences of trauma increase the likelihood of later traumatic experiences.

Sanders, B., Moore, D.L. (1999). Childhood maltreatment and date rape. ***Journal of Interpersonal Violence, 14(2)*****, 115-124.**

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Medical Director Wanted

Interested in joining an award-winning health care team that puts kids first? St. Luke's Children's Hospital, located in the state capital of Boise and set near the scenic Sawtooth Mountains, seeks a medical director for its *Children At Risk Evaluation Services Program* (CARES). Responsibilities include clinical care of abused and neglected children, strong focus on outreach education, providing resources and consultation for our catchment area, and continuing the development of statewide MDT protocols. This leadership position requires ability to interface with other disciplines, team coordination as well as political advocacy for programs that address child maltreatment. Interest in clinical research is desired. St. Luke's provides clinical services to a three-state area and a population of over 700,000 people (30% children). Idaho's only children's hospital, St. Luke's has a dedicated and growing commitment to quality pediatrics resources. We have a medical staff of over 20 pediatric subspecialists, Level III NICU and PICU, and a new Children's Outpatient Speciality Center. St. Luke's family practice residency is affiliated with the University of Washington system and a member of the Northwest Consortium of Child Advocacy Centers. Please forward letter of inquiry and CV to:

Jerome A. Hirschfeld, MD
Administrator of Children's Services
St. Luke's Children's Hospital
190 E. Bannock, Boise, ID 83712
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CONFERENCES

APSAC Discount

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

October 11-14, 1999. ***Midwest Conference on Child Sexual Abuse and Incest.*** Madison, WI. Sponsored by University of Wisconsin and Family Sexual Abuse Treatment Inc. Call 608-263-5130.

January 24-28, 2000. ***San Diego Conference on Responding to Child Maltreatment.*** Sponsored by Center for Child Protection. Call 619-495-4940.

March 7-10, 2000. ***The Sixteenth National Symposium on Child Sexual Abuse.*** Huntsville, AL. Sponsored by the National Children's Advocacy Center. Call 256-534-1328.

July 10-15, 2000. ***APSAC's 8th National Colloquium.*** Chicago, IL. Sponsored by the American Professional Society on the Abuse of Children. Call 312-554-0166.

Upcoming Conferences

July 25-28, 1999. ***Sixth International Family Violence Research Conference.*** Durham, NH. Sponsored by the Family Research Laboratory at he University of New Hampshire. Call 603-862-3541

July 25-28, 1999. ***Working with America's Youth: Your World of Possibilities.*** Minneapolis, MN. Sponsored by the National Resource Center for Youth Services. Call 918-585-2986.

August 2-4, 1999. ***Moving Mountains to Close the Gap: Tenth Biennial Conference.*** Seattle, WA. Sponsored by the National Healthy Mothers, Healthy Babies Coalition. Call 703-836-6110.

August 2-5, 1999. ***Eleventh Annual Crimes Against Children Conference.*** Dallas, TX. Sponsored by the Dallas Children's Advocacy Center. Call 214-818-2600.

August 9-13, 1999. ***Investigation and Prosecution of Child Abuse.*** Tucson, AZ. Sponsored by the National Center for Prosecution of Child Abuse. Call 703-739-0321.

August 18-20, 1999. ***Honoring and Preserving Family Ties: Second National Kinship Care Conference.*** Atlanta, GA. Sponsored by the Child Welfare League of America. Call 202-942-0318.

September 8-10, 1999. ***Seventh Oklahoma Conference on Child Abuse and Neglect.*** Tulsa, OK. Sponsored by the Center on Child Abuse and Neglect, University of Oklahoma Health Sciences Center and the Office of Child Abuse Prevention Oklahoma State Department of Health. Call 405-271-8858.

September 15-18, 1999. ***Growing Pains 1999 – Annual National Independent Living Conference.*** Atlanta, GA. Sponsored by the Daniel Memorial Institute and the National Independent Living Association. Call 800-226-7612.

September 30 – October 1, 1999. ***Child Protection: Our Responsibility.*** Cedar Rapids, IA. Sponsored by the St. Luke's Child Protection Center. Call 319-369-8136.

October 10-13, 1999. ***Bridging the Gap for Children: 29th Annual Conference.*** Houston, TX. Sponsored by the National Black Child Development Institute. Call 202-387-1281.

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.

October 18-19, 1999. ***New England Conference on Child Sexual Abuse.*** Burlington, VT. Sponsored by the State of Vermont Agency of Human Services. Call 802-479-4260.

October 14-15, 1999. ***Fifth National Roundtable on Managed Care in Child Welfare Services.*** St. Petersburg Beach, FL. Sponsored by Child Welfare League of America. Call 303-792-9900.

November 3-5, 1999. ***Early Years: Critical Years for Idaho Children.*** Boise, ID. Sponsored by the Idaho Department of Health & Welfare Family & Children Services. Call 208-334-0674.

November 15-17, 1999. ***Northeast Child Maltreatment Conference.*** Providence, RI. Sponsored by MAPSAC and the Massachusetts Society for the Prevention of Cruelty to Children. Call 617-636-0972.

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

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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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As a non-profit organization, APSAC depends on the support of members to continue our mission of ensuring that everyone affected by child abuse and neglect receives the best possible professional response. Revenue from membership dues covers less than 40% of our annual operating budget - the balance comes from Colloquium and other training registrations, publications and the generous support of donors who believe in the work we are doing together.
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