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Introduction: Medical Assessment of Sexual Abuse in Children

Lori D. Frasier, MD, FAAP

This issue of the *APSAC Advisor* includes two articles regarding the medical assessment of sexual abuse in children. The first article, "Child Sexual Abuse: Are Health Care Providers Looking the Other Way?" by Sheila Savell, is reprinted from the Summer 2005 issue of the *Journal of Forensic Nursing.* Savell gives a brief review of the literature regarding medical assessments for sexual abuse and also offers basic guidelines for health care providers to improve recognition and reporting on child sexual abuse.

The article segues nicely into the most recent version of Dr. Joyce Adams' assessment guidelines for the medical evaluation of sexual abuse. Dr. Adams and colleagues have produced a 2005 revision of her well-known assessment system. Readers familiar with this system will immediately notice a change in the title. The revised document is titled "Approach to Interpreting Physical and Laboratory Findings in Children With Suspected Sexual Abuse: 2005 Revision"—the term "classification system" has been dropped. This reflects efforts by Dr. Adams and colleagues to reformulate the assessment guidelines within an evidence-based framework. Within this context, clinicians should not use these guidelines as a "check the box" or "cook book" approach to the analysis of physical findings in children and adolescents being evaluated for alleged sexual abuse. Rather, this document is a tool, a framework, or a paradigm to assist professionals in evaluating, teaching, and formulating, their opinions.The revised document has been developed following more than 3 years of meetings at various child abuse conferences, such as the San Diego Child Maltreatment Conference and annual meetings of the Ray Helfer Society. These meetings were designed to promote consensus on the contents of the document. The nation's most experienced physicians, nurse practitioners, nurses, and other clinicians were involved in the revisions and in reformatting the former classification system. Dr. Adams has worked diligently in a spirit of collegiality and openness to include new data and expert opinions. Because of the consensus model, it is expected that this document will receive wide acceptance by clinicians.

Most clinicians recognize that the diagnosis of sexual abuse rarely relies on medical findings, as they are absent in the vast majority of cases. The history from the child remains the most important piece in the assessment process. How that history is obtained, documented, and integrated with the medical evaluation and other components of the protective services assessment remains an area of tremendous interest and fertile research. While no longer an integrated part of Dr. Adams' assessment guidelines, obtaining the child's history must be accomplished with skill and compassion.

When an earlier revision of these assessment guidelines was published to replace prior versions, the question that concerned most experts was whether they should go back and reclasify their findngs according to the new system. Research studies published in the last 15 years have challenged and changed our approach to evaluating child sexual abuse, resulting in a better understanding by medical professionals of both normal anatomy and of findings considered to be sequelae of sexual trauma. Medicine is not static, and child abuse medicine is no different. It continues to advance, as research provides new information about disease and treatment. Further, no single study or publication is sufficient to provide conclusive data. Consequently, clinicians performing medical assessments of sexual abuse should always question their process, and rather than using these guidelines as a classification system to pigeonhole findings, medical professionals should consider this document as a reference tool. The clinician should read and independently analyze the articles that are referenced, and those articles should be at hand to be reanalyzed in light of new studies.

Updated information will continue to modify our approach to patients. When tempted to consider a specific finding as abnormal and a sequelae of abuse, clinicians need to be critical thinkers, asking themselves, "What is the evidence for this? Is there a differential diagnosis to consider? Is there another explanation?" Less experienced clinicians should develop relationships with experienced colleagues who can provide advice and can assist in case review. In all of this difficult work, the protection of children is crucial, as is the defense of the innocent. Medical providers are the guardians of the science in their field—no one else can do this.

About the Author

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Child Sexual Abuse: Are Health Care Providers Looking the Other Way?

Shelia Savell, MSN, RN

Child sexual abuse (CSA) is defined as any sexual activity with a child when consent is not or cannot be given; it includes sexual penetration, sexual touching, exposure, and voyeurism (Berliner, 2000; Finkelhor, 1979). Child sexual abuse is a crime and all states have laws related to CSA that specify the age at which an individual can consent to sexual contact, usually between 14 and 18 years (Myers, 1998). In addition, every state mandates that professionals, including physicians and nurses, report suspected child abuse to child protection agencies. The mandate does not require the ability to prove the suspicion, only that reporting must occur any time there is suspicion of CSA. However, multiple studies have demonstrated that professionals do not always report suspected child abuse (Delaronde, King, Bendel, & Reece, 2000; Horner & McCleery, 2000; Ladson, Johnson, & Doty, 1987; Lentsch & Johnson, 2000).

Barriers to reporting CSA include inadequate knowledge and training related to CSA, lack of confidence in the evidence collected, fear of harming the child and/or family, lack of confidence in the ability of the social service agency to deal with the investigation, concerns about interacting with the legal system, loyalty to the family, and the belief that an accusation might lead to undesirable consequences (Delaronde et al.,2000; Leder, Emans, Hafler, & Rappaport, 1999; Vulliamy & Sullivan, 2000; Willis & Horner, 1987). In addition, Willis and Horner (1987) in their survey of 101 Family Medicine physician faculty and residents found that many physicians did not believe CSA actually occurred at the rates indicated by the literature.

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In 2002, 56% of reports of alleged child abuse and neglect were made by professionals. The remaining 44% were made by parents, relatives, friends, alleged victims, alleged perpetrators, and anonymous callers. The largest percentage (16.1%) of professional reports were made by educational personnel, followed by legal and law enforcement personnel (15.7%), and social services personnel (12.6%). Medical personnel reports accounted for only 7.8% of professional reports (United States Department of Health and Human Services [US DHHS], 2004).

Physicians, nurses, and other health care professionals have an important role to play in identifying and treating CSA (American Academy of Pediatrics [AAP], 1999). They can afford the child a safe and private environment in which to disclose and they have the skills to assess, document, and treat or refer for treatment of CSA (Diaz & Manigat, 1999). Clearly, health care providers must expand their role in identifying and reporting CSA. The American Academy of Pediatrics (1999) and the American Professional Society on Abuse of Children (1998) both recommend that providers observe for signs and symptoms of child sexual abuse during routine encounters. They agree screening for abuse (physical or sexual) should be incorporated in every well-child visit.

Criteria for Initiating Preventive Health Services

Both the U.S. Preventive Services Task Force (USPSTF) and the *Journal of the American Medical Association* (JAMA) evidence-based medicine working groups have developed criteria for evaluating the initiation of preventative services. They propose that before screening for any health problem is implemented the following criteria must be considered:

(a) Is the health problem serious?
(b) Is a clear diagnosis available?
(c) Is there evidence that earlier intervention works?
(d) Does a suitable screening test exist?
(e) What are the potential harms?
(f) Is screening cost-effective? (Barratt et al., 1999; Goodyear-Smith, 2002; USPSTF, 2004)

These criteria provide a framework to discuss the value of screening for CSA. The main objective is to determine whether the benefits of screening are greater than the potential harm of screening.

Seriousness of the Problem

In the United States, the number of substantiated cases of CSA decreased by 40% between 1992 and 2000; however, the numbers have remained stable since then. During 2000, 2001, and 2002, substantiated cases of CSA occurred at a rate of 1.2 per 1,000 children (Jones, Finkelhor, & Kopiec, 2001; US DHHS, 2004). These numbers only include cases reported to child protective services and do not include cases in which the abuser was not a caretaker. Cases involving noncaretakers are typically handled by the criminal justice system, and there is currently no national database with information related to those cases. According to Finkelhor (1994), 20% to 25% of women and 5% to 15% of men experienced contact sexual abuse during childhood. A recent review of English-language articles published after 1989 that contained data on CSA (n=117), reported prevalence rates of 16.8% and 7.9% for adult women and men, respectively (Putnam, 2003). This means that approximately 160 to 250 per 1,000 women and 50 to 150 per 1,000 men report experiencing child sexual abuse, though only 1.2 cases per 1,000 children are reported and substantiated by child protective services. The difference in the number of cases of CSA identified during childhood and the prevalence numbers obtained from adult retrospective reports [are] disturbing. It is difficult to know the actual prevalence of CSA; however, it is clear that the issue deserves attention and action on the part of health care providers.

Multiple negative sequelae have been associated with a history of CSA. Sexually abused children are more likely to be diagnosed with depression, attempt suicide, have lower self-esteem, and have more anxiety than their nonabused peers. They may also develop posttraumatic stress disorder (Berliner & Elliott, 2002). Adolescents with a history of CSA exhibit more risk-taking behaviors and are at higher

risk of becoming pregnant (Putnam, 2003). The National Comorbidity Survey found that adult respondents who reported a history of CSA had a higher prevalence of psychiatric disorders than those not reporting CSA. They were almost twice as likely to have lifetime depression, mood, anxiety, or substance abuse disorders (Molnar, Buka, & Kessler, 2001). Putnam (2003), who did a 10-year review of the literature on CSA, concluded that a history of CSA was associated with major depression, borderline personality disorder, somatization disorder, post-traumatic stress disorder, dissociative identity disorder, bulimia nervosa, and an increase in alcohol and drug abuse. CSA has both acute and long-term detrimental effects, and it is a serious health problem in childhood that frequently carries over to adulthood.

Is a Clear Diagnosis Available?

The American Academy of Pediatrics (AAP) Committee on Child Abuse and Neglect (1999) and the American Professional Society on Abuse of Children (1998) maintain current recommendations for classifying findings on CSA. Specific guidelines for deciding to report or not to report CSA are provided by AAP. History, physical, and laboratory data are analyzed to establish the level of concern, which then dictates the reporting decision (AAP, 1999).

Adams (2001) has proposed a classification system based on the AAP recommendations and on current research. Part 1 of the system offers health care providers a means to categorize physical and laboratory findings and children's statements and behaviors possibly related to CSA. The findings are categorized as normal, normal variants of other causes, not specific (may or may not be related to CSA), concerning (have been associated with CSA), or clear evidence of CSA. In Part 2 the likelihood of abuse is assessed by determining which class the evidence places the child in: no indication of abuse, possible abuse, probable abuse, or definite evidence of abuse (Adams, 2001). It is important to note that only 4% of children evaluated for sexual abuse have abnormal examinations at the time of the assessment and the child's history is the single most important diagnostic criterion (Heger, Ticson, Velasquez, & Bernier, 2002). The diagnosis of CSA is not always clear; however, a health care provider who is up-to-date on evidence-based practice guidelines and who uses expert resources should be able to recognize CSA and make the decision whether or not to report with confidence.

Early Intervention

It is difficult to compare CSA victims who receive early intervention with those who do not. The National Comorbidity Survey found that the prevalence of lifetime psychiatric disorders was significantly higher among those who did report experiencing CSA than among those who did not report CSA (Molnar et al., 2001). Also, studies examining the effect of specific interventions on victims of CSA have demonstrated an improvement in psychopathology (Berliner & Elliott, 2002). Abuse-specific cognitive behavioral treatment (CBT) has been very effective in reducing post-traumatic stress reactions. Children whose parents also receive treatment have less depression and fewer behavior problems (Berliner & Elliott, 2002; Cohen, Deblinger, Mannarino, & Steer, 2004). Early identification and treatment of child sexual abuse has the potential to minimize the acute and long-term effects of the abuse (Jenny, 2002). Early recognition and reporting of child maltreatment may also lead to preventing repeated abuse of the victim and abuse of other children (Johnson, 2002).

Screening

Currently there is no evidence-based CSA screening tool. In fact, only one study has addressed the development of a specific screening procedure (McGlinchey, Keenan, & Dillenburger, 2000). In that study, stimulus equivalence training, a behavioral-analytic procedure, was used in an attempt to differentiate children who had been sexually abused from those who had not. The differences were not significant, however, and the procedure is too complex to administer in a health care setting.

Several tools to screen for domestic/family violence have been studied and some of these tools include questions related to CSA. However, according to the USPSTF (2004), no studies addressed the effectiveness of screening in reducing harm and therefore the balance of benefits and harms cannot be decided. Nevertheless, they do note that asking questions about physical abuse is justified by the high prevalence of undetected domestic violence (USPSTF, 2004). Further study is needed to develop and validate specific screening techniques for CSA.

Potential Harms

Lack of knowledge may cause harm if signs of CSA are not recognized and addressed or if normal variations are mistaken for signs of CSA. Hibbard and Zollinger (1990) examined knowledge of CSA among social, legal, and medical professionals (n = 902) who interacted with CSA cases regularly by administering a survey at a conference on CSA. Social workers had the highest knowledge scores (85.9), followed by physicians (84.7) and then nurses (82.6). Legal professionals had the lowest knowledge scores (80.6). Less than half of the respondents reported prior training related to CSA. A survey tool developed by Ladson, Johnson, and Doty was used in two physician studies (Ladson et al. 1987; Lentsch & Johnson, 2000) and one nurse practitioner study (Horner & McCleery, 2000). The findings of all three studies were essentially the same and demonstrated a deficiency in knowledge related to basic anatomy and findings that are indicative of CSA. Forty percent of the physicians (n = 295) and nurse practitioners (n = 83) surveyed were unable to correctly identify the hymen and vaginal opening of a 6-year-old female's genitalia. Thirty to forty percent of survey respondents said they would not order a culture in the presence of vaginal discharge (Horner & McCleery, 2000; Ladson et al., 1987; Lentsch & Johnson, 2000).

Lack of knowledge may lead to either under- or over-diagnosis of CSA. False-negative screening results may minimize the identification of children who are truly at risk, and false-positive results may cause incorrect labeling and undeserved punishment. Possible negative outcomes related to suspicion and reporting of domestic violence in general include psychological distress, escalation of the abuse, family tension, loss of family resources, erosion of family structure, and the child's loss of established support systems (USPSTF, 2004). However, if health care providers rely on standard guidelines and the clinical expertise of specialists, the chance of false positives can be minimized. The lives of young innocent children are at stake.

Cost-Effectiveness

The cost of screening for CSA is unknown. Any assessment added to the health care visit will increase the practitioner's time and the skill level required to complete the exam. If CSA is suspected and a report is made, then the provider will have to commit even more time to the process. One Canadian study (Vulliamy & Sullivan, 2000) examined pediatricians' (n=26) experiences with reporting

child abuse (physical and sexual) to Child Protective Services (CPS). The survey asked about their personal experiences and reactions to reporting and why they thought other physicians might not report child abuse. Concerns about interacting with CPS and the court system were listed as barriers to reporting suspected child abuse.

Conclusion

Screening for CSA has a long way to go to meet the requirements for evidence-based criteria established by the USPSTF and the JAMA evidence-based medicine working group. However, the seriousness of the problem warrants work toward achieving that goal. Identifying and reporting child sexual abuse can be difficult and intimidating to the general health care provider; however, there are evidence-based diagnostic criteria and experts available for consultation (Adams, 2001).

There is also evidence that identifying and treating CSA early may be beneficial. The potential benefits of stopping the sexual abuse of a child and perhaps preventing abuse of more children far outweigh any potential harm or cost.

The Joint Commission on Accreditation of Healthcare Organizations mandates that hospitals screen for domestic violence, and as a result, reporting and referrals for domestic violence have increased (Punukollu, 2003). CSA is also highly prevalent and under-reported, but CSA may or may not be addressed by domestic violence screening tools. Experts in the CSA field must focus their efforts on developing an evidence-based screening tool that could be used easily during encounters with children for various types of health care visits.

Recommendations

Health care providers cannot ignore the problem of CSA. Children need advocates to intervene on their behalf. Health care providers are in a unique position to reach out to children who may be suffering in silence. The first step in eliminating the sexual abuse and exploitation of children is acknowledging that it happens and recognizing that health care providers come into contact with CSA victims regularly and must be prepared to assess for it.

In the absence of an evidence-based screening tool, providers must at least have a heightened level of suspicion and stay current on psychological, behavioral, and physical signs of abuse. Vigilance is required to recognize the signs of CSA, which are frequently subtle. Being aware of and utilizing expert resources are also key. Continuing education to increase knowledge related to CSA is recommended.

Communication and anticipatory guidance on the risks of CSA and prevention of abuse should be incorporated into well-child visits. The Massachusetts Medical Society (2004) has developed a parent education card, "Protecting Your Child from Sexual Abuse," which emphasizes that most sexual abusers are not strangers to their victims and children should never keep secrets from their parents. Resources such as the card can increase patient knowledge and awareness of the problem. Also, during the physical exam the provider can inform children that adults should not touch their body parts and they should not keep secrets from their parents.

General inquiry directly to children about how they are doing and whether they have any concerns may be enough to elicit disclosures of sexual abuse (Petronio, Reeder, Hecht, & Mon't Ros-Mendoza, 1996). Adolescents should be asked for a complete sexual history and questioned about unwanted sexual activity (Diaz & Manigat, 1999). Table 1 gives specific developmental recommendations.

Table 1.
Recommendations for Assessing and Preventing CSA by Developmental Level

Developmental Level	History/Assessment	Anticipatory Guidance
Infant/Toddler	Child care arrangement. General physical exam, including genitalia.	Teach children correct terminology for body parts.
Pre-school	Child care arrangement. General physical exam, including genitalia. Behavior changes.	Give children permission to say "no" to advances. Explain good touch and bad touch and how to deal with strangers.
School age	General physical exam, including genitalia. Behavior changes.	Provide sex education and education on personal safety. Encourage open communication with parents.
Adolescent	STD screening. Vaginal exam. Sexual history.	Emphasize personal safety, risk taking, sexuality. Explain risk of sexual assault.

(American Academy of Pediatrics, 1999; Jenny, Sutherland, & Sandahl, 1986)

Child sexual abuse is a disturbing and difficult issue. Looking the other way will not solve the problem and will cause undue suffering to children who are dependent on the professionals who serve them. Health care providers must equip themselves with the knowledge and resources to meet the needs of the children they serve. Early recognition and reporting are necessary to eliminate the problem of CSA. No child should be a victim of this crime.

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Savell, S. (2005). Child sexual abuse: Are health care providers looking the other way? *Journal of Forensic Nursing, 1*(2), 78-81, 85. Reprinted with permission of the International Association of Forensic Nurses. For a free copy of the *Journal of Forensic Nursing,* contact IAFN at 856-256-2300; East Holly Ave. Box 56, Pitman, NJ 08071-0056.

Approach to the Interpretation of Medical and Laboratory Findings in Suspected Child Sexual Abuse: A 2005 Revision

Joyce A. Adams, MD

When child sexual abuse is suspected, a medical examination is often one part of the overall evaluation. A suspicion of sexual abuse may result when a child has disclosed such abuse, has developed behaviors suggestive of sexual abuse, is diagnosed with a sexually transmissible infection, when there are suggestive medical or laboratory findings, or because the abuse has been witnessed by others or documented by photographs or videotapes. Health care providers responsible for performing medical examinations in these situations are often asked by parents, care givers, social service workers, or law enforcement officers whether or not any "evidence" of sexual abuse was found.

During the past 15 years, many changes have occurred in the way medical professionals perform evaluations of children suspected of having been sexually abused, and in how physical and laboratory findings are interpreted (Heger, Ticson, Velasquez, & Bernier, 2002). During the early 1990s, research studies documented genital and anal findings in children who were not suspected of having been sexually abused, which provided medical practitioners with a better understanding of the range of normal variations in the appearance of these tissues (McCann, Voris, Simon, & Wells, 1989; McCann, Wells, Simon, & Voris, 1990; Berenson, Heger, & Andrews, 1991; Berenson, Heger, Hayes, Bailey, & Emans, 1992).

All participants agreed that the revised document should be used solely as a tool to assist medical providers in making clinical determinations of the possible significance of medical findings in children they evaluated for suspected sexual abuse.

A comprehensive listing of findings in nonabused children and medical and laboratory findings associated with suspected child sexual abuse was first published as a table in an article by Adams, Harper, and Knudson (1992). This classification system, sometimes referred to as the Adams Classification System, had been developed using published data on both abused and nonabused children. It was intended to assist team members to arrive at sound conclusions from medical evaluations of children suspected of having been sexually abused, and to help achieve some consistency among these providers in interpreting their medical findings.

The table, listing physical and laboratory findings, has been modified multiple times since 1992 in response to newly published research findings in order to refine the characterization of listed medical findings not supported by research data. The most recent set of revisions was begun in January, 2003, when groups of interested physicians were convened at the San Diego Child Maltreatment Conference and at annual meetings of the Ray Helfer Society. Participating physicians were asked to review the most recently published version of the document, to reassess the listings of medical and laboratory findings, and to attempt to reach consensus on how to define and interpret those medical findings. In January, 2004, under the sponsorship of the American Professional Society on the Abuse of Children, a group of 18 physicians met to further discuss proposed changes. These physicians achieved consensus on most of the criteria to be included in the document, including those criteria that should be listed for newborns and nonabused children as well as criteria thought to be diagnostic of trauma or sexual contact. The document was then circulated via e-mail to 46 physicians in the United States and Canada who had expressed interest in being involved in the revision process.

The document produced as a result of these reviews is included in Table 1. It has received support from the majority of physicians who participated in the review process. This version does not differ significantly from the 2004 version of the proposed classification system, which was published in the *Journal of Pediatric and Adolescent Gynecology* (Adams, 2004), but it has been renamed to remove the word *classification* from the title. The research studies that support inclusion of specific findings under each heading are referenced in the body of the instrument for each listed finding. Many of these studies are cross-sectional and retrospective in nature; only a few are prospective, longitudinal, or case control studies. The recommendations for interpreting the significance of sexually transmissible infections or lesions differ slightly from the guidelines published by the American Academy of Pediatrics (AAP) Committee on Child Abuse and Neglect (2005), and those differences are noted in the table.

The tables in the article published by the author in 2001 continued to incorporate a section, titled "Overall Assessment of the Likelihood of Sexual Abuse." The rating categories in the Overall Assessment table were "no evidence of abuse," "possible abuse," "probable abuse," and "definitive evidence of penetrating injury or sexual contact." To rate the first three categories required heavy reliance on historical information from the child and other professionals, behavior changes observed in the child, and direct observations from witnesses, in addition to medical and laboratory findings. It had become clear that the Overall Assessment section was being inappropriately used by some programs as a checklist approach to the diagnosis of child sexual abuse, a use for which it was never intended. It was also believed that inexperienced medical providers were using the tables as a substitute for a more thorough clinical assessment and determination of the likelihood of sexual abuse.

In response, the author solicited input from medical colleagues to refine and clarify the instrument's purpose and content and to redesign it accordingly. All participants agreed that the revised document should be used solely as a tool to assist medical providers in making clinical determinations of the possible significance of medical findings in children they evaluated for suspected sexual abuse. The tool was also intended to provide guidelines for teaching physicians and nurses to demonstrate what is known, and what is not known, about physical findings in abused and nonabused children. Subsequent to these decisions, the Overall Assessment table, which was present in previous versions, was removed.

cont'd on page 8

There is not complete agreement regarding this listing of findings and its guidelines for interpretation among physicians with expertise in the medical evaluation of suspected child sexual abuse. Several contributors still believe strongly that findings such as deep notches in the hymen and a marked narrowing of the rim of the hymen should be listed as more significant than "indeterminate." The majority of participants, however, do agree that these findings should not be considered diagnostic of trauma, because at present, data from published research are insufficient to justify that conclusion. Pragmatically, it is also problematic to rely on measurements as small as one millimeter, or to determine whether a notch is through 50% or more than 50% of the width of the hymen. Medical or laboratory findings of indeterminate significance could raise the suspicion of sexual abuse, even in the absence of a history from the child. In those cases, a report to child protective services, for further investigation, is appropriate.

Other participants are skeptical of an approach that does not emphasize the importance of the child's statement in the overall medical evaluation, which of necessity must include more than just a physical examination. It is clear that the history from the child is the most important part of any evaluation for suspected child sexual abuse. Further, unless the physical examination is performed within a very short time after an assault that causes injury, the physical exam will likely show no signs of either acute or healed trauma. We also know that injuries to the genital and anal tissues heal rapidly and often completely, and that many types of sexual contact do not cause apparent physical injury. As reported in studies since 2000, the percentage of children giving a history of abuse who have abnormal physical examination findings is about 4% to 5% (Heger et al., 2002; Berenson, Chacko, Wiemann, Mishaw, Friedrich, & Grady, 2000) in most clinical settings.

Medical professionals must take great care to interpret physical findings using research-derived knowledge concerning the variations of normal and the particular conditions that may be mistaken as abuse.

Certainly, children suspected of having been sexually abused deserve to be heard and believed in addition to receiving careful medical evaluations. Further, children deserve to have as much attention directed to what they disclose about their abuse experiences as to the microscopic appearance of their genital or anal tissues. However, sexually abused children are often too young to provide a coherent history, and some may deny having experienced any acts that may have caused injury. In these circumstances, physical examination findings may take on greater importance in the overall evaluation. Medical professionals must take great care to interpret physical findings using research-derived knowledge concerning the variations of normal and the particular conditions that may be mistaken as abuse. That said, the history provided by the child, the child's medical history, the history as reported by parents or other care givers regarding behavioral or emotional changes in a child, and the results of a careful physical examination must all be integrated into a comprehensive assessment by those individuals with responsibility to perform these evaluations.

Accurate documentation, using diagnostic-quality photographs or videotapes of the examination, is essential for health care providers conducting medical evaluations of children and youth who may have been sexually abused. It is also helpful for physicians, nurse practitioners, physician assistants, and nurses to have access to experts who can review records, photographs, and/or videotapes of examination findings in difficult cases, especially when a child is too young to provide a history, or the history is insufficient to explain the injuries. High-quality still photographs or videotapes that provide sufficient magnification to clearly show all the genital and anal tissues are necessary for meaningful peer review and to obtain second opinions.

For newly trained providers, or for those practicing in relative isolation, consultation can be obtained from experts in children's hospitals, medical schools, or regional referral centers located throughout the United States and Canada. Medical providers who perform these evaluations should establish formal networks for ongoing peer review of cases and continuing medical education. The Ray E. Helfer Society is an honorary association of physicians who are recognized as leaders in the field of child abuse evaluation, treatment, or prevention. A listing of current members and their academic affiliations is available at www.helfersociety.org. However, not all members are active in the medical evaluation of suspected sexual abuse.

In this rapidly evolving field, health care providers with responsibility to examine children for suspected child sexual abuse also need opportunities to participate in comprehensive and ongoing educational programs and peer review. They should have access to expert consultation as needed. Continual review of the literature is also essential for health care providers to attain and maintain competence in a field as dynamic and critically important as this.

The document presented in Table 1, Approach to Interpreting Physical and Laboratory Findings in Children With Suspected Sexual Abuse: 2005 Revision, reflects the latest thinking on how findings should be considered and interpreted when evaluating children who may have been sexually abused. This document replaces all prior tables in publications referred to as the Adams Classification or Research-Based Classification.

The individuals who actively participated in the revision process, either in person or via e-mail, are listed in Table 2. The listing of individual names here does not necessarily imply complete agreement with every detail of the document, but rather is an acknowledgment of one's participation in the process over the last several years and general acceptance of the final product.

Finally, participants in the review process have acknowledged that these guidelines may continue to undergo revisions as additional research studies are completed that clarify the significance and appropriate interpretation of clinical findings.

TABLE 1. APPROACH TO INTERPRETING PHYSICAL AND LABORATORY FINDINGS IN SUSPECTED CHILD SEXUAL ABUSE: 2005 REVISION

This product is the result of an ongoing collaborative process by child maltreatment physician specialists, under the leadership of Joyce A. Adams, MD.

This document was developed to provide a useful tool to assist health care providers in interpreting physical examination findings and laboratory results, based on information currently available in the medical literature.[1-34] It may also be useful in training health care providers who are learning how to conduct examinations of children. Because updated research studies continue to appear in the medical literature, this document will likely undergo further revisions.

A medical evaluation of suspected child sexual abuse involves much more than a physical examination. Any medical professional who provides these examinations should be able to obtain a medical history from the parent/caretaker and also from the child, if developmentally appropriate. Details of the alleged events leading to the request for an examination should be obtained by the individual(s) designated by local protocols. The health care professional who examines the child needs to understand and utilize the process of differential diagnosis, since many physical signs and symptoms may be caused by conditions other than abuse.

IMPORTANT NOTE: Recent studies have shown that 85% to 95% of children who have given clear histories of being sexually abused will have no findings of acute or healed trauma on examination, either because the injuries they sustained have healed completely by the time they are examined, or because the acts of abuse did not cause any physical injury to the child.[8, 21, 22] Many children do not have a clear concept of what "penetration" means, and they may be describing rubbing or pushing against their external genitalia or between the buttocks or, for prepubertal girls, penetration beyond the labia majora but not the hymen. Even penile penetration of the anus or the hymen may not cause any injury, because of partial penetration or because of the ability of the tissues to stretch[25] or it may cause minor injuries that heal completely.[22]

The numbering of the findings below is for ease of reference only and does not imply increasing significance.

Findings Documented in Newborns, or Commonly Seen in Nonabused Children

(the presence of these findings generally neither confirms nor discounts a child's clear disclosure of sexual abuse)

Normal Variants

1. Periurethral or vestibular bands[9, 17, 30, 10, 8, 6]
2. Intravaginal ridges or columns[9, 30, 10, 8, 6, 32]
3. Hymenal bumps or mounds[9, 17, 30, 10, 86, 32]
4. Hymenal tags or septal remnants[9, 17, 30, 10, 8, 6]
5. Linea vestibularis (midline avascular area)[17, 30, 6, 26, 32]
6. Hymenal notch/cleft in the anterior (superior) half of the hymenal rim (prepubertal girls) on or above the 3 o'clock–9 o'clock line, patient supine[9, 10, 8, 6]
7. Shallow/superficial notch or cleft in inferior rim of hymen (below 3 o'clock–9 o'clock line)[9, 17, 10, 8, 6, 20, 4, 28, 22, 19]
8. External hymenal ridge[9, 10, 8, 6, 32]
9. Congenital variants in appearance of hymen, including crescentic, annular, redundant, septate,[30. 10] cribiform, microperforate, imperforate[19, 32]
10. Diastasis ani (smooth area)[29, 11, 31]
11. Perianal skin tag[29, 11, 31]
12. Hyperpigmentation of the skin of labia minora or perianal tissues in children of color, such as Mexican-American and African-American children[29, 11]
13. Dilation of the urethral opening with application of labial traction[17, 30]
14. "Thickened hymen" (may be due to estrogen effect, folded edge of hymen, swelling from infection, or swelling from trauma; the latter is difficult to assess unless follow-up examination is done)[17, 30, 4, 28]

Findings Commonly Caused by Other Medical Conditions

15. Erythema (redness) of the vestibule, penis, scrotum or perianal tissues (may be due to irritants, infection, or trauma*)[17, 30, 10, 6, 20, 4, 28, 27, 31, 32]
16. Increased vascularity ("dilatation of existing blood vessels") of vestibule and hymen (may be due to local irritants, or normal pattern in the nonestrogenized state)[17, 30, 10, 6, 20, 4]
17. Labial adhesion (may be due to irritation or rubbing)[17, 30, 10, 6, 20, 4, 32]
18. Vaginal discharge (many infectious and noninfectious causes; cultures must be taken to confirm if it is caused by sexually transmitted organisms or other infections)[17, 6, 4]

Table 1 continued on page 12

19. Friability of the posterior fourchette or commisure (may be due to irritation, infection, or may be caused by examiner's traction on the labia majora)[17, 6, 28, 32]
20. Excoriations/bleeding/vascular lesions. These findings can be due to conditions such as lichen sclerosus, eczema or seborrhea, vaginal/perianal Group A streptococcus, urethral prolapse, hemangiomas)[22, 34, 19, 14, 16, 12, 23, 13,
21. Perineal groove (failure of midline fusion)[19]
22. Anal fissures (usually due to constipation, perianal irritation)[19, 16, 31]
23. Venous congestion, or venous pooling in the peranal area (usually due to positioning of child; also seen with constipation)[29, 11, 31, 4, 27]
24. Flattened anal folds (may be due to relaxation of the external sphincter or to swelling of the perianal tissues due to infection or trauma*)[29, 4, 27, 31]
25. Partial or complete anal dilatation to less than 2 cm, with or without stool visible (may be a normal reflex, or may have other causes, such as severe constipation or encopresis, sedation, anesthesia, neuromuscular conditions)[29, 4, 27, 31]

* Follow-up examination is necessary before attributing these findings to trauma

INDETERMINATE Findings: Insufficient or Conflicting Data From Research Studies

(may require additional studies/evaluation to determine significance; these physical/laboratory findings may support a child's clear disclosure of sexual abuse, if one is given, but should be interpreted with caution if the child gives no disclosure)

Physical Examination Findings

26. Deep notches or clefts in the posterior/inferior rim of hymen, in contrast to transections (see 41). One case-control study [6] found notches through more than 50% of the width of the posterior hymen only in girls who described digital or penile-vaginal penetration; however, this was seen in only 2/192 girls between the ages of 3 and 8 years alleging penetration. In a study of the appearance of the hymen in adolescent girls admitting consensual intercourse compared with girls who denied such contact, there was not a statistically significant difference in the frequency of deep notches in the posterior rim of hymen, but more girls describing intercourse had deep notches at 3 or 9 o'clock. [2] Distinguishing between superficial notches (through 50% or less of the width of the hymen) and deep notches (through more than 50% of the width of the hymen) can be extremely difficult
27. Deep notches or complete clefts in the hymen at 3 or 9 o'clock in adolescent girls. In the adolescent study referenced above, the finding of deep notches or complete clefts in the hymen at 3 and 9 o'clock was significantly higher in girls admitting vaginal intercourse than in girls who denied intercourse (26% v. 5%, $p<.01$), but each type of finding was seen in 5 of 58 subjects denying intercourse[2]
28. Smooth, noninterrupted rim of hymen between 4 and 8 o'clock, which appears to be less than 1 millimeter wide, when examined in the prone knee-chest position, or using water to "float" the edge of the hymen when the child is in the supine position. This finding was not seen in girls selected for nonabuse in four separate studies,[30, 10, 6, 32] However, a rim estimated to be less than 1 to 2 millimeters was found in 22% of girls selected for nonabuse in another study.[20] In addition, most experts acknowledge that it is very difficult to accurately measure the posterior rim of hymen in many cases
29. Wart-like lesions in the genital or anal area (may be skin tags or warts not of the genital type; may be condyloma accuminata that was acquired from perinatal transmission or other nonsexual transmission)[34, 18, 5, 19] (biopsy and viral typing may be indicated in some cases)
30. Vesicular lesions or ulcers in the genital or anal area (infectious and noninfectious causes, including herpes, syphilis, varicella or other viruses, Behcet's disease, Crohn's disease, idiopathic causes)[34, 18, 5, 19] (need to obtain viral cultures or PCR[33] to diagnose herpes or serology to diagnose syphilis)
31. Marked, immediate anal dilation to a diameter of 2 cm or more, in the absence of other predisposing factors such as chronic constipation, sedation, anesthesia, neuromuscular conditions (a rare finding in both abused[4] and nonabused[29, 31] children; no consensus exists currently among experts as to how this finding should be interpreted)

Lesions With Etiology Confirmed: Indeterminate Specificity for Sexual Transmission

32*. Genital or anal condyloma accuminata in child, in the absence of other indicators of abuse[18, 5]
33*. Herpes Type 1 or 2 in the genital or anal area in a child with no other indicators of sexual abuse[18, 5]

* Report to child protective services is recommended by AAP Guidelines[5]

Findings Diagnostic of Trauma and/or Sexual Contact

The following findings support a disclosure of sexual abuse, if one is given, and are highly suggestive of abuse even in the absence of a disclosure, unless a clear, timely, plausible description of accidental injury is provided by the child and/or caretaker.

It is recommended that diagnostic quality photodocumentation of the examination findings be obtained and reviewed by an experienced medical provider before concluding that they represent acute or healed trauma. Follow-up examinations are also recommended.

Acute Trauma to External Genital/Anal Tissues

34. Acute lacerations or extensive bruising of labia, penis, scrotum, perianal tissues, or perineum (may be from unwitnessed accidental trauma or from physical or sexual abuse)[28, 22, 14, 23]
35. Fresh laceration of the posterior fourchette, not involving the hymen (must be differentiated from dehisced labial adhesion or failure of midline fusion; may also be caused by accidental injury[28, 22, 19, 14, 16, 12, 23, 13] or consensual sexual intercourse in adolescents[24])

Residual (Healing) Injuries

These findings are difficult to assess unless an acute injury was previously documented at the same location.

36. Perianal scar (rare; may be due to other medical conditions, such as Crohn's disease, accidental injuries, or previous medical procedures)[27, 22, 19, 14, 13]
37. Scar of posterior fourchette or fossa (pale areas in the midline may also be due to linea vestibularis or labial adhesions)[28, 22]

Injuries Indicative of Blunt Force Penetrating Trauma, or From Abdominal/Pelvic Compression Injury, If Such History Is Given

38. Laceration (tear, partial or complete) of the hymen, acute[28, 22, 19, 14, 16, 12, 13]
39. Ecchymosis (bruising) on the hymen (in the absence of a known infectious process or coagulopathy)[28, 22, 19, 14, 16, 12, 13]
40. Perianal lacerations extending deep to the external anal sphincter (not to be confused with partial failure of midline fusion)[27, 22, 19, 16, 13]
41. Hymenal transection (healed). An area between 3 and 9 o'clock on the rim of the hymen where it appears to have been torn through, to or nearly to the base, so there appears to be virtually no hymenal tissue remaining at that location. This must be confirmed using additional examination techniques, such as a swab, prone knee-chest position, Foley catheter balloon (adolescents only), or water to float the edge of the hymen. This finding has also been referred to as a "complete cleft" in sexually active adolescents and young adult women [4, 27, 22, 19, 14, 16, 12, 13, 15, 2]
42. Missing segment of hymenal tissue. Area in the posterior (inferior) half of the hymen, wider than a transection, with an absence of hymenal tissue extending to the base of the hymen, which is confirmed using additional positions/methods[4, 19, 14]

Presence of Infection Confirms Mucosal Contact With Infected and Infective Bodily Secretions, Contact Most Likely to Have Been Sexual in Nature

43*. Positive confirmed culture for gonorrhea (from genital area, anus, throat) in a child outside the neonatal period[18]
44*. Confirmed diagnosis of syphilis, if perinatal transmission is ruled out[18]
45. Trichomonas vaginalis infection in a child older than 1 year of age, with organisms identified by culture or in vaginal secretions by wet mount examination[18, 5] (by an experienced technician or clinician)
46*. Positive culture from genital or anal tissues for chlamydia, if child is older than 3 years at time of diagnosis and specimen was tested using cell culture or comparable method approved by the Centers for Disease Control[18]
47*. Positive serology for HIV, if perinatal transmission, transmission from blood products and needle contamination have been ruled out[18]

* Considered diagnostic of sexual transmission by AAP Committee guidelines[5]

Diagnostic of Sexual Contact

48. Pregnancy[5]
49. Sperm identified in specimens taken directly from a child's body[5]

Table 1 continued on page 12

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TABLE 2. PARTICIPANTS IN REVISION PROCESS

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Martin Finkel, MD	University of Medicine & Dentistry, New Jersey, School of Osteopathic Medicine	Stratford, NJ
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Karen St. Claire, MD	Center for Child and Family Health	Durham, NC
R. Daryl Steiner, MD	Children's Hospital Medical Center of Akron	Akron, OH
Naomi Sugar, MD	Harborview Medical Center University of Washington	Seattle, WA
Jay M. Whitworth, MD	University of Florida	Jacksonville, FL

13th Annual Colloquium a Major Success

The 13th Annual Colloquium held June 15 to 18 in New Orleans was successful both in providing quality training for some 700 professionals and in financially exceeding budget expectations. The evaluations by attendees praised the Sheraton New Orleans as an excellent facility for the meeting and indicated the workshops were generally well received. The following excerpts are from the evaluation forms:

"I have been coming to APSAC [Colloquium] for the past 10 years on and off and this was the best conference yet!"

"I appreciated the large range of topics and speakers and the wonderful collaboration with NCTSN."

"Everything was wonderfully run, professional, and organized!"

"Excellent Colloquium—getting better and better."

"Everything was excellent!"

"I liked the inclusion of multicultural issues."

"Very good speakers—good handouts and staff!"

"New Orleans was a wonderful location and a lot of fun!"

APSAC is grateful to Jim Campbell for his efforts in managing the myriad details involved in planning and executing the 5-day conference. Thanks also to the Sheraton New Orleans staff for its assistance and cooperation before and during the Colloquium.

APSAC Handbook Winners

During the Colloquium, both members and nonmembers who visited the APSAC booth in the exhibit area could enter a drawing to win a hardcover copy of *The APSAC Handbook on Child Maltreatment, Second Edition*. The two lucky winners were Joni Darnell from Norman, Oklahoma, and Pamela Munger from Ft. Lauderdale, Florida. Congratulations to Joni and Pamela!

Welcome to New Board Members

We welcome three newly elected members of the APSAC Board of Directors—Elissa Brown, Susie Samuel, and Mike Haney. They were elected by the membership in June and will begin their 3-year terms in January of 2006.

Elissa Brown is an associate professor of psychology at St. John's University in Jamaica, New York. She is a clinical psychologist dedicated to the assessment and treatment of maltreated youth. Her work has focused on symptom development, service delivery, and treatment outcome research. This work allows her to collaborate with CPS workers, pediatricians, school personnel, and other mental health professionals. Elissa also teaches graduate and undergraduate students about child maltreatment.

Susie Samuel recently moved to Hendersonville, Tennessee. For the past 25 years she has worked in the child protection arena. As a CPS investigator for 12 years, Susie conducted more than 2,000 investigations in Kentucky. She was a child maltreatment investigation trainer for 15 years and trained over 10,000 professionals in 28 states, Russia, and South Africa. As a multidisciplinary team specialist in Kentucky, she assisted prosecutors in establishing community-based teams for investigation and case review. She is also a founding member and the first executive director of Parents Anonymous of Tennessee.

Mike Haney serves as Director of Prevention and Intervention in the Florida Department of Health with program responsibility for child protection teams and sexual abuse treatment programs. He has been directing these programs over 10 years and has been involved professionally with serving children who have been abused or neglected for 20 years. Mike is a licensed mental health counselor, a critical incident stress manager, and a national board-certified counselor.

Hats Off to Outgoing Board Members

APSAC is deeply indebted to the four members of the Board of Directors whose terms end December 31 of this year. All four have served two terms (6 years) and have devoted a great deal of time and effort to the organization. The outgoing Board members are Sandra Alexander, Brian Holmgren, Terry Hendrix, and Cynthia Cupit Swenson. They will be sorely missed on the Board but will remain involved in APSAC activities.

APSAC Forensic Interview Clinics Scheduled

The Forensic Interview Clinics focus on training professionals responsible for conducting investigative interviews with children in suspected abuse cases. These comprehensive clinics offer a unique opportunity to participate in an intensive 40-hour training experience and have personal interaction with leading experts in the field of child forensic interviewing. APSAC's curriculum emphasizes state-of-the-art principles of forensically sound interviewing with a balanced review of several models.

Upcoming Clinics

Portsmouth Virginia, September 19-23, 2005
Seattle, Washington, October 10-14, 2005
Seattle, Washington, April 24-28, 2006

For more information, visit www.apsac.org, or call APSAC toll-free at 877-40APSAC, or contact Patti Toth at ptoth@cjct.state.wa.us or 206-835-7293.

Save the Date

14th APSAC Annual Colloquium in Nashville, Tennessee
June 21-24, 2006

APSAC Advanced Training Institutes in San Diego, California, January 23, 2006 (in conjunction with the 20th Annual San Diego International Conference on Child and Family Maltreatment, January 23-27, 2005)

Log-on Instructions for Online Access to *Child Maltreatment*

For log-on instructions to access APSAC's official journal, *Child Maltreatment*, visit the APSAC Web site at www.apsac.org. The instructions are listed under the publications tab on the site.

APSAC ADVANCED TRAINING INSTITUTES

JANUARY 23, 2006
TOWN & COUNTRY RESORT AND CONVENTION CENTER
SAN DIEGO, CALIFORNIA

The APSAC Advanced Training Institutes will be held in conjunction with the 20th Annual San Diego International Conference on Child and Family Maltreatment on January 23-26, 2006.

Registration information and forms for the following Advanced Training Institutes can be accessed on the APSAC Web site (www.apsac.org) or by calling 843-764-2905. Continuing Education Credits (CEUs) are offered for all Advanced Training Institutes.

ADVANCED TRAINING FOR MANAGING THE THERAPEUTIC RELATIONSHIP: EMPATHY, COUNTER TRANSFERENCE, VICARIOUS TRAUMA, AND ETHICS

Jon R. Conte, PhD

This institute provides an opportunity for therapists to discuss the mutual relationship between clinical work and their personal lives, and to review key concepts useful in understanding and managing therapeutic relationships. Content includes a review of current thinking about vicarious trauma, empathetic engagement, counter transference, therapeutic listening, and ethical decision making. The training presents a model for the management of key processes and suggests ways to remain open, refreshed, and vital in the therapeutic relationship. This session includes 4 hours of content on ethics.

ADVANCED TRAINING FOR FORENSIC INTERVIEWERS: IMPROVING YOUR KNOWLEDGE AND SKILLS IN THE INTERVIEW WITH MALES AND CHILDREN WHO HAVE DEVELOPMENTAL DISABILITIES

Deborah Davis, LCSW, Kee MacFarlane, MSW, Martin Henry, PhD, & Katherine Eagleson, LCSW

This institute is designed for child abuse interviewers and supervisors who have previously attended an APSAC Forensic Interview Clinic or a comparable 40-hour interview training program. Training focuses on refining existing knowledge and skills in relation to two challenging populations—boys and children with developmental disabilities and/or cognitive disabilities. It includes topics such as obstacles to disclosure specific to males, differences in interviewing young boys and teens, common myths and mistakes, question design, suggestibility, and memory and witness capabilities.

ADVANCED TRAINING INSTITUTE ON BASIC TRAINING IN TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY

Anthony P. Mannarino, PhD, & Judith A. Cohen, MD

This institute reviews the theoretical rationale for trauma-focused cognitive behavioral therapy (TF-CBT) and the basic components of this treatment model. These include psychoeducational affective regulation skills, stress management, creating the trauma narrative, cognitive processing and restructuring, safety education, and parenting skills. This workshop incorporates numerous clinical examples as well as complete case presentations.

ADVANCED TRAINING INSTITUTE ON PEDIATRIC SEXUAL ABUSE WITH UPDATE ON MEDICAL EVALUATION

Joyce Adams, MD, & Lori Frasier, MD, FAAP

This workshop reviews recent research studies related to the medical evaluation of child sexual abuse, including a discussion of a tool for the interpretation of medical and laboratory findings in children, recommendations on when and how to test for sexually transmitted diseases, and how to assess the likelihood that conditions such as genital herpes or genital warts were transmitted sexually. Instructors present cases demonstrating the appearance of acute and healing genital and anal trauma, along with an update on the evaluation of adolescent victims of sexual assault and how to interpret the presence or absence of injury in these cases. This is not an introductory workshop.

CALL FOR PAPERS for the *APSAC ADVISOR*

Purpose: The *APSAC Advisor*, a quarterly publication of the American Professional Society on the Abuse of Children, serves as a forum for succinct, practice-oriented articles and features that keep multidisciplinary professionals informed of current developments in the field of child maltreatment. *Advisor* readers are the more than 2,500 social workers, physicians, attorneys, psychologists, law enforcement officers, researchers, judges, educators, administrators, psychiatrists, nurses, counselors, and other professionals who are members and supporters of APSAC.

Appropriate material: *Advisor* editors are seeking practical, easily accessed articles on a broad range of topics that focus on particular aspects of practice, detail a common problem or current issue faced by practitioners, or review available research from a practice perspective.

Inappropriate material: Articles should be well documented and of interest to a national multidisciplinary audience. The *Advisor* is not an appropriate outlet for poetry or fiction, anecdotal material, or original research-based articles heavy on statistics but lacking clear application to practice.

Length: *Advisor* articles range from 4 to 12 double-spaced manuscript pages set in a 12-point typeface.

Previous publication: The *Advisor* prefers original material but does publish excerpts from previously published articles on topics of unusual or critical interest.

Peer review: All articles submitted to the *Advisor*, whether solicited or unsolicited, undergo peer review by the appropriate consulting editors. If he or she thinks pursuing publication is appropriate, the associate editor may send copies of the article to one or two additional reviewers or return the article with comments to guide a revision.

Submission: All articles should be typed and double-spaced in 12-point type on 8.5 x 11 inch white paper, and submitted with an accompanying disk in Microsoft Word and a brief cover letter indicating that the article is offered for publication in the *APSAC Advisor*. The *Advisor* uses the manuscript format set forth in the latest edition of the style manual of the American Psychological Association.

Please send unsolicited manuscripts to:
Ronald C. Hughes, PhD
Institute for Human Services
1706 East Broad Street
Columbus, Ohio 43203

NOTE: An abbreviated style sheet prepared by APSAC to assist *Advisor* authors in manuscript preparation is available from the editor in chief on request.
Please e-mail the request to Susan Yingling at: syingling@ihs-trainet.com

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_____Descriptive Terminology in Child Sexual Abuse Medical Evaluations (1995)
_____Use of Anatomical Dolls in Child Sexual Abuse Assessments (1995)
_____Psychosocial Evaluation of Suspected Psychological Maltreatment in Children & Adolescents (1995)
_____Photographic Documentation of Child Abuse (1995)
_____Investigative Interviewing in Cases of Alleged Child Abuse **(New, 2002)**

Practice Guidelines subtotal: _____

The APSAC Handbook on Child Maltreatment, Second Edition (2002)
_____Hardcover (582pp.,8.5"X11") Members **$104.00** Nonmembers **$117.00**
_____Paperback (582pp.,8.5"X11") Members **$42.00** Nonmembers **$47.00**

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APSAC Study Guides (Members **$24.95**) (Nonmembers **$27.95**)
_____Volume 1 – Assessment of Sexual Offenders Against Children, **2nd Edition (2001)**(paperback, 96pp.)
_____Volume 4 - Psychological Maltreatment of Children (2001) (paperback, 112pp.)

Study Guides subtotal: _____

Other APSAC Publications (Members **$10**) (Nonmembers **$20**)
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Washington Update

Thomas L. Birch, JD
National Child Abuse Coalition

TIGHT MONEY HURTS CHILD WELFARE FUNDING

Federal support for child welfare services has come up short in the fiscal 2006 appropriations legislation working its way through Congress this summer. By the end of June, the House had passed all eleven such bills; and by mid-July, the Senate had voted on four of the money bills and had sent four others to the floor for passage—including the Labor-HHS-Education Appropriations Bill for the 2006 fiscal year. Contrasting recent years of stalled budget negotiations and late-session passage of catch-all funding measures, Congress has outdone itself this year in getting the federal funding bills to the floor for votes. In an otherwise contentious atmosphere centered on Senate approval of Presidential court appointments, Congress has steadily moved forward to approve legislation for the coming fiscal year.

In the Senate bill, while the overall funding for the Department of Health and Human Services is up by $1.64 billion over the 2005 level to $65.4 billion, none of that increase goes to either child protective services or child maltreatment prevention. Major funding increases were given instead to health research. Support for the Centers for Disease Control and Prevention was up by $1.33 billion in the House and by $1.48 billion in the Senate. Similarly, the National Institutes of Health were marked for significant increases in the Senate's bill, with an additional $1.05 billion penciled in for 2006.

Unfortunately, the rapid action on Congressional money decisions has not given a boost to underfunded child welfare services. Except for Head Start, which got a small increase in both bills, almost all child welfare programs are left with level funding. In fact, two programs aimed directly at the prevention of child abuse and neglect receive short shrift in both the Senate and House money bills. Both measures completely eliminate the $35 million allocated for the early learning fund to support community programs that work with new parents and young children to promote cognitive development and learning readiness. Since its inception in 2001, this program has enjoyed the support of the Senate, in spite of intentions by the Bush administration and House of Representatives to zero out its funding. This year, however, the Senate joined the House and the President in eliminating the program.

The Promoting Safe and Stable Families program, also aimed at preventive and family support services, was level-funded in the House bill but was cut by 2% in the Senate. The President ran in 2000 on a commitment to increase the Safe and Stable Families money by $1 billion over 5 years. Congress has never agreed with that level of increase, and presumably, the White House hasn't pushed it. While proposing a cut in funds for 2006, the Senate Appropriations Committee noted that federal funding for child welfare is generally provided for the removal and placement of children in out-of-home care, and Promoting Safe and Stable Families program funds are allocated to provide family supportive services to prevent such removal or out-of-home placement. Other administration initiatives fared better. The Children's Bureau's abstinence education fund gets a $2 million increase in the Senate bill, up to $105.5 million in 2006. The Compassion Capital Fund, which promotes grants to community and faith-based organizations, gets an increase in the House bill of $20 million and an increase of $40 million in the Senate, where $45 million of the $95 million total is earmarked for a new antigang initiative outlined by the President in his State of the Union address.

The tight budget resolution passed by Congress earlier in the year proposed billions of dollars in cuts to domestic discretionary pro-

grams and imposed a 3-year cap on discretionary spending. The appropriations bills now working their way through Congress follow that spending blueprint. The House and Senate have locked in 2006 spending at the 2005 levels for 1) the Child Abuse Prevention and Treatment Act state grants, 2) discretionary grants for research and program initiation, and 3) community-based prevention grants. The same is true for the Title XX Social Services block grants, child welfare services, abandoned infants grants, adoption opportunities grants, and child welfare training.

Curiously, in its report, the Senate Appropriations Committee recognized the difficulty states have in recruiting and retaining qualified child welfare staff, particularly staff with social work degrees. The Committe recommended grants to schools of social work as well as traineeships to social work students to suport specialized child welfare education. They also recommended funding research to determine how such specialized education affects outcomes for children and families. However, no additional funds were allocated for child welfare training.

HOUSE AND SENATE MONEY BILLS PROMOTE NIH CHILD ABUSE RESEARCH

In their reports accompanying the FY06 Labor-HHS-Education Appropriations Bills, both the House and Senate Appropriations Committees included language drafted and submitted by the National Child Abuse Coalition, instructing the National Institutes of Health (NIH) to continue support for research in child abuse and neglect and to direct attention to research in treatment interventions.

In 1996, the Coalition appealed to Congress for leadership in calling upon NIH to develop a research agenda designed to address problems and gaps that exist in child abuse and neglect research. That year, for the first time, the Fiscal Year 1997 appropriations legislation for NIH encouraged NIH to devote attention to addressing a research agenda in child maltreatment. The effort at NIH is significant because it represents a collaboration across several institutes to identify how they address, or might address, research needs in child maltreatment. It represents a pooling of funds to support both research activities and professional development. There is a focus on encouraging research proposals in topic areas identified as gaps by the NIH Child Abuse and Neglect Working Group's (CANWG) ongoing review of the NIH grant portfolio.

The research agenda developed by CANWG grew out of its analysis of the 1993 National Research Council report, *Understanding Child Abuse*, as an initial point of reference. It highlighted, among other concerns, the lack of information about causes, prevention, and amelioration of child neglect. The first round of research grants was given in this area.

TEMPORARY RENEWAL FOR TANF, AGAIN

For the tenth time in 4 years, Congress has temporarily extended the statutory authority for the Temporary Assistance for Needy Families (TANF) block grant. The new extension is good for 3 months, until September 30, 2005, when Congress will again have to decide how to proceed with the legislation that includes mandatory child care funding.

Both the House and Senate committees with jurisdiction over TANF have approved bills reauthorizing the public assistance job training program. The House bill adds only $1 billion in new money for child care, compared with $6 billion in the Senate's bill. Given the tight spending picture in Congress, assembling additional funds for child care remains a challenge. Other issues around work requirements and provisions to promote marriage also remain to be addressed.

About the Author

Since 1981, Thomas Birch, JD, has served as legislative counsel in Washington, D.C., to a variety of nonprofit organizations, including the National Child Abuse Coalition, designing advocacy programs, directing advocacy efforts to influence congressional action, and advising state and local groups in advocacy and lobbying strategies. Birch has authored numerous articles on legislative advocacy and topics of public policy, particularly in his areas of specialization in child welfare, human services, and cultural affairs.

JOURNAL HIGHLIGHTS
Ernestine C. Briggs, PhD

The purpose of Journal Highlights is to inform readers of current research on various aspects of child maltreatment. APSAC members are invited to contribute by sending a copy of current articles (preferably published within the past 6 months) along with a two- or three-sentence review to Ernestine C. Briggs, Ph.D., Duke University Medical Center, Trauma Evaluation, Research and Treatment Program, Center for Child and Family Health – North Carolina, 3518 Westgate Drive, Suite 100, Durham, NC 27707 (Fax: 919-419-9353).

SEXUAL ABUSE

Randomized Clinical Trial of CBT for Women with PTSD and CSA

This article describes the findings of a randomized clinical trial of individual psychotherapy for women with posttraumatic stress disorder (PTSD) related to childhood sexual abuse (n = 74), comparing cognitive-behavioral therapy (CBT) with a problem-solving therapy (present-centered therapy; PCT) with a wait-list (WL). CBT participants were significantly more likely than PCT participants to no longer meet criteria for a PTSD diagnosis at follow-up assessments. CBT and PCT were superior to WL in decreasing PTSD symptoms and secondary measures. CBT had a significantly greater dropout rate than PCT and WL. The authors also concluded that both CBT and PCT were associated with sustained symptom reduction in this sample.

McDonagh, A., Friedman, M., McHugo, G., Ford, J., Sengupta, A., Mueser, K., Demment, C., Fournier, D., Schnurr, P. P., & Descamps, M. (2005). Randomized trial of cognitive-behavioral therapy for chronic posttraumatic stress disorder in adult female survivors of childhood sexual abuse. *Journal of Consulting and Clinical Psychology, 73*(3), 515-524.

Survey Explores Clinicians' Perceptions of Exposure and Adaptation to Complex Trauma

Complex trauma exposure is the experience of multiple or chronic and prolonged, developmentally-adverse traumatic events, most often of an interpersonal nature (e.g., sexual or physical abuse, war, community violence) and with onset early in life. The Complex Trauma Workgroup of the National Child Traumatic Stress Network conducted a survey in 2002 to assess clinicians' perceptions of the extent and nature of complex trauma exposure and its sequelae in children and families receiving services at network sites. The survey also assessed the types and perceived effectiveness of interventions used with children affected by complex trauma. The results overwhelmingly indicated that complex trauma exposure and posttraumatic adaptation involving impairment in self-regulation were prevalent in children and families served by clinicians working with traumatized patients. These results suggest that mental health professionals need strategies, tools, and protocols for effective assessment and treatment of this population that can be integrated into existing professional practices.

Spinazzola, J., Ford, J. D., Zucker, M., van der Kolk, B. A., Silva, S., Smith, S. F., & Blaustein, M. (2005). Survey evaluates complex trauma exposure, outcome, and intervention among children and adolescents. *Psychiatric Annals, 35*(5), 433-439.

Review Explores Empirical Support for Criminal Child Abuse Investigation Practices

This article reviews the research relevant to seven practices widely considered to be among the most progressive approaches to criminal child abuse investigations. They are multidisciplinary team investigations, trained child forensic interviewers, videotaped interviews, specialized forensic medical examiners, victim advocacy programs, improved access to mental health treatment for victims, and Children's Advocacy Centers (CACs). The review found little currently available outcome research to document the success of these practices. However, preliminary research supports many of these practices or has influenced their development. Knowledge of this research can assist investigators and policy makers who want to improve responses to victims, to understand the effectiveness of particular programs, or to identify situations in which assumptions about the effectiveness of an intervention are not empirically supported.

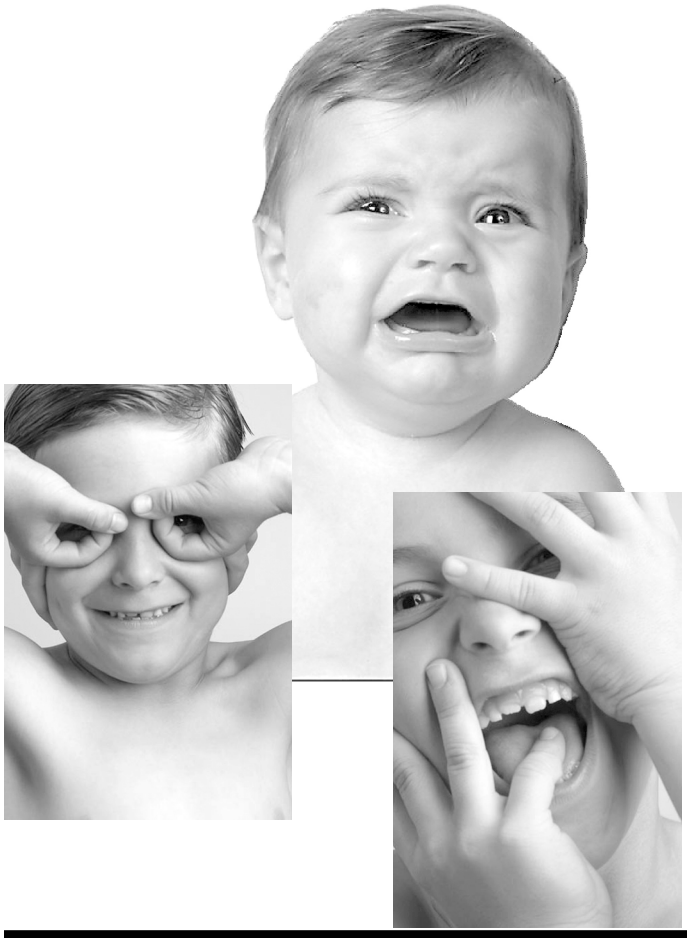
Jones, L. M., Cross, T. P., Walsh, W. A., & Simone, M. (2005). Criminal investigations of child abuse. *Trauma, Violence & Abuse, 6*(3), 254-269.

PHYSICAL ABUSE

Perceptions of Child Maltreatment: The Role of SES and Parenting Knowledge and Behaviors

This study examined the perceptions of nurse practitioners who work with low birth-weight children and their parents. Specifically, the investigators examined the relationship between two variables (socioeconomic status, and parenting knowledge and behaviors) and the nurse practitioners' perception of maltreatment. Data regarding the two variables were collected during in-home interviews (N = 891). Multiple interviews were conducted with the participants over a 3-year period. The results indicated that both variables were significantly related to the likelihood that the nurse practitioner would consider a child maltreated. Parenting knowledge and behaviors, however, accounted for more variance than socioeconomic status. The authors suggested that these results demonstrate a need for more comprehensive interventions for these families than are typically offered by the child welfare system.

Berger, L. M., & Brooks-Gunn, J. (2005). Socioeconomic status, parenting knowledge and behaviors, and perceived maltreatment of young low-birth-weight children. *Social Service Review, 79*(2), 237-269.



Impact of Child Maltreatment on Affect Regulation and Information Processing

More research is needed to understand the neurobiological substrates of self-regulation in people who experience early childhood trauma and who have been diagnosed with posttraumatic stress disorder (PTSD). The concept of self-regulation can provide a basis for theoretical models and interventions that emphasize posttraumatic resilience. To this end, this article sought to 1) identify affect regulation processes that may be influenced by maltreatment during childhood, 2) discuss possible effects of child maltreatment on information processing, and 3) describe the utility of assessing affect dysregulation and information processing when determining psychiatric diagnoses and treatment for people who have experienced childhood maltreatment. The author suggested that future success in developing effective treatments for children and adults who experienced trauma during early childhood is dependent on the continued dialogue between scientists and clinicians who share a focus on the nature, neurobiology, and development of affective and cognitive self-regulation.

Ford, J. D. (2005). Treatment implications of altered affect regulation and information processing following child maltreatment. *Psychiatric Annals, 35*(5), 410-419.

Black-White Racial Disparity in Child Maltreatment

The goal of this study was to explore possible explanations at the structural level for the racial disparity in child maltreatment rates. Variables examined in the study included poverty rates, areas of concentrated poverty, female-headed households, reporting rates for black families and for white families, and differences in reporting rates. Socioeconomic data were collected from Florida's 2000 census data, and child maltreatment data were collected from the Florida Department of Children and Families. The results found differences in poverty rates and exposure to concentrated poverty, as well as the likelihood of living in a female-headed household, by race, and that these differences can explain some, but not all, of the black-white racial disparity in child maltreatment. The author posited that an increase in the number of programs that focus on reducing poverty in black, female-headed households and reducing those families' exposure to concentrated poverty may decrease some of the overrepresentation of black children in the child welfare system.

Schuck, A. S. (2005). Explaining black-white disparity in maltreatment: Poverty, female-headed families, and urbanization. *Journal of Marriage and Family, 67*(3), 543-551.

TST: A New Approach to Treatment for Traumatized Children

Traumatized children frequently live in social environments characterized by domestic violence, child maltreatment, parental mental illness, and substance abuse—conditions demonstrated to be detrimental to child development and to increase the risk of exposure to trauma. This article describes the results of an open trial of an innovative model of care for traumatized children, trauma systems therapy (TST). TST is designed to address both a child's trauma-related symptoms and the perpetuating factors in the social environment.

Saxe, G., Ellis, B. H., Fogler, J., Hansen, S., & Sorkin, B. (2005). Comprehensive care for traumatized children. *Psychiatric Annals, 35*(5), 443-448.

OTHER ISSUES IN CHILD MALTREATMENT

Policy Implications of Child Maltreatment Among Homeless Families

This study examined rates of child maltreatment among families who were homeless. The types of maltreatment considered in this study included physical maltreatment, emotional maltreatment, and sexual abuse. The findings indicated high incidence rates of child maltreatment among homeless families. The author discusses the policy implications of these findings.

Pardeck, J. T. (2005). An exploration of child maltreatment among homeless families: Implications for family policy. *Early Child Development and Care, 175*(4), 335-342.

A Schematic Model for Juvenile Victims in the Juvenile Justice System

This article posited that a de facto juvenile victim justice system currently exists in the form of a complex set of agencies and institutions that respond to juvenile victims of crime and violence, such as child maltreatment and conventional crime. A schematic model of a juvenile justice victim system was proposed that outlines case flow (e.g., likely occurrences in various types of cases, such as what typically happens in a child maltreatment case). The authors argued that more professionals are needed who understand the entire juvenile victim justice system, rather than just one part of the system (e.g., their agency's role), to help integrate the system so that it works more effectively.

Finkelhor, D., Cross, T. P., & Cantor, E. N. (2005). The justice system for juvenile victims: A comprehensive model of case flow. *Trauma, Violence, and Abuse: A Review Journal, 6*(2), 83-102.

Recent Rulings in Florida on Termination of Parental Rights

This article examined major rulings in the Florida judicial system during 2004 regarding juveniles. Two of these rulings were significant for the child welfare field. One ruling found that the state could not terminate parental rights just because parents had already had their parental rights terminated for another child. Instead, it is the state's responsibility to demonstrate how specific children in question had been harmed by their parents. In a related ruling, the courts found that the state must tie specific parental acts to the child in question in a termination hearing.

Dale, M. J. (2005, Winter). Florida legal affairs: 2004 survey of Florida juvenile law. *Nova Law Review, 29*(Book 2), 395-427.

CONFERENCE CALENDAR

October 3-6, 2005
Mid-Atlantic Conference on Child Abuse and Neglect
Ocean City, MD
call Sgt. Dave Betz 410-638-4979
or e-mail: info@mcaca.org
or visit: www.mcaca.org

October 10-14, 2005
APSAC's Forensic Interviewer Clinic
Seattle, WA
call 877-402-7722
or e-mail: apsac@comcast.net
or visit: www.apsac.org

October 16-18, 2005
Bridging Culture in a Changing World
Orlando, FL
call the National Black Child Development Institute (NBCDI)
202-833-2220
or visit: www.nbcdi.org/ac/cfp/05/

October 24-28, 2005
Our Kids Training in the Evaluation and Management of Child Sexual Abuse
Nashville, TN
call 615-341-4920
or e-mail: Suzanne.v.petrey@vanderbilt.edu

October 26-28, 2005
7th Annual Conference on the Power of Mission Centered Grantsmanship
Scottsdale, AZ
call 913-980-5310
or visit: www.grantprofessionals.org

October 31-Nov 1, 2005
Comprehensive Forensic Interviewer Training
Cedar Rapids, IA
call Julie Kelly 319-369-8702
or fax: 319-369-8726
or e-mail: kellyja@crstlukes.com

January 23-27, 2006
20th Annual San Diego International Conference on Child and Family Maltreatment
San Diego, CA
visit: www.chadwickcenter.org

November 2 -5, 2005
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write to: 4900 SW Griffith Drive, Suite 274, Beaverton, OR 97005
or visit: www.atsa.com

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APSAC Advanced Training Institutes
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or visit: www.cwla.org

June 21-24, 2006
APSAC 14th Annual Colloquium
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call 843-764-2905
or visit: www.APSAC.org

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Save these dates!!!!!

APSAC Child Forensic Interview Clinics
September 26-30, 2005
Portsmouth, VA
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October 10-14, 2005
Seattle, WA
&
April 24-28, 2006
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