CHILD MALTREATMENT: STATE OF THE FIELD

NADINE J. KASLOW, PH.D., ABPP
NKASLOW@EMORY.EDU
Agenda

- Definitions
- Epidemiology
- Presentation
- Risk and Protective Factors
- Consequences
- Mandated Reporting
- Evaluations
- Interventions
- Prevention Programs
- Case Vignettes
DEFINITIONS
Adverse Childhood Experiences (ACE)

- ACEs – Stressful or traumatic events including:
  - Abuse – physical, sexual, emotional
  - Neglect – physical, emotional
  - Exposure to domestic violence
  - Household substance abuse
  - Household mental illness
  - Parental separation or divorce
  - Incarcerated family member
Adverse Childhood Experiences (ACE)

Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan
Definition – Child Maltreatment

- General term to describe all forms of child abuse and neglect
- No one commonly accepted definition
- Each state provides its own definition

"It shouldn’t hurt to be a child."
Definition – Child Maltreatment

- Federal government definition in Child Abuse Prevention and Treatment Act (CAPTA) - Recent act or failure to act on the part of a parent/caregiver, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act that presents an imminent risk of serious harm.

- "Child"
  - Person < 18 and not an emancipated minor
  - Child sexual abuse - has not attained age 18 or the age specified by the child protection law of the State in which the child resides, whichever is younger.
Definition – Child Maltreatment

- Child maltreatment encompasses physical abuse, sexual abuse, neglect and emotional abuse, which can be defined as follows:
Definition - Abuse

- Physical Abuse – Intentional use of physical force against a child that results in or has a high likelihood of resulting in harm for the child’s health, survival, development, or dignity
Definition - Abuse

- Sexual Abuse – Involvement by an adult or older child of a child in a sexual activity that he/she does not fully comprehend, is unable to give informed consent to, or which the child is not developmentally prepared, or else that violates the laws or social taboos of society, and this exploitation is for the sexual gratification of the other party
Definition - Abuse

- Psychological (Emotional) Abuse - Involves both isolated incidents and a pattern of excessive or aggressive verbal behavior that places unreasonable demands on a child and a failure to provide a developmentally appropriate and supportive environment.
Definition - Neglect

- Neglect (mild, moderate, severe) - Failure to provide adequate food, shelter, clothing, medical care, education, supervision or failure to meet emotional or psychological needs; neglect is the most common form of child abuse
Definition – Medical Neglect

Medical Neglect - Failing to:

- Provide appropriate medical care or supervision of the child although financially able to do so, or offered financial or other means to do so, and this neglect can result in poor overall health and compounded medical problems
- Seek timely and appropriate medical care for a serious health problem that any reasonable person would have recognized as needing professional medical attention
- Get appropriate preventive medical or dental care
- Follow medical recommendations
Definition – Medical Neglect

- Withholding/denying traditional medical care due to religious beliefs generally does not constitute medical neglect.
- Some states will obtain a court order forcing medical treatment of a child to save a child's life or prevent life-threatening injury resulting from the lack of treatment.
Question

- What issues do you struggle with in terms of defining maltreatment?
Question

- How do you work with families whose family and/or cultural beliefs about discipline conflict significantly with yours?
Question

- When you suspect medical neglect, how much and what information do you share with members with the interdisciplinary medical team?
- How do you consider privacy issues and keeping concerns contained versus having all potential providers involved?
EPIDEMIOLOGY
Public Health Concern

- National emergency and major public health problem
- Affects a significant number of families and children each year
- Difficult to accumulate precise statistics nationally
  - Methodological reasons
  - Some percentage of violent incidents are reported to law enforcement, health care clinicians, or child protective services
    - Fang et al., 2012; Finkelhor et al., 2012; US Department of Health and Human Services, 2015; Wideman et al., 2014
CPS Referrals (2016)

- CPS agencies received an estimated 4.1 million referrals involving ~ 7.4 million children
  - 58% of referrals were screened in, 42% were screened out
  - 2.3 million were screened in for a CPS response and received a disposition
- Professionals submitted (64.9%) of reports – educators, law enforcement, social service personnel
Incidence

- 9.1 children/1000 children in the US had substantiated cases of maltreatment in 2016 with a total of 676,000 victims
- 15.2% of youth experienced maltreatment from a caregiver during their youth
  - Finkelhor et al., 2015; US Department of Health and Human Services, 2016
Demographics

- **Age** - Children under the age of 3 have the highest rate of victimization (28.5% of victims)
  - Children in the 1st year of life have the highest rate (24.8/1000)
- **Gender** - Girls (51.0%) and boys (48.6%) have similar rates of victimization
  - Boys experience more physical abuse and girls more sexual abuse
    - Finkelhor et al., 2015; Sedlak & Basena, 2014; US Department of Health and Human Services, 2016
Demographics

- Race/Ethnicity – Most victims are from three races or ethnicities
  - White (44.9%)
  - Hispanic (22.0%)
  - African American (20.7%)

- Rates of Victimization by Race/Ethnicity
  - American Indian/Alaska Native children had highest rate (14.2/1,000)
  - African American children had second highest rate (13.9/1,000)
  - Hispanic and White children had lower rates at 8.0 and 8.1/1,000 children

  - US Department of Health and Human Services, 2016
Children with disabilities are at increased risk
- 11% of childhood maltreatment victims have a disability
- At increased risk for experiencing multiple types of maltreatment, with neglect being the most common

Imgur user fights for justice after her disabled brother dies of neglect

All she ever wanted for her little brother Quinten was a normal, happy life.
Perpetrators: Fatalities

- One or both parents - 78.0%
- Nonparent caregivers - 16.7%
- Unknown/missing - 5.3%
- Physical abuse fatalities – fathers and other male caregivers
- Child neglect fatalities - mothers
Among the 518,136 alleged offenders investigated:
- 83.4% were ages 18 – 44
- 854 were under 13
- 77.6% were parents
- More than one-half (53.7%) were women
- Three largest percentages of perpetrators were White (49.8), African American (20.0%), or Hispanic (18.8%)
Mortality

- The US has one of the worst records among industrialized nations – lose on average 4-7 children every day to child abuse and neglect
- 1,750 children died from abuse and neglect in 2016
  - 7.4 percent increase from 2012
- > 70% of the children who died were ≤ 2 and more than 80% were not old enough for kindergarten
Mortality

- Boys had a higher child fatality rate than girls (2.87/100,000 versus 2.11/100,000)
- Rate of African-American child fatalities (4.65/100,000) is 2.2 times greater than the rate of White children (2.08/100,000) and nearly 3 times greater than the rate of Hispanic children (1.58/100,000)
- More than three quarters (78.0%) of child fatalities involved at least one parent
What do you look for as indicators of
- Physical abuse
- Sexual abuse
- Psychological (emotional) abuse
- Neglect
Signs of Physical Abuse

- Injury that cannot be explained (bruise, burn, fracture, abdominal or head injury)
- Caregiver denial of trauma
- Fractures – multiple and different ages
- Bruises, abrasions, and burns
  - Ordinarily protected areas of body (genitals, inner thighs, torso, ears, neck, soft portion of cheek)
Signs of Physical Abuse

- Blunt abdominal trauma
- Asphyxial injury
- Intracranial injury
  - Shaken baby syndrome
Signs of Sexual Abuse

- Fearful behavior (nightmares, depression, unusual fears, attempts to run away)
- Extreme sexual behavior that is age-inappropriate
- Early pregnancy
Signs of Sexual Abuse

- Medical symptoms
  - Abdominal pain
  - Enuresis (Bedwetting)
  - Urinary tract infection
  - Genital pain or bleeding
  - Sexually transmitted diseases
  - Genital injury or bleeding
Signs of Psychological (Emotional) Abuse

- Sudden change in self-confidence
- Headaches or stomachaches with no medical cause
- Abnormal fears
- Increased nightmares
- Attempts to run away
Signs of Neglect

- Poor hygiene
- Delays in growth and development
- Failure to gain weight (especially in infants)
- Desperately affectionate behavior
- Voracious appetite and/or stealing food
- Untreated medical conditions
RISK AND PROTECTIVE FACTORS
Parent/Caregiver Risk Factors

- Difficulties bonding and nurturing
- Maltreated as a child
- Limited awareness and appreciation of child development
- Believes in the effectiveness of physical punishment
- Mental health or cognitive problems interfering with parenting
- Feel inadequate as a parent
  - WHO, 2006
## Parent/Caregiver Risk Factors

- **Problems with self-esteem and emotion regulation**
- **Misuse of substances**
  - For child maltreatment fatalities < 1, percentage with the alcohol abuse child risk factor increased to 4.8 in 2016 and rates increased to 1.2/1,000
  - For child maltreatment fatalities < 1, percentage with the drug abuse child risk factor increased to 15.2 percent in 2016 and rate increased to 3.9/1,000
- **Social isolation**
- **Financial difficulties**
  - Children’s Bureau, US Department of HHS, 2018; WHO, 2006
Child Risk Factors

- Product of unwanted pregnancy or multiple birth that taxed parents’ resources
- Difficult to soothe
- Temperament/behavior perceived as problematic (e.g., hyperactivity)
- Exhibits or is exposed to dangerous behaviors (e.g., criminal or abusive behavior)
  - WHO, 2006
Child Risk Factors

- Does not fulfill parents’ expectations (e.g., sex, appearance)
- Chronic illness or disability
- Siblings demanding of parental attention
  - WHO, 2006
Relationship Risk Factors

- Lack of parent-child attachment
- Family members’ mental health problems
- Family violence
- Hostile gender attitudes
- Lack of support
- Discrimination
- Involvement in criminal activity in the community
  - WHO, 2006
Community Risk Factors

- Tolerance of violence
- Social inequality
- Lack of services
- Poverty
- Unemployment
- Community instability
- Access to intoxicants
  - WHO, 2006
Societal Risk Factors

- Policies contributing to social inequality
- Acceptance of violence
- Rigid gender norms
- Diminished status of the child
- Existence of child pornography, prostitution, and labor

- WHO, 2006
Resilience Factors

- Secure attachment with an adult family member
- High levels of paternal care during childhood
- Lack of associating with delinquent or substance abusing peers
- Warm and supportive relationship with non-offending parent
- Lack of abuse related stress
  - WHO, 2006
Resilience Factors

- Safe, stable, nurturing relationships may decrease maltreatment continuity
- Social support can decrease the negative impact of childhood maltreatment
  - Herrenkohl et al., 2016; Schofield et al., 2013
CONSEQUENCES
Emotional and Behavioral

- Childhood maltreatment accounts for 26% to 32% of the risk for all adolescent and adulthood psychiatric disorders attributed at a population level
  - Green et al., 2010
Emotional and Behavioral

- PTSD and associated symptoms (dissociation, emotion dysregulation)
- Anxiety (GAD, panic disorder)
- Depression and low mood
- Suicidal behavior
  - Armour et al., 2016; Bailey & Brand, 2017; Cecil et al 2014; Herringa et al., 2013; Holshausen et al., 2014; Lee, 2015; Liu, 2017; Messman-Moore & Bhuptani, 2017; Miller et al., 2017; Ports et al., 2017; Romano et al., 2014; Teicher & Samson, 2013
Emotional and Behavioral

- Eating disorders
- Personality disorders (Cluster B)
- Psychotic symptoms
  - Armour et al., 2016; Bailey & Brand, 2017; Cecil et al., 2014; Herringa et al., 2013; Holshausen et al., 2014; Liu, 2017; Messman-Moore & Bhuptani, 2017; Ports et al., 2017; Romano et al., 2014; Teicher & Samson, 2013
Emotional and Behavioral

- Externalizing disorders (ODD, CD)
- Substance use – alcohol, drug
- Anger and aggression
- Violence perpetration
- Sexually risky behaviors
- Increased risk for crime and recidivism
  - Cecil et al., 2014; Cross et al., 2015; Fitton et al., 2018; Hamburger et al., 2008; Li et al., 2015; Romano et al., 2014; Shin et al., 2015; Widom, 2014, 2017
Social

- Attachment problems
- Social skills deficits
- Poor interpersonal relationships including negative peer relationships
- Adolescent peer victimizations
- Dating violence
- IPV relationships
- Abuse own children
  - Aakvaag et al., 2017; Benedini et al., 2016; Doyle et al., 2017; Romano et al., 2014
Academic

- Impaired cognitive functioning
- Impaired school performance (lower grades, grade retention, special education)
- Lower levels of educational attainment
  - Currie & Widom, 2010; Romano et al., 2014
Occupational and Economic

- Lower levels of employment
  - 14% gap between individuals with histories of maltreatment and controls in the probability of employment in middle age controlling for background characteristics
- Lower levels of earnings and fewer assets as adults
- Larger negative impact on women than men
  - Currie & Widom, 2010
Neurocognitive

- Problems with inhibitory control
- Problems on working memory performance
  - Cowell et al., 2015
Neurobiological

- Problems with regulation of neurobiological stress systems, alterations in brain maturation, and problematic neuropsychological outcomes
- Brain changes may be adaptive responses to facilitate survival
- Unclear if they are reversible
  - Teicher & Samson, 2016
Neurobiological

- Alterations and dysregulation in hypothalamic-pituitary-adrenal (HPA) axis activity
- Changes in a number of neurotransmitter systems (e.g., corticotrophin-releasing factor (CRH), monoamines, substance P, and others)
- Increased markers of inflammation including inflammatory cytokines (interlukin-6, C-reactive protein, and others)
  - Cross et al., 2017; Gonzalez, 2013; Nemeroff, 2016; Nemeroff & Binder, 2014
Changes in limbic (amygdala, hippocampus) and cortical brain regions

Identification of single nucleotide polymorphisms that mediate the effects of early life trauma

- Cross et al., 2017; Gonzalez, 2013; Nemeroff, 2016; Nemeroff & Binder, 2014
Pathway of risk from childhood maltreatment to emotional and behavioral outcomes is due in part to structural and functional alterations within the hippocampus, prefrontal cortex, and amygdala resulting from chronic or repeated activation of the HPA axis and its interaction with and influence on genetic and epigenetic processes during sensitive periods of development.

- Cross et al., 2017; Gonzalez, 2013; Nemeroff, 2016; Nemeroff & Binder, 2014
Medical

- Cardiovascular disorder (myocardial infarction, stroke, ischemic heart disease, coronary heart disease)
- Diabetes
- High blood pressure/hypertension
- Cancer
- Immune disorders
- Premature mortality
  - Basu et al., 2017; Brown et al., 2009; Felitti et al., 1998
Treatment Response

- Poorer response to both psychosocial and pharmacological treatment
  - Nanni, Uher, & Danese, 2012
MANDATED REPORTING
Mandatory Reporters

- All states have statutes to protect mandatory reporters from civil and criminal liabilities when reports are filed in good faith, or in the absence of malicious intent, regardless of whether findings are substantiated.
- Immunity is to encourage reporting without fear or reprise of legal retaliation by the child’s family and to remove hesitations when reporter is not certain abuse has taken place.
  - Kenny et al., 2017
**Mandatory Reporters**

- Individuals required by law to report cases of suspected child abuse or neglect immediately upon having suspicion or knowledge of an abusive or neglectful situation; can face criminal and civil liability for not doing so
- Typical mandatory reporters - physicians, social workers, educators, mental health professionals, child care providers, medical examiners, and police
- State statutes specify procedures for mandatory reporters making a report of child abuse or neglect
Reporting Law

- Who must report?
- What constitutes child abuse and neglect?
- Where and when do you report?
- What should the report include?
- What if you’re wrong?
- Will your name be revealed?
- Will you get feedback?
Reporting Questions

- Is the behavior acceptable given the child’s age and developmental level?
- Is the behavior culturally normative?
- Where is the line between discipline, corporal punishment, and abuse?
- What does potential harm mean?
- Is homelessness neglect?
- Is witnessing IPV reflective of child maltreatment?
Reporting Questions

- What are the minimum requirements associated with caring for a child?
- What action/inaction by a parent/caregiver constitutes neglectful behavior?
- Must the parent/caregiver's action/inaction be intentional?
- What impact does the action/inaction have on the health, safety, and well-being of the child?
Reporting Questions

- What constitutes "failure or inability to provide" adequate food, shelter, protection, or clothing?
- Should "failure or inability to protect" be included?
- Is the action/inaction a result of poverty rather than neglect?
Reporters

- More than one-half of reports of alleged child maltreatment were made by professionals including educators, law enforcement, medical professionals, social service personnel, and child care staff.
- Friends, neighbors, and relatives submitted approximately 43.2% of reports.
# Specificity of Indicators

<table>
<thead>
<tr>
<th></th>
<th>Low Specificity</th>
<th>Moderate Specificity</th>
<th>High Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual Abuse</strong></td>
<td>Anxiety&lt;br&gt;Depression&lt;br&gt;Low self-esteem&lt;br&gt;Social maladjustment</td>
<td>Sexual acting out&lt;br&gt;Excessive involvement with pornography</td>
<td>Sexual acting out of very young children&lt;br&gt;Complaints of genital or anal discomfort&lt;br&gt;Detailed verbal account&lt;br&gt;Medical reports of STD</td>
</tr>
<tr>
<td><strong>Physical Abuse</strong></td>
<td>Anxiety&lt;br&gt;Depression&lt;br&gt;Low self-esteem&lt;br&gt;Social maladjustment</td>
<td>Aggressive acting out</td>
<td>Bruises, welts, burns&lt;br&gt;Verbal account of abuse</td>
</tr>
<tr>
<td><strong>Neglect</strong></td>
<td>Anxiety&lt;br&gt;Depression&lt;br&gt;Low self-esteem&lt;br&gt;Social maladjustment</td>
<td>Social withdrawal</td>
<td>Inadequate clothing&lt;br&gt;Poor hygiene&lt;br&gt;Malnutrition&lt;br&gt;Leaving child unsupervised&lt;br&gt;Failure to provide medical care</td>
</tr>
<tr>
<td><strong>Emotional Abuse</strong></td>
<td>Anxiety, Depression&lt;br&gt;Low self-esteem&lt;br&gt;Social maladjustment</td>
<td>Verbal Account of Humiliation, Rejection, Degradation, Terrorizing</td>
<td>Observation of Humiliation, Rejection, Degradation, Terrorizing</td>
</tr>
</tbody>
</table>
Reporting Decision Tree

- Indicators below threshold
  - Further evaluate cause of symptoms
  - Consult with a colleague
  - Preliminary consultation with CPS
  - Document steps leading to decision not to report

- Indicators above threshold
  - Report to CPS (with family)
  - Document process
  - Request name of CPS worker
  - Request report status
  - Follow-up plan
Factors Influencing Reporting Decisions

- Situational Influences
  - Victim and perpetrator attributes
  - Type of maltreatment
  - Available evidence
  - Severity of maltreatment and specificity indicators

- Legal Factors
  - Knowledge of the law
  - Statutory wording
  - Legal requirements
Factors Influencing Reporting Decisions

- **Professional Characteristics**
  - Years of experience
  - Training
  - Experience reporting

- **Organizational Characteristics**
  - Ethical guidelines
  - Formal reporting
  - Institutional policy
  - Support for reporting
Mandated Reporting Challenges

- No clear definition of when a clinical hunch or intuition becomes a suspicion
- How to proceed with ascertaining if clues reflect maltreatment
- Autonomy – family may not have consented to address this issue
- Justice – therapist decision to report may be viewed as unfairly discriminating against one or more members
Mandated Reporting Challenges

- Question of what therapeutic actions are appropriate when cues consistent with maltreatment are noted involves nonmaleficience, fidelity, and autonomy
  - May feel breeching autonomy if all did not consent to pursue this line of inquiry, yet nonmaleficience is violated if fail to do so and there is harm, and thus clues must be pursued

- Therapist competence in conducting such an evaluation or seeking consultation is key
Mandated Reporting Challenges

- Reporting abuse that is suspected is legally mandated, yet may bring harm (e.g., retaliation against the child), which is unethical.
- By not taking action, the child’s rights to protection are violated, and yet taking action may result in serious disruption and harm in the family.
Mandated Reporting Challenges

- While reporting must occur, risks need to be considered and tended to and possibilities for change and safety must be considered.
- Reports must be timed to maximize safety of all parties.
- Therapist must strive to collaborate with child protective works and maintain and alliance with the family.
## Costs and Benefits of Reporting

<table>
<thead>
<tr>
<th>Report</th>
<th>Costs</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Disrupting treatment</td>
<td>• Maintaining safety</td>
</tr>
<tr>
<td></td>
<td>• Relying on CPS to handle cases</td>
<td>• Stopping maltreatment</td>
</tr>
<tr>
<td></td>
<td>• Requiring family to face CPS investigation</td>
<td>• Maintaining trust</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Taking action and believing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Starting the therapeutic process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Getting child/family services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Upholding the law</td>
</tr>
</tbody>
</table>
## Costs and Benefits of Reporting

<table>
<thead>
<tr>
<th>Not Report</th>
<th>Costs</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Failing to be trusted in terms of taking care of the child/family</td>
<td>• Maintaining confidentiality</td>
</tr>
<tr>
<td></td>
<td>• Increasing potential for further maltreatment</td>
<td>• Protecting the child and family from system</td>
</tr>
<tr>
<td></td>
<td>• Reinforcing disempowerment</td>
<td>• Keeping family engaged in treatment</td>
</tr>
<tr>
<td></td>
<td>• Assuming liability for failure to report</td>
<td></td>
</tr>
</tbody>
</table>
Mandatory Reporting: Policy without Reason

- Designers of modern CPS grossly underestimated scope of problem
- Existing resources are not adequate to handle the magnitude of the problem
- System is so over-taxed that cases of egregious maltreatment get insufficient attention
- Unclear what protective steps are best in most cases
  - Melton, 2005
Mandatory Reporting: A Policy without Reason

- Little service is offered to most families
- CPS evaluations address legal mandates rather than what is in the families best interests
- Response process has punitive connotations and is perceived by most adults as a coercive dramatic act
- The focus is less on children’s safety and best interests than on legal obligation
  - Melton, 2005
Mandatory Reporting: A Policy without Reason

- Threat of a report keeps many families from seeking help
- Act of reporting leads to disruption of treatment in ¼ of cases
- Ideally, we should consider friendly systems of assessment (rather than investigation), monitoring, and control, and respectful care except in extreme cases
  - Melton, 2005
Model for Ethical Decision-Making

- Be cognizant of key assumptions
  - All youth need to be protected from abuse and neglect
  - Mental health and medical providers act as data analysts/decision makers on a daily basis
  - All of us practice within a code of ethics
  - Decision-making is complex and subject to variations imposed by differences in people, situations, and environments
Model for Ethical Decision-Making

- Engage in a thoughtful decision-making process
  - Progress through an ethical framework, that has at its center the possession of knowledge needed for working with maltreated youth, awareness of relevant research, knowledge about legal obligations related to mandatory reporting, capacity to gain knowledge of relevant situational data in each suspected case, and willingness to consult
Model for Ethical Decision-Making

- Attend to and balance the various ethical principles, which may come into conflict
  - Autonomy
  - Fidelity
  - Justice
  - Beneficence
  - Nonmalficence

- Attend to and balance ethical guidelines that may conflict
  - Informed consent
  - Confidentiality
Model for Ethical Decision-Making

• Be mindful of
  ○ Family’s belief system
    ▸ Personal experience
    ▸ Culture
  ○ Therapeutic process
    ▸ Build trust and confidence to gather necessary information
    ▸ Collaborate with the family in devising care plan
Ethical Dilemmas

- Multiple family members make individual consent decisions and consequences of therapy and confidentiality may be different for each person and may depend on ability to give consent.
- Nonmaleficence – Therapists full disclosure about mandatory reporting invites each member to monitor disclosures, which might mean maltreatment is hidden, which prevents therapist to act to avoid harm.
Ethical Dilemmas

- Do you include the family in the reporting and/or inform them that a report was made
EVALUATIONS

Children are Fragile Handle with Care

It's going to be OK.

Put on your seatbelt I don't want you to get hurt.

OK.
Evaluations

- Evaluations need to be
  - Interdisciplinary and collaborative
    - Medical, Forensic, Behavioral Health
  - Comprehensive
  - Attuned to the inclusion (and possibly exclusion) of certain informants
  - Focused on the safety of the child’s/children’s current living environment
    - Collaborative safety planning
  - Open about issues of informed consent related to reporting (done orally and in writing with all participants)
Key Collaborators

- Evaluations may need to involve key collaborators
  - Statutory Child Protection Agency
    - Child Protective Services
  - Law Enforcement
  - Child Advocacy Centers
  - Juvenile Court System
  - Court-Appointed Special Advocates (CASA)
Evaluations: Medical

- Clinical presentation
- Medical history (e.g., accidents)
- Physical examination
  - General assessment
  - Skin injuries
  - Cranial injuries
  - Thoracoabdominal injuries
  - Skeletal injuries
- Diagnostic testing and consultations
- Documentation and diagnostic considerations
- Treatment and legal considerations
  - Kellogg & the Committee on Child Abuse and Neglect, 2007
“Guided by an ecological systemic perspective in which child victim’s functioning and development are shaped by complex, transactional processes at the levels of the individual child, the family, and the community”

- Greenbaum & Celano, 2014
Evaluations: Behavioral Health

- Developmentally-informed
- Assess
  - Child’s functioning
    - Emotional, cognitive, behavioral, social, and psychobiological
  - Trauma history and impact of trauma (PTSD?)
    - Semi-structured interviews or behavior checklists
  - Family context
    - Constellation and structure, parent-child relationship, parental stress, parenting practices, family support, etc.
  - Treatment targets for family
  - Parents’/caregivers’ reaction to maltreatment disclosure
Evaluations: Forensics

- Separate therapist versus forensic evaluator
- Therapist evaluator questions
  - Do I have enough suspicion to report?
  - How can an interdisciplinary team provide the child and family needed support?
- Forensic evaluator questions
  - Did suspected abuse occur?
    - How, What, Where, When
  - What does the child need?
  - How fit is the parent to care for the child?
Evaluations: Forensics

- Typical care and protection evaluations include:
  - Obtaining informed consent
  - Interviewing one or more parents or caregivers
  - Observing parents/caregivers with child (when appropriate)
  - Interviewing the children
  - Gathering collateral information and relevant records
  - Seeking releases for access to privileged and/or confidential records
  - Administering psychological measures or tools when indicated
    - Weiner & Otto, 2013
Evaluations: Forensics

- Key components to presenting findings:
  - Specific answer to referral question (if results are inconclusive say so directly)
  - Use theory as template to guide data interpretation
  - Interpret data in light of examinee’s history
  - Describe strengths and limitations of the data

- When making recommendations consider relevant statutory limitations (e.g. availability of services or time limits for successful rehabilitation)
INTERVENTIONS
Interventions

- Approximately 2.3 million children received post response services from a CPS agency in 2016
- Sexually abused youth receive more mental health services than other abused and neglected youth
- African American and Latino maltreated youth receive less mental health services than do Caucasian youth
  - DHHS, 2018
Interventions

Many families receive child welfare related interventions through:

- Family support (respite care, assistance to families for basic needs, mentoring and parent education programs, teen parent programs, parent support groups),
- Family preservation
- Family reunification programs (often home visiting services that provide case management, social support, and life or parenting advice)
Conducting Interventions

• Need to
  ○ Be informed by culture, development, and gender
  ○ Take into account biopsychosocial factors
  ○ Capitalize on the strengths of the child and family
  ○ Be based on the evidence
Conducting Interventions

- Therapists need to attend to
  - Conflicting needs and agendas of individuals versus the family system
  - Position of neutrality
  - Systemic attributions of responsibility for the abuse
  - Value of maintaining an intact family system – nonmaleficience for the children needs to take precedence over this value and the autonomy of the perpetrator
  - Potential conflicts between systemic perspective (justice) and responsibility to the child – ethical principles must take precedence over theoretical perspective and flexibility is key
Conducting Interventions

- Core Components of Complex Trauma Intervention
  - Safety – Create and enhance internal and environmental safety
  - Self-regulation – Bolster capacity to modulate arousal and restore equilibrium after dysregulation across domains of affect, behavior, physiology, cognition, interpersonal relatedness, and self-attribution
  - Self-reflective information processing – Develop ability to effectively engage attentional processes and executive functioning to construct self-narratives, reflect on past and present experience, anticipate and plan, and make decisions
Conducting Interventions

• Core Components of Complex Trauma Intervention
  ○ Traumatic experiences integration – Transform, incorporate, or resolve traumatic memories, reminders and associated psychiatric sequelae into a productive and fulfilling existence using meaning-making, containing or processing traumatic memories, remembering and mourning traumatic loss managing symptoms, developing coping skills, and cultivating present-oriented thinking and behavior
Conducting Interventions

- Core Components of Complex Trauma Intervention
  - Relational engagement: Repair, restore, or create effective working models of attachment and apply these to current interpersonal relationships (including the therapeutic alliance) with emphasis on development of such critical interpersonal skills as assertiveness, cooperation, perspective-taking, boundaries and limit-setting, reciprocity, social empathy, and the capacity for physical and emotional intimacy. 6. Positive affect enhancement: The enhancement of self-worth, esteem and positive self-appraisal through the cultivation of personal creativity, imagination, future orientation, achievement, competence, mastery-seeking, community-building and the capacity to experience pleasure
Conducting Interventions

- Core Components of Complex Trauma Intervention
  - Positive affect enhancement – Enhance self-worth, esteem and positive self-appraisal through the cultivation of personal creativity, imagination, future orientation, achievement, competence, mastery-seeking, community-building and the capacity to experience pleasure
  - Cook et al., 2005
Trauma-Focused Cognitive-Behavior Therapy (TF-CBT)

- Can be used with children and adolescents who have experienced traumatic life events
- Short-term treatment (12-16 sessions) that combines trauma-sensitive interventions with CBT strategies and includes individual sessions for both the child and the parents, as well as parent-child joint sessions
TF-CBT Components

- Denoted by the “PRACTICE” acronym
  - Psychoeducation and Parenting skills
  - Relaxation
  - Affective Expression and Regulation
  - Cognitive Coping
  - Trauma Narrative Development and Processing
  - In Vivo Gradual Exposure
  - Conjoint Parent-Child sessions
  - Enhancing Safety and Future Development
TF-CBT

- Best supported treatment for maltreated children
  - 5 studies contained a child and non-offending parent component
  - Between group effect sizes ranged from 0.22 – 0.70
  - Reduces symptoms of PTSD, depression, anxiety, externalizing behaviors, sexualized behaviors, and feelings of shame
  - Improves positive parenting skills and support of the child through the enhancement of parent-child communication
    - Deblinger et al., 2011; Jensen et al., 2017; Leenarts et al., 2013; Weiner et al., 2009
TF-CBT

- Best supported treatment for maltreated children
  - Addition of a trauma-narrative component is most effective in reducing abuse-related fear and general anxiety
  - TF-CBT has good support with minority youth
  - Impact of TF-CBT is maintained over time
    - Deblinger et al., 2011; Jensen et al., 2017; Leenarts et al., 2013; Weiner et al., 2009
## Eye Movement Desensitization and Reprocessing (EMDR)

### Description
- Uses eye movements, sounds, or pulsations in conjunction with focusing on a traumatic memory to create changes in the brain that help a child overcome symptoms.
- Does not require child to share trauma aloud or in order.
- The therapist follows the child along journey through memory while periodically asking what he/she is noticing.
- When each new stage of the memory is reached, the therapist “installs” the memory with eye movements or tapping.
- Allows child to mentally visit a disturbing memory in brief doses while simultaneously focusing on an external stimulus so can create new associations with traumatic memories and exercise more control.
EMDR

**Evidence-Base**

- 3 studies that made age-specific modifications including attending explicitly to emotions and cognitions and instilling motivation for behavior change
- Promising findings in terms of reductions in PTSD scores, memory related distress, and problem behavior
  - Ahmad et al., 2007; Jaberghaderi et al., 2004; Soberman et al., 2002
Child-Parent Psychotherapy (CPP)

- Description
  - Designed for 0-6 year olds with a history of trauma and symptoms
  - Based in attachment theory; integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories; addresses contextual factors that may impact the child-caregiver relationship
  - Sessions include the child and parent/primary caregiver
  - Aims to strengthen the child-caregiver relationship as a vehicle for restoring the child's cognitive, behavioral, and social functioning
Empirical Support

- 1 study with minority youth revealed a small effect size with regard to improving functioning and reducing trauma-related symptoms
  - Weiner et al., 2009
Art Activities

- 2 studies evaluated treatments in which art activities (e.g., drawing, making collages) was an important component of a holistic approach to actively address emotional and cognitive issues.

- Sample sizes were small, but one study found support for art activities as a useful tool for traumatized children to express their feelings/thoughts and release tensions.
  - Lyshak-Stelzer et al., 2007
Other Promising Interventions

- Cognitive Processing Therapy
- Therapist-Assisted Web-Based Treatment
- Seeking Safety
- Trauma Systems Therapy
- Open and Closed Group Therapy
  - Ahrens & Rexford, 2002; Lange & Ruwaard, 2010; Najavits et al., 2006; Saxe et al., 2017; Tourigny et al., 2005
Together, we can STOP child abuse and save lives.
Early Identification and Intervention

- Involvement of groups not traditionally considered as child service agencies, that can have a significant impact on risk reduction:
  - Family planning and reproductive health
  - Housing authorities
  - Neighborhood community centers
  - Community nursing services
  - HIV prevention programs
  - Programs addressing violence against women and youth violence
  - Religious institutions
  - The media
Early Child Visitation

- **Goals:**
  - Increasing parental knowledge/altering expectations about child development
  - Changing parental attitudes about child-rearing
  - Modifying interaction between parent and child
  - Increasing professional surveillance of the family

- **Outcomes**
  - Early childhood visitation programs detect a 38.9% reduction in episodes of childhood maltreatment in intervention as compared to control participants
    - Bilukha et al., 2005
Successful Relationship-Focused Programs

- Focus on families in greater need of services (e.g., preterm/chronically ill infants, teenage mothers, history of substance abuse)
- Intervention beginning in pregnancy and continuing as long the 5th year of child’s life
- Flexibility to adjust services to the family’s level of risk
- Promotion of positive physical/mental health behaviors and qualities of infant care-giving
- Measures to reduce stress within the family
- Use of nurses or trained semi-professionals
  - WHO, 2006
Parent and Family Focused Programs

- Provide education and training to parents with the goal of improving emotional bonds between parents and children

- Teach participants how to
  - Effectively discipline, monitor, and supervise children
  - Strengthen access to social support and other resources

- Programs may be particularly indicated when there are co-occurring risk factors
  - Parental mental illness and/or substance abuse
  - Intimate partner violence
  - Child conduct problems
    - Barth, 2009
Parent and Family Focused Programs

Outcomes – Universal Parent Education Program

- Improve parenting strategies
- Improve child behavior
- Important strategy for the universal prevention of violence and maltreatment against children
  - Altafim and Linhares, 2016
Parent and Family Focused Programs

- Outcomes – High Risk Families (RCTs)
  - 3/8 RCTs showed statistically significant reductions in abuse by any measure
  - 2/8 found reductions in incidents reported to CPS
  - Only home visitation has a significant evidence base for reducing child abuse and findings vary considerably
    - Levey et al., 2017
Parent and Family Focused Programs

- **Outcomes**
  - Programs for young children with components that teach parents communication skills and positive parent-child interaction skills and that include active role play and practice produce greater preventive effects than those without these components
    - Kaminiski et al., 2008
  
  - The earlier parenting and family programs are delivered in a child’s life the greater the benefits
  
  - However evidence of benefits even to adolescents
    - Spoth et al, 2000
Parent and Family Focused Programs

- Potential Prevention Programs
  - Triple P: 5 levels
    - Universal – An overall media campaign that informs about parenting issues and gets them involved in parenting programs
    - Selected – Targets one topic about which parents may receive direct or phone contact with a trainer or attend a seminar
    - Primary Care – Provides four programs for parents concerned about their children’s development or behavior and may include contact with a primary care provider
    - Standard – Teaches parenting skills in 12 individual or group sessions to parents of children with severe behavior problems
    - Enhanced – Offers 11 one-hour individual sessions and possibly home visits to parents whose children have behavioral problems and there is serious family dysfunction
  - Sanders et al. 2003
Individual-Level Strategies

- Reducing unintended pregnancies
- Increasing access to prenatal and postnatal services
- Early childhood education programs
- Training children to recognize and avoid potentially abusive situations
  - WHO, 2006
Childhood Education

- **Examples**
  - Chicago Child-Parent Center Program – provides a comprehensive educational program beginning in preschool as well as other family support services to economically and educationally disadvantaged youth
    - Reynolds et al, 2001

- **Outcomes**
  - Early childhood education programs are associated with:
    - Lower rates of official reports of abuse and neglect
    - Positive social and emotional development,
    - Less aggression and child behavior problems
    - Lower rates of juvenile arrests,
    - Higher rates of secondary school completion, and
    - Lower long-term rates of violent and criminal behavior
    - Reynolds et al., 2001; Reynolds & Robertson, 2003; Schweinhart et al., 2005
Societal and Community Strategies

- Implementing legal reforms and promoting human rights
  - Strengthen police and judicial systems
  - Promote social, economic, and cultural rights
- Introducing beneficial social and economic policies
  - Early childhood education/universal primary & secondary education
  - Unemployment reduction
- Changing social and cultural norms
- Reducing economic inequalities
- Reducing environmental risk factors
  - WHO, 2006
# Multi-Level Outcome Goals

<table>
<thead>
<tr>
<th>Time between intervention and measurement</th>
<th>Infant and child</th>
<th>Parent and family</th>
<th>Community and society</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short-term</strong></td>
<td>Infant and child development – including physical, verbal and intellectual</td>
<td>Parent-child attachment</td>
<td>Belief in the social acceptability of physical punishment for children</td>
</tr>
<tr>
<td></td>
<td>Health – for example, visits for preventive care; immunization</td>
<td>Competency as parent; attitudes about parenting</td>
<td>Discharges from hospital of children under 5 years of age, having been admitted as a result of child maltreatment and assault</td>
</tr>
<tr>
<td></td>
<td>Externalizing and internalizing behaviours</td>
<td>Parental knowledge and expectations of infant and child development – including physical, emotional, cognitive and sexual developments</td>
<td>Availability of community services to address consequences of child maltreatment</td>
</tr>
<tr>
<td></td>
<td>Hospital emergency department and other hospital admissions for intentional injuries</td>
<td>Parental knowledge, attitudes and behaviour related to discipline</td>
<td>Emergency room visits as a result of child maltreatment and assault in children under 5 years of age</td>
</tr>
<tr>
<td></td>
<td>Social competency</td>
<td></td>
<td>Adults in specified age ranges reporting adverse childhood experiences</td>
</tr>
<tr>
<td></td>
<td>Educational achievements, including school performance</td>
<td>Encounters related to child maltreatment with criminal justice system and child welfare services</td>
<td>Homicides of children under 5 years of age</td>
</tr>
<tr>
<td></td>
<td>Encounters with criminal justice system – as victim or perpetrator</td>
<td>Contacts with community service agencies</td>
<td>Deaths from child maltreatment in children under 5 years of age</td>
</tr>
<tr>
<td></td>
<td>Use of health services, for all reasons – including as hospital outpatient or inpatient, or visit to general practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-reported health-risk behaviours – such as harmful alcohol and drug use; multiple sexual partners; smoking; intimate partner violence</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parental knowledge, attitudes and behaviour related to discipline</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(UNICEF, 2006)
CASE VIGNETTES
Case 1: Linda and Stacy

- You are treating Linda, a 35 year old divorced mother of two, for depression
- She reports during a session that she is concerned about her 2 1/2 year old daughter Stacy, who returned from a visit with her father saying that her “tootie” hurt
- Linda said her daughter has been scratching at her vaginal area, making it pink and inflamed
- When she asked her daughter if anyone touched her “down there,” she said “Daddy”
Case 1: Linda and Stacy

- Linda is quite upset about the possibility that Stacy may have been sexually abused and recalled how her uncle’s friend had touched her in a way that made her feel uncomfortable when she was five.
- HOW WOULD YOU PROCEED?
Case 2: Jones Family

- You have been asked to evaluate a 10 y.o boy, Quantavious ("Tay"), referred to the clinic by CPS following an incident in which Tay’s 9 month old brother, Antwon, was mildly injured falling out the window of their one story apartment.
- The case was reported to CPS by a neighbor because the mother was not at home at the time of the accident.
- The CPS worker informs you during the intake visit that she will be closing the case now that the mother has quit her 3 to 11 pm job in a hospital so she can be home with her children.
Case 2: Jones Family

- You evaluate Tay and determine that he meets criteria for ADHD and oppositional defiant disorder.
- His mother, Ms. Jones, appears to care for both boys, but seems distracted by personal and financial issues.
- You believe Tay’s acting out behavior reflects both his desire for closeness with his mother and his resentment that she doesn’t seem to have time for him.
- You wonder if Tay expresses his anger toward his mother and his jealousy of Antwon by acting aggressively toward his brother when his mother is unavailable.
Case 2: Jones Family

- Tay, Antwon and their mother attend three evaluation sessions, but miss their next 2 sessions.
- After several unreturned phone messages, she leaves you a message that she cannot schedule any more appointments because she doesn’t want Tay to miss school and she now has a job in the afternoons/evenings.
- You try to call her back but her phone is disconnected.
- WHAT ARE YOUR NEXT STEPS?
Case 3: Alysha

- Alysha, your 15 y.o. patient, recalls your promise to keep discussions with her confidential except in cases of suicide, homicide, or abuse, and asks you to clarify “abuse”
- After determining she is interested in your definition of sexual abuse, you explain that abuse occurs when a child is touched in their private parts by an adult or is asked to touch an adult’s private parts
Case 3: Alysha

- Upon hearing your explanation, she sighs with relief and reports she is having sex with Donte, her 18 y.o. boyfriend.
- She enjoys having sex but is afraid she will be caught by her mother, who forbid her to “sleep with a boy” until she is 18.
- She says her mother doesn’t know she has a boyfriend, but that Donte’s mother knows about her.
- Asked how old Donte’s mother thinks she is, she giggles and says “16, ‘cause that’s what I told them!”

**WHAT ARE THE ETHICAL AND LEGAL CONSIDERATIONS WITH THIS CASE AND HOW WOULD YOU RESPOND CLINICALLY?**
Case 4: Terrell

- You are supervising an intern who has been asked to evaluate and treat Terrell, a 4 y.o. boy for sex play, nightmares, and oppositional behavior.
- His mother reports he frequently plays with his penis and was caught touching his 3 year old sister’s genitals during a shared bath.
- During play with a dollhouse, Terrell places a male doll on top of a female doll, makes kissing sounds and humping movements with the dolls.
- You ask “Did someone do that to you?” and he says anxiously, “They are loving” and then moves to play with some toy trucks.
- WHAT ARE YOUR NEXT STEPS?
You have been retained by a criminal defense attorney to conduct a confidential evaluation to assist with a possible insanity defense for Ms. Chandler, a defendant charged with aggravated assault against a neighbor.

In the course of her interview with you, Ms. Chandler, who is out on bond, related that she has physically abused her children a number of times, including shortly prior to her arrest for the current charges.

There is no indication that this abuse has been reported or investigated.
Case 5: Ms. Chandler

- You tell her attorney of your obligation to report this suspected abuse
- The attorney directs you not to make a report, stating that attorneys have no such reporting obligation and indicating that all that has been related to you is covered by attorney-client privilege
- **HOW DO YOU DEAL WITH THE MOTHER AND THE ATTORNEY AND HOW WOULD YOU PROCEED WITH CPS?**
Case 6: Lopez Family

- You see Ms. Lopez (depressed) and her two children Julio (10) (aggressive, oppositional) and Adrianna (8) (anxious) for family therapy
- Mr. Lopez refuses to attend
- Ms. Lopez privately discloses to you that her husband has repeatedly threatened and assaulted her, most recently a month ago
- She denies he abuses the children, but admits the children have witnessed some of the domestic violence incidents

WHAT ARE YOUR ETHICAL, LEGAL, AND CLINICAL RESPONSIBILITIES?
Case 7: Newborn Kim

- Kim is born to a mother who heavily uses alcohol and drugs
- Upon her birth, Kim shows no signs of being under the influence
- SHOULD YOU SEND KIM HOME WITH HER ADDICTED PARENTS WHOSE BEHAVIOR AND CONDITION MAY CONSTITUTE A FUTURE HIGH RISK TO KIM OR CONTACT CPS?
- HOW, IF AT ALL, WOULD YOU HANDLE THIS DIFFERENTLY, IF KIM APPEARED QUITE JITTERY UPON BIRTH?
Case 8: Asthmatic Chun

- Chun is a 9yo with serious asthma, who is extremely symptomatic, needs frequent hospitalizations, and often misses school
- When you speak with her parents, Mr. and Mrs. Han, they are very deferential and nod in agreement, but cannot give specifics about what they do to manage her asthma at home
- HOW DO YOU DETERMINE MEDICAL NEGLECT AND IF FOUND, HOW SHOULD IT BE ADDRESSED?
Case 9: Past Abuse

- You are a psychologist who works mainly with adolescents and young adults
- You begin treating a 20 year old woman for relationship difficulties who discloses that when she was 12 her uncle sexually molested her on a number of occasions
- You are the first person she has told and she fears that if anyone in the family learned of the abuse, a major rift would occur
- The uncle has moved away and she has had no further contact with him
- HOW DO YOU PROCEED?
Questions
Make the World Violence Free
Engage in Social Change