Common Core 3.0

Child Maltreatment Identification Skills Lab

Trainee Guide

December 31, 2018

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Introduction to Common Core

Common Core curriculum and training for new child welfare workers in California is designed to be generalizable across the state, cover basic child welfare knowledge and skills and is important for all CWS positions with in an agency.

California's Common Core Curricula for Child Welfare Workers is the result of the invaluable work and guidance of a great many people throughout the child welfare system in California and across the country. It would be impossible to list all of the individuals who contributed, but some groups of people will be acknowledged here.

The Content Development Oversight Group (CDOG) a subcommittee of the Statewide Training and Education Committee (STEC) provided overall guidance for the development of the curricula. Convened by the California Social Work Education Center (CalSWEC) and the California Department of Social Services (CDSS), CDOG membership includes representatives from the Regional Training Academies (RTAs), the University Consortium for Children and families in Los Angeles (UCCF), and Los Angeles County Department of Children and Family Services.

In addition to CDOG, a Common Core 3.0 subcommittee comprised of representatives from the RTAs, the Resource Center for Family Focused Practice, and counties provided oversight and approval for the curriculum development process.

Along the way, many other people provided their insight and hard work, attending pilots of the trainings, reviewing sections of curricula, or providing other assistance.

California's child welfare system greatly benefits from this collaborative endeavor, which helps our workforce meet the needs of the state's children and families.

The Children's Research Center provided technical support as well as The Structured Decision Making System that includes the SDM 3.0 Policy and Procedure Manual and Decision Making Tools. These resources are used in compliance with CRC copyright agreements with California. Additionally, content in this curriculum has been adapted from CRC's SDM 3.0 classroom curriculum to meet the training needs in California.

In compliance with the Indian Child Welfare Act (1978) and the California Practice Model, social workers must identify American Indian/Alaska Native children in the system. For an overview of *Implementing the Indian Child Welfare Act* view: https://www.youtube.com/watch?v=BIQG65KFKGs

The curriculum is developed with public funds and is intended for public use. For information on use and citation of the curriculum, please refer to: : https://calswec.berkeley.edu/programs-and-services/child-welfare-service-training-program/common-core-30

FOR MORE INFORMATION on California's Core Curricula, as well as the latest version of this curriculum, please visit the California Social Work Education Center (CalSWEC) website: http://calswec.berkeley.edu

Curriculum Introduction

This classroom module is preceded by an e-learning module that introduces key knowledge components used in the class. It is strongly recommended that trainees complete the e-learning module prior to attending the classroom module.

This training module is intended to be an activity-based skill building exercise for new child welfare social workers. The module offers trainer facilitated vignette activities with a focus on providing a framework for identifying child maltreatment using direct observation, interview, and consultation. The curriculum does not include practice identifying sexual abuse, but instead provides a framework for consulting with law enforcement, medical practitioners, and others to coordinate forensic interview and examination. Trainees will need additional, advanced training to further develop skills in forensic interviewing and identifying sexual abuse.

Agenda

Segment 1: Welcome and Stage Setting

Segment 2: Defining Maltreatment

Break

Segment 3: Identifying Maltreatment

Lunch

Segment 4: Culture, Bias and Child Maltreatment Identification

Segment 5: Assessing for Sexual Abuse

Segment 6: Indicators of Maltreatment

Break

Segment 7: Review

Segment 8: Embedded Evaluation

Learning Objectives

Knowledge

K1. The trainee will be able to identify physical, emotional, and behavioral characteristics of children who have been maltreated.

K2. The trainee will be able to identify cultural practices that may be mistaken for child maltreatment.

K3. The trainee will be able to identify when to seek consultation from medical staff, Behavioral Health professionals, law enforcement, or forensic experts during child maltreatment identification efforts.

Skill

S1. The trainee will be able to use the child maltreatment indicators to identify child maltreatment in a vignette.

S2. Using a vignette, the trainee will be able to identify cultural factors that affect child maltreatment identification, including distinguishing child maltreatment from cultural factors.

S3. Using a vignette, the trainee will be able to identify developmental factors that affect child maltreatment identification.

S4. Using a vignette, the trainee will critically analyze motivation, credibility and the information provided by family members and others regarding sexual abuse.

Values

V1. The trainee will value using a strength-based model of practice that provides a holistic view of the family as part of the child maltreatment identification process.

V2. The trainee will value an understanding of how poverty, lack of education, community distress and environmental stressors can contribute to risk for child maltreatment.

V3. The trainee will value working collaboratively with agency resources, law enforcement and medical, mental health, and forensic experts in identifying child maltreatment.

Multicultural Guidelines

Instructions:

1. Read the Multicultural Guidelines.
2. Identify the guideline that resonates most with you.
3. Introduce yourself and share the guideline that you identified.

Multicultural Guidelines for Communicating Across Cultures[1]

Try things on	• **Try on** each other's ideas, feelings, and ways of doing things for the purpose of greater understanding. Keep what you like and let go of the rest at the end of each interaction, discussion, session.
It's OK to disagree	• **It's okay to disagree and NOT okay to blame, shame, or attack ourselves or others because** of our differences. One of the necessary ingredients for differences to be expressed and valued is that people let go of the need to be, think, or act the same.
"I" statements work!	• Begin by **talking about your own experience**. It is helpful to make "I" statements when speaking about your experience, rather than saying "you", "we," or "someone." When you intend to refer to others, be specific about them by name or group. This invites and creates space for multiple perspectives to be shared especially when they are different than yours.
Intent and impact matter	• Be aware that **your good intentions may have a negative impact**, especially across racial, gender, or other cultural differences. Be open to hearing the impact of your statement.
Think both/and	• Look for ways **to fit ideas together** and not set up an "either/or" process or a competition between ideas. Look for the existence of many truths from the perspectives of the many cultural backgrounds involved or that you are serving.
Process and Content	• **Notice both process and content** during work sessions. Content is what we say, while process is how and why we say or do something and how the group reacts. Notice who is active and who is not, who is interested and who is not, and ask about it.
Confidentiality	• **Confidentiality** with regard to personal sharing is important. Allow others to tell their own stories. Ask first to see if an individual wants to follow up on the initial conversation. Do not use any information shared negatively toward a progress report or against a supervisor.
It's OK to be uncomfortable	• **Learning from uncomfortable moments** is an important part of this process, so pay attention to your feelings.
Which of these resonates most with you?	

[1] Adapted from the Multicultural Tool created by VISIONS, Inc.—added info by Amy Cipolla-Stickles. VISIONS, Inc. is a nonprofit training and consulting enterprise providing a variety of services that support organizations, communities, and individuals as they continue to clarify their diversity-related goals and engage in a dynamic process of multicultural development. VISIONS, Inc. was established in 1984 as a nonprofit, educational organization. Today it is a 501(c)(3) entity with offices in Roxbury, Massachusetts and Rocky Mount, North Carolina and is supported by a team of consultants around the United States and abroad. www.visions-inc.org

Definitions of Abuse and Neglect

Penal Code

The California Penal Code, specifically the Child Abuse and Neglect Reporting Act (CANRA), outlines the criteria and definitions of abuse and neglect to be used to guide social workers when assessing a referral that contains an allegation of abuse and/or neglect. In addition to defining what meets the criteria of child abuse and neglect to assist the social worker when investigating and assessing for abuse and neglect, CANRA also outlines how the referrals are concluded (substantiated, inconclusive or unfounded) after the investigation is completed. Social workers must consider these definitions when identifying an outcome for a child maltreatment allegation: A social worker should not look to the Welfare and Institutions Code to determine if a referral meets the criteria of child abuse and neglect. That step takes place later.

PC 11165.1	Sexual Abuse and Exploitation – defines sexual abuse as sexual assault or exploitation including rape, statutory rape, incest, sodomy, oral copulation, sexual penetration, child molestation, commercial sexual exploitation, or lewd and lascivious acts
PC 11165.2	Neglect – defines neglect as the negligent maltreatment of a child by a parent or designated caregiver.
PC 11165.2	Severe neglect – defines severe neglect as withholding food/water on a prolonged, willful basis and / or failure to provide medical treatment which will result in permanent and/or severe illness or death.
PC 11165.3	Willful harming and endangering – defines abuse as a situation in which any person willfully causes or permits any child to suffer unjustifiable **physical pain** or **mental suffering** or permits the child to be placed in a situation in which his or her person or health is endangered.
PC 11165.4	Unlawful corporal punishment – defines abuse as willfully inflicted cruel or inhuman corporal punishment or injury by any person resulting in a **traumatic condition.**

It is important for social workers to understand that the Penal Code sections above (as part of CANRA) do not always require the act against the child to be committed by the parent or legal guardian. Please note those sections that would allow a social worker to substantiate an allegation against a non-parent if the investigation found that it was more likely than not that child abuse or neglect as defined within PC 11165.1-11165.4 has occurred.

Welfare and Institutions Code

Once a social worker has found that child abuse or neglect has occurred and substantiates a referral, court intervention may be necessary. If the social worker determines that court intervention is necessary, the social worker will then need to determine where the case facts fit in within the definitions set forth in the Welfare and Institutions Code. The Welfare and Institutions Code is different from the CANRA that is contained within the

Penal Code. The sections of CANRA contained in the Penal Code MUST be found to be true (substantiated) before any next steps regarding the Welfare and Institutions Code can take place. Once the social worker substantiates and determines that court intervention should take place, THEN the social worker will look to the Welfare and Institutions Code. The Welfare and Institutions Code Section 300 (a-j)[2] outlines the criteria that are used to petition the juvenile court for intervention on behalf of maltreated children. The juvenile court must find that one or more of these sections describes a child in order to become involved or take jurisdiction over that child:

300(a)	Physical harm/abuse – Physical harm/abuse – The child has suffered, or there is a substantial risk that the child will suffer, serious physical harm inflicted non-accidentally upon the child by the child's parent or guardian.
300(b)(1)	General neglect – The child has suffered, or there is a substantial risk that the child will suffer, serious physical harm or illness, as a result of the failure or inability of his or her parent or guardian to adequately supervise or protect the child, or substantial risk that the child will suffer, serious physical harm or illness, as a result of the failure or inability of his or her parent or guardian to adequately supervise or protect the child.
300(b)(2)	Commercial Sexual Exploitation – sexual exploitation of a child who is sexually trafficked or who receives food or shelter in exchange for, or who is paid to perform, sexual acts and whose parent or guardian failed to, or was unable to, protect the child
300(c)	Emotional abuse – The child is suffering serious emotional damage or is at substantial risk of suffering serious emotional damage, evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior toward self or others, as a result of the conduct of the parent or guardian or who has no parent or guardian capable of providing appropriate care.
300(d)	Sexual abuse – The child has been sexually abused, or there is a substantial risk that the child will be sexually abused by a parent, guardian, or member of the household.
300(e)	Severe physical abuse of a child under age 5 – a single act of abuse inflicted by a parent or any person known by the parent which if left untreated could cause permanent physical disfigurement, disability, or death
300(f)	Death of a child through abuse – parent or guardian caused the death of another child through substantiated abuse or neglect
300(g)	Caregiver absence – the child has been left with no provision for support
300(h)	Relinquishment or termination of parental rights – the child has been freed for adoption for 12 months or no adoption has been made
300(i)	Cruelty – the child experienced acts of cruelty by the parent, guardian, or a member of the household

[2] Click here for the full text: W&I Code 300 (a-j)

300(i)	Substantial risk based on substantiated abuse of a sibling – the child is at risk based on maltreatment of a sibling

Key Things to Note[3]

- These things (if found to be true) allow the juvenile court to become involved in the child's life – they allow the court to take jurisdiction – these are not the definitions used to substantiate allegations of abuse or neglect or to bring criminal charges – we'll look at those next.
- It is important to be aware of the differences in who commits the abuse or neglect in each of these sections. For sections a, b, and c, the abuse or neglect must be caused by a parent or guardian. For section d, it must be caused by a parent, guardian or member of the household. For section e, it must be caused by a parent or a person known by the parent.
- For sections a, b, c, and d, the section applies if the abuse or neglect occurred **or** if there is **substantial risk** that it could occur.
- Pay careful attention to section c. This section may not be used to describe a child whose family chooses not to provide Behavioral Health treatment based on a sincerely held religious belief as long as there is a less intrusive judicial intervention is available.
- In order for sections f or j to apply, the acts against a sibling must be substantiated.
- Caregiver absence does not apply to situations in which an absent parent has made arrangements for the care of their child unless that designated caregiver is refusing to provide care and the parent cannot be located or cannot provide care. This section does not apply in situations where there is a parent present who is able to provide care (for example the mother is present and able to provide care, but the father is whereabouts unknown). Just remember, if the child has a caregiver, section g does not apply.
- Section h is used to allow the court to take jurisdiction if an adoption plan did not work out. It is used only in specialized situations.
- Like section d, Section i is applicable if the abuse is committed by a parent or guardian or member of the household. This could include a non-related household member.

Exceptions to W&I Code Sections 300(a-j)

The Welfare and Institutions Code provides some important exceptions to sections 300(a-j). These exceptions are intended to protect individual rights related to use of corporal punishment; to protect religious freedom; and to clarify that a parent's disability status, foster care status, or homelessness is not considered neglectful. It is important to remember these

- **Serious physical harm does not include reasonable and age-appropriate spanking to the buttocks where there is no evidence of serious physical injury.**
- **No child shall be found to be dependent solely due to the lack of an emergency shelter for the family.**
- **A physical disability, such as blindness or deafness, is not considered a bar to raising happy and well-adjusted children unless a parent's disability prevents him or her from exercising care and control.**
- **A child whose parent is in foster care shall not be considered to be at risk of abuse or neglect solely because of the age or foster care status of the parent.**
- **In any case in which a child is alleged to be dependent on the basis that he or she is in need of medical care, the court must give consideration to any treatment being provided to the child by spiritual means through prayer**

[3] From: https://www.childwelfare.gov/systemwide/laws_policies/statutes/define.pdf

exceptions when applying the 300 code sections[4]:	**alone in accordance with the tenets and practices of a recognized church or religious denomination by an accredited practitioner thereof.**

[4] From the Child Welfare Information Gateway Definitions of Child Abuse and Neglect

Maltreatment Definition and Identification Activity

Instructions:

1. In the field you would never draw conclusions based solely on written information. You would need to collect information from multiple sources and complete a thorough investigation that assesses the safety concerns and the family's strengths for the purposes of this training room activity we will be reading information and identifying possible code sections that may apply in the scenario. The purpose of this activity is to allow you to practice assessing and considering maltreatment definitions and factors associated with maltreatment.
2. Read the first vignette (Ashia and Paislee).
3. Working as a table group, use the definitions of abuse and neglect set out in CANRA to decide which, if any, Penal Code (PC) Sections apply and why
4. Read the next vignette (Frank and Gorindi)
5. Now assume the referral has been substantiated and this family requires court intervention, use the Welfare and Institutions Code (WIC) Section(s) to determine which sections may apply (if any) to this family in order to allow for court jurisdiction.
6. Working as a table group, use the ***Identifying Neglect***, ***Identifying Physical Abuse***, ***Identifying Emotional Abuse***, and ***Identifying Sexual Abuse*** content to identify key factors that contribute to your conclusion.
7. Working as a table group, develop a ***short*** statement explaining which factors in the vignette justify your conclusion - imagine using this statement in a conversation with a family member or supervisor to explain why you think maltreatment did or did not occur.

Vignette 1: Ashia and Paislee

According to the report, 2-year-old Paislee is not walking or talking. Paislee is delayed and her hand/eye coordination is equivalent to a child about six to eight months old. Paislee does not crawl but will pull herself up. She cannot stand alone. Paislee does not get startled at loud sounds. When Paislee looks at an object, she will move her head back and forth as if trying to focus. Paislee has problems swallowing and it appears she is choking when trying to swallow. Paislee had an eye infection and an in-grown toenail for months, but her mother, Ashia, did not take her to the doctor until the reporting party threatened to call children's services, and even then, Ashia did not follow up with the treatment recommended by the doctor. Paislee was referred to a neurologist but did not have an appointment. Ashia was also supposed to follow up with lab work, schedule an MRI and have Paislee tested by an audiologist. To date, Ashia has not followed up on any of these appointments. Ashia appears distant and unconnected to Paislee, leaving her alone in her crib for big chunks of the day. Ashia does not have basic information about developmental milestones or clear expectations of what a 2-year-old should be doing developmentally.

1. Look at the facts in the referral and discuss the dynamics on neglect and what you would need in order to substantiate neglect or severe neglect.

2. Identify the appropriate Penal Code and Welfare and Institutions Code you would use based upon your discussion.

Vignette 2: Shilpa, Frank, and Gorindi

According to the report 14-year-old Gorindi has been seen by the school counselor daily for the past 4 months because she is experiencing periods of crying in the classroom and becomes disruptive by frequently interrupting the teacher and other students by touching them inappropriately. Gorindi is in a special day class and is diagnosed with a non-specific developmental delay. Gorindi lives at home with both parents. She speaks lovingly of her mother Shilpa but does not talk about her father Frank. Shilpa reports that Gorindi is afraid of the dark and has frequent nightmares. Because of the change in her demeanor, Gorindi's mother took her to the doctor for a physical and the doctor noted vaginal redness and anal tearing. After speaking with the child, Gorindi has disclosed that her father has been coming into her room at night which is why she has nightmares. The child also indicates that her mother is also fearful of the father. You substantiate the referral against the father and the mother as well.

1. What kind of abuse do you think is present in this vignette; Identifying ***Neglect***, ***Identifying Physical Abuse***, ***Identifying Emotional Abuse***, **or** ***Identifying Sexual Abuse?*** Identify 3 key factors from the material on this content (pg. 18-39) that contributed to your conclusion.

2. Assume that the referral against the father was substantiated (talk amongst yourselves to determine which allegations you could substantiate). This family will now require court intervention, which Welfare and Institutions Code (WIC) Section(s) (pg.11) apply (if any).

3. Develop a ***short*** statement explaining which factors in the vignette justify your conclusion - imagine using this statement in a conversation with a family member or supervisor to explain why you think maltreatment did or did not occur.

Vignette 3: Mackenzie, Nina, and Madrid

According to the report, Mackenzie and Nina adopted 4-year-old Madrid at birth. Madrid appeared at school with a bruise on his forehead and multiple red, scabbed, linear scratch marks on his arm, curving around the arm. The teacher notes that Madrid has attention and focus challenges and can be difficult to contain during class time. The teacher notes that Mackenzie speaks often of her ongoing behavioral challenges with Madrid and describes him as a "bad" child. When asked about the injury, Madrid stated that his mom grabbed him and fought him to make him stay in time out. He hit his head when she pushed him down.

1. What kind of abuse do you think is present in this vignette; Identifying ***Neglect***, ***Identifying Physical Abuse***, ***Identifying Emotional Abuse***, **or** ***Identifying Sexual Abuse?*** Identify 3 key factors from the material on this content (pg. 18-39) that contributed to your conclusion.

2. You have investigated the allegations and believe the family is in need of court intervention. Given the facts provided in this vignette, which Welfare and Institutions Code (WIC) Section(s) would allow for court jurisdiction?

3. Develop a ***short*** statement explaining which factors in the vignette justify your conclusion - imagine using this statement in a conversation with a family member or supervisor to explain why you think maltreatment did or did not occur.

Vignette 4: Jenny, Tyler, Isabelle, and Joshua

According to the report, Jenny and her husband Tyler were involved in a domestic dispute. The parents were arguing in the kitchen. The father was trying to leave the home and the mother was blocking his exit. The father grabbed the mother by the throat and pushed her down to the ground. She hit her head on the edge of the table as she fell. The mother experienced a head wound with significant bleeding. 8-year-old Isabelle attempted to get between her parents during the incident and was splashed with her mother's blood. 6-year-old Joshua called 911. The father left the home prior to the arrival of police and paramedics. Both children witnessed the incident. Paramedics responded and were unable to stop the bleeding at the scene. The mother was transported to the Valley Medical Center where she received 14 stitches. She also had bruises on her throat and her left arm from the altercation. The mother reported that this was the third incidence of physical fighting in her relationship with her husband. She had never contacted police about the intimate partner violence. There is no history of police interaction with the family. The mother was not under the influence of drugs or alcohol at the time of the incident, but she stated the father had been drinking beer. Isabelle and Joshua were very upset by the blood in the home on this occasion and following previous events of intimate partner violence. They have experienced symptoms of anxiety and hyper-vigilance. Isabelle is showing delays in her school work and is reading below grade level. Joshua sees the resource teacher for assistance with social skills and anger management at school.

1. What kind of abuse do you think is present in this vignette; ***Identifying Neglect***, ***Identifying Physical Abuse***, ***Identifying Emotional Abuse***, **or** ***Identifying Sexual Abuse?*** Identify 3 key factors from the material on this content (pg. 18-39) that contributed to your conclusion.

2. What sections of the Penal Code would you look to in order to assess whether or not there has been child abuse or neglect? Which definition of child abuse and neglect would you possibly substantiate? Following substantiation, what Welfare and Institutions Code applies, if any?

3. Develop a ***short*** statement explaining which factors in the vignette justify your conclusion - imagine using this statement in a conversation with a family member or supervisor to explain why you think maltreatment did or did not occur.

Identifying Neglect

What could neglect look like?

Lack of food

- **What to look for:** Look in the kitchen to determine whether or not there is safe, edible food in the home; Child is thin, begging for food, malnourished, dehydrated; Child is depressed/ withdrawn/fearful; Child rocks, self-comforts, is extremely clingy
- **Additional considerations:** Infant with non-organic failure to thrive (medical assessment of low weight identifying no known illness causing the low weight)
- **Information to gather:** What food is available in the house now; What the children ate for dinner last night; What is the caregiver's plan for getting food for the family; What food assistance the family receives
- **Think about:** Consider cultural differences when assessing food. It is not necessary to have "typical" foods of any one culture.

Lack of clothing

- **What to look for in the home:** Available, clean, weather appropriate clothing
- **Think about:** Consider cultural differences when assessing for adequate clothing. For example, families vary in their definition of cold weather and their use of winter clothing
- **Information to gather:** What clothes the child has for tomorrow; What the child wears when it is cold; What is the caregiver's plan for keeping the child clean, warm, and dry

Inadequate or unsafe shelter

- **What to look for in the home:** Hazards such as electrical wires, structural problems; Health hazards due to cleanliness concerns; Fire safety due to extreme clutter
- **Information to gather:** The reason for the wires/structural problems and when they will be resolved; What is the caregiver's plan for getting out in case of a fire; What actions on the part of the caregiver have contributed to the unsanitary conditions

Lack of supervision

- **What to look for:** Child left unattended in an unsafe situation (too young to be alone; unsafe environment – hot car, near hazards); Child left with caregiver who is inattentive due to behavioral health or substance use disorders; Child frequently injured; Child chronically sleepy, dirty, hungry, truant; Child is depressed, withdrawn or fearful; Child rocks, self-comforts, is extremely clingy; Child is destructive
- **Information to gather:** The usual plan for watching the children; Who is usually in charge of making sure the children are safe, clean, fed, etc.; What supports the family has for helping with watching the children
- **Think about:** Family differences related to leaving children in the care of older children

Medical neglect

- **What to look for:** Significant and painful tooth decay with failure to obtain treatment; Failure to obtain medical treatment resulting in pain or prolonged illness
- **Information to gather:** What the caregiver has done to get medical or dental care for the child; What alternative treatments they have tried; Barriers to getting treatment; The family's religious or cultural beliefs about medical treatment

Exposure to unsafe situations

- **What to look for:** Presence of dangerous substances in the home (drug lab in the home; unsecured weapons, drugs, or drug paraphernalia within reach of the child); Violence in the presence of the child, behavioral health of the parent(s)/caregivers
- **Information to gather:** Where the child was located in relation to the harm; The plan the parent(s)/caregivers had to keep the child safe

Behavioral and Developmental Indicators

Children who are neglected may exhibit a variety of internalizing or externalizing behaviors because of the maltreatment. These behaviors don't indicate that neglect is happening, but they may raise a red flag for additional inquiry.

- agitation and irritability
- nightmares, bedwetting, and other sleep difficulties
- avoidance of certain activities or people
- hyper vigilance
- poor appetite or overeating
- low self-esteem
- feelings of hopelessness
- attention problems such as not listening when spoken to or difficulty organizing tasks
- excessive talking
- difficulty awaiting their turn
- bullying or threatening others
- being physically cruel to people or animals
- playing with or starting fires
- stealing
- destroying property (DePanfilis, 2006).

Child neglect also negatively affects child development. All aspects of a child's development are negatively affected by neglect. These behaviors don't indicate that neglect is happening, but they may raise a red flag for additional inquiry (DePanfilis, 2006).

Data indicate several key elements commonly associated with neglect. These elements do not cause neglect. Their presence does not always mean neglect is present. Their presence should raise concern and lead to greater efforts to engage with the family and determine if neglect is present.

Behavioral indicators may raise suspicion that a child is being neglected or abused. However, certain behaviors that may indicate neglect or abuse may, in fact, NOT be due to neglect or abuse. Red flags in terms of behavior should be checked out with others such as teachers, relatives, etc. as well as by observation and interview.

Other Factors Linked to Neglect

Factors Related to the Child	
Developmental Needs	□ Children with intellectual, developmental or physical disabilities are more likely to experience neglect. □ Special needs children experience maltreatment at 1.7 times the rate of children without a disability (DePanfilis, 2006 as cited in Goldman, J & Salus, M.K., 2003).
Chronological Age	□ Children ages 1-5 experience the highest rates of neglect (NCANDS 2012 data). □ Children aged 15 to 17 are at greater risk for physical and educational neglect compared to children of other age groups (Schumacher, Slep & Heyman (2000) as cited in Sedlak, 1997).
Temperament and Behavior	□ Children who experience early neglect exhibit higher levels of aggression □ Children who are described by their mothers as having behavior problems are more likely to be neglected □ Passive, nonassertive and withdrawn behaviors (DePanfilis, 2006). □ Maternal report of child conduct disorder symptoms is predictive of child neglect (Schumacher, 2000).
Factors Related to the Parents	
Child Development Knowledge	□ Parents who are unaware of the developmental and cognitive abilities of children at different ages may have unrealistic expectations and be more likely to neglect their children (DePanfilis, 2006).
Child Welfare History	□ Mothers who have neglected their children are three times more likely to have been sexually abused than mothers who do not neglect their children (DePanfilis, 2006).
Family Communication and Interaction Patterns	□ Families with a history of neglect showed less empathy, openness, emotional closeness, willingness to negotiate and willingness to take responsibility for actions (DePanfilis, 2006). □ Parents who are inconsistent with discipline or use harsh or excessive punishment can be at risk for neglecting their children (DePanfilis, 2006). □ Mothers with a history of substantiated neglect are more likely to: o engage in verbal aggression and negative behavior towards their child; o issue more commands at their child; o have low self-esteem and be less outgoing and socially skilled; o report a high-level of pervasive and smaller daily stressors; and o Perceive their child's behavior as conduct disorder, socialized aggression, and/or attention problems. □ Mothers with a history of substantiated neglect are less likely to: o interact positively with their child; o be verbally accessible (i.e., warmth when talking to or in discussion with children, answering questions with complete sentences, and stating opinions directly);

	○ attach internal and stable attributions to their child's positive behaviors
Family Composition	Single parenthood is associated with higher incidence of neglect (DePanfilis, 2006).
Stress	Neglectful families report more day-to-day stress than non-neglectful families. Stressors include: financial difficulties; substance use disorder problems; housing problems; or illness. (DePanfilis, 2006).
Substance use disorder	Neglect has the strongest association with substance use disorder among all maltreatment subtypes. Children whose parents abused alcohol and other drugs were likely to be neglected at four times the rate of children whose parents do not abuse substances; and 65-percent of maltreated children whose parents have problems with substance use disorder were maltreated while the parent was intoxicated (DePanfilis, 2006).
Intimate Partner Violence	Children who live in a home where intimate partner violence is present are at a greater risk of being neglected (DePanfilis, 2006).
Behavioral Health	As with all risk factors, the presence of Behavioral Health problems doesn't mean that a parent will be neglectful, but it is a characteristic that can be present more often in neglectful parents (DePanfilis, 2006)
Elements Related to the Environment	
Poverty	Compared to other child maltreatment subtypes, neglect is more directly associated with poverty; however, it is important to note that many poor families are well adjusted and competent (DePanfilis 2006) and poverty can be mistaken for neglect if social workers are not carefully considering class differences and possible bias when assessing for neglect. Communities with high poverty, high school dropout rates, and fewer two parent families also experience greater rates of substantiated neglect (Schumacher et al, 2000).
Social Support	Families lacking formal and informal social supports experience higher rates of neglect (DePanfilis, 2006).

Challenges in identifying neglect

There is a statistical link between child maltreatment, including neglect, and poverty (Lane et al, 2011). The Fourth National Incidence Study in 2010 found that children living in poverty had a significantly higher rate of identified neglect compared to children not living in poverty. The risk of neglect for children living in poverty is over 8 times the rate for children not living in poverty.

Children with an unemployed parent experience neglect at a rate of 23.0 children per 1,000, which is almost 4 times the rate of physical neglect for children with employed parents (6.0 children per 1,000). Children who had no parent in the labor force (25.5 per 1,000) were neglected at more than 4 times the rate of children with employed parents.

- **Cultural groups have differences in values, norms, and standards of acceptable child rearing**
- **Poverty itself does not constitute neglect, but children living in poverty are more likely to experience neglect**
- **Neglect and class differences can sometimes be confused with neglect**

This link between child abuse and poverty can be explained in a number of ways. It is possible that experiencing poverty generates family stress, which in turn, leads to greater likelihood of abuse or neglect. Parents living in poverty do not have access to the resources necessary and are unable to provide appropriate care for children. Or, it's possible that other factors (e.g., substance use disorder) may cause parents to be more likely to be both poor and abusive or neglectful.

Neglect must be considered within the family's culture and the social worker must talk to the family about cultural expectations for parenting. Reaching an understanding between cultural expectations and legal requirements can be challenging. Social workers should seek assistance through supervisor consultation and exploration of cultural values.

Identifying Emotional Abuse

Emotional abuse has the lowest substantiation rate of any child maltreatment subtype (Kairys et al., 2002), perhaps because psychological maltreatment involves "a relationship between the parent and the child, rather than an event or series of repeated events occurring within the parent-child relationship" (Hibbard et al., 2012).

Emotional abuse often occurs along with other forms of child abuse and neglect. Garbarino (et al 1986) define emotional abuse as a "concerted attack by an adult on a child's development of self and social competence, as a pattern of psychically destructive behavior".

Emotional abuse can be:

- **Difficult to define and evaluate - the child must have a Behavioral Health condition that is explicitly linked to behavior by the parent**
- **Difficult to prove in court**
- **Often combined with other factors of abuse**

Emotional abuse must be considered within the family's culture.

What could emotional abuse look like?

Parent behaviors to look for:

- Spurning (belittling, degrading, shaming, or ridiculing);
- Terrorizing (committing life threatening acts; making a child feel unsafe);
- Denying emotional responsiveness (ignoring a child or failing to express affection)
- Rejecting (avoiding or pushing away)
- Isolating (confining)
- Unreliable or inconsistent parenting (contradictory or ambivalent demands)
- Neglecting Behavioral Health needs (failing to provide treatments or services for emotional problems)
- Exposing the child to intimate partner violence

Child behaviors to look for:

- Child experiencing untreated behavioral or emotional difficulties
- Child prohibited from leaving home or interacting with others
- Child who is very clingy with parent
- Child who is very fearful of parent

Information to gather:

- What has the caregiver done previously undertaken to help with the behavior
- The parents' or caregivers' thoughts about the child's Behavioral Health needs
- Possible systemic barriers to getting Behavioral Health treatment

Think about:

- Cultural differences in use of Behavioral Health treatment
- Cultural differences in autonomy of children
- Cultural differences in parent child interactions

Data indicate several key elements commonly associated with emotional abuse. These elements do not cause emotional abuse to occur. Their presence does not always mean emotional abuse is present. Their presence

should raise concern and lead to greater efforts to engage with the family and determine if emotional abuse is present.

Behavioral indicators may raise suspicion that a child is being abused. However, certain behaviors that may indicate emotional abuse may, in fact, NOT be due to abuse. Red flags in terms of behavior should be checked out with others such as teachers, relatives, etc. as well as by observation and interview.

Other Factors Related to Emotional Abuse

Factors Related to the Child	
Race and Ethnicity	Children who self-identify as "other" are at increased risk for child emotional abuse, compared to white, Black, and Hispanic children (Black et al, 2000).
Gender	Boys are slightly more likely to experience emotional abuse compared to girls (Black et al, 2000).
Temperament and Behavior	Child aggression, vandalism, and interpersonal problems (e.g., difficulty making friends) are significantly associated with emotional abuse (Black et al, 2000).
Factors Related to the Parents[5]	
Family Communication and Interaction Patterns	Harsh parenting interactions: o Isolation – Confining the child and limiting interaction with others o Unreliable or inconsistent parenting - Rejection, contradictory or ambivalent demands o Spurning - belittling, degrading, shaming, or ridiculing) o Terrorizing - committing life threatening acts; making a child feel unsafe) (Moran et al, 2008) Neglecting Behavioral Health, medical and educational needs - Ignoring, preventing, or failing to provide treatments or services for emotional, behavioral, physical, or educational needs or problems Mothers who are psychologically abusive report having received less affection from their husbands; and greater levels of verbal aggression and physical aggression in the husband-to-wife relationship (Black et al, 2000). The most significant risk factor for emotional abuse is verbal and physical aggression within the parent-to-parent relationship (Black et al., 2000).
Family of Origin Experiences	Mothers who psychologically abuse their children reported less caring mothers and fathers than non-abusive mothers; and if they yelled at their own children daily, they were likely yelled at daily as children by their own parents (Black et al, 2000).

[5] Many of these elements focus on maternal behaviors because they come from a study involving mothers who emotionally abused their children. More research is needed regarding fathers and emotional abuse.

Substance use disorder	Children whose parents abuse alcohol and other drugs are more likely to experience emotional consequences of mistrust, guilt, shame, confusion, ambivalence, fear, and insecurity (The American Academy of Experts in Traumatic Stress, 2014).
Intimate partner violence	Children who live in a home where intimate partner violence is present are at a greater risk of being emotionally abused (Kairys et al., 2002).
Behavioral Health	Mothers who are emotionally abusive towards their children report more dysthymic symptoms; neurotic symptoms; aggression; and hostility (Black et al, 2000).
Factors Related to the Environment	
Poverty	Children from very low-income homes (i.e., less than US $15,000) are at higher risk for experiencing emotional abuse compared to children from families earning more than US $30,000 per year (Black et al, 2000).

Identifying Physical Abuse

What could physical abuse look like?

- What to look for:
  - Serious unexplained injuries or injuries that don't match the explanation
  - Child who is clingy with caregiver or fearful of caregiver
  - Untreated serious physical injuries
- Information to gather:
  - How the injury occurred
  - Details about the (place, implement, etc.) that caused the injury
  - The person who caused the injury
- Think about:
  - Physical discipline is not the same as physical abuse
  - Accidental injuries are not physical abuse (they may be neglect)

Key Considerations

Injury Location

- **What to look for:** Injuries that continue along curved parts of the body (from the side to the back of the leg); Bruises on buttocks, genitalia and the top of the ear are suspicious for abuse
- **Information to gather:** A detailed, step-by-step description of how the injury happened; Exactly where the injury occurred (ask to see it for yourself)
- **What to do:** Think critically about the explanation and investigate to see if the injury could have happened as described

Bruises

- **What to look for:** Age of the child (bruising in children who don't yet walk is rare); A bruise from a short fall (such as off a couch) is suspicious for abuse; Bruises that don't match the explanation given
- **Information to gather:** Detailed explanation of what specifically caused the bruise; The exact location of where the injury occurred (ask to see it for yourself)
- **Get consultation:** Talk to your supervisor about the injury and the severity; Get medical consultation if you have questions about the cause, severity or timing of the injury

Burns

- **What to do:** Get medical consultation for burns to determine what caused the burn, when and whether or not the burn has been treated
- **What to look for:** Symmetrical or patterned burns (from being burned with an object or dipping hands or feet into hot water) are suspicious for abuse; Burns to the diaper area are suspicious for abuse; Burns that don't match the explanation (a burn caused by a splatter will have splatter marks, a child must be tall enough to reach the counter to pull down a hot liquid)
- **What information to gather:** Detailed description of exactly what happened that caused the burn; The exact location of where the burn happened (ask to see it for yourself); Direct knowledge of the (hot water heater settings/pot or pan, etc.) that contributed to the burn (ask to see it for yourself)

Fractures

- **What to do:** Get medical consultation for all fractures
- **What to look for:** Fractures of the collar bone, long bone shaft, and linear skull fractures are less likely to be caused by abuse; Fractures of the rib, shoulder blade, and chest bone (sternum) are suspicious for abuse
- **What information to gather:** Detailed description of exactly how the injury happened; The exact location of the injury (ask to see it for yourself); What happened after the injury

Abusive Head Trauma

- There has been recent research on abusive head trauma (Shaken Baby Syndrome) that calls into question some previously accepted information about how to differentiate accidental and abusive head trauma (Findlay et al, 2013). Making this determination requires medical expertise and legal consultation – you will not be making this kind of determination alone.
- **What to do:** Medical and legal consultation needed
- **What to look for:** Often accompanied by related injuries such as bleeding in the brain and increased intracranial pressure, retinal tearing, and rib fractures; Delay in treatment; Explanation that doesn't match the severity of the injury (such as a short fall)
- **Information to gather:** A detailed description of exactly how the injury happened; Names and contact information for anyone who witnessed the injury; What the parent/caregiver did following the injury; When the caregiver noticed symptoms

Sentinel (warning) Injuries

- Abused infants are more likely have had a previous suspicious or unexplained injury. When assessing an injured infant and trying to determine if abuse has occurred, it is important to ask about previous unexplained injuries

Other Factors Linked to Physical Abuse

Factors Related to the Child	
Chronological Age	▯ Children under four comprise the majority of maltreatment cases (Algood et al, 2011). ▯ Bruising in pre-ambulatory children is rare, occurring in only approximately 1% to 2% of infants. Therefore, any bruises in children not yet cruising (i.e. walking with support) should raise suspicion for possible abuse. ▯ Child behaviors related to particular stages of early development are linked to physical abuse. These include: – Colic or incessant crying – Awakening at night – Separation anxiety – Normal exploratory behavior – Normal negativism – Poor appetite – Toilet training resistance or accidents (Lane et al, 2011)

Health and Developmental Status	Children with developmental disabilities are at increased risk for experiencing physical abuse. One in four children with disabilities experience physical violence (Hamby & Grych, 2013). Any characteristic that demands increased caregiver attention, including premature birth, infant colic, behavioral problems such as attention deficit hyperactivity disorder, can raise the risk of abuse (Lane et al, 2011) Boys who have a developmental disability are at increased risk for experiencing physical as compared to girls who have a similar disability (Algood et al 2011)
Factors Related to the Parents	
Child Welfare Involvement	Previous substantiated abuse allegations and child welfare intervention are linked to increased risk (Lane, et al, 2011)
Family of Origin Experiences	Personal history of maltreatment as a victim is linked to increased risk (Lane, et al, 2011).
Substance use disorder	Substance use disorder may contribute to maltreatment (Lane, et al, 2011). Substance-using mothers were found to use aggressive tactics in parenting as compared to mothers who did not have issues with substances.
Intimate Partner Violence	Intimate partner violence may increase the risk for physical abuse (Lane, et al, 2011).
Behavioral Health	Clear links were found by researchers between maternal anger problems and reactivity and potential for child abuse. (Hien et al, 2010). Depression may contribute to maltreatment (Lane, et al, 2011).
Factors Related to the Environment	
Poverty	Family income is inversely related to physical abuse (Black et al 2000)
Community Violence	Children living in communities with higher rates of violence are more likely to experience physical abuse (Lane, et al, 2011).
Social Support	Families with low social support are at increased risk for abuse and neglect (Lane, et al, 2011).

Physical Abuse and Medical Assessment

Regarding types of injury – If the cause of an injury is unknown or you have concern that explanation for an injury does not make sense, it is important to work with medical teams to identify whether or not the injury was caused by abuse. In some cases, there may be no way to know for certain, but some injuries are much more likely to be caused by abuse.

Questions for medical staff

Here are some key questions to ask medical staff to gather information about an injury:

- What is the nature of the injury?
- Is injury consistent with explanation?

- What mechanism would cause this injury?
- How old is the injury?
- Would the child be in pain?

Physical Abuse and Critical Thinking

Think critically about the explanation given for an injury. Look at the location and determine if it could have happened the way it is described. For example, if the child has a splatter burn and the explanation is that the child pulled a pot off the stove, measure the height of the pot on the counter and determine whether or not the child could have reached the pot.
Don't assume you can identify the timeframe for an injury by looking at it. The color of bruises is not a reliable indicator of the timing or age of the injury. Bruises assume a range of hues as extravagated red blood cells break down; the appearance over time can be affected by skin color, the severity of injury, the depth and location of the bruise, and the vascularity of the area (Lane et al 2011).

Culture's Influence on Physical Discipline

Culturally responsive definitions of child maltreatment acknowledge that cultural differences exist in child rearing practices and recognize that within each cultural group deviations from culturally appropriate child-rearing practices may be considered abusive.

- **Ask about:** The family's culture and cultural practices related to parenting
- **Think about:** Possible biases you may have about parenting norms; Possible harm that the child may experience related to not following cultural norms
- **Consult with your supervisor or peers about:** Community culture; Intersection of cultural practices and child abuse law

The social worker must seek out information to differentiate abuse from culturally accepted practice of child rearing. Talking to the family about their cultural practices is important. It is also important to consider
injuries experienced by the child in the context of the family's culture and the law.

Reflection about possible personal biases and consultation with supervisors are useful processes in determining whether or not abuse has occurred.

It is equally important that even though there are some cultural practices that are seen as normal within the culture, some cultural practices violate the law (female circumcision for example). We work with families to help them understand that some cultural practices are illegal in this country and cannot be practiced here.

Identifying Sexual Abuse

Allegations of sexual abuse are often investigated by both the police and child welfare. Close cooperation among investigating agencies is very important to be sure that all physical evidence is gathered and to prevent multiple interviews or problematic interviews. Often, the social worker will avoid interviewing the child about the sexual abuse disclosure until after the forensic interview has occurred, in order to avoid problems that can happen if the child is asked the same questions over and over. Whatever role the social worker has in the process, he or she should maintain a focus on ensuring the child's physical and emotional safety and offering support and assistance with the trauma associated with the abuse.

Forensic interviews

In many counties, social workers do not complete child interviews if there is a disclosure of sexual abuse - special forensic interviewers take over.

A forensic interview is conducted with the expectation that it will become part of a court proceeding. It is intended for a judicial audience and governed by rules of evidence. Its goal is to obtain facts for a court trial or hearing.

The forensic interviewer strives to:

- Maintain a neutral and objective stance to facilitate the child's recall of previous events they witnessed or experienced.
- Ascertain the child's competence to give accurate and truthful information.

Please consult your supervisor about procedures involving forensic interviewing in your county. Forensic interviewing requires special training and anyone conducting forensic interviews should obtain this training.

What could sexual abuse look like?

What to look for:

- Contacts between a child and an adult in which the child is used for sexual stimulation of the perpetrator or another person.
- A lack of consent and a power differential because of age difference (chronological or developmental); bribery, manipulation, coercion, threat, force, or use of a weapon; nature of the relationship contains implied authority or control; or relationship of developmental age to sexual behavior.
- In some instances, the victim does not view the activity as abusive or non-consensual and may even find it physically pleasurable; this does not mean that it should be construed as non-abuse.
- Multiple incidents of sexualized behavior by the perpetrator on the child
- Progression of sexualized behaviors from less to more intrusive over time, "grooming" behaviors
- Details of the abuse:
  - Explicit knowledge of sexual behavior presumably beyond what would be expected of a child of that age
  - Richness of details (as age appropriate), sensory details (sounds, smells, tastes, feelings)
  - Internal logic, consistency, and feasibility—does the statement make sense, could it logically have happened the way described?
  - Secrecy
  - Child's affect during disclosure
  - Developmentally appropriate language and sentence structure

When analyzing statements, recognize that:

- Many children disclose in increments.
- Younger children do not provide as much detail.
- Individually and collectively, cultural factors and sexuality may affect need for the need secrecy and limit disclosure.
-

Many complex factors are involved with the family's reaction to possible sexual abuse, including:

- Power dynamics and possible abuse between the perpetrator and the non-offending parent
- Behavioral Health concerns that limit a non-offending parent's ability to understand the situation or to recognize who is responsible for the sexual abuse
- Substance use disorder issues that limit the non-offending parent's ability to protect
- The non-offending parent may feel such guilt that they deny the possibility of the abuse
- Survival concerns and fear that criminal prosecution will affect the family negatively
- Shame and a desire to handle the problem within the family

Other Factors Linked to Sexual Abuse

Elements Related to the Child	
Chronological Age	Children aged 12-14 experience the highest incidences of substantiated sexual abuse (26.3%); followed by children aged 15-17 (20.9%); 9-11 (18.4%); 6-8 (17.2%); 3-5 (14%); and 1-2 (2.6%).
Gender	Gender - Female children are at greater risk for experiencing sexual abuse (Finkelhor, 1993).
Health and Developmental Status	Health and Developmental Status – children with intellectual and developmental disabilities experience higher rates of sexual abuse (Hamby et al, 2013). One in six children with an intellectual or developmental disability will experience sexual victimization (Hamby et al, 2013). Boys who have a developmental disability are at increased risk for experiencing sexual abuse as compared to girls who have a similar disability (Algood et al 2011)
Elements Related to the Parents	
Child Welfare Involvement	Children of a parent that was sexually abused as a child are at increased risk for CSA (Black et al, 2000). History of CWS involvement is a risk factor
Family Composition	Male victims of sexual abuse are more likely to have no father (38%) or reside in a home where their natural father is absent (24%) Female victims of sexual abuse are more likely to have their natural father present in the home (58%) Sexual abuse victims are more likely than non-abused children to come from families with high incidence of marital separation/divorce The presence of a stepfather in the home is a risk factor (Pierce & Pierce, 1985)
Family of Origin Experiences	Personal history of maltreatment as a victim is linked to increased risk (Lane, et al, 2011).

Substance Use disorder	Sexual abuse victims are more likely than non-abused children to come from families with parental substance use disorder problems
Intimate Partner Violence	Non-offending parents may be unable to protect children from victimization due to their own intimidation, fear, or abuse or a large power imbalance with perpetrator
Behavioral Health Problems	Sexual abuse victims are more likely than non-abused children to come from families with mental illness (Beitchman, 1991).

Sexual Abuse Victims and Behavioral Health Symptoms

Red Flags

- Behavioral indicators may raise suspicion that a child is being abused. However, certain behaviors that may indicate sexual abuse may, in fact, NOT be due to abuse. Red flags in terms of behavior should be checked out with others such as teachers, relatives, etc. as well as by observation and interview.

What to Look for

- Physiological reactivity/Hyper-arousal (hyper vigilance, panic and startle responses, etc.)
- Retelling and replaying of trauma and post-traumatic play
- Intrusive, unwanted images and thoughts and activities intended to reduce or dispel them
- Sleeping disorders with fear of the dark and nightmares
- Dissociative behaviors (forgetting the abuse, placing self in dangerous situations related to the abuse, inability to concentrate, etc.)

Psychological Effects

- Posttraumatic Stress: More than 80% of sexually abused children report symptoms of posttraumatic stress;
- Cognitive Distortions: Sexually abused children may suffer with chronic self-perceptions of helplessness and hopelessness, impaired trust, self-blame, and low self-esteem;
- Emotional Distress: Sexually abused children and adult victims of CSA disproportionately suffer with major depression compared to non-abused children and adults;
- Impaired Sense of Self: Sexually abused children may suffer with an inability to define their own boundaries; and may have inadequate self-protectiveness that makes them susceptible to being victimized and/or exploited by others;
- Avoidance: Common avoidance responses of sexually abused children include: dissociation, substance use disorder, suicide, and tension-reducing activities (i.e., indiscriminate sexual activity, binging or chronic overeating, and self-mutilation);
- Interpersonal Difficulties: Sexually abused children tend to be less socially competent, more aggressive, and more socially withdrawn than non-abused children.

Sexual Abuse and Critical Thinking

When assessing whether or not sexual abuse has occurred, social workers are likely to hear different accounts of what happened from different people. It is important to think critically about each person's

statement and consider their credibility and their possible motivations for making their statement. Alleged offenders have a significant motivation to deny or minimize abuse as they face criminal action. Non-offending parents and other family members may be motivated to deny or minimize the abuse as well, due to fear of physical harm, fear of financial ramifications if the perpetrator provides the main financial support for the family, shame, or denial.

Consider these elements related to the allegation:

- Credibility of the report (and the reporter)
- Type and credibility of the child's disclosure
- Corroboration of the disclosure/report

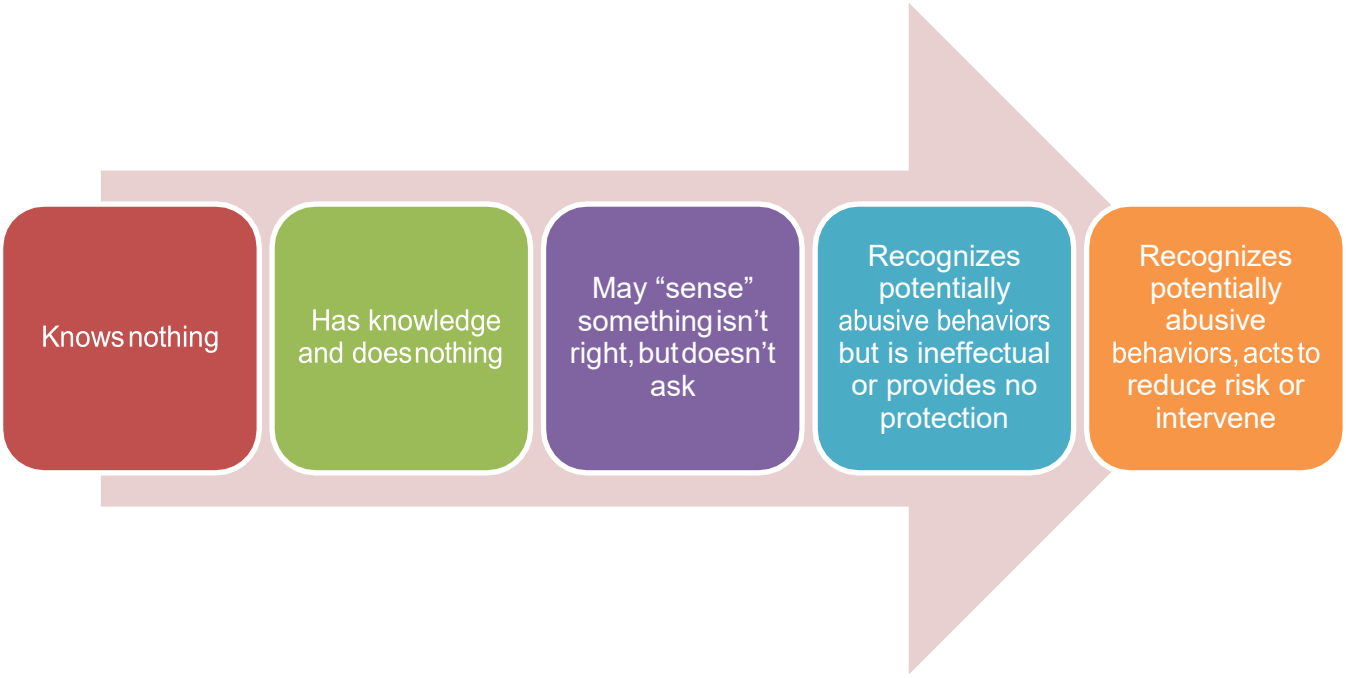
In analyzing the child's statement, look for:

- Multiple incidents of sexualized behavior by the perpetrator on the child
- Progression of sexualized behaviors from less to more intrusive over time, "grooming" behaviors
- Details of the abuse:
  - Explicit knowledge of sexual behavior presumably beyond what would be expected of a child of that age
  - Richness of details (as age appropriate), sensory details (sounds, smells, tastes, feelings)
  - Internal logic, consistency, and feasibility—the statement makes sense, the abuse could logically have happened the way described
  - Secrecy
  - Child's affect during disclosure
  - Developmentally appropriate language and sentence structure

In considering the sexual abuse allegation, it is important to evaluate all of the evidence, including:

- Physical and behavioral indicators
- The child's statement/disclosure
- Collateral information such as statements of other witnesses, including other children, non-offending parent, teachers, other professionals, and other adults
- Evidence discovery such as pornography, letters from perpetrator to child, sexual devices or other items found as described by child as being connected with the context of the sexual abuse or exploitation
- Medical findings (normal, suggestive of abuse, indicative of abuse)
- Child/family/perpetrator history
- Reasonable alternative hypotheses
- Evaluation of the source of the information which has been provided (source monitoring)
- The statement of the perpetrator

Continuum of Non-Offending Parent Response (Byerly, 1992)



Following child sexual abuse disclosure, most non-offending caregivers experience both psychological and emotional distress (Toledo and Seymour, 2013).

Gathering Information from Perpetrators

While law enforcement generally takes the lead on perpetrator interviews, many child welfare protocols specify that during the assessment process the worker is to speak with the person alleged to have committed the abuse. Concerted efforts need to be made to coordinate with law enforcement prior to attempting to interview an alleged perpetrator.

Interviews with sexual abuse perpetrators will not always follow a typical pattern, but some common responses include initial denial of any knowledge of the acts, minimizing any behaviors which may be incriminating, justifying their behaviors if at all possible, blaming the victim or others for the abuse, deflecting personal responsibility by identifying their behaviors as a form of "sickness", or trying to gain the sympathy of the interviewer by pointing out all the negatives which will happen to him/her when this abuse becomes known.

Juvenile Sexual Abuse Perpetrators

There are a growing number of cases where the perpetrator is a juvenile or a child engaging in sexually abusive behaviors with another child where law enforcement will choose not to become involved due to the low potential for criminal prosecution. This does not mean that the situation does not merit a complete investigation. In those instances the worker should be prepared to discuss the allegations with the accused.

Most recently, the term "adolescents with illegal sexual behavior" has been adopted rather than use of the more pejorative term "juvenile sex offender". Current research indicates that these youth do not engage in the same patterns of sexual abuse and the potential for positive results from treatment is higher than with adults. Additionally, there is concern that adolescents struggling with problematic sexual behaviors are being lumped in as a category with adult sex offenders and hence not getting the services they need.

Commercial Sexual Exploitation

Commercial Sexual Exploitation of Children (CSEC) has been identified as a significant concern, especially for children and youth already in the child welfare system (Wright et al, 2013). It is important to be aware of elements that will help determine when a child or youth may be experiencing CSEC.

Data indicate several key factors commonly associated with sexual exploitation. These elements do not cause sexual exploitation to occur. Their presence does not always mean sexual exploitation is present. Their presence should raise concern and lead to greater efforts to engage with the family and determine if sexual exploitation is present.

Other Factors Linked to Commercial Sexual Exploitation

Factors Related to the Child	
Gender	Girls are more likely to be exploited than boys. Boys and young men involved in CSEC tend to be far less visible than females, perhaps due to the stigma of homosexuality and resultant secrecy (Wright et al, 2013).
Sexual Orientation	LGBT youth are at higher risk for engagement in survival sex, CSEC and sex trafficking compared to non-LGBT youth (Wright et al, 2013).
Health and Developmental Status	Given the association between disability, sexual abuse, and CSEC, children with disabilities should be considered at increased vulnerability for CSEC involvement (Wright et al., 2013).
Behavioral Health	Poor self-esteem, chronic depression, and external locus of control are individual risk factors for sex trafficking and CSEC involvement (Wright et al, 2013).
Substance Use Disorder	Early age of initial drug or alcohol use is linked to commercial sexual exploitation as a child or youth (Howard and Reimers, 2013).
Child Welfare Involvement	Children involved in commercial sexual exploitation are highly likely to have experienced a combination of parental abuse, neglect, or incest (Wright et al, 2013).
Factors Related to the Parents	
Family Communication and Interaction Patterns	Youth unable to tolerate their family environment due to child maltreatment, other family conflict, or disruption were likely to run away (Flowers, 2011), placing them are increased risk for involvement in CSEC as a means of survival (Wright et al, 2013)
Substance Use Disorder	Substance use disorder is a familial risk factor for involvement in CSEC and sex trafficking (Wright et al, 2013).

Intimate Partner Violence	Intimate partner violence is a familial risk factor for involvement in CSEC and sex trafficking (Wright et al, 2013).
Behavioral Health	Serious mental illness is a familial risk factor for involvement in CSEC and sex trafficking (Wright et al, 2013).
Factors Related to the Environment	
Poverty and Lack of Social Supports	Homelessness puts young people at "special risk" for CSEC involvement because street life puts them at risk to encounter CSEC offenders (Wright et al, 2013).

Behavioral Indicators of Commercial Sexual Exploitation

In addition to the elements listed above, social workers interacting with youth should be aware of the behavioral indicators listed below that raise concern that a child or youth may be experiencing commercial sexual exploitation:

- Cannot and will not speak on own behalf
- Is not allowed to speak to you alone
- Is being controlled by another person
- Works long hours
- Is paid very little or nothing for work or services performed
- Has gaps in memory
- Has a demeanor that is fearful, anxious, depressed, submissive, tense or nervous
- Is not in school of has significant gaps in schooling
- History of running away and homelessness
- Mentions a pimp/boyfriend
- Has engaged in sexual acts in exchange for food, shelter, money
- Has hotel keys
- Does not consider self a victim
- Is not enrolled in school
- Lies about age/has a false ID
- Has excess amounts of cash
- Sleeps/lives separately from the "family" (in the garage or on the floor instead of bedroom)
- Tries to protect his or her trafficker from authorities

Sexual Abuse Statistics

Recent research found that:

- 64% of victims were assaulted by an acquaintance, 25% were assaulted by a stranger, and 10% were assaulted by a family member. Other research has found the percentage who are family members to range from 14%–47% (Douglas & Finkelhor, 2005).
- 29% of victims were assaulted by youth age 17 or younger, and 44% of victims were assaulted by an adult age 30 or younger.
- Studies using law enforcement and self-report data found that more than 90% of offenders are male (Douglas & Finkelhor, 2005).
- By all accounts, female sexual abuse perpetrators are less common than male ones, but they do exist. If you look at reports that come into child protection agencies, about 3 to 5% of them involve female perpetrators.

- Women are more likely to abuse boys than girls (20% boys and 5% girls, respectively) and are more likely to abuse younger children (Snyder, 2000). Forty percent of the reported cases of daycare sexual abuse involve female offenders (Finkelhor, Williams, & Burns, 1988).
- Of the substantiated reports across the US the vast majority (79.5%) of victims were neglected, 18.0 percent were physically abused, 9.0 percent were sexually abused, and 8.7 experienced emotional abuse. (Children's Bureau, 2015)
- In California, 65% of victims were neglected, 8.6% were physically abused, 4.6% were sexually abused, and 6.7% were emotionally abused (Lucile Packard Foundation for Children's Health, 2015)
- It is important to be aware that some studies report disproportionately high rates of sexual abuse for Native American children while other studies have found that sexual abuse rates among Native American children are comparable to those of non-Indian children, with some variations among different tribes (Ross, 2014).

Culture, Bias, and Maltreatment Identification Activity

Instructions:

1. Read the ***Bias and Maltreatment Identification*** content below and answer the question that follows (How does bias impact our work?)
2. Read the ***Application Scenario*** and work as a table group to answer the questions that follow.
3. What bias triggers can you identify in the vignette?
4. What can you do to separate possible bias from child maltreatment?
5. What other information do you need to determine if maltreatment occurred?

Bias and Maltreatment Identification

A number of studies have identified racial and class biases in the identification and reporting of maltreatment. For example, some studies have indicated that mandated reporters are more likely to evaluate for and report abuse in minority families, when compared to white families. Poor children with accidental injuries are more likely to be referred to child protective services (CPS) than are non-poor children with similar injuries, and abuse is more often missed in middle and high income families (Lane, et al, 2011).

Social workers making decisions about child maltreatment are influenced by a multitude of factors, including personal biases and our inability to fully weigh and consider multiple intervening factors.

As individuals, our preconceived ideas can affect decision making, as can our mood. Wishful thinking can cloud our judgment and lead us to give more weight to evidence that supports the conclusion we hope to reach. This is called **confirmation bias** and it can lead us to pay more attention to information that supports a desired outcome and disregard information that refutes the desired outcome. We may even subconsciously use more rigorous standards to criticize opposing evidence.

Further, because our memory is faulty and our brains can only really consider a small number of possibilities at one time, we don't pay attention to all the information available. We sort it and end up focusing on information that supports our theory, information that is easiest to obtain, information that is the most dramatic, or the first information we received. We also tend to consider information sequentially rather than in context and this can prevent us from seeing how things fit together (Gambrill and Shlonsky, 2000).

1. Take a few minutes to respond to this question and then share your answer with your table mates: How does bias impact our work?

Application Scenario

The agency received a referral that a young Caucasian woman, Butterfly, was arrested for panhandling on the median of a busy downtown street with her 14 month old child, Genysys. Butterfly was holding a sign that read "Help! Need money for pampers and weed! J" Genysys was seen sitting on the median looking lethargic. The day was very sunny and 84 degrees.

The mother, Butterfly, showed an Oregon State ID for identification. She says her daughter was born at home in Oregon and has no birth certificate. She says she does not have food or water for her child, but she is nursing. There was a previous referral in another city where she did the same type of panhandling. The mother is currently pregnant and breastfeeding Genysys. The parents say Genysys has been hard to wean because she doesn't like solid foods or cereals. Genysys seems subdued. Butterfly notes that Genysys is a very calm baby and is usually napping at this time of day.

The father, Smokey, reports he was in town for a job, but it fell through. He had dropped Butterfly and Genysys off at the corner while he went to look for food. Smokey says that this was all a mistake and that they have food, money and a place to stay in the local area with his aunt.

The police believe the parents may be engaged in a scam called "Madonna and Child" where they use a child to panhandle for money from the public. The child is usually drugged with alcohol and other drugs so they can stay out all day. Both Smokey and Butterfly deny any active drug use and deny that Genysys is drugged.

Based on the presenting situation, the social worker and police officer placed Genysys in an emergency foster home and sought medical intervention for Genysys to ensure she was not drugged or dehydrated.

Genysys became extremely upset upon being removed from her mother's care. She refused to take any food or formula and cried for hours until she fell asleep. She was seen in the emergency room and tested for substances. There was no evidence of any drugs or alcohol in her system. Genysys did not have any health problems identified by the hospital. Her weight was adequate and her development was within range for her age. The foster parent noted that Genysys was extremely upset, agitated and tearful. Butterfly reported this was the first time she had ever been away from Genysys.

1. What bias triggers can you identify in the vignette? These can be bias triggers that make you think maltreatment is more likely to be happening or bias triggers that make you think maltreatment is less likely.

2. What can you do to separate possible bias from child maltreatment?

3. Was the removal justified? What other information should be gathered to determine if maltreatment occurred?

Assessing for Sexual Abuse Activity

Instructions:

1. Read the ***Assessing for Sexual Abuse*** content below and answer the question that follows (What are the challenges associated with sexual abuse allegations?)
2. Utilize the Worksheet: Indicators of Maltreatment
3. Read the ***Application Scenario*** and work as a table group to answer the questions that follow.
4. What bias triggers can you identify in the vignette?
5. What can you do to separate possible bias from child maltreatment?
6. What other information do you need to determine if maltreatment occurred?

Assessing for Sexual Abuse

Because of the criminal aspect of a sexual abuse investigation, it's important to ensure evidence is gathered via a forensic process whenever possible. As a social worker, your focus will be on ensuring the child's physical and emotional safety and offering support and assistance with the trauma associated with the abuse. Law enforcement and medical providers will work on gathering any evidence and completing initial interviews (sometimes these interviews are in conjunction with child welfare, the district attorney or other victim support organizations - be sure to follow your local protocol). In many situations the social worker must avoid interviewing the child about the sexual abuse disclosure until after a forensic investigation interview has occurred, in order to avoid interviewing the child multiple times as this can compromise the evidence.

Sexual abuse can bring up strong emotions. Our own issues related to sexual abuse may cause us to be more controlled and legalistic in this assessment or may cause us to be overly emotional and identify closely with victims. It is important to identify this when it happens and move past it to be supportive to the family.

Additional challenges related to sexual abuse allegations include:

- Power dynamics and possible abuse between the perpetrator and the non-offending family members
- Behavioral Health concerns that limit a non-offending parent's ability to understand the situation or to recognize who is responsible for the sexual abuse
- Substance use disorder issues that limit the non-offending parent's ability to protect
- The non-offending parent may feel such guilt that they deny the possibility of the abuse
- Survival concerns and fear that criminal prosecution will affect the family negatively
- Shame and a desire to handle the problem within the family.

1. Take a few minutes to respond to this question and then share your answer with your table mates: What are some of the challenges associated with sexual abuse allegations?

Application Scenario

Anna, age 10, disclosed to staff at her school that yesterday, Dale (her adult step-brother) touched her in a sexual way. Anna stated that Dale got in bed with her, tried to kiss her, and put his hands between her legs, under her underwear, before leaving the room. She said she was red and sore from the incident. Later, Anna texted him telling him not to touch her again. Dale texted back "of course not…LOL. I have a girlfriend." Another time (a few weeks ago), Anna and Dale were in a room watching TV. Dale sat next to Anna and started massaging her

shoulders. When Dale fell asleep, Anna left the room. Anna's parents say she has been flirtatious with Dale, who is 19, and he wouldn't do anything inappropriate. They say Anna made up a story she was sexually abused by her father in the past. They describe Anna as having emotional problems and being "hysterical." Anna lives with her mother, stepfather and stepbrother (Dale). There is a history of intimate partner violence between Anna's mother and stepfather, and a history of substance use disorder on the part of Anna's mother.

When Anna was taken for a medical exam, there was evidence of redness in her vaginal area. The police also took Anna's underwear into evidence which contained blood.

1. Who should you talk to next?

2. What information or follow-up would you want from the following sources?

   - Medical
   - Law enforcement
   - Educational
   - Behavioral Health
   - Family and friends

3. How do you ensure you are following county protocol?

Judy, Ron, and Sarah

A report was received that an 80 lb. television fell on 3-year-old, Sarah, in the home of her parents, Judy and Ron. Sarah was air lifted to the local hospital where she has a skull fracture and is in a coma. When the first responders, including police, arrived they observed the house to be filthy. The home was full of dirty clothes, soiled and torn furniture. There were dog feces smashed into the carpet and the sofa had cockroaches crawling on it. The beds were soiled and did not have linen on them. The bathroom was dirty and it appeared the toilet had not been flushed in weeks. The bathtub and sink were dirty as well. The windows of the second story bedroom were open and had no screens. There was one bunk bed in the corner adjacent to the window which had a stained mattress and linens. The police reported that there is a stay away order for the father to not be in contact with the children, but he was living in the home.

At the hospital, the parents were attentive and cooperative with medical staff. When asked what happened, father reports he put his daughter in a "time out" in the bedroom. She is very hyperactive and has a speech delay. He planned to leave her there 3 minutes. But about a minute later he heard a large crash and found Sarah and his 5-year-old son Jacob under the TV. Once he lifted the TV, he saw Sarah bleeding from the mouth and nose. Jacob appeared uninjured. He called 911. Dad said he knew the TV could fall but had not fixed it.

When asked why the house was in such disrepair, Ron blamed their roommate who had 3 children. Judy said she has no excuse as to why her house is dirty other than the fact that she works 6 days a week and is tired when she comes home.

The social worker assigned discovered that the family had a previous open child welfare case which focused mostly on intimate partner violence and substance use disorder problems for both parents. Sarah and Jacob spent 6 months in foster care and then reunified with their mother. After the child welfare case closed, Ron completed substance use disorder and anger management treatment on his own and returned to the family.

Worksheet: Indicators of Maltreatment for Judy, Ron, and Sarah

Use this column to sort the strengths within the family	Use these columns to sort your concerns and identify which concerns are directly impacting the child		
What are some things that are working well in the family? ☐ Mother employed ☐ Parents sought immediate medical care ☐ Mother and Father are both providing care for the child in the same home together. ☐	What are the things that worry you? ☐ Sarah has Speech delays. ☐ Child is hyperactive and this could be related to developmental delays. ☐ Age of the children being 3 and 5 ☐ Previous Intimate Partner violence, unclear current status. ☐ Previous substance use. ☐ Filthy home and small children accessible to feces. ☐	Which of these worries have actually impacted the child as a result of something the caregiver did or didn't do? ☐ Possible Inadequate supervision for a hyperactive child ☐	Which of these worries have no direct impact on the child? ☐ Appear to have financial difficulties ☐ IPV at this time was not related to the TV falling. ☐

Would you want to gather any additional information? ī ◯ Yes ī ◯ No

If so, what would you need to know to make an informed decision?

Would you want to seek any additional consultation (e.g. from your supervisor, medical personnel, others)?
ī ◯ Yes ī ◯ No

If so, who would you like to consult with?

What would you like consultation on?

Based on the information in the scenario, do you think child maltreatment is present? ○ Yes ○ No

If yes, are you concerned about:

- ○ physical abuse
- ○ neglect
- ○ emotional abuse
- ○ sexual abuse

What are your next steps?

Nova, Kay, and Winona

The Child Welfare agency received a report regarding 8-year-old Winona from the maternal grandmother, Kay. Kay reports Winona makes frequent very negative comments about herself, describing herself as the worst person who ever lived. Sometimes Winona will just spontaneously make these comments. At other times she will have an extreme reaction to a small setback such as being corrected in the way she is doing a homework problem and will become extremely emotionally upset, even inconsolable, repeating really negative things about herself and saying that she hates herself.

Kay reports that Winona and her mother, Nova, both live with Kay. Kay is the primary caregiver, but there is no legal custody or guardianship arrangement and Kay and Nova often argue about Winona. Winona is eligible for counseling services through Victim Witness compensation because she was considered a victim in previous intimate partner violence between Nova and her boyfriend (not Winona's father). Winona has asked to go to counseling, but neither Kay nor Nova has arranged for treatment for Winona as they want her to put the negative incident behind her.

The social worker contacted Nova who expressed anger at the child welfare report but agreed to allow the social worker to meet with Winona at school. The social worker responded to the school and met with Winona, a clean and well-groomed girl who described herself as mixed race (Native American and white). Through the interview process, the worker asked Winona what she is worried about and are good things at her house.
Winona reports being worried about the following:

- ☐ How much my mom and grandma yell at each other and say I'm bad
- ☐ that my mom calls me stupid
- ☐ because my mom calls me a crybaby
- ☐ that she is bad because her grandma says my dad is Native American and my grandma is white
- ☐ that my mom told me not to talk to people about the yelling

Winona reports the good things too:

- ☐ I am happy when my mom and grandma sing songs with me and take me to gymnastics
- ☐ I am happy when my mom plays dress up with me and we put on makeup
- ☐ I am happy when my grandma reads to me at nighttime.

The social worker met with the school counselor who reported that Winona is a very bright child who seems somewhat fragile and gets upset easily. She doesn't have many friends and tends to spend time alone or with adults.

The social worker met with Nova and asked about Winona's Victim Witness compensation. Nova explained that her previous boyfriend assaulted her in the car while he was driving both Nova and Winona home from the 4th of July fireworks. He punched Nova multiple times in the head and face, screamed at them and threatened them. Because many other cars were around, a witness called the police and they were stopped. The boyfriend was arrested and Nova got a restraining order. They haven't seen him since then. The court approved the Victim Witness counseling for Winona because she had signs of Post-Traumatic Stress Disorder, but Nova never took her to counseling because she could never get through to get an appointment. Nova receives social security income because of her PTSD diagnosis. She reports that she has depression, anxiety, and episodes of extreme anger as a result of the attack.

Worksheet: Indicators of Maltreatment for Nova, Kay and Winona

Use this column to sort the strengths within the family	Use these columns to sort your concerns and identify which concerns are directly impacting the child		
What are some things that are working well in the family? ☐ Child care provided ☐ Child is clean ☐ Child on target developmentally, very bright child. ☐	What are the things that worry you? ☐ Winona MH needs are not being addressed (medical, educational, emotional), signs of PTSD ☐ Winona witness of intimate partner violence between her mother and mom's boyfriend. ☐ Mother calls child names ☐ Mother has hx of Behavioral Health (anger, depression and hospitality) ☐	Which of these worries have actually impacted the child as a result of something the caregiver did or didn't do? ☐ Child witnessed IPV and is showing signs of PTSD and mother has not taken steps to mitigate her symptoms. ☐ Mothers own unaddressed MH is likely getting in the way of her being able to address Winonas. ☐	Which of these worries have no direct impact on the child? ☐ IPV in the past ☐ Child not having friends and spends a lot of time with adults ☐

Would you want to gather any additional information? ◯ Yes ◯ No

If so, what would you need to know to make an informed decision?

Would you want to seek any additional consultation (e.g. from your supervisor, medical personnel, others)?
◯ Yes ◯ No

If so, who would you like to consult with?

What would you like consultation on?

Based on the information in the scenario, do you think child maltreatment is present? ◯ Yes ◯ No

If yes, are you concerned about:

- ☐ physical abuse
- ☐ neglect
- ☐ emotional abuse
- ☐ sexual abuse

What are your next steps?

Maliah, Dartanyan, and Elon

Seventeen-year-old Maliah is mother to 18-month-old Elon. Elon's day care provider contacted the Child Welfare agency to report possible physical abuse of Elon. The day care provider said that usually Elon is a very happy baby, but today he arrived at day care very upset. When the provider changed Elon's diaper, she noticed a large, dark bruise on Elon's right buttock and the right side of his lower back. She contacted Elon's mother Maliah to ask about the injury and was told that Elon came home from a visit with his father with the bruise. The father told Maliah that Elon was bruised after he pulled himself up and sat down too hard. The day care provider said she has really been impressed with Elon's parents before now. They are young, but they seem to take very good care of Elon and are very responsible.

Elon has two prior reports to child welfare. The first (at age 3 months) was for a burn on his forearm. After investigation the social worker concluded the burn was accidental and occurred when the hot seat belt buckle came into contact with Elon's arm. The second (at age 6 months) was a report of incessant crying from a neighbor. The social worker who responded found Elon to be clean and happy at home with his mother. Elon was up to date on medical visits and on target developmentally.

The social worker responded to the day care provider and met Elon. Elon is an 18-month-old African American infant with a large, dark bruise on the right side of his lower back and right buttock. Elon is non-verbal.

The social worker contacted Elon's father, Dartanyan. Dartanyan reiterated his explanation for the injury (that Elon was bruised after he pulled himself up and sat down too hard). When the social worker discussed the injury further, it became clear that Dartanyan assumed the injury occurred when Elon sat down too hard because Elon cried. Dartanyan agreed Elon may have cried because he was already injured at the time he sat down hard. Dartanyan reported that when he has visits with Elon they stay with Dartanyan's aunt and uncle. Dartanyan agreed that Elon was not injured when he took him from Maliah. Dartanyan also stated that he was not with Elon throughout the visit. He went out and left Elon with his aunt and uncle for part of the visit. Dartanyan stated he hesitated to leave Elon with his aunt because she had been drinking, but he had to go to work or risk being fired.

The social worker made an unannounced visit to the home of Dartanyan's aunt and uncle, Josefine and Omar. Josefine was home and invited the social worker in. The social worker noticed an odor of alcohol and observed an open beer on the coffee table. Josefine reported she did spank Elon because he wouldn't stop crying, but she didn't cause any injury that she knew of. She expressed her love for both Dartanyan and Elon but noted that Elon

is very fussy. She believes Maliah spoils him by picking him up every time he cries. She doesn't believe in that and thinks her method of spanking will help Elon learn to control himself and be less impulsive.

The social worker completed a criminal clearance on Maliah, Dartanyan, Josefine, and Omar. The results revealed that Josefine has had three DUI arrests in the past three years.

Worksheet: Indicators of Maltreatment for Maliah, Dartanyan and Elon

What are some things that are working well in the family?	What are the things that worry you?	Which of these worries have actually impacted the child as a result of something the caregiver did or didn't do?	Which of these worries have no direct impact on the child?
☐ Child care provided ☐ Child is clean ☐ Child up to date on medical visits ☐ Child on target developmentally ☐ Mother and Father are both providing care for the child ☐	☐ Age of parents ☐ Elon's age (18 months) ☐ Location of the injury ☐ Explanation of the injury ☐ Previous injury (2 CWS reports) ☐ Substance use (aunt) ☐	☐ Child is bruised ☐ Explanation of injury doesn't make sense ☐ Aunt who was providing care may have a substance use disorder problem ☐	☐ Age of parents ☐

Would you want to gather any additional information? ○ Yes ○ No

If so, what would you need to know to make an informed decision?

Would you want to seek any additional consultation (e.g. from your supervisor, medical personnel, others)?
○ Yes ○ No

If so, who would you like to consult with?

What would you like consultation on?

Based on the information in the scenario, do you think child maltreatment is present? ○ Yes ○ No

If yes, are you concerned about:

- ☐ physical abuse
- ☐ neglect
- ☐ emotional abuse
- ☐ sexual abuse

What are your next steps?

Appendix: Self-care and Secondary Traumatic Stress Reduction Activities[6]

Do something from this list every day!

- □ Eat healthy
- □ Exercise (Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun)
- □ Get regular medical care for prevention
- □ Take time off when needed
- □ Get massages
- □ Get enough sleep
- □ Take vacations (even day trips or mini-vacations)
- □ Make time away from telephones and electronics
- □ Make time for self-reflection
- □ Write in a journal
- □ Read literature that is unrelated to work
- □ Learn something new - try something at which you are not expert or in charge
- □ Practice mindfulness about your inner experience—listen to your thoughts, judgments, beliefs, attitudes, and feelings
- □ Engage your intelligence in a new area, e.g. go to an art museum, history exhibit, sports event, auction, theater performance
- □ Say "no" to extra responsibilities sometimes
- □ Give yourself affirmations, praise yourself
- □ Identify comforting activities, objects, people, relationships, places and seek them out
- □ Allow yourself to cry
- □ Find things that make you laugh
- □ Express your outrage in social action, letters and donations, marches, protests
- □ Play with children
- □ Spend time with nature
- □ Find a spiritual connection or community
- □ Meditate
- □ Pray
- □ Sing
- □ Take a break during the workday (e.g. lunch)
- □ Set limits with your clients and colleagues
- □ Get regular supervision or consultation
- □ Build a peer support group

[6] Adapted from: Transforming the Pain: A Workbook on Vicarious Traumatization. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996)

Bibliography

Algood, C., Hong, J, Gourdine, R., & Williams, A. (2011). Maltreatment of children with developmental disabilities: An ecological systems analysis. Children and Service Review, (33), 1142–1148.

American Academy of Experts in Traumatic Stress (2014). Effects of Parental substance Abuse on Children and Families.

Beitchman, J., Zucker, K., Hood, J., DaCosta, G., & Akman, D. (1991). "A Review of the Short-Term Effects of Child Sexual Abuse," *Child Abuse and Neglect*, vol. 15, 1991, pp. 537-556.

Black, D. A., Heyman, R. E., and Slep, A. M. S. (2001a). Risk factors for child physical abuse. Risk factors for child sexual abuse. Aggression &; Violent Behavior 6: 121-188.

Black, D. A., Heyman, R. E., and Slep, A. M. S. (2001b). Risk factors for child psychological abuse. Aggression &; Violent Behavior 6: 189-201.

Black, D. A., Heyman, R. E., and Slep, A. M. S. (2001c). Risk factors for child sexual abuse. Aggression &; Violent Behavior 6: 203-229.

Briere, J., Elliott, D. (1994). The Future of Children: Sexual Abuse of Children. Vol 4. No. 2.

California Child Welfare Council. Commercial Sexual Exploitation: The Intersection with Child Welfare. Downloaded from http://www.courts.ca.gov/documents/BTB_XXII_IIH_10.pdf.

Clayton, E., Krugman, R., and Simon, p. (2013). Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States. NY: National Academies Press.

criticalthinking.org http://www.criticalthinking.org/pages/becoming-a-critic-of-your-thinking/478

DePanfilis, D. (2006). Child neglect: A guide for prevention, assessment, and intervention. Washington, DC: U.S. Department of Health and Human Services, Administration on Children and Families, Administration for Children, Youth, and Families, Children's Bureau, Office on Child Abuse and Neglect.

Dettmeyer, R., Verhoff, M., and Schutz, H. (2014). Forensic Medicine: Fundamentals and Perspectives. Chapter 19. Child Sexual Abuse. P. 309-317.

Dube, S., Anda, R., Felitti, V., Croft, J., Edwards, V., & Giles, W. (2001). Growing up with parental alcohol abuse: exposure to childhood abuse, neglect, and household dysfunction. Child Abuse & Neglect, (25), 1627-1640.

Easterbrooks, M., Chaudhuri, J., Bartlett, J., & Copeman, A.(2011). Resilience in parenting among young mothers: Family and ecological risks and opportunities. Children & Youth Service Review, (33), 42-50.

Estes, R., & Weiner, N. (2001). The Commercial Sexual Exploitation of Children In the U.S., Canada and Mexico. Full Report.

Gambrill, E. and Shlonsky, A. (2000). Risk assessment in context. *Children and Youth Services Review, Vol. 22*, Nos. 1 l/12, pp. 813-837.

Godbout, N., Briere, J., Sabourin, S., & Lussier, Y. (2013). Child sexual abuse and subsequent relational and personal functioning: The role of parental support. Child Abuse & Neglect.

Hamby, S., & Grych, J. (2013). Essential information about patterns of victimisation among children with disabilities. Evidence-Based Nursing (16), 50-51.

Hibbard, R., Barlow, J., MacMillan, H., and the Committee on Child Abuse and Neglect. (2012). Psychological Maltreatment. Pediatrics. Vol. 130, No.2, pp.372-378.

Hien, D., Cohen, L., Caldeira, N., Flom, P., & Wasserman, G. (2010). Depression and anger as risk factors underlying the relationship between maternal substance involvement and child abuse potential. Child Abuse & Neglect, (34), 105-113.

Howard, J., & Reimers, B. (2013). An evaluation of a child welfare training program on the commercial sexual exploitation of children (CSEC). Evaluation & Program Planning, (40), 1-9.

Jenny, C. (2007). Recognizing and Responding to Medical Neglect. Pediatrics, (120), 1385.

Johnson, T. (2011). Updated 2011, Understanding Children's Sexual Behaviors, What's Natural and Healthy.

Kairys, S., Johnson, C., Committee on Child Abuse and Neglect. (2002). The Psychological Maltreatment of Children—Technical Report. Pediatrics. Vol. 109, No. 4, Pe68.

Katz, C., & Barents, Z. (2014). "Love covereth all transgressions": Children's experiences with physical abuse as portrayed in their narratives during forensic investigations, Vol 43, 1-7.

Lucile Packard Foundation for Children's Health. (2015). Kids Data: Substantiated Cases of Abuse and Neglect. Downloaded from: http://www.kidsdata.org/topic#cat=1,2.

Lynch, M., & Cicchetti, D. (1998). An ecological-transactional analysis of children and contexts: The longitudinal interplay among childhood maltreatment, community violence, and children's symptomatology. Development and Psychopathology, vol.10, n.2, pp.235-257.

Mitchell, K. J., Finkelhor, D., & Wolak, J. (2010). Conceptualizing juvenile prostitution as child maltreatment: Findings from the National Juvenile Prostitution Study. Child Maltreatment, 15:18–36.

Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Putnam-Hornstein, E., King, B., Sandoval, A., Yee, H., Mason, F., Benton, C., Pixton, E., Lou, C., & Peng, C. (2014). *CCWIP reports*. Retrieved 10/23/2014, from University of California at Berkeley California Child Welfare Indicators Project website. URL: http://cssr.berkeley.edu/ucb_childwelfare

Pence, D.S. (2012). Culture and Trauma-Informed Child Abuse Investigations. 24th Annual Child Abuse Prevention & Treatment Conference.

Putnam, F. W. (2003). Ten-year research update review: Child sexual abuse. Journal of the American Academy of Child and Adolescent Psychiatry, 42, 269-278.

Raman, S., & Hodes, D. (2011). Cultural issues in childhood maltreatment. Journal of Paediatrics and Child Health, (10), 1440.

Rourke, M.T. (2007). Compassion fatigue in pediatric palliative care providers. *Pediatric Clinics of North America, 54*, pp. 631–644.

Saakvitne, Pearlman & Staff of TSI/CAAP (1996). Transforming the Pain: A Workbook on Vicarious Traumatization. Norton Press.

Toledo, A., & Seymour, F. (2013). Interventions for caregivers of children who disclose sexual abuse: A review. Clinical Psychology Review, (33), 772-781.

Twill, S., Green, D., & Traylor, A. (2010). A Descriptive Study on Sexually Exploited Child in Residential Treatment, Child Youth Crime Forum, (39), 187-199.

U.S. Department of Health and Human Services, Children's Bureau. (2013). Childhood maltreatment 2012. Retrieved from http://www.acf.hhs.gov/programs/cb/ resource/child-maltreatment-2012.

U.S. Department of Health and Human Services, Administration on Children, Youth and Families. (2014). *Child maltreatment 2013*. Washington, DC: U.S. Government Printing Office. Available at: http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2013.

Valle, L. A., & Lutzker, J. R. (2006). Child physical abuse. In J. E. Fisher & W. T. O'Donohue (Eds.), Practitioner's guide to evidence-based psychotherapy, (pp. 169-176). New York: Springer.

Walker, K. (2013). Ending the commercial sexual exploitation of children: A call for multi-system collaboration in California. California Child Welfare Council. Retrieved from http://www.youthlaw.org/fileadmin/ncyl/youthlaw/publications/Ending-CSEC-A-Call-for-Multi-System_Collaboration-in-CA.pdf.

Woodruff, K. & Lee, B. (2011). Identifying and predicting problem behavior trajectories among pre-school children investigated for child abuse and neglect. Child Abuse & Neglect, (35), 491-503.

References

Some content in this curriculum was developed by NCCD and the Northern California Training Academy as part of the Safety Organized Practice Curriculum. Safety Organized Practice (SOP) is a collaborative practice approach that emphasizes the importance of teamwork in child welfare. SOP aims to build and strengthen partnerships with the child welfare agency and within a family by involving their informal support networks of friends and family members. A central belief in SOP is that all families have strengths. SOP uses strategies and techniques that align with the belief that a child and his or her family are the central focus, and that the partnership exists in an effort to find solutions that ensure safety, permanency, and well-being for children. Safety Organized Practice is informed by an integration of practices and approaches including:

- Solution-focused practice[7]
- Signs of Safety[8]
- Structured Decision making[9]
- Child and family engagement[10]
- Risk and safety assessment research
- Group Supervision and Interactional Supervision[11]
- Appreciative Inquiry[12]
- Motivational Interviewing[13]
- Consultation and Information Sharing Framework[14]
- Cultural Humility
- Trauma-informed practice

[7] Berg, I.K. and De Jong, P. (1996). Solution-building conversations: co-constructing a sense of competence with clients. *Families in Society*, pp. 376-391; de Shazer, S. (1985). *Keys to solution in brief therapy.* NY: Norton; Saleebey, D. (Ed.). (1992). *The strengths perspective in social work practice.* NY: Longman.

[8] Turnell, A. (2004). Relationship grounded, safety organized child protection practice: dreamtime or real time option for child welfare? *Protecting Children, 19*(2): 14-25; Turnell, A. & Edwards, S. (1999). *Signs of Safety: A safety and solution oriented approach to child protection casework.* NY: WW Norton; Parker, S. (2010). *Family Safety Circles: Identifying people for their safety network*. Perth, Australia: Aspirations Consultancy.

[9] Children's Research Center. (2008). Structured Decision Making: An evidence-based practice approach to human services. Madison: Author.

[10] Weld, N. (2008). The three houses tool: building safety and positive change. In M. Calder (Ed.) Contemporary risk assessment in safeguarding children. Lyme Regis: Russell House Publishing.

[11] Lohrbach, S. (2008). Group supervision in child protection practice. *Social Work Now*, 40, pp. 19-24.

[12] Cooperrider, D. L. (1990). Positive image, positive action: The affirmative basis of organizing. In S. Srivasta, D.L. Cooperrider and Associates (Eds.). *Appreciative management and leadership: The power of positive thought and action in organization*. San Francisco: Jossey-Bass.

[13] Miller, W.R. & Rollnick, S. (2012). *Motivational Interviewing*, (3rd Ed.). NY: Guilford Press.

[14] Lohrbach, S. (1999). *Child Protection Practice Framework - Consultation and Information Sharing.* Unpublished manuscript; Lohrbach, S. & Sawyer, R. (2003). Family Group Decision Making: a process reflecting partnership based practice. *Protecting Children. 19*(2):12-15.