Module 6: Understanding Child Maltreatment
Module 6: Understanding Child Maltreatment

Display Slide 6.0.1

Time: 24 hours

Module Purpose: To build a solid understanding of maltreatment of children.

Demonstrated Skills:

1. Given scenarios and pictures, use the Child Maltreatment Index to determine the type of physical abuse.
2. Given a scenario, differentiate between abusive head trauma and other abuse.
3. Determine whether certain scenarios support findings of sexual abuse. If so, apply the Maltreatment Index and determine the specific type(s) of sexual abuse.
4. Given scenarios, determine if mental injury is supported, and explain the rationale for your determination.
5. Given a scenario, identify the probable short-and long-term impacts resulting from specific types of mental injury.
6. Given a scenario and using the Maltreatment Index, evaluate if the description represents substance abuse, and explain your rationale.
7. Given scenarios, determine if whether there is neglect and, if so, the specific type of neglect as described in the Maltreatment Index. Justify your determination.
8. Differentiate between chronic and situational neglect.
9. Given a scenario and using the Maltreatment Index, evaluate if it supports Domestic violence, and explain your rationale.
10. Given a scenario, determine the extent of and nature of the maltreatment exhibited in that scenario.
Materials:
- Trainer’s Guide (TG)
- Participant’s Guide (PG) (Participants should bring their own.)
- PowerPoint slide deck
- Markers
- Flip chart paper
- Highlighters/Markers (at least three per participant)

Display Slides 6.0.2

Agenda:

Unit 6.1: Maltreatment: Overview
Unit 6.2: Neglect
Unit 6.3: Physical Abuse
Unit 6.4: Sexual Abuse
Unit 6.5: Mental Abuse
Unit 6.6: Substance Abuse
Unit 6.7: Domestic violence

Review the agenda with the participants.

Activities:

Unit 6.1
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Activity: The Gavin Family – 31

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Activity: Physical and Psychological Effects of Substance Abuse – 150
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Activity: Physical, Psychological and parenting Effects of Substance Use – 155
Activity: Family Roles – 170
Activity: Family Sculpture – 172

Unit 6.7:
Activity: Does it reach the Level of maltreatment? Impact on the Child. - 209

Trainer Note: ***Important*** READ THIS CAREFULLY!
Allow for an open dialogue with the class about the abuse, neglect and abandonment of children. It is vital that the trainer have a comfort level in leading discussions that allow for the class members to "process" their own thoughts, feelings and questions about topics that are typically considered taboo in day-to-day conversation. The attitude, willingness to openly discuss dynamics of sexual abuse, physical abuse or neglect, and the way in which topics are introduced and discussions facilitated will be key to two important elements. The first element is the ability of new trainees to comprehend their role. The second element includes expectations for a professional approach, with families experiencing difficult circumstances that are both serious and disturbing from a child safety perspective.

As a trainer, you must model respect for the topic, the levels of comprehension that may or may not exist for the new trainees and the ability of trainees to talk about and/or not talk about the topic. Many new staff need internal time to cognitively digest the presentation of many of the maltreatment modules, with sexual abuse being one of the more difficult topics to grasp from a number of perspectives.

There may also be individuals in class who have experienced their own sexual or physical abuse or any other variety of concerning childhood histories. It is not our job to be "therapists" in the classroom, but as the trainer, it is incumbent upon you to demonstrate respect and a heightened sensitivity to all in your classroom setting. Be prepared for comments of bias, initial reactions in which trainees indicate they “cannot or will not” work with certain types of people (such as sex offenders or individuals who seriously injure children). There is often an “evolution” of thinking for trainees, as they...
are introduced to the complex family conditions that exist and this attitude may change as trainees get a better comfort level in perceiving their own role in the child welfare system.

Trainees will come to understand that they are part of a larger child welfare professional culture, in which they will have support from supervisors, and agency guidance and ongoing training to help prepare them for work with people with whom they are uncertain. As that happens, they may become more open and confident in their ability to cope with difficult topics, and understand that they may be able to make a positive impact for children and families.

We hope that trainers and training teams will continue to be vigilant, focused on the cognitive and emotional progress of trainees who may be struggling. We also hope trainers will maintain a keen level of educational assessment as we work to build skills and instill standards for our new colleagues who will be a “good fit” for their role as a child welfare professional.
Unit 6.1: Maltreatment: Overview

Display Slide 6.1.1

Time: X hours

Unit Overview: To provide participants with a broad understanding of maltreatment, setting the stage for a deeper look (in the other units of this module) at some specific types of maltreatment.

Display Slides 6.1.2

Learning Objectives:
1. Locate and review definitions for abuse, abandonment and neglect in Florida Statutes.
2. Define “maltreatment.”
3. Identify key concepts within the Child Maltreatment Index.
4. Explain the difference between danger threats and maltreatments.
5. List the types of warning signs or indicators that occur in family systems that enable a child welfare professional to determine that a child is unsafe.
This module will develop detailed knowledge about maltreatment and its impact on children. We will discuss Physical Abuse, Sexual Abuse and Neglect.

In this unit, you’ll get an overview of maltreatment. This will include the definition of maltreatment as well as exploration into how maltreatment occurs. You will also review the maltreatment tool, called the Child Maltreatment Index, which outlines the assessment of maltreatment from the initial screening at the Florida Abuse Hotline through the findings of the Investigation.

Display Slide 6.1.3

What is the definition of a maltreatment? Why do maltreatments matter to you as a child welfare professional?

Participants should highlight that there are many different maltreatments. Make sure to correct anything that is incorrect and answer any questions.

What is the difference between a maltreatment and a danger threat?

Responses to the questions should include:

Maltreatment is parenting behavior that is harmful and destructive to a child’s cognitive, social, emotional, and/or physical development. For the purposes of the Maltreatment Index, a “maltreatment” is the resulting harm that occurs as the result of harmful parenting behavior.

Danger Threats are specific family situations or behaviors, emotions, motives, perceptions or capacities of a family member that are out-of-control, imminent and likely to have severe effects on a vulnerable child.
Display Slide 6.1.4 & 6.1.5 (PG: 5)

Let’s take a look at the **PG: 6-47, Child Maltreatment Index** and see what information it provides.

*Refer participants to the Child Maltreatment Index.*

*Discuss the purpose, scope, definitions, objective and utilization of the Index.*

*Take this opportunity to review the definitions of abuse, neglect and abandonment, and discuss as a group.*

Now, let’s focus on the maltreatment descriptions.

The Child Maltreatment Index incorporates the mandates of state law, administrative rules, operating procedures and recognized best practices. This allows each specific type of abuse and neglect to be clearly defined and assessed consistently throughout the state.

The objective is to improve the consistency and accuracy of findings made by child welfare professionals when dealing with similar allegations of harm or threatened harm. Improved consistency and accuracy help to ensure families are treated with fairness throughout the reporting and investigative process.

*Point out that each specific maltreatment is organized in the same way:*
  * Definition*
  * Examples of Maltreatment*
  * Factors to Consider in Assessment of Maltreatment*
  * Assessing for Frequently Associated Maltreatments*
• **Excluding Factors**
• **Information Necessary to Support a Verified Finding.**

Each maltreatment has a definition, specific questions to ask when assessing whether a situation describes that maltreatment and examples of that particular maltreatment. The Index also indicates when a situation that is assessed for a particular maltreatment should also be assessed for another maltreatment. There are also factors listed that would exclude a specific type of situation from being considered a maltreatment. And, last, there is a list of documentation the child welfare professional would need in order to verify a finding of maltreatment.

In this Unit, we will look at a few definitions for the maltreatments that are not presented in later units of Module 6. Some of our units, such as Physical Abuse, for example, cover a number of different maltreatments.

Documentation to support a finding will be covered in the specialization curricula for child protective investigators pre-service training course.

*Over the next few pages, you will be discussing specific maltreatments. For each of the maltreatments discussed, have participants turn to the section before you speak. Read, or ask a participant to read, the definition and discuss what it means, if explanation is needed. Foster brief discussion throughout.*

*Ask participants to come up with an example of the maltreatment, and give them corrective feedback. Add examples when needed.*

*Answer any remaining questions.*
Activity: Child Maltreatment Index Scenarios

Display Slide 6.1.6

Materials:
PG: 48-49, Child Maltreatment Index Scenarios

Instructions:
• This activity can be done individually or as a group. Ask participants to read each scenario, or read each scenario aloud to the class.
• After reading each scenario, ask participants to identify which maltreatment applies.
• Discuss responses as a group.

Activity: Child Maltreatment Index

Read the scenarios and identify which maltreatment applies.

Scenario 1:
The children, ages 4 and 6, are suspected to be endangered, on those occasions when their mother leaves them in the care of her mother, Mildred. Mildred is an amputee who is dependent on a wheelchair. She currently has a broken arm and is described as being unable to provide safe and adequate supervision for her grandchildren. The children are aware that they can leave the residence and wander anywhere in the neighborhood that they choose, without being found and returned, because of their grandmother’s physical limitations. The mother and grandmother have been cautioned previously but continue with this arrangement.
Maltreatment: Inadequate Supervision (Mother); Inadequate Supervision (Grandmother)

Scenario 2:
Mary tested positive for cocaine at the time of delivery today. The drug
screen on the baby is pending. The baby is doing fine. APGARS were 5 and 9 and she was delivered by C-section. The mother received prenatal care through the clinic and also a private physician.

**Maltreatment:** Substance Misuse – Illicit Drugs

**Scenario 3:**
The single mother, Lorine, passed away last night. There are no known family members willing or able to take custody of Lorine’s children.

**Special Conditions Referral:** Careviger Unavailable

**Scenario 4:**
The mother and her children live in a condemned apartment building, apartment 3. No one else actually lives in the building. The mother is said to have no visible means of income. The children cannot stay awake during the day and are obviously not getting sufficient sleep at night. The older son has to urinate frequently and has a history of pus coming from his penis. The mother has failed to get him medically checked. The younger son is showing some of the same signs and smells strongly of urine. The children are not clean. Michelle has ringworm on her face and the mother put shoe polish on it to try to cover it up, instead of obtaining medical treatment.

**Maltreatments:** Medical Neglect; Environmental Hazards

**Scenario 5:**
The parents advise that their 14-year-old child refuses to go to school or to abide by the parents’ rules. They are unable to control his behavior and are worried that he will get harmed when he is “running the streets” instead of going to school. They want help in getting him to listen and to behave.

**Special Conditions Referral:** Parent Needs Assistance

**Scenario 6:**
It is alleged that a young girl, approximately 9 years of age, is residing with the Gutierrez family. She is forced to live in the garage and does not attend school. Allegedly, this girl “works” for the family and is forced to clean and do laundry for 16 hours per day.

**Maltreatment:** Human Trafficking - Labor

**Activity STOP**
There are a few maltreatments that may not fall easily into one of the categories you will review in subsequent units. We will highlight some of them to illustrate the type of information contained in the Index.

The first maltreatment in the Index is “Abandonment.”

The definition of Abandonment is a situation in which the parent(s) or legal custodian(s) of a child or, in the absence of a parent or legal custodian, the caregiver(s), while being able, makes no provision for the child’s support and has failed to establish or maintain a substantial and positive relationship with the child. “Establish or maintain a substantial and positive relationship” includes, but is not limited to, frequent and regular contact with the child through frequent and regular visitation or frequent and regular communication to or with the child, and through the exercise of parental rights and responsibilities.

s. 827.10, F.S., Unlawful desertion of a child.

Can you give me a scenario that would be an example of that definition?

Discuss their answers and give corrective feedback. Give them examples, if needed. Point out the other guidance in the allegation description, including examples and exclusions. Answer questions to clarify any misunderstandings.
The next maltreatment we will look at in the Index is “Threatened Harm.” The definition of Threatened Harm is a behavior that is not accidental and which is likely to result in harm to the child.

The Hotline is limited to only two situations for selecting this maltreatment:

- The preventable death of one child provides reason to suspect that another child is at risk, or
- The caregiver’s children are currently in out-of-home care or parental rights have been terminated.

**Can you give me a scenario that would be an example of the definition of Threatened Harm?**

Discuss their answers and give corrective feedback. Give them examples, if needed. Point out the other guidance in the allegation description, including examples and exclusions. Answers questions to clarify any misunderstandings.

There are “warning signs” or “symptoms” of maltreatment that should be assessed on an ongoing basis. Certain family factors
might influence the occurrence of maltreatment, while behaviors exhibited by parents may serve as a clue that abuse is already occurring.

These warning signs are not the causes and conditions that led the child to be unsafe, but rather are the indicators that the child is unsafe.

It is impossible for the child welfare professional to have a list to just check off that tells whether a child is unsafe. It is only through the effective and sufficient collection of information from the six domains, as well as the critical assessment and analysis of this information, that the child welfare professional is able to determine if child is safe or unsafe.

Nonetheless, it is good to be able to practice working with some of these indicators to sharpen participants’ skills at being able to “see” more clearly what is going on in the family.

Facilitate a group discussion on this topic. What are some of the “warning signs.” Utilize the Information Collection Protocol and discuss how a Child Welfare Professional might “see” these signs through the information collection process.

Before we leave the overview of maltreatment, one of the maltreatments listed in the Child Maltreatment Index is “Human Trafficking.”

Section 787.06(2)(d), Florida Statutes, defines “human trafficking” as “transporting, soliciting, recruiting, harboring, providing, enticing, maintaining, or obtaining another person for the purpose of exploitation of that person.”

We will talk primarily about Labor Trafficking and Sex Trafficking.
**Labor Trafficking:**

Labor Trafficking cases require proof of force, fraud or coercion.

Florida is an especially big target for labor traffickers who bring in people from other countries. This is because of the unique characteristics of a multicultural tourist and travel state. Although traffickers also abduct U.S. citizens, they have greater control when they import people from other countries who are not literate in English.

These victims may have been told they were being brought to the U.S. for legitimate work, but that they must be indentured to their trafficker and work off a debt. When they get to the U.S., they may have their passports and ID taken away from them by their “hosts,” and told if they don’t make money for their host, their families in their countries of origin will be harmed.

As a result, individuals being trafficked may be afraid to reach out for help. In addition, because of language differences, they may not be able to communicate clearly with others they encounter. They may have been brought here illegally, or they may be legal residents. In either case, they may think they are illegal in this country and are bound to their “hosts.”

U.S. citizens also can be victims of labor trafficking. In Florida, and especially in the Central Region, unscrupulous "traveling sales crews" have become popular, exploiting children as young as 8-years-old, offering false promises to parents and children, and imposing harsh working conditions and abuse on children. Many of the crews operate of the guide of a false nonprofit organization, forcing children to sell cheap products door-to-door, unsupervised. In some cases, children have been forced to work long hours without food or water, and have been transported to other cities far away from home. The crews often target children from lower socioeconomic neighborhoods, promising them jobs and money. There are some additional terms to be aware of:
COMMERCIAL SEX ACT - The term “commercial sex act” means any sex act of which anything of value is given to or received by any person. Examples: exotic dancing, pornography, sexual acts.

DEBT BONDAGE - The term “debt bondage” means the status or condition of a debtor arising from a pledge by the debtor of his or her personal services or of those of a person under his or her control as a security for debt, if the value of those services as reasonably assessed is not applied toward the liquidation of the debt or the length and nature of those services are not respectively limited and defined.

IN VOLUNTARY SERVITUDE - The term “involuntary servitude” includes a condition of servitude induced by means of –
   (A) any scheme, plan or pattern intended to cause a person to believe that, if the person did not enter into or continue in such condition, that person or another person would suffer serious harm or physical restraint; or
   (B) the abuse or threatened abuse of the legal process.

Sex Trafficking
If the victim is under the age of 18, there is not a requirement for force, fraud or coercion.

The majority of human trafficking cases we see are domestic minor sex trafficking incidents. These victims are U.S. citizens or hold green cards. They were not brought to the country to exploit, but were instead recruited from within the U.S. Certain populations have a higher risk for victimization. These groups include: children with a history of abuse or neglect, especially sexual abuse; homeless youth; children with a history of engagement with child welfare and foster care; and children who identify as gay, lesbian, bisexual, and transgender. No individual under the age of 18 can consent to an act of prostitution. If the individual is under the age of 18, it is automatically human trafficking.
There are 4 forms of sex trafficking:

**Renegade/Survival Sex**: There is no third party. No pimp. The victim may “broker” exchanges for a sexual act independently. There may be an exchange of a sexual act for money, food, housing, clothing, etc. Any exchange of a sexual act for any tangible thing, or the promise of a tangible thing, is human trafficking.

**Pimp Trafficking**: There is a third party who is “brokering” the exchanges of the sexual act for a tangible item, typically money. Pimps can be any age, any gender, and come from all types of backgrounds.

**Familial Trafficking**: A family member is involved in the trafficking of the child. There may be an exchange for money, for drugs, for rent, etc.

**Gang Trafficking**: The trafficking is a source of generating money for the gang, and the gang member is involved in the trafficking of the victim. This might be a local, state, national, or transnational gang. A gang is defined as “An association of three or more individuals whose purpose, in part, is to engage in criminal activity.”

Trafficking victims, labor or sex, rarely self-disclose. You cannot rely solely on an admission from this victim to support findings. Factors to consider: lack of attendance in school, older boyfriend, runaway episodes, arrests for “masking charges” most typically battery or petit theft, history of abuse, history of involvement with child welfare or foster care. Males are victims of sex trafficking, as well. Each year, approximately 15% of such reports received by the Florida Abuse Hotline are regarding male victims.

Choice is an illusion when discussing human trafficking. While it
may appear that victims have opportunities to leave or ask for help, often the threats, the psychological and emotional manipulation they are subjected to, and the lack of appropriate support systems, prevent the child from leaving the situation and often drive the victim back to the trafficker, even when the victim has left the situation for a period of time.

**PG: 52-53**

USING THE CHARTS BELOW: For Labor Trafficking, there is a process + a way or means + a goal to support a finding of human trafficking. For Sex Trafficking, if the victim is under the age of 18, there is a process + a goal – a finding of human trafficking **does not require** a ways or means.

### Labor Trafficking

<table>
<thead>
<tr>
<th>Process</th>
<th>+</th>
<th>Way/Means</th>
<th>+</th>
<th>Goal</th>
</tr>
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<tbody>
<tr>
<td>Recruitment or Transportation or Transferring or Harboring or Receiving</td>
<td>A</td>
<td>Threat or Coercion or Abduction or Fraud or Deceit or Deception or Abuse of Power</td>
<td>A</td>
<td>Prostitution or Pornography or Violence/Sexual Exploitation or Forced Labor or Involuntary Servitude or Debt Bondage (with unfair wages) or Slavery/Similar practices</td>
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Sex Trafficking (victim under age 18)

<table>
<thead>
<tr>
<th>Process</th>
<th>+</th>
<th>Goal</th>
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<tbody>
<tr>
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<td>Violence/Sexual Exploitation or Forced Labor</td>
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<td></td>
<td>D</td>
<td>Involuntary Servitude or Debt Bondage (with unfair wages) or Slavery/Similar practices</td>
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Changes to state law during the 2014 legislative session require specially trained child protective investigators and dependency case managers to handle cases involving human trafficking victims. If you are interested in developing this specialty, please discuss this with your supervisor.

In the next unit we will discuss neglect, which may be co-occurring with another type of maltreatment or not.
Unit 6.2: Neglect

Display Slide 6.2.1

Time: X hours

Unit Overview: This unit provides participants with an understanding of neglect, including:

1. Identification and ability to differentiate between types of neglect in the Maltreatment Index.
2. Ability to identify indicators of different types of neglect in family scenarios through descriptions, photographs, behaviors and words.
3. Ability to explain and appreciate the longer-term impact of child neglect maltreatment.

Display Slides 6.2.2

Learning Objectives:

1. Define and explain “neglect” and the types of neglect, based on the Maltreatment Index.
2. Explain the long-term traumatic impact of neglect on a child.
3. List and explain the indicators of child neglect.
4. List the types of evidence that would be collected in order to demonstrate neglect.
5. Given scenarios: 1) determine if it is neglect and, if so, the specific type of neglect as described in the Maltreatment Index; 2) justify your determination.
6. Define and describe “failure to thrive”.
7. Differentiate between chronic and situational neglect.
8. Describe the effects of neglect on toddlers, school-aged children, and adolescents.

Think back to Module 3, what are the potential impacts of neglect to children?

Trainer Notes: Accept any and all answers, as this question is intended to direct and focus participants toward critically thinking about the effects of neglect. Ensure there is a discussion on emotional and behavioral impacts, as well.

Display Slide 6.2.3  (PG: 54)

The most severe consequence of neglect is death. In 2012, neglect was reported as the primary component in 70% of US child maltreatment deaths (Children’s Bureau, 2013).

The Florida Child Abuse Death Review (CADR) is a statewide multidisciplinary, multiagency child abuse death assessment and prevention system that consists of state and local review committees. The requirements and expectations are outlined in section 383.402, Florida Statutes.

The purpose of the review shall be to:
(a) Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse.
(b) Whenever possible, develop a communitywide approach to address such cases and contributing factors.
(c) Identify any gaps, deficiencies, or problems in the delivery by public and private agencies of services that may help prevent deaths that are the result of child abuse.

(d) Make and implement recommendations for changes in law, rules, and policies, as well as develop practice standards that support the safe and healthy development of children and reduce preventable child abuse deaths.

The State Child Abuse Death Review Committee is established within the Department of Health and shall consist of a representative of the Department of Health, appointed by the State Surgeon General, who shall serve as the state committee coordinator. The head of each of the following agencies or organizations shall also appoint a representative to the state committee:

1. The Department of Legal Affairs.
2. The Department of Children and Families.
3. The Florida Department of Law Enforcement.
4. The Department of Education.
5. The Florida Prosecuting Attorneys Association, Inc.
6. The Florida Medical Examiners Commission, whose representative must be a forensic pathologist.

The DCF Child Fatality Prevention website was created to raise public awareness about child fatalities throughout the state and assist communities with identifying where additional resources or efforts are needed to assist struggling families. This website includes information regarding all child fatalities called into the Florida Abuse Hotline alleged to be a result of abuse or neglect. The definitions for abuse, abandonment and neglect can be found in Ch. 39, Florida Statutes. The data can be sorted and viewed by county, child's age, causal factor and prior involvement. Cases listed as verified indicate that enough evidence exists to determine that the child’s death was caused by abuse, abandonment or neglect. Prior involvement indicates that the deceased child or the family of the deceased child had contact with Florida’s child welfare system—this could have been through a child protective investigation conducted by DCF or one of six sheriff’s offices, and/or by foster care or family support services.
provided by one of Florida's Community-Based Care lead agencies. The site also includes information about DCF’s prevention campaigns relating to the leading causes of child fatality in Florida—unsafe sleep, drowning and inflicted trauma. These campaigns provide useful information for parents and caregivers and avenues for communities to get involved.

**Trainer Notes:** Florida Child Abuse Death Review Committee was established by statute in 1999. The program is administered by the Florida Department of Health and utilizes state and locally developed multidisciplinary committees to conduct detailed reviews of the facts and circumstances surrounding child abuse and neglect deaths.

Section 383.402, Florida Statutes
The purpose of the child abuse death review process is to:
- Develop a community-based approach to address child abuse deaths and contributing factors.
- Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse or neglect.
- Identify gaps, deficiencies or problems in service delivery to children and families by public and private agencies that may be related to child abuse deaths.
- Develop and implement data-driven recommendations for reducing child abuse and neglect deaths.

*PG: 55-56*

*As a group, explore this website and look at data for the state as a whole, as well as local information.*
Father of murdered infant charged with child neglect

Marcus Harden, 38, was arrested and charged with child neglect on Wednesday.

TAMPA --

The father of an infant police said was murdered by her mother is facing child neglect charges.

Marcus Harden, 38, was arrested and charged with child neglect on Wednesday. Police said Harden left 4-month-old Markala Thompson alone with her mother, Eboni Shameeca Thompson, 31, who was not allowed to be unsupervised with the child.

Detectives said they learned Eboni Thompson was living in the home with the child despite a court order barring her from doing so.

Investigators said Harden left the baby in Thompson's care for 15 minutes on Dec. 14, even though he was aware she was not supposed to be with the children.

While Harden was away from the home, Thompson choked the crying infant until she stopped breathing, police said.

The medical examiner said the little girl had also suffered multiple broken ribs and a broken arm.

Thompson was arrested on Dec. 17 and charged with first-degree murder and two counts of aggravated child abuse. Police said she admitted to abusing the baby several times over the past four months. Tampa police also said an autopsy found the baby, 4-month-old Markala Thompson, had three broken ribs and a broken arm from a previous injury. Thompson also is charged with two counts of aggravated child abuse.

Four other children who were living with Harden - three girls, ages 17, 6 and 4, and a 21-month-old boy - are in the custody of the Department of Families and Children.
Now, we will explore further the causes of some of the highest incidences of neglect and death.

Florida leads the nation for children ages 1-4 who drown in pools. According to the Department of Health (DOH), there were 79 children ages 0-5 who drowned in 2012. The 10 Florida counties with the highest rates of childhood drowning between the ages of 1 and 4 were: Brevard, Broward, Charlotte, Hillsborough, Miami-Dade, Orange, Osceola, Palm Beach, Pinellas, and Polk counties.

Source: Florida Department of Health

An alarming number of pool drownings occur annually. The CADR has recommended installation of various security mechanisms. Pool alarms, fences, locked gates and other protective barriers represent some of the best intentions for protection, but are rendered useless when not used or used improperly.

Many investigations have revealed that the caregivers were distracted, using the Internet or other computer-related activities, and/or were impaired by substance abuse.

Bathtubs are the second most common bodies of water to claim children by drowning and can occur with very little standing water. Infants and toddlers should never be left unattended in tubs.
Another death related to inattentive parenting is caused by suffocation in a hot car.

In just 10 minutes, the temperature of a parked vehicle can rise 20 degrees. The crack of a window, even by inches, is no match to combat the rising heat. This heat can be deadly, especially for children because their body temperatures rise five times faster than adults.

Although it may be hard to believe, children can easily be left behind in the car when parents are distracted, rushing, multi-tasking or have a change in routine. This is especially true during the summer months when kids are out of school and may have a different caretaker or driver.

In the state of Florida, it is a criminal offense (see s. 316.6135, F.S.) to leave a child unattended in a vehicle. Greater than the pain of arrest or prosecution is the lifelong loss of a child.

- Anyone who sees a young child, vulnerable adult, or animal left unattended in a vehicle should call 911 immediately.

Direct participants to PG: 57 for details of section 316.6135, F.S. Provide a minute for participants to read it.
Review pointers on the slide referring to what a safe sleeping environment should look like.

Click the link on the PowerPoint screen and show video (6:20):

https://www.youtube.com/watch?v=0zoQ7n3omqQ

Optional Video: This is a shorter (3:21), local Florida video. Six years ago, Sherkendra’s daughter died while they were co-sleeping in an adult bed. Her baby was just 6 weeks old. Sherkendra’s story is powerful.

https://www.youtube.com/watch?v=Jv_ecuxcSmo&feature=youtu.be

Trainer Note: Sudden Unexpected Infant Death (SUID)
SUID was known as SIDS (Sudden Infant Death Syndrome), which was defined in 1989 by the National Institute of Child Health and Human Development as: “The sudden death of an infant less than one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history.” There has been a significant decrease in the number of infant deaths certified as SIDS in Florida and nationally in recent years since it has been recognized that unsafe sleeping conditions put infants at a greater risk for sudden death.

Data derived from numerous national initiatives have led to the recognition that certain factors increase the risk of infant death from asphyxia due to suffocation or overlay. Suc factors are: infant sleeping postions and sleeping environments, including the prone sleeping position, bed-sharing (co-sleeping, particularly with individuals who are under the influence of drugs and/or alcohol, who are obese and who are exhausted) and soft bedding. The term Sudden Unexpected Infant Death (SUID) has been designated to refer to all sudden and unexpected deaths of infants under 1 year of age of natural or unnatural causes.
As defined in Florida Statute 39.01, certain circumstance do NOT constitute neglect when:

- Caused primarily by financial inability, unless actual services have been offered and rejected.

OR

- The parent/legal guardian is legitimately practicing his religious beliefs under a recognized church or religious organization and thereby does not provide specific medical treatment for a child. That parent must not, for that reason alone, be considered a negligent parent or legal custodian.

Questions regarding the name of the organized church and any other pertinent information regarding the religion must be asked. The child welfare professional still would gather information and conduct a Family Functioning Assessment.
The court can order that services be provided when the health of the child requires:

- Medical Services from a licensed physician, dentist, optometrist, podiatrist, or other qualified health care provider; or
- Treatment by an accredited practitioner who relies solely on spiritual means for healing under the tenets and practices of a well-organized church or religious organization.

In the Maltreatment Overview, you reviewed some of the definitions in the Maltreatment Index. We will now explore a little deeper and look at some assessment questions that will help us with determining whether or not neglect exists. This next section is taken directly from the Child Maltreatment Index.

Refer participants to PG: 60, Environmental Hazards.

Ask participants to silently read the portion in Environmental Hazards entitled “Assessing ‘Environmental Hazard’ as Maltreatment” and the portion in Inadequate Supervision entitled “Assessing ‘Inadequate Supervision’ as Maltreatment.”
Debrief any questions, comments or “aha” moments.

**Trainer Note:** These questions will be referred to in our next activity, “Is it Neglect?”

Display Slide 6.2.11

Now, we will explore three Maltreatments that are closely tied to neglect. They are: Failure to Thrive, Malnutrition/Dehydration and Medical Neglect.

Refer participants to **PG: 60-69** for excerpts from the Child Maltreatment Index and ask them to review Failure to Thrive, Malnutrition/Dehydration and Medical Neglect.

Display Slide 6.2.12

“Failure-to-thrive” is a medical term used to diagnose infants who are underweight and malnourished.

Doctors compare the infant’s weight and height to a chart of standard height/weight measurements for infants.

Failure to thrive (FIT) is not always a result of maltreatment. Failure
to thrive can occur due to organic or non-organic reasons.

- Weight or height is below the 5th percentile of the population on a standard weight/height curve (some experts recommend 3rd percentile)
  - Actual weight is 20% or more below the ideal weight for height
  - Weight gain is significantly slower than normal
  - Triceps skin-fold thickness (total body fat measurement) is below 15th percentile for the population.

- Organic FTT results from congenital or genetic causes.

- Non-organic FTT results from action or non-action on the part of the caregiver.

Display Slide 6.2.13

Activity: The Gavin Family

Display Slide 6.2.14

Purpose: Participants must understand how to identify situations that are indicative of neglect. This activity provides them with that opportunity.
Materials:
*PG: 70, The Gavin Family story*

Trainer Instructions: *Use the information in PG: 70. While you are reading, consider the questions on the PowerPoint slide.*

**What indicators suggest the Gavins are suffering from chronic neglect?**

*Suggested Answers:*
- condition of the furniture
- dirty and clean laundry strewn about
- rotting food, dirty dishes, rancid canned meat left open
- mother depressed; rarely moves from sofa
- mother was not parented by her mother
- mother verbally abusive to the children
- children frequently miss school
- children failing in school
- 6-year-old child wanders the city/truant from school
- strained relationship with the father of the children
- referred to the agency many times in the last several years
- strained relationship with maternal grandmother

*Discuss additional points if they have not already been mentioned:*
- *Mrs. Gavin appears to be depressed and suffers from the neglect and rejection she experienced from her mother.*
- *She lacks basic parenting skills and yet professes a deep love for the children.*
- *She has no obvious supports/friends.*

**The Gavin Family**

**Gavin Scenario**
The Gavin family is not new to the agency. On this occasion, a call was received, alleging that the children were begging for food. The Gavin family home is unkempt and dirty. The sagging couch was piled high with mixed loads of dirty and clean, unfolded laundry. The front window has a large piece of cardboard covering the broken-out pane. The greasy kitchen table holds remnants of food: an open loaf of bread, soggy cereal in bowls, and an opened can of potted meat that looks rancid.

Ms. Gavin is a divorced woman in her mid-30’s and the mother of seven children. She
is obese, weighing close to 300 pounds, and by her own admission, she seldom leaves the sofa. From her position on the couch, she talks on the telephone (mostly fending off bill collectors) and yells at the children when they cross her path. Ms. Gavin was the first-born child of a 16-year-old mother who ultimately had four children.

At about the age of 5, Ms. Gavin was placed in care after having been given up by her mother. She stayed institutionalized until the age of 10, when she was placed in a number of successive foster care homes. At the age of 16, she returned home to her mother for one year until she became pregnant with her oldest daughter, Joy, and moved out on her own. Joy is currently being raised by Ms. Gavin’s mother, and Ms. Gavin has had no contact with either Joy or her mother in over two years. At the age of 18, Ms. Gavin began working in a poultry processing plant where she met “John,” whom she had a relationship with for 12 years but never married because “he had a wife someplace else.”

John is the father of the other six children, but seldom comes around anymore, according to Ms. Gavin.

Ms. Gavin expects the 11-year-old daughter, Jennie, to take care of all of the other children. Jennie is older and larger than any of the other fourth-graders in her school and is frequently absent. Her mother allows this and expects Jennie to cook and clean when Ms. Gavin is not present. Lately, Jennie has been leaving the house pretending to go to school and has been found wandering the city on two occasions.

The 7-year-old, Jimmy, also often stays home from school, but Ms. Gavin says she does not mind because he is her “little man around the house.” However, she also says that she is concerned because he is failing in school and has no friends. Both Jennie and Jimmy have a speech impairment that makes it difficult to understand them and for which they are receiving special services at school.

The four preschoolers spend most of their day watching TV and squabbling. They seldom go outside. The children all bear the scars of a woman who cannot communicate joy, interest, or love. Yet, she clings to them tightly and says, “They are my whole life.”

Do you think contracting with a cleaning service to clean the house and/or providing the family with new furniture would have a long-lasting change for this family? If so, how?

**Trainer Note:** Reiterate here the depth of the situation and that these types of measures would only be temporary until the underlying factors are addressed. Provide any real stories you may have about dealing with chronic neglect.

**Activity STOP**
Point out the types of services and interventions needed will be different depending on whether the family suffers from situational or chronic neglect.

### Chronic vs. Situational Neglect

#### Crisis/Situational
- Parents fundamentally able to cope but temporarily overwhelmed
- Major crisis, or series of crises
- History of adequate child care
- Regular employment
- Sufficient income and skills
- Emotional support from friends and relatives
- Average problem-solving abilities
- Generally good physical health, minimal use of illegal substances, and essentially no illegal activity
- Adequate education and housing that allow for individual space and organization of belongings
- Intimacy is non-sexualized
- Acceptance of differences in opinion
- Understanding and acceptance of their respective roles
- Generally good mental health
- Likely to be cooperative with genuinely supportive child protection personnel
- Likely to regain ability to solve problems themselves when crisis has passed

#### Chronic
- Parents with continual and serious child-rearing difficulties
- Constantly in stressful situation or crisis
- Little parenting knowledge
- Limited education/vocational opportunities and skills
- Generational poverty
- Extreme social isolation
- Little support from relatives or friends
- Poor problem-solving skills; blame others
- Ill health, substance abuse, drug-dealing, legal problems, physical/developmental disability
- Overcrowded or run-down housing
- Prostitution
- Abuse between adults
- Untreated mental illness
- Parental history involves neglect as a child
- Distrustful of professional helpers
- New crises constantly arise even as old crises are resolved

Display Slide 6.2.16

Display Slide 6.2.17 (PG: 72)

As we have already discovered, the child’s age is one factor we use in determining neglect.

Let’s explore this a little further.

Refer to PG: 73, Common Effects of Child Neglect and direct participants to review.
Common Effects of Child Neglect

Infants
The effects of neglect in infancy are likely to result in failure to thrive, which can lead to death of the child. Other effects:
- lack of attachment to mother
- impaired brain, motor and physical development
- malnutrition, significant health problems
- development of anxious, insecure attachments in other relationships
- insecurity limits ability to explore environment
- development of feelings of incompetence

Toddlers
- extremely withdrawn and passive
- engage in random, undisciplined activity
- impaired brain, motor and physical development
- deficits in coping skills - displays frustration, anger and noncompliance
- attention/affection need sought indiscriminately from adults
- malnutrition, significant health problems

Kindergarten/School-aged Children
- lack of attachment
- significant health problems
- delayed or impaired speech
- developmental delays
- violent acts
- severely withdrawn
- inability to concentrate
- serious learning deficits and delays
- low self-esteem
- curiosity blunted, almost nonexistent

Adolescents
- low self-esteem
- poor school attendance
- work and learn below average levels
- high risk for delinquent behavior
- high risk for “ungovernable” behavior (e.g., truancy, running away, substance use/abuse)

Review the remaining factors and have a brief class discussion about how each would affect the short-or long-term impact.
Trainer Note: Option: Divide the remaining topics among table groups and ask them to discuss for 5 minutes and present their findings to the class. Continue discussion.

Display Slide 6.2.18 (PG: 74)

Depending on time remaining, this activity can be done as a brief group discussion or each Gavin family member can be assigned to a table group.

Behavioral and Emotional Effects of Neglect

- **Developmental delays:** A large percentage of neglected children are developmentally delayed in all domains. The degree of delay is determined by comparing the child's developmental level with expected developmental achievements for the child’s chronological age. Neglected children may display from mild to serious delays in physical/motor development, cognitive ability and school achievement, social skill and interpersonal relationships, and emotional development. Severely neglected children may become mentally challenged as a result.

- **Unresponsiveness:** Neglected children are often characterized as unresponsive, placid, apathetic, dull, lacking curiosity and uninterested in their surroundings. They do not approach other people, or exhibit a normal degree of exuberance in their interactions. They may not play, or they may play half-heartedly. In cases of serious neglect, the child may exhibit signs of depression.

- **Hunger/Fatigue:** Some older children who are inadequately fed use their own resources by scrouncing for, or stealing and hoarding food.

- **Out-of-Control Behavior:** The child may be "out of control" due to an absence of limits from adult caretakers. The child exhibits a variety of behavior problems, anxiety, and other signs of emotional distress. A false bravado may be seen.

- **School Failure:** School failure may be an indicator of neglect, particularly when combined with an inability to concentrate, falling
asleep in class, and a lack of interest in the school environment. School failure by itself cannot be considered the result of neglect, but can support a diagnosis of neglect when other indicators are present.

- **Physical Signs of Stress and Anxiety:** The child may show physical signs of stress and anxiety, including physical illness and regressive behaviors.
- **Aggression:** The child may be aggressive with other children, have temper tantrums, may be "touchy."
- **School-age child shows many of the same characteristics as the preschool child:** The child’s problems in relationships and developmental delays are more pronounced the longer he/she has been maltreated.
- **The child assumes the "adult" role in his/her relationship with the parent:** The child is often a "little helper," who cares for the parent, demonstrates excessive concern when the parent is distressed, is unusually compliant.
- **Difficulty in Relating:** The child has difficulty relating to other children and to adults. He may be manipulative, or withdrawn and distant. He may have angry, aggressive outbursts and temper tantrums.
- **Chronic Anxiety:** The child may appear to be "hyperactive," including having an unusually short attention span, an inability to concentrate. The child often does not do well in school and may appear to be "preoccupied."
- **Fear of the parents:** The child may demonstrate a fear of the parents or, in some cases, an absence of fear or concern in the face of parental or adult authority.

What behavioral and/or emotional effects do we see or can we expect to see in the Gavin family?

- Mr. Gavin?
- Mrs. Gavin?
- Jennie?
- Jimmy?
- The 4 Other Children?
## Behavioral and Effects on the Gavin Family

*PG: 75*

Check the box and briefly explain

<table>
<thead>
<tr>
<th></th>
<th>Mr. Gavin</th>
<th>Ms. Gavin</th>
<th>Jennie</th>
<th>Jimmy</th>
<th>4 Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental delays</td>
<td></td>
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<td>Unresponsiveness</td>
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<tr>
<td>Hunger/Fatigue</td>
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<td>Out-of-Control Behavior</td>
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<td>School Failure</td>
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<tr>
<td>Physical Signs of Stress and Anxiety</td>
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<td></td>
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<tr>
<td>Aggression</td>
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<tr>
<td>School-age same as the pre-school child</td>
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<tr>
<td>The child assumes the &quot;adult&quot; role</td>
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<tr>
<td>Difficulty in Relating</td>
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<tr>
<td>Symptoms of Chronic Anxiety</td>
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<tr>
<td>Fear of the parents</td>
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</tr>
</tbody>
</table>
Take a moment to think about all you have learned in this Unit.

**Ask each participant to:** Provide one item that you learned today that you can apply toward your job in child protection.

Raise your hand when you are ready to provide one. No repeats, so you may want to think of more than one or two.

In the next unit, we will learn about physical abuse.
Unit 6.3: Physical Abuse

Display Slide 6.3.1

Time:

Unit Overview: This unit provides participants with definitions and a detailed examination and understanding of child physical abuse.

Display Slide 6.3.2

Learning Objectives:
1. Define “physical injury.”
2. Given a scenario, determine what type of physical abuse is presented based on the Florida Statutes and Maltreatment Index.
3. List and describe physical indicators and medical findings indicative of non-accidental trauma and abuse.
4. Define and describe “abusive head trauma.”
5. Given a scenario, participants 1) determine if it might be abusive head trauma or not, and 2) justify their determinations.
6. Explain the impact of physical abuse on the child in terms of his/her safety as well as longer-term effects.
7. Describe how these various maltreatments impact the child in the short-term and long-term.
8. Explain the role of the Child Protection Team (CPT) in physical abuse cases of maltreatment.

Display Slide 6.3.3 (PG: 76)

You have learned so far about maltreatments in general, and specifically about the maltreatment called “neglect.” You also have learned that in Florida we utilize CFOP 175-28, which is the Child Maltreatment Index, to assess for use of the appropriate maltreatment.

In this unit, as in all of the Maltreatment units, we will be using the Child Maltreatment Index as the focusing lens for our work, supplementing it with pictures and descriptions of physical abuse.

The reality is that, most of the time, you will not see the maltreatment occur. Someone else will report to a Hotline counselor either that they saw what they believe to be a physical injury maltreatment occurring, or they see or hear evidence indicating that a physical injury or other maltreatment is or may soon be occurring.

It will be the hotline counselor’s responsibility to gain as much descriptive evidence of what the reporter has seen or heard in order to make a determination that the investigation of whether a maltreatment has occurred or is likely to occur is warranted. It will be the responsibility of the child protective investigator to make a true determination as to whether or not a maltreatment has occurred or is likely to occur.
Let’s take a look at abuse and the maltreatments that make up physical abuse in greater depth.

Display Slide 6.3.4 (PG: 76)

Florida Statutes 39.01(2) defines “abuse” as follows:

“...any willful act or threatened act that results in any physical, mental, or sexual injury or harm that causes or is likely to cause the child’s physical, mental, or emotional health to be significantly impaired. Abuse of a child includes acts or omissions...”

Physical abuse spans several different categories of maltreatments in the Child Maltreatment Index.

(These instructions relate to the next three slides).

- Have participants pull out the Child Maltreatment Index.
- As you read through the name of the maltreatment on each slide, have them leaf through the Index and earmark each page that has a physical abuse category that we will be studying.
- As you are discussing the first Maltreatment – Asphyxiation – remind them that the Maltreatment Index, contains the following standard categories of information for each maltreatment. Reiterate from the Unit 1 Overview that these categories include:
  - Definitions
  - Assessment questions they can use as they work to identify a specific maltreatment.
  - Assessment questions or actions they can take to rule in another maltreatment.
  - Excluding factors that make it less likely that what is being observed is indicative of that specific maltreatment.
  - A list of the documentation needed to support a finding of maltreatment.
- If anyone has a hard time finding any of these maltreatments in the Index, they should be sure to let you know so you make sure everyone is on the same page.

- When you get to the last of the three slides, in discussing an overview of Bizarre Punishment and Malnourishment/Dehydration, discuss how this could be neglect or abuse. Acknowledge that while these manifest as physical abuse, they are categorized as separate, stand-alone maltreatments.

- Tell participants they will be working with these in depth over the next few hours. Answer any initial questions they might have.

*Display Slide 6.3.5 & 6.3.6 (PG: 76)*

*Display Slide 6.3.7*

Now that we’ve completed a brief overview of the maltreatments that fall under the category of Physical Abuse, we’re going to now take a little deeper look into each of them.

**Trainer Note:** In this section, you will be walking through each of the specific maltreatments with participants. First, read through the definition, and at a very high level, point out what information they will find in each of the sections. Highlight the fact that they will be seeing a lot of graphic pictures portraying, for the most part, evidence of that specific maltreatment.
This serves as an overview of the document, in which they will be engaged over the next 1.5-2 hours or so.

Display Slide 6.3.8 (PG: 77)

Display Slide 6.3.9 (PG: 77)

Display Slide 6.3.10 (PG: 77)
Display Slide 6.3.11 (PG: 77)

Internal Injuries
- Florida Malpractice Index (6/1/10)
  "...an injury to the organs occupying the thoracic (chest) or abdominal cavities that is not visible from the outside. Internal injuries may be accompanied by other external injuries. A person so injured may be pale, cold, perspiring freely, have an anxious expression, seem semiconscious, or exhibit other symptoms, such as lethargy, disorientation, blood in bowel movements or urine, and/or loss of consciousness."

Display Slide 6.3.12 (PG: 77)

Physical Injury
- Florida Malpractice Index (6/1/10)
  "Physical injury includes any physical mutilation of a child which is not covered by other abusive maltreatment that results in permanent or temporary disfigurement, permanent or temporary loss or impairment of a bodily part or function, or by a willful act or threatened act which causes or is likely to cause the child's physical health to be impaired."

Display Slide 6.3.13 (PG: 77)

Bizarre Punishment
- Florida Malpractice Index (6/1/10)
  "Bizarre punishment is caused by a willful act of a caregiver(s) that includes inflicting or subjecting a child to intense physical or mental pain, suffering, or agony that is repetitive, increased, prolonged, or severe. Bizarre punishment also includes confinement, torture, and inappropriately/malnourishment or restraint or isolation."

Display Slide 6.3.14 (PG: 77)

Malnutrition/Dehydration
- Florida Malpractice Index (6/1/10)
  "Malnutrition is a lack of necessary or proper nutrition or liquids in the body caused by lack of access to food, inadequate food, lack of food or liquids, or insufficient amounts of protein, minerals or vitamins."

Core Child Welfare Pre-Service Curriculum | Module 6-TG
Does anyone have any questions before we really work with this information?

*Respond appropriately to questions.*

**PG: 78**

In Dr. Robert Reece’s article, “Recognition of Non-accidental Injuries,” he states that the physical abuse that is most life-threatening includes:

- Any abuse resulting in head injuries, particularly:
  - Subdural hematomas
  - Abusive Head Trauma: serious, often fatal injuries caused by violent shaking of a very young child.
    - Shaken infants do not often show visible signs of external trauma.
    - Generally seen in children 2 years of age or younger - most common in children less than 6 months of age.
    - Three main signs: 1) subdural hematoma; 2) retinal hemorrhage; 3) metaphyseal lesions.
  - Battered Child Syndrome
  - Internal injuries
  - Burns, both non-intentional and abusive. One of the most common causes of death in children. Children are most likely burned in the bathroom and are at risk during toilet-training.
  - Weapon injury
  - Poisoning: About 17% of children who are poisoned die.
When considering whether or not the child has been physically abused, s. 39.01(30)(a), F.S., states that when the child appears to have had physical abuse inflicted on him or her, it is important that the child be evaluated for physical, mental or emotional injury. The factors to be considered include:

- The age of the child.
- Any prior history of injuries to the child.
- The location of the injury on the body of the child.
- The multiplicity of the injury.
- The type of trauma inflicted.
When child abuse or neglect is reported to the Florida Abuse Hotline and accepted for investigation, the case also is reviewed by the Child Protection Team (CPT) to determine whether face-to-face medical evaluation by CPT is necessary (s. 39.303(3), F.S.). Many types of abuse or neglect must be referred for CPT assessment. Let’s look at these required referrals:

- Any sexually transmitted disease in a prepubescent child.
- Injuries to the head, bruises to the neck or head, burns, or fractures in a child of any age.
- Bruises anywhere on a child 5 years of age or younger.
- Any report alleging sexual abuse of a child.
- Reported malnutrition or failure of a child to thrive.
- Reported medical neglect of a child.
- Symptoms of serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected.
- A sibling or other child remaining in a home where one or more children have been pronounced dead on arrival or have been injured and later died as a result of suspected abuse, abandonment or neglect.
Once a referral from DCF or law enforcement has been accepted, the CPT may provide one or more of the following services:

- Medical diagnosis and evaluation
- Nursing assessments
- Child and family assessments
- Multidisciplinary staffings
- Psychological and psychiatric evaluations
- Specialized and forensic interviews
- Expert court testimony.

Have participants take out PG: 86, Child Physical Abuse Critical Indicators.

Read through all of the first section together (Behavioral and Emotional Indicators of Physical Abuse) and then provide a high-level overview of each section.

Respond to any questions participants may have.
Refer participants to PG: 81-85, *Is it Physical Abuse or Not?*, and walk them through the document fairly briefly, pointing out the different topics (e.g., Fractures, Burns, etc.) and the questions, plus steps to confirm, which are provided for them as a resource.

Respond to any questions participants may have.

Point out that these two documents are very useful in determining physical abuse, but in addition, the Child Maltreatment Index provides useful guidance in making a decision about whether or not the child was physically abused.

**Activity: Assessing Situations for Physical Abuse**

Display Slide 6.3.21 (PG: 80)

**Purpose:** Participants must have some experience working with PG: 86-95, *Physical Abuse Critical Indicators* and PG: 81-85, *Is it Physical Abuse or Not?*. This provides them with pragmatic experience using these tools together as a class, and then in their groups.

**Materials:**
- PG: 81-85, *Is it Physical Abuse or Not?*
- PG: 86-95, *Child Physical Abuse Critical Indicators*
- Child Maltreatment Index
- Six Domains of Information Collection List of Factors
- PG: 95, *Assessing for Physical Abuse*

**Trainer Instructions:**
- This activity will likely take 1 hour and 45 minutes.
- In this activity, there are 3 scenarios. For each of the scenarios, we have different maltreatments. The first second scenarios are to be reviewed as one class, and the third is to be addressed in smaller groups and debriefed as a large group.
The instructions in all three cases are the same:
- Read the scenario.
- Identify and list the kinds of physical evidence in the scenario.
- Review PG: 81-85, Is it Physical Abuse or Not? and PG: 86-95, Child Physical Abuse Critical Indicators, and identify which questions and actions might be useful to utilize in that particular scenario, being prepared to explain why they would be useful. For scenario 1, identify the questions and actions by checking box #1. For scenario 2, check box #2, and for scenario 3, check box #3.
- For scenarios 1 and 2, brainstorm these with the entire class. For scenario 3, have participants brainstorm in small groups, and then debrief as a class.

---

**Is It Physical Abuse, or Not?**

<table>
<thead>
<tr>
<th>Fracture</th>
<th>Steps to Confirm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is It Non-intentional?</td>
<td></td>
</tr>
<tr>
<td>• Birthing trauma (fractured clavicles most common)</td>
<td>• Consult with physician to decide cause of fracture.</td>
</tr>
<tr>
<td>• Little league elbow</td>
<td>• (Refer to Types of Fractures for a description of the different types of fractures.)</td>
</tr>
<tr>
<td>• Nurse-maid elbow</td>
<td>• Check for discrepancies between the fracture and the history provided by the caregiver.</td>
</tr>
<tr>
<td>• Fractures from passive exercises for therapeutic reasons</td>
<td></td>
</tr>
<tr>
<td>Is it a Medical Condition?</td>
<td></td>
</tr>
<tr>
<td>• Congenital syphilis</td>
<td>• A physician can use radiology to decide if a fracture exists and also to gain insight into how it was produced.</td>
</tr>
<tr>
<td>• Infantile cortical hyperostosis (Caffey disease)</td>
<td>• Request pediatric radiologist if possible.</td>
</tr>
<tr>
<td>• Leukemia</td>
<td>• It is critical to tell radiologist that child abuse is suspected.</td>
</tr>
<tr>
<td>• Menkes kinky hair disease</td>
<td>• X ray is fine for screening.</td>
</tr>
<tr>
<td>• Osteogenesis imperfecta</td>
<td>• A bone scan can be used to reveal old, healed fractures caused by suspected abuse.</td>
</tr>
<tr>
<td>• Osteomyelitis</td>
<td></td>
</tr>
<tr>
<td>• Rickets</td>
<td></td>
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<tr>
<td>• Scurvy</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Burns</th>
<th>Steps to Confirm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is it Non-intentional?</td>
<td></td>
</tr>
<tr>
<td>• Spilling of a hot liquid</td>
<td>• Check location of splash burns; non-intentional burns are most likely to occur on the front of the head, neck, trunk, and arms. It is usually possible to estimate the direction from which the liquid came and the position of the body.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th><strong>Is it a Medical Condition?</strong></th>
<th><strong>Steps to confirm</strong></th>
</tr>
</thead>
</table>
| • Brushing against a cigarette | • Check location of burns; often non-intentional if found on child’s face, arms or trunk.  
• Check shape of burn; usually non-intentional if burn is more elongated than round, with a higher degree of intensity on one side.  
• Check for discrepancies between the appearance of the burn and the history provided by the caregiver. |

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<thead>
<tr>
<th><strong>Is it a Medical Condition?</strong></th>
<th><strong>Steps to confirm</strong></th>
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</thead>
</table>
| • Impetigo  
• Insect Bites | • Suspicious blisters are generally cultured by a physician to test for streptococcal infections that may be found with impetigo and treated with antibiotics.  
• Examine lesions: Impetigo lesions have various shapes and sizes; cigarette burns are symmetrical. |

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<thead>
<tr>
<th><strong>Is it Non-intentional?</strong></th>
<th><strong>Steps to Confirm</strong></th>
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</thead>
</table>
| • Falling into a hot bath | • Check for clear lines of demarcation; non-intentional burns have no clear line separating burned and unburned skin.  
• Check deepness of burn; non-intentional burns typically are not as deep as forced burns because an unrestrained child will rarely be unable to remove himself or herself from the burning environment.  
• Check to see if perineum and feet are burned, but not the hands; it is impossible for a child to non-intentionally fall into a tub without hands going into water.  
• Check for doughnut hole, parallel lines, and flexion burns; these burns may be indicative of abuse.  
• Check for discrepancies between the appearance of the burn and the history provided by the caregiver. |

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<tr>
<th><strong>Is it a Medical Condition?</strong></th>
<th><strong>Steps to Confirm</strong></th>
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</table>
| • Staph Scalded Skin Syndrome (SSSS)  
• Toxic Epidermal Necrolysis (TEN) | • Ask about symptoms of fever, malaise, and sore throat.  
• Check for mouth and nose crusting.  
• Ask about onset of medical condition. |

| • Coming into contact with a burning object | • Check location of burn; some areas of the body are clearly more difficult for a child to self-inflict burn.  
• Check pattern of burn; an irregular burn will be left when a young child moves away from a burning object reflexively.  
• Check deepness of burn; non-intentional burns are usually deep on one edge of the burn.  
• Check margins of burn; non-intentional burns usually do not have crisp overall margins.  
• Check for discrepancies between the appearance of the burn and the history provided by the caregiver. |
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<tr>
<th>Is it a Medical Condition?</th>
<th>Steps to Confirm</th>
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<tbody>
<tr>
<td>• Varicella (chickenpox)</td>
<td>• Check history.</td>
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<td>• Consult with physician.</td>
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**Bruise**

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<th>Is it Non-intentional?</th>
<th>Steps to Confirm</th>
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<tr>
<td>• Non-intentional Falls</td>
<td>• Check for location of bruises; bruises on knees, shins, forehead, or elbows are often non-intentional.</td>
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<td>• Check for bruises on the forehead; bruises to the forehead often drain through soft tissues to give appearance of black eyes 24-72 hours afterward, usually confirmed with history and when/if bruise is not tender.</td>
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<td>• Check to see if bruises are on a single surface or clustered; one bruise on a single surface is caused accidentally.</td>
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<td>• Correlate non-intentional incident with developmental age and motor skills of child.</td>
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<td>• Check for discrepancies between the appearance of the bruise and the history provided by the caregiver.</td>
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<th>Is it a Medical Condition?</th>
<th>Steps to Confirm</th>
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<tr>
<td>• Hemophilia</td>
<td>• Have medical tests done to check bleeding function: prothrombin time (PT), partial prothrombin time (PTT), bleeding time, platelet count, and complete blood count (CBC).</td>
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<tr>
<td>• Leukemia</td>
<td>• Have histopathologic examination by physician.</td>
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<tr>
<td>• Idiopathic thrombocytopenic purpura</td>
<td>• Find out if spots were present at birth.</td>
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<tr>
<td>• Mongolian spots</td>
<td>• Check history; 90% of skin medical conditions are detected within the first month of life.</td>
</tr>
<tr>
<td>• Maculae ceruleae</td>
<td>• Check to see if flesh is torn or just compressed; torn flesh is commonly from a dog bite, and compressed flesh is commonly from a human bite.</td>
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<tr>
<td>• Salmon patches</td>
<td>• Measure the distance between the center of the canine teeth, typically the third tooth on each side; if it is greater than 3 centimeters, the bite is most likely from an adult.</td>
</tr>
<tr>
<td>• Hemangiomas (&quot;strawberry marks&quot;)</td>
<td>• Check for discrepancies between the appearance of the injury and the history provided by the caregiver.</td>
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**Bite Marks**

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<th>Is it Non-intentional?</th>
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<td></td>
<td>• Check to see if flesh is torn or just compressed; torn flesh is commonly from a dog bite, and compressed flesh is commonly from a human bite.</td>
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<tr>
<td></td>
<td>• Measure the distance between the center of the canine teeth, typically the third tooth on each side; if it is greater than 3 centimeters, the bite is most likely from an adult.</td>
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<td></td>
<td>• Check for discrepancies between the appearance of the injury and the history provided by the caregiver.</td>
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**Head Injury**

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<th>Is it Non-intentional?</th>
<th>Steps to Confirm</th>
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<tbody>
<tr>
<td>• Birth trauma causing effusion, cephalohematoma, diffuse cerebral edema, infarction, cerebral contusions, post-traumatic hypopituitarism</td>
<td>• Check onset of injury; injuries from birth traumas should become apparent shortly after birth.</td>
</tr>
<tr>
<td>• Insect bite on head (usually forehead)</td>
<td>• Check for discrepancies between the appearance of the injury and the history provided by the caregiver; subdural hematomas found in an infant or toddler without adequate explanation of trauma may be indicative of abuse.</td>
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<tr>
<td>Is it a Medical Condition?</td>
<td>Steps to Confirm</td>
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</table>
| Infectious meningitis     | • Check compatibility between the history and physical findings.  
|                           | • Consider child’s developmental maturity. |

**Hair Loss**

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<th>Is it a Medical Condition?</th>
<th>Steps to Confirm</th>
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</table>
| • Trichotillomania        | • Check to see if loss of hair is in a localized spot.  
| • Tinea capitis (ringworm of the scalp) | • Varying bald spots may be indicative of abuse.  
| • Idiopathic of unknown cause (e.g., alopecia areata) | • Localized spot is usually on back of the head.  
| • Nutritional deficiencies | • A child will be at least 3 years old for this condition to occur.  
|                           | • Check for scaly skin.  
|                           | • Fungal culture of scalp by physician.  
|                           | • Check history. |

**Eye Injury**

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<th>Is it Non-intentional?</th>
<th>Steps to Confirm</th>
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<tbody>
<tr>
<td>• Chemical burns</td>
<td>• Check for discrepancies between the appearance of the injury and the history provided by the caregiver.</td>
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<tr>
<td>• Non-intentional foreign body to the eye (e.g., sticks, sand, or paper edge)</td>
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</table>

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<thead>
<tr>
<th>Is it a Medical Condition</th>
<th>Steps to Confirm</th>
</tr>
</thead>
</table>
| • Sub-conjunctival hemorrhaging during birth | • Sub-conjunctival hemorrhaging during birth usually disappears by one month.  
| • Allergy conditions (“allergic shiners”) | • Check history |

**Ear Injury**

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<thead>
<tr>
<th>Is it Non-intentional?</th>
<th>Steps to Confirm</th>
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</table>
| • Injury from inserting cotton swab | • Check if laceration is of the ear canal; this injury can occur only by inserting a pointed object into the ear.  
|                           | • Check for discrepancies between the type of or appearance of the injury and the history provided by the caregiver. |

**Nasal Injury**

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<tr>
<th>Is it Non-intentional?</th>
<th>Steps to Confirm</th>
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</thead>
</table>
| • Injury from inserting foreign bodies into the nose | • Check to see if foreign bodies are found in more than one site; if found only in nose, this is common in the developing child.  
|                           | • Check for discrepancies between the appearance of the injury and the history provided by the caregiver. |
Child Physical Abuse Critical Indicators

Behavioral and Emotional Indicators of Physical Abuse
There are many variables that affect the child’s response to maltreatment and the effects of maltreatment on the child’s development.

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<td></td>
<td>The age of the child when the maltreatment begins</td>
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<td></td>
<td>The younger the child when first abused, the more likely the child will have serious developmental problems from the maltreatment.</td>
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<td></td>
<td>The length of time the child is maltreated</td>
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<td></td>
<td>The greater the period of time the child is maltreated, the more severe the developmental outcomes will be.</td>
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<tr>
<td></td>
<td>The frequency of the maltreatment</td>
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<tr>
<td></td>
<td>The more often the child is abused, the more pervasive the effects will be.</td>
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<tr>
<td></td>
<td>The nature of the child’s relationship with the abuser</td>
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<tr>
<td></td>
<td>The closer the relationship of the abuser to the child, the more likely the child will be negatively affected. Abuse by a parent has significant, long-lasting consequences.</td>
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<tr>
<td></td>
<td>The type of maltreatment</td>
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<tr>
<td></td>
<td>The more severe the pain and the greater the injury inflicted on the child, the more negative the psychological, as well as the physical, outcomes will be.</td>
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<td></td>
<td>The availability to the child of support</td>
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<tr>
<td></td>
<td>The presence of other, non-abusing adults who can provide proper care and nurturance, either in the home or easily available to the child, can help to mediate the negative effects of abuse.</td>
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<td></td>
<td>Constitutional factors</td>
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<td>The child’s basic personality and temperament can affect the outcomes of abusive treatment.</td>
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<td>Some children are more resilient than others and have unusual coping strengths. Other children are more vulnerable.</td>
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<td></td>
<td>Young children who have been abused severely and at an early age</td>
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<td></td>
<td>May display pervasive indicators of developmental delay and typical developmental patterns.</td>
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<td>The child may be remote, withdrawn, lacking in curiosity, compliant, and detached; the child may not relate to other people.</td>
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<td></td>
<td>The child may whine, whimper, or cry, with no expectation of being comforted.</td>
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<td></td>
<td>The child may not look to adults for help.</td>
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<td></td>
<td>A state of ‘frozen watchfulness’ has been noted in severely abused children</td>
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<tr>
<td></td>
<td>They remain emotionally withdrawn and uninvolved, but watch carefully what is going on around them.</td>
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<tr>
<td></td>
<td>They may exhibit discomfort with or fear of physical contact</td>
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<tr>
<td></td>
<td>Severely abused children may appear to be autistic</td>
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<tr>
<td></td>
<td>Many do not relate in typical ways to the people and objects in their environment.</td>
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<tr>
<td></td>
<td>Most seriously abused infants show serious delays in all areas of development.</td>
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<tr>
<td></td>
<td>The child may display a forlorn, clinging dependency, but may be lacking in healthy attachment to any adult, and may appear unable to attach in healthy ways.</td>
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<tr>
<td></td>
<td>The child may appear depressed, or display flat affect and lack of emotion. He/she may not:</td>
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</tr>
<tr>
<td></td>
<td>Cry or respond when in pain when injured</td>
<td></td>
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</tbody>
</table>
Pre-school-aged children who have been abused may display the following characteristics. They may:
- Be timid, easily frightened.
- Duck, cringe, flinch, withdraw, attempt to get out of the way, or otherwise exhibit fear of the parent.

The child may be very eager to please, may crave affection, and may show indiscriminate attachment by becoming affectionate with anyone, including strangers.

Early signs of role reversal may be present. The child may:
- Try hard to meet the parent’s needs.
- Demonstrate a clingy attachment and verbalize love for the abusing parent.

The abused adolescent may show behavior problems:
- Lying, stealing, acting out, and other aggressive behaviors.
- Use of alcohol or drugs.
- Truancy, including repeatedly running away and refusing to go home.
- Generalized difficulty in entering into and sustaining interpersonal relationships.

<table>
<thead>
<tr>
<th>Injuries and Evidence</th>
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<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>Does the child experience frequent injuries?</td>
</tr>
<tr>
<td>Does the child have multiple bruises and injuries?</td>
</tr>
<tr>
<td>Are the child’s bruises and injuries in inaccessible places?</td>
</tr>
<tr>
<td>Are the child’s injuries at different stages of healing?</td>
</tr>
<tr>
<td>Are the child’s injuries inconsistent with the adult’s explanation?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Clues: How to Check the Injury</th>
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<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>Refer to the Child Maltreatment Index.</td>
</tr>
<tr>
<td>Consider the location of the injury on the child’s body.</td>
</tr>
<tr>
<td>Look at the skin, which may be the first identifiable location for abuse and the most accessible location for non-health professionals to inspect for trauma.</td>
</tr>
<tr>
<td>Check other areas of the child’s body, not just the area of the injury.</td>
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<tr>
<td>Consider the shape and appearance of the marks or other injuries.</td>
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<thead>
<tr>
<th>Child Vulnerability</th>
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<tbody>
<tr>
<td>1</td>
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<tr>
<td>Is the child 5-years-old or younger?</td>
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<tr>
<td>Have there been prior intakes/investigations?</td>
</tr>
<tr>
<td>Has there been limited access to or contact with the child by the outside world?</td>
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</tbody>
</table>

Target Child Factors

Core Child Welfare Pre-Service Curriculum | Module 6-TG
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<tr>
<th>1</th>
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<tbody>
<tr>
<td>Is there no observable sign of bonding with the target child?</td>
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<tr>
<td>Does the child have flat or depressed affect?</td>
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<tr>
<td>Does the child lack peer relationships?</td>
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<tr>
<td>Has the child been subjected to unusual forms of discipline?</td>
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<tr>
<td>Is the only type of discipline used physical?</td>
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<tr>
<td>Does the child exhibit behaviors indicative of abuse and neglect?</td>
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<tr>
<td>Is the child secretive about his or her injuries?</td>
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**Parent/Caretaker Characteristics**

Does the parent/caregiver:

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<tr>
<td>Portray a sociopathic personality (overly charming, extremely cooperative), externalizing role in abuse or other problems (“not my fault,” smooth talker)?</td>
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<tr>
<td>Appear to make extreme progress (always pleasing, complete/appear to complete assignments quickly, give the right answers all the time)?</td>
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<tr>
<td>Tell you what you want to hear?</td>
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<tr>
<td>Display violent and aggressive behavior (domestic violence reports, other police reports, charges involving violence, etc.)?</td>
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<tr>
<td>Have unrealistic expectations of the child?</td>
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<tr>
<td>Appear to be alienated from the family with no family support network?</td>
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<tr>
<td>Appear to be isolated, lacking in social contacts, such as friends or having activities?</td>
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**Child/Caregiver Behaviors**

Interview parents separately and look for the following behaviors:

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<tr>
<td>Shows inappropriate concern given the nature and severity of the child’s condition or injury.</td>
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<tr>
<td>Is extremely compliant/cooperative (This behavior might be an indicator of abuse when considered along with other factors. “If I say what they want to hear, they’ll go away.”)</td>
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<tr>
<td>Exhibits explosive or threatening behavior when discussing possible maltreatment.</td>
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<tr>
<td>Accuses the other parent or a child in the household.</td>
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<tr>
<td>Contradicts the story of the other parent.</td>
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<tr>
<td>Describes a minor accident, yet major injuries have occurred.</td>
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<tr>
<td>Dates the injury differently from the clinical dating.</td>
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<tr>
<td>Describes behavior impossible for the child’s development.</td>
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<tr>
<td>Explains the injury by being evasive or vague.</td>
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## Parent/Caretaker History

Does the parent/caregiver’s history indicate or portray:

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## Parent/Caretaker Relationship(s)

Do the parent/caregiver’s relationship(s) characteristics include:

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## Adult Behaviors Indicative of Child Abuse

Does the adult:

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<td>Question</td>
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<td>Demonstrate poor impulse control?</td>
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<tr>
<td>Often blame the child for problems?</td>
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<tr>
<td>Provide inaccurate, illogical, or conflicting explanations for a child’s injury?</td>
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<tr>
<td>Expose a child to a hostile or dangerous situation?</td>
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</tr>
<tr>
<td>Fail to protect a child from inflicted injury?</td>
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<tr>
<td>Abuse substances to the degree that he/she is unable to provide adequate care?</td>
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<tr>
<td>Beat or corporally punish a child so that it leaves or it is likely to leave an injury?</td>
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<tr>
<td>Kick, scratch, or punch a child?</td>
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<tr>
<td>Hit or slap an infant?</td>
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<tr>
<td>Pull a child’s hair?</td>
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<tr>
<td>Over-medicate or poison a child?</td>
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<tr>
<td>Tie a child’s limbs together or to an object?</td>
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**Physical Environment**

Does the physical environment portray any of the following?

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<tbody>
<tr>
<td>An environment that poses a safety risk (such as electrical or fire hazards, weapons)</td>
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<tr>
<td>A sleeping area for the child that is inappropriate</td>
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</tr>
<tr>
<td>A child who is removed from others during common activities, such as eating, sleeping, etc.</td>
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</tr>
<tr>
<td>A home that is physically isolated, such as being far away from other homes/people</td>
<td></td>
</tr>
</tbody>
</table>
| An unsecured swimming pool (since drowning is the leading cause of neglect deaths [inadequate supervision] annually in Florida)  
***You must be aware of drowning risk factors when there are bodies of water or a pool on the premises or close by the home, and you must include these factors in any safety plans, etc. that are developed with the family.*** (See questions below on Drowning/Inadequate Supervision.) |

**Factors to Consider on Drowning/Inadequate Supervision**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the pool in safe condition? Was the pool water murky or unkempt?</td>
<td></td>
</tr>
<tr>
<td>Were there layers of protection, such as locks on doors that are out of reach of the child, pool alarm, pool fence, etc.?</td>
<td></td>
</tr>
<tr>
<td>How did the child get access to the pool?</td>
<td></td>
</tr>
<tr>
<td>Were the locks/layers of safety being used?</td>
<td></td>
</tr>
<tr>
<td>Was this the child’s residence or relative’s, friend’s, vacationing home, etc.?</td>
<td></td>
</tr>
<tr>
<td>Was the caregiver under the influence of drugs (prescribed or otherwise)/alcohol?</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Is there a criminal history or DCF history of drugs/alcohol?</td>
<td></td>
</tr>
<tr>
<td>Is there evidence of alcohol or drug paraphernalia observed?</td>
<td></td>
</tr>
<tr>
<td>Has the child gotten into the pool area alone before?</td>
<td></td>
</tr>
<tr>
<td>Does the parent have a developmental impairment?</td>
<td></td>
</tr>
<tr>
<td>Does the child have any delays or impairment, such as autism?</td>
<td></td>
</tr>
<tr>
<td>Are there priors of inadequate supervision and/or substance misuse?</td>
<td></td>
</tr>
<tr>
<td>Collateral contacts of neighbors on supervision issues in past – unreported?</td>
<td></td>
</tr>
<tr>
<td>If the parent was sleeping, had he/she been diagnosed as depressed and taking medication, past or present?</td>
<td></td>
</tr>
<tr>
<td>Who was designated to watch the child? If a child, what is the relationship and how old is the child?</td>
<td></td>
</tr>
<tr>
<td>Has code enforcement been involved?</td>
<td></td>
</tr>
<tr>
<td>Did caretaker know how to swim?</td>
<td></td>
</tr>
<tr>
<td>Did the child know how to swim?</td>
<td></td>
</tr>
<tr>
<td>Did the caretaker know CPR?</td>
<td></td>
</tr>
</tbody>
</table>
Factors to Consider on Intentional Physical Abuse Cases

Questions to consider with intentional physical abuse:

<table>
<thead>
<tr>
<th>Question</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Who called 911?</td>
<td></td>
</tr>
<tr>
<td>Was it delayed? Did alleged perpetrator call someone else before calling 911?</td>
<td></td>
</tr>
<tr>
<td>Check cell phone and text records.</td>
<td></td>
</tr>
<tr>
<td>Did the caregiver/alleged perpetrator drive to the hospital? If yes, what is the distance – how long would it take for EMS to arrive?</td>
<td></td>
</tr>
<tr>
<td>Initial statement, child stopped breathing, found unresponsive, sick, accidentally dropped or fell on child?</td>
<td></td>
</tr>
<tr>
<td>Where was mom and dad? If at work, what type of work does mon/dad do?</td>
<td></td>
</tr>
<tr>
<td>Was alleged perpetrator employed, or was he/she full-time caretaker?</td>
<td></td>
</tr>
<tr>
<td>Were they working in shifts?</td>
<td></td>
</tr>
<tr>
<td>Were finances for day care an issue?</td>
<td></td>
</tr>
<tr>
<td>How long had mom/dad known alleged perpetrator?</td>
<td></td>
</tr>
<tr>
<td>What was motivating factor – crying, toilet-training, illness?</td>
<td></td>
</tr>
<tr>
<td>What was the activity of the alleged perpetrator right before the crying started?</td>
<td></td>
</tr>
<tr>
<td>Did alleged perpetrator have a DV history, criminal history?</td>
<td></td>
</tr>
<tr>
<td>Was alleged perpetrator on probation, past or current?</td>
<td></td>
</tr>
<tr>
<td>Was alleged perpetrator on probation, past or current?</td>
<td></td>
</tr>
<tr>
<td>Was mom/dad aware of abuse or suspect?</td>
<td></td>
</tr>
<tr>
<td>Has he/she seen any previous bruises while in alleged perpetrator’s care, or child fearful?</td>
<td></td>
</tr>
<tr>
<td>What was her/his reason for alleged perpetrator watching child (no day care, cannot afford, work schedule)?</td>
<td></td>
</tr>
<tr>
<td>Has she/he been a victim of domestic violence in this situation or in the past?</td>
<td></td>
</tr>
</tbody>
</table>
Investigative Techniques for Physical Abuse

When assessing for physical abuse, use the following techniques:

|☐ | Always investigate, even if the explanation seems plausible. |
|☐ | Check other areas of the child’s body, not just the area of the injury. |
|☐ | Interview all subjects of the intake individually. |
|☐ | Check for and analyze all prior case histories and intakes. |
|☐ | Refer the child to CPT. |
|☐ | Notify Law Enforcement/SAO within mandated timeframes. |
|☐ | Interview all persons in the environment who may have information. |
|☐ | Gather information from school personnel and family physicians. |
|☐ | Get the child’s version of what happened. |
|☐ | Always probe deeper with each piece of information you gather. |
|☐ | Each answer you receive is only one piece of the puzzle; it should spark another question or clue to investigate. |
|☐ | Always ask to see the physical source of the injury: iron, stove, burner, rope, etc. |
|☐ | Visit the site of the “accident.” |
|☐ | Consider whether if physical environment and explanation for how the injury occurred match. |
|☐ | Visit and observe entire home environment for clues, especially child’s bedroom. |
|☐ | Take photographs. |
**Trainer Notes:** Included below are key pieces of information for you as a trainer in your debrief of this activity.

### For Scenario #1 (Daniel):

- **What was the physical evidence you identified?**
  There was a clear imprint of an iron on Daniel’s upper back. Daniel had a small bruise on his forehead.
  Have a discussion with the class about how a “glancing burn” is different in appearance than a full-force imprint of an object, such as an iron.

- **What items did you use in the handouts to assist in your thinking process?**
  - Review of Handout: Is it Physical Abuse or Not?, going through questions to rule out physical abuse of bruise and iron.
  - Review of Handout: Child Physical Abuse Critical Indicators; at least the following are relevant:
    - **Injuries & Evidence**
      - the child’s bruises and injuries are in inaccessible places
      - the child’s injuries are inconsistent with the adult’s explanation
    - **Physical Clues**
      - Considering the location of the injury
      - Checking other areas of the body
      - Considering the shape and appearance of the marks
      - Child’s age
    - **Child/Caregiver Behaviors**
      - Shows inappropriate concern given the nature and severity of the child’s condition or injury
      - Describes a minor accident, yet major injuries have occurred
      - Explains the injury by being evasive or vague
    - **Adult Behaviors Indicative of Child Abuse**
      - Demonstrate a failure to bond with their infant – child.
      - Blame the child for problems
      - Provide inaccurate, illogical, or conflicting explanations for a child’s injury
      - Fail to protect a child from inflicted injury
    - **Physical Environment**
      - Environment poses a safety risk
Extent of Maltreatment

- **Type of maltreatment**
  - Physical abuse

- **Description of emotional & physical symptoms**
  - Physical observation of burn.
  - Child’s stress and hysterical crying.

- **Severity of maltreatment**
  - Diagnosis from physician regarding depth and degree of burn.

- **Identification of the child & maltreating caregiver**
  - Adella was the only one home with Daniel. She was considered the maltreating caregiver.

- **Description of specific events**
  - Adella was getting ready for work and heard something tip over.

- **Condition of the child**
  - This would include whatever was visible plus whatever the doctor said at diagnosis. That will enable you to say if this was a glancing burn (due to the iron simply falling on Daniel). If this were a full-on imprint of the iron on Daniel, it would more likely be an intentionally inflicted burn on Daniel.

Circumstances Surrounding Maltreatment

<table>
<thead>
<tr>
<th>Circumstances Surrounding Maltreatment</th>
<th>Your Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The duration of the maltreatment</td>
<td>This is unknown. We don’t know if this is the first, second or an even later injury, nor do we know what the pattern is. We know that Daniel had at least one episode we can consider an inflicted burn, but not sure. Duration is also related to pervasiveness – good to determine how pervasive the maltreatment has been with Daniel.</td>
</tr>
<tr>
<td>History of maltreatment</td>
<td>It depends on whether or not there were prior reports of maltreatment in the agency or within the family on Daniel.</td>
</tr>
<tr>
<td>Patterns of functioning leading to or explaining the maltreatment</td>
<td>That would have to be something further determined during Family Functioning Assessment, where patterns of caregiving would be explored.</td>
</tr>
<tr>
<td>□ Parent/legal guardian or caregiver intent concerning the maltreatment</td>
<td>Intent requires exploration with the caregiver regarding intentional acts vs. ‘accidental’ vs. ‘possible lack of supervision.’ Based on what Adella said only, there may not be intent to inflict this burn on Daniel. Verbalized intent on the part of the caregiver may not always be accurate and must be taken in context with the other investigative findings.</td>
</tr>
<tr>
<td>□ Parent/legal guardian or caregiver explanation for the maltreatment and family conditions</td>
<td>It is important that what mom Adella said be examined. It would also be important to determine what kind of priors exist and whether there are similar patterns and behaviors with other children or with Daniel. Are there other conditions in the home to be considered, such as substance abuse, alcohol problems, or domestic violence?</td>
</tr>
</tbody>
</table>
| □ Unique aspects of the maltreatment, such as whether weapons were involved | Questions to be asked would include:  
• Should the iron be considered a weapon? Intentional and willful act may determine if the iron was used as a weapon.  
• Would medical treatment have been sought if the neighbor had not heard Daniel’s crying?  
• Is Daniel able to tell what happened? |
| □ Caregiver acknowledgement and attitude about the maltreatment | Questions to ask:  
• Is Adella concerned?  
• Does she acknowledge the severity of the child’s injury?  
• Does Adella minimize her own response and Daniel’s need for treatment?  
• Are there other questions that could be asked? |
| □ Other problems occurring in association with the maltreatment | Check into the forehead bruise. Other family conditions would be good to look at here. |

**Note to the Trainer:** The suggested answer key is not in any way meant to be the final work on these issues, but only serves as guidance to support participant critical thinking. If you are able to bring more to this discussion based on your previous case experience, feel free to enhance upon the
• **What other professionals must be notified to verify the abuse or accidental injury?**

Any sexual or physical abuse case must be referred to both law enforcement to conduct a criminal investigation and to the Child Protection Team for medical diagnoses, which help investigators in child welfare and law enforcement detectives.

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**For Scenario #2 (Mattie) (PG: 99)**

• **What was the physical evidence you identified?**

Diagnosis from doctor of inflicted head trauma due to the type of injuries. Seizures were noted by the mother upon her return home, which precipitated the hospital visit.

**What items did you use in the handouts to assist in your thinking process?**

- Review of Handout: Is it Physical Abuse or Not?, going through questions to rule out physical abuse of head injury.
- Review of Handout: Child Physical Abuse Critical Indicators; at least the following are relevant:
  - Injuries & Evidence
    - All of these questions are relevant
  - Physical Clues
    - Refer to the Child Maltreatment Index
  - Child Vulnerability
    - Questions 1 and 2 are relevant.
  - Child/Caregiver Behaviors
    - Does the caregiver display violent behavior (domestic violence reports, other police reports, charges involving violence, etc.)?
    - Some of the questions regarding child/caregiver behaviors may be useful.
  - Adult Behaviors Indicative of Child Abuse
    - Some of these questions may be useful in further interviewing as investigation seeks to gain a clear view in all six domains of information collection about the parent/caregiver and the alleged perpetrator.
### Extent of Maltreatment

<table>
<thead>
<tr>
<th>Type of maltreatment</th>
<th>Description of emotional &amp; physical symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td>Mattie had seizures, was crying before the seizures and had a medical diagnosis.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Severity of maltreatment</th>
<th>Identification of the child &amp; maltreating caregiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>The maltreatment is severe: Hospitalization is required and prognosis unknown.</td>
<td>This is unknown until a timeline is created and further interviews are conducted. However, if we presume that the mother’s boyfriend was the only caregiver, then the likely timeframe of injury (as defined by doctors) would lead us to believe the mother’s boyfriend was the maltreating caregiver.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description of specific events</th>
<th>Condition of the child</th>
</tr>
</thead>
<tbody>
<tr>
<td>The baby was crying, and the boyfriend put her down to sleep. Need additional events from the boyfriend.</td>
<td>Seizures noted by the mother, and medical evaluation determines child in need of intensive care unit and a shunt to drain swelling in brain. Very severe.</td>
</tr>
</tbody>
</table>

### Circumstances surrounding maltreatment

<table>
<thead>
<tr>
<th>Circumstances surrounding maltreatment</th>
<th>Your Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The duration of the maltreatment</td>
<td>Duration is unknown without intensive interviews. Important to determine how long she was shaken.</td>
</tr>
<tr>
<td>History of maltreatment</td>
<td>Important to check prior history.</td>
</tr>
<tr>
<td>Patterns of functioning leading to or explaining the maltreatment</td>
<td>Would be good to know the history of caregiving by mother’s boyfriend and level of attachment to infant on the part of the boyfriend.</td>
</tr>
<tr>
<td>Parent/legal guardian or caregiver intent concerning the maltreatment</td>
<td>Unknown until further interview data is known. Did he shake the baby? Did he drop the baby? Was he aggravated with the crying infant and not coping well?</td>
</tr>
<tr>
<td>☐ Parent/legal guardian or caregiver explanation for the maltreatment and family conditions</td>
<td>Unknown until further interviews take place. What was the history of violence in home? What was the history of violence with mother’s boyfriend? What was the criminal history or involvement in other families by the boyfriend?</td>
</tr>
<tr>
<td>☐ Unique aspects of the maltreatment, such as whether weapons were involved</td>
<td>Unknown until further interviews and perhaps may or may not be determined by medical evaluation.</td>
</tr>
<tr>
<td>☐ Caregiver acknowledgement and attitude about the maltreatment</td>
<td>Unknown until further interviews</td>
</tr>
<tr>
<td>☐ Other problems occurring in association with the maltreatment</td>
<td>Unknown until further interviews</td>
</tr>
</tbody>
</table>

- **What other professionals must be notified to verify the abuse or accidental injury?**

  CPT physicians and medical evaluations

**For Scenario #3 (Melanie) (PG: 101)**

- **What was the physical evidence you identified?**

  Scars old and new. Infection that was fairly advanced. Current untreated impetigo.

- **What items did you use in the handouts to assist in your thinking process?**
  - Review [PG: 81, Is it Physical Abuse or Not?](#), going through questions to rule out physical abuse of head injury.
  - Review of [PG: 86, Child Physical Abuse Critical Indicators](#), at least the following are relevant:
    - Information in PG: on physical injuries.
    - This was subjective. Listen to what participants said might be true.
### Extent of Maltreatment

<table>
<thead>
<tr>
<th>Type of maltreatment</th>
<th>Description of emotional &amp; physical symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scarring, ear infection, and diagnosed impetigo have been noted.</td>
<td>Child is in pain with ear and presentation of scars, as well as a new lesion on back.</td>
</tr>
<tr>
<td>However, type of maltreatment is not known until more interviews related to duration of ear infection occur. While scars may have initially been inflicted, the doctor determined it to be old scarring from impetigo. (Sometimes, cigarette burn scars and impetigo can appear similar, and that is what needs to be explored.)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Severity of maltreatment</th>
<th>Identification of the child &amp; maltreating caregiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is unknown until further diagnostic for ear treatment and maybe treatment for impetigo.</td>
<td>Were the child’s father and/or other caregivers in the home? This is unknown until further interviews. Is it medical neglect maltreatment?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description of specific events</th>
<th>Condition of the child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child taken to doctor due to expressed pain in ear. No specific ‘event’ described. Need additional information.</td>
<td>In pain and in need of treatment for ear infection and impetigo. (Impetigo is very contagious and can spread easily on child’s own body.)</td>
</tr>
<tr>
<td>Circumstances surrounding maltreatment</td>
<td>Your Notes</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>The duration of the maltreatment</td>
<td>Not sure if it is medical neglect or any type of specific injury. Need more confirmation from doctor of what is reasonable in terms of treatment that should have been sought.</td>
</tr>
<tr>
<td>History of maltreatment</td>
<td>Check priors.</td>
</tr>
<tr>
<td>Patterns of functioning leading to or explaining the maltreatment</td>
<td>Who is caregiver? Who else is caregiver? What is happening in the home? How often and by whom does child receive routine care?</td>
</tr>
<tr>
<td>Parent/legal guardian or caregiver intent concerning the maltreatment</td>
<td>Unknown until further interview data known about awareness and a timeline of when and how child gets medical care.</td>
</tr>
<tr>
<td>Parent/legal guardian or caregiver explanation for the maltreatment and family conditions</td>
<td>Unknown until further interviews</td>
</tr>
<tr>
<td>Unique aspects of the maltreatment, such as whether weapons were involved</td>
<td>This does not appear to be the situation, but a more specific interview of the doctor may be advisable about the level of medical certainty related to the scarring (whether from impetigo vs. from cigarette burns).</td>
</tr>
<tr>
<td>Caregiver acknowledgement and attitude about the maltreatment</td>
<td>Unknown until further interviews. Medical care sought how often? When was impetigo noticed? When was there notice of ear problems for child by caregiver?</td>
</tr>
<tr>
<td>Other problems occurring in association with the maltreatment</td>
<td>Unknown until interview with child and with caregiver.</td>
</tr>
</tbody>
</table>
• **What other professionals must be notified to verify the abuse or accidental injury?**

   It would be important to make sure that CPT is contacted to consult with treating physician, so that confirmations on child scars and current lesions can be coordinated. Depending on the treating physician’s area of specialty, there is a possibility that she or he may not have enough information to know what to look for to have confidence in diagnostics of old scars, in particular.

**Activity STOP**

*Display Slide 6.3.22*

It is vital that you work closely with not only law enforcement – who will conduct the criminal investigation – but also the Child Protection Team.

Information about the CPT is provided directly from Florida Statutes. **Section 39.303, Florida Statutes**, to review information.

In this unit, you have learned a great deal about physical abuse maltreatments, and you have had some scenario-based practice in the work of identifying child maltreatments – both the extent and the nature of the maltreatment. In this next fairly brief section, we will be reviewing more pictures of child physical abuse. Each child physical abuse situation is different, and, sadly, there are countless ways that a child can be physically abused. It is important, therefore, to take a little time to expose you to these pictures and briefly explain each.
Walk through each picture with participants, briefly describing each and pointing out key components of the physical abuse evidence.

Answer any questions as they arise. This can be a difficult time for participants, as these pictures are highly graphic and depict cruelty that many participants may have not been exposed to.

Display Slide 6.3.23

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Display Slide 6.3.28

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Display Slide 6.3.30

Display Slide 6.3.31

Display Slide 6.3.32

Display Slide 6.3.33
Display Slide 6.3.34

Fresh lacerations on child’s jaw and neck.

Display Slide 6.3.35

Parallel lacerations on upper left thigh, caused by beating with an electrical cord with bare wires sticking out of the chord.

Display Slide 6.3.36

X-rays showing old calcification of broken leg (on left).

Display Slide 6.3.37

Arrows on the x-ray pointing to old calcified broken ribs, typical of a child’s rib cage squeezed in abusive “bear hug.”
Display Slide 6.3.42

Display Slide 6.3.43

Display Slide 6.3.44

Display Slide 6.3.45
Discuss this as a group. This is an important time to discuss Vicarious Trauma, how it can effect you and coping strategies.

Respond appropriately.
As is the case with any maltreatment, physical abuse leaves lasting scars. For these maltreatments, they leave physical as well as psychological and emotional scars.

In the beginning, the scars from physical abuse are the pain and other problems stemming from the actual physical abuse. Emotional and behavioral problems can arise quickly, including anger, hostility, fear, anxiety, humiliation, aggression toward others, self-destructive behavior, hyperactivity and other manifestations in the child.

Long-term, the consequences of child physical abuse may include the following:

- Long-term physical disabilities (for example, closed head injuries or eye damage).
- Disordered interpersonal relationships (for example, difficulty trusting others within adult relationships or violent relationships).
- Feelings of low self-esteem and/or depression
- Drug or alcohol abuse.

The next maltreatment we will discuss is sexual abuse. It often lacks injuries or the type of evidence found with physical abuse, but the life-long consequences are equally significant.
Unit 6.4: Sexual Abuse

Display Slide 6.4.1

Time:

Unit Overview: To provide information about the effects of child sexual abuse, including identification of it in the Maltreatment Index, ability to determine if what is alleged actually rises to the definition of sexual abuse, ability to identify indicators in family scenarios and through descriptions, and to explain and appreciate the longer-term impact of sexual abuse on the child.

Display Slides 6.4.2

Learning Objectives:
1. Define and describe “sexual abuse” and the various categories of sexual abuse.
2. Given scenarios, determine if they indicate sexual abuse.
3. Identify potential indicators of sexual abuse in children.
4. Describe the dynamics of child sexual abuse using the five phases of sexual abuse.
5. Explain the impact of sexual abuse on the child in terms of short-and longer-term effects.
maltreatment, by options available based on location in Florida.

7. Given scenarios, determine whether or not the abuse is sexual abuse. If it is sexual abuse, apply the Maltreatment Index and determine the specific type of sexual abuse.

8. List and explain each indicator of child sexual abuse.

The purpose of this unit is to provide you with a sufficient understanding of child sexual abuse, including how to recognize indicators of it using the Maltreatment Index. Through practice, you will develop the ability to determine if what is alleged actually rises to the definition of sexual abuse, as well as the ability to identify indicators in family scenarios and through descriptions, behaviors and words. In addition, you will be able to explain and appreciate the longer-term impact of sexual abuse on a child.

Display Slide 6.4.3

Refer participants to PG: 104-106, Florida Maltreatment Index: Sexual Abuse Definition.

Other words you may have associated with child sexual abuse are words such as “rape,” “assault,” “incest,” and (insert any others that were mentioned by the class).

For example, “incest” is defined as “sexual battery or sexual intercourse by a relative of lineal consanguinity (blood relative: parent, grandparent, or adult brother, sister, uncle, aunt, nephew, or niece) while responsible for the child’s welfare.” This definition contains sexual battery.

Remember, also, that the legal definition for child sexual abuse
also includes caregivers who are not blood relatives, such as step-parents or step-brothers or step-sisters, etc.

Although these words may be descriptive, in the state of Florida they are not used in the legal definitions.

**Trainers Notes:** Examine together the information in the PG and discuss each of the definitions and the acts involved. Note that the types of sexual abuse described increase in severity from molestation to exploitation. Give examples when needed for clarification, particularly regarding what does NOT constitute sexual abuse.

---

**Florida Maltreatment Index**

**SEXUAL ABUSE**

**DEFINITION**

Sexual abuse is sexual conduct with a child for arousal or gratification of the sexual needs or desires of the caregiver(s). This maltreatment includes both allegations of sexual abuse and the threat of harm by sexual abuse. Three types of sexual conduct are included in this maltreatment:

1. **Sexual Molestation:** Sexual conduct with a child when contact, touching, or interaction is used for arousal or gratification of the sexual needs or desires of the caregiver(s), including, but not limited to:

   - The intentional touching of the genitals or intimate body parts, including the breasts, genital area, groin, inner thighs, penis, and buttocks, or the clothing covering them.
   - Encouraging, forcing, or permitting the child to inappropriately touch the same parts of the caregiver’s body.

2. **Sexual Battery:** Sexual conduct involving the oral, anal, or vaginal penetration by, or union with, the sexual organ of a child; the forcing or allowing a child to perform oral, anal, or vaginal penetration on another person; or the anal or vaginal penetration of another person by any object. This includes digital penetration, oral sex (cunnilingus, fellatio), coitus, and copulation.

3. **Sexual Exploitation:** Sexual use of a child for sexual arousal, gratification, advantage, or profit. This includes, but is not limited to:

   - Indecent solicitation of a child or explicit verbal enticement.
   - Allowing a child to participate in pornography.
   - Exposing sexual organs to a child for the purpose of sexual arousal or gratification, aggression, degradation, or similar purposes.
   - Intentionally perpetrating a sexual act in the presence of a child for the purpose of sexual arousal, gratification, aggression, degradation, or similar purposes.
   - Intentional masturbation of the caregiver’s genitals in the child’s presence.
**Use this maltreatment when a child has been sexually abused or is at threatened harm of sexual abuse due to the actions or non-actions of the caregiver(s). The caregiver(s) is alleged to have sexually exploited the child not only if he/she engages in the behaviors or activities listed under “Sexual Exploitation”, but also if s/he condones or does not stop another non-caregiver(s) from exposing the child to these behaviors or activities.

**If the alleged perpetrator has current access to the child, this must be an immediate response.

**When an allegation of “Sexual Abuse” is made due to threatened harm from sexual abuse, at times a CPI is able to determine that a child has not been sexually abused but is at serious risk of sexual abuse because of the evidence obtained. In such situations, the CPI should add the allegation of “Threatened Harm” to their investigation and determine findings accordingly.

ASSESSING “SEXUAL ABUSE” AS MALTREATMENT

- Is the child being used for sexual arousal, advantage, or profit?
- How did the reporter obtain their information (eye witness, child statement, third party, etc.)?
- Does the child have a sexually transmitted disease?
- Did the caregiver(s) expose their sexual organs to a child that is inappropriate or appears to be for sexual gratification?
- Has one child in the home been sexually abused by the caregiver(s) and are there siblings in the home who may also be victims as well?
- Did the caregiver(s) sexually abuse a child and also have other children living in their household who are the same sex and similar age to the child victim?
- What is the extent of the primary caregiver’s knowledge of the situation to include if they were present?
- Is there prior sexual abuse history involving the child or the caregiver(s)?
- Does the child have a disability or medical condition that increases their vulnerability?
- Is there a threat that the child is being sexually abused, for example a child is exhibiting sexual acting-out behaviors beyond their developmental level that is so severe it is expected that someone may have sexually abused them?

ASSESSING FOR OTHER MALTREATMENT

- Allegations of child prostitution should also be assessed for “Human Trafficking.”
- When a child has been sexually abused in the past and the caregiver(s) allow the abuser to have contact, the child may be at risk. Also assess for “Failure to Protect.”

EXCLUDING FACTORS

- A situation involving touching that can be reasonably construed to be normal caregiver(s) responsibility such as wiping a child who is not able to do so without assistance does not constitute “Sexual Abuse.”
- Normal caregiver(s) interaction with affection does not constitute “Sexual Abuse.”
- Touching that is intended for valid medical purposes does not constitute “Sexual Abuse.”

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Information obtained from all medical records and professionals to include the Child Protection Team and the child’s Primary Care Physician.
  - **A mandatory referral to CPT is required for any report alleging sexual abuse of a child or any sexually transmitted disease in a prepubescent child.
- Documentation from any reports and interviews from law enforcement.
- Documentation of an arrest being made related to the sexual abuse incident.
- Documentation of physical evidence observed by the CPI, law enforcement, medical professionals,
or the Child Protection Team.

- Results of any psychological exams of the child and/or the caregiver(s).
- Documentation of the statement given by the child (preferably through a forensic interview by a CPT professional), caregiver(s) and siblings to include an assessment of credibility.
- Documentation from interviewing witnesses to the incident or persons who know the family well.
- Documentation from prior history of sexual abuse in this family or by the caregiver(s) with different child victims including prior allegations of sexual abuse made by the child.

Answer any questions the participants may have.

Now, let’s look at the Florida statute that defines sexual abuse of a child.

Refer participants to **PG: 107-108, Sexual Maltreatment – Florida Statutes**.

Read aloud (or ask various participants to do so) each of the bulleted sections of “Sexual Abuse: s. 39.01(69), F.S.”

**Trainer Note:** Discuss the other statutes and operating procedures listed here. Tell the participants they should take notes while you summarize each of these statutes or operating procedures. Describe how each one is related to child sexual abuse. Point out the ones related to upcoming topics in this unit.

**PG: 107-108**

**Sexual Maltreatment—Florida Statutes**

**Sexual Abuse: Section 39.01(67), F.S.**

“Sexual abuse of a child” means one or more of the following acts:

- Any penetration, however slight, of the vagina or anal opening of one person by the penis of another person, with or without semen emission.
- Any sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person.
- Any intrusion by one person into the genitals or anal opening of another person, including the use of any object for this purpose, except that it does not include any act intended for a valid medical purpose.
- The intentional touching of the genitals or intimate parts, including the breasts, genital area, groin, inner thighs, and buttocks, or the clothing
covering them, of either the child or the perpetrator, except that this does not include any act:
  o which may reasonably construed to be a normal caregiver responsibility, any interaction with, or affection for a child; or
  o intended for a valid medical purpose.
• The intentional masturbation of the perpetrator’s genitals in the presence of a child.
• The intentional exposure of the perpetrator’s genitals in the presence of a child, or any other sexual act intentionally perpetrated in the presence of a child, if such exposure or sexual act is for the purpose of sexual arousal or gratification, aggression, degradation, or other similar purpose.
• The sexual exploitation of a child, which includes allowing, encouraging, or forcing a child to:
  o solicit for or engage in prostitution; or
  o engage in a sexual performance, as defined by chapter 827.

• Section 39.302, F.S. - Institutional Child Abuse, Abandonment, Neglect
  Describes procedures, timelines, and notifications of law enforcement, state attorney, etc., for investigating reports of sexual abuse occurring in institutions by staff. These institutional settings include licensed facilities, such as foster care homes, as well as other types of institutionalized care, such as group homes or residential therapeutic facilities.
• Section 39.303, F.S. - Child Protection Teams
  Establishes the requirement for area multi-disciplinary child protection teams (CPT), which are overseen by the Department of Health to support DCF child protective investigations, including sexual abuse cases, with specialized medical and psychological expertise. Procedures and services are defined.
• Section 39.3035, F.S. - Child Advocacy Centers
  Establishes requirements for membership in the Florida Network of Child Advocacy Centers, which must include a child protection team and facility, and determines how they are funded.
• Section 39.304, F.S. - Photos, Medical Exams, X-rays, Treatment
  Establishes authority of investigators and CPTs to take
photographs of injuries and arrange for/provide medical exams, x-rays, and medical treatment, and delineates the consents and other requirements for doing so.

- **Section 39.307, F.S. - Reports of Child-on-Child Sexual Abuse** Establishes procedures and requirements for investigating reports of child-on-child sexual abuse.

- **Section 39.806(1), F.S. - Child Sexual Abuse-Grounds for TPR** Identifies child sexual abuse as a grounds for termination of parental rights, as well as identifying other grounds.

- **65C-28.004(10), F.A.C. - Placement of Children Who are Victims of Sexual Abuse**
  Describes the special requirements for placement of child sexual abuse victims, including full disclosure of case details with the caregiver, standards for sleeping and bathroom privacy, and special expertise resources and training available to caregivers.

- **65C-28.004(6), F.A.C. - Placement of Alleged Abuser**
  Describes the special requirements for placement of alleged juvenile sexual offenders, including full disclosure of case details with the caregiver, standards for sleeping and bathroom privacy, and special expertise resources and training available to caregivers.

- **CFOP 175-20 - CPT and Sexual Abuse Treatment Programs** Establishes the operating procedures for child protection teams and protocols for sexual abuse treatment programs.

*Display Slide 6.4.4 (PG: 109)*
Sexual abuse of a child usually occurs in five phases. The phase that is being experienced will affect what the child and the abuser may say or do. Let’s talk about the phases and their key elements.

*Describe each phase and their elements.*

*You may choose to have the phases pre-written on flipchart pages or a white board and record the elements as you go along while the participants take notes.*

**Five Sexual Abuse Phases**

- **Engagement** – Initial stage when a child is “groomed” by the abuser. The abuser:
  - is usually in child’s family
  - has power and authority over child
  - has opportunity.

- **Sexual Interactions** – Over time, the abuser will engage the child in sexual activity. It likely will begin with a lesser behavior, such as inappropriate touching, and progress to a more serious behavior, such as intercourse.

- **Secrecy** – The primary task for the abuser is to ensure the child keeps the activity secret.
  - Essential and enables repetition
  - Encouraged with rewards
  - Enforced with threats
  - Secrecy phase often lasts for months or years.

- **Disclosure** – Disclosure can be accidental or initiated by one of the participants, and, therefore, purposeful. How this happens and how others respond is critical to the child.

- **Suppression** – In most cases, there is a period of suppression following disclosure.
  - Family may try to suppress publicity, information, and intervention.
  - Perpetrator may exploit power position and pressure the child and family.
How do you think the patterns of sexual abuse begin in a family?

Discuss participants’ answers. Discuss the pattern of multigenerational child sexual abuse and how the secrecy is passed down along with it.

Children who are sexually abused may grow up to do the same to their own children, or marry someone who sexual abuses their children.

Activity: Sexual Abuse – Does it Meet the Legal Definition?

Display Slide 6.4.5 (PG: 110)

Purpose: To allow participants, as a class, to identify and discuss which type of child sexual abuse is described in scenarios.

Materials:
- PG: 110 -111

Trainer Instructions:
- Tell the class that now they will get a chance to talk about various scenarios. Explain that you will read several scenarios that may or may not according to statute describe sexual abuse. Tell them they may use the Handouts and information they just reviewed in their participant’s guide.
- Read each of the scenarios below aloud to the class.
- After reading each scenario, ask if it is or is not sexual abuse. If it IS sexual abuse, have participants explain which of the types of sexual abuse – sexual battery, sexual molestation, sexual exploitation, or child-on-child sexual abuse – is being described.
- Refer to the answers provided below each scenario.
- Have participants discuss why the scenario describes the particular type
they chose, explaining which details in the scenario lead them to their choice.

Practice Scenarios

Scenario 1: The father of a 13-year-old girl has been touching his daughter’s breasts over her clothes. The 1-year-old tells her best girlfriend, who tells her mother, who calls the Hotline.

**Answer:** Sexual molestation (intentional touching of the genitals or intimate parts, including the breasts.... or the clothing covering them, of the child by the abuser. s. 39.01(69)(d), F.S.

Scenario 2: An 8-year-old girl discloses to her teacher that her grandfather has put his finger in her “hoo-hoo” many times (as she pointed to her vaginal area) – whenever they are alone together. She called this the “Sweet Secret Game,” but she doesn’t like it.

**Answer:** Sexual battery (vaginal penetration of another by any other object. s. 39.01(69)(a), F.S.). Point participants to the Florida Statutes on this.

Scenario 3: An anonymous caller reports that an 11-year-old boy is watching his 25-year-old aunt undress and masturbate herself. She lives in the home and leaves the door of her bedroom open when his parents are away and encourages him to watch.

**Answer:** Sexual exploitation (self-masturbation in the child’s presence. s. 39.01(69)(3), F.S. Training NOTE: Male and female caregivers can perpetrate sexual abuse. Sometimes, the caregiver of young children perpetrates sexual acts under the guise of caregiving behavior during such events as bath time, dressing and/or have them do things to the caregiver or expose them to behavior that is sexual in nature. In addition, even if there is absolutely no physical contact between perpetrator and child, it can still be sexual abuse under Florida law.

Scenario 4: A mother is reported for taking her 2-year-old daughter’s temperature anally when she is feverish. The mother explained that her daughter was so fussy that she could not put the thermometer in her mouth to get her temperature orally.

**Answer:** Not sexual abuse (touching that is intended for valid medical purposes. s. 39.01(69)(d)2, F.S.)

Scenario 5: A 4-year-old girl made a comment in her pre-school that her 12-year-old cousin licked her “cootchie” between her legs when they play of the “Lollipop Game.” When the girl was interviewed, she confirmed the “Lollipop Game” and identified her cousin.
**Sexual battery** (includes acts commonly known as oral sex [cunnilingus, fellatio], coitus, and copulation. s. 39.01(69)(b), F.S.).

**Scenario 6:** Everyone just got back from the beach, and Dad and his 6-year-old son are trying to get ready to go out with the family for dinner. Dad and his son are taking a shower together.

**Answer:** This is not sexual abuse, as there is no underlying intent or action that is sexual in nature. This would be regular family life functioning. Trainer NOTE: This scenario will instigate intensive debate with some participants. Allow the debate to continue, but highlight the fact that there would have to be intent and action related to sexual behavior in order for it to be considered sexual abuse.

**Activity STOP**

*Display Slide 6.4.6*

As a child welfare professional, it is your job to identify through interviews, observation and other means the necessary evidence to determine if a maltreatment occurred, what kind of maltreatment occurred, and if there is present or impending danger.

Children who have been sexually abused may or may not portray indicators that they have been abused. However, it is important that you be prepared for any eventuality by being aware of the types of physical and behavioral indicators that children may exhibit.

Some physical indicators are:

- Physical injury to the genitals.
• Sexually Transmitted Diseases.
• Bladder or Urinary Tract Infections.
• Painful Bowel Movements or Retention of Feces.
• Early, Unexplained Pregnancy.

Some behavioral indicators are:
• Sexual knowledge and inappropriate sexual behavior.
• Prevalent generalized indicators of emotional distress.

Turn to PG: 113-115, Sexual Maltreatment—Indicators of Sexual Abuse. In your groups, review this information and discuss it. Consider how you might mentally prepare yourself as a child welfare professional to be best able to assess for possible child sexual abuse by a parent/caregiver.

Sexual Maltreatment—Indicators of Sexual Abuse

Physical Indicators

The indicators of sexual abuse vary in children of different ages.

• Sexual abuse includes a wide range of behaviors and activities, some of which have no physical signs. These can include:
  o Kissing
  o Fondling
  o Genital exposure
  o Observation of adult sexual activity by a child
• When a child has been physically involved in sexual activity, there may be physical indicators or injury. These may be validated through a medical examination by a physician trained in sexual abuse.
• Several physical indicators common in sexually abused young children.
• Depending upon how recent and how extensive the sexual activity, there may be no clear physical evidence.

Physical Injury to the Genitals

• Injuries include bruising, cuts or lacerations, bite marks, stretched rectum or vagina, fissures in the rectum, or swelling and redness of genital tissues.
• These injuries may have been caused by penetration of the vagina or rectum with fingers, an adult penis, or other objects.
• Injuries to the genitals in older infants and toddlers may be the result of physical punishment for toileting accidents.
Sexually Transmitted Diseases
- The presence of sexually transmitted diseases, including herpes on the genitals, gonorrhea, syphilis, venereal warts, or Chlamydia, strongly suggests sexual exposure.
- The presence of monilia (yeast infection) in a female child or adolescent may not necessarily be the result of sexual abuse.
- Yeast infections may occur from having taken systemic antibiotics, or from excessive douching.
- A yeast infection in a preadolescent child, however, warrants a medical examination and further investigation.

Suspicious Stains, Blood, or Semen on the Child’s Underwear, Clothing, or Body
- The presence of blood or semen strongly suggests sexual exposure and all evidence must be collected by law enforcement.

Bladder or Urinary Tract Infection
- This includes pain when urinating, blood and pus in the urine, and high frequency urination.
- Urinary tract infections are common in sexually active women.
- They are uncommon in children, unless the child has a physical abnormality of the urinary system, such as children with spina bifida who often have chronic urinary tract infections as a result of neurological dysfunction.
- Any urinary tract infection in a child must be medically evaluated for the possibility of sexual abuse.

Painful Bowel Movements or Retention of Feces
- Might indicate that the rectum has been penetrated. Chronic constipation may also cause painful bowel movements and retention of feces by a child.

Early, Unexplained Pregnancy
- Particularly in a child whose history and behavior does not suggest sexual activity with peers.

Behavioral Indicators

Verbal Disclosure
- When a child discloses sexual involvement, or that an adult has done "bad things" to them, this disclosure must always be taken seriously.
- If a child's disclosure is handled improperly, the child may be unwilling to talk about the abuse again.
- The child is often hesitant to disclose due to threatened consequences
imposed by the perpetrator.
• Disclosure may only be hinted at (e.g., "I don't want to go home." or "I don't like my dad anymore.")

Precocious Sexual Knowledge and Inappropriate Sexual Behavior

You must have a basic knowledge of appropriate sexual knowledge/behavior in children of different ages in order to recognize when a child possesses sexual knowledge or engages in sexual behavior that is not typical for his or her age.

• Behaviors that often indicate unusual sexual involvement include:
  o Seductive behavior toward adults of the opposite sex (generally, female children toward adult men).
  o Sexual acting out in pre-adolescent and adolescent children including promiscuity or blatantly provocative dress
  o Excessive masturbation (again, beyond what is age appropriate)
  o Enticing other children into sexual play (beyond normal curiosity and visual or tactile exploration, such as the "doctor" games and mutual disrobing often engaged in by younger children)
  o Involving other children, either of the same or opposite sex, in more extensive sexual behavior. Adolescent male perpetrators are themselves very often victims of sexual abuse.
  o Creating and playing out sexual scenarios with toys or dolls
  o The "child" doll presses her face into the "daddy" doll's groin and says "he likes this;" or the "daddy" doll puts his hand under the "child" doll's skirt and rubs her.
  o Specific fears of males or females
  o Adolescent fear of sex (beyond normal adolescent ambivalence and anxiety)
  o Some children wear extra layers of clothing, or clothing that is inappropriate for the weather:
    ▪ An apparent symbolic attempt to hide, or to protect their bodies.
    ▪ The child may hide clothing that is stained, bloodied, or otherwise soiled as a result of sexual activity.
  o A sexually abused child may have difficulty with, or appear to lack interest in participating in normal physical activities.
  o Indicators: difficulty sitting in a chair, sitting awkwardly, or squirming, having difficulty walking, staying seated and choosing not to become involved in games or sports. Indicators may be the result of pain or discomfort in the genital area.
Generalized Indicators of Emotional Distress are Prevalent

*NOTE: These indicators are also prevalent in other maltreated children and are not direct indicators of sexual abuse:*

- Fears and phobias (of the dark, of school, going out, going home, being left alone, or free floating anxiety).
- Aggressive behaviors, tantrums, acting out, running away from home, fighting.
- Withdrawal from social relationships, secrecy, isolation, and a prevailing lack of trust in relationships. This is often mistaken for independent activity.
- Low self-esteem, poor body image, perceives oneself in a negative way with a distorted sense of one's own body.
- Regression in young children; enuresis, encopresis, thumb sucking, baby talk, clinging behaviors.

*Debrief as a large group.*

*Ask if anyone has any questions about the indicators and, if so, respond appropriately.*

*Display Slide 6.4.7 (PG: 116)*

**Trainer Note:**

*PG: 116*

The National Center on Sexual Behavior of Youth (NCSBY) states that research on sexual behavior of children ages 2 to 12 has documented that:

- Sexual responses are present from birth.
- A wide range of sexual behaviors for this age range are normal and non-problematic.
- Increasing numbers of school age children are being identified with inappropriate or aggressive sexual behavior. It is not clear if this increase reflects an increase in the actual number of cases or an increase in identification and reporting.

**Typical sexual knowledge of children age 2 to 6 years old includes:**
• Understanding that boys and girls have different private parts.
• Knowing labels for sexual body parts, but using slang words such as weenie for penis.
• Having limited information about pregnancy and childbirth.

Typical sexual knowledge of children ages 7 to 12 years old:
• Learn the correct names for the genitals but use slang terms.
• Have increased knowledge about masturbation, intercourse, and pregnancy.
• Understand the physical aspects of puberty by age 10.

From the time they are born, children exhibit normal sexual behavior, and it is essential that you understand the difference between developmentally typical child sexual behavior and behavior that is indicative of some type of sexual abuse.

It can be hard to tell the difference between typical, natural sexual behaviors and behaviors that are signs that a child may be developing a problem. Sexual play that is more typical or expected in children will more often have the following traits:
• The sexual play is between children who have an ongoing, mutually enjoyable play and/or school friendship.
• The sexual play is between children of similar size, age, and social and emotional development.
• It is lighthearted and spontaneous. The children may be giggling and having fun when you discover them.
• When adults set limits (for example, children keep their clothes on at day care), children are able to follow the rules.

Preschool age (0 to 5 years)
Common:
• Will have questions and express knowledge relating to:
  o differences in gender, private body parts
  o hygiene and toileting
  o pregnancy and birth
• Will explore genitals and can experience pleasure
• Showing and looking at private body parts

Uncommon:
• Having knowledge of specific sexual acts or explicit sexual language
• Engaging in adult-like sexual contact with other children
School-age (6-8 years)

Common:
- Will need knowledge and have questions about
  - Physical development, relationships, sexual behavior
  - Menstruation and pregnancy
  - Personal values
- Experiment with same-age and same-gender children, often during games or role-playing
- Self-stimulation in private is expected to continue.

Uncommon:
- Adult-like sexual interactions
- Having knowledge of specific sexual acts
- Behaving sexually in a public place or through the use of phone or Internet technology

School-age (9-12 years)

Hormonal changes and external influences, such as peers, media and Internet, will increase sexual awareness, feelings and interest at the onset of puberty.

Common:
- Will need knowledge and have questions about
  - Sexual materials and information
  - Relationships and sexual behavior
  - Using sexual words and discussing sexual acts and personal values, particularly with peers
- Increased experimentation with sexual behaviors and romantic relationships
- Self-stimulation in private is expected to continue

Uncommon:
- Regularly occurring adult-like sexual behavior
- Behaving sexually in a public place

Adolescence (13 – 16 years) *(PG: 156)*

Common:
- Will need information and have questions about
  - Decision-making
  - Social relationships and sexual customs
  - Personal values and consequences of sexual behavior
- Self-stimulation in private is expected to continue.
- Girls will begin menstruation; boys will begin to produce sperm.
- Sexual experimentation between adolescents of the same age and gender is common.
- Voyeuristic behaviors are common in this age group.
- First sexual intercourse will occur for approximately one third of teens.
Uncommon:

- Masturbation in a public place
- Sexual interest directed toward much younger children
- For those children exhibiting problematic sexual behavior, several treatment interventions have been found to be effective, such as cognitive behavioral treatment.

Source: stopitnow.org


http://www.nationalcac.org/images/pdfs/LocalServices/Prevention/ForParents/HealthySexualDevelopmentOverview.pdf

Have participants turn to PG: 157-160, Sexual Maltreatment, Sexual Development and Behavior in Ages 2-12. Briefly overview the contents of the following, highlighting the significance of each section. Participants will be working with this again as they review the four cases from the prior activity in light of this information on sexual development and behavior:

- Developmentally common Sexual Behaviors
- Common vs. Infrequent Sexual Behaviors in Children
- Infrequent Sexual Behaviors (ages 2-12)
- Sexual Play vs. Problematic Sexual Behavior
- Children with Sexual Behavior Problems
Sexual Maltreatment,
Sexual Development and Behavior in Ages 2-12

NCSBY Fact Sheet

This Fact Sheet provides basic information about sexual development and problematic sexual behavior in children ages 2-12. This information is important for parents and professionals who work with or provide services to children such as teachers, physicians, child welfare personnel, daycare providers, and mental health professionals. Understanding children’s typical sexual development, knowledge, and behavior is necessary to accurately identify sexual behavior problems in children. Guidelines to distinguish typical sexual behaviors from problematic sexual behaviors are described below.

Research on sexual behavior of children ages 2 to 12 has documented that:
- sexual responses are present from birth;
- a wide range of sexual behaviors for this age range are normal and non-problematic;
- increasing numbers of school age children are being identified with inappropriate or aggressive sexual behavior; it is not clear if this increase reflects an increase in the actual number of cases or an increase in identification and reporting;
- several treatment interventions have been found to be effective in reducing problematic sexual behavior in children, such as cognitive behavioral group treatment; and
- sexual development and behavior are influenced by social, familial, and cultural factors, as well as genetics and biology.

Typical sexual knowledge of children age 2 to 6 years old:
- understand that boys and girls have different private parts;
- know labels for sexual body parts, but use slang words such as weenie for penis; and
- have limited information about pregnancy and childbirth.

Typical sexual knowledge of children ages 7 to 12 years old:
- learn the correct names for the genitals but use slang terms;
- have increased knowledge about masturbation, intercourse, and pregnancy; and
- understand the physical aspects of puberty by age 10.

Developmentally-Common Sexual Behaviors

<table>
<thead>
<tr>
<th>AGES 2-6</th>
<th>AGES 7-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Do not have a strong sense of modesty,</td>
<td>-Sexual play with children they know,</td>
</tr>
<tr>
<td>enjoys own nudity</td>
<td>such as playing “doctor”</td>
</tr>
<tr>
<td>-Use elimination words with peers</td>
<td>-Interested in sexual content in media</td>
</tr>
<tr>
<td>-May explore body differences between girls</td>
<td>(TV, movies, radio)</td>
</tr>
<tr>
<td>and boys</td>
<td>-Touch own genitals at home, in private</td>
</tr>
<tr>
<td>-Curious about sexual and genital parts</td>
<td>-Look at nude pictures</td>
</tr>
<tr>
<td>-Touch their private parts, even in public</td>
<td>-Interested in the opposite sex</td>
</tr>
<tr>
<td>-Exhibit sex play with peers and siblings;</td>
<td>-Shy about undressing</td>
</tr>
<tr>
<td>playing “doctor”</td>
<td>-Shy around strange men</td>
</tr>
</tbody>
</table>

Core Child Welfare Pre-Service Curriculum | Module 6-TG
Common vs. Infrequent Sexual Behaviors in Children

In the last decade, research has described typical sexual behaviors in boys and girls ages 2-12. The table below lists sexual behaviors that are commonly observed or reported by parents of pre-school and school age children.

<table>
<thead>
<tr>
<th>Infrequent Sexual Behaviors (Ages 2-12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Puts mouth on sex parts</td>
</tr>
<tr>
<td>-Puts objects in rectum or vagina</td>
</tr>
<tr>
<td>-Masturbates with objects</td>
</tr>
<tr>
<td>-Touches others’ sex parts after being told not to</td>
</tr>
<tr>
<td>-Touches adults’ sex parts</td>
</tr>
<tr>
<td>-Asks to engage in sex acts</td>
</tr>
<tr>
<td>-Imitates intercourse</td>
</tr>
<tr>
<td>-Undresses other people</td>
</tr>
<tr>
<td>-Asks to watch sexually explicit television</td>
</tr>
<tr>
<td>-Makes sexual sounds</td>
</tr>
</tbody>
</table>

Research has also described infrequent and uncommon sexual behaviors in boys and girls ages 2-12. Sexual behaviors reported by parents of pre-school and school age children to be infrequent or highly unusual follow.

Sexual Play vs. Problematic Sexual Behavior

Professionals in the field have developed a continuum of sexual behaviors that range from common sexual play to problematic sexual behavior. These are described below.

Sexual play
- is exploratory and spontaneous;
- occurs intermittently and by mutual agreement;
- occurs with children of similar age, size, or developmental level, such as siblings, cousins, or peers;
- is not associated with high levels of fear, anger, or anxiety;
- decreases when told by caregivers to stop; and
- can be controlled by increased supervision.

Problematic Sexual Behavior:
- is a frequent, repeated behavior, such as compulsive masturbation.
  
  Example: A six-year-old repeatedly masturbates at school or in other public places.
- occurs between children who do not know each other well.
  
  Example: An eight-year-old girl shows her private parts to a new child during an after school program.
- occurs with high frequency and interferes with normal childhood activities.
Children with Sexual Behavior Problems

Children with sexual behavior problems (SBPs) are children 12 years and under who demonstrate developmentally inappropriate or aggressive sexual behavior.

This definition includes self-focused sexual behavior, such as frequent public masturbation, and intrusive or aggressive sexual behavior towards others that may include coercion or force. Although the term “sexual” is used, the children’s intentions and motivations for these behaviors may be unrelated to sexual gratification.

Some children who have been sexually abused have inappropriate sexual behaviors and others have aggressive or highly problematic sexual behavior. However, it should be noted that the majority of children who have been sexually abused do not have subsequent inappropriate or aggressive sexual behaviors.

Although only a small number of children develop problematic sexual behavior, professionals and parents may have concerns about (1) whether the behavior is problematic, (2) whether a child should be referred for mental health services, and (3) when an incident should be reported to the proper authorities.

Additional information about adolescent sex offenders and children with sexual behavior problems is available from the National Center on Sexual Behavior of Youth, www.ncsby.org

This Fact Sheet was prepared through the National Center on Sexual Behavior of Youth at the Center on Child Abuse and Neglect, University of Oklahoma Health Sciences Center and was authored by Jane F. Silovsky, PhD and Barbara L. Bonner, PhD. This project is funded by grant number 01-JR-BX-K002 from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), US Department of Justice.
Activity: What are the Indicators in These Situations?

Display Slide 6.4.8 (PG: 123-125)

Purpose: The most effective way for participants to be prepared to assess situations so they can identify possible sexual abuse indicators, as subtle as the indicators might be, is to provide them with scenario-based practice to identify them. That is what this exercise seeks to provide.

Materials:
- PG: 113-115, Sexual Maltreatment—Indicators of Sexual Abuse
- PG: 123-125, Scenarios

Trainer Instructions:
- Together as one large group, have a participant read through Scenario 1. Discuss with the group what they identify as indicators and whether or not they believe this is sexual abuse. Emphasize that they should be looking for physical, behavioral, or reported evidence that is consistent and can be reconciled with other information and reports.
- In their groups, have them work through the next scenario in the same manner. Debrief as a large group.
- In their groups, have them work through the last two scenarios. Debrief as a large group.

For more information on behaviors related to see also:

Activity: What are the Indicators?

Directions:
1. Read scenario 1. Using PG: 113-115, Sexual Maltreatment—Indicators of Sexual Abuse as the focus, work through the questions together.
2. In your groups, review the next scenario and determine what the indicators are related to the scenario, and whether it describes sexual abuse, according to FL statute. Discuss as a class, as well as responding to the discussion questions.
3. You may use all jobs aids and information that has been reviewed in this unit.
4. Someone from the group should record the group’s answers and be prepared to report to the class.

Scenario 1 - Billy: Seven year-old boy Billy has been playing aggressively with other younger children in the neighborhood. One of the smaller children complained that the seven-year-old is mean and pushes her down and lays on top of her and “pushes” against her with his “pee-pee part.” Billy lives with his mother and her new boyfriend in a small apartment. He has also starting using language that seems much more mature for his age and words no one has ever heard him use before.

Discussion Questions:
- What could be the cause of child’s behavior?
- Why do you think he is doing sexual things to younger children?
- Is what he is doing a “normal” behavior for his age or not?

Scenario 2 - LaShonda: Five-year-old LaShonda at kindergarten is very shy about toileting in front of other girls and won’t ask for help with her clothes from the teacher, when she needs it. When she did get help one time the teacher noticed that the child had on three pair of underwear. She is often scratching her genital area and constantly adjusting her pants or dresses around herself when she sits with other children. She is quiet and keeps to herself a bit more than other children her age. Once when she was playing by herself with some dolls, one of the teachers saw her lift the doll’s skirt and poke a pencil in and out between the doll’s legs.

Discussion Questions:
- Why would child wear so many pair of underpants?
- What about her observed play with dolls? Normal or not normal?
- What could be causing her to scratch herself so much?
- What is your hypothesis of this behavior in a five year-old?

Scenario 3 – Charlie: Three and a half year-old Charlie is boisterous and frequently touches himself in the genital area over his clothes and squeals with laughter. He has
been found at his day care facility in the play-yard and in the play tunnels with a three year-old girl. Both children had taken their pants off and were looking at each other in the genital area.

**Discussion Questions:**
1. Is this normal behavior or not? Why?
2. Are you concerned of sexual abuse?
3. If yes, then why?
4. If not, then why?
5. What else should we know or want to know before determining there is concern for sexual abuse?

**Scenario 4 - Amanda:** Eleven year-old girl Amanda is a chronic runaway. She is picked up by law enforcement and taken to the local runaway youth shelter. She seems somewhat mature for a pre-pubescent and initially will not discuss why she continues to run away from her family. The counselors note that she is very behaviorally solicitous (in a physical way) with the male residents, as well as the male counselors.

**Discussion Questions:**
1. What do you think is the cause of her behavior?
2. What may have happened to her at home or maybe somewhere else?
3. What approach would be helpful to find out about her home life?
4. If she has no physical findings (after a CPT exam) is that a definitive indication of no sexual abuse?
5. Is it possible that she is a victim and will not tell anyone? Why wouldn’t she tell? What would keep her willing to keep a secret?
6. If she was sexually abused, what reason would she have to be overtly sexual with others?

**Activity STOP**

_Explain the likelihood that the child will recant at some point, usually during the Suppression stage, but it can happen before sexual abuse is reported. This is a very typical part of the pattern of sexual abuse._
Who can think of some of the reasons that a child might recant?

Record on flipchart. Be sure the following are included:

- Secrecy
- Denial
- Lack of support and pressure from others
- Societal attitudes
- Child and family interactions with professionals
- Intervening events over time.

Let’s review each of these reasons that children recant.

Discuss each of the reasons, and tell the participants to take notes in their participant guide.

- Secrecy:
  - Study of adult survivors of child sexual abuse indicates most victims never tell anyone.
  - Family has rigid boundaries between itself and the outside world, leading to exaggerated family loyalty.
  - Disclosure by the child is considered aberrant behavior and disloyal.
- Denial
  - A defense mechanism against the emotional pain and the cognitive dissonance of the abuse and its disclosure.
  - A study of 630 sexual abuse cases found that 72% involved an element of denial.
- Lack of support and pressure from others
Disclosure is already difficult, but without the support of a parent for telling the truth, it is nearly impossible for children. Because of guilt, fear, and confusion, recanting is an attempt to “make it go away” and return to the way things were before the child disclosed. A child victim may experience a great deal of pressure from loved ones to recant when an abuser on whom they are dependent emotionally or financially is to be incarcerated. Typical family dynamics in sexual abuse cases, such as a controlling parent (usually the father), isolation, and lack of control by the children contribute to a child recanting.

- Societal attitudes
  - Adults do not want to believe such a thing could happen.
  - Freud’s theories (Psychoanalyst Sigmund Freud coined the term “Oedipus Complex” to describe his theory that a state of psychosexual development includes a child having a desire for sexual involvement with the parent of the opposite sex and a sense of rivalry with the parent of the same sex.)
  - Belief that children are not credible witnesses
  - Child will recant to a non-abusing relative and give a reason for telling the abuse story. That lie may be more credible despite the evidence to the contrary.

- Child and family interactions with professionals
  - The social services and law enforcement systems, at their best, can be traumatizing, with the number of people with which a child must discuss the abuse, a medical exam, the potential for a child to be removed from home and placed in foster care, etc. It should be no surprise when a child recants.
  - If professionals lack sensitivity and understanding, this is further traumatizing.

- Intervening events over time.
- The more time that passes between the initial disclosure by the child and legal resolutions, the greater the chance that
the child will recant.


Display slide 6.4.10

When it is revealed in a family that sexual abuse has been occurring, what do you think the family responses might be?

Discuss the answers given, and highlight these as dynamics that occur in the family.

Endorse the following answers:

• Denial and disbelief – not only the abusive parent, but the non-offending parent, as well
• Anger – at the child for “lying” or anger for disclosing, even if the child is believed
• Guilt – If the child is believed, both or either of the offending and the non-offending parents may feel guilty; if the offending parent is charged and taken to jail, then the abused child may feel guilt.
• Disgust/horror – Even when faced with the situation, the response may be one of disgust.
• Blame – The non-offending parent may blame the child for being “seductive.”
• Break-up of the family
• Offending parent may go to prison.
Discuss how the multi-generational aspect may play into the response, as well – denial, secrecy, etc.

Considering the possible family responses, it may not come as a surprise that children often recant, and say that the abuse never occurred.

There are a number of reasons for this, but it’s important to note that, according to research, it is rare that a child makes this allegation when it is not true. Remember, there are always underlying family dynamics that lead a parent/caregiver to respond in a particular way. This does not make unproductive responses acceptable, but it does provide an explanation for certain behavior or lack of behavior.

Activity: Grappling with Potential Sexual Abuse Cases

Display Slide 6.4.11 (PG: 128)

**Purpose:** This activity helps participants grapple with some of the more nuanced issues related to child sexual abuse. It is important to note that this is only an introduction to the complexity of child sexual abuse cases. Be prepared to talk through the cases with participants to help them begin to appreciate the complexity.

**Materials:**
- **PG: 128-129, Scenario: Destiny**
- **PG: 130-132, Scenario: Lee-Ann**

**Trainer Instructions:**
1. As a class, read through the first scenario about Destiny. Facilitate
discussion using the five questions provided to participants:

a) What could be the cause of Destiny’s “itchies”? See if you can think of at least 4-5 possibilities.

b) If you were an investigator, what would you want to ask Destiny to gain more information?

c) Do you think Destiny should get an examination, and, if so, by whom?

d) Is there someone else besides the CPI who should talk with a child of this age with this type of history (concern of possible sexual abuse due to hands in pants and “itchies”)?

e) What should be considered if Destiny does not disclose sexual abuse?

The causes of Destiny’s “itchies” could be any one of the following:

- Medical condition
- Sexual Abuse
- Irritation from bubble baths
- Improper cleaning and irritation from incomplete wiping
- Normal childhood self-sexual exploration and masturbation

**Trainer Note on this part of the Activity:**

Trainer leads discussion of all as possibilities and what to ask and how to react to a child who presents with “itchies” in the absence of any other indicators, medical diagnosis, interview confirmations or behavioral concerns from daycare or other adults. Particular attention should be paid to bias on the part of the class when considering if they immediately went toward “Uncle Jake” as a perpetrator simply because he is a male in the child’s home.

Reinforce the necessity to look at all aspects of the presenting allegation, child’s developmental status, confirmations or lack of confirmations from behavioral reports, the need to take medical findings (or lack of findings) in context with all other information.

It is especially important to reinforce for new trainees that medical findings of physical evidence or lack of evidence do not define how much further or what other steps we may need to take to confirm or refute possible sexual abuse.

This can be done by reviewing carefully that many, many children who are sexual abuse victims do not present with any type of physical findings and that molestation takes many forms that do not necessarily result in physical “damage” to a child. (Fondling, touching, having a child do things to the perpetrator or even some types of sexual actions that may be invasive, but still may not result in tissue disruption of the child’s genitalia - vaginal or anal.)
2. In their individual groups, have participants read through the second scenario and work through the questions. Debrief as a class.

Destiny/ age 4
Destiny, age 4 lived with her mother and grandmother. Also in the home was the 32 year-old cousin to the mother, whom Destiny knew as “Uncle Jake.” He was new in the home and had only lived with Destiny, her mother and her grandmother for about one year.

When mom was at work it was either grandma or Uncle Jake who watched over Destiny. Mom worked at Walmart and sometimes had different hours, depending on schedule issues. Destiny went to daycare in the daytime and was picked up by grandma after daycare if mom was not available. Uncle Jake worked the midnight shift at a local factory and would come home and sleep in daytime when Destiny was in daycare and mom and grandma were at work. Grandma worked as a “lunch lady” at the local elementary school and was able to both take and pick up Destiny daily when necessary due her part time work hours.

Destiny started complaining of being “itchy” in her “potty parts” to her mother and grandmother when they would see her with her hands in her pants at night, nap times or in the tub. Whenever she was asked about this she told her mom and grandma that she was “scratching her itchies.” The mom and grandma did not notice any redness or irritations for Destiny and could not figure out why she had “itchies.” She did not seem fearful of anyone in the house and was an outgoing and happy child otherwise.

Lee-Ann/age 13
Lee-Ann moved to Florida from Kentucky with her mother, stepfather and two younger siblings. Her family was in Florida about 6 months when an anonymous report came in that Lee-Ann may have been a victim of sexual abuse by her stepfather.

During interview Lee-Ann did confirm that her stepfather had been “doing it” to her for a few years now. “It” happened in both Kentucky and in Florida. Lee-Ann presented as a pretty street savvy child, was sarcastic, sometimes openly disrespectful when spoken to by teachers, the CPI and when interviewed at CPT. She openly acknowledged that she didn’t really care about what was happening at home and that sometimes her stepdad would give her money or gifts afterwards when they had “date night.” She also casually made the comment in her interview that at least he is not “doing” her sisters.

Lee-Ann’s description of “date night” included her going to the back yard with her stepdad while her younger sisters had to stay in the house. The family lived on a large piece of property in a rural area and the shed was far from the house. The younger siblings knew that Tuesday night was “gardening night” for Lee-Ann and stepdad. They were allowed to stay up later and watch a scary movie or a favorite TV program,
as long as they did not come outside or anywhere near the “gardening shed.” This was because their stepdad said he did not want them to get hurt around the yard tools.

Lee-Ann’s younger siblings were 7 and 8 years old. They did not confirm knowing anything about what was happening with Lee-Ann and her stepdad and did not disclose anything happening with themselves with the stepdad. Both younger sisters describe Lee-Ann as mean, bossy with them and always telling them what to do at home. They both gave examples where Lee-Ann would not let them go with Stepdad to the local ice cream store (or anywhere else), unless they would go together or unless she went with them.

Lee-Ann’s mom worked night shift at the local hospital and would not come home until after 11:30pm on Tuesdays. Those evenings, Lee-Ann detailed being required to “blow” stepdad, having him “put his fingers in her” and her being forced to “jerk him off.” She was very descriptive and nonchalant with her descriptions and almost seemed indifferent in her presentation of the sex acts.

School personnel (Guidance Counselors) have described that Lee-Ann is bit “wild” at school with the boys. She is apparently known for being quite sexually active and not well-liked by many of the other girls. Lee-Ann is often sent home for dressing inappropriately, she skips classes, and she uses very foul language. She seemed to get a lot of satisfaction in talking about sex acts, making sure that the boys (as well as her female peers) all know she is experienced and making no effort to hide her sexual behaviors. It was no secret that she would engage in sex acts in and around the school with almost anyone and had no real ongoing relationships with her peers regardless of her sexually intimate physical interactions.

Some of the boys were intimidated to be around Lee-Ann because she took a lot of pride in actively shaming them verbally in front of their friends about their willingness or lack of willingness to get involved with her on a physical level. An example of this was when she called out to one of the boys in front of the other boys and call him “dinky dick.”

There were also rumors of possible drug use that includes distribution—“probably pot” according to the guidance counselor. Lee-Ann seemed clever enough to never get caught, but it was well known among the student population that she was a source. The kids at school referred to her as the “whore-ti-culturist”, which she seemed to self-promote when she heard it. She was so proud of this nickname that she had it written on her notebooks and the bottom of her shoes.

Because of the sexual abuse, Lee-Ann and her siblings spent some time in foster care. Lee-Ann never reunited with her mother and aged out of foster care due to her mother’s rejection of Lee-Ann. The stepfather was eventually convicted and went to prison. Even during trials and time in shelter care, Lee-Ann frequently recanted the very specific history of her molestation and would beg the CPI to let her and her sisters return home. However, during the investigation, the sisters unknowingly supported the history by Lee-Ann about times and dates in which Lee-Ann’s stepfather would take her out into the yard, and they would spend time in the shed.
"gardening."

**Trainer Note:** Use the following questions as the focal point of the discussions.

**Discussion of behavior of children who have been sexually abused:**

- Why would Lee-Ann, who has been a victim of sexual abuse for many years, want to be sexual with her peers?
- What value do you think Lee-Ann places on her own sexuality?
- Where does that value come from?
- Lee-Ann’s behavior is not often likeable by adult authority figures. What is it about Lee-Ann that presents a challenge to adults in her life?
- Why would her mother not want to believe Lee-Ann? What motivation may a mother have for not believing her own child?
- What was Lee-Ann’s attitude toward her sisters?
- Assuming that Lee-Ann’s siblings and Lee-Ann went into foster care because the mother did not believe Lee-Ann, what attitudes do you think her siblings would have with Lee-Ann if they also did not believe her?
- What type of concerns or traumatic issues could Lee-Ann face when she becomes an adult woman?
- What might her relationships be like? What about trust? What about her value of herself and her relationships with men? With other women?
- What are some factors that you consider when you think of the possibility of working with a “Lee-Ann” at some point in your child welfare career?

**Activity STOP**

*Have participants look up Chapter 39.303, Florida Statutes about Child Protection Teams. Once they have found it, have them take a few minutes to read through it before you move on to discuss this topic.*

From what you’ve learned about sexual abuse, you can see that it is a very complex issue that can be difficult to detect, as well as challenging to provide interventions for and resolution. Each community and region usually has intervention programs, such as counseling, available to children and families to address
victimization, as well as programs that deal with sexual offenders and provide therapy for that population as well.

All sexual abuse cases and any sexually transmitted disease in a prepubescent child must be referred to the Child Protection Team in the geographic area in which the child is located.

Once a referral from the Department of Children and Families or law enforcement has been accepted, the Child Protection Teams may provide one or more of the following services:

- Medical diagnosis and evaluation
- Nursing assessments
- Child and family assessments
- Multidisciplinary staffings
- Psychological and psychiatric evaluations
- Specialized and forensic interviews
- Expert court testimony.

At this point, you should introduce the Child Protection Team member from your area. They should share for about 30 minutes on their experiences working in the area of child sexual abuse – the challenges CPTs face, how they work with others on the team to support the child, and any other comments they believe are important for beginning child welfare professionals to know.

The CPT member should be ready to answer questions for about 15 minutes.

You will be learning more about forensic interviewing as well as how you should interview children who may have been sexually abused in the Lab 4. The CPI or a case manager will often be the “first responder” who interviews a child victim of sexual abuse. Your skills in helping a child begin to tell their story will be critically important, both in terms of a potential criminal investigation and helping a child who has experienced the emotional trauma of sexual abuse. In the next unit, we will turn our attention to mental injuries.
Unit 6.5: Mental Injury

Display Slide 6.5.1

Time:

Unit Purpose: The purpose of this unit is to provide participants with sufficient understanding of mental injury, including the ability to differentiate between types of mental injury; identify indicators of mental injury in family scenarios and through descriptions, behaviors and words; and explain and appreciate the longer-term impact of mental injury abuse on the child.

Display Slide 6.5.2

Review Objectives

Learning Objectives:
1. Define and describe “mental injury.”
2. List and explain the types of mental injury.
3. Describe the indicators of mental injury.
4. Given scenarios, determine if mental injury exists and explain the rationale for your determination.
5. Given a scenario, identify the probable short- and long-term impacts resulting from specific types of mental injury.
6. Explain when an evaluative professional would be used to determine mental injury.

**Do you think that mental injury would be easy to identify and prove?**

Mental injury is less evident and may be more complex than most other maltreatments.

Let’s start by discussing some of the myths about mental injury.

**What exactly is mental injury?**

*Display Slide 6.5.3 (PG: 133)*

There are many different names and definitions pertaining to emotional abuse and mental injury.

*s. 39.01(42), F.S., defines “mental injury” as:*
Any injury to the intellectual or psychological capacity of a child as evidenced by a discernible and substantial impairment in the ability to function within the normal range of performance and behavior.

The Maltreatment Index adds:
The impairment may be in the emotional, affective, cognitive, physical or behavioral functioning of the child. Damage can be present and observable, or can be forecast as highly probable for the near future.
How does someone’s intellectual or psychological capacity become damaged? What would that look like?

One of the most common ways to cause mental injury is through verbal abuse.

We all have most likely been victims of mental injury through what we know as verbal abuse.

Let’s look at some common myths about verbal abuse.

Display Slide 6.5.4 (PG: 133-134)

Myths about Verbal Abuse (PG: 133-134)

1. Sticks and stones break bones, but words don’t hurt.
   • In some cases, words can hurt more than a stick or stone ever could.

Trainer Note: As you go through each myth, invite participants to tell stories about incidents that they can relate to the myth being mentioned. Starting with “Sticks and Stones,” tell a story about a time someone called you a name and how you still remember it. Explain how children look to their parents to find out “Who am I?” and what it is like when they are told they are dumb.

Encourage each class member to participate as this will provide the emotional buy-in adult learners often need to join in the learning process.

Provide time between each myth for the participants to think and process.
• It is often not just about the words hurled abusively but also about who is the abuser.
• If it is a parent whom a child needs to trust and depend on for love and support, the result can be an experience of abandonment and betrayal.

2. Verbal abuse is no big deal - it doesn’t hurt.
• Abuse leaves children doubting their own feelings.
• Part of the reason it is most destructive, painful and damaging is because it threatens to invalidate the reality of the victim.
• Verbal abuse is damaging to the victims mental health and self-esteem and self-worth.

3. The target (victim) of the abuse deserved it.
• Each and every adult is responsible for managing his or her own feelings.
• Verbal abusers try to hold the victim responsible for what they feel, then they want to “get the victim” or “pay the victim back” for it.
• How the verbal abuser feels is NOT the child’s responsibility.

4. It is the victim’s fault for disagreeing with the abuser.
• There is nothing that the victim does that warrants or justifies verbal abuse.
• Verbal abuse is an aggression and an emotional violation.

5. The target of the abuse made the abuser mad.
• Abusers notoriously think their poor choices and inability to take responsibility for their choices are someone else’s fault.
• It is the abuser’s responsibility.

6. Verbal abuse is less impactful than physical abuse.
• Verbal abuse is an element of emotional abuse.
• Verbal abuse is emotional battering.
• Verbal abuse bruises the child emotionally, in a way that hurts as much, if not more, than actual physical bruises.

7. Verbal abuse only involves name-calling or yelling.
• Verbal abuse is more than name-calling or yelling and screaming.
• It is using words to intimidate or control.
• It involves threats, put-downs and/or making fun of someone.
• Verbal abuse is any language used to demean, criticize, teardown, make fun of, embarrass or otherwise intimidate or control another person.
8. Verbal abuse is not as bad as hitting someone.
   - Verbal abuse is as painful and debilitating emotionally, if not more so than physical abuse.
   - As victims of physical abuse walk on egg shells and try not to upset the abuser, the same is true for the victim of verbal abuse.
   - Many victims of both physical and verbal abuse state that the physical bruises heal a significant amount faster than the emotional bruises.

Let’s look at another definition that describes Mental Injury – Emotional Abuse.

Emotional abuse refers to the psychological and social aspects of child abuse, and it is one of the main causes of harm to abused children.

Display Slide 6.5.5 (PG: 134)

Emotional abuse is a pattern of behavior attacking a child’s emotional development and sense of self-worth and includes:
   - Excessive, aggressive or unreasonable demands placing expectations on a child beyond the child’s capacity.
   - Failure to provide psychological nurturing necessary for a child’s psychological growth and development – providing no love, support or guidance.

Source: National Committee for the Prevention of Child Abuse

Trainer Note: After saying the above (or during), click the PowerPoint and the words will appear.
Can anyone think of a person or child who has been emotionally abused?

Trainer Note: Encourage participants by mentioning names of famous people, such as Michael Jackson and Oprah Winfrey.

Who is most likely to be emotionally abused, boys or girls?

Boys and girls are equally likely to be victims of emotional abuse by their parents. Emotional maltreatment has been reported to peak in the 6- to 8-year-old range and to remain at a similar level throughout adolescence (Source: Kaplan, S. J., Pelcovitz, D., Labruna, V. "Child and Adolescent Abuse and Neglect Research: A Review of the Past 10 years. Part I: Physical and Emotional Abuse and Neglect", Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 38, No. 10, 1998, pp 1214-1222.).

Who is most likely to be emotionally abusive?

Display Slide 6.5.6 (PG: 135)

Both men and women are emotionally abusive. Research findings suggest that emotionally abusive parents:

- Have negative attitudes toward children.
- Perceive children as unrewarding and difficult to enjoy.
- Associate their own negative feelings with the child's difficult behavior, particularly when the child reacts against their poor parenting methods.

Emotional abuse has increasingly been linked to:
• Parental mental health problems
• Domestic violence
• Drug and alcohol misuse

Many parents are emotionally abusive without being violent or sexually abusive; however, emotional trauma invariably accompanies physical and sexual abuse.

Emotionally abusive parents practice forms of child-rearing that are oriented towards fulfilling their own needs and goals, rather than those of their children.

Their parenting style may be characterized by overt aggression toward their children, including shouting and intimidation, or they may manipulate their children using more subtle means, such as emotional blackmail.

Parents may also emotionally abuse their children by "mis-socializing" them, which means that they may encourage their children to act in inappropriate or criminal ways with direct encouragement and/or by surrounding the child with adults for whom such behavior is normative.

Emotional abuse does not occur only in the home. Children can be emotionally abused by teachers and other adults in a position of power over the child.

Children also can experience emotional abuse by other children, and one of the most common experiences of child-to-child emotional abuse is "bullying."

Remember our previous discussion of mandatory referrals to the Child Protection Team? Well, mental injury often falls into the mandatory referral category, specifically if there are “symptoms of
serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected.” Now let’s learn about the types of mental injury.

Display slide 6.5.7 (PG: 136)

Advise participants that we will be doing an activity in a minute, but first we will read the descriptions of the Types of Mental Injury.

Provide a few minutes.

Refer participants to PG: 136, Types of Mental Injury, and provide a few minutes for them to read it.

A repeated pattern or extreme incidents of the conditions described here constitute psychological maltreatment.

Such conditions convey the message that the child is worthless, flawed, unloved, endangered, or only valuable when meeting someone else’s needs.
Activity: Types of Mental Injury

Display Slide 6.5.8 (PG: 139)

Purpose: To provide participants with an experiential opportunity to see and feel the effects of mental injury.

Materials:
- Print out the name and description of each Type of Mental Injury. A print page that you can copy and cut is on the next page.
- PG: 136-138, Types of Mental Injury
- PG: 140-141, Mental Injury - Examples of Caretaker Behavior by Age of Child as a reference.

Trainer Notes: Plan in advance how you will divide the participants. There are six types of mental injury, and each group should have at least two participants but no more than five.

Trainer Instructions:
- Provide paper cutout with name of one type of mental injury to each group. (If small class, each group can do two role plays.)
- Direct participants to create a brief role play (under one minute) that demonstrates the behavior.
- Advise participants not to let other groups know their type of mental injury or hear their discussion, as the class must eventually guess which type they are demonstrating.
- Provide 5 minutes for each group to produce a brief role-play.
- Ask groups to volunteer who goes first.
- After each role-play, ask what type of mental injury was demonstrated. Ask them to identify what specifically they said or did that reflected
certain aspects of that particular type of mental injury.

- Refer participants to Participant Guide if they are not sure or disagree.
- Be prepared to provide corrective feedback if they miss the mark.

**Trainer Note:** Encourage class to provide a big round of applause after each group has finished. If groups have more than one role-play, allow another group to go first.

The identity of the last role-play will be evident as there will be no other types left. You may leave out one type when you are assigning (medical and educational are usually the best to leave out as it is easier to identify).

<table>
<thead>
<tr>
<th>Spurning (Hostile Rejecting/Degrading)</th>
<th>Terrorizing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploiting/Corrupting</td>
<td>Mental Health, Medical and Educational Neglect</td>
</tr>
<tr>
<td>Isolating</td>
<td>Denying Emotional Responsiveness (Ignoring)</td>
</tr>
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**PG: 136-138**

Types of Mental Injury

After the description of each type of mental injury, a brief scenario provides examples of each.

**Spurning (Hostile Rejecting/Degrading)**
- Includes verbal and non-verbal caregiver acts that reject and degrade a child.
- Belittling, degrading and other nonphysical forms of overtly hostile or rejecting treatment.
- Shaming and/or ridiculing the child for showing normal emotions such as affection, grief, or sorrow.
- Consistently singling out one child to criticize and punish.
  - ex: to perform most of the household chores, or to receive fewer rewards
- Humiliating in public.

Scenario 1: Nathan is not allowed to eat with his family, even though his two older siblings are allowed to do so. On Fridays Nathan gets to eat out of a dog bowl on the
floor to celebrate the weekend. Nathan is also not allowed to watch tv with the other kids because, he is told by his parents, his presence disturbs them. He is also not allowed to have a bet of his own – he is forced to sleep on the wood floor outside the hallway, while his siblings sleep comfortably in their beds.

**Terrorizing**
Includes caregiver behaviors that threaten or are likely to physically hurt, kill, abandon, or place the child or child’s loved ones/objects in recognizable dangerous situations.

- Placing a child in:
  - unpredictable or chaotic circumstances
  - recognizable dangerous situations
- Setting rigid or unrealistic expectations with threat of loss, harm, or danger if they are not met.
- Threatening or perpetrating violence against:
  - the child
  - a child’s loved ones or objects

Scenario 1: Joey’s dad makes Joey go to the backyard and him sit on a chair in the hot sun because he left some toys on the floor. He makes their trained pit bulls sit there and guard Joey until he says they can back off.

Scenario 2: Emma’s parent will take her pet guinea pig Oink-Oink and does things like twist Oink-Oink’s ears, choke him, and burn his paws in front of Emma.

Scenario 3: Jamie’s dad thinks that five year-old Jamie needs to get tougher, and that his mom babies him. He tells Jamie he is tired that he is not swimming like he needs to swim, so he throws Jamie into the deep end and tells him to swim. Jamie – who has had two swimming lessons – is terrified that he is going to die and doesn’t believe his dad or mom will save him.

**Exploiting/Corrupting**
Includes caregiver acts that encourage the child to develop inappropriate behaviors (self-destructive, anti-social, criminal, deviant or other maladaptive behaviors).

- Modeling, permitting, or encouraging:
- Antisocial behavior
  (e.g., prostitution, performance in pornographic media, initiation of criminal activities, substance abuse, violence to or corruption of others)
- Developmentally inappropriate behavior
  (e.g., parentification, infantalization, living the parent’s unfulfilled dreams)
- Encouraging or coercing abandonment of developmentally appropriate autonomy through extreme over involvement, intrusiveness, and/or dominance (e.g., allowing little/no opportunity/support for child’s views, feelings, and wishes; micromanaging child’s life)
- Restricting or interfering with cognitive development

Scenario 1: Amanda’s mom takes her to Walmart ever Saturday night and teaching
her how to shoplift.

Scenario 2: Henry’s dad makes Henry do sexual things for his friends when they come over to watch wrestling on TV.

Scenario 3: Bennie’s mom takes Bennie to the street corner of their low income neighborhood and teaches him how to deal drugs in the neighborhood.

**Isolating**
Includes caregiver acts that consistently deny child opportunities to meet needs for interacting/communicating with peers or adults inside/outside home.
- Confining the child or placing unreasonable limitations on the child’s freedom of movement within his/her environment
- Placing unreasonable limitations or restrictions on social interactions with peers or adults in the community

Scenario 1: Isolating must be strongly intentional, where the child is locked in the bathroom overnight, or is put in the closet to remain overnight, or is chained to a piece of furniture, or is put in a dog cage and left there.

**Denying Emotional Responsiveness (Ignoring)**
Includes caregiver acts that ignore the child’s attempts and needs to interact (failing to express affection, caring, and love for the child) and showing no emotion in interactions with the child.
- Detached and uninvolved through either incapacity or lack of motivation
- Interacting only when absolutely necessary
- Failing to express affection, caring, and love for the child

Scenario 1: In this case, the parent does not respond to the child when the child talks to the parent. The parent might look beyond the child, or doesn’t talk to the child at dinner time. Perhaps the parent talks with everyone in the house except the child. In essence, the child is considered a non-person and treated as such.

**Mental Health, Medical and Educational Neglect**
Include unwarranted caregiver acts that ignore, refuse to allow, or fail to provide the necessary treatment for the mental health, medical, and educational problems or needs of the child.
- Ignoring the need for, failing or refusing to allow or provide treatment for serious:
  - emotional/ behavioral problems or needs of the child
  - physical health problems or needs of the child
  - educational problems or needs of the child

Scenario 1: The child has one or more serious mental health symptoms, such as major Attention Deficit or Head Banging, and the parent refuses to treat child. Instead, the parent might lock the child in the closet, might refuse medication for the child, or might just keep the child home and not allow an education at all.
## Mental Injury:
### Examples of Caretaker Behavior by Age of Child

The chart below portrays the different types of mental injury behaviors you would likely see the parent/caregiver inflict on the child at various ages. Portrayed here are the behaviors towards:
- Infants
- School age children
- Adolescents

<table>
<thead>
<tr>
<th></th>
<th>Rejecting</th>
<th>Terrorizing</th>
<th>Ignoring</th>
<th>Isolating</th>
<th>Corrupting</th>
</tr>
</thead>
<tbody>
<tr>
<td>INFANTS</td>
<td>Refuses to accept child’s primary attachment</td>
<td>Consistently violates child’s ability to handle new situations and uncertainty</td>
<td>Fails to respond to infant’s social behaviors which form the basis for attachment</td>
<td>Denies the child social interactions with others</td>
<td>Reinforces bizarre habits or creates addictions</td>
</tr>
<tr>
<td></td>
<td>Refuses to return smiles, punishes child for vocalizations, abandons baby</td>
<td>Teasing/scaring infants by throwing them up in the air, reacting in unpredictable ways to infant’s cries</td>
<td>Mechanical caregiving without affection, fails to make eye contact with infant</td>
<td>Refuses to allow relatives and family friends to visit the infant, leaves the infant unsupervised for long periods of time</td>
<td>Creates drug dependencies, reinforces sexual behaviors</td>
</tr>
<tr>
<td>SCHOOL AGE CHILD</td>
<td>Consistently communicates to child that they are inferior/bad</td>
<td>Places child in “double binds” or places inconsistent or frightening demands on child</td>
<td>Fails to protect the child from threats while aware of the child’s need for help</td>
<td>Attempts to remove the child from social relationships with peers</td>
<td>Rewards child for anti-social or illegal acts, exposes child to poor role models</td>
</tr>
<tr>
<td></td>
<td>Uses labels such as “bad child”, “dummy”, always tells children they are responsible for family problems</td>
<td>Sets up unrealistic expectations and criticizes the child for not meeting them, forces children to choose between parents, teases the child, plays cruel games</td>
<td>Behaviors: Fails to protect the child from assault by other family members, shows no interest in child’s education or life outside the home</td>
<td>Behaviors: Refuses to allow other children to visit the home, keeps the child from engaging in after school activities</td>
<td>Behaviors: Exposes the child to pornography, rewards the child for stealing</td>
</tr>
<tr>
<td>ADOLESCENTS</td>
<td>Rejecting</td>
<td>Terrorizing</td>
<td>Ignoring</td>
<td>Isolating</td>
<td>Corrupting</td>
</tr>
<tr>
<td>-------------</td>
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<td>------------</td>
</tr>
<tr>
<td></td>
<td>Refuses to acknowledge the changes in child as they grow up, attacks child's self-esteem</td>
<td>Threatens to or actually subjects child to public humiliation</td>
<td>Gives up parenting role and shows no interest in the child</td>
<td>Over-controlling the child’s social interactions, restricting the child’s freedom to an extreme degree</td>
<td>Involves child in illegal or immoral behavior, encourages child to be part of this lifestyle at the expense of the child</td>
</tr>
<tr>
<td>Behaviors</td>
<td>Treats an adolescent like a young child, excessive criticism, verbal humiliation</td>
<td>Threatens to reveal embarrassing facts to the child’s friends, forces the child into degrading punishments</td>
<td>Says “this child is hopeless, I give up” &amp; means it, refuses to listen to child’s discussion of their lives &amp; activities, focuses on other relationships at the exclusion of children</td>
<td>Punishes child for engaging in normal social activities (dating), accuses child of lying/doing drugs, etc., whenever they leave home, refuses to allow engagement in social activities</td>
<td>Involves child in prostitution, encourages child to hit or verbally abuse siblings, encourages drug use</td>
</tr>
</tbody>
</table>

**Activity STOP**

Refer class to the Maltreatment Index to show that mental injury IS considered abuse.

*Display Slide 6.5.9 (PG: 142)*

The law requires you to establish a direct cause and effect relationship between parental behavior and harm to the child. This is because courts make rulings based on expert testimony about the child’s mental and emotional well-being.
Harm to the child must be demonstrated in the form of significant impairment in the child’s functioning. To determine significant impairment, a professional evaluation must be obtained.

The suffering the child experiences causes, or will cause, continuing difficulties in the child’s ability to think, reason and relate to others. A child who has experienced mental injury will have sufficient indicators and substantial, observable symptoms.

In addition, there must be identifiable parental behavior that could cause harm. This parental behavior must be established through substantial, observable action or lack of action on the part of the caregiver.

It is important to underscore that you must show a direct cause and effect link between the parent’s behavior that is mental injury and harm to the child.
What are some difficulties in establishing a case involving mental injury?

The law requires a direct cause-and-effect relationship between the parental behavior and the harm to the child.

Do you think statistics reporting substantiated cases of mental injury might be underrated in terms of percentages of occurrence? Why or why not?

Many cannot be substantiated due to the difficulty in proving the causal link.

Why does mental injury have a life-long damaging impact?

Accept all answers.

Display Slide 6.5.10 (PG: 143)

Refer participants to PG:143 and ask them to read/review the indicators.

We will be using these indicators in the next activity.
Activity: Margaret

Display slide 6.5.11 (PG: 144-145)

Purpose: Participants will discover the indicators of mental injury using a case scenario.

Materials:
- PG: 182, Indicators of Mental Injury
- PG: 183, Margaret Scenario
- Maltreatment Index

Trainer Instructions:
- Direct participants to read the scenario on PG: 183, Margaret.
- After reading, ask participants to answer and discuss the three questions that follow the scenario with their table groups, using PG: 182: Indicators of Mental Injury, the Maltreatment Index and anything else they have learned to answer these questions.
- Allow 7-8 minutes for discussion.
- When complete, reveal each question on the PowerPoint slide and discuss with the entire class, asking each table group to provide one answer.
Indicators of Mental Injury

<table>
<thead>
<tr>
<th>General Behavioral Indicators</th>
<th>General Physical Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Habit disorders such as poor eye contact, sucking, biting, rocking, enuresis, or eating and other food-related disorders</td>
<td>• Hair missing because of pulling</td>
</tr>
<tr>
<td>• Conduct disorders, including withdrawal and anti-social behavior</td>
<td>• Nails bitten</td>
</tr>
<tr>
<td>• Neurotic traits such as sleeping disorders, inhibition of play, compulsiveness, hysteria, obsession, phobias, and hypochondria</td>
<td>• Body posture/facial expressions are withdrawn</td>
</tr>
<tr>
<td>• Suspicious, untrusting, pessimistic, depressed, anxious, preoccupied behavior</td>
<td>• Hives</td>
</tr>
<tr>
<td>• Inappropriate adult behavior or inappropriate infantile behavior</td>
<td>• Nervous tics</td>
</tr>
<tr>
<td>• Developmental lags in mental and emotional growth</td>
<td>• Overweight</td>
</tr>
<tr>
<td>• Suicide attempts</td>
<td>• Depression - low self-worth, low self-esteem</td>
</tr>
<tr>
<td>• Poor self-image</td>
<td>• Thoughts and/or acts of suicide</td>
</tr>
<tr>
<td>• Running away</td>
<td>• Rebelliousness</td>
</tr>
<tr>
<td>• Adaptive behavior in an attempt to respond to family’s inconsistent interactions or expectations</td>
<td>• Self-inflicted injuries</td>
</tr>
<tr>
<td>• Nervous tic, persistent stuttering, or speech disorder</td>
<td></td>
</tr>
<tr>
<td>• Subservient role in the home</td>
<td></td>
</tr>
<tr>
<td>• Developmental lag in decision-making</td>
<td></td>
</tr>
<tr>
<td>• Hesitant to participate in discussions</td>
<td></td>
</tr>
<tr>
<td>• Overriding worry about pleasing authority figure</td>
<td></td>
</tr>
<tr>
<td>• Anger/hostility when not feeling in control</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Caregiver Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Have a need to always be in charge; can never let go, always critical</td>
</tr>
<tr>
<td>• Practice the abuse daily, ongoing and continuous</td>
</tr>
<tr>
<td>• Have distant, shallow, or superficial relationship with family members</td>
</tr>
<tr>
<td>• Deny themselves fulfillment of emotional needs</td>
</tr>
<tr>
<td>• Are usually isolated from society</td>
</tr>
<tr>
<td>• Totally reject the child</td>
</tr>
<tr>
<td>• Make any positive interaction between the child and themselves inconsistent and unpredictable</td>
</tr>
<tr>
<td>• Program the child for failure</td>
</tr>
<tr>
<td>• Impose unrealistic expectations on the child</td>
</tr>
<tr>
<td>• Refuse to make allowances for the child’s individuality</td>
</tr>
</tbody>
</table>

Margaret

Margaret was reported by a family friend to be a victim of mental injury, because the friend felt Margaret is being “abused.”

The friend reported that Margaret, who is 11 years old, is treated differently from her three siblings. She is not allowed to eat with the family, nor is she included in family social outings. She is also not permitted to participate in any social activities outside the home.
You interview Margaret, and the descriptions of her treatment agreed with the allegations.

Margaret said she deserved this treatment because, “I’m a trouble-maker. I can’t control myself. They have to watch me all the time, or I’ll go crazy and hurt someone.”

Margaret’s teacher said Margaret is a good student but has few friends. The teacher also said Margaret is sensitive and cries when she makes mistakes.

You conduct a family interview. Margaret’s parents describe Margaret as “a problem child, one of those kids you have to watch all the time.” Neither parent spoke to Margaret or made eye contact with her throughout the interview. Even Margaret’s youngest sibling, a five-year-old girl, described Margaret as “bad”.

Margaret - Answer Key
Below are the three questions participants should consider and respond to, along with information for the trainer to use in the debrief.

1. What was observed that might indicate mental injury?
   List child and caregiver behaviors.
   • Margaret’s lack of social interactions and crying, as noted by the teacher, indicate emotional trauma.
   • Margaret’s suffering could be directly linked to her parents’ treatment because of her statements. She said she deserves the treatment.
   • Her self-esteem is obviously diminished by her parents’ treatment.
   • The family friend has witnessed the treatment.
   • The family interview verified that Margaret’s family perceives her as bad and different.
   • Poor or non-existent interactions with Margaret.

2. Is there a direct link between the caregiver’s actions or lack of actions and the child’s suffering?
   There appears to be a direct link between Margaret’s self-image and her parent’s behavior (lack of eye contact, silence toward Margaret, repeated phrases made by Margaret).

3. What else would you do to support the observations?
   Refer class to the Child Maltreatment Index for recommendations.

   Note that there was no expert witness (CPT), psychiatrist, or psychologist in this case.
   • Refer the family to CPT or a professional practitioner for a thorough assessment.
Document the child’s statements to establish emotional suffering and to demonstrate a connection between family functioning and emotional suffering.

Document all behavioral indicators obtained from both direct observation and collateral contacts (siblings, grandparents, school and daycare personnel, neighbors) of the child, parents, parent/child interaction, environment (consider societal and cultural context, and family dynamics).

Activity STOP

Display Slide 6.5.12

As we stated earlier, for many of your parents and caregivers, the way they talk to their children is very often a learned behavior. It is just the way they were brought up and they don’t know any other way.

The key to helping families change abusive behaviors is to first help them understand the negative impact of their behavior on their child. Often, the positive things that parents want for their children is contradicted by the parent’s actions. When a child welfare professional is able to help a parent begin to articulate and to see that discrepancy, they are helping the parent become motivated to change. This is a form of interviewing known as “motivational interviewing.” Motivational interviewing was first developed and used in the field of substance abuse treatment. The maltreatment of substance abuse is our next topic.
Unit 6.6: The Dynamics of Substance Abuse

Display Slide 6.6.1

Time:

Unit Overview: The purpose of this unit is to educate participants about substance abuse issues and their effect on the family. This unit provides information about the continuum of use, abuse and dependency, and explores signs and symptoms. Learning opportunities are provided that are designed to support child protection professionals in working with families from various cultural groups affected by alcohol and/or drug-related problems. Participants will also be provided opportunities to evaluate these elements through a scenario-based activity, and explain the family dynamics and culture issues they observe. We will also explore substance abuse as a maltreatment.

Display Slide 6.6.2

Learning Objectives:
1. Define substance abuse and the terms related to it.
2. Explain the elements of a disease and that substance abuse is a disease.
3. Recognize substance abuse symptoms or indicators.
4. Given scenarios, 1) determine if there is an indication of substance
abuse and 2) provide justification for their determination.
5. Explain the impact of substance abuse on the family.
6. Recognize the family roles in substance-abusing families.
7. Describe the substance abuse evaluation and treatment services considerations and how they impact the child’s home and family circumstances.
8. Identify key elements of the Substance Misuse maltreatment.
9. Recognize the relationship between substance misuse and child abuse.
10. Identify when substance misuse results in neglect of a child.
11. Discuss the types of evidence that can be acquired in the case of substance misuse.
12. Explain the short- and longer-term impacts of substance abuse on the child.
13. Using the Maltreatment Index, evaluate the indicators and effects of substance misuse on child.

The information you will hear today can help you help families succeed in treatment. The bottom-line goal is safe care of children.

**Trainer Note:** For this unit, we will be using the facts of an actual case to apply the knowledge and skills we learn in this module to that family.

**Trainer Instructions:**
- **Assess who the experts are in the room by asking who has a background in or good knowledge of substance abuse.** Encourage narrative responses of their experience.
- **Invite participants to share their expertise during the training.** Remember who they are and ask for their input throughout the training.
- **Advise participants that you are not a “substance abuse” expert and neither should they expect themselves to be.**

As we have learned, we are a part of a team. Our job is to assess, recognize and understand the indicators, and then to refer to the experts for evaluation and treatment. We then will team with the experts to help the parent change and provide a safe home for their children.

We will begin by looking at some statistics that will point out the prevalence of substance dependence and abuse by parents.
Trainer Note:
- You will need to conduct research prior to the training to be able to deliver relevant national, state and local statistics in this area.

The following are good websites to use for the national data:
- [www.samhsa.gov](http://www.samhsa.gov) (The Substance Abuse and Mental Health Services Administration)
- [www.drugabuse.gov](http://www.drugabuse.gov) (National Institute on Drug Abuse)
- FSFN (Florida Safe Families Network)

What do you think is the most largely abused substance
Nationally? Statewide? In our local area?

Trainer Instructions:
- Accept a few answers.
- Reference the results of your research. You may insert some slides to have a visual reference or report them verbally.

With these numbers in mind, what is the standard for when a child should be removed in the context of parental addiction?

Allow discussion on this topic. There will likely be varying opinions.

All of us in this room may have different opinions about what those standards should be. In this unit, we will explore further the effects of substance abuse on the person, the child and the family, and learn to assess and analyze the information you collect to determine if a child is safe or unsafe in the home of a substance-abusing parent.
This topic will cover the basics of addiction, the common drugs people use, how they become addicted and the effects drug use has on their bodies. We will begin by discussing why people use drugs.

**Why do people use drugs? What reasons do people give when asked about why they started?**

**Activity: Alcohol and Drug Abuse**

**Trainer Instructions:**
- Write responses on flipchart or whiteboard. Provide encouragement to offer all ideas and thoughts. When participants have finished, tie these ideas to what participants already have said.
- Distribute a case example related to a substance-abusing parent. Allow the class to read it.
Let’s discuss the circumstances around the parent beginning to abuse substances. What are some of the underlying dynamics that led to experimentation and patterns of behavior?

Record the answers.

Some of the reasons that people use drugs are:

- To feel good. Most abused drugs produce intense feelings of pleasure. This initial sensation of euphoria is followed by other effects, which differ with the type of drug used. For example, with stimulants such as cocaine, the “high” is followed by feelings of power, self-confidence and increased energy. In contrast, the euphoria caused by opiates such as heroin is followed by feelings of relaxation and satisfaction.

- To feel better. Some people who suffer from social anxiety, stress-related disorders, and depression begin abusing drugs in an attempt to lessen feelings of distress. Stress can play a major role in beginning drug use, continuing drug abuse, or relapse in patients recovering from addiction.

- To do better. Some people feel pressure to chemically enhance or improve their cognitive or athletic performance, which can play a role in initial experimentation and continued abuse of drugs such as prescription stimulants or anabolic/androgenic steroids.

- Curiosity and "because others are doing it." In this respect, adolescents are particularly vulnerable because of the strong influence of peer pressure. Teens are more likely than adults to engage in risky or daring behaviors to impress their friends and express their independence from parental and social rules.

Research over the past two decades has tried to determine how drug abuse begins and how it progresses. Many factors can add to a person’s risk for drug abuse. Risk factors can increase a person’s chances for drug abuse, while protective factors can reduce the risk.


### Activity: Risks and Protective Factors

**Trainer Instructions:**

*Have participants briefly (no more than 5 minutes) brainstorm in groups some risk factors and protective factors. Then, have them report out while you record them.*

*After the groups report out, refer them to PG: 147, Risk and Protective Factors. Compare their answers to the handout, and during the group discussion, reiterate how some of the risk and protective factors would be information you would determine and analyze in the Adult Functioning and Child Functioning domains which will be discussed further in Module 7.*

#### Display Slide 6.6.5

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Domain</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Aggressive Behavior</td>
<td>Individual</td>
<td>Self-Control</td>
</tr>
<tr>
<td>Lack of Parental Supervision</td>
<td>Family</td>
<td>Parental Monitoring</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Peer</td>
<td>Academic Competence</td>
</tr>
<tr>
<td>Drug Availability</td>
<td>School</td>
<td>Anti-drug Use Policies</td>
</tr>
<tr>
<td>Poverty</td>
<td>Community</td>
<td>Strong Neighborhood Attachment</td>
</tr>
</tbody>
</table>


It is important that you understand risk factors and protective factors, because people who enter substance abuse treatment often first use drugs or alcohol in middle to late adolescence - the age of many of the children you will serve. Many behavioral, social,
and environmental factors affect whether and how a person develops a substance use disorder.

There are also biological risk and protective factors for substance use disorders. For example, people have differences in brain, sensory, and cognitive functioning. For instance, if a person has a heightened physiological reaction to a substance (i.e. the combination of brain, sensory and cognitive reactions), that person may be more vulnerable to substance use problems, while another person's diminished physiological reaction may make him less vulnerable.

Every person has unique combinations of risk and protective factors, which form a complex interplay that will affect the probability that that person will use or abuse substances.

Children are exposed to both risk and protective factors that can either increase or decrease the likelihood of them developing substance use problems themselves. Child, parenting, and family factors can influence the likelihood of a substance use problem later in life, including protecting against its occurrence.

**Activity STOP**

*Display Slide 6.6.6 (PG: 148)*

*Deliver scripted presentation describing the spectrum of addiction using the next seven PowerPoint slides.*
There are different theories about how substance use disorders develop. One thing seems clear—that people progress from substance use to abuse and addiction in different ways.

But in all cases, alcohol and other drug use exist on a continuum that starts with substance use, and moves to abuse, and then dependence. The differences between the categories are based on how many and what type of negative consequences are associated with the substance use.

The process starts with experimental use. At this point, the person experiences the positive effects of the substance—effects like euphoria.

As the person continues to use, he or she may begin to experience some of the negative physical or psychological consequences. These could include things like a DUI charge or waking up on New Year’s Day realizing that they don't remember what happened while they were drinking the night before.

Despite these negative consequences, some people will continue to use, trying to capture that initial euphoria and run a risk of becoming dependent. Using more of the substance to get the same effect and in some cases using the substance more often, they will experience many more of the negative physical, psychological and social effects with fewer and less intense positive effects.

So, why do people continue to use substances even when the negative effects outweigh any positive effects?

Two reasons: physical dependence on the substance and the changes in their brain chemistry (which we will discuss soon).
Addiction is a disease with its own psychopathology characterized by compulsion, loss of control, and continued use in spite of adverse consequences.

Addiction is progressive, potentially fatal if untreated and incurable but remissible through abstinence and recovery.

**Trainer Note:** Some may disagree with this definition and feel that people have a choice to use or not use drugs. This can become a heated debate.

The next slide will point out that everyone has a viewpoint with regard to addiction that is based on his/her own experiences.

This is a good time to allow the class to briefly discuss this concept with each other. Ask them to discuss their viewpoints on substance misuse, and allow and encourage them to discuss among themselves as you mediate.

All of us bring our personal perspectives to our work, many including views and experiences regarding addiction from our families of origin. Know how your viewpoint affects your view of parents.
Each person’s experience with substance use is unique; what worked for you or your family may be different from what will work for a family you encounter as a child welfare professional.

Discuss your issues with your supervisor to ensure that your own life experiences do not interfere with your ability to work objectively with your families.

**Trainer Note:** Tell a story based on your own experience, about how your views/experiences about substance abuse affected how you worked with someone OR use a story based on someone else’s experience OR ask the participants if anyone can relate to how this may apply to their job.

For example: If a person had an addiction of any kind in the past and has recovered or overcome that addiction, they may believe that if they can do it, anyone can do it; they may not see it as a disease or fatal. OR, they may believe that it is useless to try to help people who are addicts, because they don’t want help.

Remind participants to keep their own viewpoints in mind as they continue this training.

After a brief discussion, continue on to describe the characteristics of a disease.

A nonuser or casual alcohol/drug user may have difficulty understanding why addicts just don't stop. Use and abuse of psychoactive (mood-altering) drugs seem to be voluntary; addiction seems to be characterized by involuntary, compulsive use. In most cases, addicts just don't stop because they are addicted; they cannot stop on their own.

A person may start out taking drugs voluntarily. But as time passes, and drug use continues, something happens that makes a person go from being a voluntary drug user to a compulsive drug user. Why? Because the continued use of addicted drugs changes your brain - at times in dramatic, toxic ways, at others in more subtle ways, but often in ways that result in compulsive and even uncontrollable drug use.
Let’s briefly look at the criteria for substance abuse dependence.

Addiction (termed “substance dependence” by the American Psychiatric Association) is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring any time in the same 12-month period:

- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of the substance to achieve intoxication or the desired effect, or
  - Markedly diminished effect with continued use of the same amount of the substance.

- Withdrawal, as manifested by either of the following:
  - The characteristic withdrawal syndrome for the substance, or
  - The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.

- The substance is often taken in larger amounts or over a longer period than intended.
- There is a persistent desire or unsuccessful efforts to cut down or control substance use.
- A great deal of time is spent in activities necessary to obtain the substance (such as visiting multiple doctors or driving.
long distances), use the substance (for example, chain-smoking), or recover from its effects.

- Important social, occupational or recreational activities are given up or reduced because of substance use.
- The substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance (for example, current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).


When a person is addicted, he/she engages in compulsive behavior, even when faced with negative consequences. The person’s loss of control in limiting the use of the addictive substance is a major hallmark of addiction.

Trainer Note: Ask if there are any brief questions that can be answered before moving on to the next discussion. Keep answers brief and only answer questions for which you know the answer. Put any questions that need further research in the Parking Lot. To learn more about addiction and dependence, review the National Institute on Drug Abuse (NIDA) website. (www.drugabuse.gov).

Activity: Danger of Being At Risk

Trainer Instructions:

- Refer participants to PG: 150, Implications for Child Welfare.
- Assign to groups or use tables as groups.
- Advise participants that they will be working in small groups to fill in the 2nd column “Implications for Child Welfare” and “Examples of Risk to Children.”
  - As an example, do the first topic (Substance Use) together.
### Alcohol and Drug Use Continuum

<table>
<thead>
<tr>
<th>Implications for Child Welfare and Examples of Risks to Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Substance use</strong>—the use of alcohol or other drugs to socialize and feel their effects.</td>
</tr>
<tr>
<td>Use may not appear abusive and may not lead to dependence; however, the circumstances under which a parent uses can put children at risk of harm.</td>
</tr>
</tbody>
</table>

| **Substance abuse**—includes at least one of these factors in the last 12 months: |
| Effects have seriously interfered with health, work, or social functioning |
| Person has engaged in hazardous activity on a recurring basis, such as driving or operating machinery under the influence |
| Person has experienced use-related legal problems |
| Person has continued use despite ongoing or recurring problems caused or exacerbated by use—this includes a maladaptive pattern of use, such as binge drinking |

| **Addiction (or substance dependence)**—a pattern of use that results in three or more of the following symptoms in a 12-month period: |
| Tolerance—needing more of the drug or alcohol to get —high |
| Withdrawal—physical symptoms when alcohol or drugs are not used, such as tremors, nausea, sweating, and shakiness |
| Unable to control use—a strong craving or compulsion to use and an inability to limit use |
| The alcohol or drug increasingly becomes the focus of the person’s life at the expense of all other areas, including family, work, social, and recreational |
| Continued use despite ongoing or recurring physical or psychological problems caused or exacerbated by the alcohol and drug use |

**Sources:** American Psychiatric Association, 2000; SAMHSA, 2005.
<table>
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<td><strong>Substance use</strong>—the use of alcohol or other drugs to socialize and feel their effects.</td>
<td>Use may not appear abusive and may not lead to dependence; however, the circumstances under which a parent uses can put children at risk of harm.</td>
</tr>
<tr>
<td>Use during pregnancy can harm the fetus.</td>
<td></td>
</tr>
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<td><strong>Substance abuse</strong>—includes at least one of these factors in the last 12 months:</td>
<td></td>
</tr>
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<td>Effects have seriously interfered with health, work, or social functioning. Person has engaged in hazardous activity on a recurring basis, such as driving or operating machinery under the influence. Person has experienced use-related legal problems. Person has continued use despite ongoing or recurring problems caused or exacerbated by use—this includes a maladaptive pattern of use, such as binge drinking.</td>
<td></td>
</tr>
<tr>
<td>Children may be left in unsafe care—with an inappropriate caretaker or unattended—while parent is using alcohol or other drugs. A parent may neglect or sporadically address the children’s needs for regular meals, clothing, and cleanliness. Even when the parent is in the home, the parent’s use may leave children unsupervised. Behavior toward children may be inconsistent, such as a pattern of screaming insults then expressing remorse.</td>
<td></td>
</tr>
<tr>
<td><strong>Addiction (or substance dependence)</strong>—a pattern of use that results in three or more of the following symptoms in a 12-month period:</td>
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<td></td>
</tr>
<tr>
<td>Despite a clear danger to children, the parent may engage in addiction-related behaviors, such as leaving children unattended while seeking drugs. Funds are used to buy alcohol or drugs, while necessities, such as buying food, are neglected. A parent may not be able to think logically or make rational decisions regarding children’s needs or care.</td>
<td></td>
</tr>
</tbody>
</table>

**Sources:** American Psychiatric Association, 2000; SAMHSA, 2005.
How might a parent simply using a substance put a child at risk? What are some examples of how a child might be put in danger by the parent or caregiver using substances?

Suggested Answers:
- Driving with children in the car while under the influence
- Use during pregnancy can harm the fetus

*Keep the focus on the definition of use; the use of alcohol or other drugs to socialize and feel their effects.*

After receiving the answer, move on to the activity.

- Direct participants to read the information in the first column of *Substance Abuse and Addiction,* and write down ideas and provide examples of risks to children in the right-hand column.
- After 10 minutes or when groups are complete, refer to *PG: ARM 5C*
- Ask each group to review the job aid and compare their answers.
- Ask each group to choose a spokesperson and present to the large group their findings, fleshing out the material presented in Job Aid.
- Debrief by asking for any questions, thoughts or “aha” moments. Assess whether participants have a good understanding of the difference between use, abuse and dependence.

**Activity STOP**

We will now talk about the “Physical and Psychological Effects of Substance Abuse.”

**Trainer Instructions:**

For the content of both slides, refer to *PG: 151-155, Physical and Psychological Effects of Substance Use.* (TG: 156)
Display Slide 6.6.10

Display Slide 6.6.11

**Trainer Note:** Depending on the level of experience participants have with substance use disorders, you can spend as little or as much time needed to cover the physical and psychological effects of substance use and the related short-term and long-term consequences. The intent is to give a general overview. This is not intended to be a comprehensive review of the effects and consequences of every substance.

**Activity: Physical and Psychological Effects of Substance Abuse**

**Purpose:** Participants will become familiar with types of drugs and their effects on people by creating questions about each drug.

**Materials:**
- Index cards or small size loose paper.

**Trainer Instructions:**
- Refer to **PG 151-155: Physical and Psychological Effects of Substance Use**
- Assign one or two substance types to table groups, and ask each group to create four questions from the handout. The questions can be multiple choice, fill in the blank or True/False, or any combination.
• Ask the group to write questions on an index card and give it to you, the trainer.
• Read the question cards to the group, and the participants will look up the answers and compare each answer with their table group.
• Choose a volunteer to answer the question aloud.
• Direct participants to PG: 156, *Substance Abuse and Child Maltreatment*, and ask them to read the *Effects of Substance Abuse and Maltreatment* and note if there are any that haven’t been mentioned so far.
• Briefly discuss and point out that we will be talking about many of these in the next section.

**Substance Abuse and Child Maltreatment**

**Substance abuse may serve as a dis-inhibitor for the parent**
- Leads to hitting the child (physical abuse)
- Leads to emotional abuse (vilifying, scape-goating)
- Leads to having fun and not supervising (neglect)
- Leads to children getting caught in the crossfire when parents are engaged in inappropriate behaviors (endangerment-threatened harm)
- Being drunk may serve as a rationalization for sexual abuse of a child

**Substance abuse can lead to illegal activity to support parental addiction**
- Prostitution of parent (absent caretaker)
- Prostitution of child (sexual Abuse)
- Stealing, passing bad checks, etc. (corruption, mental injury)
- Buying and selling drugs (mental injury, threatened harm)
- Parent involves child in criminal activity (corruption, endangerment, mental injury)

**Substance Abuse can drain family resources**
- No money for food clothing (physical) neglect
- Failure to seek medical care (medical neglect)
- Homelessness (failure to provide shelter)
- Pawns household items, etc. (failure to provide basic needs)

**Substance abuse may impair child caring behaviors**
- Parent doesn’t cook and/or feed.
- Parent doesn’t send child to school
- Parent doesn’t physically care for child
- Parent doesn’t provide adequate supervision
- Parent uses inappropriate caretakers, who may endanger or abuse the child.
We will now discuss prescription drug abuse; it is the most rapidly escalating form of substance abuse.

Display Slide 6.6.12 (PG: 156)

Review definition on the slide.


Ask participants to review PG: 157, Prescription Drug Abuse Fact Sheet, and then discuss in large group.

Prescription Drug Abuse Fact Sheet

Source: U.S. Drug Enforcement Administration (2009)

In 2009, nearly 7 million Americans abused prescription drugs—more than the number who are abusing cocaine, heroin, hallucinogens, Ecstasy and inhalants combined.

Prescription pain relievers are new drug users’ drug of choice versus marijuana or cocaine.
Opioid painkillers now cause more drug overdose deaths than cocaine and heroin combined.

Nearly 1 in 10 high school seniors admits to abusing powerful prescription painkillers.

Forty percent of teens and an almost equal number of their parents think abusing prescription painkillers is safer than abusing "street" drugs.

Hydrocodone is the most commonly abused controlled pharmaceutical in the U.S.

Twenty-five percent of drug-related emergency department visits are associated with abuse of prescription drugs.

Methods of acquiring prescription drugs for abuse include “doctor-shopping,” traditional drug-dealing, theft from pharmacies or homes, illicitly acquiring prescription drugs via the Internet, and from friends or relatives.

Doctor involvement in illegal drug activity is rare—less than one-tenth of 1 percent of more than 750,000 doctors are the subject of DEA investigations each year—but egregious drug violations by practitioners, unfortunately, do sometimes occur. DEA pursues criminal action against such practitioners.

DEA Internet drug trafficking initiatives over the past 3 years have identified and dismantled organizations based both in the U.S. and overseas, and arrested dozens of conspirators.

Because of major investigations, tens of millions of dosage units of prescription drugs and tens of millions of dollars in assets have been seized.

After the discussion, use a case example involving prescription substances. Allow the class to review the case example and then begin the critical thinking activity.

**Did the parents’ addiction to prescription drugs affect their child?**

**In what ways?**

Endorse: Have each participant discuss with their table briefly after reading the case example, then report out to the larger group. Emphasize the importance of information collection and then analysis of that information. Be sure to discuss how this information relates to the Information Collection domains.
Activity: “The OxyContin Express”

Instructions:
- Watch the video “The OxyContin Express” in class. This video is about 45 minutes long.
- Facilitate a group discussion about the video. Include the following topics:
  - How did Todd and Stephanie’s addictions impact their ability to parent their child?
  - What about the women in jail in Kentucky?
  - How has the substance abuse affected these parents’ ability to make sound judgments regarding the welfare of their children?
  - Refer to previous case example and the examples in the video for the next slides.

Activity STOP

Display Slide 6.6.14 (PG: 157)

Children need parents and caregivers to perform basic functions to support their physical, social, emotional, intellectual and spiritual development.

When a parent has a substance use disorder, it can reduce the parent’s ability to perform many parenting functions and fully meet the children's needs. Frequently, life becomes topsy-turvy and chaotic for the children.
Activity: Physical, Psychological and Parenting Effects of Substance Use

Purpose: Participants will become familiar with the various ways each drug may affect a person’s parenting ability.


Materials: Flip chart and markers

Trainer Instructions:
- Refer to PG: 151-155, Physical, Psychological and Parenting Effects of Substance Use. This illustrates ways that use of specific substances may affect parenting.
- Assign each drug type to a table group.
- Direct participants to record on a flipchart the assigned drug’s effects on parenting, using the Job Aid.
- Ask each group to present their findings.

Trainer Note: If time is short, information on this handout can be generated through discussion rather than a presentation. For example, the trainer may ask the following questions:
- What are some ways that substances might affect a person’s behavior?
- What are some ways that substance might affect a person’s parenting?
As you can see, there are many ways that drugs and alcohol – legal or illegal, stimulants or depressants – can impact parenting. Keep in mind that this list is not exhaustive, and that substances can have a wide range of effects on parenting.
<table>
<thead>
<tr>
<th>SUBSTANCE</th>
<th>PHYSICAL/PsyCHOLOGICAL EFFECTS</th>
<th>PARENTING EFFECTS</th>
</tr>
</thead>
</table>
| Alcohol   | **Short-term effects of alcohol use include:**  
* Distorted vision, hearing and coordination  
* Impaired judgment  
* Altered perceptions and emotions  
* Bad breath; hangovers  

**Long-term effects of heavy alcohol use include:**  
* Loss of appetite, vitamin deficiencies, stomach ailments  
* Skin problems  
* Sexual impotence  
* Liver damage  
* Heart and central nervous system damage;  
* Memory loss  

• A parent may forget or neglect to attend to parenting responsibilities.  
• A parent may stay out all night and leave children alone due to intoxication.  
• A parent may have rages and depressive episodes, creating an unstable environment for children. |
| Cocaine   | **Physical risk associated with using any amount of cocaine and crack:**  
* Increases in blood pressure, heartrate, breathing rate, and body temperature  
* Heart attacks, strokes, and respiratory failure  
* Hepatitis or AIDS through shared needles  
* Brain seizures  
* Reduction of the body’s ability to resist and combat infection  

• A child's crying, which may be only a mild annoyance to a non-using parent, is magnified in its intensity to the parent on cocaine.  
• A parent may become angry or impatient with a child for any reason because of thought distortion and misperception of the child's intent.  
• A parent addicted to crack can leave an infant or toddler alone for hours or sometimes days at a time to pursue the drug. |
<table>
<thead>
<tr>
<th>Cokeine</th>
<th>Psychological risks:</th>
</tr>
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</table>
| Crack is a smokable form of cocaine that has been chemically altered. Crack cycles rapidly through the body so that a physical and psychological "high" vanishes quickly, within 5 to 15 minutes, leaving in its wake anxiety, depression, and paranoia, as well as an intense craving for a return to the euphoric state. Crack heightens feelings of power and control over one's life, feelings that may be sorely lacking in those belonging to oppressed social groups. | • violent, erratic or paranoid behavior  
• hallucinations and "cokebugs" - a sensation of imaginary insects crawling over the skin  
• confusion, anxiety and depression, loss of interest in food or sex  
• "cocaine psychosis" - losing touch with reality, interest in friends, family, sports, hobbies, and other activities. Some users spend hundreds or thousands of dollars on cocaine and crack each week and will do anything to support their Many turn to drug selling, prostitution and other crimes. Cocaine and crack use has been a contributing factor in a number of drowning's, car crashes, falls, burns and suicides. Cocaine and crack addicts often become unable to function sexually. Even first time users may experience seizures or heart attacks, which can be fatal. |
| Cocaine and crack are highly addictive. This addiction can affect physical and mental health and can become so strong that these drugs dominate all aspects of an addict's life. | • CPS workers frequently investigate maltreatment reports in homes barren of furniture and appliances that have been sold to purchase crack and other drugs. • The absence of food in the refrigerator or cupboards is evidence of parental inability to attend to a child's most basic needs. • Some parents will do whatever it takes to pursue their habit, even if it means sacrificing the health and well-being of loved ones. • Crack can contribute to a significant increase in sexual abuse of young children in two ways: 1. The heightened physical sensations induced by crack can lead users to seek out sexual encounters. A child who is available and unprotected by a functioning adult, as when children accompany parents to so-called crack houses, is an easy target for sexual abuse by an individual high on crack. 2. Very young children, even babies, can be prostituted by their crack-addicted parents desperate to obtain the drug. |

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Methamphetamine is a stimulant drug chemically related to amphetamine but with stronger effects on the central nervous system. Amphetamines are synthetic psychoactive drugs that stimulate or increase the action of the central nervous system.

Methamphetamine is produced in clandestine laboratories with relatively inexpensive ingredients such as caffeine, ephedrine and phenylpropanolamine—all legal substances that are usually found in over-the-counter diet pills and decongestants, making it a drug with a high potential for abuse.

<table>
<thead>
<tr>
<th>Core Child Welfare Pre-Service Curriculum</th>
<th>Module 6-TG</th>
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The effects of methamphetamine use include:
- euphoria
- increased heart rate and blood pressure
- increased wakefulness; insomnia
- increased physical activity
- decreased appetite; extreme anorexia
- respiratory problems
- restless, anxious and moody
- aggressive and hostile
- excited or talkative experience a false sense of self-confidence or superiority
- hypothermia, convulsions, and cardiovascular problems, which can lead to death
- irritability, confusion, tremors
- anxiety, paranoia, or violent behavior
- can cause irreversible damage to blood vessels in the brain, producing strokes
- for users who inject the drug, skin abscesses may occur

Long-term effects
- Users of large amounts of amphetamines over a long period of time can develop an amphetamine psychosis, a mental disorder similar to paranoid schizophrenia. Those with amphetamine psychosis exhibit bizarre, sometimes violent, behavior. Users may experience fatigue; long, disturbed periods of sleep; irritability; intense hunger, and moderate to severe depression.
- Long-term use of methamphetamine can cause users to exhibit violent behavior, confusion, and insomnia. They may also exhibit paranoia, auditory hallucinations, mood disturbances and delusions. The paranoia can result in homicidal and suicidal thoughts.

- Methamphetamine is an increasing problem among parents in the child welfare system.
- Parents may not supervise children or provide for their basic nutritional, hygienic, or medical needs.
- Violence, aggression, and paranoia may lead to serious consequences for children of meth abusers.
- Additional risks to children can be quite extreme if the drug is being "cooked" in their residence.
- These risks include fire and explosions as well as unintentional absorption of the drug from the home environment.
### Methamphetamine

It is a white, odorless crystal like powder that readily dissolves in water or alcohol. Amphetamines have the potential to produce tolerance, which means that increased amounts of the drug are needed to achieve the desired effects.

Methamphetamine users have been known to forego food and sleep and indulge in binging that is called a “run.” This occurs when the user continually takes the drug every 2 or 3 hours over several days until they either run out of the drug or are too disorganized to continue.

<table>
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| Hallucinogens | Hallucinogenic drugs are substances that distort the perception of objective reality. The most well-known hallucinogens include phencyclidine, otherwise known as PCP, angel dust, or love boat; lysergic acid diethylamide, commonly known as LSD or acid; mescaline and peyote; and psilocybin, or "magic" mushrooms. Under the influence of hallucinogens, the senses of direction, distance, and time become disoriented. These drugs can produce unpredictable, erratic, and violent behavior in users that sometimes leads to serious injuries and death. The effect of hallucinogens can last for 12 hours. LSD produces tolerance, so that users who take the drug repeatedly must take higher and higher doses in order to achieve the same state of intoxication. Physical risks associated with using hallucinogens:  
- Increased heart rate and blood pressure  
- Sleeplessness and tremors  
- Lack of muscular coordination  
- Sparse, mangled, and incoherent speech  
- Decreased awareness of touch and pain that can result in self-inflicted injuries, convulsions  
- Coma; heart and lung failure  
- Psychological risks associated with using hallucinogens:  
- A sense of distance and estrangement  
- Depression, anxiety, and paranoia  
- Violent behavior  
- Confusion, suspicion, and loss of control  
- Flashbacks  
- Behavior similar to schizophrenic psychosis  
- Catatonic syndrome whereby the user becomes mute, lethargic, disoriented, and makes meaningless repetitive movements Everyone reacts differently to hallucinogens--there's no way to predict if you can avoid a "bad trip." |
|-----------|------------------------|-------------------|
|           |                        | • A parent may forget or neglect to attend to parenting responsibilities.  
|           |                        | • Parents may leave children alone while seeking, obtaining, or using the drug.  
<p>|           |                        | • A parent may become angry or impatient with a child for any reason because of thought distortion and misperception of the child's intent. |</p>
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</table>
| Marijuana                              | Marijuana is the most widely used illicit drug in the United States and tends to be the first illegal drug teens use. It can be either smoked or swallowed. Marijuana blocks the messages going to your brain and alters your perceptions and emotions, vision, hearing, and coordination. | Short-term effects of using marijuana:  
- sleepiness  
- difficulty keeping track of time, impaired or reduced short-term memory  
- reduced ability to perform tasks requiring concentration and coordination, such as driving a car  
- increased heart rate  
- potential cardiac dangers for those with preexisting heart disease  
- blood shot eyes  
- dry mouth and throat  
- decreased social inhibitions  
- paranoia, hallucinations  
Long-term effects of using marijuana:  
- enhanced cancer risk  
- decrease in testosterone levels for men; also lower sperm counts and difficulty having children  
- increase in testosterone levels for women; also increased risk of infertility  
- diminished or extinguished sexual pleasure  
- psychological dependence requiring more of the drug to get the same effect  
The physical effects of marijuana use, particularly on developing adolescents, can be acute.  

- A parent may forget or neglect to attend to parenting responsibilities.  
- Parents may leave children alone while seeking, obtaining, or using the drug.  
- Parents may fall asleep while under the influence of depressants and be unable to supervise or protect their children. |

Activity STOP
Parenting is particularly difficult when children have been prenatally exposed to substances and exhibit neurological and behavioral effects of this exposure.

Infants may be fretful and cry continuously.

Toddlers and young children who have been exposed may have emotional and developmental delays or disabilities, such as a failure to attach or hyperactivity.

Older children and adolescents may have behavioral management problems. Without behavioral and/or medical treatment, these problems can make parenting even more difficult.

“The lives of millions of children are touched by substance use disorders (SUDs). The 2007 National Survey on Drug Use and Health reports that 8.3 million children live with at least one parent who abused or was dependent on alcohol or an illicit drug during the past year. This includes 13.9 percent of children aged 2 years or younger, 13.6 percent of children aged 3 to 5 years, 12.0 percent of children aged 6 to 11 years, and 9.9 percent of youths aged 12 to 17 years. These children are at increased risk for abuse or neglect, as well as physical, academic, social and emotional problems.”

Source: https://www.childwelfare.gov/pubs/usermanuals/substanceuse/substanceuse.pdf

Display Slide 6.6.15 (PG: 158)

Drinking alcohol during pregnancy can have serious effects on fetal development. Collectively, these defects are called Fetal Alcohol Syndrome (FAS). FAS is one of the most commonly known birth
defects related to prenatal drug exposure. Children with FAS may exhibit:

- Growth deficiencies, both prenatally and after birth
- Problems with central nervous system functioning
- IQs in the mild to severe intellectual disabilities range
- Small eye openings and poor development of the optic nerve
- A small head and brain
- Joint, limb, ear, and heart malformations.

*Display Slide 6.6.16*

Similar to alcohol use, use of other substances can have significant effects on the developing fetus. For example, cocaine or marijuana use during pregnancy may result in premature birth, low birth weight, decreased head circumference, or miscarriage. Prenatal exposure to marijuana has been associated with difficulties in functioning of the brain. Even if there are no noticeable effects in the children at birth, the impact of prenatal substance use often can become evident later in their lives. As they get older, children who were exposed to cocaine prenatally can have difficulty focusing their attention, be more irritable, and have more behavioral problems. Difficulties surface in sorting out relevant versus irrelevant stimuli, making school participation and achievement more challenging.

Transition Statement:
Several Native American tribes teach that health and well-being depend on a balance between mind, body, spirit, and context. This model, known as the relational worldview, suggests that life is a complex interplay between all of these factors.

Substance abuse affects each of these factors in a unique way, often causing life to spin out of balance.

Families often experience escalating problems, along with the progression of the disease. Substance use disorders have pervasive effects on the user and on people related to the user.

The negative consequences of substance use disorders can have an enormous impact on individuals, their families, and their friends - in many aspects of their lives.

Let’s take a look at the effect on the Family.
Trainer Note: Reiterate in a generalized way what has been discussed already about the impact of substance abuse on the child, how substance abuse can be seen as a family disease, and the different roles that can exist in a family to enable it to cope with the dysfunctional dynamics of the family system.

Display Slide 6.6.19 (PG: 158)

Substance abuse does not occur in a bubble. People with addictions are often portrayed as the main character struggling alone. We may see the addict destroy his/her most valued relationships, destroy a prized possession or squander important opportunities.

We get to know a lot about the addict, but we rarely see is the family’s role in the addictive behavior.

The truth is, a person's battle with addiction is usually closely tied to the personal relationships he or she has with family members. As child welfare professionals, we are called to look at the family conditions to determine if a child is safe or unsafe. It is important to look beyond the addict and start asking questions about his or her family.
There are often family dynamics that reinforce addictive behaviors, and family members may have no idea that these behaviors exist.

Display Slide 6.6.20 (PG: 159-160)

Let’s talk about the impact on children.

Exposure to parental substance abuse during childhood also can have dire consequences for children. Compared to children of parents who do not abuse alcohol or drugs, children of parents who do, and who also are in the child welfare system, are more likely to experience physical, intellectual, social, and emotional problems. Among the difficulties in providing services to these children is that problems affected or compounded by their parents’ substance abuse might not emerge until later in their lives.

Some of the consequences of parental substance abuse of childhood development are the following:

- Disruption of the bonding process
- Emotional, academic and developmental problems
- Lack of supervision
- Parentification
- Social stigma
- Adolescent substance use and delinquency.

Source:

**Trainer Note:** The source above provides more detailed explanations of each of these categories. Feel free to review this to enhance your leadership of class discussions.
Let’s take a look at how these consequences would present themselves in a child’s life.

Ask for ideas from the group and then go over the list below once they have provided examples.

Children affected by their parents’ substance misuse may:

- **Appear unkempt** - can be the result of neglect by a substance-abusing parent.
- **Be frequently sleepy** - can be connected to fighting, arguing, or violent behavior in the home in the evening.
- **Be late to school** - may be in charge of getting themselves there because their parent is still in bed. Their responsibilities in the morning may include preparing breakfast, taking care of younger siblings, etc.
- **Have unexplained bruises** due to inadequate supervision or abuse from a parent.
- **School performance fluctuates** especially at the end of the day as the child dreads returning home.
- **Know too much about drinking** for their age or they may be extremely guarded when the topic of substances is approached.
- **Appear withdrawn/depressed.**
- **Display behavioral problems.**
- **Be frequently absent from school** in order to take care of the substance abuser.
- **Complain of stomachaches, headaches or other physical**
ailments, with no explainable cause, often at the same time every day.

- Be teased by peers or may have peers who hint about the problem in the child’s home.
- May have parents who are predictably hard to reach and often do not show for child’s activities at school.
- May have parent(s) who may attend school-related functions drunk or high.

Review slide to point out conditions for participants to look for.

Ask participants to think about the case examples they have previously reviewed. Did they see any of these factors present?

Display Slide 6.6.22 (PG: 161)

Children whose parents or caretakers are alcoholics or drug users are at greater risk of developing a substance use disorder. Children of alcoholics are 50 to 60 percent more likely to develop alcohol use disorders than people in the general population (1). Similarly, children of parents who abuse illicit drugs may be 45 to 79 percent more likely to do so themselves than the general public (2–4).

Sources:
The conflicts that happen in an addicted family all happen slowly and gradually, so the family may not realize the depth of the disease or the dysfunction in which they live.

Display Slide 6.6.23 (PG: 161)

Children begin to learn that they cannot rely on substance abusers to follow through on what they have said.

Family members adapt by reassigning family roles and responsibilities. Children may be easily overburdened with the tasks of taking care of themselves and their siblings, preparing meals, getting to school alone, caring for the substance abusing parent, etc. Due to the family’s secret, the child has less support for the stress of his increased responsibilities.

**Trainer Notes:** When chemical abuse or addiction is suspected or identified in a family, it is important for child welfare professionals to identify family roles and recognize that these roles may also apply to relatives who are acting as caregivers and other kin. This will assist the child welfare professional in understanding the family functioning and family condition.

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Show the above slide and ask participants to try to identify the behaviors/actions of a person in each of these roles.

PG: 162

In a family where substance abuse is occurring, there are series of roles that family members take. Depending on the number of family members, these can include:

**Rescuer/Enabler:** Often steps in to save the addict, bails the addict out, makes excuses or fills in for the addict. Shielding the addict from consequences of substance abuse makes it easier for the addict to continue using.

**Hero/Caretaker:** Tries to divert attention away from the problem by being too good to be true, secretly hoping that exemplary behavior will somehow make it easier for the addict to stop using. High achievers who do everything to assure that the addict has as little responsibility as possible, minimizing the possibilities for trouble to occur.

**Adjuster/Lost Child:** Behaves apathetically to distance self from pain; passively withdraws from upsetting situations; hurting but attempts to avoid feeling the pain by refusing to confront the addiction or its consequences.

**Scapegoat/Rebel:** Draws attention away from the family’s primary problem of dependency through delinquency or other misbehavior; reacts to feeling trapped by the situation at home by poor school performance, hostility and other behavior problems.

**Mascot/Pleaser:** Also draws attention away from the family by trying to please, by acting in a humorous way, “the clown.”
Activity: Family Roles

Purpose: Participants will better understand the various family roles through an experiential activity.

Trainer Instructions:
Remind participants what they have learned about family dynamics. Draw three overlapping circles and label them as you see below.

One is the father. He has areas of responsibility that overlap with the mother, and they exchange ideas and experiences.

There is an area where the father’s relationship overlaps the child. This is where the father/child sharing takes place, and finally there is overlap is where all three overlap for sharing and concerns.

You will notice there is room around each of the family members for growth and development. Each can expand, take on new interests and develop into the person he or she wants to become.

Now, draw three concentric circles and label them as they are below.
Draw 3 more rings like this:

Now look at this family. The outer ring is the dependent person. He has room to grow and develop. He is developing new friends, new excuses for drinking, not going to work, etc. The next circle is the spouse. She is totally engulfed by the user. There is no place to grow that is not restricted. The child is even further inhibited by the enabler and the dependent person.

Activity STOP

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Activity: Family Sculpture

Purpose: In this activity, each individual is assigned a particular role within a substance-abusing family. The group will then create a sculpture of a substance-abusing family that will show the roles people in the family play.

Materials:
- 2 duffle-type bags (stuffed to look heavy)
- 1 sports jersey, mortar board, tennis racquet (something to show success)
- 1 large stuffed animal
- 1 clown or jester hat
- scruffy clothing, dark glasses, beer cans
- chair

Trainer Instructions:
1. Choose 6 volunteers from the class.
2. Before assembling the sculpture, assign each participant a role and give each a script. (See the content below for each of these individuals that describes in greater detail what each will do).
3. Dependent Person: “I want a drink! Give me a drink!”
4. Enabler: “Things are fine, really! We’re all doing just fine!”
5. Hero: “Look at me, I’m doing great!”
6. Scapegoat: “You’re a drunk! You’re nothing but a drunk!”
7. Mascot: “Look at me! Pay attention to me!”
8. Lost child: says nothing
9. Tell them they need to say their lines loudly and clearly whenever you cue them. You may need to remind them of their lines the first time they say them.
10. Begin creating the sculpture.
11. Describe each participant as you place each in a role.

Dependent Person: The user, meaning alcoholic or substance abuser, may be angry, the stern disciplinarian or the unloving, rigidly religious one, aggressive, blaming, manipulative...
- Place this person on a chair facing the class.
- Ask the person if s/he has a specific drink favorite.
- Ask the person to look out to the back of the room and focus on something above the heads of the audience.
- Give this person two large bags to hold up, representing the baggage that s/he is carrying around.
- Line: “I want a drink! Give me a drink!”
• Cue: The Dependent to repeat this line in unison with other family members as they join him/her.

**Enabler:** The closest one to the Dependent person. S/he allows the behavior to continue out of love, shame, loyalty and fear. Protector of the family, martyr, physically sick...
- Place this person so that s/he can help hold the baggage.
- Ask how the new character feels.
- Help the Dependent person hold the bags of emotions.
- Line: “Things are fine, really! We’re all doing just fine!”
- Cue the Dependent person and Enabler to say their lines together.
- Remind the Dependent person to focus on back wall.

**Hero:** Usually the oldest child. Learns to help the family by being very good. Caretaker, high achiever, very responsible...
- The Enabler leans heavily on her/him for support.
- Direct Enabler to lean on the Hero.
- Ask the Hero: How do you feel about this family? Who will you help?
- Advise Hero to help his/her parent hold the bags and act as if nothing is wrong.
- Props: tennis racket, football jersey – anything that would model success
- Line: “Look at me, I’m doing great!”
- Cue: Dependent person, Enabler and Hero to say their lines together.

**Scapegoat:** Usually second child. Cannot compete with Hero. Attracts negative peer group, rule breaker, in trouble. His/her actions are designed to keep the family together at the counselor’s office, in the principal’s office...
- Ask Scapegoat to pick two friends to stand in front with him.
- Props: scruffy clothing, gang wear, dark glasses, bandanas, beer cans
- Line: “You’re a drunk! You’re nothing but a drunk!”
- Direct Scapegoat to say this while holding out his/her arm and pointing at the Dependent
- Cue: Dependent person, Enabler, Hero and Scapegoat to say their lines together.

**Mascot:** Usually the youngest child. Highly anxious about what is going on and thinks she/he is crazy because no one else is addressing it. Is the family clown. Makes everyone relax, cute, hyperactive. Mascot runs around the family tickling them, making faces, anything to get their attention.
- Props: funny hat, feather boa, bell.
Now that we have an understanding of what substance abuse is and how it can impact family dynamics, let’s look at the Substance Misuse maltreatment and the statutory definitions of harm associated with substance abuse.

**Trainer Note:** Ensure that all participants have their Maltreatment Index for the next section.

*PG: 146*

The Maltreatment Index divides substance misuse into three areas:

1. The caregiver(s) inappropriately using drugs or alcohol,
2. A child inappropriately consuming or being given drugs or alcohol, and
3. Poisoning due to caregiver(s) actions or neglect.

We will begin by discussing how the parent/caregiver inappropriately using drugs or alcohol may affect the child. For this part of the maltreatment, there are three subsections. Let’s take a brief look into each of these.

The first subsection of this maltreatment is the caregiver inappropriately using drugs or alcohol. One way this can be established is through “A test administered at birth which indicates that the child’s blood, urine, or meconium contained any amount of drugs, alcohol or a controlled substance or metabolites of such substances, the presence of which was not the result of medical treatment administered to the mother or the newborn infant.” As we learned earlier in this unit, prenatal exposure to substances can have devastating, lifelong effects to the child. Because of this, the positive test alone, is evidence to support the statutory definition of “Harm.”
Review what is considered to be normal behaviors of infancy.

If you look at these typical newborn behaviors in the context of a non-substance-abusing parent, they can be challenging. When you think of them in the context of a substance-abusing parent, whose behaviors, thoughts and actions are controlled by the substance he/she is abusing, you can have a dangerous situation.

As we discussed previously in this module, this combination of factors also leads to most of our co-sleeping deaths.

**Trainer Notes:** Again, stress the importance of having a discussion with about co-all families we work with about co-sleeping, and provide additional resources on safe sleeping environments.

The second way to establish this maltreatment is through “Evidence of extensive, abusive, and chronic use of drugs or alcohol by the caregiver(s) when the child is demonstrably affected by such usage.”

The third way to establish this maltreatment is through the mother “Breastfeeding a child while frequently consuming drugs or alcohol, or by using an excessive amount of drugs or alcohol.”
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**Breastfeeding Death**

Stephanie Greene, 39, faces 20 years to life in prison when she is sentenced for killing her 6-week-old daughter with what prosecutors say was an overdose of morphine delivered through her breast milk.

**SC woman gets 20 years in breast feeding overdose**

BY JEFFREY COLLINS
Associated Press April 4, 2014

SPARTANBURG, S.C. — A judge sentenced a South Carolina woman to 20 years in prison Friday for killing her 6-week-old daughter with what prosecutors say was an overdose of morphine delivered through her breast milk.

A prosecutor said Stephanie Greene, 39, was a nurse and knew the dangers of taking painkillers while pregnant and breast feeding, instead choosing to conceal her pregnancy from doctors so she could keep getting her prescriptions. She lost her nursing license in 2004 for trying to get drugs illegally.

The 20-year sentence was the minimum after a Spartanburg County jury found Greene guilty of homicide by child abuse Friday. She could have faced up to life behind bars. Greene will have to serve 16 years before she is eligible for parole. She said nothing in court and quietly shuffled out of the courtroom, her hands and feet shackled, after she was sentenced.

Her lawyer said she will appeal and it's likely the case will be tied up for years to come. Both the prosecutor and Greene's lawyer agree no mother has ever been prosecuted in the United States for killing her child through a substance transmitted...
in breast milk. Also, prosecutors didn't prove how the baby got the morphine and there is little scientific evidence that enough morphine can gather in breast milk to kill an infant.

**History**
Greene's fourth pregnancy in 2010 was unplanned, but she and her husband of 10 years joyously accepted the surprise. She has two children from a previous marriage. Greene's husband supported his wife and was devastated as he prepared to raise their 7-year-old son alone.

Alexis was born healthy, and her mother chose to breast feed. Forty-six days later, Greene called 911 to report her baby was unconscious in her bed. On a recording of the call, she sounds groggy and unfocused. The former nurse first tries to do CPR compressions on the baby's back and has trouble counting to keep pace. Investigators at the scene found dozens of pill bottles and painkiller patches on her nightstand where the couple's then 4-year-old son could get to them.

A toxicology report from the baby's autopsy found a level of morphine in the child's body that a pathologist testified could have been lethal for an adult.

A review of her medical records showed Greene carefully hid her pregnancy from her primary doctor. After a home pregnancy test showed she was pregnant, she told her doctor she needed to go to a gynecologist for a birth control. She then got prenatal care from that doctor while not telling her all the painkillers she was taking.

Greene had her nursing license suspended in South Carolina in 2004 because she was irrational at work, tried to call in a prescription illegally and refused a drug test, according to an order from the state's Nursing Board.

*Display Slide 6.6.28 (PG: 164)*

**Trainer Note:** After each section, have a brief group discussion of how we may see this in the families we work with.

Now, let’s look at the second subsection of Substance Misuse in the Maltreatment Index:
“Child has consumed drugs or alcohol due to the caregiver(s) actions or neglect” -

- A child has consumed drugs or alcohol that substantially affect the child’s behavior, motor coordination or judgment, or that result in sickness or internal injury.
- When a child is consuming drugs or alcohol to the point of being affected, it must be determined that the child is doing so with the consent, encouragement, insistence or neglect of the parent.
- Substance misuse also occurs when the caregiver exceeds the proper dosage for drugs and the drug substantially affects the child’s behavior, motor coordination or judgment, or when the child sustains an internal injury from the drug.

*Display Slide 6.6.29 (PG: 164)*

And now, the third subsection of substance misuse:

“Poisoning due to caregiver(s) actions or neglect” -

- Poisoning is defined as any substance, other than controlled substances or alcohol, taken into the body by ingestion, inhalation, injection, or absorption that substantially affects the child’s behavior, motor coordination or judgment and results in sickness or internal injury.
- Virtually any substance can be poisonous if consumed in sufficient quantity; therefore, the term “poison” often implies an excessive degree of dosage rather than a specific group of substances.
- This includes noxious substances that, when taken into the
Substance abuse often co-occurs with other family conditions, which can make it difficult to assess its impact on child maltreatment. Parental substance abuse is likely to co-occur with the following problems that also are associated with child maltreatment:

- Lack of knowledge about child development
- Poor problem-solving and social skills
- Low maternal affection
- Poor attachment relationships
- Poor attention to the needs of an infant
- Disinterest in spending time with one's children
- Inconsistent disciplinary practices
- Social isolation
- Mental health problems, especially depression
- Anger toward or a lack of attention to one's children
- Difficulty maintaining employment
- Engagement in criminal behavior
- Failure to provide appropriately for the needs of one’s children (clothing, food, medical care, hygiene and emotional attention).

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It is important to note that the association between substance abuse and family violence has been well-documented. For many years, experts have tried to explain the relationship between substance abuse and family violence, but research has demonstrated that substance abuse by itself does not cause violence.

Studies focused on alcohol agree that alcohol facilitates or triggers, rather than causes, physical violence. It is often used to legitimize or excuse the violence. Furthermore, the relation between alcohol and violence is most affected by multiple factors, such as personality, provocation and threat, as well as learned alcohol expectancies, situational factors and biochemical factors.

In the next unit, we will learn about domestic violence.
Unit 6.7: The Dynamics of Domestic Violence

Display Slide 6.7.1

Time: 4 hours

Unit Overview: This unit provides an overview of the dynamics of domestic violence, its impact on the children and the survivor of domestic violence, and how to assess when domestic violence may be actively occurring in the family and threatening the child. It also helps participants understand the survivors’ actions to protect themselves and their children.

Display Slide 6.7.2

Review Objectives

Learning Objectives:
1. Define and identify the dynamics of domestic violence.
2. Recognize the relationship between domestic violence and child abuse.
3. Discuss types of family responses when domestic violence is occurring as part of their family dynamics.
4. List strategies survivors of domestic violence may use to protect themselves and their children.
5. Explain the importance of criminal background checks and information
to inform assessment of patterns of family violence and/or domestic violence.

6. Explain the role of injunctions and interventions for the victim, the children and the batterer.

7. Discuss the roles of domestic violence advocates with child welfare professionals.

8. Define the maltreatment Family Violence Threatens Child and how it applies to families where there is domestic violence.

9. Given a scenario and using the Maltreatment Index, evaluate if it represents domestic violence, and explain your rationale.

10. Explain the domestic violence services options available locally.

**Trainer Note:**

*Here are a list of You Tube videos that you can use during the unit.*

- [http://www.youtube.com/watch?v=G_ht2vAYPoc](http://www.youtube.com/watch?v=G_ht2vAYPoc) (911 call by a child during a domestic violence incident)
- [http://www.youtube.com/watch?v=WL3rfk2iFww](http://www.youtube.com/watch?v=WL3rfk2iFww) (PSA showing woman with injuries)

*Display Slide 6.7.3 (PG: 172)*

**What do you think of when you hear the words “domestic violence”?**

Write participant responses on a flipchart page or white-board without judging their responses as correct or incorrect. Later, if there is a response on the flipchart that is an example of what you are discussing in the definitions or dynamics, you can point it out then. Also, if you have information later that is in opposition to a response, you can note it then.
**Trainer Note:** The following discussion below may prompt people to disclose violence they have experienced in their own lives.

It is important to let participants know that if they have had experience with domestic violence (either as a victim themselves or a friend or family member that has been victimized), they should not feel that they must disclose.

However, if they do, recognize that this is not a confidential group, so although folks may say they will not share their colleague’s story, there is nothing stopping them. This way, folks can think through and decide if they are comfortable with sharing, knowing the potential risk of such.

There may also be content that triggers difficult emotions for participants and/or memories of traumatic events in their lives. Let participants know that they should feel free to take care of themselves and if they need to leave the room at any point to do so.

**Can you tell me about some people in relationships or families who have been impacted by domestic violence?** These don’t have to be personal examples of people you know – it could be a celebrity or someone who has been in the news lately. What happened in those situations that you know about?

Write their responses on a flipchart page or white-board. Keep the flipchart page or white board visible for the remainder of this unit. Use their examples to discuss the definitions of domestic violence described later on in the unit.

**Trainer Note:**
Do some research prior for any recent stories in the news regarding domestic violence. Be prepared to discuss details. There are also some common celebrities who may come up in this discussion:

- Ray Rice
- Rihanna and Chris Brown
- OJ Simpson and Nicole Simpson
- Ike Turner and Tina Turner
- Phil Hartman and wife, Brynn

**PG: 167**

We are going to look at some of the definitions of domestic
violence. There are several different definitions; let’s see if we can identify the similarities and the differences.

**Florida Coalition Against Domestic violence:** “A pattern of controlling behaviors – violence or threats of violence – that one person uses to establish power over an intimate partner in order to control that partner’s actions and activities. Domestic violence is not a disagreement, a marital spat, or an anger management problem. Domestic violence is abusive, disrespectful, and hurtful behaviors that one intimate partner chooses to use against the other partner.”

**Section 741.28, Florida Statutes:** “Any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another family or household member.”

**Florida Department of Children and Families, Family Violence Threatens Child Maltreatment:** “Family violence threatens child means an adult who is a family or household member commits any violent criminal behavior, such as assault or battery, on another adult who is a family or household member, that demonstrates a wanton disregard for a child and could reasonably result in injury to the child.”

**Trainer Note:**
1. The danger threat of “parent/legal guardian/caregiver is violent, impulsive, or acting dangerously in ways that seriously harmed the child or will likely seriously harm the child” includes an operational definition of domestic violence as follows, “When violence includes the perpetrators dynamics of power and control it is considered domestic violence.” When the maltreatment index is next updated, it is expected to include the dynamics of power and control.
2. The mission of the Florida Coalition Against Domestic violence is to work toward ending violence through public awareness, policy development, and support for Florida’s domestic violence centers. FCADV operates Florida’s toll-free domestic violence hotline (1-800-500-1119), linking callers to the nearest domestic violence center and providing translation assistance when needed.
In addition, FCADV maintains a resource library of books, periodicals and videos regarding domestic violence issues. FCADV also has developed posters, brochures, safety plans, and other resources. Many of these are available in several languages and may be ordered through FCADV.

FCADV administers state and federal funding earmarked for Florida's 42 certified domestic violence centers, and its quality assurance department is responsible for ensuring both administrative and programmatic standards are achieved. FCADV partners with the certified domestic violence centers to ensure optimum provision of services to victims of domestic violence and their children.

Take a few moments and discuss the different definitions. Point out key components that are the same and key components that are different.

- The operational definition of domestic violence includes a broad spectrum of abusive behaviors that a perpetrator uses to establish power and control in an intimate partner relationship.
- Criminal offenses for domestic violence relate only to behaviors that result in physical injuries.
- A maltreatment finding is based on any violent criminal behavior that demonstrates a “wanton disregard for a child and could reasonably result in injury to the child.”

Demonstrate that while there are different perspectives about Domestic Violence, there are common threads and collaboratively working with community partners is the most effective way to provide support and assistance to survivors of domestic violence, and to hold perpetrators of domestic violence responsible for their behavior.
Key Points about domestic violence:

- Reflects a pattern of an individual’s conduct, not an isolated event.
- Includes possible use of physical force or the threat of physical harm against adult victims (or children) to establish dominance. Domestic violence perpetrators may use physical force frequently or infrequently.
- Can occur through financial and verbal power-and-control efforts, even in the absence of physical abuse.
- Can include a wide range of assaultive and coercive behaviors. Some of these are criminal, some are not; some of these are physically damaging, some are not. It is important to note that not all domestic violence perpetrators use all of the tactics. One domestic violence perpetrator’s pattern may include one event of physical force (e.g., shoving the adult victim against a wall) combined with repeated incidents involving non-physical tactics (e.g., threats to kill, to abduct the children, etc.,). Another domestic violence perpetrator may repeatedly use physical violence against the adult victim and/or children.

Not all assaults are part of an ongoing pattern of coercive behaviors that result in gaining power and control over a partner. A domestic violence victim may use physical force (in self-defense or in retaliation) without engaging in a pattern of assaultive and controlling behavior against the domestic violence perpetrator.

For the purpose of this training, we refer to domestic violence pertains to the intimate partners of spousal, live-in partners and dating relationships; however, as a child welfare professional, you will also see violence in familial relationships, which is encompassed in the maltreatment definition of Family Violence Threatens Child. Family violence, between non-intimate partners, may not include a pattern of coercive control and may involve combative behaviors between household members, with no
manner of control involved in the incident or in their daily life.

In domestic violence cases, you, as a child welfare professional, must look beyond the physical force to determine the following:

- Who has the power in the relationship?
- Who is afraid of whom?
- What is the perpetrator’s pattern of coercive control?
- What is the impact of the perpetrator’s behavior on the child(ren) in the home?
- Who makes the family “rules”?

Display Slide 6.7.4  *(PG: 168)*

To examine the family dynamics related to domestic violence further, let’s talk about the characteristics of the different roles involved in intimate partner violence. I use the term “intimate partner violence” to stress that while a majority of abusers are male and the majority of victims are female, this is not always the case.

Let’s look at the characteristics of victims of domestic violence.

*Can you list or describe individuals who might be battered?*

*Call on several participants to respond. You may need to help start the list.*

*Endorse:*
- Male/Female
- Old/Young
• Hetero/Homosexual
• Rich/Poor

*Emphasize that victims of domestic violence can be all ages, genders, sexual orientation, socio-economic status, etc.*

According to the National Coalition Against Domestic violence, adult domestic violence victims come from all groups: all ages, races, religious affiliations, occupations, educational levels, and personality types.

**Trainer Note:** Great resource to hauntout:

The majority (85%) of domestic violence victims are women.

One in every four women will experience domestic violence in her lifetime. Rural and urban women of all religious, ethnic, socio-economic and educational backgrounds, and of varying ages, physical abilities and lifestyles can be affected by domestic violence.

There are two important facts to remember:

- There is not a typical woman who will be battered - the risk factor is being born female.
- A female’s use of retaliatory violence in response to the domestic violence is not considered a campaign of power and control over another; instead, it is considered an isolated incident of violent behavior. This is not to say that there are not female perpetrators but rather to show that often times when women are arrested or labeled a perpetrator in some other way, it is the result of self-defense and/or retaliatory violence.

Males – Straight men may be victims of domestic violence perpetrated by their female partners, and homosexual males may be victims of violence perpetrated by their male partners. These individuals experience the same dynamics of intimate partner violence as female victims, including experiences of disbelief,
ridicule and shame that only enhance their silence.

Regardless of who the victim is, he or she may tend to minimize and deny the violence in order to protect their children and himself or herself from the batterer. It may be safer if the victim doesn’t “rock the boat.”

It is important to note that, although battering is occasionally an isolated act, once it begins, it often continues and escalates in frequency and severity.

Source:

There are specific cultural groups whose particular vulnerabilities may put the members of that population at greater risk of experiencing violence in their relationships. These include:

- Battered Immigrant and Refugee Women
- Individuals with Physical, Psychiatric and Cognitive Disabilities
- Older Battered Women
- Battered Women Living in Rural Communities
- Lesbian, Gay, Bi-sexual, Transgendered, Queer, or Questioning (LGBTQQ) Individuals

**PG: 168-169**

**Battered Immigrant and Refugee Women**

In the United States, battered immigrant and refugee women face additional barriers to accessing safety due to their issues of gender, race, socioeconomic status, immigration status and language.

A battered woman who is not a legal resident or whose immigrant status depends on her partner is isolated by cultural and legal dynamics that may prevent her from leaving her husband, seeking support from local agencies that may not understand her culture or requesting assistance from an
unfamiliar American legal system. Some obstacles may include a distrustful attitude toward the legal system, language and cultural barriers (that may at the least be unknown and at the worst hostile), and fear of deportation.

Individuals with Physical, Psychiatric and Cognitive Disabilities
People with disabilities experience sexual and domestic violence at higher rates than the mainstream population. They may also experience maltreatment from their caretakers, including personal assistants, paid staff, family members and parents.

Examples can include:

- The denial of medications and personal care.
- The use of psychotropic medication as a restraint.
- Daily and intimate care mistreatment and neglect.
- Inaccessible organizations, facilities and equipment
- Unavailable or disabling assistive technology devices essential for communication and movement.
- Improper use of restraints and the denial of life-sustaining medical treatment and therapies.

Older Battered Women
Domestic violence in later life is a subset of the larger issue of elder abuse. Older women are a nearly invisible, yet a tragically sizable population who are uniquely vulnerable to domestic violence. Unlike domestic violence, elder abuse may not be perpetrated by an intimate partner or include power and control dynamics. Older women are more likely to be:

- Bound by traditional and cultural ideology that prevents them from leaving an abusive spouse or from seeing themselves as a victim.
- Financially dependent on their abusive spouse without access to the financial resources they need to leave an abusive relationship.
- Isolated from their family, friends and community, due to their spouses' neglect and abuse.
  - This is especially true because older women suffer greater rates of chronic illness, which makes them dependent upon their spouses or caregivers and, thus, reluctant or unable to report abuse.

Battered Women Living in Rural Communities
Survivors in rural areas often face a lack of resources, isolation, small-town familiarity among neighbors, few (if any) support agencies, and poor or little transportation and communication systems in addition to the other barriers to safety that may be compounded by the rural lifestyle.
There may be a sense that sexist, racist, misogynistic, anti-Semitic and homophobic language and actions are often more acceptable in some rural communities, and that attitudes seem slower to change.

The patriarchal "good old boys" network, fundamentalist religious teachings, deep-rooted cultural traditions and commonly accepted sexual stereotyping can form a chorus of accusations that the battered rural woman is unfaithful in her role as a woman, wife and mother.

The act of leaving the home place, land and animals that could depend on her may be emotionally wrenching leaving the battered rural woman surrounded by walls of guilt and self-abasement.

**GBTQQ Survivors**

Same-sex battering is one person's use of physical, sexual or emotional violence, or the threat of violence or the fear of outing, to gain and maintain control over another. Same-sex battering can happen in any same sex relationship regardless of culture, race, occupation, income level and degree of physical or cognitive ability.

*Display Slide 6.7.5 (PG: 170)*

*Walk participants through the eight types of behaviors used by batterers.*

*Tell participants they will be working closely with this handout in their work and discuss how this assessment tool can help them identify and describe a batterer’s pattern of coercive control.*

**Trainer Note:** This wheel presumes the batter is a male.

This is the Power and Control Wheel. The wheel is another way of graphically representing the dynamics in a family that has inter-partner violence issues. You can see the Power and Control Wheel in your Participant’s Guide.
As you can see, the wheel has eight different sections. These wheel sections represent many of the tactics batterers use to gain and maintain power and control in the relationship.

Now, let’s look at each of these categories . . .

The major categories of the Power and Control Wheel include:

- Coercion and Threats
- Intimidation
- Use of Emotional Abuse
- Use of Isolation
- Minimizing, denying and blaming
- Using children against the adult victim
- Using male privilege
- Using economic abuse.

Below includes descriptions of some batterer behavior for each of these categories. These are not inclusive of every behavior of a batterer.

Coercion and Threats
- Making and/or carrying out threats to do something to hurt her.
- Threatening to leave her, to commit suicide, to report her to child welfare.
- Making her drop charges.
- Making her do illegal things.

Intimidation
- Making her afraid by using looks, actions, gestures.
- Smashing things.
- Destroying her property.
- Abusing pets.
- Displaying weapons.

Use of Emotional Abuse
- Putting her down.
- Making her feel bad about herself.
- Calling her names.
- Making her think she’s crazy.
- Playing mind games.
- Humiliating her.
• Making her feel guilty.

Use of Isolation
• Controlling what she does, who she sees and talks to, what she reads, where she goes.
• Limiting her outside involvement.
• Using jealousy to justify actions.

Minimizing, denying and blaming
• Making light of the abuse, and not taking her concerns about it seriously.
• Saying the abuse didn’t happen.
• Shifting responsibility for the abusive behavior.
• Saying she caused it.

Using children against the adult victim
• Making her feel guilty about the children.
• Using the children to relay messages.
• Using visitation to harass her.
• Threatening to take the children away.
• Undermining her parenting efforts, such as putting her down in front of the children and/or disregarding her parenting decisions in front of the children.

Using male privilege
• Treating her like a servant.
• Making all the big decisions.
• Acting like the “master of the castle.”
• Being the one to define men’s and women’s roles.

Economic abuse
• Preventing her from getting or keeping a job.
• Making her ask for money.
• Giving her an allowance.
• Taking her money.
• Not letting her know about or have access to family income.
Discuss with the class how this video illustrates the categories of the power and control wheel.

PG: 174

There is a direct relationship between domestic violence and child abuse. Here are a few of the many facts that clearly underlie the fact that domestic violence can lead to child abuse:

The U.S. Advisory Board on Child Abuse suggests that family violence may be the single major precursor to child abuse and neglect fatalities in the United States.
• Child abuse occurs in up to 70% of families who experience domestic violence.
• The risk of child abuse is 1500% greater in homes where there is domestic violence.
• Children who are exposed to domestic violence are at higher risk of physical abuse.
• 40-60% of men who abuse women, also abuse children.
• Research indicates that some child abuse begins with spouse-battering that escalates to include the children.
• Domestic violence, when pervasive in a child’s life, sets a pattern and models an interactive response that can establish an expectation for children of how individuals treat each other.
• The perpetrator’s behavior can directly impact the child, such as being:
  o hit by the batterer when trying to intervene and protect the abused parent.
  o forced to witness or participate in the beatings.
  o threatened to be beaten if the child discloses to anyone.
  o hit with objects by the batterer, who intended to strike the abused adult.
• A child who is exposed to a perpetrator’s abuse, over time, may accept this type of behavior as acceptable or normal.
• The child may use similar behaviors with his or her peers, unaware that this is not acceptable in other families.
• Male children are at greater risk of becoming abusers if they witness their father abusing their mother. However, not all of these boys become perpetrators. Battering is a choice, and many men who witnessed abuse as a child do not abuse their partners.

*Display Slide 6.7.6 (PG: 175)*

It is important that you know and understand that if the batterer speaks about killing himself or herself, OR threatens to kill the spouse or children, you must take the statement very seriously. If
the survivor of domestic violence believes his or her life is in
danger, believe him or her, and take appropriate measures. These
are some of the circumstances that can put the survivor at
increased risk of being killed:

If the abuser exhibits the below activities, a survivor’s risk of being
killed are higher:

- Used, or threatened to use, a gun, knife, or other weapon
  against the victim.
- Threatened to kill or injure the victim.
- Tried to strangle (choke) the victim.
- Is violently or constantly jealous.

There are also signs to look for in the abuser that indicate a high
risk of lethality:

- The abuser threatens suicide or homicide. If he says he will
  kill himself, understand that this likely means he will kill the
  partner, as well.
- The abuser fantasizes of homicide or suicide. If he sees this
  as a "solution" to his problems, he may attempt it. Beware
  of the abuser threatening to kill himself. Usually, it means
  he plans to kill the partner first.
- The abuser has access to weapons. If the abuser owns
  weapons or has access to weapons, and has used them or
  threatened to use them in the past, there is a potential for a
  lethal assault. The use of guns is a strong predictor of
  homicide.
- Separation violence. If the abuser believes the partner will
  leave him, and he can't imagine life without the partner, he
  may try to kill the partner.

Other Important Facts

- Many homicides occur when a victim is leaving her abusive
  partner.
- Seventy-five percent of women are seriously injured when
  they leave or try to leave an abusive relationship.
- If there is escalating danger and the batterer begins to act
more and more as if he has no regard for the consequences of his actions—legal or otherwise—the victim is at extremely increased risk of danger.

We will look at a lethality assessment in your next lab and discuss ways to interview with this in mind. It is important to remember that batterer behavior cannot be predicted with certainty. Any batterer may become lethal at any time.

*Be sure you emphasize this next section in strong terms.*

*Refer to PG: 182-183, If the Woman Leaves*

*Display Slide 6.7.7 (PG: 176-177)*

Because the most dangerous time for a survivor of domestic violence (not always a spouse) is when he/she leaves the batterer, it is very important for the survivor of domestic violence to have a safe place to go, if the best decision is for her or him to leave the home to protect herself or her children. In this case, it will be your responsibility to help her/him find resources to do so. There may be times when a safety plan is put in place in which she is not leaving the home with the children.

Even if the domestic violence has come to the attention of law enforcement and the batterer is temporarily jailed, the domestic violence is present and requires safety planning. Some batteres will be out of jail quickly; others can continue to intimidate their partner from jail through their friends and family members and sometimes their own gang members. Physical location of the survivor and perpetrator does not always ensure safety.
Florida has 42 certified domestic violence centers serving 67 counties, and the Florida Coalition Against Domestic violence (FCADV) serves as the professional association for the state’s certified domestic violence centers. To access the nearest domestic violence center by telephone, just dial the FCADV toll-free number, 1-800-500-1119, and you will be connected to the domestic violence center nearest to you. You can also go to www.fcadv.org/centers for contact information for your local certified domestic violence center.

These centers provide a safe shelter for battered women and their children. There, the domestic violence survivor can access services and resources, such as shelter services, counseling for her and her children, and other services, depending on the location.

Survivors and their children will also have access to basic needs, such as food, clothing and safety planning. Here are the core services that all of Florida’s certified DV centers provide: information and referral services, counseling and case management services, temporary emergency shelter for more than 24 hours, a 24-hour hotline, training for law enforcement personnel, assessment and appropriate referral of resident children, and educational services for community awareness relative to the incidence of domestic violence and the prevention of such violence.

Section 90.5036, F.S., establish privileged, confidential communication between domestic violence center staff and their clients.

Information about the shelter location cannot be disclosed to ensure the safety of the clients and staff. In accordance with s. 39.908, F.S., exceptions are law enforcement and medical and firefighting personnel, when they need access to the shelter in emergency situations.
As with other professionals, domestic violence center staff are required to report suspected abuse or neglect of children; however, they are still bound to the confidentiality rules regarding their clients’ privileged communication. Domestic violence advocates can only share information with other service providers with the informed, reasonably time-limited, written consent of the survivor. The release of information can only last for a short time, typically 30 days, but can be renewed by the survivor if needed. There are both state and federal laws that mandate this confidentiality standard (s. 39.908, F.S., s. 90.5035, F.S., s. 90.5036, F.S., and the Federal Violence Against Women Act of 2005).

Typically, it takes a survivor multiple attempts at leaving before he/she is successful. That tells us that likely, after leaving the survivor will return to the batterer. The following factors may or may not come into play regarding a woman’s decision to return to her batterer or to leave permanently.

1. If the criminal justice system, such as law enforcement or the state attorney’s office, has not held him accountable for his violence in the past, the woman may feel she is unsafe to leave because there will be no one there to protect her and her children.
2. The longer the abuse has been going on, the greater the chance she will choose to stay.
3. If the abuse is “not that bad” according to her perception, she has a greater chance of staying. Or, if the injuries are severe, she may have more pressure from others to leave, as well as her own fear for herself.
4. The less able the victim is to provide financially for herself and the children, the greater chance she will stay.
5. Depending on how severely the children are being affected, their presence may keep her from leaving, especially if she is financially dependent and if he has threatened to take them away if she leaves.
6. Extended family may or may not be supportive. If there is no family support, it is more likely she will stay, especially if services, such as shelter, are unavailable or scarce. This is one of the reasons why batterers isolate survivors from their survivor networks.
7. If the children are being abused, she is more likely to leave to keep them from further abuse. On the other hand, if the batterer does not abuse the children, she may be more willing to stay.
8. Depending on her culture or religious beliefs, she may be heavily criticized for leaving. On the other hand, if she is part of a society that expects her to leave the situation, she may be ashamed if she doesn’t leave. On top of this, she may have a very real fear of being killed. As noted, she’s at the greatest risk of death when she tries to leave.

Display Slide 6.7.8

It’s not a surprise that the survivor of domestic violence – the partner who is being abused - will be more open and willing than the batterer to change behavior.

However, it may surprise you that a survivor of domestic violence may choose not to leave the batterer, even when you are attempting to provide help and safe shelter. Alternatively, she may be willing to leave, but she may also choose to return.

Statistically, she will return seven times on average, and each time, she will take the children back with her. (Burman, 2003)

Refer participants to PG: 178, Protection Strategies for the Woman Who Remains with the Batterer.

Many survivors are already implementing these safety strategies to keep themselves and their children safe. It is wise then to ask the survivor to share what she has already been doing before telling her what she should do. She is the expert on her safety and the safety of her children. The safety strategies that are most effective are those that build on her current efforts.

1. When she feels the tension building and an episode feels imminent, she can get the children to a safer place, such as with neighbors, friends or relatives for a day or night or a short period of time, until after an incident occurs.
2. Have a safety plan that is shared with the children for when a violent
incident begins suddenly. For example, if battering begins, the children know to go to their rooms and close the doors, or to the house of a neighbor, who has agreed ahead of time to provide safe haven for the children when needed.

3. Teach the children never to get in the middle of an adult fight, even if they are trying to help protect her, and never to put themselves in danger.

4. Give her children permission and encouragement to have relationships with at least one other non-violent, trusted adult they can talk to as well as someone who can be a good role model. Examples might be a teacher, a minister, a school counselor, a coach, an aunt or an uncle.

5. When the violent incident is over, assure them that they are safe and what has scared them is now in the past. Speak to them in a calm, soothing voice.

6. Encourage them to ask questions, so they can voice their fears and misunderstandings, so she can correct them. For example, children may misunderstand and think the domestic violence is their fault or is their responsibility to resolve.

7. Stick to established, daily routines, such as a bedtime ritual and meals at usual times, although it’s important to note that the batterer may sabotage her efforts to do this. Routine helps children to feel the world is secure and predictable.

8. When the home is unsafe, older children should know:
   - How to call 911.
   - Names and phone numbers of trusted adults they can call for help any time of the day or night.
   - Hiding places and exits from the house.
   - To stay out of the way of the violence.

Display Slide 6.7.9 (PG: 179)

The family is the social unit from which children learn how to live in the world. We have provided you with a list of a number of more long-term consequences of domestic violence on the family, and
we will discuss a few salient points here.

If a child witnesses abuse of a parent, he is at risk of growing up to be a batterer if the child is male, and she is at risk of growing up to be involved with a batterer. Seeing someone else being battered can be as emotionally harmful as actually being battered oneself. In the United States, at least a third of American children have witnessed violence between their parents.

In fact, boys who witness domestic violence are twice as likely to abuse their own partners and children when they become adults, although it is also important to note that battering is a choice, and many male children exposed to domestic violence grow up choosing to not batter.

In addition, the greater the severity and frequency of the victimization, the greater the likelihood of severe and frequent violent offending outside of the family.

As is the case for many other areas of this curriculum, we have only touched the surface of this topic. As a child welfare professional, it is your responsibility to build capacity and capability so that you can correctly identify domestic violence situations and effectively respond to them. The danger is not just for the victim/survivor and children; when you become involved, the danger could also transfer to you.

You are encouraged to take opportunities to learn more about domestic violence.


Now that we have learned a little about domestic violence, let’s look at the Child Maltreatment Index and see what it says about Family Violence as a maltreatment.

Child Maltreatment Index

FAMILY VIOLENCE THREATENS CHILD

DEFINITION

Family violence threatens child means an adult who is a family or household member commits any violent criminal behavior, such as assault or battery, on another adult who is a family or household member, that demonstrates a wanton disregard for a child and could reasonably result in injury to the child.

- “Family or household member” means spouses, former spouses, intimate partners, persons related by blood or marriage, persons who are presently residing together as if a family or who resided together in the past as if a family, and persons who are parents of a child in common regardless of whether they have been married. With the exception of persons who have a child in common, the family or household members must be currently residing or have in the past resided together in the same single dwelling unit.
- When the alleged perpetrator of the violent criminal behavior is a minor who is a parent, s/he can only be an alleged perpetrator of this maltreatment for his/her own child, not for other children in the home.

The criminal definition for “domestic violence” is contained in Chapter 741, Florida Statutes, which states that domestic violence is any assault, aggravated assault, battery, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another who was residing in the same single dwelling unit. (section 741.28, F.S.). This definition is provided for information only. It includes behaviors which do not meet the criteria for this maltreatment (such as stalking).

**For a report of “Family Violence Threatens Child” to be accepted, the incident must have occurred between two adults who meet the above definition for “family” or “household members”, or between a minor who is a parent and the other parent or an adult who is a family or household member.

**If the "primary aggressor" is not clearly identified by the reporter at the
Hotline, the intake should be conceded as, caregiver responsible, perpetrator unknown and the CPI will determine the identity of the perpetrator during the investigation on "family violence threatens child" maltreatments. Only one caregiver should be identified as the domestic violence perpetrator. This person can best be determined by the protective investigator during the investigation.

ASSESSING “FAMILY VIOLENCE THREATENS CHILD” AS MALTREATMENT

- Was law enforcement called related to the incident and/or was an arrest made?
- Are there current or past protective orders or injunctions?
- Were there elements of control present such as financial or isolation?
- Where were the children during the incident?
- Were the children injured as a result of the incident?
- Were weapons used or present during the incident?
- Is there a history or pattern of domestic violence?

ASSESSING FOR OTHER MALTREATMENT

- If a weapon was used during the violent episode and the child was injured with the weapon, also assess for “Physical Injury.”
- If the allegation is verbal abuse without threats of physical violence assess for “Mental Injury” to the child.
- The only time the alleged perpetrator for this maltreatment can be under 18 is when that minor child is the parent. If the child is attacking an adult in the home, assess for a special conditions “Parent Needs Assistance” referral.

EXCLUDING FACTORS

Caregiver(s) who are a participant in violent behavior with someone other than an adult who is a family or household member or intimate partner does not constitute “Family Violence Threatens Child.” If the child was injured use the appropriate maltreatment and assess for other maltreatments such as “Mental Injury.”

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT
• Obtain and consider any reports and interviews from law enforcement that include 911 call history to the residence.

• Documentation and communication from the State Attorney’s Office.

• Review and documentation of psychological examinations.

• Documentation from interviewing the children in the home about current and past incidents.

• Documentation of the effects on the children’s daily routines, functioning, development, education and medical.

• Documentation from interviewing and observing the caregiver(s) and other participants in the incident (if any). Focus should be on their interaction and reasons for the incident and the extent of the violence.

• Documentation of coercive control behaviors as disclosed by the adult victim and/or child whether current and/or past behaviors.

• Documentation from interviewing witnesses to the incident or person who know the family well.

• Documentation for collateral contacts that may include neighbors or the family’s landlord.

• Documentation of a pattern of domestic violence related incidents.

• Documentation of the lethality of the situation (choking, escalating incidents, threats to kill, etc.).

According to the Index, the definition of this allegation has four parts:

• An adult who is a family or household member.

• Commits any violent criminal behavior, such as assault or battery.

• On another adult family or household member.

• And does this with wanton disregard for a child and could reasonably result in injury to the child.

The last part of this definition is crucial to determining whether DCF would have cause to intervene. In this unit, we will be looking at domestic violence from the perspective of the effect on the child.

In order to intervene in a family with Domestic violence issues, there must be cause to believe that the batterer commits the
violence in such a way that demonstrates disregard for the effect on the child and could reasonably result in injury. And as in all situations, it is easier to identify physical injury or the potential for physical injury than other types. Mental injury, for example, is harder to detect and predict, especially as some effects may not be seen until far into the child’s future.

Who is considered a family or household member?

*Take the term listed in the Index and give an example. Call on several participants.*

**Endorse:**
- Spouses – husbands, wives.
- Former spouses – ex-husbands, ex-wives.
- Intimate partners – people who are sexually intimate, but not married to each other.
- People related by blood or marriage – aunts, uncles, cousins, in-laws.
- People who are presently residing together as if a family or who have resided together in the past as if a family
- People who are parents of a child in common, regardless of whether they have been married

There is an exception to the stipulation that the family or household members must be living together or had lived together or in the past. And that is when they are parents of a child in common. In this case, it is not required that they live together or have lived together.

Also note that if the batterer is a minor who is a parent, he or she can only be considered as a perpetrator against his or her own child, and not other children in the home.

It’s also important to recognize that this definition that comes from Chapter 39 is different than the criminal definition in Chapter 741.
and does not include behaviors such as stalking.

Feel free to take a moment to review the other information contained in the description of this maltreatment, such as assessment and documentation information; however, it will be covered in detail in the specialty tracks.

Replay the recording of a 911 call - a phone call to police with a 6-year-old girl named Lisa calling with panic in her voice about her mommy and the baby getting hurt.

http://www.youtube.com/watch?v=G_ht2vAYPoc

Discuss the participants’ feelings after listening to the little girl a second time:

- What was their perception of the mom? Of the situation?
- Describe the behavior of the perpetrator through the child’s eyes. How would that impact Lisa – psychologically, emotionally, and even physically – in the short-term? In the longer-term, if she does not receive help?

Would you say that the step-father acted with wanton disregard for Lisa and that his actions could reasonably result in injury to her or another child? How? What did you hear in the call that supports that?

Discuss as a group.

Endorse:

- He was holding the baby during the violence.
- Lisa was traumatized by the events.
- The 4-year-old was pushed down.

Continue this discussion and work on how you would present this information to support the maltreatment.

Display Slide 6.7.10
We’ve spent a good deal of time talking about domestic violence and how it impacts the dynamics in the family, as well as the effects, direct and indirect, short-term and long-term on the children. So, you should be able to imagine how domestic violence in a family could result in neglect of the child.

What do you think are some ways in which neglect of a child could occur in a family with Domestic violence issues? What kind of scenarios can you imagine?

Responses may include some of the following answers listed below. If some are not mentioned, use this list to fill in the gap.

- If the batterer is financially abusive, a child could be deprived of food, shelter, etc. as a way of controlling or punishing the survivor of Domestic violence.
- The batterer may cause mental injury to the child who witnesses the survivor being yelled at or beaten.
- In an effort to protect herself, the survivor of Domestic violence is in a double-bind that could lead her to not having the ability protect the child. She might try to get out of the way of a blow by the batterer or, to defend herself, she might unintentionally place the child in the target range. Or she may leave to increase the children’s safety and, therefore, not have the financial resources to meet their basic needs.
- The survivor of domestic violence’s depression or fear, which is common, could cause her to neglect her child’s needs.
- The survivor of domestic violence could puts the demands of the batterer above the needs of the children. For example, fulfilling his demand for sex may supersede tending to the children, even when the children are distressed, or dangerously unsupervised, or are infants crying because of hunger or wet diapers. Why do you think the survivor may at times prioritize the perpetrator’s demands?

Many of these situations may occur as a result of the survivor of...
domestic violence attempting to maintain peace and the safety of herself and her children. Her actions must always be considered with this in mind. It is OK to talk to her privately about the reasons for the decisions she has made regarding her children. If you partner with a survivor in this way, you help to increase the safety of the children.

**Activity: Does it Reach the Level of Maltreatment? Impact on the Child.**

*Display Slide 6.7.1 (PG: 182)*

**Purpose:** To evaluate a case scenario for Domestic violence that threatens the child(ren), according to the Florida Child Maltreatment Index.

**Materials:**
- *PG: 182-186, Scenarios*

**Definition:** Family violence threatens child means an adult who is a family or household member commits any violent criminal behavior, such as assault or battery, on another adult who is a family or household member, that demonstrates a wanton disregard for a child and could reasonably result in injury to the child.

**Trainer Instructions:**
- *Assign the participants to one of three groups.*
- *Assign one of the case scenarios that follow to each group.*
- *Tell each group they are to read their case scenario and evaluate whether it describes a Domestic violence situation that would rise to the level of the maltreatment index allegation of “Family Violence Threatens Child.”*
- *Tell them to list the reasons the group decided the scenario described is maltreatment or not. What were the indicators of Domestic violence*
and what were the indicators of the effect on the child? They should write their answers and may use a flipchart or whiteboard.

- Give them 25 minutes to complete the activity. Tell any groups that finish early to read the other case scenario, for discussion purposes.
- Give each group 5 minutes to report their results. Encourage participants from other groups to critique the results and discuss if they would have come to a different conclusion.

The Parkins Family

Mother, Mary, 37, and her husband, Dale, 65, have been married for four years. They have a blended family: two children of hers, Lisa, 15, and Ken, 13. Their father is dead. When they married, Dale moved his daughter, Tammy, also 15, into their home. Tammy, prior to this, had been living with her mother in another state. Within a few months of the marriage, Dale moved the family to another state, Florida, near a military base, since he is a retired Army colonel. Prior to this, Mary and her children had lived in the same neighborhood as her family, and she had a good deal of support as a single, working mother.

The Parkins have come to the attention of DCF because of a report to the Hotline from a neighbor, alleging an incident of Domestic violence. The narrative stated that Dale was heard from outside the home yelling and screaming obscenities at the mother and the sound of breaking glass and loud thuds. Mary is also heard yelling back. Two of the children, Lisa and Ken, quickly retreated to this neighbor’s home not long after it started. The children don’t say much to the neighbor about what is happening next door, they just ask to come in and visit with her children.

The Parkins live in a nice house in an upper middle class neighborhood. Each child has his or her own room. The home is orderly and neat. Both parents are home together as Dale is retired and Mary no longer works. The children seem well-dressed and well-fed, although Lisa is underweight. Lisa and Ken have good grades and are involved in many after-school activities. Lisa, in particular, exceeds academically and in relationships with others. Tammy is an average student, but has no significant problems in school, academically or with teachers or peers.

The CPI conducts an introduction with the family and advises them of the report that the Department has received. When the family is together, the incident is downplayed, and most questions are answered by Dale, unless he prompts Mary or one of the children to agree with him. Dale admits to having a temper, but only when he is not respected or obeyed. The other family members agree. All say it doesn’t happen often. When the children are with
the family, Lisa and Ken are quiet and subdued, compared to their typical demeanor, which is more relaxed and animated when interviewed away from the other family members. Tammy seems comfortable either when she is with the family or alone. Dale doesn’t want the others to be interviewed alone; however, he agrees to it when the CPI explains that it is standard procedure. The CPI begins the interviews with the family, interviewing each family member alone, starting with the victim children.

The children tend to fight with each other, sometimes to the point of physical injury – especially Lisa and Ken. When questioned about this, they say they’ve always fought, but lately it has been worse. Both Lisa and Ken say Dale is a much harsher, stricter parent than their mother is or their father was. They both say they are afraid of him when he erupts. Both also agree that it happens about two or three times a year. Both children have a standard plan to leave the home when the violence begins or before, if they can sense it coming. Both children seem to love their mother and trust her to take care of their needs, but they fear for her. Lisa says she stays at school as much as possible, just to avoid the whole thing. All three children agree that Dale picks on Lisa more than the others and is very critical. For example, when they go out to dinner, Dale insists that everyone eat everything on their plate. Lisa rarely can eat a whole adult dinner, and she is too old for the children’s menu. Dale will insist on staying at a restaurant until Lisa eats everything. Sometimes, this takes hours. When she makes a “B” instead of her usual “A” on her report card, she is restricted to her room until the next report card is released. Ken and Tammy are not held to this standard, and Tammy routinely makes “C”s. They receive no punishment for this. When Tammy is interviewed, she just rolls her eyes and says, “That’s just how Daddy is,” and tells you that Dale and her mother used to fight like this, and that’s why they divorced. She says she’s learned to just stay out of the way and retreat to her room.

When Mary is interviewed, she admits that the incidents are worse than Dale says, but that she has never been physically injured, nor have the children. She says he “just calls me names, but he has never threatened to hurt me” and “if he ever touches me or my kids, I’ll hit him over the head with an iron skillet, and I’ll make sure he never will again.” Mary says that she can sense when he’s about to erupt, and it happens about once a year. She says she “knows how to handle him,” and she never fears that he is going to physically hurt her. During the incident in question, Dale was yelling at her and then he went into another room, away from her, and began throwing things and turning over furniture. He typically does that, however, he never does it when she or the children are in the room. She says he is a controlling husband. She is not allowed to work out of the home, because Dale wants her home with him since he is retired. This initially was a welcome relief from being a
working mother, but Dale also resents any friends she wishes to see. He does not allow her to use the car unless she asks his permission and tells him exactly where she is going. Then he checks the gas gauge and odometer before and after, as well as monitors the time, to be sure she obeys him. She has limited access to the checking account, and Dale gives her a small allowance, but most purchases require his permission.

When Mary is asked about how Dale’s behavior affects the children, she says it doesn’t seem to affect Tammy much, and she just goes to her room and shuts the door. Dale rarely yells at Tammy, and Mary says his relationship with his own daughter seems good.

Mary’s children are more affected and, sometimes during a violent outburst, Lisa is targeted by her stepfather and is referred to as a “little bitch.” He shouts and blames her for whatever issue he and Mary are fighting over. They have learned to leave the house as soon as they are aware an incident is starting. They go to a neighbor’s home or that of a friend. After an incident is over, Dale takes the only car the family has and will be gone anywhere from a few hours to a day or two. He arrives back refreshed and acts as if nothing has occurred. When others in the family feel anger at any time, they know they must try to hide it or repress it, lest they “set off” Dale.

Dale is interviewed last. As mentioned, he is a retired military officer. He is very amiable and charming. He says he is trying to teach Mary’s children responsibility. He thinks they are “soft” and could use some military discipline. He says he adheres to strict limits for bedtimes, curfews, etc. He continues to minimize the reported incident and denies any “out of control” behavior. Sure, he gets upset and may raise his voice, but he is just trying to be firm.

**ANSWER KEY: The Parkins Family**

Break down the four main components to determine if, based on the current information we have, we would be able to verify the maltreatment. Note: There will likely be additional questions that participants come up with that could potentially change the outcome of this activity. Encourage that discussion, but bring them back to the information we know for certain.

- An adult who is a family or household member. (Yes)
- Commits any violent criminal behavior, such as assault or battery. (No)
- On another adult family or household member. (Yes)
- And does this with wanton disregard for a child and could reasonably result in injury to the child. (No) It should be noted that there are indicators of possible emotional impact to the children, but not to the
level that would indicate a verification of a maltreatment.

The Domestic violence indicators are:

- Episodic, violent eruptions, throwing objects
- Financial control
- Isolation
- Male privilege

However, there are few indicators that the Domestic violence threatens a child at this time. Although Dale frightens the children, he has not physically injured their mother or them. He disengages and leaves the home after episodic tantrums and returns when he is calm. The episodes are infrequent—one to three times a year.

**Child functioning** is adequate for all of the children and above average in some areas. All children have passing grades and relationships outside of the home. Lisa excels, in fact, outside of the home. Children are teens who all have strategies for staying out of harm’s way.

**Adult functioning** of both parents is adequate, although the relationship between the parents is off-balance. Financial needs are adequately met and above average in some regards. Financial control is an issue, but does not prevent the survivor of Domestic violence from meeting her own basic needs or the needs of the children (shelter, food, clothing, etc).

**General Parenting** Dale’s military, strict style of parenting leaves room for improvement. He holds Lisa and Ken to a higher standard than Tammy. Mary’s parenting style, when allowed, helps to balance his.

Because there is indication that Lisa is a target, she should also be assessed for Mental Injury.

Mary should be given information about the certified domestic violence center in her area.

**The Smith Family**

Brad, 25, and Janet, 24, met in high school and married soon after graduation. They’ve been married 7 years and have four children: Darnell, 6; Keisha, 4; Frank, 2; and Sharrone, 6 months. Brad is a day laborer at several construction companies. Janet works at a local daycare, where she is able to take the three youngest children. They live in a three bedroom trailer in a trailer park near the outskirts of town. The boys share a room, and Keisha and the baby share a room.

DCF became involved with this family when it was reported to the Hotline that
the children were seen outside on the deck of the home late at night. The oldest child, Darnell, was holding the baby, who was crying. They were dressed in their pajamas, and the temperature was in the lower 40’s. Screaming adults could be heard, as well as crashing objects and loud thumps against the walls. The caller said she started to call the police, but soon the noise stopped, and Brad left the house and drove away. Then Janet brought the children in-doors, and nothing else went on. The next day the neighbor decided to call the Hotline because of the children, but did not want to leave her name.

When the CPI arrives later that day, the home is sparse but clean. The children are in front of the TV. Keisha is watching the baby, and the boys are playing on the floor. They are adequately clothed. Janet answers the door, and she has a black eye and she limps slightly with her right leg. The CPI notes that there is minimal food in the refrigerator. When asked, Janet explains that Brad didn’t give her money for groceries this week. She gives him her paycheck, and then he gives her cash for the household needs. She says he’ll be home soon and will let her go grocery shopping tomorrow. She says she has enough to feed the kids today. She says she has milk and bread and cheese. She plans on making grilled cheese and has a can of soup she can heat up. She explains she doesn’t drive or have access to the bank account.

When Janet is interviewed and asked about the incident last night, she is reluctant to talk about it or her noted injuries. She says Brad loves her children very much. She says that Brad is just a very jealous man, and sometimes he gets mad when she is tending to the children when he wants something. “He’s really just a big baby, himself. But he lets his tantrums get out of hand sometimes, and he pops me one. Especially on Friday night after he has a little too much to drink, he’ll want my ‘attention’, you know. But, I make sure he doesn’t hit the kids. I send them outside and lock the door, so they won’t get hurt and he won’t hear them cry. They just sit outside on the deck until I tell them it’s safe. Usually, Brad will pass out or take off in the truck. Darnell, my oldest, is such a good boy. He takes care of the others just like a little man. He always knows just what to do. I swear, they never stay out very long.”

Examination of the children indicates there are no physical injuries. The baby, Sharrone, is small for her age and is fussy and irritable. She seems to startle easily, and then begins to cry and fret. The older children try to calm her. Two-year-old Frank is in diapers and keeps taking away his baby sister’s bottle to feed himself. Keisha is very quiet and timid. She has a doll that she clutches as the 2-year-old attempts to take it away. Janet explains that Keisha is just scared of strangers. Darnell seems old beyond his years. He is very solemn, polite and pays close attention to everything. He is quick to stop one
of the other children before they get hurt or hurt each other, or in some other way cause trouble. Janet seems to expect this from him and depends on him being her assistant.

Brad arrives and is surprised to see the CPI. The children do not interact with Brad when he arrives and “steer clear.” He pays them little, if any, attention. He refuses to discuss his family with the CPI and says, “I never laid a hand on them kids. Unless you can show me where they got hurt, or you got a warrant, you need to get out of here.” Brad sounds very threatening, and Janet seems afraid and begs the CPI to leave. The CPI explains that he/she has seen that the children aren’t physically harmed, but there are some concerns and the CPI will return, with law enforcement if necessary.

The director of the day care where Janet works and three of the children stay says that Janet is a good employee and is very good working with the children at the center. She says that Janet is as good a mother as her husband will allow. But sometimes she comes in injured, especially after a weekend, and offers some unlikely reason for her injuries. Sometimes, the injuries make it hard for her to do her job with the kids at the center and must make it hard at home. Sometimes, they also show up in the morning and it’s obvious they haven’t been fed. Janet says that Brad “forgot” to take her grocery shopping. The baby is always fussy and seems to be exhibiting some signs of delays in her development.

The director says 2-year-old Frank is especially aggressive, even for a 2-year-old, and is always fighting with the other children. He seems to regress and, though he has been potty-trained, he episodically shows up in diapers. Sometimes, he uses baby-talk and cries and demands a bottle. Four-year-old Keisha is shy and doesn’t seem to make friends with other children. She just cries a lot for her older brother, Darnell, who is in elementary school. Reports from Darnell’s teacher are that he is very mature for his age and keeps up with his studies, despite not always having his homework completed. He says he has to help with the kids at home. Other than that, he is a model student, if a little too serious.

**ANSWER KEY: The Smith Family**

Break down the four main components to determine if, based on the current information we have, we would be able to verify the maltreatment. Note: There will likely be additional questions that participants come up with that could potentially change the outcome of this activity. Encourage that discussion, but bring them back to the information we know for certain.

- An adult who is a family or household member. (Yes)
• Commits any violent criminal behavior, such as assault or battery. (Yes)
• On another adult family or household member. (Yes)
• And does this with wanton disregard for a child and could reasonably result in injury to the child. (Yes)

The Domestic violence indicators are:
• Violent eruptions, physically injuring the survivor of Domestic violence
• Alcohol abuse
• Financial control
• Isolation
• Male privilege

Although not severe, there are indicators that the Domestic violence threatens the children, though not from direct physical injury due to Domestic violence. The safety plan of the mother of putting the children outside in the cold at night with the 6-year-old in charge is not a safe plan, and there are dangers to the children outside as well, from the elements as well as there being too much responsibility put on the 6-year-old. And although the allegation did not include concerns about issues feeding the children, the CPI noted that, although sufficient food was present, it might not always be and was completely controlled by the batterer.

Child functioning: Marginal. The baby is showing some signs of trauma (irritability) and possibly some developmental delays. The 2 year-old Frank shows regressive behavior (wanting diapers and a bottle) and is aggressive with other children. Keisha has trouble connecting with others and is very dependent on her brother, Darnell. Darnell seems to be the least negatively affected; however, the expectation of maturity and responsibility is inappropriate for his age and may well result in negative effects as he ages.

Adult functioning of both parents is adequate, although the relationship between the parents is abusive. Some financial needs are adequately met (shelter, clothing) but necessities such as food show need for improvement. Brad’s financial control is an issue and does at times prevent the survivor of Domestic violence from meeting her own needs and the needs of the children for the basics. Both parents have jobs and likely have the finances needed to feed their family.

General Parenting: Janet is a loving and concerned parent; however, she must put the needs of Brad first, at the potential danger of her children (sending them outside at night in the cold). Brad was not sufficiently interviewed or observed at this time, but the lack of interaction with his children was noted.
So what do these scenarios tell us? We have two families who are experiencing Domestic violence, one of those at a level we would consider as “Verified” maltreatment, and one that is not. However, they both would benefit from some intervention such as voluntary referrals.

It is also important to note that whether a maltreatment is Verified or not is not the sole indicator of whether a child is Safe or Unsafe. It is a piece of the assessment process.

Activity STOP

What might be especially important to check for in families with Domestic violence issues, especially for assessing the domains of parental functioning and adult functioning?

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Discuss how criminal background checks can inform child welfare assessment information on the family.

Also note that failure to check on past criminal background can put the survivor and her children in danger.

It is critical that you review this information prior to making contact with the family. Without this information, you may not be aware of the severity of past behavior, and so would not be sufficiently prepared for what you may encounter. This could result in danger to you and the other family members. Important information to note is:

• If the batterer has been convicted of Domestic violence,
especially if firearms were involved.
- If the batterer has been convicted of other violent crimes, especially if firearms were involved.
- If the batterer has been convicted of child abuse or neglect regarding other children in other families.
- Domestic violence Injunctions in current and past relationships for batterer and survivor.

This information will help you decide whether you may require law enforcement backup.

A criminal background check will also tell you whether there are any active protective orders (injunctions).

*Discuss the local procedure, if any, for obtaining a criminal background check.*

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When you are working with families who are experiencing domestic violence, you will also likely be interacting with domestic violence victim advocates. Several investigative units across the state will have co-located domestic violence victim advocates. Advocates’ expertise in this area assists survivors of domestic violence/non-offending parents to increase protective factors already existing in the home. The co-located advocates assist child protective investigators and case managers in clearly identifying batterers’ patterns of coercive control, gathering information to address harmful batterer behaviors, and assessing the impact of that behavior on the children.

In order to work best with domestic violence victim advocates, it’s helpful to understand their role, focus and perspective. This is
important, so that you can recognize the differences and similarities between your role with the family and theirs.

When differences between domestic violence victim advocates and child welfare professionals arise, focus on the common goals you have together. Realize that you are all there for the safety of the family.

(Emphasize this) Florida Coalition Against Domestic Violence (FCADV) provides a number of different trainings that can augment your understanding of Domestic Violence and your role as a child welfare professional. Included in these offerings is an 8-hour training on child welfare and Domestic violence partnerships, which you are encouraged to take.

The family dynamics and conditions that lead to maltreatment of all types are complicated, yet the symptoms and effects are known, and most of the time can be addressed with interventions, including treatment. That said, our first step in helping a child who might be living in a pervasive state of danger is to identify a vulnerable child and what protective capacities in a family are not working. Only then can we determine how to remedy the family problems.

A child may live in a home where these conditions exist, and based on concerns that maltreatment is happening or is about to happen, a call will be made to the hotline. When an investigation is conducted, an assessment of family functioning is developed by the investigator to determine if a child is living in a pervasive state of danger, and also whether a maltreatment has occurred. Module 7 will introduce you to the information that must be gathered in order to know whether or not a child has experienced maltreatment, and is in a state of danger due to specific caregiver protective capacities that are compromised.