CHAPTER 1
RESOURCE MATERIALS

Introducing the CASA/GAL Volunteer Role

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CASA
Court Appointed Special Advocates

Child Neglect

FACTS ABOUT CHILD NEGLECT

Deprivation-related disorders develop when the basic needs of the child are not being met, including adequate nutrition, clothing, shelter, emotional support, love and nurturing, education, safety, and medical and dental care. There may be multiple reasons why parents fail to meet those needs, including lack of resources, inadequate access to care, parental substance abuse, mental illness (e.g., depression), the parent putting his/her own needs above the needs of the child, or even a history of abuse of the parent when he/she was a child. In the latter case, the psychological effects may limit the caretaker's recognition of neglect as maltreatment. It is critical to make the distinction between poverty and neglect—a family without financial resources should be offered assistance, not punishment, to help them provide a safe home for their children. Neglect is more than poverty. Below is a list of findings typical to neglect situations:

Family Social History

- Lack of appropriate well-child care, including immunizations
- Lack of appropriate medical care of chronic illness
- Failure to provide necessary health aids such as eyeglasses or hearing aids
- Failure to provide appropriate dental care
- Poor school attendance

Physical Findings

- Lack of adequate nutrition (on examination or as evidenced by charting growth)
- Poor hygiene, such as being extremely filthy or having extraordinarily severe diaper rash
- Developmental delay due to lack of stimulation
- Untreated medical conditions
- Rampant dental cavities

Behavioral Findings

- Depression
- Anxiety
- Enuresis (wetting)
- Sleep disturbances
- Excessive masturbation
- Difficulty relating well or appropriately to other people (e.g., lack of cuddliness, gaze avoidance, preference for inanimate objects)
- Discipline problems, aggressive behavior
- Poor school performance
- "Role reversal," in which child assumes caretaker role
- Taking on household responsibilities, including childcare, that are not appropriate for age

(Note: These findings are not unique to cases of neglect.)

Adapted from "Diagnostic and Treatment Guidelines on Child Physical Abuse and Neglect," American Medical Association, 1992.

Child Physical Abuse

FACTS ABOUT CHILD PHYSICAL ABUSE

Although child abuse was identified as a social problem in the nineteenth century, it took almost one hundred years for violence toward children to be considered a major national problem. In the 1940s, through the use of diagnostic x-ray technology, physicians began to notice patterns of healed fractures in young children that could have resulted only from repeated blows. Although pediatric radiologists were diagnosing child abuse, it was not until C. Henry Kempe and his associates published their classic work, "The Battered Child Syndrome," in the *Journal of the American Medical Association* in 1962 that battering and abuse became a focal point of public attention. By the end of that decade, all states had passed laws requiring the reporting of child abuse and neglect and had initiated efforts to treat abused children and their families. In 1974, the U.S. government established the National Center on Child Abuse and Neglect to provide a mechanism for increasing knowledge about the causes of child abuse and neglect and to identify steps toward prevention and treatment.

The causes of child abuse are complex and varied. Child maltreatment can be inflicted by anyone responsible for caring for children, and it occurs in all types of families and settings. Children of all ages may be physically abused. Although infants and young children are more likely to receive serious or life-threatening injuries, adolescent abuse also occurs and often is unrecognized. Emotional abuse is hard to prove but generally exists with other types of abuse and neglect.

Child abuse may be occurring even when the child discloses nothing or says that he/she has never been hurt. Children frequently do not complain about abuse. Current research has found that the following child and family characteristics may be risk factors for child abuse or neglect:

Child Characteristics

- The child was born prematurely.
- The child has disabilities or abnormalities.
- The child exhibits certain different behaviors of infancy and childhood, such as persistent crying.

Family Characteristics

- There is other violence in the home (in particular, the father abuses the mother or siblings abuse one another).
- The parents or caretakers have substance abuse problems, including alcohol abuse.
- The parents or caretakers lack the necessary maturity to care for the child and have poor coping skills.
- Parental expectations do not match the child's developmental abilities.
- The caretaker is socially isolated (i.e., has no external support systems).
- The parent is a teenager.
- The family is experiencing high levels of stress from events such as loss of a job, increased financial burdens, serious illness, death in the family, separation, or divorce.
- Adult members of the family have themselves been abused as children, either physically or sexually.

These risk factors do not always lead to abuse. However, abuse or neglect must be considered whenever physical or behavioral signs are suggestive or recurrent, regardless of the presence or absence of the risk factors above. Different forms of abuse can and do coexist in families. Moreover, abusive behavior often occurs in successive generations of families, a phenomenon known as the "cycle of violence."

DIAGNOSIS OF ABUSE

Physical abuse is defined as inflicted injury to a child and can range from minor bruises and lacerations to severe neurological trauma and death. The following physical findings may be indicative of physical abuse:

Burns

- Cigar or cigarette burns, especially on the soles of feet, palms, back, or buttocks
- Immersion burns (stocking- or glove-like without splash burns on extremities, doughnut-shaped on buttocks or genitals)
- Patterned burns resembling an electrical appliance (e.g., iron, burner, grill)

Fractures

- Skull, ribs, long bones, metaphyseal (bone growth plates at the bone ending)

Central Nervous System Injuries

- Subdural hematoma (internal bruising/bleeding in the space between the skull and the brain)—often reflective of blunt trauma or violent shaking
- Retinal hemorrhage (bleeding inside the eye)—often reflective of blunt trauma or violent shaking
- Subarachnoid hemorrhage (bleeding between the brain and skull)—often reflective of shaking
- Cerebral infarction (blocking of blood to the brain, stroke), secondary to cerebral edema

Bruises & Welts

- Forming regular patterns, often resembling the shape of the article used to inflict the injury (e.g., hand, teeth, belt buckle, electrical cord)

Lacerations/Abrasions

- Rope burns, particularly on wrist, ankles, neck, torso
- Visible on palate, mouth, gums, lips, eyes, ears
- Visible on external genitalia

Abdominal Injuries

- Bruises on the abdominal wall
- Bleeding into the wall of duodenum or proximal jejunum (stomach or colon)
- Intestinal perforation (upturned or torn intestines)
- Ruptured liver or spleen
- Ruptured blood vessels
- Kidney, bladder, or pancreatic injury
- Collapsed lung

Other Indicators

- Münchausen syndrome by proxy (a form of child abuse in which the parent/ caretaker relates fictitious illnesses in a child by either inducing or fabricating the signs/symptoms)
- Symptoms of suffocation

Adapted from "Diagnostic and Treatment Guidelines on Child Physical Abuse and Neglect," American Medical Association, 1992.

Child Sexual Abuse

FACTS ABOUT CHILD SEXUAL ABUSE

Child sexual abuse can be defined as the engagement of a child in sexual activities for which the child is developmentally unprepared and cannot give informed consent. Generally, the perpetrator is an adult, but a child may sexually abuse another child. Sexual abuse need not involve sexual intercourse. Often physical force is not used. Rather, the perpetrator uses gradual seduction techniques. The sexual activities may include genital or anal contact by or to the child, or non-touching abuses, such as exhibitionism, voyeurism, or using the child in the production of pornography. Sexual abuse may result in ano-genital (rectal, vaginal, or penile) injury or be accompanied by other signs of physical abuse, such as bruises, or by signs of neglect, such as poor hygiene. Survivors of child sexual abuse often experience long-term adverse effects on their psychological and social well-being and may be more likely to be victimized or perpetrate in later life as well.

Recent studies suggest that approximately twenty percent of children will be sexually abused in some way before they reach adulthood, with this figure cumulating at a rate of about one percent each year (studies vary widely on these numbers). Boys as well as girls may be victims. The abuse may take place within the family or outside it. Although abusers are more often male than female, women also may be perpetrators. Adolescents are perpetrators in at least twenty percent of reported cases. Offenders are more often people children know rather than strangers. Sexual abuse often continues for a long period of time. Children living in a home where other abuse is ongoing (e.g., spousal abuse) are at particular risk.

Evidence also suggests that the sexual and physical abuse of children often occur in successive generations of families. This "cycle of abuse," as it is commonly called, rarely ends unless intervention takes place. The problem of sexual molestation by a stranger, although foremost in the minds of many people, actually represents only a small percentage of total cases.

Behavioral Findings

Presenting behavioral symptoms are nonspecific, and caution must be exercised not to attribute all such complaints to sexual abuse. The symptoms may also be indicators of stressors not related to abuse. Reactions to stressors depend on the age and emotional maturity of the child, the nature of the incident, the duration of the stress, the child's history, and the manner in which the child relates to the source of the stress.

The child, depending on age, may:

- Display extremeness of activity (hyperactivity or withdrawal)
- Manifest poor self-esteem
- Have poor peer relationships
- Display a distortion of body image (distorted drawings)
- Display regressive behavior
- Express general feelings of shame or guilt
- Have enuresis (wetting) and/or encopresis (involuntary bowel movement)
- Appear frightened or phobic, especially of adults
- Wear excessive layers of clothing
- Engage in adolescent prostitution
- Have severe dissociative disorders
- Tend to be dreamy, "spaced out," or in a trance, especially in stressful situations

With appropriate support from important adults and therapy, the outcome for sexually abused children can be very good. Children can be remarkably resilient if someone believes them, intervenes to keep them safe, and helps them succeed at life tasks.

Adapted from "Diagnostic and Treatment Guidelines on Child Sexual Abuse," American Medical Association, 1992.

CASA/GAL Volunteer Responsibilities

INVESTIGATION

- Obtain firsthand a clear understanding of the needs and situation of the child by reviewing all relevant documents and records and interviewing the child, parents, social workers, teachers, and other persons to determine the facts and circumstances of the child's situation.
- Have regular, in-person contact with the child sufficient to have in-depth knowledge of the case and make fact-based recommendations to the court.
- Determine if a permanent plan has been created for the child.

FACILITATION

- Seek cooperative solutions by acting as a facilitator among conflicting parties.

ADVOCACY

- Identify and advocate for the best interest of the child.
- At every hearing provide reports that include findings and recommendations.
- Appear at all hearings to advocate for the child's interests and provide testimony when necessary.
- Make recommendations for specific appropriate services for the child and, when appropriate, the child's family.
- Inform the court promptly of important developments in the case by filing interim court reports (or a motion in jurisdictions where the volunteer has party status).
- Advocate for the child's interests in the community by interfacing with mental health, educational, and other community systems to assure that the child's needs in these areas are met.

MONITORING

- Maintain regular, in-person contact with the child sufficient to have in-depth knowledge of the case and make fact-based recommendations to the court.
- Monitor implementation of service plans and court orders, assuring that court-ordered services are implemented in a timely manner and that review hearings are held in accordance with the law.

PROGRAM/ADMINISTRATION

- Participate in all scheduled case conferences with supervisory staff.
- Participate in in-service training.
- Return case files to the program after the case is closed.
- Maintain complete records about the case, including appointments, interviews, and information gathered about the child and the child's life circumstances.
- Record volunteer hours and submit time sheet to program office.

CONFIDENTIALITY

- Respect the child's right to privacy by maintaining confidentiality.
- Comply with all applicable statutory requirements pertaining to confidentiality of client information.
- Safely and securely maintain all records.

Based on National CASA Association Standards.