MiPSAC

Newsletter of the Michigan Professional Society on the Abuse of Children, Inc., the Michigan Chapter of APSAC.

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PRESIDENT'S CORNER

By Annamaria Church, MD

Henry Ford Health System

Do you remember your first encounter with a suspected victim of child abuse? Whether you're a police officer, a lawyer, a social worker, a teacher, a nurse or any other of the many disciplines involved in the field of child protection, you can probably remember your first "case". As I remember, I immediately relive my disbelief and my angst. My stomach in knots, the sleepless nights come back to me. How can that happen to a kid? How do I help? I don't want to "mess- up". What should I do? Then, after you've muddled through your first case, you suddenly become the local expert. Yikes!

MiPSAC (Michigan Professional Society on the Abuse of Children) is the state chapter of the American Professional Society on the Abuse of Children. It was established in 1996 and over the first five years, has grown from a helpless infant and clumsy toddler into a vibrant organization. The purpose of MiPSAC is to provide an interdisciplinary network of professionals to educate, guide, and support the many people working in this highly stressful field of child protection. MiPSAC, through its newsletter, conference support, and listserve is a way for all of us to learn more about this field. It also provides a support group- people who actually understand what it is we do and the emotions we all must live with. Finally, MiPSAC provides a vehicle to improve the milieu in which we work.

Thank you, each of you for the work that you do. Although none of us ever has enough time to do all of the things we want to, you can help MiPSAC in several ways:

- Encourage your colleagues to become APSAC/MiPSAC members
- Contact board members with concerns, questions, ideas, or pet peeves
- Join us for a board meeting
- Let us know how we can help you in your work

MiPSAC is your organization. I look forward to working with all of you.

In this Special Issue on Child Sexual Abuse…

MiPSAC ANNOUNCEMENTS AND UPCOMING MEETINGS

7th MiPSAC Annual Meeting
Monday, October 28, 2002, 5-7 P.M.
Ypsilanti Marriott / 1275 Huron Street South
Ypsilanti, MI 48197 Info: (734) 487-2000
1. Election of 2003 Officers/Board
2. Presentation of 2002 MiPSAC Child Advocate Award

10th Annual APSAC Colloquium
May 29 - June 1, 2002, New Orleans, LA
Contact: gethesemani@comcast.net

MiPSAC 2002 Child Advocate Award

ELIGIBILITY
Nominees should be individuals who have made substantial contributions to practice relevant to child maltreatment/welfare and who have demonstrated the potential to continue such contributions. Nominees need not be current members of MiPSAC and can be from any discipline/level of service. Ideas for potential nominees include CPS, law enforcement, judges, medical field, volunteers, attorneys, foster care and social workers.

NOMINATION DEADLINE: Postmarked by 6/1/2002
TO NOMINATE, send 4 copies of:
1) A cover letter outlining the nominee's accomplishments to date and anticipated future contributions. This letter should describe the nominee's major accomplishments related to the field of child maltreatment and how the nominee's work has had an impact on the field;
2) The nominee's current curriculum vitae;
3) Two letters of support; and
4) If possible, other relevant supporting material

SEND NOMINATIONS OR DIRECT QUESTIONS TO:
Rosalynn Bliss, MSW /DeVos Children's Hospital
100 Michigan Street NE, MC-178
Grand Rapids, MI 49503

REMINDER!
Please renew your annual membership to APSAC.
You need APSAC membership for MiPSAC.
Part of you annual dues to APSAC pays for MiPSAC membership automatically!
American Professional Society on the Abuse of Children (APSAC)
C/O Gethsemani Center
2449 Beacon Street
Charleston, S.C. 29405
Phone: (843)744-6901 Fax (843) 744-7188
Membership info: gethsemani@comcast.net

MiPSAC Goals:

- To bring together Michigan professionals working in the area of abused children
- To foster networking among Michigan professionals
- To be an information resource for Michigan professionals
- To sponsor quality training for Michigan professionals.

DISCLOSURE IN CASES OF CSA

By Kathleen Coulborn Faller, PhD
University of Michigan of Michigan School of Social Work

One of the current debates in child sexual abuse is how children tell about their abuse, or what the characteristics of a disclosure of sexual abuse are. As Mark Everson (1998) has conceptualized it, "Is disclosure of sexual abuse an event or a process?" Depending upon how children tell, different interview procedures and skills are needed to facilitate or effect disclosure.

Underlying this debate, however, is another, often unarticulated controversy--the false allegation controversy. More specifically, "Should the forensic interviewer be more concerned that nonabused children will falsely accuse someone of sexual abuse or more concerned that sexually abused children fail to disclose or deny sexual abuse?" That is, "Is the larger problem one of false positives or false negatives?"

The dominant research agenda and most practice guidelines assume false positives are a larger problem than false negatives. Nevertheless, practice experience and research on at least three different populations--on adult survivors (Bolen & Russell, 2000; Russell, 1986), on child sexual abuse cases subject to investigation and assessment (Faller, 1988; Lawson & Chaffin, 1992; Sorenson & Snow, 1991), and on children without an abuse history participating in some analogue studies (e.g. Clarke-Stewart, Thompson, & Lapore, 1989; Goodman & Clarke-Stewart, 1993; Saywitz, Goodman, Nicholas, & Moan, 1991) suggest false negatives are the greater risk.

In this article, possible causes of false negatives or disclosure failures will be described. A framework for the debate about disclosure patterns will be presented and discussed. Finally I will highlight conclusions and practice implications. Some of the research and practice literature will be referenced, with particular note to the research of Sas and Cunningham (1995), who interviewed a sample of 138 children who had been through the court process, asking them about their perceptions and disclosure of sexual abuse.

CAUSES OF FALSE NEGATIVES

Before talking about the causes of false negatives, I want to remind forensic interviewers that a case can always be a true negative, that is a child who has not been sexually abused. The facts of the case should inform the interviewer of the level of likelihood of a true negative

There are two general causes of false negatives: 1) communication problems and 2) not wanting to talk about abuse. Forensic interviewers face the dilemma of not knowing if a disclosure failure is caused by not having been abused, not understanding what to disclose, or not wanting to disclose.

Communication problems

False negatives based upon communication problems include lack of sexual knowledge, failure to understand the requirements of a forensic interview, vagueness of the interviewer's questions, and lack of salience of the sexual abuse. Each of these will be discussed and illustrated.

Children don't know they have been abused. First, a child may have been sexually abused, but not know what has happened to her/him. If the child lacks sexual knowledge, he or she may not appreciate that a taboo has been violated. Children may have no names for private body parts, no knowledge of sexual activity, and no understanding of sexual abuse. Moreover, often offenders disguise their victimization by calling it a game, pretending the sexual activity is for the purpose of child care, or describing it as part of the child's education. In these situations, the idea they should tell someone may not even occur to children.

Sas and Cunningham (1995) in their follow-up interviews of sexually abused children who had been through the court process, found that about 40% did not appreciate that they were being sexually abused when the abuse first started.

THE FOLLOWING CASE EXAMPLE IS ALSO ILLUSTRATIVE:

At least five African-American youth were sexually abused by their choir master. The activities involved mutual fellatio and mutual anal intercourse. One 11 year old boy said he did not tell because he didn't even know what it was when the choir master did it with him. He knew how babies were made because his mother constantly admonished him not to get any girls pregnant. However, it never occurred to him that the activities with the choir master were related. As a consequence, he did not disclose his sexual abuse for two years, only admitting it when his mother asked him directly following a report by another boy to the police.

In this case, a fairly old and knowledgeable youth did not tell because he did not understand what was being done to him. Arguably, the "knowledge gap" is even greater with younger children.

Children do not understand interview expectations. Second, the whole experience of being "forensically interviewed" is very strange for most children, and they do not understand what is expected of them. The exception may be children whose families have been reported numerous times to CPS or children who have previously been in therapy. Even children with prior therapy experience, however, may have trouble with forensic interview expectations because there was more play in treatment, and more things to play with. They may ask, "Where's the toys?" and they may try to play with anatomical dolls, even though the forensic interviewer admonishes them that these are "special dolls" and "not for playing."

Moreover, many children will have difficulty are figuring out the expectations because they are unaccustomed to undivided adult attention, to adults wanting them to talk at length, and to being asked strange, long questions like, "I understand something may have happened to you. Tell me about it as best you can from the beginning to the middle, to the end." So it is not surprising they don't know what interviewers want. Especially challenging is getting pre-school children to comply with the requirements of the forensic interview (Cantlon, Payne, & Erbaugh, 1997; DeVoe & Faller, 1999; Keary & Fitzpatrick, 1994), even after a prior disclosure (DeVoe & Faller, 1999; Keary & Fitzpatrick, 1994).

Forensic interviewers try to cure this problem by setting rules, so children understand the expectations. Sometimes the rules are quite numerous. For example:

1. If I misunderstand something you say, please tell me.
2. If you don't understand something I say, please tell me.
3. If you feel uncomfortable at any time, please tell me or show me with the stop sign.
4. Even if you think I already know something, please tell me anyway.
5. If you are nor sure about an answer, please do not guess.
6. Please remember when you are describing something, I was not there.
7. I will not get angry or upset at you.
8. Only talk about things that are really true and really happened. (Yuille, n.d.)

All of these are good rules, but the more rules, the less likely children will be able to process them and remember them in the stress of a forensic interview. To increase the probability children understand and remember them, sometimes forensic interviewers have children practice the rules (Poole & Lamb, 1998). Nevertheless, it is important for forensic interviewers to keep in mind disclosure failures may be a consequence of forensic interview, itself.

Open-ended questions are too vague to focus the child. A third and related cause is that children may not disclose when they have been sexually abused because they don't know the abusive activities are what the interviewer wants them to talk about. In some instances, this null response may derive from the nature of the interviewer's questions. The questions may be so open-ended the child doesn't have any idea what the interviewer is talking about. For example a question like, "Do you have any worries?" the invitation, "This is a place where we talk about feelings," or even a probe such as "Do you know why you came to see me today?" may be too vague for the child to know what to report. Often when asked these open-ended questions, children report experiences not remotely related to sexual abuse.

CONSIDER THE FOLLOWING EXAMPLES:

A Children's Advocacy Center forensic interviewer explained to a six-year-old boy that this was a special place where kids could talk about feelings--things that made them happy, sad, scared, and mad. The boy looked interested and responded that he was sad, scared, and mad because his dog, Pokey, had been run over by a car the previous week. He told the interviewer he didn't think she could make Pokey come back to life. But if she could, that would make him happy.

A forensic interviewer who is part of a multidisciplinary team described herself as a "worry doctor" and asked a 10-year-old girl from a fundamentalist Christian family if she had any worries. The girl became very quiet and somber. She asked the worry doctor not to tell her mother. The doctor said she couldn't promise that. The girl said then she wasn't going to tell. The doctor, being almost certain the girl was referring to sexual abuse, encouraged her, saying that she would probably feel better if she told, and she (worry doctor) might be able to help. Finally the girl told the worry doctor she was very worried she wasn't going to Heaven because she had said dirty words.

Most forensic interviewers experience the above types of responses to their efforts to be open-ended and not lead the child. Professionals, such as CPS workers and police officers, who are usually part of the immediate response to a child's outcry, may experience these communication problems less frequently.

Children do not tell because the sexual abuse is not memorable. In other instances, children do not know what to talk about and fail to disclose because the abuse is not memorable or salient for the child. Forensic interviewers should appreciate that the subject of their inquiry may be of no significance to the child. Sometimes this is the cause of a false negative when the sexual abuse happened in the past. However, lack of saliency may cause reporting failure when the child has experienced many other traumatic or disorienting events, for example other abuse or sexual abuse, death of a loved one, or divorce, as in the case described below.

Case example. Sally, a 7-year-old girl, was removed from the care of her mother, who was chronically neglectful. She was being questioned by a forensic interviewer about two instances of sexual abuse by her father, which she had previously disclosed to her foster care worker. The interviewer asked her focused questions about her father:

I "Tell me all about your daddy."
S "He's nice. Sometimes I stayed at his house. He gives me money."
I "What do you like about your daddy?"
S "Oh, he's really nice. He gives me money."
I "What kinds of things do you do with your daddy?"
S "We play games sometimes. He lets me steer when I ride in his car."
I "Are there any things you don't like about your daddy?"
S "No, I like everything about him. There's nothing I don't like. He gives me money."

Finally, the interviewer said, “Did you tell Miss Jones about something your daddy did?” to which Sally replied, “Oh yeah. But that was my Uncle James; he did more.” She then responded to the interviewer’s questions first about what Uncle James did and next what her father did, describing different types of sexual abuse. She had already testified in criminal court against her uncle.

Sally was in foster care because her house had burnt down. Another uncle, Alan, had caught Uncle James sexually abusing Sally and had taken her from her house. Uncle James, in order to divert attention from the sexual abuse, had set the house on fire.

In describing the scene of the fire, Sally said Uncle Alan took her back to see the house afterward, and “all the burnt animals were there, my doggy, two kitties, and the hamster, and the chickens.” But she said, “My baby brother wasn’t there. They took him somewhere else.” Not only had all the family pets been killed in the fire, but also her one-year-old brother.

In this case example, the sexual abuse by Sally’s father, about which the forensic interviewer wanted to gather information, was probably one of Sally’s less traumatic experiences, and was not salient to Sally in her current circumstances.

False negatives because children do not want to talk

As mentioned earlier, some children don't tell because they don't want to. That is, they fully understand what the interviewer is asking about, but they avoid answering the interviewer’s questions. In these instances, the failure to disclose is not caused by a memory retrieval problem. Consequently, forensic interviewers' efforts to trigger their memories are likely to be of no avail, and it is unlikely in these situations that asking more direct questions will change the child's mind. In Sas and Cunningham’s research (1995), 12% of children reported they made up their minds not to tell.

Sometimes addressing causes of reluctance to disclose or offering reasons for disclosure will be persuasive. Reasons for not talking are multiple. They include avoiding unpleasantness, feeling responsible, fear of the consequences of disclosure, and fear of the unknown.

Avoidance of stressful events. Children may be traumatized by talking about the abuse and therefore avoid the topic or deny the abuse (Berliner & Saunders, 1995). Young children, who wish to avoid distress, may simply fail to respond to the question or change the subject. If asked directly about why they are not answering questions, they may then say they don’t want to. Older children are more likely to say, “I don’t like talking about this; it makes me really upset.”

Reluctance to disclose because of shame and guilt. Children may fail to disclose because they feel shame or responsibility for the experience. Young children, who initially may have been naïve about the inappropriateness of the abuse, often think they are bad because they participated in the abuse, which they may have enjoyed. They experienced pleasure form activities they have come to discover are very, very bad. Therefore they must be bad because they enjoyed them.

Older children often blame themselves for failure to resist, failure to report, and any pleasure, attention, or material gain associated with the abuse. They see themselves as participants, rather than victims. Because they feel culpable, they want to prevent people from finding out.

False negatives because of offender instruction. Children may also fail to report because they have been bribed, admonished, or threatened with negative consequences, should they tell. Half of the children interviewed after litigation in the Sas and Cunningham study (1995) had been told by the offender not to tell. Because the frequency of offender strategies to prevent disclosure, most forensic interviewers ask children about these admonitions.

Methods that offenders employ to assure silence vary with the age of the child, the role relationship to the child, and the personality the offender. An offender with a close relationship to the victim may admonish the child by saying, “If you tell, I won’t love you anymore” or “I won’t be able to see you anymore.” An offender who is an authority figure, for example a priest, may warn the child that “God won’t love you if you tell.” Older children who are abused by a pedophile, who has befriended children, may be told that disclosure will mean he can’t help other children or continue to help the victim. Some offenders threaten to kill the victim, harm the victim, harm the victim’s pets, destroy the victim’s valued property, or injure or kill the child’s parents.

An example of the latter involved a deacon of a church who took a seven-year-old boy out into the graveyard after he had sodomized him in the basement of the church. He pointed out to the boy the spot where he would bury him if he told.

False negatives because of fear of the unknown. Finally children may not know the outcome of disclosure, and the fear of the unknown results in failure to report. Questions such as, “Will I be believed?” “What will happen to the offender?” “Where will I live?” and “What will happen to my family?” all may inhibit telling. In a study of children who disclosed sexual abuse, Petronio and colleagues found that children are often anxious about the consequences of disclosure and "test the waters" before revealing sexual abuse. These researchers found that disclosure was incremental and a process, even in a group of 38 children in treatment for sexual abuse and willing to be interviewed about their disclosure (Petronio, Reeder, Hecht, & Ros-Mendoza, 1998).

Additional factors that may affect disclosure

Additional factors that can affect the likelihood of disclosure include, but are not limited to the following: the child's relationship to the offender, the interviewer's capacity to relate to the child, child's and family's perception of the professional helpers, and characteristics of the abuse. In general, practice tells us children have greater difficulty describing abuse by someone to whom they are close. Also children are less likely to tell if they have an unsupportive non-offending parent (Lawson & Chaffin, 1992). In forensic interviews, children are expected to talk about intimate and shameful experiences to strangers. Interviewer characteristics such as race, gender, and degree of experience and comfort doing forensic interviews can affect the likelihood of disclosure in a variety of ways. Although professional sometimes forget, many children have been warned about people like us--our power, and our ability to do harm to the family. The child's perception of the forensic interviewer as helpful or harmful will impact upon the probability and pattern of disclosure. Finally, abuse characteristics can impact. As already noted, children may experience some acts as more

shameful and therefore be less likely to disclose them. On the other hand, some acts hardly seem abusive to children and this can retard disclosure.

A CONCEPTUAL FRAMEWORK FOR EXAMINING THE DEBATE

As noted at the beginning of this article, Everson (1998) has defined the issue as, "Is disclosure of sexual abuse an event or a process?" As Table 1 indicates, whether disclosure is perceived as an event or a process has implications for both professional expectations and interview practice.

Table 1 PATTERNS OF DISCLOSURE

AN EVENT?	**A PROCESS?**
1. Like a crime report shameful	1. Like a confession--embarrassing,
2. Narrative account	2. Gradual unfolding
3. Child very straightforward	3. Child hesitant, avoidant, retracts
4. Requires a single interview	4. Requires multiple interviews
a. A few open ended questions	a. Many questions
b. Follow-up questions to clarify	b. A continuum of questions
5. Standard protocol	5. Flexible use of modules
6. Forensic skills	6. Clinical skills
a. Introduction	a. Rapport building
b. Competency	b. Support
c. Elicit disclosure	c. Pacing
d. Non-leading questions	d. Vary questions by child
e. Avoid media; rely on verbal communication	e. Use media & vary use depending upon child's needs

Table 1 provides two very discrepant perspectives of disclosure of sexual abuse. If disclosure is an event, during which the child straightforwardly makes a report of his/her abuse, this implies that a single session should be adequate and that the child will provide information if asked. The child does not feel a personal sense of stigma or responsibility, but rather that the offender is the one who did wrong. The interviewer merely has to trigger the child's recollection in a way that is not leading. Perhaps leading or suggestive questions will lead to affirmation of events or details that did not happen, and use of media that might elicit fantasies or play instead of facts.

In contrast, if disclosure is a process, during which children have to overcome fears, shame, and embarrassment, this would suggest information emerges over time. Interviewers will need more than a single session (Carnes, Wilson, & Nelson-Gardell, 2000) and will need to pace their data-gathering, deciding when to continue data gathering and when to back off. In addition, the interviewer might need to use strategies to address the child's thoughts and feelings about the abuse and disclosure, in order to persuade the child to tell. If disclosure is a process, the challenge to the interviewer is to overcome denial and minimization. Many questions and a variety of approaches, including the use of media, may be required to gather all the data. Because the child may feel guilty or fearful, the child is unlikely to endorse experiences he/she has not had. Moreover, because of these feelings, recantation of actual experiences may occur during the course of revelation.

CONCLUSION

Based upon research and practice experience, the evidence suggests a proportion of children disclose sexual abuse immediately, probably a minority. In Sas and Cunnigham's research, 33% told someone within 48 hours. As a consequence, for the majority of children, disclosure is a process (Petronio, et al., 1998; Sorenson & Snow, 1991; Summit, 1983). In fact, most cases that come to the attention of professionals involve a prior disclosure (Bradley & Wood, 1996; Sternberg et al., 1997). That is, the child has told someone, who then reports the allegation to protective services. Often when the history of discovery of the child abuse is traced, professionals find a pattern of multiple disclosures before the case gets to the attention to professionals. Moreover, some children recant previously disclosed sexual abuse (Sorenson & Snow, 1991). However, there is no empirical method of differentiating a retraction of a false allegation from the recantation of a true one.

For the practitioner, each case requires careful consideration as the forensic interviewer decides what will best enable the child to describe events, if any, which he/she has experienced. The factors to be considered include what the level of suspicion is about abuse, safety issues, the child's age, functioning, and affective state, where in the disclosure process the child might be, what factors might inhibit the child's disclosure, and how many interviews should occur before a decision about the likelihood of sexual abuse is made.

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A Guide to the Medical Exam in CSA

By Mary Smyth, MD
William Beaumont Hospital

In the last ten years several published articles in the medical literature have confirmed what has been the experience of most physicians when they examine young people who are alleged to have been sexually abused – the exam is normal. In 1994 Adams et al. looked at case files of 236 children where there was legal confirmation of sexual abuse -conviction, confession etc. (Pediatrics 1994; 94: 310-317). 9% had suspicious findings and only 14% were considered clearly abnormal. More recently, Berenson and her colleagues looked at children between age 3 and 8 who gave clear history of vaginal penetration, either digital or penile (Am. J. Obstet. Gynecol. 2000; 182:820-834). Less then 5% of these cases had significant findings. This raises a few questions. Why examine these kids at all? If some kids need exams, which ones? Who should examine these kids and when?

Why should a child/teen (hereafter = child) who has been sexually abused have a medical exam? First, and foremost, to reassure the child (and the family) that their body is OK. Sexual abuse causes a great deal of anxiety, much related to investigation and prosecution, but kids and parents often worry about physical issues- are they "damaged"? These issues can be addressed during a sensitive, thorough exam. The possibility of sexually transmitted disease, pregnancy, and other medical concerns can be evaluated. Finally, an examiner can provide expert testimony if necessary (**it's NOT about the evidence).**

Does every child need an exam? Probably. Any time there is reason to believe that a child may have been sexually abused a medical exam is a good idea. Exceptions, however, would be cases of non-specific physical or behavioral concerns. For example, "she's red down there and I just want to make sure that no one's messing with her" or "my three year old masturbates" may require a medical, but perhaps not sexual abuse, evaluation.

Who should perform the exam? Here are the pros and cons of the various options; (not all doctors are equal).

Family doctor a.k.a. Family Practice, General Practitioner, Pediatrician.

Advantages: this person may have a long- standing relationship with the child. The child may be more comfortable being examined in familiar surroundings.

Disadvantages: a family doctor may not have experience with this type of case. Any physician is capable of examining genitalia; some may not know what to look for or how to interpret what they see. Busy family doctors may be reluctant to get involved in situations that would take them away from their practice.

Emergency room physician.

Advantages: always available. They can evaluate acutely injured patients, collect forensic evidence, and give prophylactic treatment for STD and pregnancy prevention.

Disadvantages: not all ER physicians are experienced and comfortable with this type of problem in children. The ER is a **scary** place and should be used for emergencies. Many ER physicians HATE to go to court (may mean lost income).

Child abuse specialist-this may be a pediatrician, ER physician, OB/GYN, or a nurse with special training and experience in child sexual abuse evaluation.

Advantages: very familiar with all aspects of these cases. Usually able to accommodate an emergency evaluation when necessary. Willing and able to go to court and cooperate with the investigation.

Disadvantages: the child usually does not have a previous relationship with this person. There are a limited number of individuals who have this expertise; there may be a "wait" for a routine appointment.

When should the exam take place? Not every case of sexual abuse is an emergency. Understandably, a parent(s) who just learned that their child was sexually abused may feel compelled to rush the child to the ER, even if the incident occurred months ago. This may result in undue stress for the child and the family, and misutilization of medical resources. In general the following guidelines may be used:

Time from the incident	When/who
<72 hours	within 24-48 hours, child abuse specialist if available, ER if necessary
3-14 days	within 2-3 days, child abuse specialist whenever possible
>14 days	child abuse specialist, family physician who feels comfortable

We know that injuries, when they occur, from sexual abuse of children heal very quickly. Redness and swelling can resolve within a few days. Most healing is almost complete in two to three weeks.

Some final suggestions: think carefully about the "when", "who" and "where" of the medical examination. As with other resources, medical resources are limited. Most importantly, we do not want to add to the trauma that the child has already experienced. When in doubt- **CALL AHEAD.** Ask to speak to the examining physician if possible, or contact a child abuse expert to give guidance on your specific case.

HOW A PROSECUTOR ASSESSES A CSA CASE

By Carol A. Siemon, JD
MSU Chance At Childhood Program

A prosecutor assesses a case of child sexual abuse in terms of "what can be proven." Depending on whether the case is being reviewed for possible criminal prosecution, civil child protective proceedings, or both, the prosecutor will need to explore "who did what to whom and how can it be proven?"

If, for example, the perpetrator of the sexual abuse on a child is unknown, no criminal prosecution will occur because there is no one to charge with a crime. A person who is alleged to have committed sexual abuse will generally only be charged with a crime if the prosecutor believes it can be proven "beyond a reasonable doubt" (about a 95% certainty) that he or she committed the crime.

The primary purposes of the criminal justice system are determining guilt/responsibility and determining appropriate punishment/consequences. The main focus is on the person who allegedly committed the sexual abuse and the child victim is viewed somewhat secondarily as a witness to a crime. There are times when a perpetrator may be ordered as a condition of probation to pay for the victim's medical or counseling expenses, but, typically, the focus remains on the perpetrator and what should be done to punish him or her and protect society from future victimization.

In a child protective proceeding, on the other hand, the focus is on the child and the family. The main issue for the court to determine is whether the child's home or environment is harmful. The primary purposes of the civil child protective proceeding are to protect the child and provide services to strengthen the family, leading to reunification of the family, if possible.

If, for example, a child is sexually assaulted by a neighbor or at school and the child's parents act appropriately to protect the child and help the child cope with the abuse, it is unlikely that a child protective proceeding will be brought because the child's home environment is appropriate.

The burden of proof in a civil child protective proceeding (except involving an Indian child, or if the court is asked to terminate parental rights) is by a "preponderance of the evidence" (about 51% of evidence that supports court involvement). This much lower burden of proof means that court involvement ("jurisdiction") in a child protective proceeding is much easier to obtain than is a guilty verdict in a criminal proceeding.

Due to the different burdens of proof and what the court is authorized to do once it is involved, a prosecutor may decide to pursue a civil child protective proceeding but not a criminal action. If both criminal and civil cases are pursued, the court actions and orders that may be sought in each case to protect the child, provide services/punishment to address the perpetrator's behavior, and to protect society may be quite different due to the differing roles of the two court systems. Ultimately, the focus of the prosecutor remains not on what may have happened, but what can be proven to have occurred.

…….Upcoming Meetings……

Join the MiPSAC email List: by emailing Vince Palusci at vincent.palusci@spectrum-health.org

Keeping Kids Alive: Child Death Review
Sponsored by Michigan FIA and MPHI
May 5-7, 2002. Shanty Creek Resort, Bellaire, MI
Contact: Teri Covington (517) 324-7330

8th Annual Child Maltreatment Conference
"A Child Abuse Course For Physicians"
Sponsored by FIA & Henry Ford Health System
May 14-15, 2002. Traverse City Holiday Inn.
Contact: Lu DeLoach, RN (517) 335-3704

10th Annual APSAC Colloquium
May 29 - June 1, 2002, New Orleans, LA
Contact: Gethesemani@comcast.net

14th International ISPCAN Conference
July 7-10, 2002. Denver, CO.
Contact: Kempe Center at www.kempe.org