RAP Sheet

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UNUSUAL SOURCES OF LEAD POISONING

Case reports from the Centers for Disease Control and Prevention suggest several sources of lead that are not widely known. In one case, a 2-year-old was exposed to high levels of lead from a metallic, beaded necklace purchased at a department store. In another case, the parents of an 11-month-old routinely applied a medicinal powder (used in Asia for centuries) to the infant's eyes to strengthen them. It was found that this powder contained 25% lead by weight. Aside from relatively well-known sources (for example, pottery and cookware), folk remedies from various countries were also included as potential sources. The authors cautioned against discounting lead poisoning in cases where only water sources and paint have been ruled out as potential contaminants.

Jones, T. F., Moore, W. L., Craig, A. S., Reasons, R. L., & Schaffner, W. (1999). Hidden threats: Lead poisoning from unusual sources. *Pediatrics, 104*, 1223-1225.

REACTIVE ATTACHMENT DISORDER: CONTROVERSIAL DIAGNOSIS MAY BE OVERUSED ON CHILDREN WITH A HISTORY OF MALTREATMENT

The number of children being labeled with a diagnosis of Reactive Attachment Disorder is increasing; this is especially true for children who have been maltreated. Although the official diagnostic criteria describe a child who does not initiate appropriate social contacts or respond appropriately to others' attempts at social interaction (likely due to a history of maltreatment), the diagnosis has come to be associated with the picture of a child who acts impulsively, destructively, cruel to humans and animals, and generally without conscience. This inappropriate extension of the diagnosis may be causing RAD to be overdiagnosed in maltreated children. As no standardized assessment tool has yet to prove valid, great care should be taken when one is considering a diagnosis of RAD. Furthermore, currently available treatments tend to focus on "rage reduction" rather than on any of the official diagnostic criteria. Treatment evaluations that have been published in academic journals generally have used antisocial behaviors as outcome measures, even though the psychological symptoms of RAD do not include aggression or delinquency. Some of the current "treatment programs" may have the capacity to harm these already vulnerable children further. Great care should be taken when assigning a diagnosis of Reactive Attachment Disorder, and when considering treatment options. Additional information about RAD and possibilities for treatment are available in the full article.

Hanson, R. F., & Spratt, E. G. (2000). Reactive Attachment Disorder: What we know about the disorder and implications for treatment. *Child Maltreatment, 5*, 137-145.

USING TECHNOLOGY TO HELP DIAGNOSE MUNCHAUSEN SYNDROME BY PROXY

Munchausen Syndrome by Proxy (MSBP) is one of the most controversial types of child abuse. In these cases, a child's parent or guardian knowingly fabricates or intentionally induces the child's medical symptoms, supposedly in order to get attention and sympathy. Obviously, MSBP is difficult to confirm, and even more difficult to convince a judge and/or jury of the diagnosis without reliable witness' testimony. One tertiary care children's hospital in Atlanta installed a covert video surveillance (CVS) system for use in cases of suspected MSBP. Multidisciplinary teams referred 41 patients to be monitored between 1993 and 1997. Hospital security officers monitored the children's rooms constantly. (More specific personnel and procedures involved are detailed in the article.) Twenty-three of these cases were determined to be instances of MSBP – in 13, the CVS documentation was required to confirm the diagnosis; in 5, surveillance was supportive of other evidence. Additionally, CVS was necessary to rule out a diagnosis of MSBP in four suspected cases. Further analyses indicate that although a certain constellation of family characteristics has come to be associated with MSBP (for example, parental enthusiasm for medical testing, closeness to medical staff, parental knowledge of medicine, distant or unavailable father, suspicious sibling death), these variables were not reliable discriminators between MSBP and non-MSBP cases in this sample. The authors provided three arguments in response to ethical concerns of rights to privacy: (1) many privacy rights are relaxed or lost when one is admitted to a hospital for any reason; (2) signs and consent forms alerted parents to potential audio/video surveillance; and (3) the safety of the child supercedes the adult's right to privacy in these potentially fatal cases. Further, the authors argue that *final* decisions about a family court or criminal court case in which CVS evidence is admitted are best left to the judges and juries assigned to the case.

Hall, D. E., Eubanks, L., Meyyazhagan, S., Kenney, R. D., & Johnson, S. C. (2000). Evaluation of covert video surveillance in the diagnosis of Munchausen Syndrome by Proxy: Lessons from 41 cases. *Pediatrics, 105*, 1305-1312.

EVALUATION OF A PROGRAM INTENDED TO REDUCE RECIDIVISM RATES IN ADOLESCENT SEX OFFENDERS

The goal of the SAFE-T (Sexual Abuse, Family Education and Treatment) Program is to reduce the risk of reoffending by enhancing family and peer relationships, while also targeting more offense-specific goals such as cognitive distortions, victim empathy, and relapse-prevention plans. Treatment plans are individually tailored for each offender and family, and offenders are usually involved in group, individual, and family therapy. Researchers compared recidivism rates of 58 (53 Male, 5 Female) adolescents in the Treatment group (adolescents who had received treatment for at least 12 months) to 90 adolescents in the Comparison group (86 M/ 4

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MISSION STATEMENT:The *RAP Sheet* is intended to inform professionals across the state of Nebraska of current findings from social science research that could impact the delivery of services to children and families. Summaries of recent articles from academic journals (and occasionally book chapters) on the areas of child protection and juvenile justice are the focus, with smaller sections reserved for announcements and websites of interest. Other topics will be included in special issues as needed. Citations are provided in the format used by the American Psychological Association (APA), and are available through many university libraries. The *RAP Sheet* is funded in part by the State of Nebraska Department of Health and Human Services System. Comments and suggestions are always welcome and can be sent to the editors or faculty advisor.

F) who did not receive the treatment (although 67% of the Comparison group did receive some kind of treatment other than the SAFE-T Program). Recidivism was defined as a criminal charge for a sexual offense, violent nonsexual offense, or nonviolent offense, during the follow-up period (average duration of follow-up was 6 years). The treatment and comparison groups were compared on several factors related to recidivism to see if any differences existed between them that might otherwise account for any recidivism differences, but none were found. The sexual assault recidivism rate was 18% for the Comparison group, and 5% for the Treatment group. For violent nonsexual offenses, the recidivism rate was 32% for the Comparison group and 19% for the Treatment group. The recidivism rate for nonviolent offenses was 50% for the Comparison group and 21% for the Treatment group. All recidivism rates for the Treatment group were significantly lower than for the Comparison group; therefore, the authors concluded that treatment programs combining a strong family-relationship component with offense-specific interventions may be most successful for adolescent sexual offenders.

Worling, J. R., & Curwen, T. (2000). Adolescent sexual offender recidivism: Success of specialized treatment and implications for risk prediction. *Child Abuse & Neglect, 24*, 965-982.

PRO-ACTIVE COPING STRATEGIES NOT COMPLETELY EFFECTIVE IN PREVENTING CHILD PROTECTION WORKER BURNOUT

Front-line child protection workers, as well as their supervisors, encounter work-related stresses that often lead to burnout (feelings of emotional exhaustion, depersonalization towards clients, and decreased feelings of personal accomplishment). A survey of 151 veteran child protection workers and supervisors examined types of coping strategies used and levels of burnout. The participants in the study had an average of 7.5 years of experience, worked an average of 46 hours per week, and had an average caseload of nearly 30 families. Most (75%) of the participants were female, and approximately half were African-American. These veteran workers were more likely to use "Engaged" coping strategies rather than "Disengaged" strategies (that is, workers were more likely to actively work towards changing a stressful situation than to attempt to avoid the situation). Of the Engaged coping strategies, workers were more likely to use problem-focused strategies (active problem-solving and cognitive restructuring) rather than emotion-focused strategies (social support and emotional expression). Unfortunately, although the use of Engaged coping strategies was associated with lower levels of depersonalization and higher levels of personal accomplishment, the use of Engaged coping strategies was *not* associated with lower levels of emotional exhaustion. The authors suggest that workers increase their use of emotion-focused strategies (while maintaining the use of problem-focused strategies), and that agencies provide more outlets for emotional expression and debriefing of workers and supervisors.

Anderson, D. G. (2000). Coping strategies and burnout among veteran child protection workers. *Child Abuse and Neglect, 24*, 839-848.

University of Nebraska-Lincoln

Center on Children, Families, and the Law
121 South 13th Street Suite 302
Lincoln, NE 68588-0227

RACIAL/ETHNIC DIFFERENCES IN MENTAL HEALTH SERVICE USE BY CHILDREN IN FOSTER CARE DO NOT REFLECT DIFFERENCES IN NEED

Mental health services utilization rates among 659 youth (aged 2-17) in the San Diego foster care system revealed striking racial/ethnic differences. Although, overall, 57% of the youth received mental health services, African-American and Latino youth were less likely than White Americans to receive mental health services. Furthermore, analyses showed that these differences were not simply due to racial/ethnic differences in need (as measured by the Child Behavior Checklist). Researchers classified all youth into low, medium, or high need categories, based on CBCL scores. For each of these categories, Latino youth were less likely than White-American youth to receive mental health services. Of those in the high need category, African-American youth and White American youth were equally likely to receive services. However, in the low and medium need categories, African-American youth were less likely than White American youth to receive mental health services. Results suggested that when the need for mental health services for a child in foster care is high, African-American and White American youth are more likely than Latino youth to receive treatment. When the need is less obvious (as evidenced by fewer emotional and behavioral problems) African-American and Latino youth are not as likely as White American youth to receive treatment. Possible explanations for these differences include factors related to service systems (referral and accessibility) and to clients themselves (cultural differences in perceptions of and knowledge about mental health services).

Garland, A. F., Hough, R. L., Landsverk, J. A., McCabe, K. M., Yeh, M., Ganger, W. C., & Reynolds, B. J. (2000). Racial and ethnic variations in mental health care utilization among children in foster care. *Children's Services: Social Policy, Research, and Practice, 3*, 133-146.

POST-ASFA REPORT AVAILABLE FROM DHHS

The first report of state and national data on the effects of ASFA is available online from The Children's Bureau (US Department of Health and Human Services). The annual report contains information regarding the safety, permanency, and well-being of children in foster care. *Child Welfare Outcomes 1998: Annual Report* is available at http://www.acf.dhhs.gov/programs/cb/ (scroll down the Children's Bureau page and click on the report title).

Editor	Jennifer M. Wyatt jwyatt@unlserve.unl.edu
Assistant Editor	Angela L. Williams awilliam@unlserve.unl.edu
Faculty Advisor	Vicky Weisz 402.472.9814 vweisz1@unl.edu
Layout Design	Chris Wiklund cwiklund1@unl.edu

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