LAKE SUMTER Children's Advocacy Center

Child Chat

"Dedicated to children and those who serve them"

Steven Wayne Dolliver, Editor

Volume III Issue 1 July 2022

Child Chat is a quarterly newsletter of Lake Sumter Children's Advocacy Center designed to acquaint the Lake and Sumter County communities with our professional staff and their trauma-focused services to children, as well as to highlight topical children's issues.

Gifted

Lake Sumter Children's Advocacy Center is pleased to recognize

Mount Dora Community Trust

for its recent generous grant award in the interest of our Expressive Therapies Program. The funds shall be utilized to facilitate innovative virtual therapeutic techniques, such as virtual sand tray, that have become both popular and necessary with the advent of COVID-19 in the past two years. For children who face challenges with verbal therapy, virtual sand tray simply offers a tactile medium for expressing feelings related to prior traumatic experiences. And for those children who possess greater facility with verbal therapy, virtual sand tray simply provides a novel complementary vehicle for their self-expression. We are so blessed to have a caring and compassionate community partner as Mount Dora Community Trust who, through its support, aids us in expediting the recovery of our child survivors of abuse. MDCT, thank you for thinking of our Center and, most importantly, thank you for thinking of our kids!

It's Official!

Loyal readers may recall that in April's edition of *Child Chat* we celebrated with Center Counselor **Sorimar Gonzalez**, as she had passed her Licensed Mental Health Counselor (LMHC) examination. At the time, she had completed two legs of the obligatory three-leg journey in meeting licensure requirements. In addition to her success with the licensure examination, Sorimar had then already surpassed the necessary one-hundred (100) hours of clinical supervision. She merely needed to execute a scant few hours of the 1500 post-Master's direct service hours to meet that final standard. Well, it is now our pleasure to announce...wait for it...wait for it...that Sorimar is officially a full-fledged **Licensed Mental Health Counselor**. We are so proud and happy for you, Sorimar—congratulations! And, so, we shall honor you once more with our traditional Happy Dance! For you, Sorimar!....

Inside This Edition

Child Quote: *"Children are the living messages we send to a time we will not see."*

- John F. Kennedy, 35th President of the United States

From the Editor

"Peace, Lillie"

Long careers working with children almost inevitably spawn a treasure trove of stories. Some stories are ***humorous*** - like the day my middle school clients conspired to commemorate my 40th birthday by decorating my counseling office with 100 black balloons and a makeshift plywood coffin displaying the foreboding message, "R.I.P." Imagine my surprise (and my virtual heart attack) when a small child, cleverly concealed, suddenly popped out of the casket! We all had a good laugh over that!

Some stories are ***painful*** - like the day a recalcitrant 6th grade boy stealthily crept behind me with malevolent intent and cracked a thick hardbound Webster's Dictionary over the back of my head. Conveniently, there was a hospital just up the street to treat my severe concussion, with nurses who graciously retrieved me from unconsciousness! The headaches serve as grim reminders of a fateful day in May. It is ironic though that the very child who perpetrated that dastardly deed later became one of my all-time favorite clients. From adversary to ally-go figure!

Some stories are ***sad***—like the case of the 9-year old boy afflicted with Prader-Willi Syndrome. Jim tipped the scales at a whopping 420 pounds and was at serious risk of literally eating himself to death. It was not his fault that his body possessed no "shut-off valve" to curb his food consumption, just as it was not his fault that his deficit intellect robbed him of impulse control. I still recall the day Jim "lost it." No one knew for sure why he was so angry and what provoked the "code black", that ominous alert reserved only for Jim that summoned male staff from all corners of the school. When I arrived on the scene, Jim was already struggling mightily against a "standing restraint", the only protocol that ensured his and others' safety from his spiraling rage—or so we thought. We could not have known the physical stress the restraint exacted on Jim's body, his excessive weight exacerbating his fragility. However, it was clear to all when blood suddenly spurted violently from his nose, soaking Jim and those around him. A frantic "911" call mustered a pair of paramedics, who fought heroically to stem the crimson geyser and thus save the day. The last I knew Jim and his family were relocating to Pittsburgh, where he would receive services at the University of Pittsburgh Medical Center, At the time it was one of only two programs in the country with a dedicated service unit treating children afflicted with Prader-Willi Syndrome. I often think

(continued on page 2)

Child Chat

Getting to Know Holly B., ARNP

Editor's Note: *We are pleased to introduce **Holly Bonynge**, an esteemed member of our Medical Services Team. Holly graduated from Georgetown University with a B.S. in Nursing in 2009 and later earned her M.S. in Nursing from Alabama- Birmingham in 2019. She has served as an ARNP for the past 2.5 years. We trust that you shall enjoy the chance to meet Holly through this "Q & A" session.*

Q1, Hi, Holly. Thanks for agreeing to this interview with me. Before we do a "deep dive" into your professional background and your work with the Center, perhaps you would share with us a bit about your upbringing. Would you kindly describe your early years – where you were born and raised, parents and siblings, family values, etc.?

I was born here in Leesburg, at Leesburg Regional Medical Center. I moved around a little bit in Florida, spent some time at the University of Florida while my dad was in law school before moving back to Leesburg, where my dad started practicing law with the law firm McLin & Burnsed. Primarily, I grew up in Leesburg and graduated from Leesburg High School. I grew up in a close-knit family with my parents and one sister. We spent a lot of time outside- hunting, fishing, scalloping, and lots of time in the woods.

Q2. Who had the greatest impact on you in those formative years and why?

Both of my parents had a huge impact on me. They both worked hard and put our family at the front of their priority list. I strive to do the same.

Q3. When did you know that you would pursue a career in medicine? Was there an individual who particularly inspired your career choice?

Growing up I loved helping my dad clean animals that he had killed. I wanted to see the organs, see how everything connected. While in high school, I interned at the Leesburg Regional Medical Center radiology department and loved it. When I got to college, I had no idea what to do. To be honest, I was more interested in the social aspect of college than in studies. I was 2 semesters from graduating when I finally decided I wanted to go into nursing school. So, I graduated and went back to school to become a Registered Nurse.

Q4. I know that the ARNP credential is a most coveted one these days. Accordingly, many agencies aggressively compete for ARNPs, which typically places professionals as yourself in the enviable position of choosing among multiple employment "suitors." Given that luxury, what was it about Lake Sumter Children's Advocacy Center that appealed to you and resulted in your employment there?

I love the nursing aspect of being an ARNP, but more than that I love taking care of people and helping them. After 2.5 years of primary practice, my favorite part of it is helping the children and parents, feeling as though I am doing something

(continued on page 3)

"Peace, Lillie" *(from p. 1)*

about Jim and pray for his good health….

Still, for all the many stories, there was only one in my lengthy tenure that could be described as ***death-defying***. And that story featured yours truly. So, without further adieu, let the story begin….

It all started (and almost ended) with a little girl named Lillie. With the exception of Lillie, I dedicated all of my counseling hours at Gateway School to twelve (12) sixth graders matriculating in a self-contained classroom earmarked for students classified as Severely Emotionally Disturbed (SED). Over time the Exceptional Student Education (ESE) nomenclature has changed, guided by prevailing perceptions of "political correctness." Consequently, the acronym E/BD (Emotional/Behavioral Disability) has supplanted the archaic SED label. But, regardless of the "tag" of the moment, students so classified occupy the margins outside of mainstream education. They are removed from conventional classrooms because their extreme emotional and behavioral presentations taint their learning and disrupt the learning of their classmates. Those presentations, it seems, fall into either of two camps. Students who are "externalized" present potential risks to others. They are angry, defiant, aggressive, oppositional, anti-social, disrespectful and mean. On the other hand, students who are "internalized", whom I shall call the "silent sufferers", often recede into the classroom "shadows.". They appear anxious, depressed, socially isolated, paranoid, fearful, and unengaged. They are barely noticeable as they wallow in their private miseries in the back of the classroom. Lillie occupied a prime seat in the former group, and that is precisely why she was the only 9-year-old referred for my services. It is not hyperbolic to say that Lillie **terrorized** her classroom. Her rage episodes, provoked by little more than a classmate's inadvertent nudge, were legendary. In fact, on my first day with Lille, I was summoned to her classroom, which was conspicuously devoid of students. You see, Lillie's teacher had

evacuated it just as Lillie began her rampage of blind and wanton destruction. I waited until she had dissipated her ferocity and cautiously entered the calamitous wasteland that once was an orderly classroom. Amidst the overturned desks and chairs and general detritus sat a slight, willowy black girl flashing a menacing "leave me alone" scowl. It was almost incomprehensible that this mere reed of a child could have fomented such chaos, but I had witnessed the whirling dervish that was Lillie with my own eyes. And in the aftermath I was firmly convinced that Lillie, in a fit of uncontrolled rage, could undoubtedly be dangerous to self and others.

(continued on page 3)

Getting to Know Holly B., ARNP *(from p. 2)*

worthwhile. This job helps me do that. I am not just there to prescribe medicine but to help children overall and advocate for their health and well-being.

On gratification: *"...my favorite part of it is helping the children and parents, feeling as though I am doing something worthwhile."*

Q5. I must admit to knowing little about medicine. I wouldn't know a stethoscope from a hammer, and the closest I ever got to the field of medicine was playing doctor as a child. With that as my pathetic preamble, would you please walk me through what you do at the Center?

As I am new to being here on a more permanent basis, I am slowly learning the day-to-day tasks that go along with the medical side of the Center. In the morning I review intakes that come in to see if they meet our medical mandatory case criteria. Furthermore, I review the cases that will be coming in to be seen. The CPT Case Coordinators let us know what the allegations are and what was said in the interview before medical exams. Then, after the medical exams have been executed, we follow up with DCF, law enforcement, and, of course, the assigned case coordinator to ensure everyone is (hopefully) on the same page with the findings of the interview and medical and the consequent as well as the recommendations. Sometimes, there is a lot of follow up with cases—requesting medical records to be reviewed, sending children for skeletal surveys, lots of questions by and for DCF/LE. In addition, I've recently had more experience with the legal aspects of the job. I had my first court deposition and first shelter hearing. In that event I gave my findings on what I found during the exam, explained what the findings signified, and responded to attorneys' questions as posed.

Q6. In my world a medical examination is a medical examination. I go to my Primary Care Physician every 6 months, and he asks some innocuous questions about any changes I may have recently experienced, reviews my labs, checks my blood pressure and heart, checks my respiration, checks my muscle tone, discusses medications, et cetera. And, six months later, it's "rinse and repeat." I suspect that medical examinations with children who have allegedly been abused are quite different. How so?

A lot of it is the same. Many of the children that come through are completely healthy. I discuss the patient's history with caregivers if they are available. Then the medical exam starts. I talk to the children, find out about their general health, how they are doing, and try to discuss the allegations that brought them in. Some children know why they are here and are forthcoming with what happened to them, others really don't know. With those I then try to explain to the kids our entire job

(continued on page 4)

"Peace, Lillie" *(from p. 2)*

Naturally, I wondered what had caused Lillie to become an unrepentantly angry young lady of such tender years. I knew that she would not offer many clues in our early days of counseling together—if she even had a clue herself. I knew that bright children as Lillie possessed a remarkable capacity for repression, especially for traumatic events they would prefer to bury. So, I resolved that I would engage Lillie's family to deduce those "kernels of truth" I could not unearth in individual sessions with Lillie.

When I ventured to Lillie's home on an early November day, I was haunted by a nagging feeling of déjà vu. How well I recalled a similar day in the same month several years before when I engaged in a desperate search to locate a "little white house sitting twenty yards back from [Parramore] Street." There I was assailed by a malevolent mob whose rage was ultimately quelled by a courageous 9-year-old boy. Curiously, my viscera conveyed the same unsettled feelings as I headed up Mercy, across SR 50, and into the depressing deprivation of Ivy Lane. I found the home as described, a spare brick ranch with a zero lot line huddled against others of like ilk in a neighborhood possessing an unkindly moniker: "the projects." I was surprised when greeted quite graciously at the front door by Lillie's entire family: Mom, Dad, Lillie and two younger children of perhaps two and three years, respectively. Mom and Dad were both smiling and congenial. Frankly, I was not sure what I had expected—suspicion, fear, anger, dread—what? I gratefully accepted a glass of chilled lemonade and settled on the couch next to Lillie. Mom confessed in a soft tone, "We were so surprised when you called and offered to come out to the house to speak with us about Lillie. No one has ever done that. Most times, we have to go to you all." I admired her candor as much as I admired her housekeeping. Her home was impeccable.

I had barely launched into the purpose of our meeting when, suddenly, a tricked-out El Dorado pulled abreast of the house—a lowrider with wide whites and a throaty, growling engine. Pop. pop! Pop, pop! Pop, pop! The Caddie's backfires offered up their version of a twenty-one gun salute—or so I thought until the home's picture window exploded in a violent spray of splintered glass. Simultaneously, I felt a sharp, insistent tug on my shirtsleeve as Lillie fiercely pulled me to the floor. As I toppled over, an object whizzed by my right ear and lodged itself emphatically into the drywall above the sofa back. Thwack! A sharp squeal of tires—wide white tires, no doubt—brought everyone up from prostrate positions. The attack was over virtually as fast as it had begun. Mom and Dad obsessively checked everyone's well-being. The babies cried, not quite knowing why. And Lillie screamed at me indignantly, "What were you doing?! What were you doing?! You stupid, stupid man! You coulda been killed! Don't you get it—you almost DIED!" She cried inconsolably as my body shook with the adrenaline rush of my own grim realization. How precious life—and so very fragile! I did not immediately notice when Lillie gathered her body into a tight ball, rocking rhythmically as she inserted her right thumb securely into her mouth. She came back to us ten minutes later, oblivious to what had occurred. By then Mom and Dad had cleared away the residual debris from the unnerving incident. "What happened to the window?", asked Lillie innocently. "Neighborhood kid with a baseball", Dad responded protectively.

(continued on page 4)

Getting to Know Holly B., ARNP *(from p. 3)*

here is to help them and ensure no one is hurting them, so that is why I ask questions and take pictures of things. I try to explain that it is just like going to the doctor. We look and listen to everything, but if there is anything hurting them— scratches, scrapes, or injuries—I take pictures. We get heights and weights and do urine collection if needed. We test samples in the office and send them out for further testing. Depending on the allegations, I do swabs for law enforcement in hopes of getting DNA samples. I take pictures of injuries when present.

On purpose: ***"I try to explain to the kids that our entire job here is to help them and ensure no one is hurting them…."***

Q7. In the context of the Center and the abused children we serve, what is the ultimate purpose in your work? How do you go about achieving that objective?

While it would be amazing to have no children be victims of abuse, the ultimate purpose of my work is hopefully to stop the abuse and prevent them from becoming repeat victims. Hopefully, through my assessments and recommendations, I can help facilitate that.

Q8. So, Holly, what happens after you have conducted your medical examination, collected evidence, and assessed and interpreted your findings? What are the next steps?

After the exam, I meet with the case coordinator, law enforcement, and DCF. I give my findings and recommendations as does the case coordinator. If there is any follow-up, I let DCF know what needs to be done. If there is evidence, I sign that over to law enforcement. Some children need x-rays, so I send them to radiology and then follow up once that has happened. I want to review some children's medical records, so I follow up with DCF to get copies of everything to review.

Q9. I know from time-to-time that alleged perpetrators of child abuse are arrested, charged and compelled to defend themselves in a court of law. I am also aware that you occasionally testify in those cases where you have conducted medical examinations. Would you briefly describe the experience of providing expert testimony – your preparation, your time on the stand, the challenges mounted by the defense, and your feelings about the experience?

Yes, as I mentioned earlier, I just had my first deposition and shelter hearing. The shelter hearing was a last minute subpoena (less than 24 hours notice) on a very contentious case that had been argued about for almost a week. Luckily, I have a wonderful team who helped prepare me. Prior to the hearing there was a lot of discussion with the State's Attorney about the injuries and why one injury would be considered abuse and the others wouldn't. There was a lot of discussion getting into technicalities of

(continued on page 5)

"Peace, Lillie" *(from p. 3)*

Lillie never did recall that early November afternoon when her counselor nearly communed with the angels. But, mysteriously, that afternoon heralded a distinct difference in the tenor of our interactions. Whereas Lillie had previously been but a nominal participant in counseling, she suddenly actively sought it. Or, perhaps more accurately, she sought the company of this counselor. She raced up to me in the hallway or bounded gracefully across the playground simply to say "hi." Truthfully, I did not know why I had become the object of her dutiful vigilance. My psychoanalytic interpretation was that she subconsciously perceived we each had survived traumatic events and needed special attention-"protection", maybe? While I well recalled my own harrowing event, I remained ignorant of the trauma that I speculated Lillie may have experienced in her young life.

Regardless of the reason for Lillie's new-found attachment to me, I treated it as a fruitful opportunity to talk with her—both in counseling and outside of it. Previously, Lillie had declared, "I don't like you knowing my stuff!". However, after my so-called "dance with death", she gradually warmed to our time together. But we did not speak of the episode at her house. Significantly, I had spoken to Lillie's Mom and Dad the day afterward and discovered that they had never witnessed the withdrawal and rocking behaviors Lillie had demonstrated the day before. Furthermore, they admitted that they were continually surprised by the phone calls they received from school administrators in the aftermath of Lillie's wild rages in the classroom. Clearly, they had no explanation for their daughter's unbridled anger. Apparently, the answers I was seeking would only come from Lillie.

Lillie and I religiously observed our weekly counseling sessions. Weeks and weeks and more weeks went by. We talked over games, we talked as we walked, and we talked as we sat. Still, there were no monumental counseling breakthroughs, and Lillie's disruptive behaviors in her classroom persisted. In fact, things were becoming desperate until one day something extraordinary happened—something out of the blue and without warning. Lillie and I were walking the hallway past the principal's office when there arose such a clatter that we could not ignore it. When we peered through the glass—Lillie on her tiptoes—we saw a wee 7-year-old girl screaming, biting, kicking and scratching an over-matched behavioral specialist. Impulsively, Lillie sighed, "Oh, oh, it's happened to her, too!". "What do you mean, Lillie?, I asked innocently, "what happened to her?". "You know," Lillie replied absently, "the thing." "What thing?" I implored, "tell me what thing?". "You know, Mr. Dolliver, the thing that little kids are told not to talk about—or else they could die!". Lillie offered her words with great earnestness. Her body trembled ever so slightly, and a lonely tear trickled down her right cheek—a tear that she quickly wiped away. "Lillie, you said that the thing must have happened to that little girl, too—you used the word too. So, are you saying that this thing also happened to you? Do you want to talk about it?". Emphatically, Lillie shook her head no and begged to return to the classroom, an environment that had only offered misery. In my efforts to get to the core of Lillie's issues, I had pushed too hard. And, in the process, I might have lost her….

The school year was closing down precipitously. Lillie's status in therapy remained at a delicate tipping point. However, I was optimistic about sustaining her counseling through the summer—until her parents shared with me that Lillie would be spending the summer with relatives in North Carolina. There was no telehealth in those days, so I was resigned to resuming her counseling at the beginning of the next school year. Anxiously, I sought out Lillie on the first day of

(continued on page 5)

Getting to Know Holly B., ARNP *(from p. 4)*

accident vs. inflicted and what of that can constitute abuse. I was terrified. Luckily, the detective that had been advocating For these children was there and offered a friendly face. My testimony was quick. I gave my findings and explained why certain injuries constituted abuse. Again, I was asked if it could be accidental. There is a big misconception with that. Even if an injury is an accident. if it is inflicted by a parent, it is still abuse. Otherwise, every abuser could use it being an accident as an excuse. I can't tell anyone what the intent of an injury is. I can only tell you it is inflicted and explain how I came to that conclusion. At the end of the hearing, the children were sheltered.

On accidental injury: ***"Even if an injury is an accident, if it is inflicted by a parent, it is abuse. Otherwise, every abuser could use it being an accident as an excuse."***

Q10. Obviously, your specialty is pediatric medicine. What is the intrinsic appeal for you in working with children, as opposed to working with adults?

Kids are (mostly) innocent. They don't have a choice in what happens to them. They are relying on adults to steer them in the right direction. Hopefully I can be one of those adults.

Q11. What is the most rewarding thing about working with children, and what is the most challenging thing?

The most challenging aspect of working with kids is when you know something is wrong, but they are too young to be able To verbalize it. The most rewarding part of working with kids is when you can get them to open up to you, getting them to smile or laugh makes my day.

Q12. We all recognize that child abuse is serious business, and I do not wish to minimize the gravity of the situation. However, children often demonstrate a capacity for producing moments of levity even under the most adverse conditions. If you recall just such a moment, would you share it with us?

I recently had a child come in carrying a small box, about the size of a 3x5 notecard. The case coordinator suggested she show me what was in the box and when she opened it one of about five lizards jumped out. It sat right on her hand and let her pet it, she had names for each lizard.

Q13. Would you describe for us your most personally and professionally trying case?

Professionally, I don't think anyone at the CAC would be surprised to find a recent physical abuse case was very trying professionally. There were multiple issues with the case, lots of confusing information, lots of pushback from DCF about

(continued to the right)

"Peace, Lillie" *(from p. 4)*

the new year but to no avail. I later learned that Lillie and her family had relocated to North Carolina to be closer to the relatives with whom she had summered. That is how it goes with counseling sometimes. Children come, and children go. Seldom do you see the ultimate culmination of your efforts. Regardless, you always remember all you serve with great fondness. Particularly, shall I recall the tiny, pigtailed girl who, on an early November day, defied a bullet and saved a life. As the years go by, I still celebrate Lillie's courage. And I hope that somewhere along the way she summoned up the full measure of her courage to confront "the thing that little kids are told not to talk about." Peace, Lillie!

Meet Holly B., ARNP *(from left)*

the injuries and why I was indicating for abuse. This was also my most gratifying case as the children were sheltered, it made me feel as though all the hard work was worth it. Personally, my first on-call case that I did on my own was an horrific sexual abuse case. There were a lot of injuries that I was not prepared for.

Q14. I would imagine that your job is a stressful one. You see so many traumatized children and so much is riding on your medical findings. Having said that, do you find it difficult not to take your work home with you? What do you do to "decompress"?

When I started at the CAC, I was worried about being able to separate home and job. I have been able to compartmentalize what I do and know that I am doing everything I can to help these kids. I hate seeing what is done to children, but I can't change it so I am able to focus on what I can do. What really keeps me up at night is being terrified I am going to mess something up for these kids. My kids don't give me the ability to concentrate on much else besides them when they are home. They are a great distraction. Other than that, running is my stress relief. I work through a lot of my emotions when running. If you ever see me running and crying, I'm ok—just working through something. I'm also a craft junkie. I can knit, crochet, cross-stitch, macramé, paint, and am taking a wheel throwing pottery class every week.

Q15. Ok, Holly. I am now going to ask you that classic question that almost invariably comes up in job interviews. It's that question about career "trajectory." Recognizing that virtually no job lasts forever, where do you see your career headed ten (10) years from now?

Hopefully, I am still here at the CAC. I really enjoy the work I do.

Holly, that is such an uplifting way to conclude our interview. We at the Center are privileged to have you on board, and we wish you a memorable and rewarding career with us. Thanks for everything you do to advocate for kids and to help them recover from the misfortunes that have befallen them. Best of luck to you!