Volume 13, Number 3 & 4, Summer/Fall 2001

APSAC ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

IN THIS ISSUE

Risk Management for Health Professionals Working with Maltreated Children and Adult Survivors
by John E. B. Myers

This article discusses the topic of malpractice, both intentional and unintentional acts that injure clients, and outlines what professionals should consider to lower their risk of lawsuits and ethics complaints. Most malpractice occurs when a professional fails to live up to a certain standard of care or code of cthics. Abbreviated from a chapter in the recent APSAC Handbook on Child Maltreatment (2nd ed.), this selection not only defines legal and related terms but also includes teaching examples and practical suggestions.

4

Professional Development and Certification- For Child Protective Service Employees: From Worker to Supervisor
by Maria Scannapieco, Ph.D. & Kelli Connell, LMSW

On the rise are both child abuse and neglect reporting as well as out-of-home placement of children. The author summarizes the response of one state, Texas, to this crisis. Rather than pass more laws that may overburden the child welfare system, Texas agencies began collaborating on a voluntary certification program in 1993. Today, Supervisor and Advanced Specialist certification profiles demonstrate that 2,735 CPS employees statewide are participating. Moreover, successes in agency communication and collaboration plus positive anecdotal feedback among professionals have made this a noteworthy initiative.

8

Consequences of Child Neglect - Children 0 to 3 Years of Age
by Maria Scannapieco, Ph.D. & Kelli Connell, LMSW

Neglect consistently accounts for over half of all substantiated cases of maltreatment in the United States (USDHHS, 2001; 2000), and the highest rate of victimization is in the 0 to 3 age group (USDHHS, 2001). Yet, neglect has continued to receive less definitional and research attention than child physical and sexual abuse (Zuravin, 1999).

20

Regular Features

Message from the President.......... 2

Policy Watch.............................. 12

Journal Highlights...................... 16

Also in This Issue:

New APSAC Handbook on Child Maltreatment...................... 11

Conferences in 2001 and 2002.. 14

APSAC Board of Directors Election... 24

APSAC Advanced Training Institute.. 26

Sandra P. Alexander
President, APSAC

Dear colleagues,

It was good to see many of you at the June Colloquium in Washington. A special thank you to the many APSAC members and friends who were involved in planning this important event, who volunteered their time to serve as faculty, or who assisted in other ways. In addition to educational and networking opportunities, the Colloquium offered the second APSAC silent auction and raised $16,000 for APSAC. Many thanks to our chapters and friends who donated items for the event, and to past Board President Diane Depanfilis, her husband, and her son, who contributed many hours to organize and run this successful event! Make your plans now to attend the next Colloquium in New Orleans in May 2002.

In order to recognize state participation at the 9th Annual Colloquium, the Past Presidents of APSAC, through the leadership of Barbara Bonner, Ph.D., created the Past President's award to recognize the state chapter with the largest number of Colloquium attendees on a per capita basis. This monetary award is comprised solely from the generous donations of APSAC's past presidents. Congratulations to the Maryland state chapter for the strongest representation at the 2001 Colloquium.

The Colloquium also offered a time to honor outstanding professionals who have made significant contributions to guide, support, or advance the work of preventing and treating child abuse and neglect. Congratulations to the following individuals, who were recognized at the annual APSAC Awards Luncheon:

OUTSTANDING PROFESSIONAL AWARD —
Howard Dubowitz, MD, MS
University of Maryland

OUTSTANDING SERVICE AWARD —
Linda Williams, PhD
Wellesley College

RESEARCH CAREER ACHIEVEMENT AWARD —
Ben Saunders, PhD
Medical University of South Carolina

OUTSTANDING MEDIA AWARD —
Timothy Roche
Crisis in Foster Care, *Time Magazine,*
November 13, 2000

OUTSTANDING RESEARCH STUDY/ ARTICLE AWARD (2000) —
Jennifer MacLeod & Geoffrey Nelson,
Programs for the Promotion of Family Wellness and the Prevention of Child Maltreatment: A Meta-Analytic Review.
Child Abuse & Neglect, 24, 1127-1149

OUTSTANDING ARTICLE PUBLISHED IN CHILD MALTREATMENT AWARD(2000) —
Rochelle Hanson & Eve Spratt,
Reactive Attachment Disorder: What We Know About the Disorder and Implications for Treatment.
Child Maltreatment, 5, 137-145

OUTSTANDING DOCTORAL DISSERTATION AWARD (2000) —
Denise Pintello
University of Maryland
Intrafamilial Child Sexual Abuse: Characteristics that Predict Maternal Belief and Protective Action Among Non-offending Mothers
(Chair: Susan Zuravin, Ph.D)

NEW ORGANIZATIONAL DIRECTIONS

As announced in the last *Advisor,* the organization's fiscal and Board year will be changing to the calendar year in January 2002. Likewise, the membership year will run from January through December. Plans are underway to effect these changes with the least disruption possible for the membership.

The meeting of the Board of Directors at the Colloquium resulted in several additional significant decisions impacting the governance structure of the organization. The terms of the President and Treasurer were changed from one to two years beginning January 2002. APSAC should benefit greatly from this new continuity in leadership in two critical Board positions.

The size of the voting Board will be reduced and

guidelines for the election of exofficio Board representation from the state chapters and past leadership of the organization will be developed for approval at the January Board of Directors meeting in San Diego. Nominations for new voting Board members, whose terms begin January 2002, have been received and the ballot for election of these directors is in this issue. Exercise your member rights by marking your votes and returning the ballot by the deadline.

DON'T CHANGE THOSE CONTACT NAMES AND ADDRESSES JUST YET!

The APSAC rebuilding effort, undertaken a year ago by the Board with the Executive Committee taking on most of the staff functions of the organization, has been going well. Renewed confidence in the organization is apparent. The infrastructure is well along to being rebuilt. New memberships and renewals are holding steady. We are paying our bills. Yet, even with our progress and hard work, we are not yet in the position of strength we anticipate for a centralized, staff-run organization.

So, the Board has decided to continue our current way of doing business for the 2001/02 fiscal year. This means that you will still be working with Toby Smith in Charleston for membership issues. Professional education will be operated out of the Center on Child Abuse at the Oklahoma University Health Sciences Center under the leadership of Trisha Williams, who has resigned her Board position to serve APSAC in the staff position of Operations Manager with the responsibility of coordinating all APSAC training and education programs. Accounting functions will remain in Chicago, and fulfillment of publication requests will be managed by Terry Hendrix from California. And, the Executive Committee will continue another year of hard work to fill in the gaps.

Our hope and plan is to be in a position by July 2002 to support the organization in a centralized location with key staff in place and the Board returning to just its governance issues. As we work toward this goal, we are counting on our membership to continue talking to us about what is working well and sharing suggestions for improvements. Your input and involvement in the future of APSAC are critical.

APSAC CONTINUES SUPPORT OF NATIONAL CALL TO ACTION

APSAC continues to support the National Call to Action effort to raise the level of urgency to protect children and mobilize communities through a new alignment of public and private organizations, professionals, and citizens. APSAC serves on the Steering Committee for the Call to Action and on the task force that is looking at the 200 key recommendations from the pivotal reports over the past decade on how to better prevent and treat abuse.

The organizations involved in the Call to Action have chosen to focus on several objectives:

PREVENTING. Families of our nation's youngest children receive the support and education necessary, so that their children will not be subjected to child maltreatment.
PROTECTING. Our nation's systems of protecting children are revised and strengthened to deliver the highest quality response.
HEALING. Any child who is abused or neglected receives the full complement of therapeutic and other services and support needed, as do their families, to recover as fully as possible from the effects of that maltreatment.

As I am writing this report, the organizations and individuals in the National Call to Action are advocating for the United States Postal Service's issuance of a postal stamp for child abuse. This stamp would raise awareness and funds for the work of the Centers for Disease Control and Prevention (CDC) to apply epidemiological research and the development of large-scale prevention programs. APSAC and the other organizations have committed to use their influence and networks to encourage Americans to support this initiative and buy the stamps if they are issued.

Clearly, the mission of the National Call to Action aligns with APSAC's mission. To be successful, the National Call to Action will require the involvement of all of us in some way. Learn more about the National Call to Action by visiting the web site available at: *www.nationalcalltoaction.com*

Sandra P. Alexander
President, APSAC

Renewed confidence in the organization is apparent.

National Call to Action

Preventing Protecting Healing

Risk Management for Mental Health Professionals Working With Maltreated Children and Adult Survivors

John E. B. Myers

Twenty years ago, mental health professionals seldom worried about lawsuits or ethics complaints, but not so today. This article outlines what professionals should consider to lower their risk of these situations. Following is a much abbreviated version of the risk management chapter from the recent second edition of *The APSAC Handbook on Child Maltreatment* (Myers, 2002).

Malpractice and Negligence

Malpractice (literally, bad practice) covers a wide range of wrongdoing, from *in*tentional acts such as sexual relations with clients to *un*intentional acts that injure clients. Most malpractice is based on a claim of negligence. Negligence occurs when a professional fails to live up to the *standard of care* required of competent professionals in that discipline, and when the failure injures someone. The standard of care is shaped by general principles of the law of torts and by the ethics codes of the National Association of Social Workers, the American Psychological Association, and the American Medical Association. That is, failure to abide by applicable ethics codes can be evidence of malpractice.

The possibility of a legal duty to a nonclient increases when a therapist causes suspicions about the nonclient to come to public attention.

Clearly, psychotherapists owe a legal duty of care to their clients, and failure to fulfill the duty can be negligence. Are there situations where psychotherapists owe a duty to care to people who are *not* clients? The courts, for example, are in disagreement about this issue. Consider an adult who enters psychotherapy for treatment of depression. During therapy, the client recovers memories of child sexual abuse by her father. The client confronts the father, who denies the allegation and sues the *therapist* for "manufacturing false memories." In such lawsuits, a critical question is whether the psychotherapist owed a duty of care to the nonclient father. If the answer is no, then the father's lawsuit dies without reaching the issue of the therapist's alleged negligent treatment. If the answer is yes, the father's lawsuit proceeds. This is not to say that the father will win. The point is that if the therapist owed a duty of care to the nonclient father, then the father is allowed to press the lawsuit forward (see Appelbaum & Zoltek-Jick, 1996; Bowman & Mertz, 1996). The courts are still sorting out such litigation (see case discussion in Myers, 2002).

Direct contact with a *non*client can transform the nonclient into a *client* even though the nonclient does not formally enter treatment. Written, telephonic, and person-to-person communication with a nonclient may, depending on what is said, create a therapist-client relationship. The line can be crossed when a therapist offers professional advice to a nonclient. On the other hand, a therapist is probably safe saying, "Because you are not my client, I cannot give you advice, treatment, or counseling on how to proceed apart from advising you that you may wish to consult a professional on your own." Such statements should be carefully documented.

Professionals who work with survivors of abuse often see themselves as advocates for their clients, and many forms of client advocacy are entirely proper. But when might this advocacy for a client create a legal duty to a *non*client? There is no simple answer, but certain activities stand out, such as advising clients to take steps that *directly* and *adversely* affect nonclients. Examples include advising a client to sue a suspected perpetrator. The possibility of a legal duty to a nonclient increases when a therapist causes suspicions about the nonclient to come to public attention. In *Hungerford v. Jones* (1998), the New Hampshire Supreme Court concluded that a therapist owed a duty of care to the nonclient father of the therapist's client. The court emphasized the harm caused by false accusations of sexual abuse.

The court wrote:

The likelihood of harm to an accused parent is exponentially compounded when treating threapists take public action based on false accusations of sexual abuse or encourage their patients to do so. Public action encompasses any effort to make the allegations common knowledge in the community. In this situation, the foreseeability of harm is so great that public policy weighs in favor of imposing on therapists a duty of care to the accused parent throughout the therapeutic process. (p. 481)

Therapist involvement in a client's memory for abuse has been a subject of considerable attention in legal and therapeutic settings. Knapp and VandeCreek (1996) point out the dangers of "questionable techniques used to retrieve lost memories," such as "age regression, body memory interpretation, suggestive questioning, guided visualization, sexualized dream interpretation, high-pressure survivor groups, aggressive sodium amytal interviews, and misleading bibliotherapy" (p. 456).

Knapp and VandeCreek note that many experienced clinicians believe that it is therapeutically indicated, under certain circumstances, to seek to retrieve (or "de-repress") memories of abuse through hypnotherapy or sodium amytal interviews. According to Gold, Hughs, and Hohnecker (1994); Terr (1994); and Herman (1992), these techniques may be justified when hidden trauma is strongly suspected on basis objective criteria and the patient's suffering is severe. We would add that they are justified only when more prosaic techniques of memory recovery (e.g., talking) have failed and the patient has been informed of the limitations of these techniques and the potential for creating false memories.

To minimize the possibility that therapist bias could influence the content of the memory, contextual cues should be kept as neutral as possible. Psychologists should record in detail the patient's statements about possible past abuse ahead of time and should video- or audio-tape the sessions to protect against possible allegations that they, the psychologists, implanted false memories (p. 456).

Hypnosis has important legal implications. In some states, individuals who have been hypnotized are not allowed to testify about events remembered during or after hypnosis. "Many courts have held or recognized that testimony concerning matters consciously recalled for the first time through pretrial hypnosis is inadmissable" (Fleming, 1990, p. 934). Therefore, a professional whose client may someday serve as a witness should seek legal advice before using hypnosis, sodium amytal, or similar methods.

Hypnosis has important legal implications. In some states, individuals who have been hypnotized are not allowed to testify about events remembered during or after hypnosis.

Child Abuse Reporting Laws

The law requires professionals to report suspected child abuse and neglect. Reporting is required when a professional has evidence that would lead a competent professional to believe abuse or neglect is reasonably likely. The decision to report depends on the facts of each case, interpreted through experience and judgment. The duty to report does not require the professional to "know" abuse or neglect occurred. All that is required is reasonable suspicion of maltreatment. The law requires reporting of suspicion, not certainty. A professional who delays reporting until all doubt is eliminated probably violates the reporting law. The law deliberately leaves the ultimate decision about maltreatment to investigating officials, not professionals. Thus, Kalichman (1999) advises that professionals "should avoid acting as investigators and restrict their actions within proper roles" (p. 117). This is not to say that professionals ask no questions and consider no alternatives to maltreatment. The point is that in-depth investigation is the domain of law enforcement and child protective services, not professionals who diagnose and treat maltreatment.

If a professional fails to report suspected abuse and a child is abused or killed as a result, the professional can be sued for malpractice. On the other side of the coin, when a professional reports suspected maltreatment, an angry parent may sue. Reporting laws provide professionals with some form of immunity from liability. Immunity clearly covers the act of reporting. In many states, immunity extends beyond the report to include acts leading up to the report and, after the report is filed, to communication with investigators and to testifying in court.

Informed Consent

Informed consent is a legal requirement for most medical and mental health treatment, and failure to obtain informed consent can be malpractice (American Psychological Association, 1992). Client consent should be in writing and should be included in the client's record. The information required for informed consent is described in the *Code of Ethics* of the National Association of Social Workers (1997):

Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions. (Standard 1.03(a))

Explaining the meaning of confidentiality and its limits is an important part of informed consent (Deed, 1993; Ebert, 1993). The American Psychological Association's (1992) *Code of Ethics* states that "[u]nless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant" (1992, Standard 5.01(b)). The duty to report suspected child abuse limits confidentiality, and "[i]t is advisable at the outset of treatment to inform your clients that the usual rule concerning confidentiality does not apply when the duty to report child abuse arises" (Committee on Professional Practice, 1995, p. 378).

cont'd on page 6

Cont'd from page 5

Is informed consent required for purely forensic evaluation, where treatment is not provided? Because informed consent is based on respect for autonomy, the answer should normally be yes. In certain court-ordered evaluations, however, informed consent may not be necessary. Even in court-ordered cases, however, professionals are encouraged to inform clients of the nature of services to be provided, and, where possible, to obtain informed consent. For example, the National Association of Social Workers' (1999) *Code of Ethics* provides that "[i]n instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse services" (Standard 1.03(d)). The American Academy of Psychiatry and the Law's (1995) *Ethical Guidelines for the Practice of Forensic Psychiatry* provide that "[t]he informed consent of the subject of a forensic evaluation is obtained when possible. Where consent is not required, notice is given to the evaluee of the nature of the evaluation. If the evaluee is not competent to give consent, substituted consent is obtained in accordance with the laws of the jurisdiction" (Guideline III). Along similar lines, the American Psychological Association's *Speciality Guidelines for Forensic Psychologists* provides that "[f]orensic psychologists have an obligation to ensure that prospective clients are informed of their rights with respect to the anticipated forensic service, of the purposes of any evaluation, of the nature of procedures to be employed, of the intended uses of any product of their services, and of the party who has employed the forensic psychologist. Unless court ordered, forensic psychologists obtain informed consent of the client or party, or their legal representative, before proceeding with such evaluations and procedures" (Committee on Ethical Guidelines for Forensic Psychologists, 1991, Guideline IV. E). Finally, the American Psychological Association's (1994) *Guidelines for Child Custody Evaluations in Divorce Proceedings* states that "[t]he psychologist obtains informed consent from all adult participants and, as appropriate, informs child participants" (Guideline III, paragraph 8).

Professionals can reduce the likelihood of being sued. The best way to avoid a lawsuit is to practice competently and compassionately.

Children are legally incapable of consenting to most forms of medical and mental health treatment. Thus, informed consent is obtained from parents or caretakers (American Psychological Association, 1992). It should be noted, however, that children above specified ages (e.g., 12) are allowed to consent to certain types of treatment including, in many states, testing for venereal disease or pregnancy, abortion, and some kinds of mental health care (for California law, see Myers, 2001).

Consultation and Peer Review

Regular consultation and peer review decrease the likelihood of being sued (Harris, 1995). If a lawsuit or ethics complaint is filed, a written record of consultation and peer review constitutes powerful evidence of proper care. Knapp and VandeCreek (1996) write that "[a]t times, it may be desirable to seek consultation with an expert who has a different perspective. . . . The consultation should be documented and include responses to specific questions, including, but not limited to, the diagnosis or presenting problem, specific treatment plans, and alternative treatment strategies" (p. 458).

Documentation

Documentation is critical to risk management (Moline, Williams, & Austin, 1998). "An axiom among malpractice defense attorneys is 'If it isn't written down, it didn't occur'" (Knapp & VandeCreek, 1996, p. 458). Rivas-Vazquez and his colleagues write that "deficient documentation can draw attention away from the appropriateness of an intervention" (2001, p. 194). Thorough, accurate, ongoing documentation is convincing evidence of proper practice (Harris, 1995). Avoid "humorous" remarks in client records. What seemed funny at the time may appear callous and unprofessional when an attorney reads the professional's notes aloud in court. Never alter records. "This is particularly true once litigation involving the records is anticipated" (Smith, 1996, p. 92). Of course, records can be corrected. Corrections, however, should be noted as such.

How long should records be retained? The American Psychological Association's Committee on Professional Practice and Standards (1993) states that

The psychologist is aware of relevant federal, state, and local laws and regulations governing record retention. Such laws and regulations supersede the requirements of these guidelines. In the absence of such laws and regulations, complete records are maintained for a minimum of 3 years after the last contact with the client. Records, or a summary, are then maintained for an additional 12 years before disposal. If the client is a minor, the record period is extended until 3 years after the ageof majority (p. 985).

Conclusion

Professionals can reduce the likelihood of being sued. The best way to avoid a lawsuit is to practice competently and compassionately. Smith (1996) suggests that professionals “promote an atmosphere of concern for patients and respect for their legal rights” (p. 91). Reaves (1998), an expert on risk management for mental health professionals, provides sound advice: (1) Be as open and honest as possible with patients regarding the parameters of the provider/patient relationship; (2) Set out your qualifications, area of practice, and expectations, including limitations on confidentiality and the fee for service arrangement, in writing and have patients sign the document; (3) Practice within areas of competence for which you can demonstrate you are competent; (4) Maintain competence in your areas of practice; (5) Maintain complete records; (6) Treat your patients with respect, the way you would expect your therapist to treat you; (7) Terminate treatment properly and in writing; (8) Know the laws that impact your practice; (9) Maintain an ongoing consultative relationship with other respected colleagues; and (10) When in doubt, seek competent advice (pp. 62-63).

Special Announcements!

Hot off the Press! The APSAC Handbook on Child Maltreatment, Second Edition.
More information on page 11.

Don’t forget to vote for the new Board! Your votes must be in by Dec. 21, 2001.
Go to pages 24 & 25 to select the new Board.

Please note upcoming conferences on pages 14 & 15.

Register for the APSAC Advanced Training Institutes on page 27.

2001 APSAC Colliquium tapes are available. Call: 1-800-747-8069 or 1-818-957-0874 - 8:30-4:00 PST, Mon - Fri. Identify by program #210620 when ordering or requesting information.

REFERENCES

American Academy of Psychiatry and the Law. (1995). Ethical guidelines for the practice of forensic psychiatry. In *Membership directory of American Academy of Psychiatry and the Law.* Bloomfield, CT: Author.

American Professional Society on the Abuse of Children. (1997). *Code of ethics*. Chicago, IL: Author.

American Professional Society on the Abuse of Children. (1996). *Guidelines for psychosocial evaluation of suspected sexual abuse in young children.* Chicago: Author.

American Psychological Association. (1994). Guidelines for child custody evaluations in divorce proceedings. *American Psychologist, 49*, 677-680.

American Psychological Association. (1992). Ethical principles of psychologists and code of ethics. *American Psychologist, 47,* 1597-1611.

Appelbaum, P. S. (1997). A theory of ethics for forensic psychiatry. *Journal of the American Academy of Psychiatry and the Law*, *25,* 233-246.

Appelbaum, P. S., & Zoltek-Jick, R. (1996). Psychotherapists’ duties to third parties: Ramona and beyond. *American Journal of Psychiatry, 153,* 457-465.

Association of Family and Conciliation Courts. (1994). Model standards of practice. *Family and Conciliation Courts Review, 32,* 504-513.

Bowman, C. G., & Mertz, E. (1996). A dangerous direction: Legal intervention in sexual abuse survivor therapy. *Harvard Law Review, 109,* 549-639.

Committee on Ethical Guidelines for Forensic Psychologists. (1991). Speciality guidelines for forensic psychologists. *Law and Human Behavior, 15*, 655-665.

Committee on Professional Practice and Standards, A Committee of the Board of Professional Affairs of the American Psychological Association. (1993). Record- keeping guidelines. *American Psychologist, 48,* 984-986.

Committee on Psychiatry and Law. Group for the Advancement of Psychiatry. (1991). The mental health professional and the legal system. (Rep. No. 131). New York: Brunner/Mazel.

Deed, M. L. (1993). Mandated reporting revisited: *Roe v. Superior Court. Law and Policy, 14*, 219-239.

Ebert, B. W. (1993). Informed consent. *Board of Psychology Update.* Sacramento: California Department of Consumer Affairs.

Flemming, T. J. (1990). Admissibility of hypnotically refreshed or enhanced testimony. *American Law Reports, 4th, 77,* 927-983.

Glassman, J. B. (1998). Preventing and managing board complaints: The downside risk of custody evaluation. *Professional Psychology: Research and Practice, 29,* 121-124.

Greenberg, S. A., & Shuman, D. W. (1997). Irreconcilable conflict between therapeutic and forensic roles. *Professional Psychology: Research and Practice, 28,* 50-57.

Harris, E. A. (1995). The importance of risk management in a managed care environment. In M. B. Sussman (Ed.), *A perilous calling: The hazards of psychotherapy practice.* New York: Wiley.

Hess, A. K. (1998). Accepting forensic case referrals: Ethical and professional considerations. *Professional Psychology: Research and Practice, 29,* 109-114.

Humphreys, K., Winzelberg, A., & Klaw, E. (2000). Psychologists’ ethical responsibilities in internet-based groups: Issues, strategies, and a call for dialogue. *Professional Psychology: Research and Practice, 31,* 493-496.

Hungerford v. Jones, 722 A.2d 478 (N.H. 1998).

Kalichman, S. C. (1999). *Mandated reporting of suspected child abuse: Ethics, law, and policy* (2nd ed). Washington, DC: American Psychological Association.

Kirkland, K., & Kirkland, K. L. (2001). Frequency of child custody evaluation complaints and related disciplinary action: A survey of the Association of State and Provincial Psychology Boards. *Professional Psychology: Research and Practice, 32,* 171-174.

Knapp, S., & VandeCreek, L. (1996). Risk management for psychologists: Treating patients who recover lost memories of childhood abuse. *Professional Psychology: Research and Practice, 27*, 452-459.

Koocher, G. P., & Morray, E. (2000). Regulation of telepsychology: A survey of state attorneys general. *Professional Psychology: Research and Practice, 31,* 503-508.

Maheu, M. M., & Gordon, B. L. (2000). Counseling and therapy on the internet. *Professional Psychology: Research and Practice, 31,* 484-489.

Melton, G. B., Petrila, J., Poythress, N., & Slobogin, C. (1997). *Psychological evaluations for the courts* (2nd ed.). New York: Guilford.

Moline, M. E., Williams, G. T., & Austin, K. M. (1998). *Documenting psychotherapy: Essentials for mental health practitioners.* Thousand Oaks, CA: Sage.

Montgomery, L. M., Cupit, B. E., & Wimberley, T. K. (1999). Complaints, malpractice, and risk management: Professional issues and personal experiences. *Professional Psychology: Research and Practice, 30,* 402-410.

Myers, J. E. B. (2002). Risk management for professionals working with maltreated children and adult survivors. In J. E. B. Myers, L. Berliner, J. Briere, T. Hendrix, C. Jenny, & T. Reid (Eds.), *The APSAC handbook on children maltreatment* (2nd ed.). Thousand Oaks, CA: Sage.

Myers, J. E. B. (2001). Legal Issues. In M. Winterstein & S. Scribner (Eds.), *Mental health care for child crime victims: Standards of Care Task Force guidelines.* Sacramento: California Victim Compensation and Government Claims Board

National Association of Social Workers. (1997*). Code of ethics.* Washington, DC: Author.

Reaves, R. P. (1998*). Avoiding liability in mental health practice.* Association of State and Provincial Psychology Boards.

Rivas-Vazquez, R. A., Blais, M. A., Rey, G. J., & Rivas-Vazquez, A. A. (2001). A brief reminder about documenting the psychological consultation. *Professional Psychology: Research and Practice, 32,* 194-199.

Smith, S. R. (1996). Malpractice liability of mental health professional and institutions. In B. D. Sales & D. W. Shuman (Eds.*), Law, mental health, and mental disorder.* Pacific Grove, CA: Brooks/Cole.

From Worker to Supervisor

Maria Scannapieco, Ph.D. & Kelli Connell, LMSW

Child welfare and particularly child protective services are in a crisis. Child abuse and neglect reporting continues to escalate (CDF, 1997) as does the out-of-home placement of children. Additionally, new laws, such as The Adoption and Safe Families Act of 1997 (P. L. 105-89), have added even more stress on a system that is already quite tenuous. The increased complexity of problems in the child welfare field requires higher levels of knowledge and skills for professionals who work with children and families. Additional training is needed to accommodate a new child welfare system given the ever-increasing demands on public social services agencies.

Child protection agencies are under federal and state mandates to preserve families and to create permanent living arrangements for children in out-of-home placements. The Adoption and Safe Family Act has also toughened the time limits for making decisions concerning a permanent plan for children out of their home. Under the new law, time limits for placement have been changed from 18 months to 12 months. Case decision making is also more demanding, requiring specialized expertise.

Thus, training and experience are key contributors to sound action by child welfare practitioners. Engaging child protection workers and supervisors in ongoing professional development that certifies them in the required competencies will strengthen the community's trust in the child protection agency and lead to the well-being of children.

In 1993, the Texas Department of Protective and Regulatory Services, through collaboration with the Protective Services Training Institute (PSTI), began a voluntary certification process for Child Protective Services supervisors. The certification program was viewed successfully and provided validation to supervisors' knowledge and skills (Scannapieco, Molidor, & Molidor, 2000).

To provide this same successful validation for workers, in July 1999 Texas expanded certification whereby the state became connected to agency policy and promotion for supervisors. A certification plan for Child Protection Specialists and Advanced Child Protection Specialists was developed and implemented in September 1999.

Overview of the Texas Initiative

In 1991, the Texas Department of Protective and Regulatory Services (TDPRS), then the Texas Department of Human Services, created the Children's Protective Services Training Institute (CPSTI). In 1999, the state of Texas expanded the role of the Institute to include all programs—Adult Protection, Child Care Licensing, and Community Projects. As a result of this initiative, the Institute was renamed (PSTI) and began operating as a consortium of the four graduate schools of social work in Texas, funded through Title IV-E funds and matching funds from the Department and the schools of social work. One of the initial projects of the Institute was certification of Child Protective Services (CPS) staff. Texas decided to certify supervisors first and then consider certification of direct service staff.

At the heart of this successful program is its function as a true collaborative effort. For example, the certification committee is formed in conjunction with PSTI. Approximately 15 representatives from the universities and the agency make up the membership. Agency representatives come from the Human Resource Department as well as state and regional offices. In addition, both a certified CPS Supervisor and CPS Certified Specialist are on the committee, and it is cochaired by an agency administrator and a university faculty member. All decisions concerning certification policy come out of this committee, which meets on a quarterly basis to discuss policy issues. Certification, like child protection practice, is an ever-evolving process of reviewing policy, and the committee is continually confronting human resource issues.

Supervisor Certification Process

Supervisors need to meet educational, professional, training, and testing requirements to be certified. Minimally, two years of supervisory experience is required along with a scheduled two-year training regimen. When all training and experience requirements are met, the supervisor takes a certification exam that is both knowledge- and skill-based. Upon successful completion, the supervisor is certified. The Supervisor Certification program has been previously described in the literature (Scannapieco, et. al., 2000), and following are the requirements:

Education and Experience Requirements

- Currently employed as a CPS Certified Specialist (Basic or Advanced)
- Currently employed as a CPS Supervisor with two years of Texas CPS supervisory experience, or a master's degree in social work or a human-service-related master's degree and 16 months of Texas CPS supervisory experience.

Performance

- Required to have applicant's supervisor certify, via his or her signature on the application, that performance evaluation and productivity are currently successful or are above

that normally expected or required.
- ◆ Not be in violation of standards of conduct or on departmental probation at the time of application.

Training
- ◆ Documented completion of attendance at all the trainings required of supervisors by PRS for the first two years as a supervisor.
  - *Managing Workplace Harmony*
  - *CPS Supervisor Management Training*
- ◆ Documented completion of attendance at the following PSTI Supervisor Trainings
  - *Supervising Individuals with Diverse Needs*
  - *Developing Worker Risk-Based Competency*
  - *Leadership: Empowering Yourself and Others*
  - *What's Happening in This Family? Using a Family Systems Approach in CPS*

Knowledge and Skills Assessment
- ◆ Passing score on a multiple-choice test of supervisory knowledge and a video exam on supervisory skills.

Child Protection Specialist and Advanced Specialist Certification Process

In July 1999, TDPRS decided to offer certification to child protection workers as one means of providing professional development and accountability for its staff. A great deal of past productive collaboration allowed for the planning phase to be successful. The administration of the program was planned for the same location as the Supervisor Certification Program, the Center for Child Welfare at the University of Texas at Arlington. The Specialist Certification program has been previously described in the literature (Scannapieco & Connell, 2000), and an overview follows.

Certification is designed to recognize the specialized knowledge and skills of Texas CPS Specialists. It includes education, experience, training, performance, and evaluation components. It differs from social work licensure in that the requirements are specific to Child Protective Services, and only Texas CPS Specialists are eligible to apply. There are two levels of Specialist certification: Specialist Certification and Advanced Specialist Certification.

Eligibility for CPS Specialist Certification

CPS Specialists seeking certification are required to meet experience, performance, and training criteria but unlike CPS supervisors do not need to pass any type of exam. Applicants must have at least one year of CPS direct service experience to be eligible for Specialist Certification and three years CPS direct service experience to be eligible for Advanced Certification. In addition and as set forth in the *CPS Specialist Guide* (PSTI, 2001), applicants must submit the following documentation:

Education and Experience
- ◆ Currently employed as at least a CPS Specialist II and have at least one year CPS direct service experience following completion of Basic Skills Development (BSD).

Performance
- ◆ Required to have applicant's supervisor certify, via his or her signature on the application, that performance evaluation and productivity are currently successful or are above that normally expected or required.
- ◆ Not be in violation of standards of conduct or on departmental probation at the time of application.

Training
- ◆ Documented completion of attendance at one-day risk assessment training and one day of child development training provided either by the agency or PSTI.
- ◆ Documented completion of attendance at agency-provided *Cultural Diversity: Building Bridges or Wall* training.
- ◆ Documented completion of attendance at agency-provided *Advanced Investigation Training* (TCLEOSE).

Eligibility for Advanced CPS Specialist Certification

Education and Experience
- ◆ Currently employed as a CPS Specialist III, IV, or V or above.
- ◆ Three years cumulative CPS direct service experience after the completion of BSD.
- ◆ Currently a CPS Certified Specialist.

Performance
- ◆ Required to have applicant's supervisor certify, via his or her signature on the application, that performance evaluation and productivity are currently successful or are above that normally expected or required.
- ◆ Not be in violation of standards of conduct or on departmental probation at the time of application.

Training
- ◆ Documented completion of 72 hours of training in the three years prior to the application date of Advanced Certification.
- ◆ Training that is applied towards Specialist Certification cannot apply to Advanced Specialist Certification.

cont'd on page 10

Cont'd from page 9

- Agency-provided, PSTI-provided, university and college courses and conference workshops and other workshops that are at least 3 hours in length are applicable.
- University/College technology courses are not applicable.

Skills

The Advanced Evaluation and Assessment of Advanced Certification is intended to recognize the advanced skills and expertise that an Advanced Certified Specialist would possess. The Advanced Certified Specialists are required to demonstrate superior skills, expertise, and leadership in their unit and practice with clients. Additionally, they must demonstrate that they represent CPS throughout the community in a professional way, such as

- Demonstrate completion of a total of four tasks on the *Advanced Evaluation and Assessment* instrument.
- Demonstrate completion of at least two tasks in the category of Advanced Knowledge, Skills, and Expertise, which includes the following categories: investigation, legal, community resources, sensitive cases, assessment skills, working with the mental health system, placement resources, utilization of bilingual skills, cultural and ethnic groups, and intervention techniques.
- Demonstrate at least one task in two or more of the other four categories (Leadership, Community Outreach, Development of Others, and Other Special Projects) in the *Advanced Evaluation and Assessment* instrument outlined in the Advanced Specialist application.
- Demonstration of completion should be indicated by supervisor signature and supporting documentation or written description.
- Complete and demonstrate the advanced skills and knowledge within three years prior to the application date of Advanced Certification.

Supervisor Certification Profiles

Supervisor Certification began in 1994 as a voluntary process, and the majority of all eligible supervisors were certified. In July 1999, Supervisor Certification became associated with a promotion and pay increase, and the profile below represents the status of certified supervisors as of July 2001.

Table 1: Certified CPS Supervisors

Mean Years CPS Supervisor	4.0
Gender	
Male	59
Female	273
Total	332

Table 1 profiles the Certified CPS Supervisors in Texas. Currently there are 332 Certified CPS Supervisors, and the mean length of employment as a CPS supervisor is four years. Eighty-two percent of the Certified Supervisors are females, a statistic aligned with the gender composition of the agency overall.

After the application process is complete and the supervisor is ready to take the test, demographic information is then recorded in order to continually validate test items. Ethnicity is collected and used only for test item validation, but not recorded on the Supervisor Certification database.

Specialist Certification Profiles

The Specialist Certification program was launched in September 1999. *The Specialist's Guide to CPS Specialist Certification* (PSTI, 2001) was developed and is available through both e-mail and mail to all CPS staff that outlines the requirements for achieving and maintaining certification. As of July 2000, Specialists profiles are as follows:

Table 3: Certified Specialists

Mean Years CPS Specialist	5.00
Gender	
Male	270
Female	1,720
Total	1,990

Table 3 profiles the Certified Specialists in Texas. Almost two thousand workers have achieved Specialist Certification, and the mean length of employment as a CPS Specialist is five years. Similar to Supervisor Certifications and the gender composition of the agency, the majority of Certified Specialists are female (86%).

Advanced Certified Specialist Profiles

In recognition that the State had many tenured child protection workers, Advanced Specialist Certification was simultaneously incorporated at the same time as Specialist Certification. Workers must first establish their Specialist Certification before they apply for Advanced Certification.

Table 5: Advanced Certified Specialists

Mean Years CPS Specialist	7.00
Gender	
Male	59
Female	354
Total	413

As shown in Table 5, 413 tenured workers have achieved Advanced Specialist Certification with 7 years average length of employment as a CPS Specialist. Similar to the Certified

Specialists, the majority of Advanced Specialists are female (85%).

Different from other certification requirements, Advanced Specialist Certification does not require specific and mandatory courses be attended. For Advanced Specialist Certification, the worker attends at least 72 hours of training (within a 3-year period) that is focused on children and families.

Conclusions

A total of 2,735 CPS employees statewide are participating in various certification programs. The Certification Office at the University of Texas at Arlington receives and processes all applications as part of the Protective Services Training Institute at the University of Texas at Austin. The information is tracked on two large databases that house all the relevant certification information of each applicant. Daily reporting of newly certified persons is communicated to TDPRS Human Resources via e-mail in order to process upgrades or promotions associated with certification. The communication between the Certification Office and Human Resources has worked very well, given the large number of certifications and the complexity of issues. The ease of communication and collaboration with TDPRS has made the inception of Specialist Certification and continuation of Supervisor Certification both efficient and successful.

The anecdotal feedback over the first nine months of Specialist Certification has been very positive. In addition, most program directors and administrators choose to renew their certification every two years, another indicator of the value of certification. Most CPS Specialists have expressed appreciation for recognizing their education, training, and experience as something that should be rewarded. Future research is planned to evaluate the program's evolution and effectiveness in meeting its objectives, but given the large number of employees already engaged in the process, it has already made progress towards better morale, accountability, and improved perception of the child protection agency.

References

Adoption and Safe Family Act, Public Law 105-89.

Children's Defense Fund. (1997). The state of America's children yearbook. Washington, DC: Author.

McCown, S. (1998). A petition in behalf of the forsaken children of Texas to the Governor and the 76th legislature. Available: *http://www.co.travis.tx.uspetition.htm.*

Protective Services Training Institute (Texas) Certification Project. (July, 2001). The Supervisor's guide to CPS Supervisor Certification. Arlington, TX: Author.

Protective Services Training Institute (Texas) Certification Project. (July, 2001). The guide to CPS Specialist Certification. Arlington, TX: Author.

Scannapieco, M., Molidor, T., & Molidor, C. (2000). Impact of professional social work education in child welfare: Assessing practice knowledge and skills. *Journal of Continuing Social Work Education.*

Scannapieco, M., & Connell, K. (2000). The professional development and certification for Child Protective Services' employees: From worker to supervisor. *Training and Development in Human Service: The Journal of the National Staff Development and Training Association, 1* (1), 21-29.

Texas Department of Protective and Regulatory Services. (1995).

Comprehensive professional development plan for CPS Supervisors. Austin, TX: Author.

NEW!

ORDER NOW FOR NOVEMBER DELIVERY!

The APSAC Handbook on Child Maltreatment, Second Edition

Editors:

John E. B. Myers **C. Terry Hendrix**
Lucy Berliner **Carole Jenny**
John Briere **Theresa Reid**

A resource of unparalleled thoroughness, **The APSAC Handbook on Child Maltreatment, Second Edition** provides a comprehensive, interdisciplinary coverage of the causes, consequences, treatment, and prevention of child abuse and neglect. Written in engaging and straightforward language and offering researh-based applications for practice, this up-to-date revision covers physical abuse, sexual abuse, neglect, and psychological maltreatment from the medical, psychological, and legal points of view. Leading authorities in a variety of specialized areas have designed each chapter to inform college students and practitioners in social work, mental health, law, medicine, nursing, law enforcement, child protective services, and education of the most current research literature available as well as strategies for intervention and prevention.

This second edition includes a thorough update of retained chapters as well as over 630 new references to literature that did not exist when the first edition was published in 1996. It also includes new chapters focusing on:

- Munchausen by Proxy Syndrome
- Child Abuse in the Context of Substance Abuse
- Child Abuse in the Context of Domestic Violence
- Child Fatalities
- Risk Management for Professionals Working with Maltreated Children and Adult Survivors
- Mental Health Service for Children Reported to Child Protective Services

November 2001 - 736 pages

APSAC HANDBOOK ON CHILD MALTREATMENT, SECOND EDITION,

Paperback edition: Member price - $36.00
Nonmember price: $41. 00

Hardcover edition: Member price - $76.00
Nonmember price - $86.00

To order fax how many copies and which version with credit card information or purchase order to 818-597-4879.
Or phone 818-597-4867 or email terry.hendrix@sagepub.com.
Or, mail with check or money order to APSAC Publications Office, 32214 Oakshore Drive, Westlake Village, CA 91361-3810.

Visit our website at *www.apsac.org*

Shipping & Handling: Up to $50.00 add $7.00, $50.01 - $95.00 add $9.00, $95.01 - $200 add $11.00, $201.00 - $300 add $15.00, Over $399, please call

Thomas L. Birch
Legislative Counsel
National Child Abuse Coalition

CAPTA UPDATE

Congress returned from the August recess with a legislative agenda heavy with issues in child welfare, including the reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA). The House Committee on Education and the Workforce, which held a hearing on CAPTA reauthorization on August 3, plans to hold an additional hearing on September 13.

The Senate Subcommittee on Children and Families expects to conduct a hearing on CAPTA sometime in October.

No legislation has yet been introduced in the House or Senate addressing the CAPTA reauthorization. The Bush administration has asked Congress to extend the CAPTA statute for five more years.

The House and Senate appropriations subcommittees are poised to draft fiscal 2002 funding legislation for CAPTA's programs. The House Subcommittee on Labor-HHS-Education Appropriations plans to approve a funding bill on September 13; the Senate counterpart subcommittee expects to do the same on September 20.

The National Child Abuse Coalition and other advocates are urging Congress to fund CAPTA's programs in 2002 at their fully authorized levels: $100 million for the basic state grants and the research and innovation grants; and $66 million for the community-based prevention grants.

CAPTA HOUSE HEARING

A House education subcommittee hearing on CAPTA: Successes and Failures at Preventing Child Abuse and Neglect, held on Thursday, August 2, ended with support for reauthorization of the federal Child Abuse Prevention and Treatment Act, but questions remain over the appropriate size of the federal investment in child abuse prevention and the child protection infrastructure.

The lead witness at the hearing, Wade Horn, HHS Assistant Secretary for Children and Families, laid out the Bush administration's support for the current statutory structure, defusing for the time any possible reservations subcommittee members might have had about the value of CAPTA. He said that the Administration did not see major changes to CAPTA necessary in this reauthorization, although more progress needs to be made in preventing child maltreatment, and national leadership is required.

Rep. Peter Hoekstra (R-MI), chair of the Subcommittee on Select Education, asked Horn if research existed on parental rights and government intervention and how to provide a balance when dealing with child abuse cases. Horn explained that states "need authority to intervene" to protect children, and that in CAPTA the balance is adequate. He suggested that more training and technical assistance could be used to address the issue.

Horn also endorsed the value of research and program development through CAPTA, with the proviso that demonstrations be "evaluated rigorously."

The complete written statements of the witnesses at the CAPTA hearing may be found on the website of the House Committee on Education and the Workforce at *http://edworkforce.house.gov/hearings/107th/sed/capta8201/wl80201.htm.*

BUSH ADMINISTRATION BILL TO REAUTHORIZE SAFE AND STABLE FAMILIES PROGRAM

During the August congressional recess, the Bush administration sent to Capitol Hill its draft bill, Promoting Safe and Stable Families Amendments of 2001. Action on the measure could happen fairly quickly. The bill would do the following:

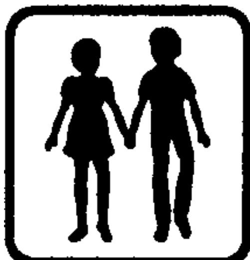
1) reauthorize for five years the Promoting Safe and Stable Families Program, set to expire at the end of the 2001 fiscal year. The bill would increase the authorized funding by $200 million to $505 million for each year 2002 through 2006, setting aside $15 million in 2002 and $20 million in the following years for research, training and technical assistance, and increase the set-aside for the State Court Improvement Program to $20 million a year. The bill identi-

fies priority topics for research and evaluation to include model programs in time-limited reunification services and postadoption services, model services to address parental substance abuse and reduce its impact on children, programs directed at specific families and children of specific ages, and the outcomes of finalized adoptions post-ASFA. For technical assistance, it would focus on identifying families with specific risk characteristics, developing treatment models (especially for families with substance abuse), implementing interventions that result in changes among families at risk, ensuring that services match the treatment model, ensuring that postadoption services meet the needs of families, and developing models to reduce disruption rates. The administration's bill would also amend the statutory definition of family support services to include "strengthen parental relationships and promote healthy marriages."

2) establish a new $67 million grant program to support mentoring services for children with parents in prison. Grants of $5 million or $10 million would be available to local governments in areas with significant numbers of children of prisoners. The mentoring programs identified for support in the Bush bill focus on matching children with "trained adult volunteers for one-on-one relationships...to meet the child's need for involvement with a supportive adult who provides a positive role model."

3) eliminate current statutory provisions permitting states to choose not to conduct criminal record background checks required for prospective foster and adoptive parents.

4) authorize $60 million annually for a new program of vouchers to young people who have aged out of foster care for the expenses of postsecondary education and training. Young people adopted from foster care at age 16 or older are also eligible for the vouchers.



BUSH BUDGET DROPS ADMINISTRATION'S FUNDING INITIATIVES FOR AT-RISK CHILDREN

Two important initiatives to strengthen families and protect children proposed by the Bush Administration at the beginning of the year have been scaled back in the Administration's mid-season budget review and could be eliminated altogether.

In February, the President proposed to increase entitlement funding for the Safe and Stable Families program by $200 million a year. The legislation President Bush sent to Congress on August 8 includes the increased entitlement funding for the program of grants for family support, family preservation, family reunification, and adoption promotion and support services.

In late August, the budget review prepared by the Administration's Office of Management and Budget deletes the request for this increase in entitlement funding for the Safe and Stable Families program. The OMB document says that the Administration supports funding the program with discretionary funds in the annual appropriations bills. However, the Administration has not raised the overall request for discretionary spending, nor have reductions been proposed in other discretionary programs to accommodate the Administration's change in funding priorities.

Similarly, the OMB budget review drops the Administration's request for $60 million in entitlement funding for the education and training vouchers the President wants Congress to enact for youth who age out of foster care. Instead, the White House supports funding its new initiative with discretionary funds, but makes no provision for increasing discretionary totals to cover this new discretionary spending category.

The scramble for discretionary money to cover these additional spending items could force cuts across HHS' discretionary spending programs.

APSAC thanks Gracia Alkema & C. Terry Hendrix for funding the copy editing and design for this issue of the *Advisor*.

Conferences in 2001

Nov. 7-10, 2001
Association for the Treatment of Sexual Abusers
San Antonio, Tx.
Call: 503-643-1023,
FAX: 503-643-5084,
email: *atsa@atsa.com,*
or visit: *www.atsa.com*

Nov. 7-10, 2001
American Society of Criminology
Atlanta, Ga.
Call: 614-292-9207
FAX: 503-643-5084
or visit: *www.ASC41.com*

Conferences in 2002

Jan. 21-25, 2002
16th Annual San Diego Conference on Responding to Child Maltreatment
San Diego, Ca.
FAX 858-966-8018
email: *dmartin@chsd.org*

Mar. 6-8, 2002
Child Welfare League of America National Conference
Washington, D.C.
email:
children2002@cwla.org

Mar. 6-8, 2002
1st Annual Eastern Conference on Child Sexual Abuse Treatment
Arlington, Va.
Call: 608-263-5130 or
1-800-442-7107
email: *PDAS-easternconf@dcs.wisc.edu*

WELLSTONE AMENDMENT CONNECTS DOMESTIC VIOLENCE/ SCHOOL PERFORMANCE

Recognizing the relationship between violence at home and success or failure in school, Sen. Paul Wellstone (D-MN) succeeded in expanding federal education legislation passed by the Senate in May to include funding aimed at combating the impact on school children of experiencing or witnessing domestic violence.

The amendment to S.1, the Better Education for Students and Teachers (BEST) Act, authorizes spending at $5 million each fiscal year from 2002 through 2004 for elementary and secondary schools to:

1. train teachers and school personnel in issues concerning children and violence;
2. provide educational material to students regarding domestic violence;
3. offer support services to students and school personnel for developing effective prevention and intervention strategies for school children experiencing domestic violence; and
4. develop and implement school system policies for identification and referral for students experiencing domestic violence.

Wellstone's amendment also would include data on rates of reported cases of child abuse and of domestic violence among the risk factors determining eligibility for funds under the education bill's Safe and Drug-Free Schools program. These funds would be used for violence prevention programs including training parents, law enforcement officials, judicial officials, social service providers, health service providers, and community leaders in domestic violence and child abuse prevention. The amendment also would include "family violence prevention" as a collaborative linkage between schools and community resources.

The education legislation passed by the House and Senate earlier in the year remains locked up in a House-Senate conference committee working to resolve the differing provisions in both bills.

ACT TO LEAVE NO CHILD BEHIND

On May 23, Sen. Christopher Dodd (D-CT) and Rep. George Miller (D-CA) introduced the Act to Leave No Child Behind (S.940 and H.R.1990), legislation that proposes a comprehensive policy agenda for America's children.

The Act is an omnibus bill for children addressing their well-being in key areas, such as child care, child welfare, child health, education, youth development, juvenile justice, and violence prevention. Two of the bill's twelve titles propose legislation specific to issues of prevention and intervention in the abuse and neglect of children.

The Parenting Title of the Act (Title II) authorizes funds for preventive services of support to parents, including voluntary home visits and parenting education programs, parent support groups, and parenting resource centers.

Title II also proposes to expand the Family and Medical Leave Act to employers with 25 or more employees, rather than 50 under current law, and to offer health insurance through CHIP and Medicaid to the eligible children of uninsured parents.

The Safe Families Title of the Act (Title VIII) on child welfare proposes a significant change in the use of Title IV-E funds, reserved under current law for foster care and adoption subsidies. The Act would open the IV-E funding to pay for time-limited services for children and parents who come to the attention of the child protection system for assessment or investigation, proposing an approach to providing major federal assistance to pay for "front-end" services. The Act would offer help to special groups of children and families at increased risk of child abuse and neglect, such as those beset by substance abuse, domestic violence, and the emotional problems of young children.

CDF ACTION COUNCIL'S CONGRESSIONAL VOTING RECORD

The Children's Defense Fund Action Council's Nonpartisan Congressional Voting Record of 2000 is available. Based on votes (or lack thereof) in the House and Senate that affected the lives of children in America, the worst voting record identifies 47 Senators and 108 House Members who scored below 50 percent; meanwhile, 34 Senators and 48 House Members consistently voted for children with scores of 100 percent.

The voting record lists the 44 Senators and 23 Members of the House who scored 30 percent or below. Also listed are the top ten and the bottom ten state delegations for children.

The 2000 Nonpartisan Congressional Voting Record can be accessed online at *http://www.cdfactioncouncil.org* .
A free copy may be obtained by e-mailing *cdfactioncouncil@childrensdefense.org* or by calling (202) 662-3576.

NEW ATTENTION TO CHILDREN IN FEDERAL CRIME VICTIMS' PROGRAM

In new program guidelines published in May 2001 by the U.S. Department of Justice, and effective immediately, the Office for Victims of Crime identifies children who witness domestic violence as one of four groups of victims with unmet needs.

The new guidelines encourage states to consider the mental health and other needs of these victims. State crime victim compensation programs use funds from the federal Crime Victims Funds to assist victims and pay for support services.

For further information, please contact:

Carol R. Watkins, Director
State Compensation and Assistance Division
Office for Victims of Crime
810 Seventh Street, N.W.
Washington, DC 20531
Phone: (202) 514-4696
E-mail: *watkinsc@ojp.usdoj.gov*

APSAC Colloquium Highlights

There were approximately 750 child abuse professionals in attendance at the 9th Annual APSAC Colloquium. The conference was held in Washington, DC, on June 20-23, 2001. The attendees represented a variety of professions, including medicine, law, social work, mental health, administration, advocacy, and law enforcement. Over the course of the 4-day conference, attendees had the opportunity to participate in workshops provided by over 150 experts in the field.

Wednesday, June 20th, was an all-day advanced setting focusing on cultural issues. There were approximately 175 attendees for this unique event. The day started with a panel focusing on Child Abuse Intervention in Communities of Color: Doing Good and Doing Harm. This was followed up with 3 sets of 1-hour workshops. In addition to nationally recognized presenters, there were several international speakers, who were sponsored by the International Society on the Prevention of Child Abuse and Neglect (ISPCAN).

Thursday was the official start to the conference. Victor Vieth, JD set the tone for the following days with an encouraging keynote address entitled "The Little Country That Could: A Multidisciplinary Success Story." Nine sets of 1-hour to 6-hour workshops were provided and during each workshop, several tracks were offered. Those tracks were advocacy, interdisciplinary, law, law enforcement, research, mental health, medicine and nursing, prevention, cultural diversity, child protective services, and ISPCAN.

In addition to the workshops, special times were set aside to focus on hot topics in the field. Friday morning provided the opportunity for participants to attend one of five mini-plenaries. Topics included allegation of sexual abuse in divorce cases, standardizing research-based protocols, why a reduction in the number of child sexual abuse reports, characteristics of perpetrators, and the DPT defense in child-abuse inflicted head injury cases. Attendees also participated in audience-participation Open Forum discussions led by experts in the topic of interest. The topics included drug-exposed infants, forensic interviewing, child fatalities, and EMDR.

Overall, the 9th Annual APSAC Colloquium was a success. We are now working on providing the same quality training at the **10th Annual Colloquium, scheduled for May 29 - June 1, 2002 in New Orleans, LA.** We look forward to seeing you there. To obtain information about this colloquium, please contact **Tricia Williams, JD at (405) 271-8202.**

Conferences in 2002 cont'd

Mar. 19-22, 2002
The 18th National Symposium on Child Sexual Abuse
Huntsville, Al.
Visit: *www.ncac-hsv.org*

Apr. 9-12, 2002
World Forum on Early Care and Education
Auckland, New Zealand
Call: 1-800-221-2864
or visit:
www.ChildCareExchange.com

May 12-15, 2002
6th World Conference on Injury Prevention and Control
(WHO) Montreal, Canada
email:
trauma@coplanor.qc.ca.

May 29 - Jun. 1, 2002
10th Annual APSAC Colloquium
New Orleans, La.
Call: 1-405-271-8202
email: *tricia-williams@ouhsc.edu*
or visit: *www.apsac.org*

Jul. 7-9, 2002
14th International Congress on Child Abuse & Neglect
Denver, Co.
Fax: 1-303-782-5005
email:
2002@kempecenter.org
or visit:
www.kempecemter.org

2000-2001 APSAC BOARD OF DIRECTORS

Executive Committee

Sandra Alexander, MEd
President
Executive Director
Georgia Council on Child Abuse
Atlanta, GA

Veronica Abney, LCSW
Immediate Past President
Private Practice
Santa Monica, CA

Jon R. Conte, PhD
President-Elect
Professor, School of
Social Work
University of Washington
Seattle, WA

Pamela J. Gosda, BS
Accenture, Reston, VA

Charles T. (Terry) Hendrix, MA
Treasurer
SAGE, Senior Editor
Thousand Oaks, CA

Nancy B. Lamb, JD
Vice President
Assistant District Attorney
District Attorney's Office
Elizabeth City, NC

Cynthia Cupit Swenson.) PhD
Assistant Professor
Family Services Research Center
Medical University
of South Carolina Charleston, SC

Tricia D. Williams, JD Secretary
Assistant Professor
University of Oklahoma
Health Services Center
Center on Child Abuse
and Neglect
Oklahoma City, OK

Board Members at Large

Judith Cohen, MD
Professor of Psychiatry
MCP-Hahnemann
School of Medicine
Department of Psychiatry
Pittsburgh, PA

David Cory, MSSW
Community Initiatives Specialist
Texas Dept. of Protective and
Regulatory Services
Abilene, TX

Sexual Abuse

Dimensions jurors use when deciding a child victim's credibility and verdict

In this study, 573 participants read a simulated trial (robbery or sexual-assault case, in which the defendant was either a stranger or an acquaintance) in which the alleged victim was either a 6- or a13-year-old girl. The supporting evidence was held constant across cases to allow for experimental assessment of the hypotheses. The defendant was more likely to be found guilty in the sexual-assault cases than in the robbery cases. The child was perceived to be more credible and honest and to have a better memory in the sexual-assault cases compared to the robbery cases. Perceptions of memory and honesty predicted verdict and punishment. The child's age did not impact credibility or verdict. Finally, more women, compared to men, perceived the child as credible. Type of case was a potent factor in jurors' determination of guilt and the child's credibility. Contrary to expectations, neither the victim's age nor the interaction between this and the type of case influenced verdict or credibility measures.

McCauley, M. R., & Parker, J. F. (2001). When will a child be believed? The impact of the victim's age and juror's gender on children's credibility and verdict in a sexual-abuse case. *Child Abuse & Neglect*, *25*(4), 523-539.

The role of dissociation as a critical mediator of psychiatric symptoms

This study investigated the role of dissociation as a mediator of mental health outcomes in children and adolescents (N=114) with a history of sexual abuse. Interviews, provider ratings, and chart reviews were used to assess the relationship of childhood abuse history, dissociative responses, and psychopathology. Sexual abuse history was associated with dissociation, whereas a history of physical abuse was not. Both sexual abuse and dissociation were independently associated with several indicators of mental health disturbance, including risk-taking behavior (suicidality, self-mutilation, and sexual aggression). Severity of sexual abuse was not associated with dissociation or psychopathology. Analysis of covariance indicated that dissociation had an important mediating role between sexual abuse and psychiatric disturbance. These results were replicated across several assessment sources and varied perspectives.

Kisiel, C. L., & Lyons, J. S. (2001). Dissociation as a mediator of psychopathology among sexually abused children and adolescents. *American Journal of Psychiatry*, *158*(7), 1034-1039.

Diagnostic utility of sexual behavior problems as an indicator of sexual abuse

The authors hypothesized that sexual behavior problems are multiply determined and consequently are variably related to sexual abuse in a clinical sample. A sample of 247 children (aged 2-12 yrs) evaluated for sexual abuse at a multidisciplinary forensic child abuse evaluation clinic was included. Results from the Child Behavior Checklist (CBCL) and the Child Sexual Behavior Inventory (CSBI) were analyzed and compared to the results of a structured abuse assessment performed independent of these scores. The forensic team assessment found evidence of sexual abuse in 25% of cases, and no evidence in 61%. Children in this sample exhibited an elevated level of both sexual and nonsexual behavior problems. However, considerable variability was noted in sexual behavior problem scores. Nonsexually abused children were just as likely to have high CSBI scores as sexually abused children. The authors conclude that community professionals should use caution in relying on sexual behavior problems as a diagnostic indicator of abuse.

Drach, K. M., Wientzen, J., & Ricci, L. R. (2001). The diagnostic utility of sexual behavior problems in diagnosing sexual abuse in a forensic child abuse evaluation clinic. *Child Abuse & Neglect*, *25*(4), 489-503.

Child sexual abuse prevention program evaluated

A total of 133 1st and 3rd graders completed a knowledge questionnaire and a video vignette measure designed to evaluate preventive skill toward abusive and potentially abusive situations. A follow-up measure (2 months) was administered to verify whether knowledge and skills were maintained. Results indicated that children participating in the prevention program showed

greater preventive knowledge and skills relative to children not participating. Follow-up data showed that knowledge gains were maintained while the preventive skill gains may attenuate. In terms of unanticipated side effects, results revealed that almost half of the parents noted positive reactions following children's participation in the ESPACE program.

Hebert, M., Lavoie, F., Piche, C., & Poitras, M. (2001). Proximate effects of a child sexual abuse prevention program in elementary school children. *Child Abuse & Neglect*, *25*(4), 505-522.

Physical abuse

Maltreatment and emotion regulation mediated by maternal socialization practices

The socialization of children's emotion regulation in 25 physically maltreating and 25 nonmaltreating mother-child dyads was investigated in this study. Children and their mothers were interviewed individually about their (1) management of emotional expression, (2) strategies for coping with emotional arousal, and (3) anticipated consequences following emotional displays. Compared to controls, maltreated children expected less maternal support in response to their emotional displays, reported being less likely to display emotions to their mothers, and generated fewer effective coping strategies for anger. Maltreating mothers indicated less understanding of children's emotional displays and fewer effective strategies for helping children to cope with emotionally arousing situations than nonmaltreating others.

Shipman, K. L., & Zeman, J. (2001). Socialization of children's emotion regulation in mother-child dyads: A developmental psychopathology perspective. *Development & Psychopathology*, *13*(2), 317-336.

Childhood physical abuse linked with morbid course of substance abuse in adulthood

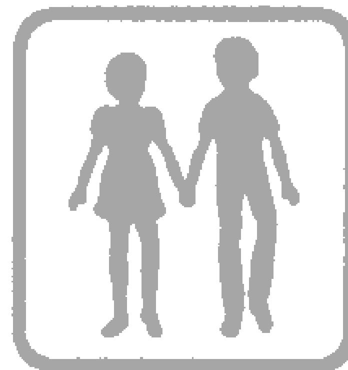
This study assessed the course and severity of Substance Related Disorder (SRD) in relation to childhood physical abuse (CPA) using retrospective data on CPA and current indices of substance use, abuse, and related morbidity. A total of 642 patients, of whom 195 (30.4%) experienced CPA, were assessed and the following information was obtained: demographic data, family history of substance abuse, problems related to substance abuse, and treatment of substance abuse. The study found that patients with CPA were more likely to be women, have lower SES, and have more extended family members with substance abuse. Patients with CPA reported more severe substance abuse and more treatment. Physical abuse during childhood resulted in a more morbid course of substance abuse later in adulthood.

Westermeyer, J., Wahmanholm, K., & Thuras, P. (2001). Effects of childhood physical abuse on course and severity of substance abuse. *American Journal on Addictions*, *10*(2), 101-110.

Abusive home environment associated with poor developmental outcomes

This study examined concurrent and longitudinal data for 182, 4th grade boys across a variety of developmental outcomes over a 10-year span. The authors hypothesized that in the context of unskilled discipline, the abusive home environment variables would be predictive of a variety of adjustment outcomes as children moved into adolescence and early adulthood. Assessments of the boys, their siblings, and their parents included direct observations, interviews, and questionnaires. Path analyses revealed that the consequences of each abusive home environment construct were, with little exception, consistent with the hypotheses.

Bank, L. & Burraston, B. (2001). Abusive home environments as predictors of poor adjustment during adolescence and early adulthood. *Journal of Community Psychology*, *29*(3),



Esther Deblinger, PhD
Associate Professor
University of Medicine & Dentistry Of New Jersey
Stratford, NJ

Gloria De La Cruz-Quiroz, LCSW
Private Practice
Santa Monica, CA

Lisa Aronson Fontes, PhD
Psychologist and Independent Scholar
Shutesbury, MA

Sandra Hodge, BS
Director, Division of Child Welfare, Policy and Practice
Maine Department of Human Services
Augusta, ME

Brian K. Holmgren, JD
Assistant District Attorney General
Office of the District Attorney General
20th Judicial Circuit of Tennessee
Nashville, TN

Dirk W. Huyer, MD
Director Suspected Child Abuse and Neglect Program
Hospital for Sick Children
Toronto, Ontario, Canada

Det. Michael Johnson, BSCJ
Plano Police Department
Plano, TX

Robert H. Kirschner, MD
Clinical Associate
Departments of Pediatrics and Pathology
University of Chicago
Chicago, IL

David Kolko, PhD
Associate Professor of Child Psychiatry,
Psychology, and Pediatrics
University of Pittsburgh School of Medicine
Western Psychiatric Institute & Clinic
Pittsburgh, PA

Thomas D. Lyon, JD, PhD
Professor
University of Southern California Law School
Los Angeles, CA

The importance of neighbors for child abuse prevention and reporting

This article summarized the results of a random telephone survey of a large, midwestern city that examined the extent to which respondents suspected their neighbors of physical child abuse. Data were also collected on how respondents learned of such physical abuse, what their response to it was, and whether they noticed a difference in the frequency of the abuse after they did or did not respond. Relatively few knew of their neighbors' physical abuse, and those who did learned of the abuse by either seeing or hearing it occur. Most reported the abuse, many did nothing, but some intervened in the situation. Parents of minor children reacted differently than adults without children.

Paquin, G., Schafer, J., & Carle, A. C. (2001). Neighbors' knowledge and reaction to suspected child abuse in an urban setting. *Journal of Sociology & Social Welfare, 28*(1), 105-118.

Other Issues

Indirect and direct correlates of exposure to community violence

The psychological and behavioral correlates of community violence exposure in psychiatrically hospitalized adolescents (aged 12-18 yrs) were investigated. Inpatients (N=89) were administered a battery of self-report instruments. Half of the patients reported exposure to multiple incidents of violence in their community (52%) and home (53%); 61% were victims of physical assault, and 39% were victims of sexual assault. Patients who had witnessed community violence reported significantly more posttraumatic stress disorder symptoms, drug use, and violence potential than patients without a history of witnessing community violence. Patients exposed to community violence were also more likely to be the victim of childhood maltreatment, as well as a perpetrator of violence. In conclusion, traumatization via exposure to community violence may serve as one important determinant in the development of mixed internalizing and externalizing psychopathology in adolescent inpatients, thus necessitating accurate assessment and treatment planning.

Fehon, D. C., Grilo, C. M., & Lipschitz, D. S. (2001). Correlates of community violence exposure in hospitalized adolescents. *Comprehensive Psychiatry*, *42*(4), 283-290.

Brain functioning, physical abuse, and perpetration of severe violence

This study used functional magnetic resonance imaging (fMRI) to address two important gaps in our knowledge of brain functioning and violence. Four groups of participants recruited from the community (controls, severe physical child abuse only, serious violence only, and severely abused/seriously violent offenders) underwent fMRI while performing a visual/verbal working memory task. Violent offenders who had suffered severe child abuse showed reduced right hemisphere functioning, particularly in the right temporal cortex. Abused individuals who refrained from serious violence showed relatively lower left, but higher right, activation of the superior temporal gyrus. Abused individuals, irrespective of violence status, showed reduced cortical activation during the working memory task, especially in the left hemisphere. Brain deficits were independent of IQ, history of head injury, task performance, cognitive strategy, and mental activity during the control task.

Raine, A., Park, S., Lencz, T., Bihrle, S., LaCasse, L., Widom, C. S., Louai-Al-Dayeh, & Singh, M. (2001). Reduced right hemisphere activation in severely abused violent offenders during a working memory task: An fMRI study. *Aggressive Behavior, 27*(2), 111-129.

Differential pattern of risk for child abuse recurrences

The purpose of this study was to investigate differences between substantiated cases that were, versus were not, opened and to examine differences in characteristics and patterns of child abuse recurrences between these two groups. Methods involved collecting data at an index report for a random sample of substantiated cases of physical abuse or neglect in an urban jurisdiction and following them prospectively over five years. Families (N=747) were compared with respect to sociodemographic characteristics, type of maltreatment, maternal substance abuse, age of mother at index, and prior substantiated reports. Results show that families with a previous substantiated report were 22% less likely to be opened

for service than families without prior substantiated reports, and cases substantiated for neglect were 20% less likely to be opened for service than physical abuse cases.

DePanfilis, D., & Zuravin, S. J. (2001). Assessing risk to determine the need for services. *Children & Youth Services Review, 23*(1), 3-20.

Guidelines for overcoming barriers to evaluating abuse histories

Psychologists are frequently faced with issues of whether, when, and how to ask clients if they have been abused. Despite the demonstrated relationship between child abuse and adult psychopathology, researchers report that many clinicians still do not routinely inquire about abuse. A questionnaire completed by 63 psychologists and 51 psychiatrists in New Zealand revealed that factors related to reluctance to ask about abuse included the following: more pressing issues, fear of disturbing clients, a diagnosis of schizophrenia, biological etiology beliefs, and fear of inducing "false memories." Significant differences were found between psychologists and psychiatrists on some of these factors. Practice guidelines for enhancing the frequency and efficacy of abuse inquiry are presented.

Young, M., Read, J., Barker-Collo, S., & Harrison, R. (2001). Evaluating and overcoming barriers to taking abuse histories. *Professional Psychology: Research & Practice, 32*(4), 407-414.

Help!

This contribution investigated the content and legal relevance of clinical evaluations of parents conducted in child abuse and neglect cases. The sample consisted of 190 mental health evaluation reports that had been completed on parents involved in a large, urban juvenile court system. As a result, 170 objective and qualitative characteristics were coded to assess for criteria recommended in the forensic literature. The authors found numerous substantive failures to meet those criteria for forensic relevance. Evaluations of parents typically were completed in a single session, rarely included a home visit, used few if any sources of information other than the parent, often cited no previous written reports, rarely used behavioral methods, stated purposes in general rather than specific terms, emphasized weaknesses over strengths in reporting results, and often neglected to describe the parent's caregiving qualities or the child's relationship with the parent. Some relevant differences were evident across assessment groups, pointing to examples of more thorough, parenting-specific evaluation practices. Recommendations to improve current practices in forensic parenting assessment are provided.

Budd, K. S., Pointdexter, L. M., Felix, E. D., & Naik-Polan, A. T. (2001). Clinical assessment of parents in child protection cases: An empirical analysis. *Law & Human Behavior, 25*(1), 93-108.

Timing of intervention for preventing abuse among adolescent mothers

This report examined the effects of a prenatal intervention for preventing child abuse and neglect. Here, 204 low-education adolescent mothers (aged 13-21 yrs at birth of 1st child) enrolled in an 18- to -27 month home-visitation intervention program before or after the birth of their first child. Ss were classified as low-risk, high-risk intervention graduates, or high-risk drop-outs. Results show that acceptance of high-risk mothers into the program prior to the infant's birth exerted a significant effect in preventing later child abuse and neglect. Child abuse and neglect rates and subsequent parity rates were not different between high-risk intervention graduates and low-risk Ss. Child abuse and neglect rates for both these groups differed significantly from rates of those dropping out of the intervention. Program costs were significantly lower than county foster care costs for children placed because of child abuse.

Honig, A. S., & Morin, C. (2001). When should programs for teen parents and babies begin? Longitudinal evaluation of a teen parents and babies program. *Journal of Primary Prevention, 21*(4), 447-454.

The purpose of Journal Highlights is to inform readers of current research on various aspects of child maltreatment. APSAC members are invited to contribute to Journal Highlights by sending a copy of current articles (preferably published within the past six months) along with a two or three sentence review to:

Ernestine C. Briggs, Ph.D.,
Duke University Medical Center,
Trauma Evaluation Treatment and Research Center,
Child and Family Health - North Carolina,
3518 Westgate Drive, Suite 100
Durham, NC 27707
or FAX: 1-919-419-9353

Children 0 to 3 Years of Age

Maria Scannapieco, Ph.D.
Kelli Connell, L.M.S.W.

Neglect consistently accounts for over half of all substantiated cases of maltreatment in the United States (USDHHS, 2001; 2000), and the highest rate of victimization is in the 0 to 3 age group (USDHHS, 2001). Yet, neglect has continued to receive less definitional and research attention than child physical and sexual abuse (Zuravin, 1999).

Child neglect affects children of all ages, but children 3 years of age and younger are the most vulnerable and suffer the most devastating consequences. Only 10% of child deaths occur to children over 4 years. Most death victims are under the age of 2, and 41 % are under the age of 1 (McClain, et al. 1993; Levine, et al. 1995). Overall, child fatality due to neglect ranges from 32% (Delambre & Wood, 1997) to 48% (Wang & Daro, 1998; Baumann, et al., 1998) of all reported child death cases. Although children between 0 and 5 comprise 35% of all children in the United States, they account for 85% of child maltreatment-related fatalities (Petit & Curtis, 1997).

Neglect is also one of the more difficult areas of maltreatment to assess...

Many young children who survive near fatalities due to child abuse and neglect forever suffer the consequences. NCCAN (1991) indicates that 141,700 children have suffered serious injury because of near-fatal abuse and neglect. Ten times as many children survive severe abuse and neglect as die from it, and a staggering 9.5% to 28% of all disabled persons in the United States may have been rendered thus by child abuse and neglect (Baladerian, 1991).

Given the scope of neglect and its perilous consequences, it is imperative that more attention be directed in this area. During the formative years, a child's development impacts the rest of her or his life. The achievement of developmental milestones and tasks during these years is paramount to adult development. This alone mandates that the youngest victims of neglect be assessed properly to improve and facilitate healthy development.

The main focus of this article is the presentation and discussion of child neglect assessment guidelines for children 0 to 3 years grounded in the theoretical context of attachment. Current risk and safety assessment instruments have "age of the child" as a risk category but do not lead practitioners to observable conditions that can inform decision making. Neglect is also one of the more difficult areas of maltreatment to assess, particularly during the first years of a child's life because practitioners must completely rely on observable indicators, and often an absence of behavior further complicates the assessment. Therefore, using attachment theory as the framework for assessing neglected children provides a comprehensive lens to view the child, caregiver, and social interaction.

It is beyond the scope of this article to discuss the conceptual and definitional issues present in the literature, which can be found elsewhere (Dubowitz, et al, 1998; Giovannoni, 1989, Wolock & Horowitz, 1984; NCCAN, 1988, Zuravin, 1999, Berrick, 1997). However, for the purposes of this article, neglect will be reviewed from both the perspective of parental behavior and the perspective of consequences to the child. Focusing on the first years requires this dual perspective because outcomes for the child may not be observable for years. Additionally, viewed from the attachment framework, the transactions between the caregiver and the child are essential in assessing quality of the relationship.

Attachment Theory and Neglect

Attachment theory has informed child maltreatment practice and research for the past two decades, and it is well established in the empirical literature that the quality of early caregiver-child interaction has important implications for child development. The attachment relationship between the primary caregiver and the child is critical to the survival and development of the child (Ainsworth, 1989; Bowbly, 1969). While the neglect assessment focuses primarily on normal and abnormal child behavior, parental behavior is assessed through the attachment relationship.

Attachment begins at birth and occurs naturally during the first 3 years of life; it is hypothesized to be dyadic and reciprocal. The infant relies totally on the primary caregiver and, in the context of this primary dependence, the caregiver's response to the dependence is how the attachment relationship is established (Perry, 2000). In order to form and maintain quality attachment relationships, primary caregivers need to provide continuous, sensitive, and responsive care to the infant. In doing so, the primary caregiver establishes a quality bond with the infant.

The reciprocal nature of attachment is important to understand in relation to assessment. Many factors may interfere with the attachment experience, and problem areas to explore may be related to the infant, the primary caregiver, the environment, or the fit between the infant and caregiver.

Infant: The fussy, nonaffectionate child or the passive one who does not react does not reinforce the parent's responsiveness, and the attachment may then be impeded. The same may be true for mentally or physically handicapped infants who do not respond in ways that are gratifying to the parent.

Primary Caregiver: The caregiver may be insensitive and unresponsive to the child because of substance abuse, depression, maltreatment history of parent, or overwhelming problems that interfere with the ability to be nurturing to the child.

Environment: Overcrowding and violence in neighborhoods may lead to distress and inability to engage in a supportive relationship. The exposure to domestic violence and child maltreatment may lead to fear in the child that causes attachment problems.

The Fit Between the Infant and Caregiver: The temperament of the child may be antithetical to the parents. The child may be active and the caregiver passive. The infant may remind the primary caregiver of the father who is no longer in the home and thus bring negative feelings to the caregiver. These circumstances could lead to problems in attachment.

The consequences of an impaired attachment relationship in early childhood ranges from the most severe loss of the capacity to form any meaningful relationships, to mild interpersonal, social, or emotional problems. When lack of bonding occurs between the primary caregiver and the infant, attachment can be categorized into four categories and observed through a process to measure the nature of a child's attachment—the stranger situation procedure. The categories of attachment are as follows: (Ainsworth, Blehar, Waters, & Wall, 1978):

Securely Aattached: The child will explore while the primary caregiver is in the room; is upset with separation; gives warm greeting upon return; seeks physical touch and comfort upon reunion.

Insecure, Avoidant: The child will ignore the primary caregiver when present; shows little distress on separation; actively turns away from caregiver upon reunion.

Insecure, Resistant: The child will demonstrate little exploration with the primary caregiver in the room; stays close to caregiver; is very distressed upon separation; is ambivalent or angry and resists physical contact upon reunion with the caregiver.

Insecure, Disorganized Disoriented: Child demonstrates confusion about approaching or avoiding the primary caregiver; is most distressed by separation; upon reunion acts confused and dazed.

The child who experiences neglect in the first 3 years of life will experience problems with attachment that have developmental consequences spanning the range of physical, emotional, behavioral, cognitive, and social functioning. As discussed in this article, parental behavior affects attachment, which then affects child behavior. When parents fail to nurture and bond with their child, the child's behavior is altered. This cycle is signified by poor attachment, ultimately increasing the possibility of neglect and children at risk of harm.

Knowledge of normal and appropriate child development is essential to understanding any abnormal or delay in child development. If neglect is present in a child's home, then awareness of normal child behavior provides the practitioner a heightened understanding of the child's developmental level, whether normal or abnormal. It is also necessary to break down the age of the child into six-month increments for the first 2 years. Children learn much during the first 2 years of their lives, with entry into the world at birth to exploration of it at 2 years by walking and talking. During the child's third year, development begins to slow and observable changes are less drastic than in the first 2 years. Thus, the 24-36 month age group is not divided into 6-month increments.

Neglect Assessment

Grounding this discussion in attachment theory and viewing the child from the four developmental domains provides a comprehensive view of the progress that is normal for children. It is imperative to note that the tasks and behaviors focus on what is known of normal development; they do not pertain to instances where a child is born with a disability or delay. Therefore, assessing the first days and months of a child's life, including prenatal and perinatal care, is essential to making an accurate assessment of what is normal development for that particular child. Each developmental time period is divided by 6-month categories. During these intervals, an assessment must depend upon where the child begins developmentally, and therefore, cognitions and behaviors may not be exactly what the assessment dictates, but approximations. More importantly, the attachment relationship should be assessed in relation to the child's developmental and physical capabilities. In assessing the child when the behaviors and tasks are not present, then an increased concern for the child's well-being and risk of neglect is present.

cont'd on page 22

Cont'd from page 21

0-6 months

During the first months of life, a child's survival is dependent upon his or her inherent vulnerability and reliance upon a caregiver. The primary task evolves from sucking for nutrition to more sophisticated behaviors, such as showing basic emotions and communicating through babbling. Infants also experience rapid physical growth and sensitivity toward the caregiver, being able to differentiate her or his primary caregiver's voice from others. The attachment figure is paramount to the survival and appropriate growth of the child. If poor attachment results in a lack of the child's nutritional needs being met or a lack of attention and stimulation, the child is vulnerable to neglect, thereby affecting future development if not noticed quickly. Those assessing children during these ages need to be aware of the manifestations of neglect including nonorganic failure to thrive, inadequate weight gain of the child since birth, as well as socioemotional developmental factors.

0-6 months

Cognitive-Behavioral

Does the child imitate adult's facial expressions?
Does the child repeat chance behaviors that produce pleasure for the child?
Can the child recognize people and places?
Does attention become more flexible with age?
Does the child babble by the end of this period?

Socioemotional

Does the child show a range of emotions including happiness, sadness, fear?
Does social smiling and laughing emerge?
Can the child imitate adult emotional expression during interactions?
Does the infant begin to distinguish self from others (the emergence of an"I")?

Physical

Does the child have rapid height and weight gain?
Can the child hold her or his head up, roll over and reach for objects?
Can the child hear sounds, with increasing sensitivity to sounds of own speech with age?
Does the child begin to habituate toward fixed stimuli?
Is the child sensitive towards motion?

6-12 months

As the child proceeds through the first year, rapid physical growth and increased learning occur. A child experiencing normal development should be able to navigate one's environment, either by crawling or walking, and should be able to exhibit goal-directed behavior. Additionally, the child should be able to recognize a primary caregiver and be able to differentiate between other caregivers. When these primary tasks are not achieved, an assessment of the environment and caregiver-infant's attachment is necessary. If the caregiver is emotionally unavailable to the child, the child is not being provided the necessary environmental stimulation in order to develop appropriately. By an absence of the indicators below, the child is delayed, possibly due to maltreatment.

6-12 months

Cognitive-Behavioral

Does the child have goal-directed and intentional behavior?
Can the child find hidden objects?
Can the child imitate adults' actions?
Can the child combine sensory and motor activities?
Does the child babble including sounds in the child's spoken language?
Does the child show preverbal gestures, such as pointing?

Socioemotional

Does the child show stranger and separation anxiety?
Does the child use the caregiver as a secure base?
Can the child engage in social referencing?
Does the child show definite attachment to caregivers?

Physical

Can the child sit alone, crawl and walk?
Can the child organize stimuli into meaningful patterns?

12-18 months

During this time, the child becomes increasingly more cognitively and socially capable while physical growth declines from its rapidity during the first year of the infant's life. The child gradually learns language and improves communication. During this time, the child's play also changes from being more individual during the first year to being more interactive. Thus, the skills acquired during 12-18 months shapes a child's schema for future cooperative activities, including peer relationships and emotional regulation. Neglected children may not be able to use words, may have an extremely short attention span, and may have difficulty interacting with other children.

12-18 months

Cognitive-Behavioral

Does the child sort objects into categories?
Can the child find hidden objects by looking in more than one place?
Does the child show trial and error learning in play?
Does the child have an improved attention span?
Can the child talk, at least saying first words?
Does the child use overextension and underextension of known words?
Can the child take turns when playing interactive games?

Socioemotional

Can the child recognize an image of oneself?
Can the child play with siblings and familiar adults?
Does the child show signs of empathy?
Can the child engage in turn-taking behaviors when playing?
Can the child understand and comply with simple directives?

Physical

Does the child continue to grow, but less rapidly than during the first year?
Can the child walk better with more coordination?
Can the child manipulate and play with small objects improving coordination?

18-24 months

Children during this age period increasingly use their imaginations for play and have increased memory skills for objects, places, and people. Children should be talking, using phrases, and have the ability to demonstrate individual emotional regulation. Physical development is slowed, but becomes increasingly refined, with the ability to jump and climb. During these ages, children can assert autonomy verbally and physically. If a child has been neglected for some time, she or he may be delayed at the age-appropriate tasks indicated below. The neglected child may exhibit delays in language development, being unable to combine words, and may also be delayed in the socioemotional tasks that become increasingly important as the child grows. If the child is unable to express self-conscious emotions (i.e., shame, embarrassment) and lacks emotional self-regulation, the immediate behaviors and consequences will be apparent if properly assessed.

18-24 months

Cognitive-Behavioral

Can the child find objects that are out of sight?
Does the child try to fully imitate adults' actions?
Does the child engage in make-believe play?
Can the child move objects into categories during play?
Can the child recall people, places or object better than before?
Does the child have a vocabulary of approximately 200 words?
Can the child combine two words?

Socioemotional

Does the child express self-conscious emotions, such as shame and embarrassment?
Does the child have a vocabulary that includes emotional terms?
Does the child use vocabulary in order to emotionally regulate oneself?
Can the child increasingly tolerate the absence of caregiver?
Can the child categorize self and other based on dichotomies, such as gender, age, good/bad?
Does the child use own name as labeled image of oneself?

Physical

Can the child jump, run and climb?
Can the child manipulate small objects with good coordination?

24-36 months

A child becomes increasingly independent during between 24 and 36 months of age. The child should be able to use a spoon and fork and dress oneself. The child is able to navigate and gain greater control of her or his environment. A child is able to know that there are consequences to behaviors, and can distinguish between intentional and unintentional activities. Language becomes even more expansive, with the ability to utilize grammatical rules and acquire a more complex vocabulary. When neglect is present in the home, the child may not be able to display conversational skills, or may lack an age-appropriate vocabulary. A neglected child may not be able to use a spoon or fork, throw objects, run and hop; and she or he may not be able to move beyond the more self-centered play during previous stages to the more complex and cooperative play that distinguished this time period.

24-36 months

Cognitive-Behavioral

Is make-believe play less self-centered and more complex?
Does the child have a well developed memory recognition?
Is the child aware of inner cognitive events versus outer physical events?
Does the child increasingly acquire a more developed vocabulary?
Can the child use sentences with increased usage of grammar?
Does the child display conversational skills?

Socioemotional

Can the child distinguish one's intentional and unintentional actions?
Can the child understand causes and consequences of behaviors?
Does the child exhibit gender stereotypes, behavior and beliefs?
Does the child exhibit cooperative or aggressive behaviors?

Physical

Does the child's appetite decline?
Can the child get dressed or undressed partly by herself or himself?
Can the child use a spoon or fork?
Can the child run, jump, hop and throw objects?
Does the child gain weight and height but less so than during the first 2 years?

Neglect is presented through a comprehensive assessment by looking at both the parental behavior through a discussion of attachment theory, and child behavior through a discussion of child development. The overall purpose of this assessment is to provide a framework for assessing neglect with the goal of reducing child death. Neglect is more likely to result in fatality than any other form of child maltreatment (USDHHS, 1999; Petit & Curtis, 1997), and the highest rate of child fatality due to maltreatment is between the ages of 0 and 5 (Gustavsson & Seval, 1994; Petit & Curtis, 1997;USDHHS, 1999). In response to these statistics, it is imperative that assessing children of neglect be awarded more attention. By identifying neglect promptly, children will be safe from future harm and neglect's most devastating consequence: child fatality.

APSAC BOARD OF DIRECTORS
List of Candidates 2001

Fellow APSAC Members:
It is time to elect five new members to serve on the Board of Directors for the organization. The following list of candidates was selected by the nominations committee from a list of 14 highly qualified individuals. The choice was difficult, but the following represents the slate the committee felt would provide the best leadership to ensure APSAC continues to prosper and grow.

Meet the candidates:

Toni Cardenas, CSW

Nominated by: Jocelyn Brown, MD, MPH and Jamie Hoffman-Rosenfeld, MD

Ms. Cardenas serves as a child advocacy center social worker at the Columbia Presbyterian Medical Center in New York, New York. Her duties include interviewing and assessing sexually/physically abused and neglected children, as well as conducting corroborative interviews with families and perpetrators. She received her degree from the Fordham University Graduate School of Social Services in 1990. She has presented at past APSAC Colloquiums and serves as the Vice-President for New York County in the New York state chapter.

Self-Statement:

APSAC is the national organization that brings together the spectrum of professionals in the field of child abuse. I have a great deal of respect for the work they do and the dedication of its members. I am passionate about my work as a social worker in a child advocacy center. The difficulties I face every day at my job are the same faced by many in the field. As a bi-lingual forensic interviewer working in a predominantly Latino neighborhood in New York City, I know first hand the challenges we face. There is a lot of work to be done in teaching and training. APSAC has taken that challenge on. I'm interested in serving on the Board of Directors so that I can bring my energy, dedication and commitment to the organization.

Nathaniel Glover, JD

Nominated by: Jeanie Ming, CPNP; Joan Kilgore, Volunteer Supervisor; and Bob Malmberg, CAST Coordinator

Mr. Glover serves as Deputy District Attorney for the Orange County District Attorney's Office in Santa Ana, California. He has served in this capacity since 1993. He has participated as a key player in the Child Abuse Services Team in Orange County for many years and received the CASA Judicial Honoree Award in March of 2001. He has served as a counselor at a juvenile hall and later became Orange County's first African American Deputy Sheriff. He has served on the California State Chapter Board for 3 years and is currently the Second Vice-president.

Self-statement:

I am interested in serving on the APSAC Board because I can make a difference. I would like to see APSAC meet the needs of those who have dedicated themselves to protecting abused children. I have served in law enforcement for over 30 years in Orange County, California. I currently serve on the Board of Directors for CAPSAC. I am on the AMICUS Committee. I was previously on the Board of Directors for both the Attorney's Association and the District Attorney's Association. For six years I have been a member of the Child Abuse Services Team (CAST), a Children's Advocacy Center in Orange, California. I have supervised about 5,000 interviews of sexually and physically abused children. I have presented at numerous seminars related to the abuse of children at the local, state and national levels. Based on my enthusiasm, training and experience I can be an asset to the APSAC Board of Directors.

Rochelle Hanson, PhD

Nominated by Cindy Cupit Swenson, PhD and Julie Lipovsky, PhD

Dr. Hanson is currently Research Assistant Professor for the National Crime Victims Research and Treatment Center located at the Medical University of South Carolina in Charleston, South Carolina. In addition to being an accomplished researcher, she also provides direct patient care to victims of trauma. Dr. Hanson was a founding Board Member of the South Carolina state chapter of APSAC and is currently serving as President. She has been heavily involved on the Editorial Board of *Child Maltreatment*, reviewed articles for the *Advisor,* published articles in *Child Maltreatment* and presented numerous workshops at past colloquiums.

Self-statement:

Since I first joined APSAC more than 10 years ago, I have considered it to be my professional home. The collaborative relationships I have developed over the years have benefitted me both personally and professionally in ways too numerous to delineate here. Serving on the APSAC Board would give me the opportunity to give back to the organization which has been such a part of my personal and professional life. Even more importantl, serving on the APSAC Board would enable me to play an important role in strengthening and expanding APSAC by having a direct role in increasing membership, furthering training, assisting with the development of the annual colloquium, and playing an integral role in the future course of APSAC. I was a founding member of the South Carolina state chapter and have served as the president for two terms; from this experience I truly believe I can become an active, vital member of the national Board.

Walter Lambert, MD

Nominated by Michael Haney, PhD, NCC-LMHC; J. M. Whitworth, MD; and Melissa Runyon, PhD

Dr. Lambert currently serves as Associate Professor of Clinical Pediatrics at the University of Miami School of Medicine. He serves as Medical Director of the Child Protection Team for the counties of Monroe and Dade in South Florida, and provides comprehensive medical examinations to children referred to the team. He is also a member of the statewide quality assurance committee for multidiscplinary teams in the state of Florida, and currently serves as Chair. Dr. Lambert is a member of the Miami-Dade County Child Abuse and Domestic Violence Fatality Review Teams and the South Florida Cuban community. Dr. Lambert has presented at past APSAC colloquiums and has been a member of the organization for 10 years.

Self-statement:

Prior to becoming a pediatrician, I was a social worker in the child welfare system for several years. My wife and I have been shelter/foster parents for too many children. For more than a decade, I have been Medical Director of the University of Miami Child Protection Team, a busy diagnostic and intervention program in this large multicultural city. As a person and professional who has participated in many aspects of the "system", I believe that I bring a different (personally interdisciplinary) perspective to the evaluation/diagnosis of child maltreatment and its effects on children and their families. I am strongly committed to improving the quality of services through education of professionals and parents, as well as through direct clinical practice.

Sarah Maiter, PhD

Nominated by Veronica Abney, MSW and Lisa Fontes, PhD

Dr. Maiter has her degree in social work and currently serves as Assistant Professor in Social Work and as Coordinator of International Placements at Wilfrid Laurier University in Ontario, Canada. Dr. Maiter has an extensive practice and teaching and continuing education training experience in child protection in Canada, the U.S. and South Africa. She is a trainer for the Ontario Association of Social Workers, an agency that provides child protection training to all of Ontario's 56 child protection agencies. Dr. Maiter has a particular interest in working at developing child protection services that are anti-racist and culturally competent. As a member of the diversity committee of APSAC she has been instrumental in extending the diversity content of the conference. Dr. Maiter has presented at past APSAC Colloquiums, published two articles in *Child Maltreatment* and also served as a reviewer for the journal.

Self-statement:

As a member of APSAC and serving on its diversity committee, I have had the opportunity to meet many caring, committed, and dedicated people who have shared their knowledge and expertise with me. Over the years I have learned a great deal by both attending and presenting at the training seminars and the research presentations at APSAC conferences and have found that APSAC plays a critical role in disseminating valuable and leading edge research based information on issues relating to child maltreatment. APSAC's commitment to social justice, equity, and culturally competent practice relate to my own research interest and provides a forum to think critically about these issues as they relates to child protective services. I feel that by serving on the Board I can contribute to APSAC as it has contributed to me. I bring expertise from the perspective of a front line child welfare practitioner, a researcher, and an academic. My 25 years of practice experience in child protection, with roles as diverse as investigator, on-going service provider, foster-care worker,

and program developer, has provided me with an understanding of the complexity of issues relating to child maltreatment, and the need for research based approaches and solutions, as well as the need for the dissemination of such information through forums such as APSAC.

Anthony Mannarino, PhD

Nominated by Judy Cohen, MD and David Kolko, PhD

Dr. Mannarino is currently Chair of the Department of Psychiatry at Allegheny General Hospital in Pittsburgh, Pennsylvania. He is also Professor of Psychiatry at MCP-Hahnemann University School of Medicine. Prior to being named chair of the department, he served (and currently serves) as Director for the Center for Traumatic Stress in Children and Adolescents and the Division of Child and Adolescent Psychiatry. In these positions, he has conducted seminal research with regard to the treatment of sexually abused children for 15 years. Dr. Mannarino's contributions to APSAC include presenting at past colloquiums and institutes, publishing in *Child Maltreatment* and the *Advisor,* and participating on APSAC task forces.

Self-statement:

I am honored to be nominated for the APSAC Board of Directors. For nearly 20 years, I have been actively involved in the field of child maltreatment. In addition to providing clinical services to abused children and their families over this span of time, I have served as the principal or co-principal investigator on several federal research grants examining the psychological impact of and treatment for child sexual abuse. I have also participated extensively in education related to child abuse issues at the local, regional, and national levels. I continue to believe that APSAC is the most important inter-disciplinary organization in this country for professionals in the field of child maltreatment. If elected to the Board, I would dedicate my efforts to assisting the current leadership in maintaining APSAC's stability and exploring new ways to better integrate the clinical and scientific areas of our field.

Mary Meinig, MSW, ACSW

Nominated by Susan Kelley, PhD and Jon Conte, PhD

Ms. Meinig currently serves as Ombudsman in the Office of the Family and Children's Ombudsman in Seattle, Washington. In this role, she investigates and assists in the resolution of complaints against DSHS relating to the provision of family and children's services. Prior to her appointment in this position in 1997, Ms. Meinig had a clinical practice that specialized in the treatment of victims and families affected by sexual abuse, and provided consultation to other professionals in this area as well. Ms. Meinig has presented at past APSAC Colloquiums and served on the state chapter Board for Washington.

Self-statement:

I have worked for 17 years as a private therapist specializing in working with victims of sexual abuse and their families. For the past four and a half years I have worked as Ombudsman at the Office of the Family and Children's Ombudsman in the state ofWashington. Over this time I have come to appreciate the importance of multidisciplinary practice. My recent experience in public service has convinced me of the importance of multidisciplinary intervention and collaboration in cases of chronic and severe neglect, physical abuse, sexual abuse and child abductions, and that APSAC has much to offer these fields of practice. I am at a point in my career where I feel that I have the energy and experience to contribute to APSAC's efforts both to support the internal operations of the organization and to continue to support child abuse practice.

Carol Plummer, MSW

Nominated by Kathleen Colbourn Faller, PhD and Elda Dawber, LICSW

Ms. Plummer is currently a doctoral student in social work and psychology at the University of Michigan. In addition, she has a private practice specializing in the evaluation and treatment of abused children and sexual assault victims. She was one of the recipients of NCCAN Prevention grants in the 1970's. She is currently taking a "sabbatical" to work as a consultant in Hawaii in the development of mental health services for special needs children in the school system. Ms. Plummer has presented at past APSAC Colloquiums and served on APSAC Task Forces.

Self-statement:

APSAC has long been a strong and sometimes a lone voice uniting professionals from multiple disciplines in joint efforts to end child abuse. I would like to assist in a leadership capacity to strengthen the organization, with a particular emphasis on building linkages with and membership from those working in prevention efforts. As a leader in promoting child sexual abuse prevention since 1979, as well as a child therapist with abuse victims, I believe I can build bridgesbetween prevention, intervention, treatment, and research, so that we can work together to promote safe and healthy children and families.

2001 BOARD OF DIRECTORS BALLOT

APSAC currently has five slots open on the Board of Directors. There are eight names listed on the ballot. Please vote for FIVE of the listed nominees. Any ballot that contains more than five votes will be discounted.

2001 BOARD OF DIRECTORS BALLOT

Please vote for FIVE of the listed nominees. Any ballot that contains more than five votes will be discounted.

_____ Toni Cardenas, CSW
_____ Nathaniel Glover, JD
_____ Rochelle Hanson, PhD
_____ Walter Lambert, MD
_____ Sarah Maiter, PhD
_____ Anthony Mannarino, PhD
_____ Mary Meinig, MSW, ACSW
_____ Carol Plummer, MSW

Please return your ballot, no later than FRIDAY, DECEMBER 21, 2001 to:

APSAC Attn: Tricia Williams, JD
PO Box 26901, CHO 3B3406
Oklahoma City, OK 73190
(405) 271-8202 Phone or Fax(405) 271-2931
Email to: tricia-williams@ouhsc.edu

Please indicate your name on the outside of the envelope. Members can only vote once, or their votes will be eliminated. You may vote by fax or email, but your name has to be present somewhere on the ballot.

Pre-Conference Programs

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN (APSAC)

Intensive Skills-Based Training With Top Professionals

Town and Country Resort & Convention Center, San Diego, CA
Monday, January 21, 2002
8:00 AM to 3:30 PM

APSAC's Advanced Training Institutes offer in-depth training on selected topics. Taught by nationally recognized leaders in the field of child maltreatment, these seminars offer hands-on, skills-based training grounded in the latest empirical research. Participants are invited to take part by asking questions and providing examples from their own experience. Take home in-depth knowledge you can use immediately by signing up for the APSAC Institute of your choice.

APSAC ADVANCED TRAINING INSTITUTES

I.Cognitive Behavioral Therapy for Traumatized Children

Judith Cohen, MD & Anthony Mannarino, PhD

This seminar will address cognitive-behavioral treatment for children exposed to a variety of traumatic life events. Although child sexual abuse will be used as a "prototypical" traumatic event, several other types of traumatic life experiences will be discussed in terms of impact on the child and family, and psychotherapeutic interventions specific to different types of trauma will be presented. Components of trauma-focused cognitive-behavioral therapy ("CBT") include exposure (direct discussion of the traumatic event or events), cognitive coping (examination and reframing of inaccurate or unhelpful thoughts and feelings about the traumatic event), relaxation techniques (muscle relaxation, directed breathing techniques, positive imagery), safety education, and parental interventions (which generally parallel the child interventions). Each of these components will be presented in a discussion format, with audio taped examples from actual treatment sessions. Participants are encouraged to bring case examples for discussion as well. The theoretical basis for including each of the above CBT components will be addressed in detail, and the available empirical data supporting CBT and its specific components will be presented. Several treatment outcome studies for traumatized children have been conducted, however, these have been limited by small numbers of subjects and variable rigor in research design. These studies will be discussed in terms of their applicability to clinical decision-making. Advances in the pharmacological treatment of PTSD and other trauma-related disorders in children will also be addressed.

II. Disposable Diapers as a Cause of Subdural Hemorrhage During Infancy: Controversial Theories from a Medical and Legal Perspec tive

Robert Block, MD; Brian Holmgren, JD; & Betty Spivack, MD

This symposium will present current controversial theories of causation offered by medical "experts" in physical abuse and child homicide cases including the medical literature and scientific data associated with those opinions. Topics discussed will include: short-distance falls and brain injury, bleeding and rebleeding of subdural hemorrhages, sagittal sinus thrombosis, immunizations as a cause of brain injury, second impact "syndromes", talk and deteriorate/die (TADD) situations, osteogenesis imperfecta and "temporary brittle bone disease", and other entities. Literature reviews, biomechanics and physics, and generally accepted scientific and medical knowledge will be presented, contrasted with the opinions being offered as alternative causal explanations during trials in cases of alleged inflicted injuries. The legal and medical components of these sometimes-complicated situations will be discussed. This session will also discuss the legal parameters for expert testimony involving novel medical defense theories and offer various suggestions on how to exclude, limit and challenge these theories through cross-examination and rebuttal testimony.

III. The Art & Science of Forensic Interviewing of Young Children

Kathleen Faller, PhD, ACSW, DCSW

This is a skills workshop that provides current information about research and practice related to forensic interviewing of children who may have been sexually abused. It will cover the following topics: forensic versus clinical interviewing; a critical review of current forensic interview protocols; the disclosure process—research and practice implications; questioning strategies —research and practice implications; decision-making. Videotapedillustrations will be employed. There will be opportunities for questions. The objectives of this workshop are to: 1) provide participants with select state of the art knowledge related to interviewing children about possible sexual abuse; 2) provide forensic interviewers with a review of current research related to child interviews; 3) impart information useful in court testimony; and 4) allow for a discussion of current controversies

IV. Clinical Management of Counter Transference, Vicarious Trauma & Trauma Treatment

Jon Conte, PhD & Lucy Berliner, MSW

It has long been recognized that clinical work and the life of the therapist are in a reciprocal relationship. Traditional notions of counter-transference aid the trauma therapist in understanding the many ways in which trauma therapy impacts and are impacted by the life of the therapist. This workshop provides a framework for understanding and identifying these reciprocal impacts. Material will be presented which reviews traditional understanding of counter transference; it's identification and management. Participants will be encouraged to share their experiences in conducting psychotherapy with traumatized individuals. Material will also be presented on the nature, identification, and management of vicarious trauma, which flows from sustained involvement in child abuse and trauma work. The differences between vicarious trauma and burn out will be reviewed. Participants will develop a personal plan for the management of vicarious trauma and burn out. This workshop will include instructor presented material and discussion and participants will be encouraged to share their own experiences. All discussions will be confidential. Case material may be presented with assurance of confidentiality. This workshop is designed with therapists as a primary audience, although child protection and medical professionals are welcome.

V. Investigation & Prosecution of On-Line Luring and Abductions

Brad Astrowsky, JD and Greg Allinich, Detective

The institute will begin with a brief introduction to the history and architecture of the Internet. We will then discuss why the Internet is a criminalís best friend and explore ways in which criminals exploit the Internet. Then, we will focus on the topic of computer-assisted child sexual exploitation, i.e. child pornography and on-line luring offenses. Attendees will be taught how to properly conduct on-line reactive and proactive investigations. A live on-line demonstration of how to conduct such investigations will be given. Finally, attendees will learn how a computer forensic examination is done, from seizure to completion; and about what hidden evidence one can find/recover in a computer. The objectives of this institute are to: 1) provide attendees with an understanding of the development and architecture of the internet; 2) demonstrate how the internet works to validate the illegal ideas of those who choose to abuse children; and 3) demonstrate how to use the internet to engage in proactive criminal investigations concerning both the distribution of child pornography and the on-line luring and abduction of children for sexual purposes.

VI. Advanced Issues in Child Sexual Abuse Examinations

Larry Ricci, MD

Please visit: *www.apsac.org* for an institute description and objectives.

VII. Forensic Application of Children's Memory and Suggestibility Research

Victor Vieth, JD and Tom Lyon, JD

Please visit: *www.apsac.org* for an institute description and objectives.

VIII. Combating Defense Strategies in Child Abuse Cases

Nancy Lamb, JD and Detective Mike Johnson

Please visit: *www.apsac.org* for an institute description and objectives.

REGISTRATION FORM FOR APSAC INSTITUTES ONLY

American Professional Society on the Abuse of Children (APSAC)

Intensive Skills-Based Training With Top Professionals

Monday, January 21, 2002, 8:00am to 3:30pm
Town & Country Resort & Convention Center, San Diego, CA

APSAC Members receive a $50 discount on the Institute Registration Fee!

Add or renew APSAC membership on this form and take advantage of the member discount today! Membership option is also available on the San Diego Conference Registration Form. Please do not duplicate. The address listed below is my __________office __________ home.

PLEASE PRINT!

First Name________________________ MI____ Last Name______________________________

Degree ________________________________ Membership ID #________________________

Agency name____

Address/Street____

City__________________________________ State______________ Zip_______________

Work Phone _____________________________ Home Phone _________________________

Fax________________________ E-mail____

Participants receive Continuing Education verifying six (6) contact hours, for submission to appropriate entities.

Institute Registration Fee	Through 12/18/01	After 12/18/01
Non-Members	$150	$175
APSAC Members (savings of $50)	$100	$125
Join or renew your APSAC membership	$100	$100

1st Choice Institute #: ______ 2nd Choice Institute #: ______ Total $______________________
(Space available on a first-come, first-served basis.)

Group rates available, call APSAC's Training Department at 405/271-8202 for details.

Enclosed is payment in the amount of $___________________ Check # _________________

By Credit Card: MasterCard VISA AMEX Discover PO #_______________________

Card #____ Exp. Date __________ /______

____ __________________
Signature Date

*****Please return this form with payment for the APSAC Institutes or Membership Only to:**

APSAC, PO Box 26901, CHO 3B-3406, Oklahoma City, OK 73190

To Register by FAX: 405/271-2931.

- Cancellations received prior to 12/31/01 are refundable, less a $50 administrative fee. Cancellations not accepted after 12/31/01. Substitutions may be made.
- Confirmation of registration will be emailed.
- For more information about Membership or APSAC's other training programs call 405/271-8202, E-mail: jennifer-moslander@ouhsc.edu, or visit the website at www.apsac.org.

Stop!

Do **not** send this form to the San Diego Conference, send it to APSAC.
Use the separate forms provided elsewhere in this brochure to register and pay for the **San Diego Conference, ISPCAN Training** and/or **NCA Institute**!

Join APSAC (or renew) and realize the benefits of membership today! When you register and select the membership option on the Institute registration form, you are immediately eligible for the member discount on the Institute registration fee. Please make check for registration and/or membership payable to APSAC, and return your registration to APSAC. See APSAC Registration Form for details. Offer not available when you join through the SAN DIEGO CONFERENCE (memberships purchased through the SAN DIEGO CONFERENCE are effective 3/31/2001 through 3/31/2002).

ABOUT APSAC: APSAC is a nonprofit interdisciplinary membership organization incorporated in 1987. Thousands of professionals from all over the world - attorneys, child protective services workers, law enforcement personnel, nurses, physicians, researchers, teachers, psychologists, clergy, and administrators have joined APSAC's effort to ensure that everyone affected by child maltreatment receives the best possible professional response.

APSAC ADVISOR

Editor in Chief
Debra Whitcomb, MA
American Prosecutors Research Institute
Alexandria, VA 22314
703-519-1675

ASSOCIATE EDITORS

Child Protective Services
Maria Scannapieco, PhD
University of Texas
Arlington, TX
817-272-3535

Cultural Issues
Michael deArellano, PhD
Medical University of South Carolina
National Crime Victims Research and Treatment Center
Charleston, SC
843-792-2945

Education
Ilene R. Berson, PhD
Louis de la Parte
Florida Mental Health Institute
Tampa, FL
813-947-7698

Journal Highlights
Ernestine C. Briggs, PhD
Duke University Medical Center
Durham, NC 27707
919-599-0572

Law
Thomas Lyon, JD, PhD
University of Southern California Law Center
Los Angeles, CA
213-740-0142

Medicine
Lori Frasier, MD
University Hospital
Columbia, MO
573-882-3713

Mental Health/Perpetrators
Steven L. Ondersma, PhD
Wayne State University
Detroit, MI
313-872-1790

Nursing
Beatrice Yorker, RN, JD
Georgia State University
School of Nursing
Atlanta, GA
404-651-2575

Policy Watch
Thomas Birch, JD
National Child Abuse Coalition
Washington, DC
202-347-3666

Prevention
Karen McCurdy, MA
Prevent Child Abuse America
Chicago, IL
312-663-3520

Research
David Finkelhor, PhD
UNH Family Research Laboratory
Durham, NH
603-862-2761

Opinions expressed in the APSAC *Advisor* do not reflect APSAC's official position unless otherwise stated. Membership in APSAC in no way constitutes an endorsement by APSAC of any member's level of expertise or scope of professional competence. ISSN 108R-3R19
© Copyright 2001 by APSAC. All rights reserved.

APSAC IMPORTANT CONTACT NUMBERS

APSAC Membership
Toby Smith
Membership Manager
2449 Beacon Street
N. Charleston, SC 29405
843-744-6901 Fax: 843-744-7188
email: gethsemani@home.com

APSAC Publications
Terry Hendrix, MA
Publications Manager
32214 Oakshore Drive
Westlake Village, CA 91361-3810
818-597-4867 FAX: 818-597-4879
email: terry.hendrix@sagepub.com

APSAC Continuing Education
Tricia Williams, JD
Operations Manager
PO BOX 26901, CHO 3B3406
Oklahoma City, OK 73190
405-271-8202 FAX: 405-271-2931
email: tricia-williams@ouhsc.edu

American Professional Society
on the Abuse of Children
407 South Dearborn Street, Suite 1300
Chicago, IL 60605

Non - Profit Org.
U. S. postage
PAID
CHICAGO, IL
Permit No. 4345