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AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

SPECIAL ISSUE

HOLDING THERAPY: PART II

Guest Editor: William N. Friedrich

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Introduction to the Special Issue: Part 2

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The impetus for these two issues of the *APSAC Advisor* has been building for a number of years. The death of Candace Newmaker, the child murdered by her therapists in Colorado two years ago (King, 2000), certainly created the need for a response to coercive therapy tactics from child mental health professionals. However, as Part I of this special issue was being prepared, another child, who was being seen at an attachment center in Utah, was killed (Broughton, 2002).

The fact that two children have died in two years demands an immediate and powerful statement: "Holding therapy" and its permutations are not therapeutic, can be thought of only as punishing, and must never be used.

Death of a Child in Utah

According to the *Salt Lake Tribune*, Cassandra Killpack, a 4-year-old girl, was killed on June 10 because her adoptive parents had allegedly forced her to drink a fatal amount of water (Broughton, 2002). Cassandra and her parents were being seen at a holding therapy center in Utah. According to the newspaper report, the Killpacks allege that the center suggested the forced water drinking as an aversive response to Cassandra's habit of sneaking food and water in their home.

As was illustrated by Speltz (2002) in the first part of this special issue, holding therapy includes many coercive components. In fact, "commanding respect" appears to be a central component of attachment therapy (Thomas, 2000, p. 85). Holding therapy is a coercive and massively insensitive treatment that positions the child as the source of the problem. Professionals who utilize such approaches are modeling the appropriateness of coercion to the therapy-naïve parents using their services. One does not need to know much social learning theory to realize that modeling is a very powerful instructor, and it "licenses" parents to act in kind.

Severely Maltreated Children Present Huge Challenges to Parents

We do not have proven treatments for children who are profoundly disturbed. Thus, it is no surprise that attachment centers exist and parents turn in desperation to punitive therapies. We typically assume that adoptive parents are well meaning and loving. When an adopted child seemingly ignores their love, it can seem evident that love has not worked and something else—some extreme remedy—is needed.

The number of children who have died or been severely maltreated from practices related to holding therapy is unknown. However, even one death is too many. It should also be noted that holding therapy received the lowest rating given in the recently published therapy guidelines from the U.S. Department of Justice's Office for Victims of Crime (Saunders, Berliner, & Hanson, 2001). It was the only treatment method reviewed that was assigned a rating suggesting that it was a "concerning" intervention. The rating was given prior to Candace Newmaker's death, and I have no doubt that future editions of the guidelines will rate holding therapy as inappropriate and dangerous.

We cannot stand by and let more children be abused by this treatment. Professional organizations must take a stand. In fact, the U.S. House of Congress recently enacted a resolution named after Candace Newmaker. It spoke out strongly against this treatment and encouraged every state to issue laws preventing such treatment from taking place (H. Con. Res. 435).

Orientation to Part II

This issue contains four brief articles, with the first by eminent attachment researchers from the University of Minnesota. Doctors L. Alan Sroufe and Martha F. Erickson responded to a series of questions developed by Lucy Berliner, Matthew Speltz, and myself.

Next is an important statement from Rosalyn Oreskovich, assistant secretary of the Children's Administration with the Washington State Department of Social and Health Services. Ms. Oreskovich includes a directive that was issued in Washington State in response to the use of holding therapy.

Lucy Berliner then focuses on the question of why parents resort to coercive approaches and, quite justifiably, criticizes the individual and nondirective techniques used by mainstream mental health professionals.

Finally, I present an article discussing factors that interfere with the adoption of severely maltreated children. In addition to identifying these points of breakdown, I provide some guidance to clinicians who work with such families. My hope is that other, less harmful, interventions can be utilized with these often very troubled children.

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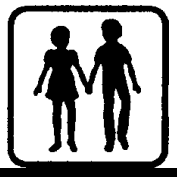

CALL FOR PAPERS

Purpose: The *APSAC ADVISOR*, a quarterly publication of the American Professional Society on the Abuse of Children, serves as a forum for succinct, practice-oriented articles and features that keep interdisciplinary professionals informed of current developments in the field of child maltreatment. *ADVISOR* readers are the more than 2,500 social workers, physicians, attorneys, psychologists, law enforcement officers, researchers, judges, educators, administrators, psychiatrists, nurses, counselors, and other professionals who are members and supporters of APSAC.

Appropriate material: *ADVISOR* editors are seeking practical, easily accessed articles on a broad range of topics that focus on particular aspects of practice, detail a common problem or current issue faced by practitioners, or review available research from a practice perspective.

Inappropriate material: Articles should be well documented and of interest to a national, multidisciplinary audience. The *ADVISOR* is not an appropriate outlet for poetry or fiction, anecdotal material, or original research-based articles heavy on statistics but lacking clear application to practice.

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Submission: All articles should be typed and double-spaced in 12-point type on 8.5 x11 inches white paper, and submitted with an accompanying disk in Microsoft Word plus a brief cover letter indicating that the article is offered for publication in the *APSAC ADVISOR.*The *ADVISOR* uses the manuscript format set forth in the latest edition of the style manual of the American Psychological Association.

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Reactive Attachment Disorder (RAD: What Do We Really Know About This Diagnosis?
Rochelle F. Hanson, PhD

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Attachment Theory and 'Attachment Therapy'

L. Alan Sroufe, PhD &
Martha F. Erickson, PhD
University of Minnesota
with William N. Friedrich, PhD, ABPP

Eminent attachment theory researchers Sroufe and Erickson have answered some critical questions (developed by colleagues) to help advance caregiver and therapeutic interventions with and treatment of children in cases involving maltreatment, unresolved trauma, attachment disorders, and the like.

1. Foster Cline, a principal figure in "attachment therapy," has created his own criteria for attachment disorders. Do attachment disorders exist?*

(L.A.S.) I think there are children whose attachment capacities are so compromised that the term attachment disorder applies. The most appropriate criteria are the ones elaborated by Charles Zeanah and his colleagues (Zeanah & Boris, 2000). However, I have a number of problems with the concept, separate from the absence of any independent reports that substantiate its reliability and validity. Many children who have attachment problems do not qualify for attachment disorder. However, they receive this diagnosis because of underlying attachment problems. What I dislike most about Cline's work is that I firmly believe that the majority of the children he calls "unattached" are attached. Bowlby wrote that attachment is an instinctual process (Bowlby, 1982). It is going to happen, although the form it takes may not be optimal to the child.

(M.F.E.) Children may be misjudged as "unattached" because they protect themselves from further rejection by acting as if they don't care. For example, during separations from their attachment figure (as in the Ainsworth Strange Situation procedure), their heart may beat faster, indicating emotional distress, but behaviorally they do not exhibit signs of upset. And when their caregiver returns after the separation, these children, rather than looking relieved or happy, may turn away or crawl away. It is almost as if they're rejecting the caregiver before this individual has a chance to reject them again. They have adapted to the caregiver's emotional unresponsiveness in a way that makes sense, but ultimately it becomes difficult for these children to engage positively with others as they get older and move into the larger social world.

2. Is there a distinction between attachment disorders and the effects of maltreatment?

(L.A.S.) Although it is true that the majority of maltreated infants and toddlers are insecurely attached (Cicchetti & Toth, 1995) and that a significant number of maltreated children have disorganized attachment, the majority of maltreated children do not qualify for an attachment disorder diagnosis, whatever the criteria.

(M.F.E.) If a child meets diagnostic criteria for attachment disorder, it's fair to say that the child has experienced maltreatment of one form or another. However, as Alan says, many maltreated children do not meet criteria for attachment disorder. The consequences of maltreatment can take many forms.

3. Is there a causal relationship between maltreatment, attachment insecurity, and sociopathy?

(L.A.S.) There is a rather sizable link between maltreatment and disorganized attachment. There is also a link between avoidant attachment and disorganized attachment, on the one hand, and later conduct problems as well as a lack of empathy, on the other (Troy & Sroufe, 1987). Because of these connections, I would say there is a developmental relationship. However, it is now widely understood that singular, linear causes will rarely be obtained. Individual risk factors are seldom that powerful, and when they are, typically they are surrogates for multiple influences (Cicchetti & Sroufe, 2000).

(M.F.E.). I agree with Alan's comments.

4. Is there a method to assess attachment quality that can be used in the typical clinical setting (separate from the Adult Attachment Interview and the Strange Situation)?

(L.A.S.) No valid method is available at this time.

(M.F.E.) I would say, however, that clinicians who are well educated in attachment theory and research—and who understand how to watch the "dance" that goes on between a parent and a baby—often can tell a lot about the quality of attachment through observation. Things to watch for are a parent's sensitivity to infant cues, how the child seeks and accepts comfort from the parent at times of distress, and how the child uses the parent as a secure base. I would be extremely cautious about drawing categorical conclusions based on these observations, especially for purposes of making major decisions, such as custody or placement. But, from an interventionist perspective, these observations can be very helpful in knowing how to work with the parent and child to move toward better competence and well-being.

5. Are there some specific treatments or interventions that can positively affect the quality of attachment? If not, what are the elements of an intervention that attachment theory would suggest?

(L.A.S.) There is a developing literature on this topic. For example, Patricia Sable (1995) has written an article on the use of pets and facilitating the attachment process at various stages of the life cycle. She also has a recent book (2001) that integrates attachment theory and psychotherapy with adults.

In his book, *The Making and Breaking of Affectional Bonds*, Bowlby (1979) reformulated the psychoanalytic principles of therapy into four attachment theory-related suggestions of his own. The following principles primarily apply to therapy with adolescents and adults:

1) Take the reported experience of the person seriously. For example, trust the patient that the problems they report to you arise from actual experience and are not the function of fantasy;
2) Treat human expressions of need and worry, which can arise over interruptions or separations in the therapy process, as normal and not as indicative of weakness. Rather, they provide

patients an opportunity to examine and then correct their subsequent relationships;

3) Provide a secure base within which the person can freely explore needs and feelings and reach his or her own conclusions; and

4) Focus the therapy on the details of how their parents behaved towards them, not only when younger but also presently.

All of this takes time. There are no quick fixes to deep attachment problems. In fact, in his book, *A Secure Base*, Bowlby wrote that treating such deeply distrustful people is comparable to trying to make friends with a shy or frightened pony; both situations require prolonged, quiet, and friendly patience (Bowlby, 1988).

(M.F.E.) To elaborate, I think there are promising strategies for working with the parent-child relationship to enhance parental sensitivity, which over time can enable the child to develop greater security. For example, in our own preventive intervention work (e.g., the STEEP™ program, i.e., "Steps Toward Effective, Enjoyable Parenting"), we videotape parent-infant interaction and then watch the tape with the parent, using questions to help the parent recognize his or her own strengths and understand the meaning of the baby's behavior and cues. (We call this the Seeing Is Believing™ approach and have trained professionals in the United States and abroad how to incorporate this strategy into their work with families having a variety of risk factors or identified problems.) Then, through both home visits and groups, we work with the parents to identify and address the factors that support or hinder them in responding sensitively to their baby day after day.

I think this kind of approach could be very helpful to adoptive parents whose child has difficulty forming an attachment because of trauma prior to adoption. It can be terribly frustrating for adoptive parents to give so much and get so little in return. But, with supportive intervention at the very beginning, perhaps they can understand and overcome the difficult behaviors their child presents. There is a need for careful, long-term study of such interventions that are grounded in attachment theory and research, especially with special populations, such as families who have adopted older infants from abroad.

For older children, I think the treatment challenge is to help them develop new models of self and other. This involves therapy with someone who can be a "secure base," to use attachment terminology, but it is also a vigorous effort to support parents, extended family, teachers, and recreation workers, who must hang in there with a child even when the child's behavior makes a person want to run the other way. This intention is easy to say and hard to do!

6. Is there a role for arousal and physical contact in therapy with disturbed children? More specifically, if the contact were not coercive, as it is in traditional holding therapy, then might these ingredients be desirable?

(M.F.E.) I'm very cautious about saying anything that would encourage such approaches with these vulnerable children. Everything I've learned about attachment indicates that sensitivity is the pathway to a secure attachment, so I'm uneasy about approaches that are intrusive. I am especially concerned about doing anything with these children that replicates a cycle of violence and control, poking and provoking until the child submits. If some professionals are convinced that arousal approaches are the way to reach these children, then I think those professionals should go out of their way to subject these strategies to rigorous research. And, above all, they should remember, "First, do no harm."

7. There is a debate about the continuity of attachment status over the period of childhood. Does attachment theory account for changes based on environmental and life circumstances?

(L.A.S.) This question always amazes me, because the answer is so clear to developmental researchers. People always think there are only two possible answers: 1) The person carries nothing forward, and all continuity is in the environment, or (2) What happens in infancy permanently scars the person.

Neither of these is a developmental position. No developmentalist believes that the attachment to mother in infancy ineluctably leads to adult personality. We do think it has a special status because it is the first primary attachment. The nature of development is that what is there before is both formative and transformed by later experience. Continuity is complex, because development is not like adding lego pieces. Yes, there should be continuity from infancy, and connections will be specifiable to some degree. Still, the problem is difficult because outcomes are complex products of infancy, toddlerhood, preschool, middle childhood, and adolescence. The experiences of infancy have different meaning depending on what happens later. But what happens later has different meanings, depending on earlier experience.

The idea that continuity is simply dependent on living in a stable environment is too simple. First of all, later environment is in part determined by earlier experience. For example, when children with avoidant histories isolate themselves from others at preschool, they are guaranteed to have a different experience than is had by others even in the same setting. In addition, the differential treatment of children by teachers is predictable from the children's histories.

Second, even similar experiences are interpreted differently (and therefore have different consequences) by different children. Some children will feel rejected when someone does not want to play, and others in the same circumstance do not. This is predictable from history, as are interpretations of hostile intent when none is present. Even the lack of continuity is typically lawful and understood (Weinfeld, Sroufe, & Egeland, 2000).

Third, developmentalists all think children have multiple models. Bowlby (1988) wrote that the child had to develop two principal types of models. One model is that of himself as a child in interaction with each parent. Another model is that of each parent in interaction with himself. How these become integrated is one of the leading developmental questions.

(M.F.E.) Another way of saying this is that infants develop certain behaviors as a natural adaptation to the way they are treated, and those behaviors in turn serve to draw to the child more of the same. This works well for the securely attached child and poorly for the insecurely attached child. Let's say, though, that a wise, sensitive adult comes into the life of the insecure child and repeatedly "contradicts the child's expectations" (i.e., treats him warmly and sensitively despite his off-putting behavior). Or, perhaps the parent becomes much more available and sensitive to the child, through

cont'd on page 6

treatment or a major life change of some sort. It will take awhile for the child's behavior to catch up to this new reality. But, given enough time and persistence, the child most likely will begin to adapt. The earlier this happens in the life of the child, the more quickly and completely the new adaptation is likely to occur. We really don't know the answer to the question "When is it too late?"

8. Some of the children who are referred for "holding therapy" are viewed as budding "psychopaths." Is psychopathy a matter of insecure attachment or is there something missing from the start?

(L.A.S.) Like many developmental questions, this one is not yet fully answered, but I think antisocial personality ultimately will be shown to have roots in early attachment experiences (as well as in later experiences) (Aguilar, Sroufe, Egeland, & Carlson, 2000). We will have adult data on this in two more years.

9. Is there a developmental window after which attachment security is not possible? For example, what is the range of outcomes for a child adopted at the age of 4 or 5 after a life of abuse and neglect while living in an institution? Are there children for whom no intervention can be helpful?

(L.A.S.) This is another question for which there is yet no answer. What Bowlby's theory says is that the longer a pathway is followed, the more difficult it will be to change. A British study of 165 children who were adopted from Romania found that the duration of deprivation was linearly related to the number of signs of attachment disorder. For example, the cluster of children who were still exhibiting indiscriminate sociability at 6 years of age had been deprived twice as long as the cluster of children who exhibited no signs of attachment disorder (O'Connor, Rutter, et al., 2000). It was completely predictable that there would be great difficulty with the Eastern European orphans who were adopted as children. There is likely something vital about having emotional connections in the first years.

(M.F.E.) Please refer to my comments to Question 5.

10. What should be the treatment target with children who evidence disorganized attachment? Should it be 1) the associated maternal history of unresolved trauma; 2) the child's behavior and manageability; or 3) skills to help the parent be more consistent and caring?

(L.A.S.) Absolutely all of the above interventions are needed.

(M.F.E.) I agree wholeheartedly. We need to do everything in our power to address all the factors that support or hinder a parent from providing sensitive care. (And, a parent's state of mind about his or her own attachment history is a big one!) Also, depending on the age of the child, we need to engage others (therapists, teachers, grandparents) in teaching and reinforcing positive behaviors that will, in turn, help the child do his or her part to build and maintain connections with others.

I would add that one does not necessarily do this intervention work once and call it a done deal. As children grow older and develop the capacity to make new meaning of their experience, they may need a"booster shot" to help them along the way. For example, a child who gets on a more positive developmental track at age 3 or 5 or 7 nonetheless may need to reconsider his or her early experience in the teen years, when questions of identity begin to emerge. Typical questions older children may have are "What kind of person must I be if my own parents couldn't even love me?" and "If I'm the biological product of a couple of losers, I must be a loser, too."

Footnote

* The attachment disorders described by Elizabeth Randolph, a frequent trainer in "holding therapy," have five criteria (Randolph, 2001). The first is that the child fails to exhibit five or more normal attachment behaviors, e.g., making long-lasting and intense eye contact, gently touching, hugging, or playing with the primary caregiver. A second criterion reflects a history of disrupted caregiving, e.g., living in an orphanage; and the third criterion is that the child exhibits neurological immaturity, e.g., mid-brain immaturity. (In actuality, the neurological symptoms are measurable only indirectly and via the presence of disturbed behaviors, e.g., if you are hyperactive you must have brain dysfunction.) The fourth criterion includes a potpourri of symptoms, e.g., food hoarding, pathological lying, and inability to keep friends. The final criterion accounts for the overlap between RAD and either 1) conduct disorder or oppositional defiant disorder, or 2) whether the child still qualifies for the attachment disorder diagnosis, as long as there is not mental retardation or a pervasive developmental disorder.

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COMMENTS FROM A CHILD WELFARE ADMINISTRATOR

Rosalyn Oreskovich, MSW

As we can see from this series about "rage reduction," it is understandable why child welfare workers and foster parents who work with children with extreme needs are susceptible to trying new treatments. This is particularly true when no treatments have proven to be successful when dealing with children with extreme needs.

In my experience, child welfare workers should be wary of individuals offering treatments that sound too good to be true. The use in the community of free lectures that feature clients sharing their stories and claiming success in order to sell the public on new treatments should raise red flags for social workers.

Child welfare administrators are responsible for giving their staff clear direction, prohibiting the use of such treatments. For example, the following was issued in Washington State:

"It has come to my attention that we have paid by Exception to Policy or contract for a treatment called Holding Therapy or Rage Reduction Therapy. This is a highly controversial form of treatment.

It has further come to my attention that a child has died from this type of treatment in another state. Also, from our exploration with the University of Washington and other professionals on this subject, there is no consensus of the efficacy of such treatment.

Effective immediately no such treatment should be authorized or paid for without **prior** approval by the Office of the Assistant Secretary. If a social worker and family believe this is the only way to treat a child they should submit a detailed request with justification and support for the treatment. I will review and consider any requests but I want you to know that I am generally not inclined to approve such treatment."

You can count on the provider of this therapy to threaten to sue for libel and restraint of trade. For that reason, I believe your legal counsel needs to review any directive you issue. In addition, a considerable effort should be made to educate social workers and foster parents about the problems described in this therapy, and you should enlist your provider community to offer alternative treatments and support to the individuals who think they finally have an answer.

We have an obligation to help our social work staff and foster parents become much more discriminating and sophisticated consumers of treatment. The Child Welfare League of America (CWLA) and many academicians and practitioners continue to make great strides in moving research to practice, and this is an idea we must embrace.

Why Caregivers Turn to 'Attachment Therapy' and What We Can Do That Is Better

Lucy Berliner, MSW

It is time that child abuse professionals formally raise concerns about the "attachment therapy" programs that have proliferated across the country. As was noted in the Summer 2002 *APSAC Advisor*, little scientific support exists for the diagnosis of reactive attachment disorder (RAD, as currently conceptualized in the DSM IV-TR), and there is much reason to be concerned about the frequency with which it is applied to maltreated children, especially those in long-term foster care. Further, some therapeutic regimens of this type appear to be based on dubious or outright erroneous interpretations of established psychological principles and carry significant risks for children. The risks are not only the use of coercive techniques that are likely to exacerbate behavior problems rather than ameliorate them, but also the fact that, in at least a handful of cases, therapists or parents have misapplied them and caused the death of children.

At the same time, it is important to examine why attachment therapy has become the treatment of choice with some foster and adoptive parents. One reason why caretakers seek out unconventional or fringe therapies is that conventional approaches have been ineffective in addressing the problems of bringing up these foster and adopted children. Therefore, if we are to successfully discourage participation in risky therapies, acceptable and effective alternatives must be made available.

Behavior Problems of Foster and Adopted Children

Children in long-term foster care and children who are adopted from the child welfare system or other extremely adverse circumstances, such as in the orphanages of some foreign countries, often have significant behavioral problems and impairments in their capacity to form relationships. This is not surprising, considering the factors that must be present for children to be in long-term foster care or to be available for adoption from the child welfare system.

In the first place, these children must have been maltreated in some fashion or have been at high risk for maltreatment to be placed in foster care. It is well established that maltreatment is associated with many emotional and behavioral problems (Horowitz,Widom, McLaughlin, & White, 2001). In addition, when children remain in foster care or become available for adoption, it is because their parents do not agree that they have maltreated their children, are unable or unwilling to correct the conditions that led to placement, or both. Children can readily interpret this parental failure as rejection or abandonment. For example, substance abuse is a common problem in families in which children are not reunified (Dore, Doris, & Wright, 1995). Despite the fact that effective treatments exist for such disorders, many parents do not follow through or they relapse. Children may view this failure as the parent choosing drugs over them. It is also possible, if not likely, that these parents were not responsive to the children as infants, which can lead to children's insecure attachment styles.

The end result is that most of these children will present significant difficulties for foster or adoptive parents. Many are depressed or anxious, but of greater relevance is the presence of externalizing behavior problems in a large percentage of them. They can be defiant, disobedient, aggressive, or delinquent, and they may lie, cheat, and steal. These children often have trouble getting along at school, with peers, or in the community. In addition, some children will suffer from enuresis or encopresis. All of these behaviors are extremely taxing to deal with on an everyday basis. They interfere with family life, require high levels of supervision and parental involvement, and can evoke negative emotional reactions in caretakers (Zeanah, 2000).

The attachment-related behaviors that characterize these children's presentation will further exacerbate the family situation. Instead of being grateful and responsive to caretakers who are providing a potentially loving and safe home, children can be aloof, rejecting, demanding, hostile, angry, manipulative, superficial, or sneaky. Quite understandably, caretakers can feel frustrated, inadequate, or unappreciated. In some cases, they may begin to see the children as intentionally resisting their well-intentioned efforts. It is hard enough to deal with children's serious behavior problems, but the difficulty is dramatically magnified when such behavior co-occurs with a child's impaired capacity to relate to caregivers.

Exacerbating Circumstances

A further complication is that in foster or kinship care situations, the caregiving relationship is explicitly intended to be temporary. Foster parents are cautioned against becoming emotionally invested in long-term relationships with the foster children, because the goal is to return them to their families. It is not considered desirable for children to become too attached to foster parents either, because it might exacerbate ambivalence toward their own parents or produce yet another experience of loss if the placement is not permanent. Even though some children will live with these alternative caregivers for years, foster parents have no legal standing, and their interests in a relationship with the child are essentially irrelevant to case planning. Although the policy interest in reunification is legitimate, it has relational consequences for both children and foster parents. In effect, a situation is created in which there are disincentives and even specific deterrents to establishing close emotional connections. It should not be surprising that this context is not ideal for repairing insecure attachment styles.

Thus, foster parents are often faced with a toxic combination of circumstances. The children have serious behavior problems and disrupted capacities to relate to others. Yet, neither children nor caregivers can approach their relationships as secure or permanent, despite the fact that secure and permanent relationships would be most corrective for the children.

Adoptive parents do not have to remain emotionally distanced from their adopted children, even though they each bring a different set of expectations and hopes in such relationships. However, such parents are not always prepared or able to tolerate the fact that many of these children are older and will continue to feel some loyalty to even the most abusive and rejecting of parents. Adoption may legally make the child their own, but it cannot erase the past or eliminate yearnings that may stand in the way of full commitment to the new parental relationship.

Nevertheless, it is important to remember that not all foster or adoptive situations involve such compromised circumstances. In most cases, foster or kinship care is a temporary situation, just as

intended. The majority of children who are placed out of the home are reunified within a relatively short period. Although most children have some emotional and behavioral problems, these are not always severe. Even so, the majority of maltreated children do have insecure attachment styles (Cicchetti & Toth, 1995). Our concern here is with a subset of situations that is especially trying, one in which parents become desperate for help.

Ineffective Treatment for Troubled Children

Ideally, help is supposed to be available. For example, all foster children are eligible for Medicaid mental health services under Title 19. This means that they can be served at community mental health centers, at community agencies, or by community providers who accept Medicaid. In some states, if the children have been crime victims, counseling may be reimbursed through Crime Victims Compensation programs. In addition, state child welfare departments often provide home-based or family preservation services to help maintain placements, and federal and state laws provide for adoption support. The question then is why these services are not perceived as sufficiently helpful by the caregivers. Why do they instead seek help from attachment therapy programs?

One reason is that traditional child psychotherapy is typically the only resource available. Traditional child psychotherapy might be described as an eclectic mix of supportive, psychoeducational, expressive, and interpretive approaches that are delivered individually. Although these elements have utility, especially in engaging children and in ameliorating internalizing problems such as depression, anxiety, and posttraumatic stress, they are insufficient even for these problems when the conditions are severe. Moreover, traditional approaches do not work for externalizing behavior problems (Kazdin, 2002). It is clear that changes in children's environments and behavioral contingencies are necessary to bring about change in behavior problems.

A second reason why caregivers do not perceive current services as sufficiently helpful is that effective treatments for externalizing behavior problems have been developed and tested in research settings but are not widely used in the real world. These proven treatments are based on behavioral or cognitive behavioral principles and require the participation of caretakers. A central element in assisting parents is to help them understand that negative behaviors persist because they are reinforced in some fashion and that positive behaviors will not ensue unless they also are consistently reinforced. Parents are taught specific skills that include praising positive behavior, ignoring inappropriate behavior, giving effective instructions, and carrying out consequences, such as time out or loss of privileges. They learn the importance of consistency and persistence as necessary ingredients for achieving results. Interventions with children are also skill-based. Children are taught self-control procedures, problem solving, and how to interact appropriately with others to meet needs. These interventions ordinarily involve practice, feedback, and homework as the mechanisms by which the new behaviors are acquired and transferred from the clinic into everyday life.

Barriers to Effective Treatments

Why don't mainstream mental health services deliver these treatments? In part, the explanation rests with the fact that most mental health treatment is delivered by professionals or paraprofessionals who have not received training and who are not supervised in providing these particular interventions. The proven treatments are usually manualized and intended to be applied in a atic way. This kind of approach is not only unfamiliar to many field practitioners but it also runs contrary to beliefs about the flexible and creative application of interventions. Also, practitioners perceive that proven interventions often ignore the complex circumstances of many children and families as well as the frequent crises they experience.

Another complication is the prerequisite that caretakers participate in treatment and be prepared to change the way they respond to the children. It is not hard to see why this becomes an obstacle. Foster and adoptive parents who are willing to take on these very difficult children are doing a great service to the child welfare system. They often get paid a pittance and must accommodate to extraordinarily difficult situations: children who are unrewarding and a burden, the marginalized role of the foster parent in permanency decision making, and the uncertainty of outcome. To expect them, in addition, to attend counseling sessions and to alter their usual parenting practices is a huge demand.

A third reason caregivers may resort to the use of attachment therapy is the absence of a proven treatment for insecure attachment. Many therapists have only a passing familiarity with formal attachment theory. They appreciate the basic concept that attachment theory relates to the capacity to form and maintain secure relationships, but they often reduce this to being "attached" or not. Attachment theory, on the other hand, suggests a universal biological imperative that begins with seeking proximity to a caregiver for survival purposes and that evolves into an adaptive response, resulting from safety and comfort-giving caregiver responses (Bowlby, 1982). For example, when parents are inconsistent, unresponsive, or the source of harm, children adopt relationship strategies that work in these situations. The theory contends that early experiences produce "working models" that are applied to new caregivers. There is evidence that children do transfer their attachment styles to foster parents.

This means that children may enter foster or adoptive families with working models and relationship strategies that were adaptive in their biological families, but are maladaptive or counter productive in new family environments. It seems likely that if professionals are unable to explain why children behave in relationships the way that they do or if those who are most knowledgeable cannot offer ways to change the outcome of such interactions, then alternative caregivers would naturally be confused, hurt, or frustrated.

It is this confluence of circumstances that creates the conditions under which the attachment therapy programs appear to be a godsend to foster and adoptive parents. They offer treatment that is guaranteed to work, is relatively brief, and locates the problems as residing in the children. As with most coercive interventions, including physical punishment, there is often an immediate response by children. When children are afraid, they may comply in the moment, but the real shortcomings of such approaches are eventually revealed in children's resentment and hostility and the impermanence of the therapeutic impact.

Solutions

In order to address this situation, there must be a resolution among the mismatch of several factors: the needs of the children, what is acceptable or perceived as reasonable to foster or adoptive parents, and the services that are typically available. The question then becomes "What changes might be helpful?"

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First, caseworkers must play a key role. For the most part, they know that simply giving children a safe environment in which they are loved will not be sufficient in many cases. These professionals are in a position to educate potential foster and adoptive parents about the problems children may have. If caseworkers increase their understanding of how children develop externalizing behavior problems and insecure attachment styles, they can explain to foster and adoptive parents the children's behaviors and reactions and what may be required for change. As a result, caretakers will need to realize that they may need to participate in therapy, change their parenting approach, and adjust to children's attachment styles if the placement is to be successful.

Second, making more services available and acceptable to caregivers would be helpful. Therapists need to learn and apply the components of effective treatments for externalizing behavior problems. The proven approaches require environmental changes and involve caretakers as change agents (Barkley, 1997). Therefore, it is essential not only to be familiar with the specific strategies that work, but also to know how to engage caretakers in carrying out interventions. For example, motivational interviewing is a strategy that may be productive in bringing caregivers to acknowledge their participation as essential (Miller & Rollnick, 1991). In addition, these treatments usually work best when there is homework, practice and feedback, and consistent application of principles in day-to-day situations. Therapists must be prepared to offer support and reinforcement to caregivers because, without their participation, intervention with children alone is unlikely to make a difference.

In the absence of proven interventions for insecure attachment styles, both caseworkers and therapists can help foster and adoptive parents to appreciate how children's responses to alternative caregivers have an adaptive origin and are not necessarily evidence of pathology. Children whose parents have been inconsistent or unresponsive or a source of pain and hurt will have learned ways of interacting that may be inappropriate with caring parent figures. It will take a long time before these children learn news ways of responding. Alternative caregivers need help in being patient with or even accommodating to these adaptations over the long term.

Attachment-Style Specific Interventions

In addition, caregivers might benefit from learning strategies for how to respond to different types of insecure attachment styles. For example, children whose parents were inconsistently responsive may show insecurity through whiny, clingy, demanding behavior and angry outbursts. These children may best respond to frequent comforting and enthusiastic praise, delivered whenever they are behaving appropriately. Explicit and consistent ignoring of the obnoxious behavior will eventually lead to its extinction. However, it may take many months for results.

In other cases, children have learned not to expect parental responsiveness and have become aloof or indiscriminately responsive to noncaretakers. For these children, it may make more sense for caretakers to be careful not to pressure them for emotional intimacy. It may be more helpful to take a very gradual approach to showing affection and have few expectations for reciprocity. Over time, many children will become more responsive, but in some cases, the caregiver may need to adjust to the child's style.

The attachment style most likely to be discomfiting to caregivers is that of children who have adapted to abusive parents by being sneaky and manipulative, who show little remorse or empathy, or who are superficially emotional. These children are generally seeking to control their environment and avoid punitive reactions. It may be helpful for caretakers to see why this behavior has a survival function and is not necessarily evidence of an emerging psychopathic personality. In such cases, a caregiver strategy of being firm and consistent, but avoiding angry responses, may be most useful. The children may respond best to an environment in which they are given more control and choices within a framework of clear expectations and consequences. Caregivers will often need a great deal of support in handling their own reactions when children appear to be driven primarily by meeting their own needs even at the expense of others.

Enhancing Caregiver and Professional Relationships

Finally, an especially gratifying characteristic of attachment therapy is that caregivers feel very validated and supported by the programs. This is in contrast to the experience that many caregivers have with busy caseworkers and mainstream therapists, who too often do not take the time to regularly check in, offer support, and express appreciation to foster or adoptive parents. The caregivers may feel taken for granted or able to get the help they need only when there is a placement crisis.

Both caseworkers and therapists need to be in regular communication with foster and adoptive parents. In addition to engaging caregivers in the therapeutic process with the children, these professionals should make a point of acknowledging the contribution that alternative caregivers are making. They can also be offered support services, respite care, and consultation in managing ongoing problems.

Summary

In sum, attachment therapy programs have flourished because they fill a need. Caseworkers and therapists serving foster and adoptive children can do better in responding to the burden of caring for these children. Solutions include educating caregivers about the nature of the children's problems, helping them understand what is required for change, and providing effective treatment. Most important, perhaps we will reduce their susceptibility to risky therapies when they experience us as supportive, available resources working collaboratively with them in a very difficult endeavor.

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Points of Breakdown in the Provision of Services to Severely Disturbed Foster and Adopted Children

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The placement of a child in an adoptive or foster home reflects the confluence of many factors. Chief among them is the fact that a new relationship is forming because a previous relationship has not been sufficient for this child. The new relationship and the previous one(s) are the critical players.

A justifiable accusation against "holding therapy" is that the child becomes the source of the problem. Proof of this comes from a review of literature published by holding therapists, such as Randolph (2001). She devotes eight pages to the office diagnosis of the child's neurological dysfunction and less than a single page to the evaluation of the parents. This highly individualistic perspective represents a curiously nonrelational view of a parent-child relational problem. In fact, it is important for any clinician providing services to these children and their caregivers to step back from the magnetic pull of the severely disturbed child and appreciate the larger relational issues that are always operative.

For example, the child is simply one level within several nested relational ecosystems (Bronfenbrenner, 1979). These levels include the larger system, which contains the adoption agency and any child protective services system that continues to be involved. State departments of social services frequently have guidelines that dictate the placement of these children. Particular agency policies may interfere with a successful placement.

Another level of the relational ecosystem includes the adoptive or foster parent. Although the majority of these individuals provide invaluable services and bring a reasonable degree of psychological health to the equation, a subset of these parents are either poorly prepared for the child's level of disturbance or have their own acute and even chronic psychiatric issues that interfere with a successful placement. Thus, the motivations to adopt a severely maltreated child need careful scrutiny during the intake.

An ancillary layer of the relational ecosystem includes the therapist or the consultant to the family. The therapist may have a narrow perspective, may not appreciate every aspect of the system, or may simply be less well-trained than is needed. Further, too many or too few mental health professionals may be involved in the child's care. These professionals may or may not interact in ways that are synergistic.

The child is at the center of these relational levels. Severely disturbed children with a history of maltreatment bring not only psychological problems to the equation but also problems with learning as well as medical and neurological issues that warrant attention. Typically, their needs are complex and can often appear to be ever-changing and even multiplying.

The remainder of this paper addresses each of these levels in turn and examines what about each level contributes to a breakdown in the adoption or fostering process.

System Level

A number of potential points of breakdown exist at the system level. Some systems have policies that are developmentally insensitive or that apply to some children but not to all. For example, many agencies and jurisdictions have policies that strongly encourage or even require that siblings be adopted together. This need to place siblings together may be applied with little regard to the fact that these siblings associate each other with prior abuse and may serve as PTSD triggers to each other (Liotti, 1999). Siblings may even contribute to the frequency that one or more of them become dissociative. Further, siblings from violent homes might even abuse each other in this new placement.

The open adoptions that characterize the placement of some severely disturbed children are a related issue. I contend that if the task is for the child to have a long-term placement with a caregiver, and the child's disturbance is rooted in an earlier relationship with the biological parent, then including these former parents and relatives in the relational equation is inappropriate. I have seen numerous situations in which only through hindsight have we appreciated the degree to which extended family members have behaved insensitively and were seen by children as threatening.

Financial considerations are also a systemic issue. Agencies and jurisdictions may lack adequate resources to support the adoptions. These are children who require ample services from the start. Multisystemic family therapy services are often needed and may not be locally available (Henggeler, et al., 1998). The availability of respite care is another issue. I have seen placements succeed in which respite care was liberally used throughout the first several years of the child's placement in an adoptive family. This may be counter to one's belief that a child must have a primary connection with the adoptive parent. However, the provision of respite care is a valuable adjunct to the adoption process because it helps to modulate the intensity of the child's developing relationship with an adoptive parent (Hazell, Tarren-Sweeney, Vimpani, Keatinge, & Callan, 2002). Therefore, if the child has learned that parental behavior leads to frustration and maltreatment, the child is more likely to adapt adequately if parental behavior is modulated through the use of respite care.

Finally, the agendas of the system and the parents may be in conflict with each other. Adoption agencies have a goal of placing children in adequate families. These agencies may use many subtle and not so subtle strategies to keep children in placements long after this placement has failed. They may lack an appreciation of the complex demands and needs of the child and may poorly prepare parents about them. Pressures can include unsupportive comments by a caseworker to a frustrated and overwhelmed adoptive parent, such as, "Please, don't let this child be rejected again."

Foster and Adoptive Parents

Adoptive parents usually deserve our support and admiration. However, the motivation to adopt may stem from unresolved loss. For example, some adoptive parents have yet to resolve a recent diagnosis of infertility. Other adoptive parents are motivated to add a child to their family either because of the loss of a child or the upcoming launching of a child from the nest. This field needs data that examine the relative success of adoptions that occur to parents who are within two years of any of the losses mentioned here versus those who are not. I would expect that the failure rate would be higher in the former group.

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The motivation for other parents is that they have functioned best as a couple when in their parental roles. This may mask an underlying marital problem. If children are used to avoid conflict in a marriage, severely disturbed children are destined to interrupt this coping strategy. Parents who have avoided conflict for years will now be forced to learn to work together. I routinely observe a temporary resolution in these situations: one parent, typically the mother, is relegated as the primary parent of the child. This resolution often adds to the ambivalence and anger between the spouses.

I know from experience that a higher than average percentage of foster parents report having had histories of being foster children. As a motivation to be helpful to a child, this is admirable as long as the historical issues that resulted in foster care have now been resolved. Regrettably, I sometimes hear from these parents that they "know what it is like to be without love." This statement indicates to me that they are likely to have difficulty knowing their own stimulus value to the child. One consequence is a problem in modulating the intensity of their affection, and the child may be quickly overwhelmed.

Adoptive parents may have the same skill deficits that occur with biological parents. For example, they may intervene insensitively and intrusively with the child. They may be excessively reactive, and their anxiety about the child's behavior may result in overly punitive behavior. They may lack the natural child management skills that characterize many parents.

Adoptive parents have explicit and implicit expectations about the success of the adoption. These expectations must be examined for appropriateness. For example, some parents may expect that the child will eventually be very well behaved, love them, and succeed in life. Adoptive parents may not appreciate that the child's gains may be very small. It is much better to have a realistic perspective early in the process than to enter into the adoption with inflated perspectives that must be ratcheted back.

Finally, foster and adoptive parents bring with them their own psychiatric issues, which may consume a significant amount of their time and energy. Adoptive parents who are being treated for depression or anxiety prior to the adoptive placement must be able to answer how they will balance child-rearing with attending to their own symptoms, getting to therapy and other appointments, and doing the relational and activity tasks that can alleviate their symptoms.

Other adoptive or foster parents have issues with unresolved trauma and maltreatment. Sexual or aggressive behavior by the adopted child may trigger their reactivity (Alexander, 1992). Other parents will have mild to moderate personality disorders that escape scrutiny by unsophisticated interviewers.

I have twice been asked by a social service agency to screen their potential foster parents. Each of them declined my services after several months because too few of the potential foster parents had satisfactory MMPIs. The generalizability of such findings is debatable, but even so, the level of psychiatric problems that some foster parents brought to the caregiving process was sobering.

Therapist Level

The adoptive parents are likely to eventually request the services of a mental health professional. It depends on the professional of their choice to appreciate that the current problems are nested within several layers of relationships. However, therapists primarily skilled in individual techniques, such as play therapy, may be only minimally useful, because their focus will be on the child and not on the contribution of the new parents or the larger system.

Individual treatment may be overwhelming to the child for several reasons. The therapy may be counter to the child's loyalty to his or her biological parents. The child may view the therapy as rejection. A language-delayed child may find the therapy frustrating. Other children may need to become more resilient to take full advantage of individual therapy.

In addition, individual therapy can be affectively intense. Consequently, the child's internal working model of adult-child relationships as punitive and frustrating becomes activated. When individual therapists are naïve about their personal need for control, or if they fail to appreciate the origins of the child's punitive and controlling behavior in the sessions, they are quite vulnerable to getting caught up in the child's internal working model (Bowlby, 1973). Thus, an individual therapy approach may actually amplify the child's behavioral problems and contribute to the child being viewed even more as the primary problem.

The child's disturbed behavior can be addressed through strategies based on attachment theory. Parent-child interaction therapy (Hembree-Kigin & McNeil, 1995) emphasizes the importance of strengthening the positive aspects of the relationship before discipline strategies are implemented. Through the use of direct coaching, parents can learn to be sensitive to their child's ability to tolerate their presence. In the process, extremely useful skills are learned and can be applied.

Matthew Speltz has developed a behavioral therapy approach for conduct disordered preschoolers that has attachment roots (Speltz, 1990). It has both an operant component as well as a skills-training component. The child's regulation of the parents' behavior during parent-child play is examined early on. The five components of the training are assessment, parent education, child-directed play with the parent, limit-setting, and parent-child communication training. The emphasis on the parent-child relationship is compelling.

The judicious and appropriate utilization of behavioral therapy skills can greatly assist adoptive parents in managing inappropriate behavior. Behavioral outbursts can almost always be reduced in both frequency and intensity through the use of creative and ever-changing behavioral strategies. However, many therapists are not as well versed in behavioral family therapy as one might expect.

A growing body of literature from infant psychiatry reflects an attachment perspective on intervention models to use with parent-child relationships characterized by insecure attachment (Cohen, et al., 1999). These authors describe a model, titled "Watching, Waiting, and Wondering," which has been empirically tested with infants but also has components that can guide work with older children. For example, parents learn to invest sensitively in their child, improve the timing of their interactions, and maintain a positive view of the child's development. Parents are also taught to reflect on their behavior.

A model of this type is very important because we do not yet have sufficient data to support one intervention over another with older

children and with teenagers who are both adopted and severely disturbed. It is possible that a model that addresses a multitude of issues at once, i.e., multisystemic therapy (Henggeler, et al., 1998), may emerge as a contender.

Seriously disturbed adopted children with child abuse and neglect histories typically must be treated by a combination of mental health providers. Sometimes this can be managed through multisystemic therapy, with some appropriate psychiatric consultation for medication. However, the child's ability to cooperate with medication usage can create another coercive parent-child cycle. Parents and children must be taught the creative techniques that are needed to get a resistant child to swallow a medication multiple times per day.

Child Level

Severely disturbed and maltreated children bring with them numerous comorbid behavioral issues that interfere with their successful placement. A recent study found significant differences between disruptive children in care and their less-disturbed counterparts. The more severely disturbed group had both more foster placements and placements of shorter duration (Garber & Delfabbro, 2002).

Other children come to their adoptive placement with cognitive impairment that may be due to neglect or secondary to prenatal exposure to alcohol. These problems interfere with the degree to which school can be an important reinforcer of appropriate behavior. Data are emerging on the effects that overwhelming trauma can have on brain function and in this way can directly contribute to problems with affect-regulation, the development of empathy, and the capacity to attach securely (Siegel,1999). Cognitive limitations only exacerbate the overall level of frustration in the parent-child equation.

Other children find therapy to be threatening. Weekly sessions become viewed as a sign that the new parent finds them wanting and hopes to be rid of them. The child may already be using the majority of his or her energy to manage this new parent-child relationship and may have very few resources to apply to an individual therapy process. I have certainly seen situations in which the adoption stabilized when individual therapy was stopped and then was started perhaps a year or two later and for a specific issue.

Summary and Recommendations

In summary, the adoption of severely disturbed children can succeed or deteriorate because of positives or negatives at a number of different levels. Clinicians must appreciate the entire range of potential breakdowns in order to serve these parents and children well. When the appropriately frustrated adoptive parents of a severely disturbed child come into your office, it is important to carefully assess the degree to which policies and services provided by the system help or interfere with the adoptive placement.

We as clinicians also need to learn to ask very difficult questions about the motivations and expectations of adoptive and foster parents. It is imperative to determine how their past history and current functioning are related to the immediate problems. Finally, if we do not have the appropriate developmental perspective, along with good parent consultation skills and a wide range of behavioral strategies, at our fingertips, we are not going to be useful to this child and family. We will have failed to demonstrate that there are alternatives to unvalidated and punitive techniques.

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Message From the President

I am reporting to the Membership at an exciting time for APSAC. After a period of financial crisis over the past several years, the outlook is very bright for the organization. The hard work of the Board has indeed paid off, and for the first time in a while, APSAC is active on a number of fronts. At this time, I wish to share just a few items of current interest.

Kentucky Training

APSAC is conducting two Forensic Interview Clinics in Kentucky in November and December. This is made possible with a generous grant from the Governor's Office of Child Abuse and Domestic Violence Services in the Office of Kentucky Governor Paul E. Patton and the Kentucky Justice Cabinet, and under the leadership of Melissa Lane, LCSW-C (MD), and Patti Toth, JD (WA). Grant money is also being used to develop, for the first time, a written clinic curriculum for use in future APSAC Forensic Interview Clinics. In addition, grant funding will be used to host a small think tank to further the possibility of developing an APSAC certification of child interviewers. I will report the results of the think tank's efforts at the February meeting.

Website

Under the stewardship of Board member Cindy Swenson, the Board is in the process of developing a new APSAC website. Its outstanding features will allow members to access more information, more easily, as well as order publications and register for the Colloquium online.

Forensic Interview Clinics

In 2003, APSAC will sponsor as many as three Forensic Interview Clinics. The clinics are open to both members and nonmembers. As you know, APSAC pioneered the development of interviewing clinics. With this new program, we will bring high quality, advanced interview training to several regions in the United States. The dates and sites of the 2003 clinics will be announced in the near future.

Advanced Clinical Training

APSAC is in the process of considering the development of a week-long, advanced clinical training in child abuse and child trauma intervention. It would be very helpful if you could let us know the topics, issues, or problems that you encounter in clinical work. Also, let us know what specific training topics or needs you have identified. Please e-mail any thoughts on this topic to me at: contej@u.washington.edu.

Publications and Materials

APSAC is currently looking toward the future in its publication program. We very much want to hear from members about suggestions for publication guidelines or special topics they feel the organization should address. Current publications are listed at: www.APSAC.org/public.html.

Please e-mail Board member Walter Lambert at: Wlambert@med.miami.edu with any ideas for the development of guidelines.

Contributions

Members will soon receive a request to keep ASPAC in mind at the time of making their year-end contributions and donations. I know from many of you that in the recent past, when no one could say whether APSAC would continue to thrive, you were reluctant to contribute more money. Please know that now is a great time to contribute to APSAC. We are particularly interested in receiving cash gifts toward an LCD player or as unrestricted gifts. It is a difficult time for social services and mental health in general, and I know there are many worthwhile programs and agencies seeking financial help. Please do not forget that APSAC needs your help as well.

Looking to the Future

Exciting things are going on at APSAC at both state chapter and national levels. Many chapters have been supportive over the past few challenging years. The national Board members, who together have been working so hard to keep things afloat, are especially grateful to the state chapter leadership and the many members who sent kind words and other encouragement.

Unfortunately, in a few regions of the country, rumors about the possible troubles of APSAC seem to persist. It is time for every member and every region of the country to get the message that APSAC is alive, strong, and growing. APSAC is doing well organizationally and financially, and vital new endeavors are underway. Let us recognize that the problems of the past were not deliberate but were a function of growing too fast with an inexperienced staff. May we join at every level of the organization and rededicate our energies and talents to making APSAC stronger and better. We are continuing our support on behalf of the professionals who work daily on the front lines of child abuse practice. I welcome your comments, suggestions, and ideas for the ongoing, vigorous development of APSAC and its mission.

Jon R. Conte, PhD
President APSAC
contej@u.washington.edu

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.

NEWS OF THE ORGANIZATION

CHILD MALTREATMENT GOES ELECTRONIC IN 2003

The quarterly APSAC journal *Child Maltreatment* will be available electronically to all members of APSAC beginning with the February 2003 issue (Volume 8, Number 1). To ascertain the publication date (sometime in January 2003), simply register for Sage Contents Alert by giving Sage Publications your name, the journal title, and your e-mail address. You may do this by e-mail (contents.alert@sagepub.com) or at the Sage website (www.sagepub.com) or by letter (Sage Contents Alert, Sage Publications, 2455 Teller Road, Thousand Oaks, CA 91320).

Sage Contents Alert also includes future article titles and author names, calls for papers, and special issue announcements. It is a **free** prepublication alerting service. You will access the journal or specific articles you wish to read through **injentaJournals.** Prior to the publication of the first issue of 2003,we will give more specific instructions for accessing *Child Maltreatment.*

FIVE-DAY FORENSIC INTERVIEW CLINICS PLANNED FOR 2003

It is imperative that professionals who investigate allegations of child maltreatment be current on the research, literature, and methods. The field of forensic interviewing is dynamic. As such, in 2003, APSAC will be conducting at least three Forensic Interview Clinics. These 5-day sessions bring together an interdisciplinary group of professional participants with an interdisciplinary faculty to focus in-depth on the most current research and methodology of forensic interviewing. The clinics are divided into three sections: didactic presentations, a practicum, and a mock court.

The didactic presentations have been developed and are presented by nationally recognized professionals. The curriculum covers the following topics: forensic interview models (APSAC does not endorse a single model), lessons from research, documentation, stages and structures, question types and design, use of media, child development, linguistic issues, eliciting details and other law enforcement concerns, interviewing reluctant children, interviewing adolescents, interviewing ethnically and culturally diverse children, interviewing children with disabilities, and legal considerations and effective testimony.

The practicum portion of the clinic allows participants to take what has been learned in the lectures and to apply it. Participants are divided into small groups facilitated by nationally recognized professionals. Throughout the week, the small groups remain intact but the facilitators change, thus allowing each group to hear the different disciplinary (social work, law enforcement, psychology, and legal) perspectives and the various practices incorporated by each of the professionals, regardless of discipline.

Each participant receives feedback from the group and the facilitator. Not only does the interviewer receive the benefit of the critique but group members also have a valuable learning experience by seeing examples related to what was discussed in the lectures. Two interviews provide the opportunity for participants to try out various aspects of interviewing or to repeat an activity with alterations based on the critique.

The week culminates with a mock court. Video segments from interviews conducted during the week are selected, and participants have the opportunity to be cross-examined and rehabilitated in the process. Videos are selected for their value in teaching, not to point fingers or to put participants "on the spot." Typically, the faculty chooses videos that illustrate common interviewer errors and common defense tactics or that emphasize a point discussed in the lectures. In both mock court and the practicum, the concept of "it's better to learn it in clinic rather than on the job" holds true.

To facilitate a more intimate environment, in which participants will take risks, and to allow more individualized attention of participants, attendance is limited to fifty participants at each clinic. If you wish to learn more about the clinics and be included on the clinic mailing list, contact the APSAC Professional Education office at 405-271-8202 or e-mail Tricia Williams, APSAC Operations Manager, at: tricia-williams@ouhsc.edu.

New Orleans was a great success!
Mark your calendar NOW for the next Colloquium!

APSAC's 11th Annual National Colloquium
July 23-26, 2003
Hyatt Orlando Hotel, Orlando Florida

JOURNAL HIGHLIGHTS

By Ernestine C. Briggs, PhD

Journal Highlights informs readers of current research on various aspects of child maltreatment. APSAC members are invited to contribute by sending a copy of current articles (preferably published within the past 6 months) along with a two- or three-sentence review to Ernestine C. Briggs, PhD, Duke University Medical Center, Trauma Evaluation, Research and Treatment Program, Center for Child and Family Health–North Carolina, 3518 Westgate Drive, Suite 100, Durham, NC 27707 (Fax: 919-419-9353).

SEXUAL ABUSE

Impact of maternal depression on sexually abused children's adjustment

The purpose of this study was to determine whether maternal depression would impact children's adjustment to sexual abuse. It was hypothesized that depressed mothers would report more behavior difficulties for their sexually abused children than nondepressed mothers. Participants were 58 children (and their mothers) who were referred for trauma symptoms related to sexual abuse. Results reveal that depressed mothers reported more conduct problems, inattention/immaturity, and psychotic behavior than nondepressed mothers. Differences were not observed for mothers' reports of depressive or anxious behaviors across groups. The children of depressed mothers reported increased levels of depression, but not anxiety, when compared to children of nondepressed mothers.

Kelly, D., Faust, J., Runyon, M. K., & Kenny, M.C. (2002). Behavior problems in sexually abused children of depressed versus nondepressed mothers. *Journal of Family Violence, 17*(2), 107-116.

Relationship among abuse, chronic fatigue syndrome, and psychiatric disorders

Researchers examined the role of sexual and physical abuse history and its relationship to chronic fatigue and psychiatric disorders. Specifically, 18,675 individuals, 780 of whom reported chronic fatigue syndrome (CFS), completed interviews and questionnaires concerning psychiatric disorders, posttraumatic stress disorder, and sexual and physical abuse history. Among CFS subjects, childhood sexual abuse and the total number of different childhood abuse events significantly predicted fatigue outcome. Similarly, sexual abuse during adolescence or adulthood significantly predicted other anxiety disorders among individuals with CFS.

Taylor, R. R., & Jason, L. A. (2002). Chronic fatigue, abuse-related traumatization, and psychiatric disorders in a community-based sample. *Social Science & Medicine, 55*(2), 247-256.

Childhood experiences associated with risk for adult sexual victimization

This study examined childhood experiences associated with risk for sexual assault victimization in adulthood. In the study, 277 female outpatients retrospectively reported family composition and cohesion, childhood maltreatment experiences perpetrated by adults and peers, and adulthood victimization. Results show that early sexual experiences with peers, childhood sexual abuse by adults, the absence of a father or father figure in childhood, perceived level of closeness to father in adolescence, and neglect by mother posed significant risks for subsequent adult victimization.

Stermac, L., Reist, D., Addison, M., & Millar, G. M. (2002). Childhood risk factors for women's sexual victimization. *Journal of Interpersonal Violence, 17*(6), 647-670.

PHYSICAL ABUSE

Utility of cognitive retraining in child abuse prevention program

This investigation tested the incremental utility of cognitive retraining as a component within a program designed to prevent child maltreatment. High-risk families (N=96) were randomly assigned to a control condition, home visitation that was modeled after the Healthy Start program (unenhanced home visitation) or a home visitation that included a cognitive component (enhanced home visitation). Mothers were identified during late pregnancy or soon after birth, and their participation continued for 1 year. Lower levels of harsh parenting were found among mothers in the enhanced home visitation condition than among mothers in the unenhanced home visitation or control conditions. Prevalence of physical abuse during the first year was 26% in the control condition, 23% in the unenhanced home visitation condition, and 4% in the enhanced home visitation condition. Benefits were greatest in families that included a medically at-risk child. A linear pattern of benefits was found for child health; as program features were added, benefits for child health increased.

Bugental, D. B., Ellerson, P. C., Lin, E. K., Rainey, B., Kokotovic, A., & O'Hara, N. (2002). A cognitive approach to child abuse prevention. *Journal of Family Psychology*, *16*(3), 243-258.

History of physical and sexual abuse associated with anxiety disorders

This study examined the prevalence of self-reported childhood physical or sexual abuse in a sample of 149 adult patients presenting for treatment of panic disorder, social phobia, or generalized anxiety disorder. Subjects were interviewed on their childhood history. As a part of this interview, physical or sexual abuse was assessed. Subjects with panic disorder had significantly higher rates of past childhood physical or sexual abuse than did patients with

social phobia. Individuals with generalized anxiety disorder had intermediate rates of past physical or sexual abuse that were not significantly different from the other two diagnostic groups. Anxiety disorder subjects with a history of childhood abuse were also more likely to have comorbid major depression than those without. These findings are discussed in terms of biological and behavioral factors that may influence the development of anxiety disorders after the experience of a traumatic event.

Safren, S. A., Gershuny, B. S., Marzol, P., Otto, M.W., & Pollack, M. H. (2002). History of childhood abuse in panic disorder, social phobia, and generalized anxiety disorder. *Journal of Nervous & Mental Disease, 190*(7), 453-456.

Does attachment mediate the impact of family violence on adolescent relationships?

Researchers examined the impact of domestic violence, child abuse, and attachment style on adolescent mental health and relationship functioning. Data were collected on 111 adolescents (aged 14-16 yrs) and their mothers. Results indicate that both attachment and family violence experiences negatively impact mental health. In addition, family violence significantly predicted attachment style. Significant protective and vulnerability factors included maternal psychological functioning, maternal positive parenting, and perceived social support from friends. However, it is stated that findings provide only limited support for the model of attachment as a mediator of the impact of family violence on adolescent relationships.

Levendosky, A. A., Huth-Bocks, A., & Semel, M. A. (2002). Adolescent peer relationships and mental health functioning in families with domestic violence. *Journal of Clinical Child & Adolescent Psychology 31(*2), 206-218.

OTHER ISSUES IN CHILD MALTREATMENT

Perceptions, attributional style, and behavioral problems in maltreated children

This study examined relations among perceptions of mothers, attributional style, and counselor-rated behavior problems in 187 school-age children (aged 8-14 yrs; 88 maltreated, 99 nonmaltreated). Hypotheses regarding the presence of higher levels of internalizing and externalizing behavior problems in maltreated children were confirmed. Attributional style was found to function as a moderator of externalizing behavior problems, suggesting that attributional style exerts a protective role against the harmful effect of child maltreatment. Perceptions of mothers were found to operate as a mediator of both internalizing and externalizing symptomatology, with maltreated children with less positive perceptions of their mothers exhibiting greater internalizing and externalizing behavior problems. These findings advance knowledge of how cognitive processes contribute to behavior problems in maltreated children and possess implications for prevention and intervention efforts.

Toth, S. L., Cicchetti, D., & Kim, J. (2002). Relations among children's perceptions of maternal behavior, attributional styles, and behavioral symptomatology in maltreated children. *Journal of Abnormal Child Psychology, 30*(5), 487-501.

Family disorganization, social service placement, and criminality

The extent to which family disorganization moderates the effect of social service placement on juvenile and adult arrests was examined. The authors tested hypotheses relating to two measures of family disorganization: family separation and family moves. Removing an abused or neglected child from the home increased the likelihood of adult arrest for children who experienced a recent family separation. Placement reduced the likelihood of arrest for males who experienced frequent moves and increased the risk of adult arrest for females who experienced frequent moves. The authors concluded that gender differences in placement outcomes should be explored, and they discussed the implications of this research for social service agencies.

McMahon, J., & Clay-Warner, J. (2002). Child abuse and future criminality: The role of social service placement, family disorganization, and gender. *Journal of Interpersonal Violence, 17*(9), 1002-1019.

Methodological lessons from the National Survey of Child and Adolescent Well-Being

The National Survey of Child and Adolescent Well-Being is a national probability study of children investigated for child abuse and neglect. This core study is complemented with a national probability study of children who have been in foster care for approximately 1 year. Plans and efforts to recruit 105 county agencies, more than 6,000 children ages 0-14, and a total of nearly 25,000 respondents associated with the child are described. Several advances in survey methodology help to manage the process in a cost-efficient and scientifically rigorous manner. Lessons from the planning stages and from the early weeks of fieldwork are presented. The sampling and instrumentation techniques are discussed alongside other methodological issues.

Barth, R. P., Biemer, P., Runyan, D., Webb, M. B., Berrick, J. D., Dowd, K., Griffith, J., et al. (2002). Methodological lessons from the National Survey of Child and Adolescent Well-Being: The first three years of the USA's first national probability study of children and families investigated for abuse and neglect. *Children & Youth Services Review, 24*(6-7), 513-541.

cont'd on page 18

Links among childhood adversities, interpersonal difficulties, and risk for suicide

Data from a community-based longitudinal study were used to investigate the association among childhood adversities, interpersonal difficulties during adolescence, and suicide attempts during late adolescence or early adulthood. In 1975, 1983, 1985 to 1986, and 1991 to 1993, researchers interviewed 659 families. Results suggest maladaptive parenting and childhood maltreatment were associated with an elevated risk for interpersonal difficulties during middle adolescence and for suicide attempts during late adolescence after age, sex, psychiatric symptoms during childhood and early adolescence, and parental psychiatric symptoms were controlled statistically. A wide range of interpersonal difficulties during middle adolescence were associated with risk for suicidal behavior after the covariates were controlled. Maladaptive parenting and childhood maltreatment may be associated with a risk for severe interpersonal difficulties during adolescence. These interpersonal difficulties may play a pivotal role in the development of suicidal behavior.

Johnson, J. G., Cohen, P., Gould, M. S., Kasen, S., Brown, J., & Brook, J. S. (2002). Childhood adversities, interpersonal difficulties, and risk for suicide attempts during late adolescence and early adulthood. *Archives of General Psychiatry, 59*(8), 741-749.

Attachment: Theory, research, and clinical considerations

This article presented a selective review of attachment theory and research that has contributed knowledge about dynamics underlying early trauma, mechanisms by which maladaptive responses to trauma may be transmitted between generations, and trauma-related risk factors for psychopathology in children, adolescents, and adults. First, the foundations of attachment theory, including the biological basis of and individual differences in infant attachment behavior, were discussed. The second section examined the connection between frightening experiences and disorganized attachment. Infants who are regularly and seriously frightened by aspects of their caregiving environment are believed to be at risk for "unsolvable fear," in which organized attachment responses to fear are impossible. The behaviors and representations characteristic of disorganized children and their parents were described. Next, the authors reviewed recent research on the relations among attachment, trauma, and psychopathology across the lifespan. Finally, the article discussed implications of these findings for clinical practice.

Cassidy, J., & Mohr, J. J. (2001). Unsolvable fear, trauma, and psychopathology: Theory, research, and clinical considerations related to disorganized attachment across the life span. *Clinical Psychology-Science & Practice, 8*(3), 275-298.

Should child advocacy centers screen for domestic violence?

This article presented preliminary data gathered from the pilot study of a domestic violence-screening tool conducted at a child advocacy center, in which 59 female caretakers of children who were being evaluated for sexual or physical abuse were screened. Of the caretakers, 67% reported a history of emotional abuse, 64% physical abuse, and 47% sexual abuse. Also, 20% of the women reported physical abuse during pregnancy, 8% reported sexual abuse, and 40% reported emotional abuse. The authors concluded that given the high incidence of the coexistence of child abuse and domestic violence in these families, child abuse evaluations need to assess for family safety.

Pulido, M. L., & Gupta, D. (2002). Protecting the child and the family: Integrating domestic violence screening into a child advocacy center. *Violence Against Women, 8*(8), 917-933.

WASHINGTON UPDATE

By Thomas Birch, JD

CONGRESS SLOW TO RESOLVE 2003 MONEY BILLS

Congress returned from the August recess with a long inventory of unfinished business on the legislative agenda, and much of it may not get done before Congress adjourns in October to go home and campaign for reelection.

Usually, the thirteen spending bills for the new fiscal year beginning October 1 are at the top of the legislative list. This fall, though, the President has shifted the election-year agenda to debate about homeland security and war with Iraq, so domestic issues, such as appropriations bills, are left waiting.

When the 2003 fiscal year began on October 1, the House and Senate had passed only the defense and the military construction appropriations bills, as well as the legislative appropriations measure, which funds Congress' own operations. With those priorities out of the way, Congress got bogged down in budget battles.

Funding for federal child and family services programs in the Department of Health and Human Services (HHS) has been held up while both parties wrangle with the President over appropriate spending levels. The Senate Appropriations Committee approved its version of the FY03 Labor-HHS-Education spending bill, with funds for most children's services. The bill still has not gone to the Senate floor.

In the House, the timing for consideration of the HHS money bill is even more uncertain. Rep. Bill Young (R-FL), chair of the House Appropriations Committee, introduced a Labor-HHS-Education appropriations bill identical to the Bush administration's budget proposal. The measure immediately met with opposition from House members of both parties complaining that more money needs to be appropriated than the levels offered by the President. The conservative Republican leadership in the House favors the President's cost-cutting approach, but moderate Republicans argue that Congress should give more attention to domestic spending needs, especially six weeks before House members stand for reelection.

In the meantime, Congress enacts a series of continuing resolutions to keep federal funds flowing to all agencies and departments while the legislators work their way through the political thicket surrounding the spending decisions. Some Capitol Hill staffers have suggested that after enacting a handful of short-term continuing resolutions, the legislators might pass a bill carrying funding over until March 2003. This would allow the new 108th Congress to deal with the final dollar amounts for the fiscal year, which by then will be already half over.

CAPTA REAUTHORIZATION BILL CLOSE TO FINAL PASSAGE

On September 25, 2002, the Senate Committee on Health, Education, Labor, and Pensions (HELP) approved legislation, S.2998, to extend the Child Abuse Prevention and Treatment Act (CAPTA) through 2007. Like H.R.3839, the Keeping Children and Families Safe Act of 2002, passed by the House of Representatives in April of this year, the Senate measure represents a bipartisan agreement to provide slight increases in authorized funding levels for the CAPTA programs. It also promises to focus CAPTA support on improving preventive and protective services.

The Senate measure was introduced on September 24 by Sen. Christopher Dodd (D-CT), with Senators Susan M. Collins (R-ME), Michael DeWine (R-OH), Judd Gregg (R-NH), Edward M. Kennedy (D-MA), and Paul D. Wellstone (D-MN) signing as cosponsors.

The House and Senate bills authorize CAPTA appropriations at levels slightly above the current authorized funding and well above appropriations in 2002. That is, CAPTA basic state grants and discretionary grants would have a combined authorization at $120 million (FY02 appropriations equal $48 million); CAPTA Title II community-based grants would be authorized at $80 million (FY02 appropriation equals $33 million.)

The CAPTA reauthorization proposal passed by the Senate committee is based on the House bill, with additions and changes to some provisions adopted by the House, notably in the amendment authored by Rep. Jim Greenwood (R-PA) on protective services for infants born drug-addicted. While H.R.3839 would require hospitals to report to CPS newborns exposed to drugs or alcohol, S.2998 offers states more flexibility in developing procedures for addressing the needs of such infants, with referral to CPS where "appropriate."

Both the House and Senate bills, in addition to reauthorizing CAPTA, extend the authority for the Family Violence Prevention and Services Act, the Adoption Opportunities Act, and the Abandoned Infants Assistance Act.

House and Senate negotiators must resolve the differences between the two bills for final passage before Congress adjourns.

TANF BILL IN LIMBO

Legislation to extend the public welfare assistance program under the Temporary Assistance to Needy Families (TANF) statute has passed the House and now awaits Senate consideration. Although the Finance Committee has approved the reauthorizing legislation, the bill has not yet made the Senate floor schedule. cont'd page 20

In September, half the U.S. Senate, from both parties, signed a letter to Senate Majority Leader Tom Daschle (D-SD) urging him to bring the bill for a floor vote before adjournment. Funding for child care remains a significant point of contention. Democrats and some Republicans who favor adding major funding increases for child care disagree with the President and the House-passed bill over the necessary amount of spending.

Child protection advocates continue to work with the Senate to recognize in TANF the relationship between employment and good parenting. Often, challenges such as inadequate child care, lack of transportation, and other services for families can interfere with a parent's ability to secure meaningful work.

Historically, the majority (60%) of children entering foster care comes from families receiving cash assistance. Flexibility in TANF would allow states to offer families an individualized mix of treatment services or supportive services to help parents prepare for work without neglecting family responsibilities.

BUDGET DEFICIT FORECAST PORTENDS SPENDING RESTRAINTS

The federal spending picture turned gloomy in August when the Congressional Budget Office reported that the federal budget faces deficits until 2006, and a projected 10-year budget surplus had shrunk by 60% in 5 months.

No wonder! With the largest tax cut in years, giving away the nation's savings account that might have helped get through the rainy day economy that has since developed, tax revenues have taken the most dramatic drop since 1946 when World War II surtaxes were repealed. The CBO analysis did not attribute the decline in tax revenues simply to an economic slowdown or the September 11 terrorist attacks, pointing out that the decrease in tax revenues was sharper than the recent drop in economic productivity.

According to news stories, the White House spokesman Ari Fleischer commented about the CBO report, saying, "The president believes the lesson from today's CBO numbers is that Congress needs to hold the line on spending."

While President Bush continues to push Congress to make last year's 10-year tax cut permanent, the CBO report shows that nearly all the 10-year budget surplus it projects would materialize after 2010, when the current tax cut is scheduled to expire. Last year, CBO projected a $5.6 trillion surplus between 2002 and 2011. That has withered to $336 billion predicted over the same period.

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SUPREME COURT URGED TO REVIEW EXECUTION OF JUVENILES

Three U.S. Supreme Court Justices have urged the court to consider abolishing the death penalty for inmates who committed their crimes as juveniles.

On August 28, 2002, in a dissent from an order declining to stay the execution of a death row inmate in Texas, Justices John Paul Stevens, Ruth Bader Ginsburg, and Stephen G. Breyer said that the Supreme Court should reconsider the constitutionality of allowing juveniles to be sentenced to death. The death row inmate in Texas, whose appeal was denied, Toronto Patterson, age 17 when he killed a cousin in 1995, was executed later in the day. He had asked the court to review his death sentence and to consider whether such executions of juveniles are unconstitutionally cruel and unusual punishment.

In his dissenting opinion, Stevens wrote, "Given the apparent consensus that exists among the states and in the international community against the execution of a capital sentence imposed on a juvenile offender, I think it would be appropriate to revisit the issue at the earliest opportunity."

A separate dissent written by Ginsburg said that the constitutionality should be questioned in cases of the execution of inmates for capital crimes committed when they were juveniles, given the court's ruling in June 2002, barring the execution of the mentally retarded. Then, the court said that it is unconstitutionally cruel to execute those who may be mentally incapable of understanding their situation, or unable to help their lawyers.

The United States is practically alone in permitting the execution of juveniles. The only other nations that allow them are Iran, Nigeria, Pakistan, and Saudi Arabia.

Sixteen states set a minimum age of 18 at the time of a murder to face the death penalty. Five more states set the minimum age at 17; the 17 other states that have a death penalty set age 16 as the minimum.

CONFERENCE CALENDAR

2003 CONFERENCES

March 3-4, 2003
40th Annual Meeting of the Academy of Criminal Justice Sciences, Boston, MA
call 800-757-2257, or
fax 310-446-2819, or
visit website at: www.acjs.org

February 3-7, 2003
17th Annual San Diego Conference on Responding to Child Maltreatment, San Diego, CA
fax 858-966-8018, or
e-mail: dmartin@chsd.org

March 12 -14, 2003
2nd Annual Eastern Conference on Child Sexual Abuse Treatment, Arlington, VA
call 608-263-5130, or
800-442-7107, or e-mail:
PDAS-easternconf@dcs.wisc.edu

March 31-April 5, 2003
14th National Conference on Child Abuse & Neglect, St. Louis, MO
call 703-528-0435,
or fax 703-528-7957,
or e-mail: 14Conf@pal-tech.com

March 11-14, 2003
19th National Symposium on Child Sexual Abuse, Huntsville, AL
call 256-534-1328, ext. 203,
or fax 256-534-6883, or
e-mail: symposium@ncac-hsv.org, or
visit: www.ncac-hsv.org

May 11-14, 2003
Child & Youth Health Congress
e-mail: congress@venuewest.com, or
visit website at:
www.venuewest.com/childhealth2003

April 17-18, 2003
2nd Annual Conference hosted by Prevent Child Abuse Nebraska, Lincoln, NE
call 402-476-7226, or visit
website at: www.pcanebraska.org

May 11-14, 2003
2nd International Conference on School Violence, Quebec City, Canada
e-mail: quebec2003@agoracom.qc.ca

July 23-26, 2003
11th Annual APSAC Colloquium, Orlando, FL
call 405-271-8202, e-mail:
tricia-williams@ouhsc.edu, or
visit website at: www.apsac.org

September 18-21, 2003
10th Male Survivor International Conference, Twin Cities of Minneapolis & St. Paul, MN
visit website at:
www.malesurvivor.org

October 8-11, 2003
22nd Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, St. Louis, MO
call 503-643-1023, or fax 503-643-5084, or e-mail: connie@atsa.com

November 19-22, 2003
55th Annual Meeting of the American Society of Criminology, Denver, CO
call 614-292-9207, or
fax 614-292-6767, or
e-mail: asc41@infinet.com

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, February 3, 2003
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 provide 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.

Join APSAC 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 your check for registration and/or membership payable to APSAC. Return your registration to APSAC. **With this registration form, you may join APSAC only as a NEW MEMBER. To RENEW your membership, please contact Toby Smith at 843-744-6901.**

I. Child Neglect: Confronting the Challenges
Diane DePanfilis, PhD & Howard Dubowitz, MD

This seminar will address the different challenges associated with neglect. The discussion will include defining neglect, both conceptually and for practice. In addition, a framework and various tools will be provided to aid in the assessment of possible neglect situations. Guidelines will be provided for managing and reducing the risk for neglect.

II. Cognitive Behavioral Therapy for Traumatized Children
Judith Cohen, MD & Anthony Mannarino, PhD

This institute will present comprehensive information regarding cognitive-behavioral therapy (CBT) with traumatized children and their families. The institute will be clinically oriented, with numerous case illustrations. The focus will be on children across the age span, including preschool children, school-aged children, and adolescents. CBT interventions to be reviewed will include psycho-education, stress management techniques, gradual exposure, cognitive processing, and behavior management. The institute will focus on interventions for both children and their parents.

III. How to Conduct a Legally Defensible Child Interview
Brian Holmgren, JD & Victor Vieth, JD

This presentation will examine current challenges to forensic interviews of child witnesses encompassing psychological research on children's memory and suggestibility and typical critiques of forensic interviewing practices. Participants will be provided an overview of how this psychological research is designed, reported, and applied in the legal setting as well as the current trend in judicial decisions supporting application of such research through defense expert testimony. Participants will learn not only how this research appropriately informs "best practices" for the interviewing process, but also why the research is inappropriately used in the courtroom setting either as a basis for cross-examining the forensic interviewer or as foundation for the defense expert's testimony challenging the investigative interview. Emphasis will be placed on why interviewers need to be familiar with this psychological research and its current application in trial settings to ensure that appropriate rejoinders are made to these challenges and the reliability of the child's disclosures of abuse are not undermined. Typical defense challenges to the qualifications and practices of the forensic interviewer will be identified through a mock cross-examination exercise involving participants, followed by a rehabilitation of the witness illustrating how interviewers can better respond to these courtroom challenges. Suggestions for how professionals can help ensure appropriate practices in forensic interviewing and courtroom testimony will be proposed

VII. Abusive Head Trauma of Children
Kent Hymel, MD & Rob Parrish, JD

This workshop will focus on the legal and medical aspects of abusive head trauma.

IV. Childhood Animal Abuse and Its Link to Child Abuse and Other Types of Family Violence: Its Significance, Assessment, and Treatment
Mary Lou Randour, PhD & Barbara Boat, PhD

Identifying and treating juvenile animal cruelty can make a significant contribution to the successful treatment of aggressive behavior in children. Research has established that aggressive behavior in children predicts adult criminality: A higher level of aggressiveness in children is associated with criminal offenses in adulthood (Vitiello & Jensen, 1995). Because of the serious nature of aggressive behavior in children, it should be assessed as soon as possible—-prevention and earlier intervention are more effective strategies than intervention at later ages. This workshop will review the research on the causes and outcomes of childhood animal abuse, reviewing the development of aggressive behavior in children, and the developmental implications of childhood animal abuse and its link to family violence, including child abuse and domestic violence. After this background, the workshop will offer concrete, practical suggestions for assessing and treating childhood animal cruelty. Various factors to be considered in the assessment phase will be described (severity, culpability, psychodynamic/motivation; attitudes/beliefs; emotional intelligence; readiness for change; and mitigating circumstances); case examples will be provided so that participants can apply this information to clinical material. Finally, a number of treatment options will be discussed, including intervention with children and parents. Again, clinical examples will be provided.

V. Testifying as an Expert Witness in a Child Abuse and Neglect Case
Randall Alexander, MD & Nancy Lamb, JD

This workshop will focus on the different aspects involved in being an expert witness in a child abuse and neglect case.

VI. Hard-core Hymenology, Pornography, Infection, and Investigation: What's New in Child Sexual Abuse Examinations
Cindy Christian, MD & Carole Jenny, MD, MBA

Do you know the difference between crescents and rings? Are you tired of looking at bumps and notches? So are we! We are offering an institute that will explore neglected, but interesting, topics related to the examination of sexually abused children. Join us if you are interested in learning more about developmental anatomy and its relationship to pornography, the latest in testing for sexually transmitted diseases, everything you (n)ever wanted to know about HPV infections, forensic evidence collection in sexually abused children, and interesting vaginal and anal pathology. Your hosts for this institute will attempt to be engaging, humorous, interactive, and informative.

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