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The National Children's Advocacy Center was established in Huntsville, Alabama, in 1985 as the first CAC in the United States. By 2003, there were 460 full or associate CACs in 49 states. Although the original function of CACs was to respond to cases of child sexual abuse, most centers now also interview alleged child victims of serious physical abuse and child witnesses to other crimes. Based on a current multisite evaluation of child advocacy centers led by the Crimes Against Children Research Center at the University of New Hampshire and funded by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), this article describes what is fundamental and consistent across CACs and discusses important ways in which CACs differ. 3

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Substance abuse is correlated with child physical abuse and neglect in between one-third and two-thirds of substantiated child protective services cases. This paper proposes utilizing a motivationally informed public health approach to large numbers of parents potentially at risk for substance abuse, rather than utilizing intensive and expensive interventions with parents for whom substance abuse is an obvious problem. Research has shown that when compared with substance abusers who have received no intervention, substance abusers who received brief (even single session) motivational interventions were more likely to quit or reduce substance use. To have a community-wide effect and to have at least some contact with the "silent majority" of at-risk parents who never cross the paths or child maltreatment professionals, we may need to adopt these public health approaches. 8

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APSAC Amicus Brief on Child Sexual Abuse in the United States Supreme Court
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This brief, coauthored by APSAC associate editor Thomas Lyon, JD, PhD, is available in full at http://www.psyclaw.org/stogner-v-california.pdf. The brief reviews the research about why most child sexual abuse victims never disclose their abuse and how child molesters do not "age out" of their behavior, thus presenting a continuing risk to children. The brief also reviews research on the long-term effects of child sexual abuse. 14

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APSAC: Ensuring that everyone affected by child abuse and neglect receives the best possible professional response.

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Children's Advocacy Centers: One Philosophy, Many Models

Wendy Walsh, PhD, Lisa Jones, PhD, and Theodore Cross, PhD
Crimes Against Children Research Center, University of New Hampshire

The growth of Children's Advocacy Centers (CACs) in the United States has been extraordinary. These innovative programs work to improve child abuse investigations and reduce stress on children and families. CACs aim to eliminate repetitive interviews for child victims, provide a child-friendly environment for the investigation, use well-trained interviewers, and coordinate forensic investigations by multiple agencies (Sheppard & Zangrillo, 1996). The first CAC, the National Children's Advocacy Center, was established in Huntsville, Alabama, in 1985 (see Cramer, 1985), but CACs have increased from 50 registered centers in 1994 to more than 460 full or associate centers in 49 states in 2003 (http://www.nca-online.org). These centers are everywhere, from Brooklyn to Alaska; Cape Cod to Native American Tribes; the corporate, suburban landscape of Marietta, Georgia, to the Appalachian Children's Center in Ellijay, Georgia. CACs appear as independent centers, units in hospitals, and departments in district attorney's offices. Even where CACs have not been established, there are programs that follow many of the same principles and program models as CACs, but have not yet affiliated with the National Children's Alliance (NCA), the national membership organization of CACs.

This article describes what is fundamental and consistent across CACs and also discusses important ways in which CACs differ. We explore how these differences may affect what outcomes we should expect from different CACs. Understanding what is fundamental about these programs and how they adapt to different communities and situations can help us develop more effective centers and improve community response to suspected child abuse.

This article is based in part on our findings from a current multisite evaluation of CACs, led by the Crimes Against Children Research Center (CCRC) at the University of New Hampshire. Supported by the Office of Juvenile Justice and Delinquency Prevention (OJJDP), this evaluation is designed to measure the impact of CACs on children, families, and communities. The four sites participating in the evaluation are the Dallas Children's Advocacy Center; the Pittsburgh Children's Advocacy Center; the Dee Norton Lowcountry Children's Center (LCC) in Charleston, South Carolina; and the National Children's Advocacy Center (NCAC) in Huntsville, Alabama. Other research has contributed to our thinking as well, including studies of the Collin County (Texas) CAC, the Massachusetts CACs and other multidisciplinary teams (Cross & Spath, 1998), the Children's Safe House in Albuquerque (Steele, Norris, & Komula, 1994), the Florida CACs (Williams, 2002), and the Seacoast Child Advocacy Center in Portsmouth, New Hampshire (Simone, Grey & Adler, 2003).

> **The CAC philosophy draws from a core set of beliefs that the intervention system should respond to the individual needs of the alleged child victim and family and that the most effective response builds upon the expertise of multiple agencies ...**

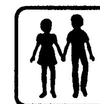
The CAC Approach

The CAC philosophy draws from a core set of beliefs that the intervention system should respond to the individual needs of the alleged child victim and family and that the most effective response builds upon the expertise of multiple agencies (Chandler, 2000). The original function of CACs was primarily to respond to cases of child sexual abuse. Most CACs today have broadened their target population to include suspected child victims of serious physical abuse, child witnesses to domestic violence, and children affected by other forms of victimization.

The National Children's Alliance (NCA), a nonprofit, CAC-membership organization, was established in 1988 to support the implementation and development of CACs nationally. Although CACs vary, a standard set of components defines participating agencies. Table 1 lists ten specific CAC-program components necessary for full membership with the NCA. These standards can be considered a consensus among CACs regarding their key services.

Probably the most defining and universal of the items listed here is the multidisciplinary team (MDT). The MDT consists of law enforcement officers, child protective service investigators, prosecutors, mental health and medical professionals, and others who provide a coordinated response designed to increase the effectiveness of investigations while reducing the stress and risk of secondary traumatization to children. To this end, CACs work to create a positive experience in a child-friendly location. For example, the CAC building is located in a welcoming environment geographically separate from police stations, child protective service, and court houses (to reduce families' fears of participating) and is designed to provide a child and family-friendly environment for interviews and family meetings.

Another defining element of CACs is providing forensic interviews. CACs typically make available specialized interviewers or specific team members, such as law enforcement officers and CPS workers, with education and experience in child development and training in forensic child interviewing. Forensic interviewers are trained to understand children's communication, talk with them clearly, and put them at ease, while still collecting sound investigative information. During the interview process, a professional typically interviews the child while multiple team members watch through a one-way mirror or closed circuit television. The one interview will serve the information needs of multiple agencies. Any additional interviews, if necessary, are conducted to allow children to disclose information at their own pace or go into more depth as needed, but they avoid asking children to "tell their story" repeatedly. Without the MDT and the related forensic interview method, children may be asked about their abuse again and again by multiple interviewers who are not working together.



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Following the interview, the team develops a coordinated plan for pursuing the investigation, if indicated, and for responding to the child and family's needs for protection and services. Child protective service and law enforcement investigators usually coordinate their plans for interviewing the alleged perpetrator, nonoffending parents, and others, and prosecutors and law enforcement will collaborate on plans to pursue additional evidence. Because CACs have formal links with medical professionals as well as agreements and protocols in place for conducting medical examinations, a plan for a forensic medical evaluation with direct feedback to investigators is often appropriate; sometimes the exams are done on-site to coincide with the forensic interview. Case-review meetings in the weeks after the initial interview give professionals further opportunities to refine planning, share new information, engage in team problem solving regarding obstacles in investigations and service delivery, and refer a child for additional services. Team members can provide details on what is alleged and how it was disclosed; data on the crime scene and victims' and perpetrators' behavior; and insight about the relationships and responses of victims, perpetrators, and family members.

CAC involvement with the family extends well beyond the interview, however. The team and CAC professionals work with families to support them through the difficult process of investigation. They continue to help families through the challenges of prosecution, if that is pursued. The CAC also works with the family to secure needed services, such as child psychotherapy, shelter, victims' compensation, and medical care—helping the child and family stabilize and begin to recover is a priority.

The reported influence of CACs also extends to the community as a whole (Cramer, 1985; Cross & Spath, 1998) and arguably changes the entire system of response to suspected child victimization. CAC staff are often among the best trained and most experienced in their communities regarding alleged child victimization, and they can influence the competence of the community through consultation, case review meetings, professional training, and community education. CACs have been active in communities developing programs and services, advocating for children's issues, and even lobbying for new legislation or regulations. They can increase interagency coordination and investigation effectiveness at the level of system structure and policy as well as in individual cases. CACs can also mobilize general community support and commitment to child abuse response through community auxiliary groups, volunteer efforts, and fundraising. Clearly, CACs play multiple roles within each community.

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Variations Among CACs

CACs share the same philosophy, but the settings, populations, and program models with which it is used vary tremendously. As the NCA notes, "No single model for an ideal multidisciplinary program exists, because each community's approach must reflect its unique characteristics" (Chandler, 2000, p. 7). Below we identify seven areas in which CACs differ. These differences are important to understand because variations in implementation affect who CACs serve, what CACs do, and what outcomes they might have.

Community Characteristics

Characteristics of the community, such as the size, diversity, and setting (rural, suburban, urban), affect the nature and development of a CAC. CACs located in rural settings are often faced with the problem of how to provide coordinated services to isolated locations over a large geographic area. The typical model of a centrally located CAC can be impractical there. For example, CACs that serve Native American populations have had to find creative ways to bring services to families who often live hours away from the host organization (U.S. Department of Justice, 2000). Instead of a stationary center, some have developed mobile units that travel to different locations in the service area asneeded. Urban CACs face different challenges, such as coordinating services for a large, diverse, and often multilingual clientele. Client volume can affect the scope and nature of service provision. The Dallas CAC, for example, faces requests for forensic interviews—a skill in short supply—in hundreds of cases for the city of Dallas, making it difficult to apply the full CAC model to referrals from other municipalities throughout the county.

In addition to demographic and geographic factors, developing CACs also must take the structure and politics of existing services into account. Even prior to widespread implementation of CACs, states and communities were developing a number of different models for coordinated investigation procedures and multidisciplinary teams (Kolbo & Strong, 1997). Florida has instigated statewide Child Protection Teams (CPTs), medically directed multidisciplinary teams available to supplement child protection investigations. CACs developing in Florida communities with a CPT must identify the best process for adapting to the existing service structure in the community and avoid overlapping efforts. Some have chosen to emphasize different multidisciplinary components, serving as partners with their local CPTs. Other communities have integrated the CPT into a single, more comprehensive CAC.

Organizational Base

CACs vary greatly in the way they are organized. Some CACs are independent, nonprofit organizations, whereas others are located within hospitals, district attorney's offices, child protective service agencies, or larger nonprofit human service agencies. Organizational base has an effect on the pattern of agency involvement, referral process, and emphasis on and development of available services. The Pittsburgh CAC, for instance, is located within Children's Hospital of Pittsburgh. One obvious outcome of this setting is that the medical component of the CAC is likely to be a major focus of the program. Less obvious is the impact that the setting of this CAC has on the nature of its cases. Because of direct referrals from the emergency department and other health care providers, initial data suggest that nearly a half of child victims are under 6 years old. In contrast, initial data at the NCAC in Huntsville show the majority of child victims are between the ages of 10 and 15 years old. Moreover, such case differences have an obvious effect on child protection and criminal justice outcomes, such as arrest and prosecution rates.

Developmental Stage

It is also important to recognize the developmental stages of CACs: the start up, structuring, cooperation, productive, and completion phases (Chandler, 2000). As CACs progress through these phases, their size, capacity, and services expand and interventions are refined. There may not be a natural progression through these phases, however, and some CACs may remain small and specific in the services they provide. Because CACs vary greatly in the portion of the eligible population they can serve, their organizational complexity, budgets, and expected outcomes must shift accordingly. Like a number of CACs, the new Seacoast Child Advocacy Center in Portsmouth, New Hampshire, began small. It operates in a suite of two rooms, and, until recently, it had a staff of one, who was simultaneously forensic interviewer, CAC coordinator, and office manager. In contrast, a few longstanding CACs (e.g., in Charleston, Dallas, Huntsville, and Plano, Texas) have staffs in the dozens, multiple services, and more ambitious agendas.

Referral Process

The CAC referral process varies greatly and influences who is served and what outcomes should be expected. In some communities, referrals come from multiple sources and in others, only from CPS and law enforcement. In some states, legislation may guide which cases are referred. According to our initial data, the Dallas CAC and the NCAC in Huntsville receive approximately two-thirds of their referrals from CPS and one-third from law enforcement. In contrast, the Dee Norton LCC receives approximately one-third from mental health providers, one-third from CPS, and one-tenth each from law enforcement and medical providers. A broader referral base leads to a greater variety of cases and is associated with differences in services. Referral processes can also be mandatory or discretionary. DCAC sees a subset of all cases of severe physical abuse and sexual abuse in Dallas County on the basis of DCAC's criteria. All cases in Dallas in which the alleged victim is younger than 15 and has made an outcry of sexual abuse or severe physical abuse are referred to the Dallas CAC. At the Dee Norton LCC, on the other hand, professionals refer only those cases they consider appropriate. Mandatory referrals bring an entire cross-section of a certain population to a CAC, but discretionary referrals may tend to give CACs a selected segment, perhaps more severe or less, younger or older—but not a cross-section.

Like many other ambitious social programs ..., CACs have a number of objectives. They aim to protect children, conduct accurate assessments, further justice when a crime has been committed, and help child victims toward recovery, among other things.

Interagency Involvement and Relationships

To be a full member of the NCA, CACs must have a multidisciplinary team with representation from at least seven different agencies or disciplines (see Standard 2), but agency participation, interagency relationships, and team activity still vary considerably even though the existence of the team is inherent to a CAC. The extent to which participating disciplines are actively involved with the leadership and sponsorship of the CAC shape, in part, the procedures most emphasized, the services offered to victims and families, and ultimately the expected outcomes.

In addition to team composition, the relationships between partner agencies and the CAC influence the nature of the CAC procedures and outcomes. At some CACs, prosecutors play a primary role in overseeing the direction of a case throughout the investigation process. At other CACs, the prosecutor's office may be only peripherally involved or participate only when the criminal justice case reaches a certain level of development. Complicating things further, election cycles affect the participation of certain officials, such as district attorneys, who are elected to their position. Fluctuations in partner involvement can have a direct impact on the types of criminal justice outcomes that can be anticipated. Therefore, outcomes such as prosecution rates and conviction rates are often dependent on the overall philosophy, interest, and commitment of the prosecutor and available resources.

Finally, the degree of interaction among team members is also important. This depends in part upon the historic interagency conflicts and turf issues, which influence the manner and time necessary for the building of a multidisciplinary team. The degree of interaction is also influenced by whether child protection and law enforcement workers are co-located, having their offices in the same building. Our discussions with professionals working at the NCAC in Huntsville, the Dallas CAC, and other CACs with co-location indicate that having a law enforcement investigator right down the hall from a child protection investigator increases the level of communication.

Agency Objectives

Like many other ambitious social programs (see McLaughlin, 1985), CACs have a number of objectives. They aim to protect children, conduct accurate assessments, further justice when a crime has been committed, and help child victims toward recovery, among other things. Though CACs carry out many different functions, especially as they develop, some objectives are emphasized more in some programs than in others. This is partially a result of the inability to do everything at once, given limited resources. The needs are many and centers have to choose their priorities. Varying objectives also reflect philosophical differences that are echoed in child abuse professional fields as a whole. Given that experts, professionals, and communities may disagree on many of the issues, it is not surprising that variations in practice exist among CACs.

For example, there is consensus that prosecution should play a role in the response to child abuse, but there is disagreement about how important this is and the range of cases that should be prosecuted, particularly with juvenile and intrafamilial perpetrators. Another example points to philosophical differences about medical response. In some CACs, a medical examination is provided for almost every child, whereas other CACs are more selective. Some CACs have medical examination rooms on site and part-time medical professionals on staff, but others rely on private pediatricians or pediatric departments in hospitals. Some CACs use specially trained nurses; in others, only physicians conduct examinations. These choices vary because of different judgments and tradeoffs about how best to engage families and reduce intrusiveness and stress, what type of information to gather and who is qualified to gather it, and how best to allocate limited resources. Differences in the emphasis on objectives would naturally lead to CACs with varying roles in the community and with different outcomes.

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CAC Outcomes

Although CACs have been in existence for over twenty years and are increasingly considered to be a leading model for agency collaboration in investigating suspected child victimization, systematic evaluation of these centers is lacking. Interest in such evaluation research is growing as funding agencies look for evidence of effectiveness and agencies themselves seek to improve their services. An important preliminary step to evaluating the effectiveness of the CAC model is to understand better what outcomes are most important to examine.

In reviewing the literature on CACs and by talking with a number of CAC professionals, we identified more than 75 specific outcomes that CACs might hope to see resulting from their program (Cross & Jones, 2001). In survey research we conducted, CAC professionals were asked to rank these outcomes according to their relative importance. Sixty-nine professionals responded out of 171. The outcomes that received the highest relative ratings included the following: More effective investigations; More thorough investigations; Increased child safety; Decreased child stress; More accurate decision making; and Increased community resources for victims.

Although we noted general consensus about what outcomes CAC professionals valued, there were still differences of opinion. For example, most professionals in one site rated the outcome, increased availability of needed services during investigation as very important, but one quarter of the respondents gave this item a relatively low score. However, some items, such as improved coordination with domestic violence investigations, were rated as relatively less important by most professionals, but extremely important by a few. Clearly, there are many important outcomes of CAC effectiveness.

The influence that a particular CAC hopes to make will be driven by the goals and expectations of the involved professionals. A CAC located in a district attorney's office, with a strong focus on coordinating law enforcement activities with child protection, for example, can expect to see different outcomes than an independent CAC with comprehensive service options for victims and frequent collaboration from a broad array of community member agencies. The first CAC might expect to see a notable effect on the quality and success of its criminal prosecution of child victimization, and the second, improved satisfaction with the availability of services. Both of these CACs may offer a good example of "a CAC model"; nevertheless, one-size-fits-all assumptions about CACs may lead to unrealistic expectations.

Implications

What are the "take home" messages of understanding CACs as the same but different? First, a core philosophy truly has captured the imagination of a wide range of professionals dedicated to helping children and has spurred tremendous growth and change in how we respond to allegations of child victimization. This philosophy is manifest in basic elements of CACs and consistent across the organizations. Every CAC we have examined has a facility that appears to be built and set up to be substantially more comfortable to children than the alternatives. Each CAC has interviewing professionals with substantially more training and experience in child development and child forensic interviewing than the typical investigating officer or CPS worker of years past. Consistently, investigations are conducted in a manner that is more coordinated than in the past, and duplicative interviewing is never standard procedure for cases coming through the CAC. Although there is still work ahead of us to improve interviewing, coordination, and service delivery, much has been accomplished in developing a consistent, professional model in hundreds of communities across the country and in defining a national standard of care that dominates professional opinion.

Second, the differences among CACs mean that we cannot adopt a "cookie cutter" approach in any aspect of their development, operation, or evaluation. CACs must be implemented in ways that are responsive to the needs of their communities and that "knit" them together with the existing service and justice systems. That alone would create variation in how CACs are structured and operate, but it also must be recognized that different CACs are going to interpret and respond differently to the many broad goals inherent in the CAC philosophy. Thus, CACs will be pursuing somewhat different goals in various ways, the biggest difference being the broad, and often divergent, goals of criminal justice and human services. It is inevitable that CACs will embody some of the philosophical differences in the field about how best to respond to alleged child victimization. Given the close link and indeed dependence on other organizations for participation and in many cases sponsorship, CACs will inevitably be affected by and reflect the orientations and structure of the organizations underlying them. Evaluation of CACs, both formal and informal, must take into account their variability, measuring each CAC by somewhat different yardsticks and focusing on different outcomes, depending on the organization, orientation, and stage of development of the CAC.

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Table 1

National Children's Advocacy (NCA) Full Membership Standards for Children's Advocacy Centers (CACs)*

1. **Child-Appropriate/Child-Friendly Facility:** A children's advocacy center provides a comfortable, private, child-friendly setting that is both physically and psychologically safe for clients.

2. **Multidisciplinary Team (MDT):** A multidisciplinary team for response to child abuse allegations includes representation from the following: law enforcement, child protective services, prosecution, mental health and medical providers, victim advocacy services,and a children's advocacy center.

3. **Organizational Capacity:** A designated legal entity responsible for program and fiscal operations has been established and implements basic, sound administrative practices.

4. **Cultural Competency and Diversity:** The CAC promotes policies, practices, and procedures that are culturally competent. Cultural competency is defined as the capacity to function in more than one culture, requiring the ability to appreciate, understand, and interact with members of diverse populations within the local community.

5. **Forensic Interviews:** Forensic interviews are conducted in a manner that is of a neutral, fact-finding nature and coordinated to avoid duplicative interviewing.

6. **Medical Evaluation:** Specialized medical evaluation and treatment are to be made available to CAC clients as part of the team response, either at the CAC or through coordination and referral with other specialized medical providers.

7. **Therapeutic Intervention:** Specialized mental health services are to be made available as part of the team response, either at the CAC or through coordination and referral with other appropriate treatment providers.

8. **Victim Support/Advocacy:** Victim support and advocacy are to be made available as part of the team response, either at the CAC or through coordination with other providers, throughout the investigation and subsequent legal proceedings.

9. **Case Review:** Team discussion and information sharing regarding the investigation, case status, and services needed by the child and family are to occur on a routine basis.

10. **Case Tracking:** CACs must develop and implement a system for monitoring case progress and tracking case outcomes for team components.

*—http://www.nca-online.org/network.html

Substance Abuse and Child Maltreatment Prevention

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Two risk factors have appeared particularly important in terms of strength of association with child physical abuse and neglect: poverty, especially receipt of public assistance (e.g., Brown, Cohen, Johnson, & Salzinger, 1998), and substance abuse (e.g., Chaffin, Kelleher, & Hollenberg, 1996). In 1993, according to the Third National Incidence Study of Child Abuse and Neglect, child maltreatment was 22 times more likely in families with annual incomes below $15,000 than in families with incomes above $30,000 (Sedlak & Broadhurst, 1996). Substance abuse increases the risk of child physical abuse or neglect report threefold (Chaffin et al., 1996; U.S. Department of Health and Human Services, 1993), and most estimates implicate substance abuse in between one-third and two-thirds of substantiated reports to child protective services (U.S. Department of Health and Human Services, 1999). The co-occurrence of these two major risks appears to be particularly associated with physical abuse or neglect. Even though maltreatment is not present in over 90% of families with incomes below $15,000 per year (Sedlak & Broadhurst, 1996), substance abuse appears to be a major discriminator of low-income families in which neglect is and is not present (Ondersma, 2002).

Although our understanding of the association between substance abuse and child maltreatment is still developing, at least four pathways could connect substance abuse with the occurrence of child physical abuse or neglect.

Although our understanding of the association between substance abuse and child maltreatment is still developing, at least four pathways could connect substance abuse with the occurrence of child physical abuse or neglect. Substance abuse may (a) directly cause physical abuse or neglect, perhaps by disrupting normal nurturing processes and parental willingness and ability to function in the parenting role; (b) indirectly lead to physical abuse or neglect through the host of additional conditions associated with substance abuse (e.g., violence, crime, trauma, physical and mental illness, poverty); (c) be caused by the same factors that increase risk for physical abuse or neglect, for example, poor coping skills, impulsivity, trauma, stress, or mental illness; or (d) simply increase the likelihood that a person will be reported to child protective services (although not all research connecting substance abuse and maltreatment uses child protective services reporting or substantiation as the key outcome). It is likely that all of these pathways play a role in the observed association between substance abuse and child maltreatment.

Substance abuse may thus be an appropriate target for universal or selective interventions designed to prevent physical abuse or neglect. First, focusing on families in which both substance abuse and poverty are present may allow for efficient identification of at-risk children not yet known to child welfare and thus provide more efficient use of limited resources (Ondersma, 2002). Second, mental health, social service, and other agencies are frequently aware of families for whom substance abuse is an issue but who are not currently involved with child welfare. Identifying many such families may thus be quite feasible. Third, substance abuse is a remarkably well-researched problem, therefore giving the maltreatment prevention field a firm empirical base from which to develop interventions.

Assuming for the moment that targeting substance abuse may allow for efficient identification of at risk parents, two questions arise: (1) Is substance abuse amenable to intervention efforts? That is, can we really make a difference in this? (2) If it is possible to affect parental substance abuse, what might a substance abuse-focused physical abuse or neglect prevention approach look like? These questions will be answered in the following two sections.

Is Substance Abuse Treatable?

A great deal of rigorous research comparing treatment and control groups suggests that substance abuse is treatable. In fact, despite assumptions that substance abusing persons never change, these disorders appear to be as treatable as other chronic illnesses, such as asthma or diabetes (Leshner, 1999). Many types of interventions can lead to reductions in substance abuse (National Institute on Drug Abuse, 1999), even very brief, single session interventions (Moyer, Finney, Swearingen, & Vergun, 2002; Wilk, Jensen, & Havighurst, 1997).

Contrary to popular belief, the majority of persons (approximately 75%) who do recover from an alcohol use disorder do so without professional help or 12-step groups (e.g., Sobell, Ellingstad, & Sobell, 2000). The same appears to be true for drug use disorders as well, although less research has focused on this issue. This finding, surprising to many, has held true in studies in the United States, Canada, and Europe. This is not to suggest that such change is easy; it is difficult for nearly all and extremely difficult for many, and most who do achieve long-term sobriety do so only after many repeated recoveries and relapses.

Regardless, many people report having ceased abusing alcohol or drugs in their own ways and for their own reasons. Some of the most common reasons involve self-image or identity, health, finances, and relationships (Burman, 1997). Quitting is often preceded by a very personal and emotional cognitive appraisal process in which the benefits of a particular substance come to be seen as outweighed by its costs, by the benefits of quitting, or both (e.g., Sobell et al., 2001). Methods commonly used by self-changers include avoiding substance abusing persons or cues, obtaining support from sober family and friends, and finding alternative pleasurable or coping activities (Burman, 1997).

How Can Prevention Efforts Address Substance Abuse?

Integrative Approach

There are a number of ways that professionals concerned with maltreatment prevention can address substance abuse to reduce the risk of child physical abuse and neglect. The most obvious way is for existing prevention programs to devote more energy to the identifi-

cation of substance abuse and for these programs to partner with substance abuse treatment agencies. Many existing prevention programs have endeavored to integrate substance abuse treatment more thoroughly into their existing treatment approaches. Although clear evidence is lacking, such an approach could facilitate better outcomes from a maltreatment prevention standpoint.

However, this approach may have limitations due to its inability to influence more than a fraction of substance abusing parents, for only a fraction of the time in which they may benefit from services. For example, it has been estimated that over six million children have a caretaker who is dependent on alcohol, drugs, or both (Huang, Cerbone, & Gfroerer, 1998). Intensive—and thus expensive—programs cannot be provided to all at-risk parents because of the tremendous amount of funding it would take to do so. Further, research concerning readiness to change suggests that most people with substance use disorders, at any given moment, are not interested in change and thus are unlikely to participate in intensive treatment (DiClemente & Prochaska, 1998). Finally, most maltreatment prevention programs—despite their emphasis on aftercare and follow-up care—can provide services for only one of many important periods in a child's life. Substance use disorders tend to be chronic relapsing conditions, and most who relapse do not return to treatment immediately. Thus, integrative approaches, although potentially helpful with parents who are willing to commit to an active prevention program, may not fit the reality of substance abuse for most at risk parents.

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Motivationally Informed Public Health Approach

Given the above concerns, what else can be done? One possibility is to attempt to apply brief motivational interventions, which have already been validated as a substance abuse intervention, to large numbers of potentially at-risk parents—whether or not they are seeking treatment or are willing to engage in long-term treatment. Such an approach would differ from the integrative approach in several ways: (a) It would be proactive, seeking to provide intervention to a high proportion of at-risk parents, regardless of whether or not they are seeking help or known to any service delivery system; (b) It would be brief and motivational in nature, designed around the reality of limited readiness to change in most substance abusing parents; and (c) It would be repetitive, seeking out parents not just once but on a regular basis to provide intervention throughout the parenting years. Similar approaches to substance abuse, smoking, diet, exercise, food safety, and a number of other behaviors have already been proven successful (e.g., Prochaska, Velicer, Fava, Rossi, & Tsoh, 2001; Thevos, Quick, & Yanduli, 2000).

What might such an approach look like when applied to substance abuse and child maltreatment? Many types of public health-related approaches have received empirical support. One common type of intervention involves community-wide media or law enforcement campaigns. In a study designed to increase public concern regarding children in substance abusing families, a multimedia campaign resulted in dramatic increases in the number of related calls received by a CPS information service (Andrews, McLeese, & Curran, 1995). In another study, a television ad followed up by surveys of representative women was associated with significantly increased self-reported concern regarding alcohol use during pregnancy (Casiro, Stanwick, Pelech, & Taylor, 1994). Community-level law-enforcement campaigns to reduce heavy alcohol use have been found to reduce self-reported episodes of binge drinking by 49% (Holder et al., 2000), and tax increases on beer have been associated with reductions in physical child abuse (Markowitz & Grossman, 2000). Such programs can be altered and repeated continually to access, however briefly, very high proportions of potentially at-risk parents at multiple points in their lives.

Regardless of the usefulness of such campaigns, however, they have little to do with the daily work of most child maltreatment prevention specialists, and they may rely upon very different principles. Fortunately, such campaigns are not the only way that low-cost and effective interventions can be brought to large numbers of at-risk parents. Research has provided evidence that brief (even single session) interventions are associated with clinically significant change in substance use (Miller, 2000; Moyer et al., 2002; Wilk et al., 1997). When compared with persons having substance use disorders who get no intervention, those who receive brief, nonconfrontive feedback and intervention are more likely to quit or reduce their substance use.

Brief interventions generally focus on increasing people's motivation to change and facilitating treatment entry. Such sessions are typically used in primary care settings, where they can be provided to very high proportions of at-risk populations (for example, women in the perinatal period, those at HIV screening clinics, and those presenting for treatment in emergency rooms). However, prevention specialists, children's therapists, family support workers, and many others who have access to large numbers of at-risk parents could also conduct brief interventions in a host of other settings. A recent study of the use of these techniques with parents in the CPS system found that parents who received a motivational interview were nearly twice as likely to attend at least one substance abuse treatment session (Carroll, Libby, Sheehan, & Hyland, 2001).

Although the study by Carroll and colleagues is the only current evidence of the efficacy of these techniques in a child welfare setting, brief motivational interventions designed to reduce problem substance use have been validated in a variety of other settings, such as outpatient treatment centers and emergency rooms. In addition, these brief interventions—being client-centered rather than confrontational—utilize methods that are more similar to those typically utilized by mental health professionals than to those often associated with substance abuse treatment.

If integrated into prevention programs, social service agencies, and primary care settings, brief interventions can potentially be provided on multiple occasions throughout the parenting years. This would allow for parents to repeatedly revisit their risks, which may change over time. With proper training, professionals from a wide range of

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disciplines can learn to comfortably provide such interventions. A greatly simplified outline of the key features of a brief intervention is provided in the following section.

Conducting a Brief Intervention for Maltreatment Prevention

Brief motivational interventions are both elegantly simple and technically challenging. With proper training, however, they can be provided with fidelity by a wide range of professionals and paraprofessionals. Although no therapeutic approach can be reduced to a few simple steps, some important points can be highlighted.

- **Think big (and brief)**. If brief interventions are provided only to those parents for whom substance abuse is an obvious problem, very few at-risk parents will be influenced. Further, any intervention increases in overall impact every time it is provided to a new person. Public health researchers define impact as the average effect of an intervention on the individuals it is given to multiplied by the number of people that the intervention has accessed. Using such a definition, many "model" interventions in fact have very little impact because they access such small proportions of the at-risk population. Certainly, we can strive to affect all of the participants in our programs, not just the ones we know have a substance use disorder. But more than this, we can attempt to affect an entire community, whether or not those affected are seeking services.

Certainly, we can strive to affect all of the participants in our programs, not just the ones we know have a substance use disorder. But more than this, we can attempt to affect an entire community, whether or not those impacted are seeking services.

- **The less stigma the better.** There is reason to believe that the less that parents feel targeted because of some perceived deficit, the more likely they are to respond. For example, the relative success of the Nurse Home Visitation Program may in part be due to its use of nurses, around whom parents may feel less stigmatized and defensive. Similarly, a recent meta-analysis found that home visitation programs targeting all parents of a given demographic, rather than via the use of a risk screener, were more likely to be successful (Guterman, 1999).

- **Start with a substance abuse screen**. The closer the perceived ties of the screener to CPS, the more likely it is that parents will minimize any substance use. However, many steps can be taken to increase the validity of a substance abuse screen. Confidentiality, to the extent that it exists, should be emphasized; for example, substance abuse is not a mandated report in many states. Second, a "norming" statement (e.g., "Most parents have some areas of strength and some areas where they struggle") can preface the screen to make admitting to some difficulties seem less stigmatizing. Embedding the substance abuse screen in a larger assessment of strengths and challenges can further enhance its acceptability. Third, a validated screening tool should always be used. For alcohol, good options include the TWEAK, CAGE, or MAST (see http://www.niaaa.nih.gov/publications/instable-text.htm for copies of all of these). For drug use, try the Drug Abuse Screening Test (available at http://www.nida.nih.gov/Diagnosis-Treatment/DAST10.html). A very subtle measure shown to identify at-risk drinking (as well as many whose drinking is not problematic) is the Trauma Scale (see www.projectcork.org, also an excellent general resource on substance abuse).

- **Respond empathically**. Responding to drug use in a low-key and empathic manner is the best way to facilitate further communication and motivation. Immediately rushing to point out negative aspects and consequences of substance use is likely to elicit defensiveness. Endeavoring to respectfully discover what parents like and dislike about drinking or drugs is more likely to lead to a meaningful and effective conversation about change.

- **Provide treatment options**. A client presented with options is more likely to engage in change than one given a single choice for change. Provide parents with handouts that list as many local treatment options as possible (even if the only options available are a 12-step group and two local counselors) and that describe some of the benefits that can be expected from decreasing one's substance use (e.g., a better relationship with children, a decreased likelihood that one's children will use drugs or abuse alcohol, more money, better health, less trouble).

- **Read, read, read**. A great deal of information is available about the use of motivational techniques. Probably the single best source is the motivational interviewing text by William R. Miller and Stephen Rollnick, the revised version of which came out in April 2002 (*Motivational Interviewing: Preparing People for Change*, Guilford). In addition, excellent web resources are available. Try www.motivationalinterview.org, which also has a nationwide list of trainers, and the guide, "Enhancing Motivation for Change in Substance Abuse Treatment" (CSAT TIP #35), provided by the U.S. Department of Health and Human Services' Center for Substance Abuse Treatment (http://www.samhsa.gov/publications/publications.html).

It must be emphasized that the foregoing is just a rough indication of what such an approach might look like. It is also important to remember that such interventions, although validated for the treatment of substance abuse with general and child protective services populations (Carroll et al., 2001), may not substantially impact maltreatment risk if substance abuse is only a correlate and not a cause of maltreatment.

Regardless of the success or failure of the brief model proposed here, our field must give serious thought to the extent to which we have devoted resources and attention to interventions that intend to be quite intensive, that consequently are too expensive to be provided to all who are at risk, and that may not be attractive to parents who are not ready to change. To have a community-wide effect and to have at least some contact with the "silent majority" of at-risk parents who never cross our path, we may need to adopt more of the methods of our colleagues in public health. Doing so may involve a broad shift away from intensive, individually based efforts and toward widespread, brief, practical, and motivational solutions.

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What Teachers Can Do to Prevent Sexual Abuse in Schools

Pegi Taylor, Milwaukee, WI

Is there anything that makes a teacher's skin crawl more than reading in the paper or seeing on TV a story about a school employee committing a sex crime against a student? Yet, this is only one of the four types of sexual misconduct that occurs in schools. The other three happen when students sexually abuse other students, students sexually assault staff, and staff sexually assaults other school personnel. This article focuses on contact that includes minors, so it will not address the category of sex crimes against coworkers within schools.

Teachers can do a great deal to prevent sexual abuse of students. But first, just what does the term sexual abuse encompass? For the purposes of this article, sexual abuse does not include verbal sexual harassment. STOP IT NOW! (a national organization dedicated to ending the sexual abuse of children) uses a definition of sexual abuse that includes both contact behaviors, such as touching a child's genitals or forcing a child to touch a teacher's genitals, and noncontact behaviors, such as exhibitionism or watching a child undress.

Robert J. Shoop, a professor of education law at Kansas State University, has testified in over thirty court cases involving sexual abuse or harassment in schools. Every week he gets calls from school districts about everything from a teacher having sex with a student in a classroom in front of 30 pupils to multiple teachers having sex with the same student.

Shoop understands how distressing it is for teachers to consider such situations. "There is this thinking that everyone knows a teacher shouldn't have sex with a student," he said during a recent phone interview (October 2002). "It's embarrassing and demeaning to talk about it." Shoop urges teachers to get beyond their discomfort because, as far as he can determine, 5% to 10% of students will be sexually abused by a staff person between kindergarten and twelfth grade. He believes this is a conservative figure due to underreporting when older teenagers are involved.

Some simple rules Shoop advocates can go a long way to protect both students and teachers:

—"Teachers shouldn't meet students outside of school. If you choose to be in an unsupervised relationship with a student, you are doing so at your own peril.

— "No room should be without visible access from the outside. Don't cover the windows with artwork.

—"Don't transport students in your own vehicle." Like all rules, this one has exceptions. "If I were driving home in a sleet storm and saw a 15-year-old student without a coat, I would take her home," says Shoop. "But I would immediately call my principal and let him or her know what I had done."

Teachers can work with administrators to make sure schools do not become sexualized environments. A sexually charged climate can start without a teacher having any intent to harm a student. For example, a student might confide in a favorite teacher and talk about having sexual struggles. This teacher, rather than refer the student to the school nurse or counselor, might get drawn into a discussion and relate stories about his or her own sexual behavior. There are two dangers to this sort of conversation. The student might misinterpret the teacher's motives, and teachers who sexually abuse students use these sorts of situations to initiate contact.

Sexual misconduct often starts with the teacher talking about sex or brushing up against a student's genitals. "If students don't understand that this is inappropriate behavior they should report," says Shoop, "then how can the school expect students to come forward after a serious incident has happened?" By this point, students will often feel responsible and guilty for their own compliance and may be infatuated with the perpetrator.

Teachers can ask school districts to identify a specific staff person to handle complaints about sexual abuse and harassment. Shoop suggests that if a school has a counselor or social worker, this is the best person for the job. All teachers can keep an eye on the staff.

STOP IT NOW!'s web site lists a number of warning signs that might indicate improper conduct. Teachers should report staff, including administrators, librarians, bus drivers, or custodians, who spend time alone with a student, buy gifts for a particular student, or repeatedly talk about a student's developing body. Teachers who coach extracurricular sports, music, and drama have the opportunity to get particularly close to students. A study conducted by *Education Week* reported that in 244 nationwide active cases (from Mar-Aug 1998), in which staff sexually abused students, at least one-third of the teachers were leaders of extracurricular activities. Instructors can ask for more oversight of after school teacher-student interactions.[1]

Resources Sidebar

In 2001, the American Association of University Women (AAUW) education foundation published the results and recommendations of a report, based on a Harris Interactive survey, conducted with 2,064 public school students in eighth through eleventh grade. The report, *Hostile Hallways: Bullying, Teasing, and Sexual Harassment in School*, can be ordered by calling 207-728-7602 or at www.aauw.org.

As another outcome of the study, the AAUW prepared (2002) a guide, "Harassment-Free Hallways: How to Stop Sexual Harassment in Schools," for students, parents, and educators (www.aauw.org/ef/harass).

The Center for Sex Offender Management has many articles available online, including "Understanding Juvenile Sexual Offending Behavior: Emerging Research, Treatment Approaches, and Management Practices" (www.csom.org, Dec 1999).

Last summer, the Nevada Coalition Against Sexual Violence published some of its findings in an article, titled "Educator Sexual Abuse Statistics" (www.ncasv.org/educator_sexual_abuse_statistics.htm). S.E.S.A.M.E. (see following) Board President Terri Miller gathered the information.

The S.E.S.A.M.E. (Survivors of Educator Sexual Abuse and Misconduct Emerge) web site provides survivor stories and links. S.E.S.A.M.E. believes "the power imbalance between a teacher and student (of any age) creates a climate that can facilitate sexual exploitation behavior by the teacher, behavior that is psychologically equivalent to incest" (www.ncweb.com/org/rapecrisis/sesamehome.html, downloaded Sept 2002).

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To have school personnel monitoring each other is risky, however. No one wants to create a "Big Brother Is Watching" atmosphere. "You have a double-edged sword," Shoop adds. "By heightening people's awareness, you can make people believe every teacher is a bad person, and that clearly is wrong. But by pretending it doesn't happen, you create conditions that allow it to keep happening."

Another risk of vigilance is teachers staying at arm's length from students. Nan Stein, a senior research assistant at the Center for Research on Women at Wellesley College, said in an interview for the *Harvard Education Letter*: "I'm in favor of teachers being able to have appropriate physical contact with kids." She has extensively studied and written about sexual contact in schools and believes touch is especially important in elementary school. "I only have two rules about touch," says Stein. "Don't put any kid on your lap, and don't give neck rubs and back massages." Rather than having young students sit on their laps, teachers can have affectionate boys and girls sit beside them.[2]

As instructors and supervisors, teachers can also do a huge amount to prevent students from sexually abusing other students. Most people are unaware of the extent of sex crimes perpetrated by children. The Center for Sex Offender Management published an article (Dec 1999) that estimated the following: "Juveniles account for up to one-fifth of all rapes and almost one-half of all cases of child molestation committed each year." Some of these crimes happen at school.[3]

David Prescott has assessed and treated adolescents with sexual behavior problems in Vermont for 15 years. In a phone interview (Sep 2002), he suggested that teachers can play a significant role in teaching students to plan and manage their behavior and thus help reduce sexual abuse by juveniles—both inside and outside of school.

First, teachers can address students' "callous sexual attitudes." For example, Prescott says male athletes may express sexual entitlement and assume, "I'm a basketball player, and if I want to have sex with a girl she should be willing and grateful." Second, instructors can help curb impulsivity, another common feature of youths who commit sexual offenses. Such students tend to be poor problem solvers and don't understand that actions have consequences. Third, and likely most important, teachers can help students develop positive self-esteem. Juveniles who don't feel adequate can become emotionally detached to the point that they will say, "What do you mean I sexually abused her? She was drunk at a party and was unconscious, so I had sex with her. What's the big deal?"

Sex education is another vehicle that can help prevent juveniles, both male and female, from becoming sexual abusers. "Kids need an owner's manual to their own bodies," says Prescott. Gail Ryan, director of the Perpetration Prevention Program at the Kempe Children's Center in Denver, Colorado, agrees wholeheartedly. In a SIECUS (Sexuality Information and Education Council of the United States) report (Vol. 29/1, 2000), "Perpetration Prevention: The Forgotten Frontier in Sexuality Education and Research," she argues, "The child's risk of sexually abusing other children has been largely ignored in sexuality education and sexual abuse prevention programs." She believes "children need to be given permission to talk about sexuality and to learn to define all types of abusive behaviors." Teachers and conservative parents might agree on sex education programming if they knew it deterred sexual abuse.

The most complicated and least discussed type of sexual abuse in schools is the situation of students assaulting teachers. In Milwaukee, Melissa Bittner, convicted in 2002 of having sexual contact with a 16-year-old student at a private high school, claimed the student had assaulted her. Bittner, a first-year teacher who had attended college in Ohio, insisted she received no training about sexual abuse issues during college or when she started teaching.[4]

She might have had more of a chance to support her claim if she had worked in a public school. In a July 2002 interview, Sam Carmen, executive director of the Milwaukee Teachers Education Association, detailed what would have happened if Bittner had taught in a Milwaukee Public School. After the youth accused Bittner, the principal would have notified the Milwaukee Public Schools Central Administration. The central administration would have called the MTEA, generally within an hour or so, and the MTEA would have immediately sent a lawyer to meet with Bittner to clarify the facts in the case and make sure Bittner's rights were protected. MPS would have removed Bittner from the school during an investigation. When the district attorney charged her with committing a crime, the MTEA's role would have ended.

Perhaps the first step for teachers to take is to demand training. As *Education Week* recommended, "Districts should consider training for educators in how to respond when sexual abuse is suspected, disclosed, witnessed, or actually experienced".[5]

Resources Sidebar

A three-part series with twelve articles about child sexual abuse by school employees appeared in *Education Week* in December 1998. (To access other recent *Education Week* articles related to sexual abuse in schools, search "sexual abuse" in the archive at: www.edweek.org. The series is available at www.edweek.org/sreports/abuse98.htm.)

Robert J. Shoop, a professor of education law at Kansas State University, has a forthcoming book, *Sexual Abuse in Schools* (Corwin Press, 2004). He has written other books and numerous articles and has developed a number of videos. Two sources that teachers might find most pertinent are *Preventing Sexual Harassment in the High School* (Shoop and Debra Edwards, 1995, Sunburst Publications, Pleasantville, NY) and *Sexual Harassment: It's Hurting People* (Shoop and Edwards, 1994, National Middle School Association, Columbus, OH).

STOP IT NOW!, a national organization dedicated to ending the sexual abuse of children, has a web page on "Warning Signs About Child Sexual Abuse" (www.stopitnow.org/warnings.html).

Notes:

1. www.edweek.org/ew/vol-18/14abuse.h18, in Caroline Hendrie, "Sex With Students: When Employees Cross the Line"

2. www.edletter.org/past/issues/2000-jf/stein.shtml, *Research Online,* Jan-Feb 2000, p. 2

3. www.csom.org/pubs/juvbrf10.pdf, in John Hunter et al., "Understanding Juvenile Sexual Offending Behavior"

4. www.milwaukeemagazine.com/112002/darness.html; Pegi Taylor with Stanley Mallach, "The Other Side of Darkness," *Milwaukee Magazine*, Nov 2002, pp. 58-63

5. www.edweek.org/ew/vol-18/16syst.h18, in Caroline Hendrie, "'Zero Tolerance' of Sex Abuse Proves Elusive, Dec 16, 1998

APSAC Amicus Brief on Child Sexual Abuse in U.S. Supreme Court

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The American Professional Society on the Abuse of Children filed an amicus brief with the U.S. Supreme Court in the case of *Stogner v. California*. The case involves the constitutionality of an extended statute of limitations for child sexual abuse, which allows cases to be prosecuted within one year of being reported to the police, despite the fact that the original limitations period has run. Joining APSAC on the brief were the American Psychological Association, the National Association of Counsel for Children, and the California Professional Society on the Abuse of Children.

The brief explained the rationale for a long statute of limitations period for child sexual abuse by reviewing research that 1) a substantial percentage of child sexual abuse victims never disclose their abuse to anyone until they are adults, 2) child molesters often remain at risk of reoffending for substantial periods of time, and 3) the ill-effects of child sexual abuse often last into adulthood.

In 1994, the California legislature adopted a special statute of limitations for certain child sexual abuse crimes, allowing charges to be brought within one year of the time that the victim reported the crime to the police. Careful not to encourage false allegations, the legislature required that cases brought under the special statute must have “independent evidence that clearly and convincingly corroborates the victim’s allegation.” One justification for the special statute of limitations was that many children delay reporting sexual abuse until they are adults, after the standard statute of limitations has run. Another justification is that child molesters often pose a risk for a substantial period of time, justifying delayed prosecution of their offenses.

The legislation was worded to apply retroactively, that is, to cases for which the standard statute of limitations had already run at the time the new statute was enacted. The legislature made it quite clear that it wanted all victims to have their day in court. It is the application of the statute to these sorts of cases that is at issue in this case. The U.S. Supreme Court is considering whether it is constitutional to revive a criminal cause of action for child sexual abuse after the statute of limitations has run. Technically, does revising a criminal cause of action constitute an ex post facto law or a denial of substantive due process? Of course, to a large extent the Court’s decision will be based on legal precedents and the somewhat abstract issue regarding the application of rules against ex post facto laws to changes in the statute of limitations.

The amicus brief did not address these arcane legal issues. Rather, amici sought to assist the Court in assessing the legitimacy of the reasons for the special statute of limitations. An understanding of the dynamics of sexual abuse may assist the Court in determining whether retrospective application of the special statute of limitations is fair.

The brief reviewed the research on disclosure of abuse, demonstrating that most child sexual abuse victims never disclose their abuse, and that those who do often delay for years. The brief explained the reasons for delay, which include ignorance, fear, and embarrassment. Second, the brief discussed research showing how child molesters do not “age out” of their offenses at the same rate as other sexual offenders, thus presenting a continuing risk at later ages. Third, the brief reviewed the research on the long-term effects of child sexual abuse. The brief emphasized recent research documenting harms controlling for family dysfunction and noted that the cases at issue–cases involving “substantial sexual contact” that are reported to the police–are unlikely to be benign.

Tom Lyon helped coauthor the brief, working with Nathalie Gilfoyle, counsel for the APA, and Kathleen Behan, Christopher Man, and Anthony Franze of the law firm Arnold and Porter. Several other child maltreatment professionals also provided assistance, including Kathleen Kendall-Tackett, Mark Chaffin, Jodi Quas, Angela Crossman, and Sharon Portwood. A copy of the brief can be found at: www.psyclaw.org/stogner-v-california.pdf. Other information about the case (including briefs and the oral argument) can be found at:www.supreme.lp.findlaw.com/supreme_court/docket/2002/march.html#01-1757.

APSAC Forensic Interview Clinics a Success

Two APSAC-sponsored forensic interview clinics were conducted in the month of May. The first was held in Ann Arbor, Michigan, on May 6 to 10 in conjunction with the Family Assessment Clinic and the University of Michigan School of Social Work. Among the approximately 30 participants were faculty members Kathleen Faller, PhD, ACSW; Dennison Reed, PhD; Detective Rick Cage; Kee MacFarlane, ACSW; Judge Harry Elias; Mary Ortega, MSW; and Steve Wilson, JD. Volunteers for the clinic in attendance included several University of Michigan social work students. Follow-up evaluations indicated that the clinic was very well received.

The second clinic was requested and contracted by the Children's Crisis Center, Inc. in Florida. The contract was to train 46 child protection team members on the correct way to conduct an interview with children alleged to have been abused or neglected. Clinic faculty included Kee MacFarlane, ACSW; Deborah Davies, LCSW, Melissa Lane, ACSW; Lisa Fontes, PhD; Tom Lockridge, JD, and Judge Harry Elias. The clinic was a definite success, and we hope to continue the collaboration in the future.

The final 2003 APSAC- sponsored clinic was held in Hyannis, Massachusetts, on June 22 to 26.

APSAC's 11th Annual Colloquium Coming Soon

Registrations are coming in daily by fax, snailmail, and the web site for the 11th Annual APSAC Colloquium to be held in Orlando, Florida, on July 23 to 26, 2003. The Colloquium site is the Hyatt Orlando, located at 6375 Irlo Bronson Memorial Highway in Kissimmee, Florida. The hotel is in a prime location, just 1.5 miles from the main gates of Walt Disney World© Resort and a short drive to Sea World©, Universal Orlando, Busch Gardens, Kennedy Space Center and other attractions. People are finalizing their plans, so register for the Colloquium and make your hotel reservations as soon as possible! The number of the hotel is 800-233-1234.

If you would like your family to join you in Orlando, the Hyatt has extended the APSAC rate of $99 per night for 5 days before and after the Colloquium. If you have not received a Colloquium brochure, please contact Tricia Williams, JD at 405-271-8202. You may register for the Colloquium at: www.APSAC.org.

The 4th Annual Silent Auction will be held in conjunction with the Colloquium. All items up for sale will be on display beginning on Wednesday, July 23. The final bids will be taken during the opening reception on Thursday, July 24. Items will range from great speakers to travel getaways and art objects, so get your checkbooks ready! All proceeds go to fund additional APSAC professional education opportunities. If you would like to donate an item to the auction, contact Bente' J. Hess at Southwest MS CAC, PO Box 7283, McComb, Mississippi 39649 (call 601-684-4009, or fax 601-684-4039, or e-mail bente@telepak.net). Donations are needed by July 5.

The Hyatt Orlando, Site of the 2003 APSAC Colloquium

APSAC to Host the First Annual Trauma Treatment Clinic

APSAC is pleased to sponsor the 1st Annual Trauma Treatment Clinic to be held in Maui, Hawaii, on December 1 to 5, 2003. The faculty will include Jon Conte, PhD; John Briere, PhD; William Friedrich, PhD; Veronica Abney, LCSW; Lucy Berliner, MSW; and Cynthia Swenson, PhD. The clinic will be held at the Westin Maui, located on Kaanapali Beach. Brochures were mailed out the last week of May. If you wish to receive a brochure or have any additional questions about this advanced training, please contact Tricia Williams at 405-271-8202.

APSAC Institutes Held in Conjunction With Prevent Child Abuse Georgia Symposium

APSAC was pleased to sponsor three all-day institutes to be held in conjunction with the Prevent Child Abuse Georgia 19th Annual Symposium. Faculty members for the institutes were Kathleen Faller, PhD, ACSW; Ronald Zuskin, LCSW-C; and Jane Silovsky, PhD. The institutes were held on Wednesday, June 25 in Atlanta, Georgia. For additional information, please contact Jeanette Meyer at 404-870-6588.

APSAC Extends a Warm Welcome to New Accountant

As announced in the last *Advisor*, accounting services for APSAC have moved to Oklahoma from Chicago. APSAC would like to extend a warm welcome to our new accountant, Judy Forgey. Judy, an independent contractor, lives near Oklahoma City in Wellston, Oklahoma, with her husband and two children. She has made a major effort to understand all the intricacies of APSAC's many projects and is doing an excellent job. Welcome, Judy!

cont'd on page 16

APSAC Hosts National Think Tank
(As reported by Judy Havlicek, MSW)

In conjunction with 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; APSAC hosted a national think tank drawn together to consider whether it is possible to develop a procedure to evaluate videotaped interviews of children. The Think Tank is part of a larger project with the State of Kentucky, which involved the development of a written interviewer training curriculum and allowed APSAC to conduct two Forensic Interview Clinics in Kentucky in November 2003.

The Think Tank was held east of Seattle at the Salish Lodge on January 25 to 27, 2003. Participants in the Think Tank were APSAC's President Jon Conte, Carol Jordon from the Kentucky Governor's Office, and national experts Gail Goodman, Kathleen Faller, Lori Holmes, Laura Merchant, Kee Macfarlane, Lucy Berliner, Kim Poyer, Patti Toth, Ray Broderick, Rick Cage, Deb Davis, Anne Graffam Walker, Julie Kenniston, Nancy Lamb David Marshall, Erna Olafson, Dennison Reed, James Clark, and Mary Meineg

The agenda was broken down into three parts. On the first day, Dr. Gail Goodman summarized the research on children as witnesses. Following this presentation, Dr. Kathleen Faller presented an overview of the process, procedures, and issues of child interviewing. On the following day, participants presented their personal perspectives on interviewing children and evaluating interviews. The participants were next separated into small groups to process ways to evaluate child interviews. Following the small group process, the entire group reconvened and presented the information that was generated.

The project with Kentucky is part of APSAC's ongoing commitment to professional education and supporting forensic interviewing throughout the United States. For a more complete report of the Think Tank, visit the APSAC web site at: www.APSAC.org.

In summary, there appeared to be two schools of thought about child interviews: 1) they can be standardized and 2) they cannot be standardized. However, think tank participants generally agreed that there are ways to evaluate interventions, but disagreed on how to do this best. All participants agreed that APSAC should continue to be involved in the process of determining best practice and standards in child interviewing. The Salish Lodge Think Tank was a first step in addressing the issues facing the field of forensic interviewing, and it will be through continued similar discussion groups that concensus can be reached to determine best practice and standards.

ABOUT OUR CONTRIBUTORS

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Opinions expressed in the Letters to the Editor section of the APSAC Advisor *are those of the authors of the letters and do not reflect APSAC's official position or that of the Editor-in-Chief of the* APSAC Advisor *unless otherwise stated.*

Evergreen Psychotherapy Center, PLLC Attachment Treatment and Training Institute, PLLC

Dear Editor:
In your recent issues of the *APSAC Advisor* (Vol. 14, No.3), Matthew Speltz describes and critiques "Corrective Attachment Therapy." His use of the term is inappropriate, inaccurate, and libelous. Corrective Attachment Therapy™ is a theory and method of working clinically with children and families, described in our book *Attachment, Trauma and Healing* (Child Welfare League of America Press, 1998). Dr. Speltz used the term Corrective Attachment Therapy to describe concepts and techniques that we do not believe in nor practice. We do agree with and advocate for safe, respectful, and empirically-supported treatment, as emphasized in your newsletter. Unfortunately, Dr. Speltz used out term (Corrective Attachment Therapy™) to describe other people's work.

Dr. Speltz also provided misinformation regarding what he refers to as the "Evergreen Attachment Center model." There are several programs in Evergreen with varying philosophies and approaches. Corrective Attachment Therapy™ is an integration of family systems, cognitive-behavioral, attachment theory, and trauma-based models. We are quite displeased to see our approach associated with the unprofessional and dangerous interventions described in Speltz's article.

We are requesting that you clarify this misleading and inaccurate information for your readers in the next issue of your newsletter. As mental health practitioners and trainers for over 30 years, we want the opportunity to inform your readers about the truth regarding Corrective attachment Therapy™, rather than distortions and negative associations. I (Dr. Terry Levy) feel particularly offended as a member of APSAC for over 10 years, and by the fact that I have presented Corrective Attachment Therapy™ at a prior APSAC conference, with positive evaluations and feedback.

Sincerely,
Terry M. Levy, PhD, BCFE
Michael Orlans, MA, DAPA
www.attachmentexperts.com

Attachment Center Northwest Kirkland, Washington

To the Editor:
Having read the articles in your Summer 2002 Special Edition on Holding Therapy, we are compelled to write to correct misinformation about Attachment Center Northwest (ACNW, referred to as The Center in your article) and the work that we do. We are independent therapists at ACNW specializing in the treatment of children and youth with serious attachment difficulties, histories of early trauma and abandonment, and their families. A small portion of our practice (less than 15%) includes "holding therapy." We fully agree with and support many of the points in this issue. For example, we agree with Dr. Hanson's emphasis on the importance of a thorough diagnosis including co-morbid conditions. We would add to this assessment of the ability of parents/caregivers to form normal, close connections and to act reciprocally in these relationships. However, we must emphatically disagree with some of the characterizations of ACNW and of holding therapy as it is practiced by us and other attachment therapists who are registered with ATTACh (Association for Treatment and Training in the Attachment of Children). This organization has developed strict standards for practice and safety in the use of holding therapy to which we fully subscribe.

There are three major areas of difference, which we will describe briefly here. We expect an opportunity to elaborate on this information in a future issue of the *Advisor*. The protocol Dr. Speltz referred to in his article is quite outdated, representing the status of "holding therapy" nearly two decades ago, when "holding therapy" was called "rage reduction therapy." It does not represent our current thinking about holding therapy, nor does it describe our current practices. Our current protocol is readily available.

We do not use the coercive techniques described by Dr. Speltz in his article. The holding itself, rather than being for the purpose of restraint (or coercion) is a nurturing hold, giving the child a message of acceptance and safety. We are, and always have been, very careful in contracting with the child and family in preparation for this intrusive intervention, and during the treatment process itself. Our purpose in this is to engage the child and family in a cooperative process rather than attempt to coerce the child into ineffective, superficial compliance. In fact, it seems to us that for most of the children we work with intensively, there are no coercive techniques that would come close to the trauma of abuse and neglect they have already survived. It continues to be our experience that the motivation to change for both the child and parents is a necessary prerequisite for success in this and other therapeutic interventions. This view is supported by the MCO studies from the University of Chicago.

A second major area of clarification is our attitude toward the birthparents, and what we expect the child's attitude to be. We do encourage the child to recognize, experience, and accept the many, often conflicting, feelings toward the birthparents. However, our goal for the child is to also accept the limitations of the birthparents and to recognize and appreciate the gift (e.g., the gift of life) given to the child by the birthparents. If we were to discourage the child's range of feelings toward the birthparents (the confusing love and hate many children have reported to us), we would be demonstrating a lack of empathy and acceptance, thereby blocking a feeling connection with the child. If, for example, we were only able to repeat the once-traditional "happy"story of the birthparents' relinquishment, we would be denying the child's own affective experience of the trauma of early abuse, neglect, and loss. We fully agree with Dr. Speltz that "derogation of one's birthparent requires derogation of one's self." However, the process of "saying goodbye" in a therapy session is very effective in providing some closure and in promoting the grieving process of that major loss. When a child is emotionally ready, we often use psychodrama, or have successfully enlisted the support and assistance of a birthparent in the goodbye process.

cont'd on page 18

Finally, and most disturbing, the association of holding therapy as practiced at ACNW (and by others successfully registered with ATTACh) with the therapeutic interventions in which children have died is markedly fallacious. Guilt by association is unfair, unhelpful, and more closely related to prejudice and libel than scholarly thoughtfulness. The children we work with are not, and have not been, injured.

We would expect a journal with the integrity of yours to have verified the information it presents rather than rely on "opinions." Dr. Speltz and others with differing opinions have neither spoken with us nor observed our work.

We appreciate your openness in addressing these issues and this chance to clarify the misinformation in this article. We look forward to the opportunity for several of our colleagues to present arguments on the other side of these issues.

Sincerely,

Tom A. Gill, LCSW
Beverly Cuevas, LCSW
Rebecca Perbix Mallos, LCSW
Attachment Center Northwest Kirkland, WA 98033
www.attachmentcenternw.com

William N. Friedrich, PhD, ABPP

Dear Editor,
I am responding primarily to the letter from Levy and Orlans and secondarily to the letter of Gill, Cuevas, and Mallos. Both letters raised issues with the recent *APSAC Advisor* articles on attachment therapies. My comments will be more generic than specific.

First, the connections between Levy and Orlans and the holding therapy that is closest to "rage reduction therapy" are obvious when you read their book, *Attachment, Trauma, and Healing* (1998). Connell Watkins is acknowledged on p. ix "for her unwavering commitment to children." I would like to remind readers that in 2000, Ms. Watkins was convicted in the murder of Candace Newmaker, whose death was captured on videotape while she was suffocated during a "holding therapy" session. It was Candace's death that motivated APSAC members to call for a special issue of the Advisor on the topic of child abuse that occurs under the guise of "therapy." Further evidence of their association with the pioneers of this method is reflected in their utilization of Foster Cline's attachment model. Foster Cline was banned from the practice of medicine in Colorado in the early 1990s after grossly negligent medical practice (Lowe & Crowder, 2000).

Second, the "Holding, Nurturing Process" (HNP) that comprises a central component of Levy and Orlans's approach is an "in arms" approach that supposedly "simulates the original attachment relationship" (p. 115) and leads to the healing of the effects of childhood deprivations. While no physical restraint is suggested in their model, it would be very important to hear more from them on how they made the decision to drop coercive restraint from their approach. On p. 272, Levy and Orlans write that they found the coercive and confrontational approach practiced by Foster Cline and staff at Evergreen Consultants to be "therapeutically effective," but decided that it would never be "widely understood or accepted by the professional community." This sounds more like a marketing decision than a clinical decision.

In addition, the concept of regression that is central to HNP is similar to the Dolman/Delcato Method, in which children are made to crawl and move as they did at each stage of early development, in an attempt to learn missing skills. No scientific studies support the effectiveness of this method, which has been in existence for over 50 years. However, parents continue to use this nonstandard approach for treatment of such phenomena as autism and cerebral palsy. The idea that a child is psychologically "fixated" at an earlier stage of development is a very simplistic conceptualization and contrary to data from developmental psychopathology that indicate children continue to grow and develop despite adverse circumstances at various stages of their life.

Third, parental psychopathology is not uncommon in situations where adoptions fail. Levy and Orlans (1998) outline a comprehensive assessment of parents, but they do not inform the reader how to identify and appropriately confront those parents whose pathology interferes with the formation of secure attachment. Their lack of guidance in this area reflects Levy and Orlans's (1998) conceptualization of attachment problems residing in the child, and not in the interaction. This then validates their child-centered approach to treatment.

Finally, research on children reared in orphanages continues to inform us of the vagaries of attachment processes in children raised under adverse circumstances (O'Connor, et al., 2003). There is a "dose response" that has been noted and the longer the children are exposed to deprivation and abuse, the less likely they are to form secure attachments and the more likely their attachment includes atypical features. It remains to be seen if any of these children can improve over time when receiving "generally responsive care in the adoptive home" (p. 38). It may be that some children never "attach" in a very adaptive fashion.

In addition, I encourage readers to examine a forthcoming book (Mercer, Sarner, & Rosa, in press). It provides a fascinating expose of the pioneers and current practitioners of coercive attachment therapy, including Levy and Orlans. It also describes how traditional therapy would have worked with Candace Newmaker and discusses the important role of parental psychopathology in failed adoptions.

Sincerely,

William N. Friedrich, PhD, ABPP
Professor & Consultant, Mayo Clinic and Mayo Medical School

References

Levy, T. M., & Orlans, M. (1998). *Attachment, trauma, and healing.* Washington, DC: CWLA Press.

Lowe, P., & Crowder, C. (2000, October 29). Therapist has strong defenders, foes. *Rocky Mountain News.*

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O'Connor, T. G., Marvin, R. S., Rutter, M., Olrick, J. T., Britner, P. A. (2003). Child-parent attachment following early institutional deprivation. *Development and Psychopathology, 15*, 19-38.

Matthew L. Speltz, PhD

To the Editor:

I would like to respond to the letters by Levy and Orlans, and Gill, Cuevas, and Mallos about my critique of coercive attachment therapies, which appeared in the Summer 2002 *APSAC Advisor*.

Regarding Levy and Orlans's note about the proprietary nature of the term "corrective attachment therapy": I was unaware of the copyrighted use of this term, which is used by other therapists both generically and in reference to their own therapeutic work. But more to the point, I was clearly *not* referring specifically to Corrective Attachment Therapy™ in my critique. I'll leave it to the *Advisor's* readers to assess the degree to which Levy and Orlans's techniques are similar to those that I described (e.g., see Levy, 2000).

Gill et al. from Attachment Center Northwest (ACNW) contend that my critique covered outdated methods, techniques used nearly two decades ago. This is blatantly incorrect. In my six-paragraph description of the ACNW treatment approach, five paragraphs focused on techniques or specific statements taken from the 2001 ACNW document, entitled "Therapeutic Protocol for Intensive Attachment Therapy," to which Gill et al. refer in their letter.

Gill et al. state that their techniques are not coercive because they seek the child's cooperation and motivation, and that the holding they do is "nurturing." However, their 2001 treatment protocol describes an approach in which holding is used as a vehicle for inducing "regression" by creating a "high state of emotional arousal," in which the child is said to "revisit infantile rage," including "anger, helplessness, fear, hopelessness, and sadness" (page 9, ACNW Therapeutic Protocol, 2001). Office detainment and out-of-home placement are among the consequences used when the child "shuts down" (page 12, ACNW Therapeutic Protocol, 2001). Although Gill et al. use positive language to describe these methods (e.g., "nurturance," "acceptance," "healthy attachment"), these words. cannot conceal the fact that they motivate by inducing emotional vulnerability (destabilization) and by threatening the child with detainment and separation from caregivers if compliance is not obtained (punishment). It worries me that Gill et al. seem not to view these procedures as coercive. Nor do I find comfort in their statement that "…for most of the children we work with intensively, there are no coercive techniques that would come close to the trauma of abuse and neglect they have already survived." This perspective strikes me as a potentially dangerous rationale for the use of coercive and forceful action in therapy with maltreated children: "It must be OK; what we're doing doesn't come close to what they've experienced before."

I do not doubt the good intentions of Gill et al. in trying to help children who often seem beyond help. However, the burden lies upon them to demonstrate empirically that holding, regression, emotional destabilization, and other similar techniques are justified by positive outcomes not obtainable by conventional treatments with proven effectiveness. Until such evidence is available, this form of treatment should be avoided. This position is consistent with policy statements and recommendations by the American Academy of Child and Adolescent Psychiatry, the American Psychiatric Association, and the recently published *Child Physical and Sexual Abuse: Guidelines for Treatment* (Saunders, Berliner, & Hanson, 2003).

Sincerely,
Matthew L. Speltz, PhD
Professor of Psychiatry & Behavioral Sciences
University of Washington School of Medicine Seattle

References

Levy, T. M. (Ed.). (2000). *Handbook of Attachment Interventions*. San Diego, CA: Academic.

Saunders, B. E., Berliner, L., & Hanson, R. F. (Eds.). (2003). *Child Physical and Sexual Abuse: Guidelines for Treatment (Final Report: January 15, 2003*). Charleston, SC: National Crime Victims Research and Treatment Center.

New Jersey Association for Infant Mental Health, An Affiliate of the World Association for Infant Mental Health

Dear Editor,

The two recent issues of the *Advisor* on treatment of Reactive Attachment Disorder included discussion of physical restraint techniques used in attempted treatment of childhood emotional disturbances. A variety of terms are used to describe their techniques by practitioners of physical restraint. This is a confusing situation, made more so by the practitioners' recent adoption of the term "therapeutic holding," an expression that had been used by the American Academy of Pediatrics to describe restraint and calming of an out-of-control child.

Because it appears that the argument about physical restraint is by no means over, I would like to propose two value-free terms to describe holding of children for short-term calming or with long-term therapeutic intention.

Child Restraint Type I: Restraint that begins after a child is behaviorally out of control, as evidenced by violent, contextually-inappropriate movements, attempts to run away, or movement toward potentially dangerous objects or places. The child is still out of control (as defined above) at the time when restraint is initiated.

Child Restraint Type II: Restraint such that the child is calm and adequately self-controlled (compared with the out-of-contol condition defined above) when restraint is initiated; Child Restraint Type I has not been used in the previous two hours.

The proposed definitions may clarify the discussion by avoiding consideration of the restraining adults' intent. Child Restraint Type II, of course, would include all of the various coercive restraint therapies directed at treatment of Reactive Attachment Disorder.

Yours sincerely,
Jean Mercer, PhD
President, New Jersey Association for Infant Mental Health

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Email: john-madden@ouhsc.edu or visit our web site at www.apsac.org.

CONFERENCE CALENDAR

2003 CONFERENCES

July 7-11, 2003
Investigation and Prosecution of Child Fatalities and Physical Abuse (APRI), Alexandria, VA
call 703-549-9222 or
fax 703-836-3195

July 20-23, 2003
17th Annual Conference on Treatment Foster Care, Universal City, CA
call 800-414-3382, ext 113 or fax 201-862-0331 or e-mail: ffta@ffta.org, or visit www.ffta.org

July 30-August 1, 2003
The 4th National Kinship Care Conference, Philadelphia, PA
call 202-638-2952 or fax 202-638-4004 or visit www.cwla.org

August 16-19, 2003
NACC 26th National Children's Law Conference, New Orleans, LA
call 888-828-NACC
or visit www.naccchildlaw.org/training/conference.html

September 16-20, 2003
8th International Conference on Family Violence, San Diego, CA
call 858-623-2777 ext. 416
or fax 858-646-0761
or e-mail: fvconf@alliant.edu

September 11-12, 2003
8th Annual Northern New England Conference on Child Maltreatment, Portland, ME
call 207-871-1204 or visit www.spurwinkchildabuseprogram.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

July 9-11, 2003
NetSafe II: Society, Safety, and the Internet Conference, Aukland, New Zealand
visit www.netsafe.orgnz/conferences/conferences_default.asp

July 20-23, 2003
National Council of Juvenile and Family Court Judges 66th Annual Conference, San Antonio, TX
call 775-784-1744 or fax 775-784-6628 or e-mail: admin@ncjfcj.unr.edu or visit www.ncjfcj.unr.edu

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call 858-966-4972
or e-mail: lkwilson@chsd.org

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15th Annual Crimes Against Children Conference, Dallas, TX
call 214-818-2638 or
e-mail: Cynthia@dcac.org or visit www.dcac.org

September 17-19, 2003
11th Annual Oklahoma Conference on Child Abuse and Neglect and Healthy Families Oklahoma, Norman, OK
call 405-271-8202
or fax 405-271-2931 eor
e-mail: Jessica-shatley@ouhsc.edu

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

July 13-16, 2003
8th International Family Violence Research Conference, Portsmouth, NH
call 603-862-0767 or
e-mail: sarahg@cisunix.unh.edu or visit www.unh.edu/frl

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

August 7-9, 2003
North American Council on Adoptable Children's 29th Annual Conference, Vancouver, BC, Canada
call 651-644-3036 or
or e-mail: info@nacac.org or visit www.nacac.org

August 21-23, 2003
Survival 2003 Worldwide Road to Recovery Conference, Hollywood, FL
call 954-981-5616 or
e-mail:angelsonearth@iwon.com or visit www.survival2003.tripod.com

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

October 20-23, 2003
19th Midwest Conference on Child Sexual Abuse, Middleton, WI
call 800-442-7101 or e-mail: midwest@dcs.wisc.edu, or visit www.dcs.wisc.edu/pda/hhi/midwest

December 1-5, 2003
APSAC Child Abuse/Child Trauma Treatment Conference, Maui, HI
call 405-271-8202 or fax 405-271-2931
or e-mail: Tricia-Williams@ouhsc.edu

WASHINGTON UPDATE

Thomas Birch, JD, PhD

CAPTA Bills Move to Final Stages in Congress

The long-awaited final passage of the Child Abuse Prevention and Treatment Act (CAPTA) is in sight. On May 22, members of the House-Senate conference committee plan to work out remaining differences between the two versions of the Keeping Children and Families Safe Act of 2003 (H.R.14 and S.342). Both bills passed House and Senate floor votes in March. Since then, staffs of the conference committee members have met to resolve the disagreements.

The two measures are not far apart, reauthorizing CAPTA appropriations through 2008 at levels slightly above the current authorized funding and well above appropriations in 2003: CAPTA basic state grants and discretionary grants would have a combined authorization at $120 million (FY03 appropriations equal $56 million); CAPTA Title II community-based grants would be authorized at $80 million (FY03 appropriation equals $33 million.)

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.

HHS Proposes Date Change in Child Abuse Reports

The HHS Administration for Children and Families is proposing to change the reporting period for submitting National Child Abuse and Neglect Data System (NCANDS) information from calendar year reporting to a federal fiscal year basis starting with FY 2003. The move is intended to improve the ability to integrate the data from NCANDS with the Adoption and Foster Care Analysis and Reporting system (AFCARS) data.

The voluntary national child abuse and neglect data collection and analysis program, begun in 1991, has annually collected reporting information from child protective services agencies in all fifty states, the District of Columbia, and the territories.

CDC Plans Project to Measure Interpersonal Violence

The federal Centers for Disease Control and Prevention (CDC) and National Center for Injury Prevention and Control (NCIPC) propose to test four different scales used to measure intimate partner violence. The project is intended to determine the appropriateness of each of the scales for use with individuals of different racial and ethnic backgrounds, with the goal of improving the quality of data and knowledge about violence against women.

CDC intends to contract with an agency to conduct the survey by telephone interviews administered to a random sample of women ages 18 to 50, from five racial and ethnic backgrounds: African American, American Indian, Asian, Caucasian, and Hispanic.

Senate Approves CARE Act/Title XX Increase

On April 9, 2003, the U.S. Senate passed by a vote of 95 to 5 the CARE Act, S.476, featuring federal tax code changes aimed at increasing charitable giving. The CARE Act originally included provisions that would have expanded federal funding to religious groups, which critics argued would lead to federally funded proselytizing and job discrimination. Before taking the legislation to the floor, the Senate leadership dropped those provisions and the opposition to the bill fell away.

The CARE Act allows a deduction up to $250 for charitable contributions by taxpayers who do not itemize their deductions. The IRA rollover, allowing taxpayers to donate their individual retirement accounts directly to charities without paying a tax penalty, is also included in the bill passed by the Senate. The measure also raises the limit on how much corporations may contribute to charity.

In the good news for hard-pressed social service agencies, the Senate's CARE Act would increase the Title XX Social Services Block Grant by $1.4 billion over the next 2 years. The block grant funding was cut severely during the Clinton administration, with further cuts taking the funding from a high of $2.7 billion to the current spend-

ing level of $1.7 billion. The White House is reported to oppose the additional Title XX spending in the Senate bill.

If the measure passes in the Senate, the bill goes to the House, where it is likely to be approved. However, the House version of the bill—the Charitable Giving Act of 2003—is not expected to include the Title XX increased funding provision. Child welfare and human services advocates are looking to the Senate to prevail in negotiations over the shape of the final charitable giving bill once it goes to a House-Senate conference committee.

In addition, congressional Democrats are hoping for assurances that the controversial religious provisions, which held up enactment of the charitable deduction measures for over 2 years, will not be restored in negotiations with the House on a final charitable package. Two years ago, the House passed a bill allowing religious groups to obtain federal funds while permitting groups to ignore state and local anti-discrimination laws in hiring and other practices.

Sen. Rick Santorum (R-PA) and other supporters of the expansion of federal funding to religious organizations have indicated an interest in looking for other vehicles for the faith-based initiative, including legislation to reauthorize the TANF federal welfare program.

HHS Reports Positive Results on Prevention Models

On April 1, 2003, at the 14th National Child Abuse and Neglect Conference in St. Louis, HHS Assistant Secretary for Children and Families Wade Horn released a new report, *Emerging Practices in the Prevention of Child Abuse and Neglect*. The publication prepared by Caliber Associates for the HHS Office of Child Abuse and Neglect documents a 2-year project to identify programs and initiatives for the prevention of child maltreatment.

The report, which features a literature review and a peer review of selected prevention programs, is part of a new Child Abuse Prevention Initiative launched by the HHS Children's Bureau, Office on Child Abuse and Neglect (OCAN), to promote greater visibility for child abuse prevention activities in 2003 to 2004, with a primary focus on sharing information on prevention programs that demonstrate positive outcomes for children and families. Program models include parenting education, family support, home visitation, crisis nursery, respite care, comprehensive service assessment, family education, parent leadership training, public awareness, and public education.

The report observes: "A common thread among most…is an attempt to change both parental knowledge and practice by building relationships through some form of interaction between a family and a teacher, home visitor, or counselor. Research suggests that the issue of 'dosage,' or the intensity and duration of involvement with families, is a crucial one that drives the potential for change and improvements in functioning."

Programs, identified through a nomination process and reviewed by an advisory group of practitioners and researchers in the field of child abuse prevention, were categorized as 1) Effective Programs, which have shown positive prevention outcomes, through rigorous evaluation, or an evaluation using a quasi- or nonexperimental design; and 2) Innovative Programs, showcasing a new approach to prevention.

The report includes detailed descriptions of each program and contact information. See the complete report at: www.calib.com/nccanch/prevention/emerging/report.pdf, or visit the Prevention Initiative web site at the Administration for Children and Families website: www.calib.com/nccanch/prevention/.

GAO Report: Child Welfare Staff Retention and Recruitment

The U.S. General Accounting Office (GAO) has issued a report recommending that HHS take actions to help child welfare agencies address staff recruitment and retention. Caseworkers interviewed by GAO cited low salaries as the principal cause of failure to attract and retain child welfare workers.

Other barriers cited were high caseloads; administrative burdens that could take from 50% to 80% of a worker's time; lack of supervision; and insufficient time for training. The report explains that large caseloads and worker turnover delay the timeliness of investigations and limit the frequency of visits with children and their families.

GAO recommends that HHS 1) use its annual discretionary grant program to promote targeted research on the effectiveness of perceived promising practices; and/or 2) issue guidance or provide technical assistance to encourage states to use their program improvement plans to address the caseload, training, and staffing issues cited in the reviews HHS conducts.

The complete report, *HHS Could Play a Greater Role in Helping Child Welfare Agencies Recruit and Retain Staff*, is available at: www.i-LawPublishing.net/news.htm.

Journal Highlights

Ernestine C. Briggs, PhD

The purpose of Journal Highlights is to inform 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, Ph.D., 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

Ten Years of Research on CSA Reviewed

This 10-year review provides information on prevalence, risk factors, outcomes, treatment, and prevention of child sexual abuse (CSA) and examines psychopathology attributable to CSA. Results indicate that CSA constitutes approximately 10% of officially substantiated child maltreatment cases, numbering approximately 88,000 in 2000. Adjusted prevalence rates are 16.8% and 7.9% for adult women and men, respectively. Risk factors include gender, age, disabilities, and parental dysfunction. A range of symptoms and disorders has been associated with CSA, but depression in adults and sexualized behaviors in children are the best-documented outcomes. To date, cognitive-behavioral therapy (CBT) of the child and a nonoffending parent is the most effective treatment. Prevention efforts have focused on child education to increase awareness and home visitation to decrease risk factors. It is concluded that CSA is a significant risk factor for psychopathology, especially depression and substance abuse. Research indicates that CBT is effective for some symptoms, but longitudinal follow-up and large-scale "effectiveness" studies are needed.

Putnam, F. W. (2003). Ten-year research update review: Child sexual abuse. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(3), 269-278.

Is Complex PTSD a More Accurate Diagnosis for Women With a History of CSA?

This study examined whether women with a history of early-onset sexual abuse (N=38) or those with late-onset sexual abuse (N=27) were more likely to meet diagnostic criteria for both borderline personality disorder and complex posttraumatic stress disorder (PTSD). The diagnoses of both borderline personality disorder and complex PTSD were significantly higher in women reporting early-onset abuse than in those with late-onset abuse. The trauma variables sexual abuse and paternal incest were significant predictors of both diagnoses. The authors conclude that in contrast to those with comorbid diagnoses, some women with a history of childhood sexual abuse may be extricated from the diagnosis of borderline personality disorder and subsumed under that of complex PTSD.

McLean, L. M., & Gallop, R. (2003). Implications of childhood sexual abuse for adult borderline personality disorder and complex posttraumatic stress disorder. *American Journal of Psychiatry, 160*(2), 369-371.

Can Family Factors Differentiate Sexually Abused and Nonabused Adolescents?

This study examined whether family factors would differentiate sexually abused and nonabused adolescent psychiatric inpatients. Psychiatric inpatients (N= 57; 11-17 years old) who either had experienced sexual abuse or had no history of sexual victimization completed a diagnostic interview and were assessed on a variety of family indices. Results indicate that after controlling for level of depression, sexually abused adolescents could be differentiated from their nonabused counterparts on the basis of family variables. Sexually abused adolescents reported their families as more authoritarian and more enmeshed. They also perceived more negative messages from their nonoffending father figures about the world. Also, exploratory gender analyses reveal that sexually abused females reported greater levels of depression than sexually abused males.

Reinemann, D. H. S., Stark, K. D., & Swearer, S. M. (2003). Family factors that differentiate sexually abused and nonabused adolescent psychiatric inpatients. *Journal of Interpersonal Violence, 18*(5), 471-489.

Hippocampal Structure and Function Differences Found in Women With CSA and PTSD

The purpose of this study was to measure both hippocampal structure and function in women with and without early childhood sexual abuse and the diagnosis of posttraumatic stress disorder (PTSD). Thirty-three women participated in this study, including women with early childhood sexual abuse and PTSD (N=10), women with abuse without PTSD (N=12), and women without abuse or PTSD (N=11). Hippocampal volume was measured with magnetic resonance imaging in all subjects, and hippocampal function during the performance of hippocampal-based verbal declarative memory tasks was measured by using positron emission tomography in abused women with and without PTSD. A failure of hippocampal activation and 16% smaller volume of the hippocampus were seen in women with abuse and PTSD compared with women with abuse without PTSD. Women with abuse and PTSD had a 19% smaller hippocampal volume relative to women without abuse or PTSD. These results are consistent with deficits in hippocampal function and structure in abuse-related PTSD.

Bremner, J. D., Vythilingam, M., Vermetten, E., Southwick, S. M., McGlashan, T., Nazeer, A., Khan, S., Vaccarino, L. V., Soufer, R., Garg, P. K., Ng, C. K., Staib, L. H., Duncan, J. S., & Charney, D. S. (2003). MRI and PET study of deficits in hippocampal structure and function in women with childhood sexual abuse and post-traumatic stress disorder. *American Journal of Psychiatry, 160*(5), 924-932.