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IN THIS ISSUE

Issues in Risk Assessment in Child Protective Services

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In recent years, child welfare organizations throughout North America have expended millions of dollars to develop, implement, and institutionalize formal risk assessment systems. This article presents an abridged version of the North American Resource Center for Child Welfare white paper about risk assessment, available in its entirety at www.narccw.com. The white paper reviews current literature about risk assessment and identifies key issues in risk assessment theory, technology, and implementation. It concludes that, considering the limitations of even the most reliable and valid risk assessment technologies, agencies should not rely solely on risk assessment to justify their casework and child placement decisions.

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The Child Forensic Interview Training Institute of the Childhood Trust, Cincinnati Children's Hospital

Erna Olafson, PhD, PsyD
Julie Kenniston, LSW

Since 1998, Cincinnati's Childhood Trust has offered a 5-day intensive child forensic interview training institute to multidisciplinary teams and individuals from more than 20 states, Canada, and Belize. Participants receive training in a structured protocol, flexible guidelines, the Cognitive Interview, the Touch Survey, and interview aids such as dolls and drawings, and trainees receive guidance about how to choose among these interview approaches for a given child. In affiliation with the Ohio Network of Child Advocacy Centers, the Childhood Trust is now training and mentoring trainers to teach the fundamentals of child forensic interviewing throughout Ohio. Funded by a grant from the National Children's Alliance (NCA), the Childhood Trust is undertaking research on training outcomes, using the peer review forms herein, to systematically evaluate randomly selected videotapes of interviews by Child Forensic Interview Training Institute graduates from various disciplines.

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Welcome to Hollywood and Colloquium 2004–Part 1

C. Terry Hendrix, MA

This first pat of a two-part article acquaints APSAC members and readers with the highlights of things to do and see in the Hollywood, CA area surrounding the site of the 2004 APSAC Colloquium. The illustrations and text describe the history, features, availability and cost of well-known attractions in and around the Renaissance Hollywood Hotel. Plan to attend this coming August so you can say "Hello to Hollywood."

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Issues in Risk Assessment in Child Protective Services

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Introduction

In recent years, the child welfare field has faced mounting moral and political pressures to improve its effectiveness and accountability and to demonstrate its public value. In response, child welfare organizations throughout North America have expended millions of dollars to develop, implement, and institutionalize formal risk assessment systems. However, the literature continues to raise provocative and disturbing questions about all aspects of risk assessment technology and implementation. The question remains whether the results have been worth the investment.

In many jurisdictions, estimates of future risk are still being made largely on the basis of personal opinion and judgment. We continue to rely on tools that lack reliability and validity while believing that these tools standardize and greatly improve decision making. We create idiosyncratic adaptations of existing models for our own use, and we support large-scale and costly implementation initiatives without sufficiently managing the overall impact on the service system. We conduct studies to validate models that are fundamentally flawed at the outset. We mandate the use of protocols that make little sense to the work force and are often abandoned in frustration by the staff who must use them. Striving for improved accountability, we "hard code" entire risk assessment models and instruments into child welfare information systems, further cementing our reliance on this technology and creating potentially insurmountable challenges when changes are needed. And, because large-scale change has historically been so difficult for many organizations, it may ultimately be easier to support ineffective, even potentially harmful, technologies rather than change them, both because of the financial investment already made and because an overburdened work force cannot sustain another large-scale change.

Unfortunately, perhaps due to the many other seemingly intractable problems facing the child welfare field, we appear to have a collective vulnerability to the promises of untested and unproven risk assessment models and technology. Further, although individual researchers and practice jurisdictions have worked to refine and improve risk assessment technologies, the child welfare profession has yet to reach consensus on a plan of action to incorporate the strongest and most promising of these into practice, or to confront the many remaining issues and challenges.

In 2002, the Center for Child Welfare Policy of the North American Resource Center for Child Welfare (NARCCW) undertook an extensive risk assessment initiative, which consisted of the following: 1) a review and analysis of the literature on risk assessment in child welfare; 2) a two-day colloquy attended by researchers, academicians, risk assessment system designers, and child welfare practitioners to identify and explore key issues in risk assessment theory, technology, and implementation; and 3) a review of state, provincial, and agency risk assessment models. This article presents an abridged version of the NARCCW policy white paper that resulted from this initiative.*

Part I: Issues in Risk Assessment in Child Protective Services

Many issues and concerns have been raised and discussed in the child welfare research and practice literature, underscoring the conceptual and operational complexity of risk assessment as a practice technology. Many of these issues can be subsumed under the following six major themes.

A. There is lack of agreement regarding the proper scope and purpose of risk assessment technology in child welfare assessment and case planning.

All risk assessment models encompass four common components: 1) the broad categories (criteria) to be assessed; 2) behavioral descriptors that define and operationalize these criteria (also known as measures); 3) procedures and calculations for determining various levels of risk; and 4) standardized forms to uniformly capture and record this information.

However, existing risk assessment models differ greatly in their scope, their stated purposes, the relative importance or weight assigned to various factors, and the mechanics of gathering, organizing, and interpreting information (Cash, 2001; Pecora, Whittaker, Maluccio, & Barth, 2000; Cicchinelli, 1995; Wells, 1995; English & Pecora, 1994; Doueck, English, DePanfilis, & Moote, 1993; Wald & Woolverton, 1994). Risk assessment models range on a continuum from a discrete, "point-in-time" assessment of the likelihood of future harm, to case management tools that promote an overarching attention to risk, and its reciprocal, safety, in a variety of contexts and at different decision-making points in the case planning and service delivery process.

Formal risk assessment technology was originally intended to help workers estimate the likelihood of future recurrences of serious child maltreatment in families (Baird, Ereth, & Wagner, 1999; Schene, 1996; Curran, 1995; English & Pecora, 1994). Some risk assessment systems, particularly actuarial models, still adhere to this discrete objective (Baird & Wagner, 2000; Johnson, 1996). In this context, risk assessment's unique purpose is to evaluate families during the intake assessment and to classify them into groups on the basis of the assessed likelihood of future maltreatment. This information helps workers determine which family cases should be opened and transferred within the agency for more in-depth assessment and subsequent protective services. As only one component of a broader continuum of case management and safety assurance strategies, "point-in-time" risk assessments help assure that agencies focus attention on families in which a future recurrence of maltreatment is most likely. Lower-risk families who have service needs can then be referred to other community providers with reasonable confidence that future child maltreatment is not likely to occur.

At the opposite end of the continuum are risk assessment models intended to serve as overarching systems of data collection, analysis, and decision making throughout the life of a case (Pecora et al., 2000; Doueck et al., 1993; Cicchinelli & Keller, 1990). In these

models, the stated purposes of risk assessment include prioritizing cases for services, identifying a family's individual service needs, informing case plan development, allocating services and resources, reassessing progress, documenting risk reduction, informing reunification decisions, guiding case closure, and establishing work load standards. Because of this disparity in fundamental concepts, premises, and scope, it is often questionable whether professionals discussing risk assessment are even talking about the same thing (Cicchinelli, 1995; Wells, 1995; Cicchinelli & Keller, 1990).

Confusion Between Risk Assessment and Family Assessment

There is also considerable confusion among child welfare practitioners about the difference between risk assessment and family assessment (Pecora et al., 2000; Schene, 1996; Wells, 1995; Cicchinelli, 1995; English & Pecora, 1994; Doueck et al., 1993; Wald & Woolverton, 1994). In contrast to risk assessment, the purpose of family assessment is to identify and explore, in considerable depth, the unique complex of developmental and ecological factors in each family and its environment that may contribute to or mitigate maltreatment. Family assessment data should be used primarily for case planning purposes, to enable the identification and delivery of the most effective interventions to address maltreatment and to prevent its reoccurrence. However, despite significant differences in purpose, scope, and depth between risk assessment and family assessment, many agencies attempt to use a single "hybrid" instrument to do both, resulting in a variety of problems that include the following: truncating the assessment to fit within limited time frames; superficial assessments and sparse, boilerplate case plans; subjecting all families at intake to a level of scrutiny that may exceed the level necessary to simply determine the likelihood of future harm; wasting caseworkers' time; and increasing the likelihood of bias and error. In such situations, neither standardized risk assessments nor in-depth family assessments are effectively completed, and a preponderance of casework decisions may continue to be made largely on the basis of individual clinical judgment (Gambrill & Shlonsky, 2000; English & Pecora, 1994; Rossi, Schuerman, & Budde, 1966, as cited in Baird et al., 1999).

B. Fundamental concepts, premises, terminology, and measures have not always been well defined or articulated, are often applied in an idiosyncratic manner, are highly inconsistent among risk models, and in some cases, are simply inaccurate. This creates ambiguity, confusion, and contradiction, and it greatly increases the likelihood of error and bias in risk ratings and subsequent practice decisions.

Confusing Language

As professionals have implemented formal risk assessment models into practice, and as organizations have modified risk models to meet their perceived unique circumstances, a confusing array of new language has been developed (Wells, 1995; Pecora et al., 2000). Idiosyncratic terminology has been coined by child welfare agencies, national child welfare organizations, national resource centers, researchers, academicians, and marketing strategists. The wide discrepancies in language increase the difficulty in understanding what is already an inherently complicated technology.

Examples of some of the terms used to represent risk are "risk elements," "risk factors," "risk influences," "risk contributors," "safety threats," "present danger," "threats of serious harm," "imminent danger," "emerging dangers," "future danger," "immediate need for a safety intervention," "family concerns," "risk correlates," and "cluster elements." Developers have also coined language to represent the intervening factors that mitigate risk, including "family strengths," "safety factors," "protective capacities," "buffering factors," "positive factors," "compensating factors," "protective influences," and "factors offsetting risk" (English & Pecora, 1994; Schene, 1996; Holder & Morton, 1999; Wagner, Johnson, & Caskey, 1999; Gambrill & Shlonsky, 2000; Holder & Lund, 1995; Pecora, English, & Hodges, 1995). Diverse terms are often used in an interchangeable or idiosyncratic manner, sometimes within a single model or document (Holder & Morton, 1999). Further increasing the confusion, the term "safety factors" is frequently used to represent factors that *compromise* safety rather than factors that *promote* it.

In addition, the language used to describe risk assessment concepts and models is often unclear and confusing. Some models attempt to differentiate, for example, between risk "factors" or "influences" and risk "elements," suggesting that one is a subset or more discrete delineation of the other (Ohio Department of Job and Family Services, 1995; New York State Department of Social Services, 1994). One source contends that the "risk field" is made up of "forces," each force being a "complex assemblage of characteristics, factors, qualities, and aspects known as elements... " (The Child At Risk Field (CARF), cited by Cicchinelli & Keller, 1990, p. 15). Another contends that "correlates for family concerns receive added weight because they reinforce cluster elements... because correlates interact with causal factors" (Ohio Department of Job and Family Services, 1995, p. 43). One final example suggests that "Danger is present when there is a threat or likelihood of serious harm. What constitutes a threat? A threat may be a condition, behavior, thought, feeling, or perception" (National Resource Center for Child Maltreatment, 2002, p. 2).

Possible reasons for this proliferation of idiosyncratic language include lack of understanding of the importance of standardizing both concepts and language in risk assessment models as well as attempts by change agents to adapt a model for local use or by developers to establish a market niche. Unfortunately, lack of clarity in language creates unnecessary confusion, interferes with our ability to communicate fundamental concepts and principles, and compromises our ability to do comparative research between risk models.

Criteria and Measures

There are equally challenging problems related to the criteria or measures used to assess risk and to quantify it at various levels. For example, little standardization of assessment criteria can be found among currently used risk assessment models (Lyons et al., 1996; Cicchinelli & Keller, 1990). One comparative study found that no factors were common to all the risk models examined, and about 40% of the criteria were unique to a single model (Lyons et al., 1996). Risk assessment models also have wide variations in their numbers of criteria, ranging from a low of about six to a high of about fifty (Lyons, Doueck, & Wodarski, 1996; Cicchinelli & Keller, 1990). In some models, the primary criteria are further divided into more discrete subcategories, thereby creating dozens of individual measures. Many models fail to differentiate among risk factors for physical abuse, neglect, and sexual abuse, even though contributors and dynamics are often different for these types of maltreatment (Gambrill & Shlonsky, 2000; Schene, 1996; English & Pecora, 1994). Most measures have not been empirically tested or their reliability and validity are not supported by research (Pecora et al.,

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2000; Johnson,, 1996; Doueck et al., 1993; Cicchinelli, 1995; McDonald & Marks, 1991). One study of eight risk assessment models determined that fewer than half of the 88 measures in these models had been empirically tested, much less validated, before being implemented into practice (McDonald & Marks, 1991).

The measures in many risk assessment models are also constructed in a manner that creates confusion, thereby undermining the instrument's reliability (Pecora et al., 2000; Wells, 1995; Cicchinelli, 1995; Wald & Woolverton, 1994; Selltiz, Wrightsman, & Cook, 1976). Measures are often poorly defined, nebulous and ambiguous, overly global, illogical, and very subjective. Some are quite simply inaccurate. These measures often leave considerable room for interpretation by different raters, and at times, the descriptors that delineate the various degrees of risk are virtually indistinguishable, making it possible to score the very same behaviors at more than one risk level.

One common practice is to develop measures that distinguish among levels of risk by creating a continuum, in which some variation of "none" or "a little" anchors one end and "a lot" anchors the other. Examples of such quantitative rating continuums include the following:

- minor, moderate, serious, severe, extreme
- safe, fairly safe, unsafe, very unsafe, extremely unsafe
- marginally, moderately, very, extremely
- isolated, sporadic, repeated
- has a history of, occasionally, sometimes, often

In an example of this practice, a set of measures to rate physical hazards in the home described a "minor gas leak" as a moderate risk and a "severe gas leak" as a high risk (Ohio Department of Job and Family Services, 1997). How would a rater determine how much gas escaping into a particular room, over what period of time, would warrant recategorizing a leak from *minor* to *severe*? These measures also ignore the fact that in typical circumstances, gas leaks have the potential to kill and should be considered, de facto, high risk.

These measures presume that changes in the amount, extent, or frequency of a behavior or condition represent gradations of harm that are meaningful in determining the existence or potential of maltreatment. In other words, a little exposure is less risky than more exposure, and both are less risky than a lot of exposure. Although this may be true in some instances, very often it is not. These measures also fail to designate exactly how much is *a lot* or *a little* and, instead, leave this differentiation to the discretion of the caseworker. Further, the words used to describe the behaviors and conditions at the various risk levels are often not easily differentiated; in fact, some descriptors, such as *severe*, *serious*, and *extreme*, are essentially synonymous. It would be similarly difficult to determine exactly how many incidents would have to occur before *isolated* behavior became *sporadic*.

At times, measures are not supported by empirical data. In one set of measures, a child who is propositioned or pressured to have sex, but in which no sex occurs, is rated at moderate risk. Only if the perpetrator has physically involved the child in a sexual act or exploitation does the risk become high (Ohio Department of Job and Family Services, 2000; Washington State Department of Social and Health Services, 2001). According to empirical data, both conditions may represent a high risk of recurrence of sexual abuse. Grooming behaviors by perpetrators typically include a sequence of escalating and more intrusive sexual involvement over time, any of which represent a significant threat of continuing and future harm as long as the perpetrator has unhindered access to the child victim (Salter, 1988, 1995).

The previous examples may appear extreme, but, in fact, reflect alarmingly common problems in risk assessment measures. They illustrate a critical point. Reliable and valid measures are the cornerstone of any effective risk assessment instrument. Well-constructed measures promote consistency and accuracy in ratings, whereas ambiguous and poorly defined measures promote individualistic, inconsistent, and potentially biased interpretations.

Confusion Among Risk, Safety, and Substantiation

The recent national emphasis on child safety has spawned the development of a variety of new safety assessment instruments. However, child safety is not a new concept in child welfare, nor are safety assessments a recent invention (DePanfilis & Scannapieco, 1994). Child safety has always been, and remains, the mission and defining principle of the child welfare profession, and child welfare professionals have been assessing children's safety as long as there has been a child welfare profession.

The stated goal of recently developed safety assessments is the accurate and timely identification of children who are "unsafe" (i.e., currently being maltreated, have very recently been maltreated, or are in circumstances where they are likely to be maltreated in the immediate future) (Wagner et al., 1999). Attention to safety issues allows agencies to develop very short-term plans, referred to as "safety plans," to stabilize family situations or to make alternative placement arrangements so children can be protected until a more in-depth family assessment and service plan can be completed. Toward this end, the data collected in safety assessments tend to cluster around three fundamental questions.

1) Has the child been recently maltreated, is the child currently being maltreated, or is the child at risk of imminent harm?
Safety assessments are intended to accurately identify children who have recently been or are currently being maltreated, or are at risk of imminent harm, and to determine the nature and type of harm, its severity, and its potential consequences for the child.

2) What additional family and environmental factors may increase the likelihood of harm in the near term?
Safety assessments attempt to identify family and environmental factors that could potentially escalate, resulting in imminent, continuing, or increasing harm to children.

3) Are there strengths and protective factors in the family that can mitigate maltreatment and assure the child's safety?
Safety assessments were originally developed to prevent unnecessary out-of-home placements by identifying family and community resources that could stabilize volatile situations and protect children in their own families (DePanfilis & Scannapieco, 1994). The objective was to prevent emergency removal and foster care placement, which, themselves, can subject children and other family members to serious emotional trauma.

Though the objectives of safety assessment are fairly clear, considerable confusion remains about the relationship among safety assessment, risk assessment, investigation, and the substantiation of maltreatment.

Abusis Inibi

Safety assessments are, in fact, a form of risk assessment. However, they are concerned only with risk of severe harm in the near term or, as the Latin appellation indicates, "abuse near at hand," rather than the likelihood of harm at some time in a more protracted future. Special emphasis on this subclass of risk assessment is not only justifiable, but a necessary correlate of risk assessment, because the two most important variables in defining risk—the likelihood of harm and the potential severity of such harm—are both very high when children are *unsafe*.

Safety assessments reflect the *a priori* assumption that we are most concerned with severe maltreatment that is *inibi*—that has just happened, is happening, or is imminent. However, although it is justifiable, even necessary, that we carve off this class of potentially severe and imminent risk for special and urgent consideration, to suggest that safety assessment is qualitatively different from risk assessment will only cause additional confusion and discontinuity.

Confusion Between Safety Assessment and Investigation/Substantiation

Upon close scrutiny, the objectives and activities of safety assessment appear to be equivalent to those of child protective services investigations, the substantiation of maltreatment, and the assessment of imminent risk—albeit repackaged and renamed. In this context, substantiation refers to the formal process of determining whether an alleged incident of child maltreatment occurred, as well as the nature, severity, and circumstances of such maltreatment. Safety assessment, stripped of ideology and rhetoric, essentially combines substantiation of maltreatment and emergency case planning. Items on safety assessments routinely probe for information about existing unsafe environmental conditions, negligent or abusive parenting practices, and conditions that currently compromise a child's health or well-being. The specific measures in safety assessments typically include the physical, emotional, and behavioral indicators of various types of maltreatment; descriptions of potentially harmful familial, environmental, and social conditions; and the extent and type of harm a child has already experienced (Wagner et al., 1999; Salovitz, 1993; Ontario Association of Children's Aid Societies, 2000; Ohio Department of Job and Family Services, 2003; New Brunswick Department of Health and Community Services, 1999).

Rhetoric contends that safety assessment is categorically different from the investigation and substantiation of maltreatment, but this sends a contradictory message. Workers are admonished not to *investigate* or to *substantiate*, as these are viewed as unfriendly and disempowering to families. Yet, the preponderance of items on safety assessments were designed to identify and document prior, current, and continuing abuse or neglect.

The current focus on safety assessment is a legitimate reemphasis of the importance of child welfare's fundamental responsibility—child safety—and, it deserves the emphasis it has received from recent federal policy and action. However, it is problematic to suggest that the substantiation of abuse and neglect is unrelated to risk and safety assessment, safety planning, case planning, and documentation of outcomes. Moreover, in no way does the substantiation of maltreatment preclude a developmental, empowering, and family-centered approach to practice (Rycus & Hughes, 1998). Child welfare workers can strengthen and preserve families, and they can help them prevent future maltreatment by assuring that information about precursor conditions to prior maltreatment and associated risk factors drive case plans and service interventions that enable families to grow and change.

C. There are serious methodological problems in the design and development of many risk assessment technologies and models and, also, in much of the research designed to evaluate and validate them. This not only affects the reliability and validity of the models, but also results in the communication of inaccurate information about their methodological soundness to the practice field.

Reliability and Validity

Effective formal risk assessment is based on sound scientific principles and statistical methods (Ruscio, 1998; Johnson, 1996; Blenkner, 1954). Two fundamental research principles, reliability and validity, underlie any assessment of the relative effectiveness of different risk assessment models (Ruscio, 1998; Johnson, 1996; Cicchinelli, 1995).

Reliability can be broadly defined as the degree to which a particular measure yields *consistent* results. One type, known as inter-rater reliability, refers to whether different people using the same criteria will reach the same conclusions from the same information. This is most relevant in formal risk assessment, in which the goal is to standardize the collection and interpretation of case-related information by different workers in different places and at different times. High inter-rater reliability reduces error and bias.

Validity in risk assessment generally refers to the degree to which an instrument can *accurately* categorize or classify families into different levels of risk. Thus, for a child welfare risk assessment instrument to be valid, the families it has identified as *high risk* should, as a group, maltreat their children significantly more often than the group of families identified as *low risk*, and the group of families identified as *moderate risk* should fall clearly in-between.

A formal risk assessment model's reliability and validity provide the "litmus test" of its effectiveness. The higher a model's reliability and validity, the more likely it is to promote the *consistent* collection of *accurate* information about the condition being examined, ultimately promoting *consistent* and *accurate* conclusions regarding potential risk (Macdonald, 2001; Johnson, 1996). Conversely, risk models that lack reliability or validity formalize and sustain the collection of inconsistent and inaccurate data, which results in faulty decision making using this data (Macdonald, 2001; Gambrill & Shlonsky, 2000; Ruscio, 1998; Wald & Woolverton, 1994).

Actuarial and Consensus Models

There are two primary types of formal child welfare risk assessment models: actuarial models and consensus models (sometimes referred to as matrix models). Actuarial models are common in many professional disciplines to formally estimate outcomes, such as who is most likely to have a heart attack or to survive one. Tables used by insurance companies to establish insurance premiums are also examples of actuarial instruments. Actuarial instruments are typically used because research has repeatedly demonstrated their superiority over clinical judgment in accurately estimating the likelihood of future outcomes (Macdonald, 2001; Gambrill & Shlonsky, 2000; Baird & Wagner, 2000; Baird et al., 1999; Ruscio, 1998; Grove & Meehl, 1996; Dawes, Faust, & Meehl, 1993; Dawes, 1993).

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Actuarial models use standardized statistical procedures to identify the specific criteria, and their combined effects, that have the greatest power to discriminate among groups of people in the future occurrence of a particular outcome. Criteria are formalized into standardized assessment protocols only *after* the relationships among the variables have been quantified and thoroughly tested. Further, the ratings of individual criteria and the scoring of an overall risk level are dictated by the previously determined statistical weighting of these previously identified associations (Macdonald, 2001; Gambrill & Shlonsky, 2000; Ruscio, 1998; Johnson, 1996). The presence of these variables in families in certain specific combinations can be said to increase the likelihood (but not to guarantee) that maltreatment will reoccur (Baird & Wagner, 2000). The greater the statistical association between the combined variables in the instrument and the occurrence of subsequent maltreatment, the greater the capacity of the instrument to consistently and accurately classify families into various levels of risk.

Consensus models, by contrast, rely on a preponderance of professional agreement about which variables or conditions are most highly associated with recurrences of child maltreatment (Pecora et al., 2000; Wald & Woolverton, 1994). Although a large body of professional literature describes and documents the individual, family, and environmental conditions found to be *associated* with child maltreatment, these factors are often not tested to determine their capacity to *estimate the likelihood* of future maltreatment (Lyons et al., 1996; Cicchinelli & Keller, 1990). Further, there are usually no empirical data regarding how the various factors interact or how they should be weighted and scored (Lyons et al., 1996; English & Pecora, 1994). Thus, consensus risk assessment models do not lend themselves to the use of numerical scoring systems.

The Fallacy of Consensus

Considerable confusion exists in the child welfare field about what constitutes consensus. Many people incorrectly interpret consensus to mean the negotiated opinions of whatever group of professionals is convened to develop or revise a risk assessment model. Ad hoc committees of practitioners are asked to present and discuss their judgments and opinions and to try to reach agreement on which criteria, definitions, and rating methods *work best for them*. Referring to this process as "generating consensus," "further refining the model," or "addressing our unique circumstances" gives apparent validity to a process that is notoriously subject to error and bias (Macdonald, 2001; Gambrill & Shlonsky, 2000; Ruscio, 1998; Dawes, Faust, & Meehl, 1989; Meehl, 1992, as cited in Ruscio, 1998; Cicchinelli & Keller, 1990). Even as the child welfare profession espouses the necessity of evidence-based practice, critical case decisions continue to be made using risk assessment instruments based not on evidence, but on the personal opinions of a variety of informants with differing degrees of expertise.

It is troublesome that many jurisdictions adapt risk assessment models, in whole or in part, without assuring that their changes are empirically based and without testing for reliability and validity. The literature delineates a variety of potential reasons for this practice (DePanfilis, 1996; Johnson, 1996; Cicchinelli, 1995; Cicchinelli & Keller, 1990). Many users revise models to make them shorter, simpler, or more easily understandable. Some believe that staff members' "buy-in" to a model depends on their participation in the model's development and their agreement with the final product (Cicchinelli & Keller, 1990). Some believe their agency's circumstances to be so unique as to warrant an individualized model. And some equate any form of standardization as a rigid mandate that undermines individuality and creativity. Even though the majority of idiosyncratic revisions in risk models are presumably well intentioned, these changes often further undermine a model's reliability and validity.

Comparative Research of Risk Assessment Models

Extensive research has been conducted in a wide variety of practice fields, including child welfare, on both actuarial and consensus-based decision-making models. These studies have repeatedly demonstrated the superior reliability, validity, and performance of actuarial models over consensus-based models in estimating the likelihood of future outcomes (Macdonald, 2001; Gambrill & Shlonsky, 2000; Baird & Wagner, 2000; Baird et al., 1999; Ruscio, 1998; Falco & Salovitz, 1997, as cited in Gambrill & Shlonsky, 2000; Grove & Meehl, 1996; Dawes et al., 1993; Dawes, 1993).

The preponderance of research literature continues to raise serious questions about the reliability and validity of most of the risk assessment models and instruments currently used by child welfare agencies (Macdonald, 2001; Pecora et al., 2000; Gambrill & Shlonsky, 2000; Baird et al., 1999; Lyons et al., 1996; Schene, 1996; Camasso & Jagannathan, 1995; English & Pecora, 1994; McDonald & Marks, 1991; Wald & Woolverton, 1994; Cicchinelli & Keller, 1990). In practice, many child welfare professionals are making decisions about children and families with little more accuracy than flipping a coin, yet believing they are using technologies that reduce subjectivity and bias and that increase the quality of their decisions.

There is also skepticism among researchers about the soundness of much of the research conducted to test the reliability and validity of risk assessment models (Pecora et al., 2000; Camasso & Jagannathan, 2000; Gambrill & Shlonsky, 2000; Baird et al., 1999; Schene, 1996; Lyons et al., 1996; Curran, 1995). Evidence-based practice stresses that research should be competently constructed and executed, reported findings should be supported by the data, and research methods should be accurately described. It also calls for full disclosure of methodological problems or other constraints that potentially skew the results or limit the generalizability of findings and conclusions (Gambrill, 2000; Gambrill & Shlonsky, 2000; Lyons et al., 1996). Risk assessment research often does not adhere to these guidelines (Gambrill & Shlonsky, 2000). Unfortunately, child welfare practitioners may believe a study's claims of reliability or validity whether or not this conclusion is warranted.

D. A variety of systemic, bureaucratic, and individual barriers impede the large-scale implementation of formal risk assessment technologies by child welfare agencies.

As is true with any large-scale change initiative, systemwide implementation of formal risk assessment requires a significant allocation of time, work, and resources; and its success depends upon strong and continuing organizational commitment and support in the face of many deterrents and barriers.

The literature has identified multiple problems related to implementation of formal risk assessment at the local agency level (DePanfilis, 1996; Curran, 1995; Cicchinelli, 1995; Cicchinelli & Keller, 1990). In some organizations, workers vary greatly in their use and interpretation of risk assessment models, even though the models ostensibly standardize decision making (Gambrill &

Shlonsky, 2000; Cicchinelli, 1995). Although many workers do use standardized risk protocols to help guide their decisions, many others use risk rating instruments simply to record conclusions and decisions they have already made by other means, including personal clinical judgment (Gambrill & Shlonsky, 2000; Schene, 1996; English & Pecora, 1994; Fluke, 1993, as cited in Lyons, Doueck, & Wodarski, 1996, and in Johnson, 1996; Cicchinelli & Keller, 1990). Many caseworkers consider formal risk assessment a burdensome, bureaucratic, and unwarranted increase in an already heavy work load. Many staff perceive it to be an administrative mandate, rather than a necessity to promote unbiased, accurate, and relevant decision making. Some workers view formal risk assessment as an unwarranted intrusion into families, and they may abandon or shortcut the assessment when they encounter resistance from family members.

Another prevalent barrier to implementation is lack of training in the prerequisite clinical competencies for effective assessment (Pecora et al., 2000; Schene, 1996, 6; Curran, 1995; Cicchinelli, 1995; Doueck et al., 1993, p. 442; Cicchinelli & Keller, 1990; Wald & Woolverton, 1990). Assessment in human services is a very complicated activity. It requires high levels of skill in critical thinking, observation and listening, interviewing, information gathering, and data analysis and synthesis. Caseworkers must also master the specialized knowledge needed to recognize and assess certain conditions. For example, caseworkers who are unable to recognize indicators of substance abuse, or who don't understand its behavioral dynamics, cannot accurately assess its presence or extent in families. Assessments can also be rendered inaccurate by lack of cultural knowledge, or by workers' inability to recognize how their personal culture, values, and beliefs can obscure their interpretations and conclusions about families. Caseworkers without thorough training can produce assessments with frighteningly inaccurate conclusions, even when they appear to be asking the right questions and properly recording the information. Finally, many workers are better at collecting information than at synthesizing it, using it effectively to inform casework decisions, or documenting it accurately to enhance both planning and accountability (Schene, 1996; Fluke, 1993; Cicchinelli & Keller, 1990).

Yet, in spite of the inherent complexity of assessment in human services, risk assessment training often consists primarily of policy briefings, a description of the risk model, an explanation of its criteria and measures, and instruction in how to complete the protocol and record the data. Many staff do not receive sufficient training in fundamental and, significantly more important, core assessment skills. Much risk assessment training has been likened to teaching airline pilots how to complete a preflight checklist before taking off, without ever having taught them navigation, meteorology, or even the essentials of flying a plane. Yet, many jurisdictions continue to expect two or three days of training on a risk assessment model to fully prepare staff to implement it consistently and accurately.

Moreover, risk assessment models are often superimposed on preexisting case management systems without thoughtful consideration of their "fit." This contributes to repetition, duplication, and even contradiction in procedures and forms for the collection, recording, and management of case-related information (Cicchinelli, 1995; Doueck et al., 1993; Cicchinelli & Keller, 1990). Finally, the common organizational dynamics and barriers that often undermine other change initiatives also impede the implementation of risk assessment. As a result, complete and successful implementation of formal risk assessment at the local level continues to be elusive (English & Pecora, 1994).

E. It is often expected that formal risk assessment activities should serve a variety of administrative, political, and systemic functions in child welfare organizations that have little to do with making accurate protective decisions for children.

The child welfare literature describes a variety of ways formal risk assessment is expected to improve child welfare practice. Among these are improving workers' decision making at all stages of casework; improving the quality and consistency of services to families; improving the case referral and case management process; providing a forum for case discussion and supervision; delineating child welfare practice standards; increasing agency accountability; demonstrating agency accountability to the public; reducing agency liability; improving court presentations; compensating for inexperienced staff and the effects of turnover; helping manage workloads; and providing a framework for case documentation (Schene, 1996; DePanfilis, 1996; Wells, 1995; Cicchinelli, 1995; Doueck et al., 1993; Cicchinelli & Keller, 1990).

Formal risk assessment is a single technology with the limited purpose of estimating, with acceptable accuracy, which children in our communities are most likely to be maltreated. Maintaining unrealistic expectations for formal risk assessment can actually deter policy makers, administrators, legislators, and potential funders from seeking and developing more appropriate strategies to address the many organizational, community, and direct practice problems that plague contemporary child welfare, thus ultimately increasing, rather than decreasing, the potential of future harm for high-risk children (Cicchinelli, 1995; Wald & Woolverton, 1994).

F. A number of ethical and legal issues related to risk assessment have not been fully addressed.

There are currently no risk assessment technologies that can predict with certainty that child maltreatment will reoccur, even in families identified to be at high risk (Gambrill & Shlonsky, 2000; Lyons et al., 1996; Dawes et al., 1989). Some formal risk assessments can accurately categorize families into high-risk, moderate-risk, and low-risk groups, on the basis of the statistical likelihood of a reoccurrence of maltreatment at some time in the future. This is the best that current research and technology have to offer. Given these realities, it is difficult to see how one could justify opening a nonvoluntary protective services case based entirely upon risk assessment findings in the absence of substantiated abuse or neglect.

Even so, child welfare professionals in some states and agencies have considered shifting the focus of child protection from the investigation and substantiation of a past incident of child maltreatment to risk assessment, which is "future-oriented" and not "aimed at proof or disproof of specific allegations of past maltreatment" (Schene, 1996; Doueck et al., 1993). Common arguments to support this action include: substantiation isn't family friendly; it focuses attention on pathology rather than strengths; it dwells on a family's past behaviors rather than growth and change; in many families, maltreatment never reoccurs; substantiation is too subjective a concept to be meaningful; and substantiation sets up a confrontational, rather than collaborative, relationship between families and the agency.

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However, a clear and well-documented indication of child maltreatment may be the only legal and ethical justification for intrusion by child protective services into the private dynamics of family life. Without such documentation, intrusion into families may violate parental rights legislation and federal civil rights law.

It must also be understood that even reliable and valid risk assessment technologies serve a limited purpose in the broader context of child protective services, and ethical and potential legal liabilities may result if these limitations are not acknowledged. Claiming, either by design or ignorance, that formal risk assessment will achieve what it cannot, creates potential liabilities that the child protection system can ill afford. The stakes increase greatly when risk assessment protocols used by agencies are neither reliable nor valid. Agencies place themselves in a precarious legal position by claiming that their decision making is based on standardized, validated risk assessment protocols when it is not (Curran, 1995). A state or provincial child protective service system that endorses or mandates a formal risk assessment model that it knows, or should know, is potentially harmful to children and families is at risk of significant legal liability. If children are harmed as a result of faulty decisions based on these models, agencies may be subject to legal remedies.

Summary

Despite all good intentions and hard work, formal risk assessment may not have significantly improved services to children and families and, in some cases, may actually have had a harmful impact. We must collectively reevaluate our options, identify and capitalize on our strengths, and implement strategic measures that will promote the most ethical and effective use of risk assessment technologies to assure equitable and legitimate protective decisions for abused and neglected children and their families.

Part II: Recommendations

A. There is lack of agreement regarding the proper scope and purpose of risk assessment technology in child welfare assessment and case planning.

A1) Formal risk assessment should be considered one tool in a broader, structured process of safety assessment and safety planning, family assessment, case planning, decision making, and ongoing risk analysis throughout the life of a case.

A2) Formal risk assessment should be used by intake assessment caseworkers to guide decisions about whether children and their families should receive ongoing protective services from the agency; whether they should be diverted to other community service providers; or whether they should be closed at the intake level.

A3) Agencies should not attempt to use "hybridized" instruments as both a formal risk assessment and a family assessment. Formal risk assessment requires measures that can accurately estimate the likelihood of future occurrences of child maltreatment. Family assessment requires measures that guide the collection of data to identify family needs, strengths, and dynamics. These goals, criteria, methodologies, and uses of data are sufficiently different to warrant two different instruments and processes.

A4) Because of frequent differences in many of the family dynamics associated with physical abuse, sexual abuse, and neglect, both risk assessment and family assessment protocols should incorporate and assess those criteria that are most relevant for each type of child maltreatment.

B. Fundamental concepts, premises, terminology, and measures have not always been well defined or articulated, are often applied in an idiosyncratic manner, are highly inconsistent among risk models, and in some cases, are simply inaccurate. This creates ambiguity, confusion, and contradiction, which greatly increases the likelihood of error and bias in risk ratings and subsequent practice decisions.

B1) The child welfare field should establish standardized and consistent terminology to represent all components and facets of the formal risk assessment process. All models should utilize the same terms for the same concepts and elements, including risk factors, protective factors, criteria, and measures.

B2) The identification and substantiation of recent or current maltreatment, and the assessment of risk of imminent maltreatment, should be clearly stated objectives for all safety assessments.

B3) Safety assessment should not replace formal risk assessment. Both are essential components of a structured continuum of decision making, but their purposes are different and the data are used toward different ends. Safety assessment evaluates both abusis inibi (i.e., the presence of recent or current maltreatment and the potential for imminent maltreatment) and factors in the family and community that can help mitigate maltreatment. With these data, children at risk of imminent harm can often be protected within their own families and communities, thereby minimizing family disruption and placement trauma. Formal risk assessment should follow safety assessment to discern the likelihood of a recurrence of maltreatment. These data help agencies determine which families should receive ongoing protective services from the agency and at what level of intensity this should occur.

B4) Safety plans should be developed for all children found to be recently or currently maltreated, or those in volatile and unstable situations in which they are at imminent risk of severe harm. Safety plans should focus only on assuring children's protection in the immediate term. Safety plans should not substitute for formal case plans. Case plans should be developed only after completion of a comprehensive, individualized family assessment that provides relevant information to guide the selection and provision of ongoing services.

C. There are serious methodological problems in the design and development of many risk assessment technologies and models, and also in much of the research designed to evaluate and validate them. This not only affects the reliability and validity of the models, but also results in the communication of inaccurate information about their methodological soundness to the practice field.

C1) All formal risk assessment protocols should be empirically derived—developed on the basis of findings and conclusions of well-designed and -implemented research. All criteria and measures should be pretested and determined to have the requisite levels of reliability and validity prior to being used in any risk assessment protocol. The structure for data analysis, scoring, and ranking should also be based on scientific and statistical procedures that promote the highest possible levels of reliability and validity. Criteria and measures in risk assessment instruments must be clearly defined and measurable and must leave as little room as possible for bias and misinterpretation.

C2) Considering the current state of formal risk assessment technology, child welfare agencies should use reliable and valid actuarial risk assessment models for formal risk assessment in all child protective service cases.

C3) Consensus decision-making models based on credible empirical data, and that include relevant and clearly-articulated measures, may be appropriate tools to guide the ongoing clinical assessment of safety and risk, family assessment, and service planning. However, consensus-based models should not be used to estimate the likelihood of future occurrences of maltreatment in place of actuarial decision-making technologies, which have higher reliability and validity.

C4) Formal risk assessment models and instruments should be developed or modified only in collaboration with professionals who have specialized expertise in the construction, evaluation, and validation of such instruments. This responsibility should not be delegated to ad hoc committees of practitioners and administrators without such support.

D. A variety of systemic, bureaucratic, and individual barriers impede the large-scale implementation of formal risk assessment technologies by child welfare agencies.

D1) Systemwide implementation of formal risk assessment should be viewed as large-scale system change and should be guided by fundamental principles of change management. Agencies must make the commitment to support and sustain the use of risk assessment technologies over time.

D2) Because of the inherent complexity of assessment in human services, and the high level of skill needed to gather and interpret assessment information, safety and risk assessments are best performed by highly skilled caseworkers with specialized training and prior child welfare experience. Although these functions are typically, and appropriately, performed by intake assessment caseworkers, many agencies assign newly hired caseworkers who have little training or practice experience to work in intake units. Lack of worker skill in interviewing and assessment will undermine even the most reliable and valid of protocols. It would be helpful if job classifications and salary levels for assessment caseworkers were upgraded to reflect these higher prerequisite qualifications.

D3) Comprehensive training in prerequisite core-level assessment and interviewing competencies should always precede training in the use of specific risk assessment models or protocols. Training should also be provided for supervisors who are assigned responsibility to monitor their staff's assessment activities. Coaching and educational supervision need to be supported by all local agencies to promote the transfer of learning and skill mastery.

D4) Risk assessment models and forms should not be "hard coded" into computerized child welfare information systems. Information systems must be sufficiently flexible to accommodate rapid changes in risk assessment criteria, measures, and scoring.

E. It is often expected that formal risk assessment activities should serve a variety of administrative, political, and systemic functions in child welfare organizations that have little to do with making accurate protective decisions for children.

E1) Agencies should not use formal risk assessment instruments for purposes other than that for which they were developed—to estimate the likelihood of a future recurrence of child maltreatment in families. More appropriate technologies must be developed to address other organizational and systemic needs, including case planning, public relations, quality assurance, communication, supervision, workload management, and monitoring and recording. Risk assessment cannot substitute for formal systems of data collection and recording to assure accountability.

F. A number of ethical and legal issues related to risk assessment have not been fully addressed.

F1) The child welfare profession must acknowledge and address the potential legal and ethical liabilities of continuing to use untested or unproven formal risk assessment models.

F2) Considering the limitations of even the most well-developed, reliable, and valid risk assessment technologies, agencies should not rely on risk assessment as the sole, or even the primary, resource to justify their casework and child placement decisions. Investigation with confirmed findings of abuse and neglect must remain the primary justification for opening nonvoluntary cases for child protective services.

* The unabridged version of the NARCCW policy white paper, "Issues in Risk Assessment in Child Protective Services," may be downloaded in PDF format from the NARCCW web site (www.narccw.com). Printed, bound copies may be requested via e-mail to JRycus@ihs-trainet.com, or by calling (614) 251-6000.

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** This list includes only sources cited in the above document. A complete listing of sources used in the NARCCW risk assessment initiative is included in the unabridged version of the policy white paper.

The Child Forensic Interview Training Institute of the Childhood Trust, Cincinnati Children's Hospital

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Training model: Do you have a training model of what constitutes a competent or "good enough" child forensic interview? What are its components and its characteristics?

A good child forensic interview is a neutral, information-gathering process intended for the courts. It is conducted by an open-minded investigator, who keeps multiple hypotheses in mind and avoids any rush to judgment. Whether forensic interviewers work in advocacy centers, law enforcement settings, medical facilities, or social work agencies, they function as neutral fact finders when they conduct interviews for the courts.

The Childhood Trust teaches both a structured protocol—Thomas D. Lyon's (2002a) adaptation of the National Institute of Child Health and Human Development (NICHD) protocol—and the Childhood Trust Flexible Guidelines. Although academic debates about structure versus flexibility continue, Cincinnati's Childhood Trust believes that interviewers need to learn more than one approach to respond effectively to the complexity and diversity of actual cases.

Underlying both the structured protocol and the flexible guidelines models are the goals of inviting lengthy responses from children early in an interview and continuing to use open questions and prompts throughout. An impressive body of research analyzing interviewer question types and child witness responses on transcripts of actual interviews has repeatedly and robustly shown the effectiveness of this narrative-inviting approach (Lamb, Sternberg, & Esplin, 1998; Orbach & Lamb, 2001; Orbach & Lamb, 2000; Orbach, Hershkowitz, Lamb, Sternberg, Esplin, & Horowitz, 2000; Sternberg, Lamb, Orbach, Esplin, & Mitchell, 2001; Sternberg, Lamb et al, 1997). However, an array of cultural, developmental, and personal characteristics of child witnesses may require interviewers to use additional strategies and interview aids to enhance communicative competence. Not every child can respond with a coherent narrative when instructed by a stranger to "Tell me all about what happened" (Saywitz, Goodman, & Lyon, 2002). Among those children who often need greater clinical sensitivity, flexibility, and pacing from interviewers are preschoolers; children of all ages who are depressed, anxious, traumatized, or developmentally delayed; children from chaotic or violent homes; and children inhibited by familial, cultural, and/or social constraints (Lyon, 2002b).

John Yuille has stated that a child interviewer's goals should be to maximize the information elicited, minimize stress or trauma to the child, and avoid contaminating the child's memory or statements (Yuille, 1996). No single approach accomplishes these ends. Child forensic interviews are by their very nature often stressful to children, as are necessary medical and dental procedures. We teach that the goal of good child forensic interviewing must realistically be to minimize stress to the child, not to eliminate it. The ultimate intention is to create an atmosphere that fosters full and accurate statements from children. A good child forensic interview avoids both false denials and false allegations (Lyon, 1995).

Since we offered our first 5-day child forensic interview training in March 1998, we have continuously modified our interviewing models as new research has appeared. For example, we originally taught only flexible guidelines, but added a structured protocol after thorough consideration of the extensive body of research in its support. We incorporated Sandra K. Hewitt's semi-structured protocol for administering the Touch Survey after her excellent book on interviewing preschoolers became available in 1999. When a review of Hewitt's book appeared (Gilstrap & Ceci, 2001) that criticized some aspects (but not the core principles) of Hewitt's version of the Touch Survey, we modified our Touch Survey flexible protocol to respond to these concerns.

We now place a stronger emphasis on teaching peer review skills after research results were published indicating the crucial importance of ongoing peer review in maintaining optimal interviewing practice (Lamb, Sternberg, Orbach, Hershkowitz, Horowitz, & Esplin, 2002). Copies of our current peer review forms are included as appendices.

Although many of the interview approaches and components we teach are derived from research studies, others are drawn from experience or common sense. For example, experienced trainees routinely tell us that interviewers should develop and maintain rapport with children, but what constitutes "rapport"? Do the guns and uniforms of police officers inhibit children, or do they make children feel safer? The research is virtually silent on this point, but many centers ask detectives to interview in plain clothes. What constitutes a "child-friendly" interview setting? Does it include toys? Experienced interviewers tell us that a room full of toys distracts children, especially those reluctant children who would rather do anything than talk about the topic of concern. It goes without saying that pagers, telephones, noisy offices, and other interruptions distract everyone. It also makes sense to interview children in a setting that feels private and safe, without the alleged offender, family members, or others close by. But even this is not a hard and fast rule. Some children absolutely will not separate from nonoffending parents or caretakers. In addition, many school districts have policies requiring that a teacher or counselor be present for child forensic interviews in schools.

Other components of rapport do have a strong research basis. For example, more than a decade of work by Gail Goodman, Bette Bottoms, and colleagues has established that a consistently supportive interviewer manner enhances recall and decreases suggestibility in young children (Carter, Bottoms, & Levine, 1996; Davis & Bottoms, 2002; Goodman, Bottoms, Schwartz-Kenney, & Rudy, 1991).

Most models include the instruction to avoid leading questions. What is your operational definition of a leading question?

We teach a typology of questions model, derived from the "Hierarchy of Questions" developed during an APSAC Think Tank in 1996 and modified by the Childhood Trust to include, among other

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changes, the language developed by Michael Lamb, Kathleen J. Sternberg, and their colleagues for their research studies. We changed "hierarchy" to "typology" after finding that a strict hierarchy from preferred, to less preferred questions does not apply in many circumstances. There are occasions when a "yes-no" question is less suggestive than a "wh" question. For example, the yes-no question "Did your uncle say something?" may be less suggestive than the presumptive "What did your uncle say?" if a child has not previously stated that the uncle said anything. The Childhood Trust typology of questions peer review sheet follows this article.

We have incorporated Laura Merchant's metaphor of the "hourglass," rather than the older and less precise "funnel" metaphor to describe the questioning strategy we teach (L. Merchant, personal communication, January 2002). Some children will disclose genital touching only in response to very direct questions (Saywitz, Goodman, Nicholas, & Moan, 1991). Using the "hourglass" approach, we teach interviewers to follow any direct question with an open, invitational prompt, rather than remaining at the narrowest point of the questioning funnel. Thus, a question such as "Did your uncle Billy touch your front private?" which we teach interviewers to ask a child only when other strategies have been exhausted, should be followed with "Tell me all about it" if the child answers "Yes." We find that many interviewers move too quickly to "where, how, when" questions in such cases. The open prompt may elicit full and idiosyncratic information in cases when Uncle Billy did touch the child and no information at all in cases when Uncle Billy did not. We are, of course, all aware of the one child in the analogue study by Karen Saywitz and colleagues who elaborated falsely in response to direct questions that the doctor did touch her anus with a "long stick" and "it tickled" (Saywitz et al, 1991, p. 687). However, without the direct yes-no questions naming both act and "perpetrator" (in this case, the analogue study pediatrician), the overwhelming majority of children in this study failed to report even nonabusive anal and vaginal touching in response to free recall and doll demonstration queries. Direct questions that name both alleged act and alleged perpetrator may be suggestive to some children, but they are not legally or linguistically leading.

What, then, is a leading question? We acknowledge that many researchers, interviewers, and fact finders carelessly refer to direct questions as "leading," but they are being linguistically sloppy. We teach precise and limited definitions. *Black's Law Dictionary* has defined a leading question as one that "instructs the witness how to answer or puts into his mouth words to be echoed back" (Black, Connolly, & Molan, 1983, p. 460), and in more gender-neutral, contemporary language, a question that "suggests the answer to the person being interrogated, especially, a question that may be answered by a mere 'yes' or 'no'" (Garner & Black, 1999, p. 897). The California Evidence Code defines a leading question as follows: "… a question that suggests to the witness the answer that the [questioner] desires" (cited in Myers, 1998, p. 125). The strict linguistic definition of a leading question is one that contains a negative tag instructing the witness how to answer. Examples of tag leading questions are "Your dad beat your mother last night, didn't he?" or "Didn't your therapist tell you what to say?" or "He put his finger inside your anus, isn't that right?" (Walker, 1999; Saywitz, Goodman, & Lyon, 2002).

In addition, we agree with Mark Everson and others that presumptive questions or prompts are also leading, even though they are not included in the strict linguistic definition (Everson, 1999; Walker, 1999). To decide whether such questions are presumptively leading, it is necessary to know what preceded them. For example, if a child has said that a man touched her, and the interviewer's next prompt is "Point to the place on the doll where the man *hurt* you," this is a presumptive leading question. Other examples include the following: "Tell me what the *bad* man did to you," "How many times did she whip you?" and, of course, the classic "Have you stopped beating your wife?" (Everson, 1999). Everson cites research indicating that children are more likely to be misled by presumptive leading questions than by more blatant tag leading questions, but this may depend on the presumptive content (Bruck, Ceci, Francoeur, & Renick, 1995). For example, if a child spontaneously describes an act of abuse and the interviewer's next question is "How many times did that happen?" John E. B. Myers argues that this question might be considered "mildly leading" because the interviewer seems to be communicating a presumption or belief that more than one abusive act took place (Myers, 1998, p. 125). A preferred question would be "Did this happen one time or more than one time?"

We also point out that in the real world of the court room, a leading question is whatever your judge defines as leading, and we warn that arguing with a judge about linguistic precision is not likely to help your case. We ultimately teach interviewers either to apply the narrow definitions of leading questions and try to avoid leading questions, or to accept looser definitions and acknowledge, with Myers (1998), that sometimes "mildly leading" questions during child interviews are unavoidable (1998, pp. 136-138). In any case, whether a yes-no question is defined as specific, direct, or leading, we instruct interviewers to remind their fact finders that they strive to follow up such questions with open and free-recall prompts.

What is the history of the Childhood Trust Forensic Interview Institute?

The Institute grew out of a peer review group of child maltreatment professionals invited by David L. Corwin, MD, to meet regularly at Cincinnati's Childhood Trust in 1995. Planning for the first 5-day forensic interview training began in 1997, when Dr. Corwin asked Julie Kenniston, a Cincinnati child protective services worker and a member of the original peer review group, to coordinate the program. Like most major forensic interview training programs, the Childhood Trust's was envisioned as a "teach, show, do" model that included lecture, filmed demonstrations, small group videotaped interviewing practice with peer review, and a concluding mock trial. The original core faculty included Corwin as training director, Kenniston, Barbara W. Boat, Jane Sites, and Erna Olafson. Guest speakers have included Karen Saywitz, Mark Everson, Toby Tyler, Robert Shapiro, John E. B. Myers, and Pat Myers.

In 1999, Olafson became director of the program, and the core faculty now includes Olafson, Kenniston, Boat, and Detective John Ladd. Selected Childhood Trust forensic training graduates from Cincinnati Children's Hospital social work and CAC staff as well as graduate interviewers from throughout Ohio return regularly to assist with small group exercises. CCHMC child psychiatrists Frank W. Putnam and Daniel A. Nelson offer guest lectures about trauma and brain development to every on-site training. Child psychiatry fellows and forensic fellows are required to attend the forensic training institute as part of their CCHMC and University of Cincinnati College of Medicine didactics.

In addition to the full 5-day training, which is nearing its thirtieth iteration, the Childhood Trust program has trained off site in Wash-

ington, DC, Indiana, Illinois, New York, Missouri's Fort Leonard Wood, Oklahoma, Wyoming, Belize, and many locations within Ohio. To give our several hundred graduates the opportunity to update their skills and receive specialized training, we offer advanced one-day trainings in Cincinnati and elsewhere about children's memory and suggestibility, child abuse allegations in the context of separated parents, interventions to assist nonoffending parents, anatomical dolls and drawings, and the toxic triad of child abuse, spousal battering, and animal cruelty. We have written statewide child forensic interviewing curricula for Illinois and Ohio. With the support of the Ohio Network of Child Advocacy Centers, we are currently training trainers to teach a new curriculum that covers the core principles of child forensic interviewing to be made available to every one of Ohio's 88 counties.

What are the characteristics of the Childhood Trust trainings?

Central to the Childhood Trust's training are adult learning theory principles. First and foremost is the principle of respect for participants, who are generally experienced professionals with much to teach the trainers. In accordance with this principle, we have transformed the mock trial theater at the end of the training into a voluntary and collaborative process. In the real world of forensic training and interviewing, there are no perfect interviews. However, if trainees become aware that their mistakes can be displayed without their consent before the entire group during Friday's Mock Trial, they may protect themselves during videotaped practice sessions by playing it safe. We want our trainees to take risks during the week by trying new approaches and experimenting with newly learned interview aids. Because people learn from their mistakes, rather than from their successes, we encourage participants to shake up old interview habits and even to flounder.

We ask participants to watch for moments in their small group videotaped interviews to bring before the assembled trainees during mock trial practice. Trainees who choose to do so then show problematic interview segments for a discussion about what they did, ways to improve, and how they might defend what they did in court. For example, if the interviewer asks a leading question, our mock trial "defense attorney" will ask the interviewer if the Childhood Trust training he or she attended recommends strongly against leading questions. Yes, the interviewer will have to concede. We then call upon a group think tank to help the interviewer find ways to manage this issue while on the stand. Yes, the group might agree, this was not a desirable question, but the group might point out, for example, that the child (or the adult actor who played the child), disclosed no forensically relevant material in response to this question, and that when disclosure did come, it was in response to an open question. Another example might be an interviewer inadvertently pointing to the private parts on the anatomical doll when asking the child where she was touched. How would the interviewer deal with this in the court room? After 5 days in a supportive learning environment where trainees are allowed and even encouraged to take risks and try new interview approaches, we find that many trainees volunteer to share their taped segments with the group. Trainees with years of experience on the witness stand share courtroom tips with beginners. This mock trial practice begins a collaborative process for subsequent peer review in the home agencies and offices of our diverse participants.

Ours is the only major training program in which trainees, not hired actors, play alleged child victims during the interview practice scenarios. Trainees are not required to play children, but most choose to do so. All trainees receive a list of brief scenarios describing the allegations to be investigated, and they meet on the afternoon of the third day of training in their small groups with one trainer to allocate cases. It is part of the respect we accord trainees that they choose their case scenarios, their interview schedules, and their actors, and thus best achieve their individual training goals. After trainees choose their adult actors, each trainer gives a copy of a fuller case scenario to the trainee actors so that they will have a full day to get into role and learn their parts. Participants scheduled to play children do not disclose the content to other trainees before the practice interviews.

The advantages of having trainees play alleged child victims are several. Many graduates inform us in posttraining feedback that the experience of being interviewed while playing a child affected them profoundly and taught them a great deal about how to interview effectively. In addition, child abuse professionals generally know a good deal more about child abuse than hired actors do; indeed, our participants play their roles with great depth and authenticity. For forensic teams from a single county who train together, enacting these child abuse scenarios functions as a powerful team builder, and this has been an unintended, positive consequence.

Every training begins with a pretest. At the end of every training day, trainees are given review questions about the day's content as part of their homework, and we go over their answers every morning. At the end of the training, the group reviews a final set of content questions, and we then administer a posttest. We average at least a 25% increase in knowledge from pretest to posttest. The over learning of training content is necessary (but not sufficient) for the acquisition and maintenance of interviewing skills.

Every trainee now receives a CD with a set of current research studies, papers, peer review forms, interview aids, and a reference list. Although we would like to facilitate ongoing contact with past trainees to update them and get feedback about how they are doing, this is an area still in development. We welcome suggestions from other training programs about how to facilitate ongoing contact with graduates.

Whom do you train? Rationale?

We train all professionals who conduct child forensic interviews, both as individuals and in teams. We have trained entire advocacy centers, as in Washington, DC, prosecutor-headed county teams, and isolated individual law enforcement, medical, or social work professionals from tiny rural counties. Despite the proliferation of child forensic interviewer training programs nationwide, there are still not enough competent trainers available to fill the need. Increasingly, we are training and mentoring trainers.

Do you see your interview protocol or guidelines as prosecution-focused or protection-focused? Do you see conflicts between these goals?

We teach both individuals and teams to practice corroborative questioning skills. Criminal prosecution ensues in only a minority of child abuse and neglect cases, but good forensic questioning belongs in every case. A case that appears to be a straightforward neglect case may suddenly reveal itself to be potentially criminal once a child starts talking. While the window is open and the child willing to speak, the social worker needs to be skilled in the basics of

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prosecution-focused interviewing. This may be the child's first outcry to anyone in authority; it may be Saturday evening and the prosecutor-headed investigation team may not be available until Monday afternoon. Thus, the time to question competently is at hand.

Even though cases involving preschoolers are prosecuted less commonly than those involving older children, we emphasize that careful forensic interviewing with these youngest victims is crucially important. When victims are young children, it can be difficult even to protect adequately, but competent forensic interviewing can help authorities to rescue these most vulnerable victims. We present trainees with recent research showing that chronic, severe childhood abuse and trauma inhibits brain development, lowers IQs, and compromises health (De Bellis, Keshavan, Clark, Casey, Giedd, Boring, Frustaci, & Ryan. 1999; Fellitti, 2002; Koenen, Moffitt, Caspi,, Taylor, & Purcell, 2003; Putnam, 2003). Whether a case ends in protection or prosecution, we argue that corroborative, evidence-gathering questioning in those cases is necessary so that the child's interview need not stand alone (Vieth, 1999).

Do you teach a structured protocol, a semi-structured protocol, or flexible guidelines?

We teach both a structured protocol and flexible guidelines. We believe that decisions about whether to use a structured protocol or flexible guidelines rest with trained interviewers, whom we teach to assess the circumstances of each case, the needs of each child, and critical points within an interview when choosing an interview approach. Our trainees come from many disciplines. They have caseloads that vary from the high suspicion child sexual abuse cases that are routine for child advocacy centers, to the miscellaneous assortment of often unsubstantiated abuse and neglect cases called in by mandated reporters to child protective services. No single child interviewing approach suffices for the variety of children and of case circumstances that child forensic interviewers confront. Abraham Maslow is widely quoted as having said that when the only tool you have is a hammer, every problem begins to resemble a nail (Maslow, 1954). Children are not nails. We give trainees a tool bag rather than a single hammer.

The structured protocol we teach was adapted by Thomas D. Lyon from the National Institute of Child Health and Human Development (NICHD) protocol developed and extensively tested by Kathleen J. Sternberg, Michael Lamb, and their colleagues (Lyon, 2002a: Orbach, Hershkowitz, Lamb, Sternberg, Esplin, & Horowitz, 2000). Professor Lyon has found that the protocol is effective with children aged 6 and older who are in at least partial disclosure, and we teach that this is its most appropriate application. We offer the protocol as one tool for the interviewer's tool bag, rather than as the single correct way to interview.

We describe the advantages and disadvantages of a structured protocol as follows:

Advantages

1. Both the NICHD protocol and Lyon's adaptation of it are designed to guide interviewers to ask open, invitational, free-recall questions that invite narratives from children, and to follow up consistently with open-ended prompts.

2. The structured protocol guides interviewers to invite narrative from children early in the interview so that when the topic of concern is reached, the child has become accustomed to responding in full sentences rather than single words. Research has shown that the repeated use of invitational prompts from interviewers results in lengthy, accurate, free-recall narratives from many (but not all) children.

3. The Lyon adaptation of the NICHD protocol offers exact language for the interviewer to introduce oneself, to inform the child about interview expectations (rules), and to practice the rules.

4. The protocol offers exact language for a simplified truth-lie ("competence") segment.

5. The protocol offers a number of structured questions to focus the child on the topic of concern.

6. The protocol offers exact language for inviting narrative about the topic of concern and about events that have been repeated many times (the "script memory" problem).

7. For beginners in agencies and departments that have high turnover, the protocol offers interviewers "training wheels" to start them out using an excellent, evidence-based interview approach.

Disadvantages

1. The protocol does not offer scripted guidelines for corroborative questioning, that is, questions about precise crime scene information to assist law enforcement with the evidence-gathering that may make or break a case. Corroborative questioning is especially crucial when the only witness to or victim of a crime is a child (Vieth, 1999).

2. The protocol does not offer guidelines for the use of interview aids such as dolls, anatomical drawings, Feelings Faces, and the Touch Survey. These tools are often necessary as demonstration aids. Indeed, both adult and child witnesses often benefit from interview aids.

3. Because the NICHD protocol was researched by tabulating interview utterances on transcriptions of actual interviews and classifying them according to the kinds of questions asked and the responses of child witnesses to them, the protocol does not address many other aspects of good child interviewing. Interviewer demeanor, flexibility, pacing, and cultural and developmental sensitivity are among the components that interview transcripts cannot fully reveal.

4. By ensuring that interviewers ask open and nonsuggestive questions, the protocol helps guard against false statements or false allegations by children, but it does less to deal with the issue of false denials (Lyon, 1995). In difficult cases, staying with the protocol rather than with the child may lead to a clumsy and nonproductive interview.

5. The danger of teaching a structured or scripted protocol is that defense attorneys may accuse interviewers of straying from "best practice" when they do not adhere rigidly to the script. For this reason, we emphasize that the structured protocol is a tool, an approach, one example of good interviewing for certain circumstances, rather than the only way to interview a child.

6. Because many abused and neglected children are developmen-

tally delayed, guidance about how to perform a developmental screening is often necessary. The protocols contain no guidelines for this screening.

Is the questioning focused on child sexual abuse only? Do your guidelines routinely include questions about physical abuse, neglect, domestic violence, substance abuse, and felony animal abuse? Rationale?

The structured protocols were designed for alleged child sexual abuse cases, and they do not include routine questions about other stressors in children's lives. Because child abuse can occur in homes where there is mental illness, substance abuse, or violence, it makes sense to ask children about their full range of experiences. The case information contained in the referral may be only the tip of the iceberg. For example, a mother who appears to be "collusive" may be a terrified battered woman. Battering is a crime that can be prosecuted. Indeed, when we protect battered mothers we help them support their abused children to maintain consistent disclosure, to testify competently in court, and to recover more completely from abuse. In addition, because of a continued backlash about child sexual abuse (Myers, 1994), it makes sense to obtain information about other potential crimes, such as drug dealing or felony animal abuse. This strategy may serve ultimately to protect children from criminally abusive adults, even when sexual abuse victims are preschoolers not admitted as competent witnesses in the court room.

Our flexible guidelines provide interviewers with a variety of questioning strategies. We instruct interviewers that a multiple hypotheses approach should cover many aspects of a child's experience. For example, the Childhood Trust Touch Survey, an interview aid that all of our trainees learn and practice, guides interviewers to ask children about physical as well as sexual abuse. In addition, Dr. Barbara Boat offers a training module about child abuse, domestic violence, and animal cruelty, with semi-scripted questions for participants to incorporate into their protocols. Our case scenarios are also designed to jar trainees out of tunnel vision about cases. Although we strive for graduates who are secure in standardized interview structure and language, we also intend for them to think while they work. No two cases are exactly alike.

How do you build rapport? How do you move to the topic of concern or the abuse allegation?

Both our interview protocol and our flexible guidelines offer guidance for rapport building. Lyon's adaptation of the NICHD protocol for children aged 6 and older gives the rules all at once as the interview begins and then builds rapport by asking children open questions about neutral topics to get the child talking. It includes no rapport-building interview aids, such as drawing with the child.

In the Childhood Trust flexible guidelines, the goals during the first stage of the interview are to get the child talking, to show interest and noncontingent warmth, and to create an atmosphere that feels safe and private. Getting down to eye level, sitting at right angles rather than interrogatively straight across from a child, and engaging in the drawing of the child's house or family are all strategies that enhance rapport. We have often seen a warmly administered developmental screening establish rapport with preschoolers. The rapport stage varies greatly in length, but it can be quite brief. Once a child is talking, interviewers transition to the topic of concern, while continuing to maintain rapport.

Transitioning to the topic of concern can be fraught with dangers, but there are a number of effective neutral ways to do so before presenting a child with anatomical drawings. We offer many such strategies, from neutral questions to more focused and direct ones. We teach that in most cases, interview aids such as anatomical drawings or the Touch Survey are used to focus on the topic of concern only when verbal inquiries have proven unproductive.

The recommended neutral prompt in most structured protocols is "Do you know why you came to see me today?" or "Tell me the reason you came to talk to me." Although these prompts work well with children aged 6 and older who are in active disclosure, these questions will be useless for the many others who have no clue why they are being interviewed. We offer lists of alternatives, including the very effective feelings prompts from Lyon's protocol, such as "Tell me the time that you were the most happy" and continuing with "sad," "mad," and "scared," followed in each case by "Tell me more" prompts. Among the other effective ways to move to the topic of concern are the balanced "best" and "worst" questions. For example, if an allegation is about one parent, we teach trainees to ask children what they like best and least about each parent, one at a time. Every protocol offers other ways to move to the topic of concern, and we make a list of these and other strategies available to trainees and discuss their merits and demerits.

With preschoolers or reticent children, interview aids such as Feelings Faces, the Touch Survey, and anatomical drawings can effectively introduce the topic of concern. The neutral and balanced touch questions of the Childhood Trust's adaptation of Hewitt's Touch Survey inquire factually and in value-free language about common forms of interpersonal physical contact young children can experience, such as hugging, tickling, spanking, hitting, and private parts touching. For a number of reasons, including forensic soundness, we prefer these questions to those taught in some other programs, such as questions about places on the body that it is "not OK" for people to touch or that people "should not" touch.

Does your protocol vary according to the developmental level of the child?

We teach the Lyon adaptation of the NICHD protocol as one option for children aged 6 and older. We teach modifications of the protocol and flexible guidelines for preschoolers and adolescents. We teach and have trainees practice the Cognitive Interview for children aged 7 and older and adult witnesses, but we emphasize that the CI should be used only to amplify previously narrated detail and not as a means to focus initially on the topic of concern. We teach the Touch Survey for preschoolers, early school age children, and children with developmental delays. All trainees learn and build skills with a variety of preprinted and freehand drawings to use with witnesses of all ages. Our module on anatomical dolls addresses developmental issues with respect to their application. We teach greatly simplified interview rules for preschoolers. For adolescents, we refer to them as "guidelines" or expectations," rather than "rules."

We positively *drill* our trainees in the basic principles of communicative competence as taught by forensic linguist Ann Graffam Walker. Every trainee leaves our training knowing, for example, to avoid asking a 4-year-old "when" or "how many times" something happened. We offer alternative questioning strategies to help find out when something happened, and we teach five scripted questions to get detailed information when children have a "script memory" problem in cases of repeated or chronic abuse. We tell every trainee to

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acquire Walker's indispensable book (1999) and to read the relevant chapters in the most recent *APSAC Handbook on Child Maltreatment* (Myers, Berliner, Briere, Hendrix, Jenny, & Reid, 2002).

We have only our years of experience and the collective wisdom in the room when the training moves to effective forensic interviewing of adolescents. Research in this area is scant to nonexistent (Saywitz, Goodman, & Lyon, 2002). We teach the older research showing that anger is the primary motivator for disclosure in otherwise corroborated adolescent sexual abuse cases, so that trainees will not automatically assume that an angry teenager is lying (Deaton & Hertica, 1993). We counsel trainees to be steady and patient as they deal with adolescent witnesses. We emphasize that there is a great need for further studies to assist professionals in both the interviewing and the treatment of abused and traumatized adolescents.

What do you teach about the use of interview aids? Rationale?

The structured protocols do not include interview aids, but we agree with Lori Holmes and Victor Vieth that children should not be deprived of interview aids when they are commonly offered to adult witnesses (2003). In our flexible guidelines, we teach and train the use of both drawings and dolls as needed at various stages of interviews. Freehand drawing may facilitate rapport with preschoolers or reticent children. Anatomical drawings, either freehand or preprinted, may assist in moving to the topic of concern, to ascertain the words children use for body parts, and as demonstration aids to clarify verbal statements by the child. An interviewer who draws the Touch Survey feelings faces and stick figures while asking a child questions can keep the attention of even the most hyperactive, distracted, or traumatized child witness.

We are fortunate to have Barbara W. Boat as a trainer for the anatomical dolls in a module that covers the research, including her recent literature review with Mark Everson (2002), as well as skills-building exercises using the dolls with practice scenarios. Dr. Boat instructs every trainee to teach their prosecutors to ask them when they are on the stand, *not* "Did you use the anatomical dolls?" but rather, "What *function* did the anatomical dolls serve in your interview?" She teaches that the dolls should be used by well-trained interviewers primarily as demonstration aids to clarify a child's verbal statements. We offer one-day advanced trainings in the use of anatomical dolls and drawings.

What do you teach about questioning reticent (nondisclosing) children?

Because we teach both a structured protocol and flexible guidelines, the interviewing of reticent children is covered at every stage of our training, and we devote one of our longer modules to this difficult topic. We go over the current debates about children's disclosure patterns and offer trainees a reference list of major studies, including Lyon's very useful recent works (Lyon, 2002b; *Stogner v. CA*, 2003). We systematically present children's many kinds of blocks to talking with interviewers, and we offer guidelines for dealing with them, including the use of free-hand drawings and other interview aids. We tell trainees that although there is an impressive body of research showing that invitational, open questions produce superior child interviews, these results may apply primarily to the easy kids, the children who know why they are being interviewed, are old enough to construct narratives, and are ready to talk. We need other approaches to respond effectively to the more challenging children in our caseloads (Faller, 2003).

We agree with the APSAC Clinics that some children are reticent because they have nothing forensically relevant to tell us. In high-suspicion cases with reluctant children, we teach that it may be preferable to stop the interview on a given day rather than to persist too long in questioning. As an alternative, we recommend to trainees that they have one specialist in each center trained in the Huntsville Extended Interview Protocol (Carnes, Wilson, & Nelson-Gardell, 1999) for children in high-suspicion cases who need more than one interview. Preliminary research results on this approach are promising (Carnes, Nelson-Gardell, Wilson, & Orgassa, 2001).

How are diversity issues integrated into your guidelines or protocol?

We address diversity as it impacts child abuse investigation and interviewing throughout the training and in a separate module. We alert trainees to ways in which social and cultural meanings can affect both the content of an interview and a child's attitudes toward the interviewer and the interview process. In addition, we stress that awareness of cultural and social meanings is essential when dealing with the families and communities of alleged victims. We offer guidelines for selection, training, and debriefing of translators. We refer trainees to the excellent works and presentations by Lisa Fontes (1995). We caution trainees about using explicit interview aids, such as anatomical drawings or dolls, when interviewing children from very modest subcultures, for example, recent immigrants from Middle Eastern countries.

What do you teach about interviewing with corroborative evidence in mind, so that the child's interview need not stand alone?

The resource CD that every trainee receives includes a copy of Vieth's 1999 paper about corroborative questioning, and we stress evidence-gathering questioning throughout the training. In good multidisciplinary teamwork, police and social workers interview together, but the reality is that a social worker is sometimes alone on a case when corroborative questioning becomes necessary. We teach every trainee the basics of corroborative, evidence-gathering approaches. We also agree with Detective Rick Cage and psychologist Dennison Reed (Reed & Cage, 2003) that when authorities move quickly to search potential crime scenes and question alleged offenders, rather than waiting days after the child interview, (as is common practice in many jurisdictions), they may increase both their rates of confession and of successful prosecution.

Have you measured training or protocol outcomes, and if so, how?

Our pretests and posttests show a good increase in knowledge in the course of 5 days of training, but we are aware of research studies showing that even when interviewers can articulate clearly what they should be doing, that does not mean they are actually doing it. With support of a grant from the National Children's Alliance (NCA), Erna Olafson, in affiliation with Frank Putnam, MD, and Heidi Malott, MSW, of Cincinnati Children's Hospital, are beginning a research study of our training outcomes. We will train raters to systematically review randomly selected videotapes of actual interviews, applying criteria from the three peer review forms or subsequent revisions of these form. Rater scores will be compared with case outcomes. In addition to studying interview practice among our graduates in various disciplines, we hope as one outcome of the study to produce sound child forensic interview peer review forms for widespread use by others.

About the Authors

Erna Olafson, PhD, PsyD, is an associate professor of clinical psychiatry and pediatrics at Cincinnati Children's Hospital and the University of Cincinnati College of Medicine. She directs the Cincinnati Childhood Trust's Forensic Training Institute and is Training Director for the CCHMC's Level II site in the National Child Traumatic Stress Network (NCTSN). Dr. Olafson is editor in chief of the *APSAC Advisor*.

Julie Kenniston, LSW, is an independent consultant and trainer presenting nationally and internationally on interviewing, investigation, and the prosecution of child abuse cases. She specializes in the areas of forensic interviews, interdisciplinary teamwork, peer review, sexual abuse issues, assessment, and planning. She mentors Children's Services workers in child maltreatment investigations and conducts training for interdisciplinary team development. Ms. Kenniston is associated with the Childhood Trust in Cincinnati, Ohio, as well as APRI Finding Words Indiana, the Office of Juvenile Justice and Delinquency Prevention, and the Institute for Human Services.

Peer Review Forms

Full size copies of these peer review forms, with instructions for their use, are available from Erna Olafson. Please e-mail your request to: erna.olafson@uc.edu. Dr. Olafson is evaluating these forms for possible revision. She welcomes feedback from interviewers and peer reviewers who use them. Please make amendments or modifications to these forms only in consultation with Dr. Olafson.

VIDEOTAPED INTERVIEW PEER REVIEW FORM 1.0

Interviewer Name _____ Reviewer Name _____

Date _____ Child's age _____ Child's Gender _____

INTERVIEWER COMPONENTS **COMMENTS**

Check off each component as it is covered.

YES	NO	N/A	STAGE ONE COMPONENTS
			Introduce self and role
			Establish rapport
Check below			Truth-Lie
			Interviewer explain
			Child demonstrate
			Child promise to tell truth and to try hard
Check below			Rules
			Don't know (explain)
			Don't know (demonstrate)
			Don't understand (explain)
			Don't understand (demonstrate)
			You're wrong (explain)
			You're wrong (demonstrate)
			"Help me understand" (explain)
			Developmental screening
			Invite narrative
YES	**NO**	**N/A**	**STAGE TWO COMPONENTS**
			Transition to topic of concern
			Invite free narrative
			Obtain specific details
			Corroborative questioning
			'Hourglass' questioning
			Explore multiple hypotheses
YES	**NO**	**N/A**	**STAGE THREE COMPONENTS**
			Safety planning
			Invite child's questions
			Ask any other concerns?
			Neutral topic
			Explain what's next
			Thank child

[Comment on the right side about components omitted or shortened because of the developmental level of the child. Rules and Truth-Lie often have to be adapted for preschoolers and adolescents, and developmental screening adapted or omitted for children aged 7 and older.]

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THE TYPOLOGY OF QUESTIONS PEER REVIEW FORM 1.0

(As you review a transcript, videotape, or live interview, count and add up kinds of questions)

Interviewer Name _____ Reviewer Name _____

Date _____ Child's age _____ Child's Gender _____

Interview Time Elapsed	0-5	6-10	11-15	16-20	21-2	26-30	31+	TOTAL
1. Free Recall questions Open, Broad "Invitational" *								
2. Focused questions Free recall on a topic								
3. Facilitators *Circle Y or N*	Y N	Y N	Y N	Y N	Y N	Y N	Y N	
4. Specific questions "Directive Utterances" *								
5. Multiple choice questions								
6. Externally derived questions								
7. Yes-no questions								
8. a.Tag Leading questions								
8. b. Presumptive Leading questions								
9. a. Bribing (Coercive)								
9. b. Shaming (Coercive)								
9. c. Threatening (Coercive)								

* Lamb, Michael E., & Fauchier, Angele. (2001). The effects of question type on self-contradictions by children in the course of forensic interviews. *Applied Cognitive Psychology, 15*, 483-491. Lamb and colleagues call broad/open/free recall questions "invitational" and specific "wh" questions, "directive utterances." Some question types included under our definition of "focused" (i.e.,"Tell me all about your last birthday") are included in the Lamb et al. "invitational" category.

THE ART OF INTERVIEWING 1.0

Interviewer Name _____Reviewer Name _____

Date _____ Child's age _____ Child's Gender _____

At the conclusion of the tape or interview, rate the interview on the following qualities and write a sentence justifying your number.

1. Develop and maintain rapport, showing interest and warmth. 1 2 3 4 5
   Be WITH that child.
   Comment:

2. Show developmental sensitivity. 1 2 3 4 5
   Comment:

3. Show cultural sensitivity. 1 2 3 4 5
   Comment:

4. Invite narrative, wait for child's answers and do not interrupt. 1 2 3 4 5
   Comment:

5. Use interview aids competently, if indicated. Comment:	1	2	3	4	5
6. Maintain consistent voice tone and posture even when child's statements are unexpected. Comment:	1	2	3	4	5
7. Keep child focused on topics at hand. Comment:	1	2	3	4	5

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WASHINGTON UPDATE

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CHILD MALTREATMENT AGENDA MOVES TO 2004

Much of the 2003 child welfare agenda in Congress will be carried over onto the 2004 legislative calendar. Even appropriations for the new 2004 fiscal year that started October 1 remain incomplete, including Head Start reauthorization and extension of the Temporary Assistance to Needy Families (TANF) legislation. Only a couple of child welfare measures made it through the 2003 legislative maze--reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA) and renewal of the adoption incentive payments.

APPROPRIATIONS

The House and Senate went into recess on November 25 without taking final votes on a $328 billion omnibus spending bill for FY 2004, even though work on the bill was completed. The bill combines seven appropriations measures–including money for the Department of Health and Human Services, which failed to pass separately during the legislative session. Controversies in the Senate over various policy issues have pushed the voting over into late January. In the meantime, spending figures in the 2004 bill are in place, but agencies continue to operate at 2003 funding levels under a continuing resolution extended to January 31.

Child abuse prevention and services program funding generally enjoyed small increases in the 2004 money bill, with a total of $1.124 million in increased spending for the Child Abuse Prevention and Treatment Act (CAPTA) programs. More than two-thirds of that increase, however, is earmarked as line items by legislators for special projects in their home states.

A significant source of federal support for child welfare and child protection services--the Title XX Social Services Block Grant--unfortunately logged in at level funding ($1.7 billion) in the 2004 spending bill. In another disappointment, the Safe and Stable Families Program failed to receive the $100 million increase proposed, but not pushed, by President Bush. Entitlement funding for foster care and adoption subsidies, however, grew by $205 million.

Two of President Bush's perennial budget initiatives—Maternity Group Homes and Promoting Responsible Fatherhood—went unfunded, with Congress again refusing to fund programs lacking the legislative authority to set out clear policy objectives. But another Bush priority, Mentoring Children of Prisoners, received one of the largest percentage increases in the funding bill—over 400% growth—going from $9.935 million in 2003, to $50 million in 2004, as requested by the White House.

HEAD START

With the end result still unresolved, legislation to reauthorize Head Start began a rocky passage through Congress in 2003. The extension of this program was made controversial by a Bush administration proposal to turn Head Start funding over to the states for integration with the states' own early childhood education programs. In addition, the Bush proposal puts a greater emphasis on cognitive development, language acquisition, and reading skills in the Head Start program.

Head Start has operated since its inception as a federal-to-local grant program for the provision of early childhood education, comprehensive services, and family support to poor preschool children and their families. Currently, only three out of five children eligible for Head Start's services are served in the program.

On July 25, the House of Representatives barely passed—217-216—legislation to reauthorize the Head Start program through 2008. The School Readiness Act of 2003 (H.R. 2210) embodies the Bush administration's proposal, allowing a limited number of states to fold Head Start into their own early childhood education programs.

Head Start advocates have warned that the House bill threatens the future of Head Start with its proposal to dismantle current operations of the program by turning funds over to the states without explicitly guaranteeing the application of federal performance standards.

H.R.2210 also includes noncontroversial provisions proposed by the National Child Abuse Coalition to build upon the ways in which abused and neglected children and children at risk of maltreatment and in need of preventive services might benefit from Head Start and Early Head Start services. The Coalition's proposal recognizes that children who are ready to learn are also children who are safe and nurtured at home. Thus, the program needs to provide:

1) greater attention to serving children who have been maltreated or are at risk of abuse or neglect,
2) greater attention to the training needs of parents in parenting skills and basic child development (especially in Early Head Start),
3) improved coordination with existing home-based services,
4) staff training in working with children who experience violence, and
5) collaboration with other agencies and organizations involved in child and family services.

In November, the Senate Committee on Health, Education, Labor, and Pensions (HELP) reported its version of the Head start reauthorization legislation, the Head Start Improvements for School

Readiness Act, S.1940, sponsored by Sen. Judd Gregg (R-NH), including several of the provisions proposed by the Child Abuse Coalition to increase attention to serving children at risk of abuse and neglect.

The Head Start reauthorization will be back on the legislative agenda when the second session of the 108th Congress convenes in January.

TANF

In September, the Senate Finance Committee approved by party-line vote legislation reauthorizing the Temporary Assistance to Needy Families (TANF) program with increased work requirements for welfare recipients, child care funding considered insufficient by child advocates, and $1 billion available over the next 5 years to promote marriage as a goal for people on welfare.

The Personal Responsibility and Individual Development for Everyone (PRIDE) Act is similar to H.R.4, which passed in February. Both would increase the number of hours recipients are required to work: 30 hours weekly under current law would go to 38 hours under the House bill and to 34 hours in the Senate measure. President Bush had asked Congress to raise the work requirement to 40 hours.

The full Senate is expected to take up the TANF reauthorization bill early in 2004.

Child welfare advocates are urging the Senate to support a measure during floor consideration of TANF, which would allow states to work individually with families to address barriers to employment so that families can move toward greater independence.

On July 21, 2003, Senators Gordon Smith (R-OR), Kent Conrad (D-ND), and James M. Jeffords (I-VT), introduced S.1523, which would allow a state to treat an individual who is participating in rehabilitation services and who is increasing participation in core work activities as being engaged in work for purposes of TANF. When the TANF reauthorization bill comes to the Senate floor, Smith, Conrad, and Jeffords plan to offer their legislation as an amendment.

Families facing barriers to employment are at risk of coming to the attention of the child welfare system if their needs are not addressed within the welfare system. Historically, the majority (60%) of children entering foster care come from families receiving cash assistance. The challenges that interfere with employment can also interfere with adequate parenting. Flexibility in TANF to recognize a wide variety of approaches for families could then offer an individualized mix of treatment and rehabilitative services as well as supportive services, such as child care and transportation, work preparation, and work activities.

FOSTER CARE FUNDING OPTION PROPOSAL

Since the summer of 2003, the Bush administration has hoped to introduce Congressional legislation embodying its foster care funding proposal to offer states the option of receiving their foster care dollars as a block grant for a period of 5 years, or to take their foster care allocation in an entitlement as currently funded under Title IV-E. The "flexible option" is meant to give states the opportunity to develop a continuum of child welfare services paid for with IV-E funds now available only for foster care.

The proposal does not represent an investment of any new dollars in the Title IV-E foster care subsidy program. In testimony before the House Ways and Means Subcommittee on Human Resources in June, Dr. Wade Horn, HHS Assistant Secretary for Children and Families, asserted that "the option encourages innovation and the development of cost-effective programming that over time will result in children reaching permanency more quickly and fewer children being removed from the home."

Child welfare advocates have raised questions about how much states would be required to maintain in matching funds, given that counties and localities may currently contribute to the match; and in foster care training, for example, universities often pay the matching funds. Congressional committee staff and budget analysts have been reviewing the specifics of the Administration's proposal since late summer, with no resolution put forward for congressional consideration.

POLITICS STALL CARE ACT

Both the Senate and House of Representatives have passed bills aimed at encouraging charitable giving by allowing nonitemizing taxpayers to deduct their charitable contributions and by permitting tax-free distributions to charity from individual retirement accounts (IRA). The Senate's bill, the CARE Act (S. 476), would also increase the funding authorized for the Title XX Social Services Block Grant by restoring dollars to the original level of several years ago at $2.8 billion. Cuts taken since the 1990s have reduced this important source of funds for human services to a level of $1.7 billion.

The differences between the two bills must be worked out by a House-Senate conference committee before the final legislation can be enacted. The Senate overwhelmingly approved the CARE Act this spring by a vote of 95-5. Now the bill has stalled in the Senate and cannot move forward to conference with the House. Among the provisions in disagreement is the Senate's measure raising the authorized funding level for Title XX. The Senate seems committed to including the Social Security Block Grant provisions in its bill. To get past the current inability to go to conference, the Senate could do a revision of its bill and send it directly to the House.

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HHS/OTHERS OPEN GRANT PROGRAMS TO RELIGIOUS GROUPS

New federal regulations extending eligibility for federal grants to faith-based groups have been issued by the Department of Health and Human Services (HHS) for the Temporary Assistance to Needy Families (TANF) program, the Community Services Block Grant (CSBG) program and programs of the Substance Abuse and Mental Health Services Administration (SAMHSA), opening up nearly $20 billion in social services grants to religious groups.

The Department of Housing and Urban Development (HUD) has also issued final regulations repealing rules that prohibited religious organizations from participating in its programs, making faith-based groups eligible to compete for $8 billion in HUD grants. The final rules for the HHS and HUD programs, published in the September 30, 2003, Federal Register, become effective October 30, 2003.

BUSH ADMINISTRATION ACCUSED OF STIFLING RESEARCH

An August 2003 report by staff of the House Democratic Committee on Government Affairs asserts that the Bush administration is manipulating scientific data and distorting or suppressing scientific findings on a range of policy issues in an attempt to control research to serve its ideology and to protect the interests of its political supporters. The report, Politics and Science in the Bush Administration, says that "the administration's political interference with science has led to misleading statements by the President, inaccurate responses to Congress, altered web sites, suppressed agency reports, erroneous international communications, and the gagging of scientists."

The report covers twenty-one subject areas and divides the issues into of categories: 1) "issues like abortion, abstinence, and stem cells that have active right-wing constituencies that support the President" or 2) "issues like global warming or workplace safety with significant economic consequences for large corporate supporters of the President."

In July 2003, attacks on researchers reached the floor of the House of Representatives. During congressional consideration of the appropriations bill for the National Institutes of Health (NIH), Rep. Pat Toomey (R-PA) proposed an amendment to de-fund five existing research grants that had already passed through the NIH two-tiered peer review system. The majority of these grants dealt with AIDS, or issues relating to sexuality and gender. The amendment barely failed, by a vote of 212-210.

At a congressional hearing in October, NIH Director Dr. Elias Zerhouni was questioned about these same grants and others, which several lawmakers criticized as a waste of taxpayer money. Following that, Zerhouni was asked by members of Congress to address a list of more than 160 academic studies that involve sexual behavior, HIV transmission, or alcohol and drug use. It has since come to light that credit for the preparation of the list of targeted scientists has been claimed by the Traditional Values Coalition. Among the grants identified by the Traditional Values Coalition Safe are several that address issues of promoting safe sex and condom usage among abused and neglected youth, teens with psychiatric disorders, teens with severe mental illness, and homeless youth.

HHS STUDY OF CPS SYSTEMS

A two-year study of the current status of the child protective services (CPS) system in the United States, and reform efforts underway around the nation to improve its operation, is available from the U.S. Department of Health and Human Services (HHS).
The report focuses on the following areas:

- State and local CPS mandates and policies,
- CPS agency functions and practices, and
- Innovative reform efforts and their impact on agency functions and practices.

The analysis of state CPS policies (e.g., looking at areas of administration, screening and intake, investigation and alternative response) finds that although there is considerable variation in policy, common functions and features of CPS policy seem to reflect the requirements of the federal Child Abuse Prevention and Treatment Act (CAPTA) and practice principles recommended by professional organizations (e.g., the Council on Accreditation and the Child Welfare League of America). According to the researchers, CPS agencies share common policies providing for 1) mandated reporters; 2) 24-hour intake hotlines; 3) involvement of law enforcement; and 4) short-term services. Turnover is high among a relatively inexperienced CPS staff, 70 percent of whom reported feeling overworked.

Policies differ among CPS agencies around such matters as 1) level of evidence required for substantiation, with a trend to raise the threshold required, especially when law enforcement is involved, 2) time frame for completion of investigations, and 3) the use of central registries. A significant trend identified by the researchers is the development of alternative responses geared toward diverting children and families toward services, especially with less severe cases.

The full report of the National Study of Child Protective Services Systems and Reform Efforts, conducted by Walter R. McDonald & Associates, Inc., in collaboration with the American Humane Association, KRA Corporation, and Westat, Inc., is available on the HHS web site at: http://aspe.hhs.gov/hsp/CPS-status03.

Welcome to Hollywood and the Site of Colloquium 2004—Part I

C. Terry Hendrix, MA
Retired Publisher and Former Resident of Hollywood

This is the first of a two-part article to acquaint you with some highlights of what you and your family can see and do in Hollywood before, during, and after the 2004 APSAC Colloquium next August. The weather will be warm in the daytime with relatively low humidity and pleasantly cool in the evenings. The Colloquium hotel has a great outdoor pool and sun deck, and the immediate area affords lots of interesting and entertaining attractions.

History of Hollywood

In the late 1800s, Los Angeles was a small town spread out along the Los Angeles River, and Hollywood was mostly empty land some eight miles north. In 1903, Hollywood was incorporated with a population of 700. Then the moviemakers arrived from the East Coast, and soon they expanded the little town, but provided no reliable water supply. To get more water, in 1913 Hollywood was annexed to Los Angeles (and it turned out to be the small part that made all the rest famous throughout the world).

The Hollywood Sign on Mt. Lee

By 1920, the population of Hollywood was 30,000, and now it is nearly 300,000. The town was the height of glamour until after World War II, but went downhill in the '60s when most of the studios moved over the hill to the San Fernando Valley and the stars moved to Beverly Hills and Malibu. However, a revival began in the '90s and continues today, anchored by the new Kodak Theater and the rest of the Hollywood & Highland entertainment complex, including the Renaissance Hollywood Hotel (site of the 2004 APSAC Colloquium). There are still some T-shirt shops, tattoo parlors, and panhandlers, but new, up-scale shops, restaurants, clubs, and condos continue to fuel the revival of this vital and exciting city. And, there is much to see and do by day and night.


Entrance to the Hollywood Bowl

The Hollywood Sign

Hollywood's most famous landmark, now recognized around the world, was erected over 70 years ago to promote a Hollywood real estate development. The supposedly temporary sign has had its trials and tribulations, but continues to shine brightly near the top of Mt. Lee, overlooking the heart of Hollywood. The best place in town to view the sign is from the bridge on Level 5 of the Hollywood & Highland center, adjacent to the Colloquium hotel, where the sign is perfectly framed in a giant arch. There is also a one-hour tour for a close-up look at the sign and some stars' homes in the area.

Hollywood History Museum

Housed in the newly refurbished Max Factor building (former home of Max Factor Cosmetics), the Hollywood History Museum offers an informative and timely look into Hollywood's history. It holds an extensive personal collection of lavish costumes and memorabilia from the careers of entertainers from Mae West to Shirley MacLaine. And, one can admire the wardrobes of *Gladiator* and *Moulin Rouge* stars, and more. But the museum is not given over entirely to fancy costumes—the complete Hannibal Lecter jail complex is part of the five floors of Hollywood memorabilia. The museum is within a stone's-throw of the Colloquium hotel (Thursdays to Sundays, 10am to 5pm, Adults $15, Students and seniors $12, Children under five $5).

Hollywood Bowl

One of the largest natural amphitheaters in the world, with a current seating capacity of just under 18,000, the Hollywood Bowl's nightly musical performances have become as much a part of a Southern California summer as beaches and barbecues, the Dodgers, and Disneyland. The fare varies from classical to jazz to pops to fireworks spectaculars, and the venue remains accessible to a wide cross-section of Los Angeles' diverse population and visitors, with ticket prices beginning at $1.00 at the top of the bowl for many concerts. During the day, children enjoy Open House at the Bowl, the Southland's most popular summer arts festival for youngsters.

It is a summer tradition to picnic at the Bowl prior to the evening performance, either in one of several picnic areas or at your seats. The Colloquium hotel, as well as many restaurants, offers picnic boxes; and food, wine, and other beverages are available at the Bowl. Best of all, the Hollywood Bowl is only a pleasant 10 to 15 minute walk up Highland Avenue from the Colloquium hotel.

Hollywood Bowl Museum

Located on the grounds of the Hollywood Bowl is the terrific and **free** Hollywood Bowl Museum offering a history in photographs, films, programs, and other artifacts. The First Floor Gallery is an interactive exhibit, featuring never-before-seen archival film foot-

age, state-of-the-art audio stations, film clips from classic movies filmed at the Bowl (including *Anchors Away* and *A Star Is Born*), and memorabilia about musical stars from Heifetz to the Beatles. Displays show the development of the Hollywood Bowl from its inception in 1921 to the present day. Visitors will delight at the programs to look through, slide shows, continuous video presentations, and a musical history of the Bowl on individual headsets.

The Hollywood Bowl Museum is open Tuesday – Saturday from 10:00 am to 8:30 pm and on Sunday 2 hours before concerts. Admission is **free**.

John Anson Ford Amphitheater

The Ford, as it is known locally, is a much smaller and more intimate musical venue across the Hollywood Freeway from the Hollywood Bowl. The 1,245 seat amphitheater has a summer season of over 100 events, including dance, theater, cabaret, chamber groups, bluegrass and jazz, flamenco, Brazilian music, and a wide variety of other productions often reflecting cultures of the world.

No seat at the Ford is more than 96 feet from the stage with great sight lines and clear sound. The historic outdoor theater is nestled in the Hollywood Hills, surrounded by natural beauty. You are invited to bring your picnic to enjoy in the terraced entryway or in the amphitheater, but food and beverages are also available in the outdoor concession stand or the indoor bar. The wide-ranging menu includes gourmet sandwiches, pizzas, cold salad plates, assorted desserts, and a variety of soft drinks, wines, and beers. Ticket prices vary with the event, but generally are in the $15 to $30 range. A free shuttle is available from the Hollywood & Vine Metro Station or from the parking structure at 1718 North Cherokee—both an easy walk from the Colloquium hotel.

Pantages Theater

Built in 1930 as a movie palace, the Pantages was painstakingly refurbished in 2000 for the 2-year run of the *Lion King* and is now one of the prime venues for big musicals. It is an art deco masterpiece with an incredible 18- foot high lobby, grand staircases, and the aura of a grand past (the Academy Awards were held here from 1949 to 1959). During the Colloquium, the Pantages will be presenting the Tony Award winning *Hairspray*, a musical comedy hit. The theater is within easy walking distance of the Colloquium hotel.

The Pantages Theater on Hollywood Boulevard

Chinese Theater

Now within the Hollywood & Highland complex, the Chinese Theater is an opulent movie house that once had 1,492 seats. Recently it was remodeled into six stadium-seating auditoriums with digital THX sound and plush seating, showing recently released major films.

Since 1927, nearly 200 imprints of feet, hands, and signatures have been impressed into wet cement in the Forecourt of Stars. There is also one nose print, that of Jimmy Durante! The Forecourt is open 24 hours a day with no charge. It is probably the most visited spot in Southern California and just steps away from the Colloquium hotel.

Entrance to the Chinese Theater seen from the Forecourt on Hollywood Boulevard

Hollywood Roosevelt Hotel

Across Hollywood Boulevard from the Chinese Theater is the Hollywood Roosevelt Hotel. Built in 1926, this historical gem features Spanish Colonial décor and a garden swimming pool (where Marilyn Monroe's first modeling job was a photo-shoot of her in a bathing suit). As you enter the hotel from Hollywood Boulevard, the room to your left is Firestein's Cinegrill, the only real supper club still remaining in Hollywood. If Michael Firestein is not performing, there will be a good performance of pop tunes or jazz, along with a good dinner.

Hollywood Roosevelt Hotel

The tiled staircase directly across the lobby from the Cinegrill is supposedly where Bill "Bojangles" Robinson taught Shirley Temple the dance routine they did in the *Little Colonel*. The Blossom Room off the balcony above the lobby was the site of the first Academy Awards in 1929. David Niven, Montgomery Clift, and other stars lived in the hotel over the years. A dining room on the lobby level serves breakfast, lunch, and dinner.

Attending the 2004 Colloquium puts you right in the heart of Hollywood and all the attractions described in this article. Register for the Colloquium and make your reservation at the Renaissance Hollywood Hotel now so you can say "hello Hollywood" next August!

12TH ANNUAL APSAC COLLOQUIUM

APSAC is pleased to announce several collaborations in conjunction with the 12th Annual Colloquium to be held in Hollywood, California, on August 4–7, 2004.

First, the collaboration with the National Child Traumatic Stress Network (NCTSN) includes several NCTSN specific activities. There is a pre-Colloquium, invitation-only meeting for all NCTSN members who attend the Colloquium. In addition, APSAC will provide a NCTSN track, consisting of presentations by NCTSN members and focusing on network-related activities. Attendance at these presentations will give all registered Colloquium participants opportunities to share the activities and accomplishments of the network with a multidisciplinary audience of professionals serving traumatized children. NCTSN Committees, Task Forces, and Work Groups will also be able to schedule meetings and engage in informal networking during the Colloquium.

Second, the collaboration with the American Psychological Association (APA) Division 37 focuses on child maltreatment. It provides an all-day intensive institute on Friday, August 6, with the most up-to-date research involved with child interviewing.

Finally, the Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, has also agreed to host an all day institute on Friday, August 6. This presentation, provided by a variety of national experts, focuses on a review of the public health model and how CDC has generated concepts, funded projects, and encouraged significant collaborations that have produced a large, universal parenting program aimed at primary prevention of child maltreatment.

Overall, APSAC is working to deliver the same quality training that our participants have come to realize. We feel that the foregoing collaborations will open up the opportunity for more networking for professionals interested in the area of child maltreatment. We look forward to seeing you there! To obtain information about the 2004 Colloquium, please contact Tricia Williams, JD, at (405) 271-8202.

FIRST MAUI TRAUMA TREATMENT CLINIC A SUCCESS

APSAC held its First Annual Trauma Treatment Clinic at the Westin Resort on Maui, December 1–5, 2003. Drawing over one hundred participants from the United States, Europe, and Australia, the Clinic was the dream child of outgoing President Jon Conte. He explained its purpose as "providing the latest, intensive, evidence-based knowledge about trauma treatment in an environment that replenishes the mind, emotions, and the senses."

Meeting daily from 7:30 am to 2 pm, participants heard presentations by John Briere, Veronica Abney, Jon Conte, Cindy Swenson, William Friedrich, and Lucy Berliner. From the untraditional opening by a local teacher of Hula (who held his infant son and explained why it takes a family and community to raise a child) to the traditional closing summation, participants were extremely pleased with the setting and content of the training. They also appreciated opportunities for informal discussions with the faculty and other participants. A significant number of participants indicated they want to return next year. Participants wrote the following in their evaluations:

"Well organized seminar! I will strongly recommend attendance to any APSAC seminars."
"I really enjoyed the opportunity to hear these celebrated masters!"
"First conference for me. My cup runneth over!"
"Outstanding! I am looking forward to APSAC's next learning opportunities."
"This was really a terrific program and opportunity. The location was terrific and speakers were really excellent."
"Very good overall! One of the best trainings that I have attended!"
"Excellent conference; it reinforced, reminded, reworked, and renewed! Many thanks!"

Plan to join APSAC's Second Annual Maui Trauma Treatment Clinic at the Kapalua Bay Hotel and Ocean Villas, December 6–10, 2004. The Kapalua is a smaller, less commercial, upscale hotel set in lovely tropical grounds. We will have even more opportunities for interaction. Please contact APSAC for additional information.

John Kapono'ai Molitau of the Na Hanona Kulike Opiilani (Hula School) and his son offer a traditional welcome at the Maui Clinic; reminding participants that it takes ohana (family) and community to raise a child.

Autumn Journal Highlights

Ernestine Briggs, PhD

Journal Highlights informs readers of current research on various aspects of child maltreatment. APSAC members are invited to contribute by sending a copy of current articles (preferably published within the past 6 months) along with a two- or three-sentence review to: Ronald C. Hughes, PhD, Institute for Human services, 1706 East Broad Street, Columbus, Ohio 43203 (fax: 614-251-6005 or phone: 614-251-6000).

From the Editor's Desk

This issue contains both the autumn and winter "Journal Highlights" columns. Ernestine Briggs, PhD, wrote the autumn column. I gratefully welcome Columbus, Ohio, psychologists Judith S. Rycus, PhD, and Ronald C. Hughes, PhD, who wrote the winter "Journal Highlights" and have agreed to continue as regular "Journal Highlights" columnists while Dr. Briggs is on maternity leave to care for her new son. Congratulations to Ernestine and thank you to Ron and Judy.

Erna Olafson, PhD, PsyD, Editor in Chief

Differential Impact of Support on Adjustment After Sexual Abuse

This study investigated age and gender differences in perceived emotional support in children and adolescents who experienced sexual abuse from the time of discovery to 1 year later. Also examined were the relations among sources of support and adjustment and whether support explained resilience. One hundred forty-seven sexually abused youth were interviewed at the time of discovery and 1 year later. Information gathered included severity of the sexual abuse, satisfaction with support from caregivers, same-sex and other-sex friends, feelings of shame about the abuse, and attributional style. Satisfaction with support was differentially related to adjustment. Youth who reported more satisfaction with caregiver support at discovery reported less depression, better self-esteem but more sexual anxiety 1 year later. More satisfaction with support from friends predicted lower self-esteem but less sexual anxiety. More satisfaction with initial caregiver support at discovery predicted better parent- and teacher-rated adjustment 1 year later.

Rosenthal, S., Feiring, C., & Taska, L. (2003). Emotional support and adjustment over a year's time following sexual abuse discovery. Child Abuse & Neglect, 27(6), 641-661.

Accoustic Startle in Maltreated Children

This study investigated the eyeblink component of acoustic startle reactions in maltreated children. Previous research indicated that acoustic startle is enhanced in adult males with posttraumatic stress disorders (PTSD), whereas findings on women with PTSD have been inconsistent. Results suggested that maltreated boys with PTSD, particularly those who had been physically abused, responded to increases in startle probe loudness with smaller increments in amplitude of startle eyeblink and smaller reductions in blink latency than did comparison boys. Results for girls were inconsistent: younger maltreated girls had smaller startle amplitude and slower onset latency than controls, whereas older maltreated girls exhibited the opposite pattern.

Klorman, R., Cicchetti, D., Thatcher, J. E., & Ison, J. R. (2003). Acoustic startle in maltreated children. Journal of Abnormal Child Psychology, 31(4), 359-370.

Maltreatment Among Children of Early Childbearers

This study explored outcomes among three groups of childbearers: mothers who began childbearing as younger adolescents (age 17 yrs or younger), older adolescents (age 18 to 19 yrs), or adults (age 20 to 24 yrs). Results suggested that sociodemographic risk factors persisted into later life for adolescent childbearers. Among younger adolescent childbearers (age 17 yrs or younger), mothers of maltreated and nonmaltreated children did not differ on self-perceptions of social support, competence, or depressive symptoms. Sociodemographic differences between these two groups suggested that younger adolescent childbearers who do not overcome sociodemographic deficits common to early childbearing are at greatest risk for child maltreatment.

Kinard, E. M. (2003). Adolescent childbearers in later life: Maltreatment of their school-age children. *Journal of Family Issues, 24*(5), 687-710.

Intervention for Sexual Abuse Evaluations Using Video Coloscopy

Examined adolescents' responses to a medical examination, which included the use of video colposcopy, were conducted during an investigation of possible child sexual abuse. The study provided an educational intervention regarding genital anatomy and a discussion about abuse issues and sexually transmitted infections. An exit interview assessed perceptions of the medical examination and video colposcopy and reassessed anxiety, using the state portion of the State Trait Anxiety Inventory. Follow-up interviews occurred 3 months later, during which knowledge of reproduction and genital anatomy was reassessed. Seventy-nine percent of the participants chose to watch the examination on the video monitor. The participants' postexamination perceptions were significantly more positive than their preexamination anticipations.

Mears, C. J., Heflin, A. H., Finkel, M. A., Deblinger, E., & Steer, R. A. (2003). Adolescents' responses to sexual abuse evaluation including the use of video colposcopy. *Journal of Adolescent Health, 33*(1), 18-24.

Effectiveness of Group Therapy for IPV

This small pilot study evaluated the effectiveness of group therapy for incarcerated women with histories of childhood sexual and/or physical abuse. The intervention was based on a two-stage model of trauma treatment and included Dialectical Behavior Therapy skills and writing assignments. Twenty-four participants were randomly assigned to group treatment (13 completed) and 25 to a no-contact comparison condition (18 completed). The Beck Depression Inventory, Inventory of Interpersonal Problems, and Trauma Symptom Inventory were used to explore treatment effects. Results suggested reductions in PTSD, mood, and interpersonal symptoms in the treatment group.

Bradley, R. G., & Follingstad, D. R. (2003). Group therapy for incarcerated women who experienced interpersonal violence: A pilot study. *Journal of Traumatic Stress, 16*(4), 337-340.

Process and Adherence Factors in a CBT Treatment Program for Men

This study used multilevel modeling to examine process and treatment adherence factors as predictors of collateral partner reports of

abuse following participation in a cognitive-behavioral group treatment program for partner violent men (N = 107). Therapist working-alliance ratings predicted lower levels of physical and psychological abuse at the 6-month follow-up and were the strongest predictors of outcome. Greater group cohesion during treatment, assessed by client report, also predicted lower physical and psychological abuse at follow-up. The findings support the use of a collaborative therapeutic environment to induce change among partner violent men.

Taft, C. T., Murphy, C. M., King, D. W., Musser, P. H., & DeDeyn, J. M. (2003). Process and treatment adherence factors in group cognitive-behavioral therapy for partner violent men. *Journal of Consulting & Clinical Psychology, 71*(4), 812-820.

Intergenerational Transmission of Partner Violence

Five hundred forty-three children were followed over 20 years to test the independent effects of parenting—exposure to domestic violence between parents (ETDV), maltreatment, adolescent disruptive behavior disorders, and emerging adult substance abuse disorders—on the risk of violence to and from an adult partner. Conduct disorder (CD) was the strongest risk for perpetrating partner violence for both sexes, followed by ETDV and power assertive punishment. The effect of child abuse was attributable to these three risks. ETDV conferred the greatest risk of receiving partner violence; CD increased the odds of receiving partner violence but did not mediate this effect. Child physical abuse and CD in adolescence were strong independent risks for injury to a partner. Implications for prevention are highlighted.

Ehrensaft, M. K., Cohen, P., Brown, J., Smailes, E., Chen, H., & Johnson, J. G. (2003). Intergenerational transmission of partner violence: A 20-year prospective study. *Journal of Consulting & Clinical Psychology, 71*(4), 741-753.

Cortisol Responsivity for Abuse-Related PTSD

This study assessed cortisol responsivity to a stressful cognitive challenge in patients with PTSD related to childhood abuse. Salivary cortisol levels, as well as heart rate and blood pressure, were measured before and after a stressful cognitive challenge in patients with abuse-related PTSD (N=23) and healthy comparison participants (N=18). PTSD patients had 61% higher group mean cortisol levels in the time period leading up to the cognitive challenge, and 46% higher cortisol levels during the time period of the cognitive challenge, compared to controls. Both PTSD patients and controls had a similar 66% to 68% increase in cortisol levels from their own baseline with the cognitive challenge. Following the cognitive challenge, cortisol levels fell in both groups and were similar in PTSD and control groups. PTSD patients appeared to have an increased cortisol response in anticipation of a cognitive challenge relative to controls.

Bremner, J. D., Vythilingam, M., Vermetten, E., Adil, J., Khan, S., Nazeer, A., Afzal, N., McGlashan, T., Elzinga, B., Anderson, G. M., Heninger, G., Southwick, S. M., & Charney, D. S. (2003). Cortisol response to a cognitive stress challenge in posttraumatic stress disorder (PTSD) related to childhood abuse. *Psychoneuroendocrinology, 28*(6), 733-750.

Exposure to Domestic Violence: Terminology and Taxonomy

Three definitional issues regarding children exposed to domestic violence were examined in this study. First, the multiple ways in which a child can be exposed to violence were discussed and a taxonomy of 10 types of exposure was proposed. Nine key characteristics of domestic violence, as they relate to children and children's exposure, were outlined. The third issue addressed concerns why children who are exposed to domestic violence can be considered victims of child maltreatment. These children, by nature of their experience in the home, are psychologically maltreated and are also at high risk for physical abuse and some risk for sexual abuse. The author concluded with a discussion of empirical questions concerning these definitions and taxonomies and their interrelations.

Holden, G. W. (2003). Children exposed to domestic violence and child abuse: Terminology and taxonomy. *Clinical Child & Family Psychology Review, 6*(3), 151-160.

Psychological Abuse Associated with IPV

This study described the prevalence and correlates of psychological abuse in a sample of 3,370 adult women assaulted by male intimate partners. History of physical and psychological abuse and other incident characteristics were collected. Prior psychological abuse was reported by most (80%) of the women, and rarely did physical aggression occur in the absence of psychological abuse. Men with a history of extra familial criminality and substance abuse were more likely to engage in psychological abuse, but demographic characteristics of the offenders showed little relationship to the use of these emotionally abusive tactics. Results also suggested that psychological abuse, independent of physical aggression, was related to victims' perceived threat and plans to leave the relationship. The authors discuss the need for evaluation of psychological abuse, independent of physical abuse, to understand its impact on victims.

Henning, K., & Klesges, L. M. (2003). Prevalence and characteristics of psychological abuse reported by court-involved battered women. *Journal of Interpersonal Violence, 18*(8), 857-871.

Winter Journal Highlights

Judith S. Rycus, PhD, MSW
Ronald C. Hughes, PhD, MScSA

Journal Highlights informs readers of current research on various aspects of child maltreatment. APSAC members are invited to contribute by sending a copy of current articles (preferably published within the past 6 months) along with a two- or three-sentence review to: Ronald C. Hughes, PhD, Institute for Human services, 1706 East Broad Street, Columbus, Ohio 43203 (fax: 614-251-6005 or phone: 614-251-6000).

From the Editor's Desk

This issue contains both the autumn and winter "Journal Highlights" columns. Ernestine Briggs, PhD, wrote the autumn column. I gratefully welcome Columbus, Ohio, psychologists Judith S. Rycus, PhD, and Ronald C. Hughes, PhD, who wrote the winter "Journal Highlights" and have agreed to continue as regular "Journal Highlights" columnists while Dr. Briggs is on maternity leave to care for her new son. Congratulations to Ernestine and thank you to Ron and Judy.

Erna Olafson, PhD, PsyD, Editor in Chief

How Drug Use and Treatment Relate to Family Reunification

This study used Cox regression to assess the relationship among parental drug use, drug treatment compliance, and reunification of children in substitute care with their families. Data were collected from in-person surveys of 277 respondents from a 508-person probability sample of parents having an open DCFS case in Cook County, Illinois, as of June 1995. The study found that case duration, infant placement, and kinship placement decreased the rate of reunification. The study also suggested the possibility that ongoing parental drug abuse, independent of its effects on parenting, decreased the likelihood of caseworkers' willingness to recommend reunification. The strongest finding was the effect of drug treatment compliance on reunification. Completing drug treatment, in itself, substantially increased the rate of reunification, even in the presence of indicators of ongoing drug use. The authors discuss the difficulties experienced by caseworkers in determining the most appropriate case outcomes to affect their decisions to pursue reunification.

Smith, Brenda D. (2003). How parental drug use and drug treatment compliance relate to family reunification. *Child Welfare, LXXXII, 3,* 335-365

Child Maltreatment Associated With Adolescent Behavior Problems and Depressive Symptomatology

This study focused on the self-reported experience of depressive symptomatology and child abuse in a sample of adolescents with severe behavior problems. Data were collected from 81 adolescents, ages 11 to 18, including 46 boys and 35 girls, receiving public children's services in the Netherlands. Thirty-two percent of the adolescents reported depressive symptomatology. Of these children, 62.8% had been physically abused and 20+% had been sexually abused. A majority of the adolescents who met the criteria for Major Depressive Episode reported a combination of neglect, physical abuse, or sexual abuse. The study concluded that for adolescents with behavior problems, there is a distinct group who has depressive symptomatology, and this group has a significantly higher reported incidence of abuse, including combinations of neglect, sexual abuse, and physical abuse.

Westenberg, E. & Garnefski, N. (2003). Depressive symptomatology and child abuse in adolescents with behavior problems. *Child and Adolescent Social Work Journal. 20*(3), 197-210.

Correlates of Child Neglect

This study reported the findings of an extensive review of the empirical literature on the correlates of child neglect. An initial group of 68 articles, published between 1990 and 2002, were reviewed to identify those that focused exclusively on the correlates of physical neglect, neglectful supervision, or neglect as an aggregate criterion variable. A total of 24 articles met the final criteria for inclusion in the review. All but one study used nonexperimental designs, including secondary data analysis, ex post facto, and survey methods. Two studies were longitudinal; the remainder were cross-sectional. The study samples were generally large, but the majority used nonprobability sampling. The author determined that the limited number of studies specific to neglect, and the diversity in definitions and study criteria found in these studies, made it challenging to draw conclusions and generalize them beyond this review. However, the composite data from these studies do offer a comprehensive picture of many of the correlates of child neglect. These characteristics are fully reported in this study, divided into categories of child characteristics, home environment, parental characteristics, and social environment. The author concluded that neglect has been insufficiently studied, and that multilevel comparison research is needed to adequately describe the correlates of neglect. Several topics are recommended for further research, including the need for exploration of age-specific indictors of neglect.

Connell-Carrick, K. (2003). A critical review of the empirical literature: Identifying correlates of child neglect. *Child and Adolescent Social Work Journal, 20*(5), 389-425.

Prevalence and Psychological Sequelae of Self-Reported Childhood Physical and Sexual Abuse

This study examined the prevalence and psychological sequelae of childhood sexual and physical abuse in adults from the general population. A written survey questionnaire was distributed to a geographically stratified, random sample of 1,442 adult subjects from the United States. A total of 64.8% (N=935) returned substantially completed surveys. The questionnaires incorporated the Traumatic Events Survey (TES), which evaluates a wide range of childhood and adult traumas, and the Trauma Symptom Inventory (TSI), a 100-item test of posttraumatic stress and other psychological sequelae of traumatic events. A total of 66 men (14.2%) and 152 women (32.3%) reported childhood experiences that satisfied the criteria for sexual abuse. One hundred three males (22.2%) and 92 females (19.5%) reported childhood experiences satisfying criteria for physical abuse. A total of 337 subjects (36%) reported at least one instance of sexual or physical interpersonal victimization at age 18 or later. Many of this study's findings were reported to be consistent with those of previous studies. Childhood sexual abuse was found to be a significant risk factor for a range of psychological symptoms in the general population, including elevations on all 10 scales of the TSI, even after controlling for other variables. Physical

abuse was also associated with TSI scores, although to a lesser extent than sexual abuse. The authors contend that this and other studies reinforce the proposition that childhood sexual and physical abuse is endemic in our culture, and that sexual abuse is likely to have significant long-term effects.

Briere, J., & Elliott, D.M. (2003). Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse & Neglect, 27*, 1205-1222.

Mainstream Service Programs Work for Minority Youth

This study reported findings from a meta-analysis of research results regarding the effectiveness of mainstream service programs for minority juvenile delinquents. Three hundred and five studies were selected from a large meta-analytic database, which included empirical research on the effects of juvenile delinquency programs conducted between 1950 and 1996. The study addressed the question of whether mainstream interventions that are not culturally tailored for minority youth have positive outcomes regarding subsequent social behavior, academic performance, and sociomoral development of minority youth. The results showed positive overall intervention effects with ethnic minority respondents on their delinquent behavior, school participation, peer relationships, academic achievement, behavior problems, psychological adjustment, and attitudes. The authors concluded that the best interpretation of the study's data is that mainstream treatments for juvenile delinquents are generally effective, and no less effective for ethnic minority youth than white youth.

Wilson, S.J., Lipsey, M.W., Soydan, H., (2003) Are mainstream programs for juvenile delinquents less effective with minority youth than majority youth? A meta-analysis of outcome research. *Research on Social Work Practice, 13*(1), 3-26.

Cross-type Recidivism Among Child Maltreatment Victims and Perpetrators

This study investigated the extent to which child maltreatment victims and perpetrators were reported for different types of maltreatment over time (cross-type recidivism.) The study also examined whether individual, community, or child welfare service variables were associated with a tendency for the first recidivism event to be the same as the initial report, in situations of sexual abuse, physical abuse, and neglect. Cross-type recidivism was examined prospectively for 4.5 years by linking statewide administrative data on child abuse reporting, at both the child and perpetrator levels, with data on child welfare services and census information. Data analyses included descriptive and logistic regression techniques. The study found substantial cross-type recidivism over time, and the majority of recidivism events involved cross-type recidivism. Further, nonneglect cases that were re-reported to child welfare agencies were likely to return for neglect, and chronically reported cases were highly likely to involve multiple types of maltreatment. The authors present implications of the findings for practice, policy, research, and theory development.

Jonson-Reid, M., Drake, B., Chung, S., & Way, I. (2003). Cross-type recidivism among child maltreatment victims and perpetrators. *Child Abuse & Neglect, 27*, 899-917.

Child Witnesses of Sexual Abuse Provide Relevant Details of Incident

This study was undertaken to determine the relative authenticity of child witnesses to sexual abuse. Reports made by children who witnessed sexual abuse incidents were compared to the reports of alleged child sexual abuse victims. Matched groups of 26 alleged victims of sexual abuse and 26 children who witnessed but did not experience similar events were interviewed about the alleged abuse. All children were interviewed using the NICHD investigative interview protocol. Using open-ended prompts, interviewers were able to elicit more information from witnesses than from victims. However, witnesses and victims provided similar amounts of information about the abuse incidents. The authors conclude that young witnesses, when given open-ended prompts, can provide substantial amounts of forensically relevant details regarding witnessed sexual abuse.

Lamb, M.E., Sternberg, K.J., Orbach, Y., Harshkowitz, I., & Horowitz, D. (2003). Differences between accounts provided by witnesses and alleged victims of child sexual abuse. *Child Abuse & Neglect, 27*(9), 1019-1031.

Co-occurring Forms of Child Maltreatment and Adult Adjustment

This study examined the nature and co-occurrence of various forms of child maltreatment (sexual, physical, emotional, and witnessing violence) reported by Latina college students; and, it explored coexisting maltreatment types and acculturation status as possible contributors to long-term adjustment difficulties. One hundred twelve Latina undergraduate students completed three measures: 1) the Child Maltreatment Interview Schedule-Short Form (CMIS-SF), which utilizes a self-report format to assess the presence, frequency, duration, and severity of childhood experiences of sexual abuse, physical abuse, emotional abuse, and witnessing domestic violence; 2) the Trauma Symptom Checklist-40 (TSC-40), which assesses adult symptoms associated with traumatic childhood or adult experiences; and 3) the Acculturation Rating Scale for Mexican Americans-2nd Edition (ARSMA-11), which assesses the degree of affiliation with each culture in terms of language use, ethnic identity, cultural heritage, ethnic behaviors, and ethnic interaction. The study found that 29% of participants reported being subjected to two or more forms of maltreatment as children. This subgroup reported more trauma symptoms than did those who experienced a single form of maltreatment or none at all. They also reported more severe maltreatment characteristics within each type. The findings did not support a direct association between acculturation and long-term adjustment. The authors suggest that future research focus both on the presence and impact of concomitant forms of maltreatment, as well as the severity of maltreatment of any form when studying possible long-term effects of childhood maltreatment experiences.

Clemmons, J., DiLillo, D., Martinez, I., DeGue, S., & Jeffcott, M. (2003). Co-occurring forms of child maltreatment and adult adjustment reported by Latina college students. *Child Abuse & Neglect, 27*, 751-767.

APSAC CHILD FORENSIC INTERVIEW CLINICS

Seattle, WA April 19 – 23, 2004
Norfolk, VA June 14 – 18, 2004

Seattle, WA, Location

The Holiday Inn SeaTac is the official hotel for the Clinic in Seattle. Next to SeaTac International Airport, it offers a free airport shuttle. A special discounted room rate of $55/night single and $55/night double (not including tax) is being offered to Clinic registrants – call 206-248-1000 by February 23, 2004 and ask for the CJTC/APSAC room block. Please note that this clinic will take place at the Criminal Justice Training Center approximately 5 miles from the hotel.

Norfolk, VA, Location

The Clarion Hotel James Madison is the official hotel for the Norfolk Clinic. It is considered the finest upscale boutique hotel, centrally located in downtown's historic, shopping and cultural districts. The training will take place at the Clarion Hotel, so the need for a rental car is not as great at this location. A special discounted room rate of $79/night (not including tax) is being offered to Clinic registrants – call 757-622-6682 by May 14, 2004 and ask for the APSAC room block.

About the Forensic Interview Clinics

Consistent with its mission, APSAC presents the Forensic Interview Training Clinics, focused on the needs of professionals responsible for conducting investigative interviews with children in suspected abuse cases. Interviewing alleged victims of child abuse has received intense scrutiny in recent years and increasingly requires specialized training and expertise. This comprehensive clinic offers a unique opportunity to participate in an intensive forty-hour training experience and have personal interaction with leading experts in the field of child forensic interviewing. Developed by top national experts, APSAC's curriculum emphasizes state-of-the-art principles of forensically sound interviewing, with a balanced review of several models.

Training Includes:

• An interview practicum component providing an opportunity to çonduct interviews where constructive feedback is utilized to build and improve professional skills. This includes videotaped trainee interviews with actors utilizing real case role-plays.
• Mock court testimony regarding interviewing with attorneys who specialize in child abuse cases.
• Didactic presentations and skill-based exercises led by nationally recognized experts.

Registration Fee Covers:

Clinic training sessions, including child interview practicum and critiques; extensive course materials; didactic presentations; mock court; continental breakfast & afternoon break each day; one closing luncheon; a videotape of your interviews; CEUs and a certificate of completion. Space is limited to 50 participants per clinic, so register early!

IMPORTANT:

APSAC's Forensic Interview Clinics are subject to cancellation in the event of insufficient registration. Therefore, DO NOT make nonrefundable travel arrangements until you receive a confirmation of your registration from APSAC (approximately 2 months prior to the start of the Clinic). In the event of cancellation due to insufficient registration, 100% of the registration fee will be refunded. Attendance at the entire clinic is imperative. Partial registration is not allowed.

For more information and to register, please contact:

APSAC; PO Box 26901, CHO 3B3406; Oklahoma City, OK 73190; phone 405-271-8202; fax 405-271-2931

IN MEMORY OF KATHLEEN STERNBERG, PHD

Kathleen Sternberg died on February 7, 2003, after a long battle against cancer. She was greatly admired by many APSAC members. Kathy grew up in North Carolina, obtained a BSW degree at the Hebrew University in Jerusalem, a masters degree in developmental psychology at the University of Utah, and a PhD in this field at the Hebrew University. Since 1998, she worked in the Section on Social and Emotional Development at the National Institute of Child Health and Human Development.

Kathy was an outstanding researcher and prolific author who made major contributions in several important areas. She initially focused on the issues of child care for young, disadvantaged children, attachment, and the influence of family relationships on children's development. In the mid-1980s, she began to examine aspects of child maltreatment in Israel and soon broadened her work to study the effect of domestic violence on children. Much of Kathy's work was in close collaboration with her husband, Michael Lamb PhD, and together, they conducted several key studies refining the approach to interviewing children about suspected sexual abuse.

Kathy was not content to be just an academic, and much of her work was geared toward improving practice and influencing policy. For several years, she chaired the Federal Interagency Research Committee, helping coordinate the national efforts to support research on child maltreatment. She was also an outstanding teacher and presented all over the world.

Kathy had an infectious enthusiasm; there was nothing jaded or cynical about her. We have sadly lost a major researcher and passionate advocate in our field, much too soon. And, many of us have lost a fine friend. Kathy is survived by Michael and their children: Damon, Aya, Darryn, Jeanette, and Phillip.

Howard Dubowitz

CONFERENCE CALENDAR

March 23-27, 2004
4th African Regional Conference on Child Abuse and Neglect in Africa, Child Trafficking and Child Sexual Abuse in Africa, Enugu, Nigeria
call Prof. Peter O. Ebigbo 234-4257923 or fax 234-42450112, or e-mail: pebigbo@infoweb.abs.net

April 19-23, 2004
APSAC Forensic Interview Clinic, Seattle, WA
call 405-271-8202 or fax 405-271-2931, or e-mail: tricia-williams@ouhsc.edu

May12-15, 2004
Family Support America's 10th Biennial National Conference, Chicago, IL
call 312-338-0900, or visit www.familysupportamerica.org

June 5-8, 2004
National CASA Conference, Washington, DC
call Tracy Flynn 800-628-3233 or fax 206-270-0078, or visit www.nationalcasa.org/casa/confer.htm

June 14-18, 2004
APSAC Forensic Interview Clinic, Norfolk, VA
call 405-271-8202 or fax 405-271-2931, or e-mail: tricia-williams@ouhsc.edu

August 4-7, 2004
APSAC 12th Annual Colloquium, Hollywood, CA
call 405-271-8202 or fax 405-271-2931, or e-mail: tricia-william@souhsc.edu

September 30, 2004
18th Annual Children's Network Conference, San Bernardino, CA
call 909-387-8966 or fax 909-387-4656, or visit www.sbcounty.gov/childnet

March 24-27, 2004
14th IFTA World Family Therapy Conference, Istanbul, Turkey
visit www.ifta2004.org

April 21-23, 2004
5th Annual Child AbuseSummit, Portland, OR
call Sheila Wright 503-655-8218 or fax 503-722-6166, or e-mail: sheilawri@co.clackamas.or.us

May 14-19, 2004
2004 Prevent Child Abuse America National Conference, Lake Buena Vista, FL
call Ann Johnson 312-663-3520 or fax 312-939-8962, or e-mail: ajohnson@preventchildabuse.org, or visit www.preventchildabuse.org/news/conf.htm

June 6-9, 2004
10th International Conference: Recognizing Strength & Resilience, Vienna, Austria
e-mail: safety2004@sicherleben.at, or visit www.safety2004.info

July 11-14, 2004
Victimization of Children & Youth: An International Research Conference, Portsmouth, NH
e-mail: sarahg@cisunix.unh.edu, or visit www.unh.edu/frl

September 19-22, 2004
ISPCAN 15th International Congress on Child Abuse and Neglect, Brisbane, Australia
call 617-3844-1138 or fax 617-6844-0909, or e-mail: ispcan2004@icms.com.ua, or visit www.congress2004.com

October 27-30, 2004
22nd Annual Research and Treatment Conference, Albuquerque, NM
write to: 4900 SW Griffith Drive, Suite 274, Beaverton, OR 97005, or visit www.atsa.com

April 7-9, 2004
4th International Conference on Domestic Violence, Sexual Assault and Stalking, San Diego, CA
call 858-679-2913, or visit www.stopdv.com

April 30 - May 1, 2004
Violence in the World of Youth: Partners in Prevention, A Mini-Conference, San Diego, CA
call Rocky Rowley 858-623-2777 ext. 442 or fax 858-646-0761, or e-mail: fvtrain@alliant.edu, or visit www.fvsai.org

May 25-28, 2004
3rd National Sexual Violence Prevention Conference, Los Angeles, CA
visit www.cdc.gov.ncipc

June 7-11, 2004
Sexual Abuse Forensic Examiner Course
call Diana Faugno 760-739-3444

July 20-22, 2004
Advocacy in Action: Becoming a Powerful Voice for Youth! Research Triangle Park, NC
call Nancy Carter 800-820-0001 or fax 919-384-0338, e-mail: nancy.carter@ilrinc.com, or visit www.ilrinc.com/eposter/productdetail1.asp?catalogID=257

September 19-22, 2004
I9th International Conference on Family Violence, San Diego, CA
call 858-623-2777 ext. 427 or fax 858-646-0761, or e-mail: fvconf@alliant.edu, or visit www.fvsai.org

November 27-30, 2004
ASC Annual Meeting, Nashville, TN
call 614-292-9207 or fax 614-292-6767, or e-mail: asc41@infinet.com or visit www.asc41.com

APSAC ADVISOR

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SAVE THESE DATES!!!!

APSAC'S 12TH ANNUAL NATIONAL COLLOQUIUM AUGUST 4–7, 2004 RENAISSANCE HOTEL HOLLYWOOD, CA!

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