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At Issue
Risk Assessment Instruments in Child Protective Services: Are They 'Evidence'?

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"*If you don't know where you are going, you'll end up somewhere else.*"
–Yogi Berra

Social scientists do not generate information with absolute exactitude. Instead, they rely on the imperfect world of testing, experimentation, debate, and review to determine which social science research is valid and which is invalid. *At Issue* is whether this research is worthy of being labeled "evidence" in the legal sense. In a court of law, *evidence* can be defined as

- a body of facts on which proof is based,
- the means by which a fact is established, or
- facts that tend to support, clarify, or prove an issue in question.

In the child abuse and neglect arena, this raises the question whether risk assessment instruments are classifiable as "evidence" and admissible in court.

Reliability of Evidence

While there is universal agreement that expert testimony and evidence must be reliable, there is less clarity regarding the issue of who has final authority to determine this reliability. The question continually presented over the last century has been whether the court, the scientific community, or the jury should be the final arbiter.

Today, in the United States, the courts are clearly the gatekeepers. However, because judges are not also social scientists, errors will inevitably be made. The hallmark feature of scientific inquiry is its steadfast reliance on empiricism. The only information acceptable as "evidence" must be able to be sensed, measured, and its results reproduced. From a legal perspective, should risk assessment instruments and the data they contain be admissible in court? To address this question it is necessary to establish what "evidence" an expert witness can present to the court, since in most cases, expert testimony is introduced to evaluate the reliability of proffered evidence. Further, the law mandates that trial judges determine whether an expert is relying on proper scientific methodology, and whether the application of that methodology to the conclusions reached is consistent and demonstrable.

Recent Case Law

An upheaval occurred in American evidence law in 1993 when the U.S. Supreme Court issued its *Daubert v. Merrell Dow* decision, overturning 70 years of law governing the area of novel scientific evidence. In writing the majority opinion for the Court, Justice Henry Blackmun held that subjective impressions are biased by the observer's model of the world and, therefore, can be misleading and do not represent definitive scientific evidence or knowledge.

Prior to *Daubert*, the admissibility of expert evidence was governed in federal courts, and in many state courts, by the *Frye* (1923) rule of "general acceptance." Despite its widespread adoption by many courts, this "general acceptance" standard was viewed by some as unduly restrictive, because it sometimes functioned to bar testimony based on intellectually credible but somewhat novel scientific approaches. This meant that novel scientific evidence could not be admitted unless the methods and principles under which it was established had achieved general acceptance within the relevant scientific or behavioral discipline. The *Daubert* court substituted a reliability test for a relevancy test.

Nonetheless, the *Frye* rule has not been discarded. Instead of *Frye's* test of "general acceptance" in the scientific community, the new test requires an independent judicial assessment of reliability. The following boxes summarize the two U.S. Supreme Court decisions.

> *Frye*: Where novel scientific evidence is at issue, the *Frye* inquiry permits the court to defer to scientific expertise as to whether or not the evidence has gained "general acceptance" in the relevant field. The trial court's gatekeeper role is to keep "pseudoscience" from being admitted.

> *Daubert*: General acceptance is considered a standard absent from and incompatible with the Federal Rules of Evidence. Accordingly, "scientific knowledge" must be derived from the scientific method supported by "good grounds" in validating the expert's testimony, establishing a standard of "evidentiary reliability."

The *Daubert* Court explicitly refused to adopt any "definitive checklist or test" for determining the reliability of expert scientific testimony and emphasized the need for flexibility. The Court did list several factors, however, that it thought would be pertinent. They include the following:

- whether the theories and techniques employed by the scientific expert have been *tested*,

- whether they have been subjected to *peer review* and *publication*,
- whether the techniques employed by the expert have a *known error rate*,
- whether they are subject to *standards* governing their application, and
- whether the theories and techniques employed by the expert enjoy widespread acceptance (*Daubert*, 1993, pp. 592-594).

Furthermore, the Court emphasized that the admissibility inquiry must focus "solely" on the expert's "principles and methodology" and "not on the conclusions that they generate."

Another "reliability" issue that courts frequently face is the one addressed by the Supreme Court in *General Electric Co. v. Joiner* (1997). It noted that

> [C]onclusions and methodology are not entirely distinct from one another. Trained experts commonly extrapolate from existing data. But nothing in either *Daubert* or the Federal Rules of Evidence requires a … court to admit opinion evidence which is connected to existing data only by the *ipse dixit* [an unsupported assertion, usually by a person of standing] of the expert. A court may conclude that there is simply too great an analytical gap between the data and the opinion proffered. (*Joiner,* p. 519)

Consequently, courts exercising their gatekeeper role under *Daubert* may properly assess whether an expert's conclusions follow from the methodology employed to reach those conclusions.

Admissibility of Risk Assessment Instruments

It is impossible to identify firm evidence standards that are universally applicable to all branches of science because each one is at a different stage of development, and each discipline employs unique tools of investigation, operates on different assumptions, and uses different methodologies. In general, once a social scientist has properly framed a research question, it is necessary to design a research instrument to gather the appropriate data. The methodological problems that can be encountered are considerable. To name only a few, there are concerns about validity (accuracy of the data regarding a particular circumstance and the ability to generalize those conclusions to other similar circumstances), statistical regression, testing, selection bias, and correlational questions.

Risk assessment in child welfare is not a novel idea, and there is ample case law that has addressed this concept (e.g., *Hernandez v. Tex. Dep't of Protective & Regulatory Servs., 2002; Nicholson v. Williams, 2002; Garcia v. Scopetta*, 2003). In contrast, risk assessment instruments, as used in child protective services, have not yet been embraced or rejected by the courts.

Breathalyzer, fingerprinting, and DNA sampling are examples of hard science "evidence" that are now universally admitted. Polygraphs are not admissible in 49 states. Posttraumatic stress disorder (PTSD), "rape trauma syndrome," and "recovered/repressed memory syndrome" are examples of social science "evidence" that have had mixed receptions.

In sum, we do not yet know what kind of a legal reception risk assessment instruments will receive. In any event, we can predict, with great assurance, that these instruments will be given a thorough shakedown before passing legal muster.

References:

Daubert v. Merrell Dow Pharmaceuticals, 509 U.S. 579 (1993).
Frye v. United States, 54 App. D. C. 46; 293 F. 1013 (1923).
General Electric Co. v. Joiner, 522 US 141, 118 S. Ct. 512 (1997).
Garcia v. Scoppetta, 2003 U.S. Dist. LEXIS 19995 (E.D.N.Y., Nov. 6, 2003).
Hernandez v. Tex. Dep't of Protective & Regulatory Servs., 2002 U.S. Dist. LEXIS 22707 (2002).
Nicholson v. Williams, 203 F.Supp.2d 153 (2002).

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In Pursuit of a More Trauma-Informed Child Welfare System

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Children's lives can be affected by trauma in a variety of ways, from natural disasters and accidents to violence in the community and home. The traumatic experience of child abuse and neglect, especially when combined with a history of other, sometimes unrelated, traumatic events can lead to a variety of emotional and behavioral problems for children. As a result of trauma, abused and neglected children are more likely to experience social, emotional, behavioral, cognitive, and physiological problems as they mature into adolescence and adulthood. This article explores the traumatic impact of child abuse and neglect on children and addresses the need for social services systems to work with children in a manner that is sensitive and responsive to their traumatic experiences in order to help them cope with trauma and prevent long-term negative outcomes.

Child welfare caseworkers serve some of the most severely traumatized children, and it is therefore crucial that they be trained to recognize traumatic stress in maltreated children and know how to respond once it is identified. A large subset of the child welfare population includes children who have been removed from their homes due to abuse and neglect and placed in substitute care. These children often lack many of the supports that facilitate resiliency and are at an extremely high risk for mental health problems, particularly traumatic stress. For this reason, we emphasize the child welfare system.

What Is Trauma?

Traumatic experiences are typically unexpected and uncontrollable (Pynoos, Steinberg, & Wraith, 1995; Terr, 1990). According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR, American Psychiatric Association, 2000), a traumatic experience includes two elements: "The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; and the person's response involved intense fear, helplessness, or horror" (pp. 427-428). Such traumatic events may overwhelm children, disrupt their sense of safety and security, and leave them feeling highly vulnerable.

Types of Trauma

Some traumatic experiences may be abrupt, lasting only a few moments or hours. Rapes, auto accidents, exposure to a natural disaster, or kidnapping are instances of this type of traumatic experience. Other traumatic experiences are more chronic, such as ongoing sexual abuse, physical abuse, or exposure to domestic violence. Children with multiple or chronic traumatic experiences are more likely to be adversely affected by trauma, even if the experiences are unrelated, than are children who have experienced a single traumatic event (Terr, 1991).

Subjective Experience of Trauma

A traumatic experience can affect children differently depending upon the type of traumatic experience, the level of exposure, the child's temperament and history, the child's environment, and the nature of the support systems available to the child. Children's reaction to trauma depends partially on their appraisal of the situation. Because each traumatic experience comprises numerous traumatic moments, the most traumatic part of an experience may differ for different children (Pynoos, Steinberg, & Piacentini, 1999). During a traumatic experience, children undertake an ongoing appraisal of both external and internal threats and make ongoing efforts to manage their reactions. They may attend to visual, auditory, kinesthetic, or somatic sensations as they process this information. During the event, there are often changes in their focus of attention from their personal safety to the safety of loved ones. They may inhibit their own wishes to intervene, retaliate, or try to protect others due to fears of self-harm. If a child is physically injured during a traumatic experience, the child may dissociate or may initiate other self-protective mechanisms to handle the pain. For many children, the most traumatic moment is not during the actual experience, but afterward, as they seek outside help or attempt to help others. They may be separated from their loved ones and support systems, and worry about the safety of others whose well-being is unknown. After the traumatic event, they may experience feelings of guilt for not thinking of or protecting others or for the family disruption that often results from the trauma or their reporting of it.

Intrinsic Factors Influencing the Experience of Trauma

Factors intrinsic to a child can either mitigate or increase the impact of the trauma (Pynoos, Steinberg, & Wraith, 1995). Some children have more biologically sensitive natures and are more easily influenced by negative experiences. These children may startle more easily or be more sensitive to anxiety-provoking situations. Children's prior experiences, typical behavioral responses in stressful situations, and developmental capacities or deficiencies can either provide children with additional resources or create additional challenges for them during trying times. Some children have preexisting psychopathology or may have experienced prior trauma or loss experiences before a traumatic event. Some children have attachment disorders resulting from early instability in their family of origin (Cook et al., 2003). The impact of a current trauma may be affected by these prior experiences.

Another intrinsic factor influencing how children may react is their stage of development at the time of the trauma (Pynoos & Nader, 1998).

1. The primary developmental tasks of infants and toddlers are attachment to primary caregivers and getting their basic needs met. Common problems following trauma for very young children may include eating disturbances, developmental regression, such as bedwetting or soiling, language delay, failure to thrive, or attachment problems (Cahill et al., 1999; National Child Welfare Resource Center for Family-Centered Practice, 2002; Pynoos & Nader, 1998).
2. Preschoolers, who are not yet able to make logical sense of the trauma, may attribute magical qualities to traumatic events and reminders of these events. They may experience cognitive confusion or generalized fear and may have trouble identifying what is distressing them (Pynoos & Nader, 1998). Preschool children may also experience attention problems or become aggressive with others.
3. School-aged children are more likely to take responsibility for a traumatic experience (Pynoos & Nader, 1998). They are more likely to internalize problems, resulting in psychosomatic symptoms and feelings of guilt. Children in this age group may be frequently absent from school and may experience inattention or depression. They may experience en-

uresis or may exhibit violent or aggressive behaviors toward others.

4. Symptoms of trauma in adolescents, who are seeking greater independence from their family of origin, may include dating violence, relationship problems, loss of trust, or runaway behaviors (Pynoos & Nader, 1998). Adolescents may also exhibit antisocial behaviors, substance abuse, or eating or sleeping disorders. They are also at a higher risk for suicide attempts.

Extrinsic Factors Influencing the Experience of Trauma

Children's environments also influence how they appraise and respond to traumatic events (Finkelhor & Kendall-Tackett, 1997). The developmental cycle of the family, including the relationship between the parents and changes in the composition of the household, can influence both stressors and the supports available to the child in the family system. Families disrupted by divorce or by medical or psychiatric illness of parents may create added stressors for a child, as can additional environmental stressors such as living in a violent neighborhood, exposure to drugs, separation from caregivers, multiple school and family placements, and other situational stressors, all of which are commonly experienced by children in the child welfare system. A disruptive family environment may also serve as a continuing reminder of the child's traumatic experience. These factors and others can influence how children respond to traumatic experiences (Cook et al., 2003) and can elevate the risk of subsequent behavioral, emotional, social, and psychiatric problems.

Coping With Trauma

Handling stress associated with trauma is difficult for even the most resourceful and well-adjusted adult with dependable social supports and easily available community resources. Many children have not yet developed either the cognitive or the emotional resources to cope adequately with trauma. When faced with traumatic situations, these children may adopt behavioral strategies to help them cope with a trauma that eventually create additional problems for them. This can be especially true for children who expect trauma to reoccur. They may develop strategies in an attempt to manage the ongoing trauma, which later become maladaptive and prevent them from functioning to their potential. For instance, some children may "check out" mentally or dissociate in response to traumatic experiences (Cook, Blaustein, Spinazzola, & van der Kolk, 2003). While this may be psychologically protective during a traumatic event, if a child is not mentally alert at school, or an adolescent is inattentive while driving, "checking out" behaviors can be disruptive and even dangerous and are associated with a range of risk-taking behaviors (Kisiel & Lyons, 2001).

Incidence and Prevalence of Psychological Problems Among Youth Within Systems of Care

There are wide variances in the reported incidence and prevalence of symptoms among children who have experienced trauma (Cicchetti & Toth, 1995). One report, the "Congressional Briefing on Mental Health Services and Former Foster Care Youth" (2005), identified that within a one-year period, more than half of the youth in the study reported clinical levels on at least one of the following mental health problems: major depression, posttraumatic stress disorder (PTSD), social phobia, panic syndrome, or drug dependence. Consistent with this, researchers in San Diego, California, found that out of 1,618 parents and youths interviewed, 54% of children in five public sectors of care, including child welfare, met criteria for at least one disorder, with the most commonly occurring disorders being ADHD/disruptive disorders and anxiety disorders. About 9% of the children from the child welfare system reported anxiety disorders, with separation anxiety being the most common (4.6%), followed by social phobia (2.5%) and posttraumatic stress disorder (1.7%) (Garland, Hough, McCabe, Yeh, Wood, & Aarons, 2001).

Short-Term Impact of Trauma

Children who have experienced traumas such as child abuse, neglect, or exposure to family violence are at risk for a variety of emotional and behavioral problems (Cahill, Kaminer, & Johnson, 1999; Kendall-Tackett, Williams, & Finkelhor, 1993). As suggested before, common sequelae of traumatic experiences include depression and anxiety (Fergusson, Horwood, & Lynskey, 1996; Lanktree, Briere, & Zaidi, 1991), anger (Flannery, Singer, & Wester, 2001), conduct problems and oppositional behaviors (Ford, 2002; Guterman, Cameron, & Hahm, 2003), dissociation (Kendall-Tackett et al., 1993; McLeer et al., 1988), problems with attention or memory, and learning impairment (Cahill, Kaminer, & Johnson, 1999). One of the most commonly seen problems is PTSD (McLeer et al., 1988). The common symptoms include persistent reexperiencing of the trauma, persistent avoidance of stimuli associated with the trauma, or persistent symptoms of increased arousal (American Psychiatric Association, 2000). Children often manifest these symptoms differently than adults. They may show some symptoms of PTSD but not meet the full criteria, or they might exhibit agitated or disorganized behaviors or other symptoms (Cahill et al., 1999). Exposure to trauma in young children can also alter the neurobiological development of the brain to reflect a repeated state of hyperarousal that can influence their responses to stress for years to come (DeBellis et al., 2002; Perry & Pollard, 1998).

Long-Term Impact of Trauma

Research shows that trauma also has a long-term impact on children's functioning, behavior, and physical health. With support from the Centers for Disease Control and Prevention (CDCP), Felitti and colleagues' Adverse Childhood Experiences (ACE) Study linked exposure during childhood to emotional, physical or sexual abuse, mental illness of a family member, or incarceration of parents to adult behaviors that increase risks to their health (Felitti et al., 1998). These behaviors included smoking, severe obesity, promiscuity, physical inactivity, depressed mood, suicide attempts, and history of sexually transmitted diseases, alcoholism, and drug use. These risky behaviors, in turn, lead to increased risk for serious health conditions, such as stroke, heart attack, cancer, and diabetes (Felitti et al., 1998). By establishing the link between early childhood stress and trauma and later health problems, Felitti and colleagues underscore the importance of treating trauma and its many sequelae in children not only to minimize the potential impact of these traumas on quality of life for these children but also to address the ever-rising healthcare costs of treating serious health problems.

Creating a Trauma-Sensitive Response System

To mitigate both the short-term and long-term impacts of trauma on children, all of the service providers who interact with children in the aftermath of a traumatic experience must be fully educated and informed about their role in treatment and in effective treatment strategies. An initial goal is to create a *trauma-sensitive response system*, in which professionals are trained to recognize children who have experienced trauma, understand the impact of such trauma, and are knowledgeable about trauma-specific service resources available in the community. Within such a system, policies and procedures must emphasize and promote easy access to trauma-specific services for children. Assessment of every child's traumatic experi-

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ences and their impact is a central component of a trauma-sensitive system. Multiple disciplines and service systems should be well educated and prepared so that each child has access to trauma-sensitive services from all involved providers, including mental health professionals, pediatricians, law enforcement officials, judges, school personnel, and child welfare professionals.

Trauma-Sensitive Services in the Child Welfare System

Creating a trauma-informed system may have different implications for different services systems. Within the public child welfare system, the creation of a trauma-informed system has far-reaching implications.

Public child welfare agencies across the country are focusing increasingly on three federally mandated goals: safety, permanency, and child well-being (Harden, 2004). Building a "trauma-informed child welfare system" is vital to achieving all three of these goals. In such a system, professionals understand the impact of trauma on children's behavior, development, relationships, and their coping and survival strategies, and can integrate that understanding into planning for the children and their families. Professionals in a trauma-informed system recognize the need for specialized trauma treatment services and know how to find providers who are qualified to provide the types of services children need. In a trauma-informed system, policies reflect this awareness, professional education supports acquisition of the necessary knowledge and skills, and contract resources and community-based services are knowledgeable about empirically sound programs and practices to treat childhood trauma.

How trauma-informed is the child welfare system currently? There has been minimal research exploring this question for child welfare organizations and for other service systems interacting with children in the aftermath of child abuse and neglect. The National Child Traumatic Stress Network (NCTSN) is a consortium of 54 organizations funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Its mission is to raise the standard of care and to improve access to trauma-sensitive services for traumatized children, their families, and communities throughout the United States (www.NCTSN.org). The NCTSN's Systems Integration Working Group has begun looking at the different agencies that touch the lives of children and their families following incidents of child maltreatment to determine how these agencies help protect children from the negative impact of trauma or, conversely, how they may actually exacerbate traumatic symptoms through their responses (Taylor & Siegfried, 2005). A small survey of 53 agencies in 11 different communities was initiated to explore how service systems gather, assess, and share trauma-related information and how they train their staff concerning child trauma. The survey included representatives from child welfare agencies, dependency courts, foster parent and foster care agencies, schools, and mental health agencies. These agencies were selected because the literature about the integration of trauma-related information and expertise into the responses of these agencies has been scant or nonexistent to date.

The survey revealed mixed results (Taylor & Siegfried, 2005). Most of the organizations surveyed indicated they gathered some information on child trauma; however, the organizations were inconsistent in screening for previous traumas. Only 70% of the sampled agencies routinely assessed for PTSD-related symptoms, and only 59% of the agencies gathered information about trauma reminders and triggers. Although 80% of the agencies trained personnel on the impact of trauma, only 45% reportedly trained their employees on the evidence-based practices available for treating child trauma.

Several recommendations for the child welfare system emerged from this small-scale study, including the following:

1. Provide education and training for front-line staff and supervisors on assessing trauma in children, evidence-based treatment practices, and the importance of recognizing and helping children deal with traumatic reminders.
2. Increase the use of standardized assessment measures.
3. Integrate the completion of a child's trauma profile instrument into child assessment and interview protocols so workers will understand a child's traumatic history and can make appropriate referrals.

Making the Child Welfare System More Trauma-Sensitive

To help the current child welfare system become more trauma-sensitive, it is recommended that education related to trauma and its effects be integrated into the system at multiple levels. At the community/state level, it is important to facilitate the expanded availability of empirically sound treatment programs for children who have experienced trauma. This objective can be achieved by training staff on how to recognize the need for specialized trauma services and how to find or develop service providers qualified to offer it. Other strategies include linking funding to best or promising practices and increasing advocacy for, and contracts with, agencies that are committed to evidence-based practices. Financial support should also be provided for essential training and associated "retooling" costs related to fully implementing a newly learned treatment program.

Governmental agencies and other funding sources can help promote this movement through the programs they fund and the ways in which they hold providers accountable. At the organizational level, policies can be developed that are more trauma-sensitive and further encourage employees to adopt trauma-sensitive practices. Training of front-line workers and substitute care providers can help them gain a greater understanding of child trauma and its impacts on a day to day basis. Training can also increase their sensitivity to the need for specialized treatments for children's problems related to child trauma.

Some specific strategies to increase trauma-sensitive casework are consistent with well-established best practices in the child welfare field. First and foremost is the need to establish the child's actual and perceived physical safety. Good active listening skills, taught at all levels of clinical practice, serve to help children feel heard and less anxious. Children have a need for structure and predictability. As long recognized in child welfare, workers should respect the continuity of the familiar for children and try, whenever possible, to help children remain in a stable environment.

Over the past few years, experts at the NCTSN and National Center for PTSD have been adapting existing adult emergency response models for use with children. While these models were developed to provide disaster-related mental health services in the aftermath of mass traumatic events (such as a natural disaster or a school shooting), many of the principles of this Psychological First Aid (NCTSN and National Center for PTSD, 2005) model can apply to the activities of child welfare workers as well.

In Psychological First Aid, the first goal is always to establish a child's safety and meet immediate, concrete needs for support or help (NCTSN and National Center for PTSD, 2005). Workers should, whenever possible, specify how the child will be kept safe. Predictability and normalcy are important for children, and workers should strive to help reestablish familiar routines to maintain continuity for children. Often when a crisis occurs, children may lose trust in the adults and in the systems that are expected to support them. One of the first goals of intervention is to help reestablish dependable adult protection so the child can regain a sense of trust. This will increase their sense of safety and also help create an environment in which they can begin to heal.

Eight Essential Elements of Trauma-Informed Child Welfare Practice

The NCTSN has identified eight practical but essential elements of trauma-informed child welfare practice to guide caseworkers (NCTSN, 2006):

1. *Maximize the child's sense of safety*: The more anxiety children have about their future, the harder it will be for them to control their fears and emotions and the deeper their problems are likely to become. Caseworkers can build a sense of physical safety by protecting children from further abuse, and they can build a sense of emotional safety by reinforcing the continuity of stable, supportive caregivers, which might include placement with supportive and protective relatives or well-trained foster parents. Maximizing predictability in children's environments through activities such as maintaining current school placements also enhances their sense of safety.

2. *Connect children with professionals who can assist them in reducing overwhelming emotions*: Caseworkers should seek out trauma-informed mental health providers who are trained to deliver well-established and empirically sound trauma treatment protocols, such as Trauma Focused-Cognitive Behavioral Therapy (Cohen, Mannarino, & Deblinger, 2005). These interventions teach children practical ways to identify and control the emotions associated with traumatic memories, including relaxation techniques, such as focused breathing and progressive muscle relaxation. Other techniques include teaching children to control their thoughts (thought stopping) and encouraging them to engage in positive, self-soothing activities.

3. *Connect children with professionals who can help them develop a coherent understanding of their traumatic experience*: A key component of recovering from trauma appears to be the ability to understand and accept what happened (Cook et al., 2003; Taylor, Gilbert, Mann, & Ryan, 2005). Effective trauma treatment includes exploration and correction of inaccurate attributions about the cause of, responsibility for, and results of the traumatic experience(s). Through this component of intervention, children learn to think in new and healthier ways about the trauma and their role in it.

4. *Connect children with professionals who can help them integrate traumatic experiences and achieve mastery over their experiences*: Beyond simply understanding their traumatic experience, children must be able to integrate these experiences within their view of themselves and the world around them (Cohen et al., 2005; Cook et al., 2003; Taylor et al., 2005). Effective trauma treatment exposes children gradually, through clinical exercises, so they are able to learn to discuss the events in ways that do not produce overwhelming emotions.

5. *Address ripple effects in the child's behavior, development, relationships, and survival strategies following a trauma*: Children sometimes adopt techniques and strategies to help them cope with traumatic experiences that are adaptive in a traumatic situation, but maladaptive if applied in different settings or contexts (Cook, et al., 2003). These behaviors or strategies become problematic if a child continues to use them once the traumatic situation has ceased. However, since these may have served a child well during the trauma, a child may resort to using them when faced with other challenges or stress. Caseworkers may be able to assist children directly or through referrals to address these issues.

6. *Provide support and guidance to the child's family*: When faced with stressors related to the involvement of child welfare agencies, children and their families often feel overwhelmed and do not know how to proceed. Caseworkers are in a unique position to assist family members in taking steps toward understanding their situation, helping them regain their equilibrium, and working toward stability for their children and themselves. Toward this end, caseworkers should have a strong commitment to guiding families, which in some cases may include providing direction to help strengthen the family system, while in others, intervention may be directed to move toward a permanent out-of-home placement for a child with the least possible stress for all involved.

7. *Coordinate services with other agencies*: Numerous organizations, including courts, mental health agencies, schools, foster care agencies, child welfare agencies, and others, become involved in the lives of children and families following incidents of child maltreatment (Taylor & Siegfried, 2005). Managing the complexity of interacting with multiple agencies can be overwhelming for children. In addition, children may be retraumatized by having to retell their story multiple times as they interact with different service sectors. Caseworkers have the potential to reduce the negative impact of working with multiple service systems by taking an active role in coordinating services among agencies.

8. *Caseworkers must manage their own professional and personal stress*: Dealing with traumatic events and children's reactions to them on an ongoing basis can be overwhelming for caseworkers. Added to this are frequently high caseloads and stressors associated with logistical and organizational demands. This can create burnout and personal stress. It is vitally important for caseworkers to find ways to manage their own personal and professional stress so they can function effectively on the job and help children and families recover from traumatic experiences.

NCTSN Child Welfare Products

The NCTSN is developing several products for use by the child welfare community to help accomplish the goals described above. These include a policy guide for child welfare administrators, a training toolkit for child welfare agencies, foster parent training materials, and a trauma profile and referral algorithm to help child welfare agencies make appropriate mental health referrals. The goals of these

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products are to help child welfare professionals appreciate the contribution of a lifetime traumatic history to a child's current behaviors; understand the range of acute and long-term responses children may display from prior trauma; recognize how child traumatic stress is exacerbated by ongoing stressors in a child's environment (including separation/loss of caregivers and foster placement stress); be able to sensitively assess children for symptoms related to child traumatic stress in the context of individual development and culture; understand how the impact of child traumatic stress can be mitigated and prevented by the responses of child welfare workers; and be able to make trauma-sensitive plans, communications, and referrals for case management and therapeutic services.

The Training Toolkit is being developed with the involvement of several state agencies and national organizations and will serve as the foundation for training of child welfare professionals in trauma-specific knowledge and skills. One component of the NCTSN initiative to support child welfare is the development of a tool to help caseworkers more fully understand the child's trauma history and its relationship to current behavior. The Child Welfare Trauma Referral Tool is an instrument designed to help child welfare workers make more trauma-informed decisions about the need for referrals to trauma-specific and general mental health services. It is completed by child welfare workers through record reviews and gathering information from key informants. The tool allows caseworkers to document all known forms of trauma in a child's history and the ages at which these traumas were experienced. Questions help to identify a variety of common problems following a traumatic experienceand help determine whether or not the presence of such problems are associated with a child's traumatic experiences. Depending on the answers to these questions, a caseworker may make no referral, make a general mental health referral, or make a referral for trauma-specific services. Additional training products will eventually be developed for foster parents and residential treatment providers as well.

Making an Informed Trauma-Specific Referral

There are a variety of trauma-treatment centers across the country, with varying levels of expertise in treating trauma. Some of these centers use techniques that are evidence-based; others use techniques with little or no research support. Some use techniques that may actually be harmful for children in treatment (Saunders, Berliner, & Hanson, 2004). To make a beneficial trauma-specific referral, caseworkers should be familiar with the core elements of effective trauma treatment and the efficacy of the practices that are being used by the potential trauma treatment providers or centers in their communities.

Common elements of trauma-specific mental health services include a strong therapeutic relationship, psychoeducation about normal responses to trauma, parent support and training, affect expression and regulation skills, stress management and relaxation skills, exposure to traumatic memories/trauma processing, the creation of a coherent narrative story to describe the traumatic experience, building strategies to cope with unpleasant feelings and physiological sensations related to the trauma, and techniques to help correct distortions in thinking or factual misunderstandings about the trauma.

Some of the treatment modalities with evidence to support their efficacy include Cohen, Mannarino, and Deblinger's (2005) Trauma-Focused Cognitive Behavioral Therapy to treat sexually abused children; Kolko and Swenson's (2002) Abuse-Focused Cognitive Behavioral Therapy to treat physical abuse; and Lieberman and Horn's (2002) Child-Parent Psychotherapy for Family Violence.

Many resources exist to help caseworkers identify practices with evidence concerning their efficacy. Some of these resources include the following: *Child Physical and Sexual Abuse Guidelines for Treatment* (Saunders et al., 2004) (www.musc.edu/cvc/guide1.htm); the Substance Abuse and Mental Health Services Administration's National Registry of Effective Programs and Practices (NREPP)(http://modelprograms.samhsa.gov/template.cfm?page= nreppover); the California Evidence-Based Clearinghouse for Child Welfare (www.cachildwelfareclearinghouse.org); the University of Colorado —Boulder's Blueprints project (www.colorado.edu/cspv/blueprints); and Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices (www.chadwick center.org/kaufman.htm). Additional resources are also available through the NCTSN Web site (www.nctsnet.org).

Conclusion

Creating a trauma-informed child welfare system can significantly enhance safety, permanency, and child well-being for the nation's abused and neglected children. This involves accurately recognizing and assessing trauma and then knowing when and to whom to refer children in order to help them manage the aftereffects of traumatic experiences. Accurate assessment and effective intervention may also reduce stress on an already overburdened system. As children's symptoms become less intense, the demands on their caregivers, including foster parents and birth families, will often ease. With reduced stress in families and greater sense of self-control on the part of the child, placements are likely to be more stable and children likely to be at reduced risk of repeated abuse.

A major challenge facing child welfare professionals who hope to enhance the trauma-sensitive nature of their system is the current lack of community professionals who are fully prepared to provide empirically sound, or at least empirically informed, trauma treatment services. While this deficit is quite significant in many communities, child welfare professionals and foster parents should not underestimate their power to help change the system. Active, informed professionals and lay consumers who ask the right questions and expect providers to be trauma-informed and trained in the most effective interventions create a social demand for change in the provider community. Consistent consumer expectations can and will lead to changes in the behavior of community agencies and providers. Merely asking about a provider's training in evidence-based, trauma-specific protocols creates a powerful incentive for providers who are ignorant of the latest research and training to seek it out and to develop new competencies. Therefore, the power to transform the system, over time, may well be in the hands of front-line child welfare professionals and foster parents.

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References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (text revision). Washington, DC: Author.

Cahill, L. T., Kaminer, R. K., & Johnson, P. G. (1999). Developmental, cognitive, and behavioral sequelae of child abuse. *Child & Adolescent Psychiatric Clinics of North America, 8*(4), 827-843.

Chadwick Center on Children and Families. (2004). *Closing the quality chasm in child abuse treatment: Identifying and disseminating best practices*. San Diego, CA: Author. http://www.chadwickcenter.org/kaufman.htm.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2005). *Child and parent trauma-focused cognitive behavioral therapy treatment manual.* New York: Guilford Press.

Congressional Briefing on Mental Health Services and Former Foster Care Youth. (2005, April). Retrieved February 22, 2006, from http://www.connectforkids.org/node/2966.

Cook, A., Blaustein, M., Spinazzola, J., & van der Kolk, B. (Eds.) (2003). *Complex trauma in children and adolescents.* National Child Traumatic Stress Network Complex Trauma Task Force. http://www.NCTSNet.org.

De Bellis, M. D., Keshavan, M. S., Shifflett, H., Iyengar, S., Beers, S. R., Hall, J., et al. (2002). Brain structures in pediatric maltreatment-related posttraumatic stress disorder: A sociodemographically matched study. *Biological Psychiatry, 52,* 1066-1078.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., et al. (1998). The relationship of adult health status to childhood abuse and household dysfunction. *American Journal of Preventive Medicine, 14*, 245-258.

Fergusson, D. M., Horwood, L. J., & Lynskey, M. T. (1996). Childhood sexual abuse and psychiatric disorder in young adulthood, II: Psychiatric outcomes of childhood sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 1365-1375.

Finkelhor, D., & Kendall-Tackett, K. A.(1997). A developmental perspective on the childhood impact of crime, abuse, and violent victimization. In D. Cicchetti & S. Toth (Eds.), *Symposium on developmental psychopathology and developmental perspectives on trauma: Vol. 8* (pp. 1-32). Rochester, NY: University of Rochester Press.

Ford, J. D. (2002). Traumatic victimization in childhood and persistent problems with oppositional defiance. *Journal of Aggression, Maltreatment and Trauma, 6*, 25-58.

Flannery, D. J., Singer, M. I., & Wester, K. (2001). Violence exposure, psychological trauma, and suicide risk in a community sample of dangerously violent adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*, 435-442.

Garland, A. F., Hough, R. L., McCabe, K., Yeh, M., Wood, P. A., & Aarons, G. A. (2001). Prevalence of psychiatric disorders in youths across five sectors of care. *Journal of the American Academy of Child & Adolescent Psychiatry, 40*(4), 409-418.

Guterman, N. B., Cameron, M., & Hahm, H. C. (2003). Community violence exposure and associated behavior problems among children and adolescents in residential treatment. *Journal of Aggression, Maltreatment and Trauma, 6*, 111-135.

Harden, B. J. (2004). Safety and stability for foster children: A developmental perspective. *Future of Children, 14*(1), 31-47.

Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin, 113*(1), 164-180.

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

Kolko, D. J., & Swenson, C. C. (2002). *Assessing and treating physically abused children and their families: A cognitive-behavioral approach*. Thousand Oaks, CA: Sage.

Lanktree, C. B., Briere, J., & Zaidi, L. Y. (1991). Incidence and impacts of sexual abuse in a child outpatient sample: The role of direct inquiry. *Child Abuse & Neglect, 15*, 447-453.

Lieberman, A. F., & Horn, P. V. (2002). *Manual of child-parent psychotherapy for infant, toddler and preschooler witnesses of domestic violence*. San Francisco: University of California, Child Trauma Research Project.

McLeer, S., Deblinger, E., Atkins, M., Foa, E., & Ralphe, D. (1988). Post-traumatic stress disorder in sexually abused children. *Journal of the American Academy of Child and Adolescent Psychiatry, 27,* 650-654.

National Child Traumatic Stress Network. (2006). *Comprehensive guide: Child trauma and the child welfare system*. Available through the NCTSN Web site at www.nctsnet.org.

National Child Traumatic Stress Network and National Center for PTSD. (2005, September). *Psychological First Aid: Field Operations Guide.* Retrieved February 22, 2006, from http://www.ncptsd.va.gov/pfa/PFA_9_6_05_Final.pdf.

National Child Welfare Resource Center for Family-Centered Practice. (2002, Winter). *Best Practice/Next Practice, 3*, 1-23.

Perry, B. D., & Pollard, R. (1998). Homeostasis, stress, trauma, and adaptation: A neurodevelopmental view of childhood trauma. *Child and Adolescent Psychiatric Clinics of North America, 7*(1), 33-51.

Pynoos, R. S., & Nader, K. (1998). Psychological first aid and treatment approach to children exposed to community violence: Research implications. *Journal of Traumatic Stress, 1*, 445-473.

Pynoos, R. S., Steinberg, A. M., & Piacentini, J. C. (1999). A developmental psychopathology model of childhood traumatic stress and intersection with anxiety disorders—Experiences from the "Jupiter" sinking. *Biological Psychiatry, 46*(11), 1542-1554.

Pynoos, R. S., Steinberg, A. M., & Wraith, R. (1995). A developmental model of childhood traumatic stress. In D. Cicchetti & D. J. Cohen (Eds.), *Developmental psychopathology, volume 2: Risk, disorder, and adaptation.* Series on personality process (pp. 72-95). New York: Wiley.

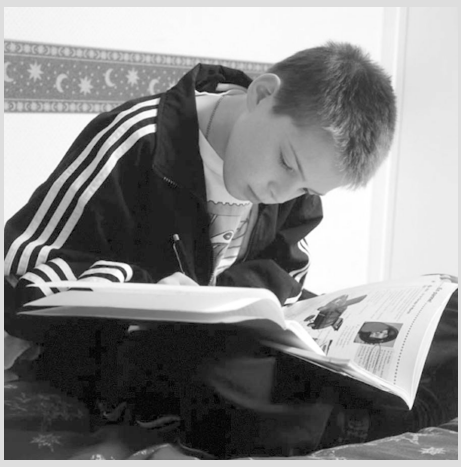
Saunders, B. E., Berliner, L., & Hanson, R. F. (Eds.). (2004). *Child physical and sexual abuse: Guidelines for treatment* (Revised report: April 26, 2004). Charleston, SC: National Crime Victims Research and Treatment Center.

Taylor, N., Gilbert, A., Mann, G., & Ryan, B. E. (2005). Assessment-based treatment for traumatized children: A trauma assessment pathway. Unpublished manuscript, Chadwick Center for Children & Families, Children's Hospital—San Diego.

Taylor, N., & Siegfried, C. (2005). *Helping children in the child welfare system heal from trauma: A systems integration approach*. National Child Traumatic Stress Network Systems Integration Working Group. Retrieved February 22, 2006, from http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/A_Systems_Integration_Approach.pdf.

Terr, L. (1990). *Too scared to cry: Psychic trauma in childhood.* New York: Basic Books.

Terr, L. (1991). Childhood traumas: An outline and overview. *American Journal of Psychiatry, 148*(1), 10-20.



General Pediatricians' Approaches to Screening for Intimate Partner Violence in the Pediatric Setting

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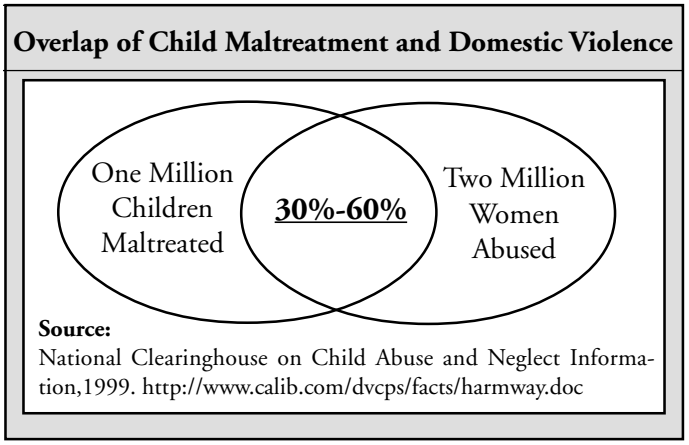
Introduction

Child maltreatment and intimate partner violence are intricately related. This overlap was made clear in a 1999 federal report, entitled "In Harm's Way: Domestic Violence and Child Maltreatment" (National Clearinghouse, 1999)(see Figure 1).

Figure 1: "In Harm's Way" Graphic Demonstrating the Relationship Between Child Maltreatment and Intimate Partner Violence



Studies show that within groups of children with suspected abuse or neglect, 45% to 59% of their mothers have been battered (National Clearinghouse, 1999; Tjaden & Thoennes, 2000). Children of battered mothers are 6 to 15 times more likely to be abused themselves (National Clearinghouse, 1999). Child abuse occurs in 33% to 77% of families in which there is abuse of an adult (Tjaden & Thoennes, 2000). However, just witnessing violence in the home may be as traumatic to children and have as significant psychosocial and developmental consequences as being directly abused (Wolfe & Korsch, 1994; Groves, 2002; Osofsky, 2003). Children who observe or overhear domestic violence significantly outnumber children who are themselves physically injured. In the United States, it estimated that between 3.3 and 10 million children yearly witness physical assaults between their parents (National Clearinghouse, 1999; Tjaden & Thoennes, 2000; Groves, 2002; Osofsky, 2003).

Intimate partner violence is a generic term that refers to a pattern of coercive behavior in which an individual establishes and maintains power and control over another with whom he or she has an intimate relationship. Intimate partner violence is synonymous with domestic violence (DV), spousal abuse (SA), wife battering, dating violence, and date rape. It includes not only physical abuse but also verbal, emotional, economic, and sexual abuse and may involve intimidation, threats, and isolation. In the United States, it is currently estimated that between 2 and 4 million women experience intimate partner violence by their male partner annually (National Clearinghouse, 1999; Tjaden & Thoennes, 2000). Nearly 25% of U.S. women will be abused by a current or former partner sometime during their lives (Tjaden & Thoennes, 2000).

It is becoming increasingly apparent that all forms of violence, including intimate partner violence, are a significant threat to the health and well-being of children (Tjaden & Thoennes, 2000; Committee on Child Abuse, 1998). Children who witness violence suffer significant psychological and behavioral problems that can interfere with their ability to function at school, at home, and with their peers and can lead to substance abuse with drugs and alcohol (Campbell & Lewandowski, 1997). These children can be anxious, socially withdrawn, depressed, preoccupied with physical aggression, and have fewer interests and social activities. Their behavioral problems have been reported to include aggressiveness, hyperactivity, conduct disorders, reduced social competence, school problems, truancy, bullying, excessive screaming, clinging behaviors, and speech disorders. They can also have physical symptoms such as headaches, bedwetting, disturbed sleep, failure to thrive, vomiting, and diarrhea. Posttraumatic stress disorder-type (PTSD) symptoms can include recurrent images of the battering, sleep disturbances, excessive worry about the mother's safety, and avoidance of certain activities and thoughts (Campbell & Lewandowski, 1997). Males raised in a household where the mother was beaten by her partner are more likely to be abusive to their own female partner in the future (Tjaden & Thoennes, 2000; Anda, Felitte, Chapman, Croft, Williamson, Santelli, Dietz, & Marks, 2001).

The American Academy of Pediatrics' Committee on Child Abuse and Neglect published a milestone statement in 1998 that advocated screening for domestic violence in pediatric practices (Committee on Child Abuse, 1998). The AAP recommended to pediatricians that questions about family violence become part of anticipatory guidance and that identifying and intervening on behalf of battered women may be one of the most effective means of preventing child abuse (Committee on Child Abuse, 1998). Studies to date have looked at general pediatrician's attitudes toward child abuse (Siegle, Hill, Henderson, Ernst, & Boat, 1999; Parkinson, Adams, & Emerling, 2001; Lapidus, Cooke, Gelven, Sherman, Duncan, & Banco, 2002), barriers to screening for intimate partner violence in the pediatric setting (Erickson, Hill, & Siegel, 2001; Seigel, Joseph, Routh, Mendel, Jones, Ramesh, & Hill, 2003), and the pediatric experience with screening for intimate partner violence in the community practice and pediatric emergency department setting (Wright, Write, & Isaac, 1997; Dowd, Kennedy, Knapp, & Stallbaumer-Rouyer, 2002). This study was conducted to explore in further detail general pediatricians' attitudes, approaches, and practice patterns regarding screening for intimate partner violence in their office settings.

Methods

Survey Sample

The survey sample included a total of 346 pediatricians from southeastern Pennsylvania, southern New Jersey, and Northern Delaware who were divided into two subsets: (1) physicians involved in various medical and resident teaching sites for a major children's hospital and (2) a random sample of physicians not associated with the hospital's teaching program.

Questionnaire

A 49-item questionnaire designed by the investigators consisted of questions about demographic characteristics, practice patterns and attitudes toward screening for domestic violence, and child abuse and domestic violence training. The survey questions were drawn from a search of the literature for commonly cited barriers to domestic violence screening in the primary care setting, situations in which primary care providers feel compelled to screen, and the risks faced by children who come in contact with domestic violence. Also included were 24 5-point, Likert-type questions (1 = strongly disagree, 5 = strongly agree) to assess respondents' perceptions of effects on children of witnessing domestic violence, obstacles to screening, effectiveness of intervening in domestic violence as a way to combat child abuse, and experience in handling domestic violence cases.

Survey Procedure and Data Analysis

The survey was exempted from Institutional Review Board review. Pocket cards detailing an approach to screening for intimate partner violence were included in the mailer as incentive to complete the survey. Mailers were tracked by numerical codes on the questionnaire and on the return envelopes to maintain confidentiality. Two mailings and phone follow-up were conducted in early 2000. The data were analyzed using the SPSS software package.

Results

Surveys were completed and returned by 210 (60.5%) of the 346 pediatricians on the original mailing list. Four surveys were returned incomplete or were refused during phone follow-up. Eighteen surveys were returned undelivered. Seventeen physicians could not be located or were out of the survey area. Seven pediatricians had retired or were no longer practicing medicine. Excluding these groups, the revised sample of pediatricians who received a survey numbered 305, yielding an adjusted response rate of 68.9%.

Personal demographics of respondents are listed in Table 1. Slightly more respondents were women than men (53% vs. 47%). The median age reported was 42 with nearly two thirds under 50. By far, most identified themselves as Euro-American/Caucasian (84%) with the next largest group Asian/Pacific Islanders (11%).

Table 1. Personal Demographics
(*Percentage totals greater than 100% are due to rounding)

Demographic	Number	Percentage*
Gender		
Male	98	46.7
Female	111	52.9
No Response	1	0.5
Age		
<40	69	32.9
40-49	64	30.5
50-59	33	15.7
60-69	13	6.2
>70	1	0.5
No Response	30	14.3
Ethnicity		
Caucasian	177	84.3
Asian/Pacific Islander	22	10.5
African American	7	3.3
Other/ No Response	4	1.9

Table 2 shows respondents' practice demographics. Ninety-five percent of respondents were boarded in pediatrics and 19% had completed fellowships. There was a fairly even distribution of respondents across length of time in practice. The majority of practitioners practiced in a suburban setting (65%), and the fewest practitioners worked in a rural setting (7%). Most respondents worked in a pediatric group practice (70%) and the majority of the remainder, in a hospital-based practice (21%). Sixty percent of practitioners reported teaching medical students.

Table 2. Practice Demographics
(*Percentage totals of less than 100% are due to rounding)

Demographic	Number	Percentage*
Pediatrics Boarded		
Yes	200	95.2
No	9	4.3
No Response	1	0.5
Fellowship-Trained		
Yes	40	19.0
No	167	79.5
No Response	3	1.4
Length of Time in Practice		
0-5 yrs	44	21.0
6-10 yrs	40	19.0
11-15 yrs	42	20.0
16-20 yrs	37	17.6
>20 yrs	47	22.4
Practice Location		
Rural	14	6.7
Suburban	134	63.8
Urban	57	27.1
No Response	5	2.4
Practice Type		
Hospital-based (community)	23	11.0
Hospital-based (university)	21	10.0
Pediatric group	146	69.5
Pediatric solo	15	7.1
Multi-specialty	2	1.0
Other/ No Response	3	1.4
Teach Medical Students		
Yes	126	60.0
No	78	37.1
No Response	6	2.9

Respondents were asked how much education they had received on domestic violence and on child abuse and neglect during their medical training (Table 3). Almost two thirds of respondents reported no domestic violence training in medical school and residency and an even greater proportion had no domestic violence training during fellowship. Training in child abuse and neglect in medical school was more common, with only one fourth of respondents reporting no training and greater than 50% having one to ten hours. In residency, only 10% of individuals had no child abuse training, and a larger proportion had more hours of training than in medical school. During fellowship, there was somewhat of a bimodal distribution of child abuse training. Almost one third of respondents had no training, almost 20% had greater than 15 hours, and the remaining respondents (fewer than 20%) fell in-between in their amount of

Cont'd on page 12

training. Most respondents had not taken a class or continuing medical education course on domestic violence in the past year (89.5%) or in the past three years (70.5%). However, 51.9% of physicians responded that they would take further training on screening and treating domestic violence if offered, 42.4% were not sure, and 5.2% would not take such training if available.

Table 3. Hours of Training on Domestic Violence and Child Abuse and Neglect During Medical Education

Hours of Domestic Violence Training	Medical School n(%)	Residency n(%)	Fellowship n(%)
0	127 (60.5)	124 (59.0)	35 (85.4)
1-4	63 (30.0)	54 (25.7)	5 (12.2)
5-10	8 (3.8)	16 (7.6)	0 (0)
11-15	4 (1.9)	6 (2.9)	0 (0)
>15	5 (2.4)	5 (2.4)	1 (2.4)
Total	207 (98.6)	205 (97.6)	41 (100)
No Response	3 (1.4)	5 (2.4)	N/A
Hours of Child Abuse Training	**Medical School** n(%)	**Residency** n(%)	**Fellowship** n(%)
0	53 (25.2)	20 (9.5)	24 (63.2)
1-4	79 (37.6)	31 (14.8)	4 (10.5)
5-10	41 (19.5)	52 (24.8)	2 (5.3)
11-15	9 (4.3)	23 (11.0)	1 (2.6)
>15	25 (11.9)	78 (37.1)	7 (18.4)
Total	207 (98.6)	204 (97.1)	38 (100)
No Response	3 (1.4)	6 (2.9)	N/A

When asked about their views on screening for domestic violence, 74.8% of respondents thought that general pediatricians should screen for domestic violence in the families of their patients, but only 3.3% had a screening protocol for domestic violence in their practice and only 6.2% had a management protocol. In addition, 35.7% of respondents felt comfortable providing intervention to a victim of DV, 37.6% did not feel comfortable, and 24.3% were unsure. The majority of respondents (62.8%) thought the prevalence of domestic violence in the families of their patients was 5% or less, 13.3% of respondents thought the prevalence was 6% to 10%, and only 5.8% thought the prevalence was greater than 10%. Respondents who were not sure totaled 18.1%.

Physicians were given a list of scenarios and asked under which circumstances they screened for domestic violence in their patients' families. Only 8.1% of respondents screened every patient's family for domestic violence. However, more than half of respondents reported screening in the following situations: when they suspected the child was being abused or neglected (84.3%), when the child had evidence of physical injury (75.2%), when the child had a pattern of acting violently (63.3%), when the child seemed depressed (60.0%), when the child seemed socially withdrawn (54.3%), or when the child had behavioral problems (51.9%). A number of respondents screened when the adolescent abused drugs or alcohol (44.3%), when the child did poorly in school (31.9%), or when the child had developmental delays (16.2%).

Respondents were asked to rate their agreement with 24 Likert-type statements on a scale of 1 (strongly disagree) to 5 (strongly agree). The statements and responses appear in Figure 2.

Discussion

The responses from our survey indicated that a majority of physicians received training and education regarding child maltreatment in medical school, in residency, and during fellowship. These same respondents indicated that few physicians received education and training in domestic violence during medical school, while serving in their residency, or during fellowship. Additionally, very few physicians reported attending in-service training regarding domestic violence, though most indicated they would attend such training if it were made available. In spite of the paucity of training, three fourths of the physicians surveyed indicated that physicians should screen for domestic violence in their patients. It may be reasonable to conclude that if more physicians were trained in the dynamics of domestic violence, even more would conclude that screening is an appropriate intervention. The responses to the opinion component of the survey indicated that respondents believed most strongly that exposure of children to domestic violence would result in behavior problems, poor school performance, and drug or alcohol abuse. There is much research to support their opinions (Graham-Bermann & Edleson, 2001). This research indicated that physicians recognize the need to screen for domestic violence, believe they should be intervening, believe they could help, yet are not intervening appropriately and believe they are ill prepared and poorly equipped to intervene as needed.

In summary, many pediatricians are ready to play their part in screening for intimate partner violence in their practice setting. Prior studies have shown that such screening can uncover the presence of intimate partner violence as well as identify cases of child maltreatment that were previously unknown (Siegel, Hill, Henderson, Ernst, & Boat, 1999; Parkinson, Adams, & Emerling, 2001; Lapidus, Cooke, Gelven, Sherman, Duncan, & Banco, 2002). We recommend that training be made available to pediatricians on topics related to dynamics of domestic violence, treatment options and their expected efficacy, the pediatrician's role in assessment and intervention, and the resources offered by collaborating disciplines. Training should be designed to address the unique needs of pediatricians, such as screening procedures, proper responses to positive findings, reporting responsibilities, and issues related to confidentiality and the physician/patient relationship. Appropriate screening protocols must continue to be developed and validated, and appropriate policies and procedures for pediatrician intervention in domestic violence must be further addressed by such professional organizations as the American Academy of Pediatrics and the American Medical Association.

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Figure 2: Pediatrians' Response to Likert-Type Questions
(5-Point Scale: 1 = Strongly Disagree, 5 =Strongly Agree)

Likert-Type Statement	95% CI (Upper Bound)	95% CI (Lower Bound)	Mean %	SD
Children who witness SA/DV are more likely to have behavioral problems.	4.62	4.46	4.54	0.60
Children who witness SA/DV are more likely to have poor school performance.	4.39	4.24	4.32	0.55
Children who witness SA/DV are more likely to have drug and alcohol problems.	4.31	4.13	4.22	0.67
Intervening to prevent SA/DV is an effective way to combat CAN.	4.18	4.00	4.09	0.67
More pediatricians would screen if there was social work help readily available.	4.12	3.89	4.00	0.83
Children who witness SA/DV are more likely to have psychiatric illnesses.	4.00	3.78	3.89	0.81
Pediatricians don't screen because there is a lack of training during medical school and residency.	3.87	3.63	3.75	0.85
Lack of office protocol is an obstacle to screening for SA/DV.	3.84	3.58	3.71	0.93
Pediatricians don't screen for SA/DV because they have a personal discomfort with handling such cases.	3.80	3.59	3.7	0.76
Pediatricians don't screen for SA/DV because they don't have enough time to handle a positive response.	3.78	3.51	3.64	0.96
There is not enough time in a general pediatrics practice to screen for SA/DV.	3.28	3.14	3.42	1.01
Children who witness SA/DV are more likely to have developmental delays.	3.39	3.17	3.28	0.81
Pediatricians don't screen for SA/DV because they feel powerless to intervene.	3.26	2.98	3.12	0.99
Pediatricians don't screen for SA/DV because they don't want to offend the patient's family.	3.19	2.91	3.05	1.01
Pediatricians don't screen for SA/DV because they don't want to get drawn into a social service or criminal justice proceeding.	3.08	2.82	2.95	0.92
Pediatricians don't screen for SA/DV because victims are unwilling to disclose when they are asked by physicians.	2.85	2.59	2.72	0.91
Pediatricians don't screen for SA/DV because there is a low prevalence of this problem in their practice.	2.73	2.48	2.60	0.89
Pediatricians don't screen for SA/DV because they fear for their own safety.	2.49	2.26	2.38	0.83
Pediatricians don't screen for SA/DV because the victim is an adult and has the responsibility to take his or her own actions.	2.42	2.20	2.31	0.80
Screening for SA/DV is an intrusion on the privacy of the family.	2.11	1.88	2.00	0.85
Screening for SA/DV is not in the realm of pediatrics.	2.07	1.85	1.96	0.76
Screening for SA/DV is possibly a conflict of interest with the child's welfare.	2.01	1.79	1.90	0.77
Pediatricians should not screen for SA/DV because only the child is the patient.	1.80	1.62	1.71	0.65

References

Anda, R. F., Felitti, V. J., Chapman, D. P., Croft, J. B., Williamson, D. F., Santelli, J., Dietz, P. M., & Marks, J. S. (2001). Abused boys, battered mothers, and male involvement in teen pregnancy. *Pediatrics, 107*(2). http://www.pediatrics.org/cgi/content/full/107/2/e19

Campbell, J. C., & Lewandowski, L. A. (1997). Mental and physical health effects of intimate partner violence on women and children. *Psychiatric Clinics of North America, 20*(2), 353-374.

Committee on Child Abuse and Neglect, American Academy of Pediatrics. (1998). The role of the pediatrician in recognizing and intervening on behalf of abused women. *Pediatrics, 101*(6), 1091-1092.

Dowd, M. D., Kennedy, C., Knapp, J. F., & Stallbaumer-Rouyer, J. (2002). Mothers' and health care providers' perspectives on screening for intimate partner violence in a pediatric emergency department. *Archives of Pediatric and Adolescent Medicine, 156*(8), 794-799.

Erickson, M. J., Hill, T. D., & Siegel, R. M. (2001). Barriers to domestic violence screening in the pediatric setting. *Pediatrics, 108*(1), 98-102.

Graham-Bermann, S. A., & Edleson, J. L. (2001). Domestic violence in the lives of children: The future of research, intervention, and social policy. Washington, DC: American Psychological Association.

Groves, B. M. (2002). *Children who see too much: Lessons from the child witness to violence project*. Boston, MA: Beacon Press.

Lapidus, G., Cooke, M. B., Gelven, E., Sherman, K., Duncan, M., & Banco, L. (2002). A statewide survey of domestic violence screening behaviors among pediatricians and family physicians. *Archives of Pediatric and Adolescent Medicine, 156*(4), 332-336.

National Clearinghouse on Child Abuse and Neglect Information. (1999). In harm's way: Domestic violence and child maltreatment. http://www.calib.com/dvcps/facts/harmway.doc

Osofsky, J. D. (2003). Prevalence of children's exposure to domestic violence and child maltreatment: Implications for prevention and intervention. *Clinical Child and Family Psychology Review, 6*(3), 161-170.

Parkinson, G. W., Adams, R. C., & Emerling, F. G. (2001). Maternal domestic violence screening in an office-based pediatric practice. *Pediatrics, 108*(3), E43. http://www.pediatrics.org/cgi/content/full/108/3/e43

Siegel , R. M., Hill, T. D., Henderson, V.A., Ernst, H. M., & Boat, B. W. (1999). Screening for domestic violence in the community pediatric setting. *Pediatrics, 104*(4), 874-877.

Siegel, R. M., Joseph, E. C., Routh, S. A., Mendel, S. G, Jones, E., Ramesh, R. B., & Hill, T. D. (2003). Screening for domestic violence in the pediatric office: A multipractice experience. *Clinical Pediatrics, 42*(7), 599-602.

Tjaden, P., & Thoennes, N. (2000). Full report of the *National Violence Against Women Survey*. NCJ 183781. Washington, DC: U.S. Department of Justice, Office of Justice Programs. http://www.ncjrs.org/txtfiles1/nij/183781.txt

Wolfe, D. A., & Korsch, B. (1994). Witnessing domestic violence during childhood and adolescence: Implication for pediatric practice. *Pediatrics, 94*(4), 594-599.

Wright, R. J. (2000). Identification of domestic violence in the community pediatric setting. *Archives of Pediatric and Adolescent Medicine, 154*(5), 431-432.

Wright, R. J., Write, R. O., & Isaac, N. E. (1997). Response to battered mothers in the pediatric emergency department: A call for an interdisciplinary approach to family violence. *Pediatrics, 99*(2), 186-192.

JOURNAL HIGHLIGHTS
Ernestine C. Briggs, PhD

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

SEXUAL ABUSE

Validity of Indicators of PTSD Using the CBCL

Expert ratings and confirmatory factor analyses were used to derive a posttraumatic stress disorder (PTSD), dissociation, and a combined PTSD/dissociation scale from the Child Behavior Checklist (CBCL). Both the sexual abuse and psychiatric sample differed significantly from the normative sample on all scales, but not from each other. Despite correlations of the dissociation and PTSD/dissociation combined scale with features of trauma and child self-report of PTSD and dissociation, the absence of differences between the clinical groups on the derived scales suggests that the scales measure generic, as opposed to trauma-related, distress.

Sim, L., Friedrich, W. N., Davies, W. H., Trentham, B., Lengua, L., & Pithers, W. (2005). The Child Behavior Checklist as an indicator of posttraumatic stress disorder and dissociation in normative, psychiatric, and sexually abused children. *Journal of Traumatic Stress, 18*(6), 97-105.

Lifetime Burden of Sexual Abuse and Health-Risk Behaviors

A multidimensional approach was used in this study to examine the severity of abuse as a predictor of posttraumatic stress, depression, sexual symptoms, and risky sexual behaviors in a multiethnic sample of 147 HIV-positive women. Results from multivariate models indicated that experiencing both intrafamilial and extrafamilial CSA, adult sexual abuse (ASA), and Latina ethnicity predicted PTSD symptoms. CSA and adult revictimization contributed independently to risk for PTSD and sexual trauma symptoms, but not for risky sexual behaviors. The authors discussed the need for interventions for HIV-positive women that address the abuse experienced and its sequelae.

Myers, H. F., Wyatt, G. E., Loeb, T. B., Carmona, J. V., Warda, U., Longshore, D., Rivkin, I., Chin, D., & Liu, H. (2006). Severity of child sexual abuse, posttraumatic stress, and risky sexual behaviors among HIV-positive women. *AIDS & Behavior, 10*(2), 191-199.

Study Explores Cumulative Effects of Repeated Sexual Victimization

The present study examined the psychological sequelae of child sexual abuse (CSA) and the factors that contributed to revictimization in the form of adult sexual assault (ASA) using a survey of 577 female college students. Results indicated that individuals who reported both CSA and ASA had more PTSD symptoms, were more likely to use drugs or alcohol to cope, acted out sexually, withdrew from people, and sought therapy services. In addition, the revictimized group reported more self-blame at the time of the abuse and currently. The number of maladaptive coping strategies predicted revictimization. The authors concluded with the implications of these findings.

Filipas, H. H., & Ullman, S. E. (2006). Child sexual abuse, coping responses, self-blame, posttraumatic stress disorder, and adult sexual revictimization. *Journal of Interpersonal Violence, 21*(5), 652-672.

PHYSICAL ABUSE

New Directions for the Assessment of PTSD in Young Burn Victims

The purpose of this study was to assess the role of trauma severity on subsequent symptoms of posttraumatic stress disorder (PTSD) and physiological reactivity in a total of 70 children, ranging from 12 to 48 months of age, who were acutely burned. Significant relationships were found between severity of childhood trauma and the total number of PTSD symptoms and physiological reactivity. This study supports the hypothesis that severity of trauma experienced by young children influences psychological and physiological stress indicators after burn injuries. These findings provide new directions for the assessment and prevention of PTSD in this age group.

Drake, J. E., Stoddard, Jr, F. J., Murphy, J. M., Ronfeldt, H., Snidman, N., Kagan, J., Saxe, G., & Sheridan, R. (2006). Trauma severity influences acute stress in young burned children. *Journal of Burn Care Research, 27*(2), 174-182.

High Rates of Violence Exposure for Substance-Dependant Pregnant Women and Their Children

This study examined the prevalence of exposure to violence among 715 substance-abusing pregnant women attending a multidisciplinary perinatal substance abuse treatment program. Their rates of lifetime abuse ranged from 72.7% for physical abuse to 71.3% for emotional abuse to 44.5% for sexual abuse. Their rates of abuse remained fairly high during their current pregnancy. Nearly one third of the women reported having physical fights with their current partner, and 25% of these women reported that children were present during those physical fights. Many of the women perceived a need for counseling regarding exposure to violence for themselves (30%) and their children (15%). This study underscored the value of routine screening for violence exposure in this at-risk population as well as the need to train therapists in specific strategies for helping such women address the psychosocial sequelae associated with abuse.

Velez, M. L., Montoya, I. D., Jansson, L. M., Walters, V., Svikis, D., Jones, H. E., Chilcoat, H., & Campbell, J. (2006). Exposure to violence among substance-dependent pregnant women and their children. *Journal of Substance Abuse Treatment, 30*(1), 31-38.

Pathways to Complicated Grief in Later Life

The purpose of this study was to examine the etiologic relevance of childhood separation anxiety to the onset of complicated grief (CG) relative to major depressive disorder, posttraumatic stress disorder, and generalized anxiety disorder in bereaved individuals. Participants included 283 recently bereaved community-dwelling residents. Childhood separation anxiety was significantly associated with CG (OR = 3.2; 95% CI, 1.2-8.9), adjusting for sex, level of education, kinship relationship to the deceased, prior history of psychiatric disorder, and history of childhood abuse. Childhood separation anxiety was not significantly associated with major depressive disorder, posttraumatic stress disorder, or generalized anxiety disorder.

Vanderwerker, L. C., Jacobs, S. C., Parkes, C. M., & Prigerson, H. G. (2006). An exploration of associations between separation anxiety in childhood and complicated grief in later life. *Journal of Nervous and Mental Disease, 194*(2), 121-123.

OTHER ISSUES IN CHILD MALTREATMENT

Reporting Decisions: Does the Mandate Make a Difference?

Mandated (N = 57) and nonmandated (N = 94) reporters were questioned as to their perceptions of the seriousness of 20 vignettes related to child emotional abuse, as well as their willingness to report the actions contained in the vignettes to child protective services. Results from separate regression equations for mandated and nonmandated reporters indicated two different models in predicting reporting tendencies. Mandated reporters were most affected by the seriousness of the situation and their willingness to engage in prosocial behavior, whereas nonmandated reporters were most motivated by judgments of the seriousness of the abusive situation and their faith in child protective services.

Carleton, R. A. (2006). Does the mandate make a difference? Reporting decisions in emotional abuse. *Child Abuse Review, 15*(1), 19-37.

Ten Years After the Genocide: PTSD in Rwandan Adolescents

A decade after the 1994 Rwandan genocide, the authors interviewed a total of 68 Rwandan orphans about their war experiences and posttraumatic stress disorder (PTSD) symptoms. The two samples comprised youth living either in a child-headed household (CHH) or in an orphanage. All had been exposed to extreme levels of violence and 41% had witnessed the murder of their own mother or father. Of the sample, 44% had PTSD. PTSD vulnerability was greater for youth who at the time of the study lived in CHH than those living in an orphanage; it was also higher in children that were older (i.e., aged 8-13) rather than younger (aged 3-7) during the outbreak of the genocide.

Schaal, S., & Elbert, T. (2006). Ten years after the genocide: Trauma confrontation and posttraumatic stress in Rwandan adolescents. *Journal of Traumatic Stress, 19* (1), 95-105.

Does Severity of PTSD Symptoms Alter Handedness Preference?

This study examined the relationship between PTSD and laterality with respect to handedness in a sample of traumatized children (N=59). Increased mixed laterality was found in all children exhibiting symptoms of PTSD when compared with healthy controls, and children who met DSM-IV diagnostic criteria for PTSD had more mixed laterality than the subthreshold traumatized group (F = 7.71; df = 2,96; p= 0.001). Mixed laterality was positively associated with PTSD symptoms in traumatized children, suggesting that neurological abnormalities may be related to degree of PTSD symptom expression.

Saltzman, K. M., Weems, C. F., Reiss, A. L., & Carrion, V. G. (2006). Mixed lateral preference in posttraumatic stress disorder. *Journal of Nervous and Mental Disease, 194*(2), 142-144.

Washington Update

Thomas L. Birch, JD
National Child Abuse Coalition

CONGRESS STALEMATES ON SPENDING PLAN FOR 2007

Congress began 2 weeks of recess in April without agreement on a budget resolution for 2007. With Republican moderates and conservatives in the House at odds over the $2.8 trillion budget proposal, fiscal policy may continue to exasperate legislators on Capitol Hill. It has been just 3 months since the House moderate Republicans challenged their House Republican leaders over the 2006 budget—a battle that dragged on for some 13 months. Despite the efforts of the moderates, the 2006 budget adopted deep cuts in children's programs.

Now, legislators are back in the fray. The politics of the congressional battle over the 2007 budget resolution reflect the frustrated desire of moderate Republicans and most Democrats to maintain support for popular domestic programs in the face of the President's proposed budget cuts for the coming fiscal year. Conservatives who want to impose deeper spending cuts feel they have compromised enough by accepting the President's spending caps. Moderates say that added spending is needed for education, health, social services, and workforce development. Appropriations leaders object to new rules forced by conservatives to control earmarks and spending authority in emergency situations. If the House continues to stalemate on the budget resolution, the issue will disintegrate and shift focus to battles over the spending in individual appropriations bills.

The 2007 White House budget calls for a cap on discretionary domestic spending. Because the Bush budget would increase defense and security spending, the cap actually represents cuts in most programs. The President's spending plan proposes to continue squeezing funds out of the one-sixth of the budget that lies outside of defense and homeland security and that is subject to annual appropriations. Total discretionary spending for the Department of Health and Human Services would fall by $1.5 billion, with an overall cut of 2.3% in HHS funds. With an inflation rate of 3.2% since 2005, level funding proposed by the President in child welfare means that child abuse prevention, family support, and child protective services continue to suffer cuts in available spending. The assault on domestic programs rests against a backdrop of the $285 billion in additional upper-bracket tax cuts the President aims to achieve during the next 5 years.

Included in the budget narrative sent to Congress is the administration's continuing proposal to introduce legislation offering Title IV-E foster care assistance to states in the form of "flexible grants" as "an option available to all states to participate in an alternative financing system for child welfare that will better meet the needs of each state's foster care population." The proposal to offer foster care funding to states as a block grant, rather than an entitlement to the states as currently provided, has been floated by the Bush administration for the past few years with no forthcoming congressional action.

With the President's $2.77 trillion spending plan for 2007, the deficit is expected to rise to an all-time high of $423 billion, due to increased outlays for the Iraq war and hurricane relief. Defense spending would account for more than half of the federal budget's discretionary funds, representing a 45% increase in the Pentagon's budget since President Bush took office 5 years ago. Even so, the FY07 budget request for the Defense Department does not include the costs of fighting wars in Iraq and Afghanistan, for which the administration will ask Congress to appropriate an additional $120 billion—"off-budget"—to cover fighting for the remainder of this year.

The Senate passed its version of the budget in March and rejected the President's cap on domestic spending. By a 73–27 vote on March 16 with 28 Republicans joining all Democrats—the Senate passed an amendment offered by Senators Arlen Specter (R-PA) and Tom Harkin (D-IA) to add $7 billion in extra spending authority above the President's benchmark for discretionary programs in labor, education, and human services. Republican moderates in the House would like to force the same increase in spending for domestic discretionary funds. They say those programs have faced stagnant spending, while increases have been given to domestic security and the Pentagon. Rep. Michael Castle (R-DE) along with Reps. Fred Upton (R-MI) and Nancy Johnson (R-CT) have forged a coalition of moderates to push an effort in the House to adopt the Senate plan to increase domestic discretionary funding by $7 billion. If their effort fails, and the budget resolution collapses, the appropriators will begin moving their appropriations bills limited only by the ceilings set by their own appropriations committee leadership.

2006 BUDGET CUTS BILL HARMS ABUSED AND NEGLECTED CHILDREN

President Bush signed into law the Deficit Reduction Act of 2005 on February 8, 2006, invoking "a commitment to fiscal responsibility." At the bill signing, the President explained that the legislation was intended to reduce unnecessary spending of taxpayer dollars. In fact, the new law cuts funds for a range of services that have helped protect and treat abused and neglected children. The budget-cutting measure would appear to do little for deficit reduction. According to a January report from the Congressional Budget Office, the federal budget deficits are projected to continue through the decade.

The House cleared the bill for the President's signature on February 1, passing the measure by a slim majority of 50% plus two members of the House of Representatives (216–214). The package of

cuts in entitlement spending, pushed through as necessary for budgetary discipline, takes less than .5% from the total federal spending expected over the next 5 years but will affect significantly the lives of children and families in need.

The spending cuts bill takes particular aim at federally funded foster care services, eliminating $397 million over 5 years—$879 million over 10 years—in foster care assistance for at least 4,000 abused and neglected children who are not able to live safely with their parents, and who have been placed in low-income homes with their grandparents or other relatives. Rep. Heather Wilson (R-NM), one of 13 Republicans in the House voting against the bill, was quoted by the *Washington Post* (November 3, 2005) during debate of the bill last year as saying, "Why would we want to do anything to discourage a family member from taking in a child who has been abused or neglected by his birth parent?"

In cutting these funds, the bill repeals the *Rosales* decision by the Ninth Circuit that expanded Title IV-E foster care eligibility to children placed in the care of grandparents or other relatives. The new bill sets the Title IV-E income eligibility for federal foster care assistance to the criteria used before the *Rosales* ruling: determined by looking at the home—usually the parents—from which the child was removed for abuse and neglect allegations. The new law makes it less likely that states would place children with relatives and thereby undercuts the placement of children with relatives as specified by the Adoption and Safe Families Act (ASFA). Because of the ASFA preference, state child welfare agencies in recent years have chosen to place many abused and neglected children with relatives, thereby respecting family ties and also recognizing the difficulties inherent in recruiting and retaining qualified foster parents. According to HHS, relatives have also become the fastest growing source of permanent adoptive homes for foster children. In some states, the majority of foster children are placed in relatives' homes.

The reconciliation bill further undermines protections for abused and neglected children by restricting the use of Title IV-E administrative case management funding for the placement of children in unlicensed kinship homes, as well as for children leaving some institutional care and moving to foster care. These changes reduce federal spending on Title IV-E by $180 million over 5 years and $411 million over 10 years. These administrative and child placement funds pay for the casework that links children and families with needed services.

Under the new budget provisions, states may not claim federal IV-E funds for children placed "temporarily" in foster care with unlicensed relatives for more than 12 months. The new law also limits federal support for casework provided to children transitioning into foster care from certain institutional settings, such as psychiatric hospitals or juvenile detention centers. Rather than pay for ongoing casework to help children move out of a facility into another foster care setting, the new law limits federal support for only one month prior to the transition.

Finally, the so-called deficit reduction bill cuts Medicaid funding used to provide services to children in foster care to address disabilities and other special needs. The bill also limits access to Medicaid Targeted Case Management for children in the child welfare system. These cuts are estimated to total $760 million over 5 years and $2.1 billion over 10 years. Restricting access to these services will mean that more abused and neglected children do not get the treatment they need.

HHS REPORTS: PROBLEMS IN PREVENTING MALTREATMENT RECURRENCE; STATES IMPROVE IN REDUCING THE ABUSE OF FOSTER CHILDREN

The HHS Children's Bureau reports annually to Congress, as required by the Adoption and Safe Families Act, on the national condition of child welfare services. The results of the most recent report, *Child Welfare Outcomes 2002: Annual Report to Congress*, suggest that many states are improving with regard to reducing maltreatment of children in foster care, while at the same time, states continue to fail in efforts at reducing the overall recurrence of maltreatment.

This fifth in a series of annual reports discusses the results of measuring state performance on seven child welfare "outcomes":

- Outcome 1— Reduce recurrence of child abuse and/or neglect
- Outcome 2—Reduce the incidence of child abuse and/or neglect in foster care
- Outcome 3—Increase permanency for children in foster care
- Outcome 4—Reduce time in foster care to reunification without increasing reentry
- Outcome 5—Reduce time in foster care to adoption
- Outcome 6—Increase placement stability
- Outcome 7—Reduce placements of young children in group homes or institutions

The outcomes reflect specific "performance objectives" for child welfare practice, using data drawn from the federal Adoption and Foster Care Analysis and Reporting System (AFCARS) and the National Child Abuse and Neglect Data System (NCANDS). The report also incorporates information from the HHS Child and Family Services Reviews (CFSR). Two of the outcome measures relate to the prevention of child abuse and neglect.

Reduce recurrence of child abuse and/or neglect (Outcome 1): whether children who are victims of maltreatment are protected from further abuse or neglect. States are measured on the following: *Of all children who were victims of substantiated or indicated child abuse and/or neglect during the first 6 months of the reporting period, what percentage had another substantiated or indicated report within a 6-month period?*

In 2002, many states "experienced challenges" in preventing the recurrence of child maltreatment, according to the report. The incidence of maltreatment recurrence within a 6-month period scored a median of 7.5%. Only 16 of the 42 states providing sufficient data met the national standard for this measure of 6.1% or less.

The HHS study found that states with a higher rate of child victims tended to have a relatively high percentage of maltreatment recurrence, and vice versa. The report concludes that the findings suggest a relationship between a state's performance on the measure of maltreatment recurrence and the state's policies and definitions of child maltreatment. Sates with definitions relatively broad in scope might have higher victim rates and higher percentages of maltreatment recurrence than states with narrower definitions of child maltreatment.

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The report cites CFSR findings that identified barriers to preventing maltreatment recurrence in at least one third of the states:

- Agency risk and safety assessments often are not sufficiently comprehensive to capture underlying issues that contribute to maltreatment, such as substance abuse, mental illness, and domestic violence.
- The child welfare agency does not provide sufficient services to address risk of harm to children, particularly when children remain in their homes.
- The child welfare agency does not consistently monitor families to assess service participation and change in risk factors.

Reduce the incidence of child abuse and/or neglect in foster care (Outcome 2): keeping children safe applies to children in foster care as well as children in their own homes. States are measured on the following: *Of all children who were in foster care during the reporting period, what percentage were the subject of substantiated or indicated maltreatment by a foster parent or facility staff member?*

In 2002, the percentage of children in foster care who were victims of maltreatment scored a median of 0.39, less than the national standard of 0.57% or less, with 25 of the 42 states meeting the national standard. In addition, state performance on this measure improved from 1999 to 2002, the report states.

Information cited from the CFSR findings suggests that states promote the safety of children in foster care by establishing licensing standards for foster homes and care facilities, including standards that prevent overcrowding in foster homes and standards regarding the use of restraints and corporal punishment. Children's safety also is supported when states mandate training for foster parents and facility staff.

TANF CHANGES THREATEN CHILD ABUSE PREVENTION

The reauthorization of the Temporary Assistance for Needy Families (TANF) and child care development programs, which has been stalled in Congress since 2002, finally moved to resolution, with new provisions attached to the Deficit Reduction Act signed into law on February 8. The new TANF provisions include several changes to work participation requirements for states, which could have a negative impact on child welfare services and child abuse prevention efforts.

A significant new provision in the TANF law could compromise the use of TANF funds to support child welfare and child abuse prevention services. The final legislation extends the new work requirements to apply to state-funded TANF programs as well as to federal TANF funds. Currently, states may use their state TANF dollars to support a variety of child welfare and child abuse prevention services. The change would force states to dedicate more of their TANF dollars to work activities rather than child welfare and prevention services, which could restrict the states' flexibility.

Congress bypassed several issues in the reauthorization of TANF, instead leaving it up to the Secretary of the Department of Health and Human Services (HHS) to develop regulations, including determining whether an activity of a TANF recipient counts as work. For that reason, members of the National Child Abuse Coalition recently signed a letter to HHS Secretary Michael Leavitt urging that the TANF regulations give states the flexibility to tailor services to individuals with physical and mental disabilities and those affected by substance abuse. This would support families facing the dual challenges of working and caring for their children and would provide assistance to families moving from welfare to work, while concurrently promoting safety for their children.

In child care funding, the bill increases mandatory child care spending by $1 billion over the next 5 years, which is far below the $12 billion needed, according to Congressional Budget Office estimates, to cover child care costs expected to arise due to the new TANF work requirements. The bill will also continue paying child care support for low-income families who are not receiving TANF. The Center on Budget and Policy Priorities predicts that 255,000 fewer children will receive child care support in 2010 compared with 2004 because of insufficient child care funds and the new TANF work rate.

In addition to addressing TANF and child care reauthorization, the budget reconciliation bill includes TANF provisions that authorize grants at $100 million annually to promote healthy marriage and $50 million each year to promote responsible fatherhood. The funding includes $2 million set aside for competitive awards to fund demonstration projects designed to test the effectiveness of tribal governments in coordinating child welfare services to tribal families at risk of child abuse or neglect. The marriage promotion activities, funded by competitive grants, include developing marriage skills, parenting skills, and conflict resolution skills. Responsible fatherhood activities funded under the statute include counseling, disseminating information on the causes of domestic violence and child abuse, and skills-based parenting education, among others.

About the Author

Since 1981, Thomas Birch, JD, has served as legislative counsel in Washington, D.C., to a variety of nonprofit organizations, including the National Child Abuse Coalition, designing advocacy programs, directing advocacy efforts to influence congressional action, and advising state and local groups in advocacy and lobbying strategies. Birch has authored numerous articles on legislative advocacy and topics of public policy, particularly in his area of specialization in child welfare, human services, and cultural affairs.

APSAC EXPRESSES APPRECIATION TO RECENT INSTITUTE SPEAKERS

The San Diego Institute in January was a great success for APSAC. This could not have been done without the support of the Institute speakers. APSAC would like to recognize these individuals for their ongoing assistance in educating individuals in various areas of child maltreatment:

Joyce Adams
Lori Fraser
Anthony Mannarino
Judith Cohen
Kee MacFarlane
Martin Henry
Deborah Davies

This year APSAC set a record for attendance at the Institutes, which is a testament to its commitment to providing those in the field of child maltreatment the best of educational opportunities. APSAC appreciates your support!

SAVE THE DATE!
JANUARY 22, 2007
APSAC'S ADVANCED INSTITUTE
Town & Country Resort
San Diego, California

FREE REPORT ON CHILD MALTREATMENT

"Child Maltreatment 2004" was released the beginning of April, in conjunction with National Child Abuse Prevention Month. This federally-mandated report includes state-by-state as well as national data on child abuse and neglect. The report is available online via the Children's Bureau Web site at http://www.acf.hhs.gov/programs/cb/pubs/cm04/index.htm.

A free, print copy of the report can be requested from the National Clearinghouse on Child Abuse and Nelgect Information, a service of the Children's Bureau at http://nccanch.acf.hhs.gov, or E-mail: nccanch@icfcaliber.com or 1-800-394-3366.

FREE WEB-BASED LEARNING COURSE

A grant awarded from Substance Abuse and Mental Health Services Administration and the US Deptartment of Health and Human Services offers a free Web-based learning course with 10 free credits for taking the training on Trauma-Focused Cognitive-Behavorial Therapy. Go to http://TFcbt.musc.edu to register and for more information.

ONLINE ACCESS TO *CHILD MALTREATMENT*—FREE TO MEMBERS

Don't miss your chance to have access to APSAC's online journal, *Child Maltreatment*. This service is provided to current members free of charge. All APSAC members should have received a membership card and instructions in the mail. If members did not receive this card, please contact the national office.

ADDRESS UPDATES

The national office would like to remind members that it is important that we maintain current contact information. If you are moving, please contact our office and update your information. It only takes an E-mail or phone call.

SHAKEN BABY SYNDROME AWARENESS WEEK

APSAC supports a resolution by Senator Dobbs designating the third week of April 2006 as Shaken Baby Syndrome Awareness Week. To read the complete resolution, go to www.apsac.org.

The National Center on Shaken Baby Syndrome can provide more resources. The National Center is an organization whose mission is to educate and train parents and professionals, and to conduct research that will prevent the shaking and abuse of infants in the United States. For more information go to www.dontshake.org or call 801-627-3399.

ATTENTION!!! APSAC SEEKS BOARD NOMINATIONS FOR 2007-2009

Board members' contributions of time, energy, and talent play an enormous role in APSAC's success. To remain effective and powerful, APSAC needs the active participation of all members of the Board of Directors. Members who are enthusiastic and supportive but unable to perform duties of a Board member are highly valued and can serve APSAC in many capacities, but should not be nominated for Board Service unless they can devote the time necessaary to fully discharge a Board member's duties.

Nominations are due at APSAC's National Office on June 30, 2006. Complete nominations consist of a nomination form, a 100-400 word letter of nomination from one person or a self-nomination outlining the candidate's qualifications for service on the Board of Directors, and a copy of the candidate's resume and/or curriculum vita. The Nomination Form is on the following page.

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NOMINATION FORM

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

2006 CALL FOR NOMINATIONS
Board of Directors, January 2007 – December 2009

APSAC is seeking nominations of members to stand for election to the Board of Directors for 3-year terms beginning January 2007 – December 2009.

Board members' contributions of time, energy, and talent play an enormous role in APSAC's success. To remain effective and powerful, APSAC needs the active participation of all members of the Board of Directors. Members who are enthusiastic and supportive but unable to perform duties of a Board member are highly valued and can serve APSAC in many capabilities, but should not be nominated for Board Service unless they can devote the time necessary to fully discharge a Board member's duties. These duties include, but are not limited to

- attending at least one board meeting a year
- chairing a committee or subcommittee
- waiving speaking fees for a minimum of 1 APSAC sponsored training event each year
- actively working to generate members and revenue for the association

Nominations are due at APSAC's National Office on June 30, 2006. Complete nominations consist of a nomination form, a 100-400 word letter of nomination from one person or a self-nomination outlining the candidate's qualifications for service on the Board of Directors, and a copy of the candidate's resume and/or curriculum vita.

Nominee_____

Address _____
Street

_____
City State ZIP

Phone Number (_____)_____**E-mail** _____

ATTACHMENTS

1) Summary description of nominee's contributions and past involvement with APSAC, as well as contributions in the field of child maltreatment or specific qualifiers to enhance the overall function of a nonprofit organization. NOT to exceed 100-400 words.

2) Brief job history—a synopsis of the nominee's professional job history. A resume is acceptable.

Nominator: _____

Phone Number (_____)_____**E-mail** _____

DEADLINE
Applications must be received by: June 30, 2006

Nominations may be mailed to:

APSAC

PO Box 30669
Charleston, SC 29417

Or E-mailed to:
apsac@comcast.net

Message From the President

In response to a number of requests from our members, APSAC will be developing new Practice Guidelines in 2006 and over the next few years. In the past, the Guidelines have proven tremendously popular both with our members and with others practicing in the variety of fields addressing child maltreatment. As a tool developed by experts, a set of Guidelines helps professionals new in the field to understand the standard of care in particular practice areas and become familiar with recommended approaches to their work. For those professionals with a great deal of experience, the Guidelines aid in monitoring their own practice and in communicating practice concepts to others.

The development of a set of Practice Guidelines is a labor-intensive process and requires participation from a large number of experts in the field. Adequate representation of the spectrum of views characterizing that field is critical to developing Guidelines that are helpful to professionals working directly with children and families. The Guidelines must go beyond summarizing current theory and research. They must provide a fair and concise depiction of how people practice, the knowledge upon which practice is based, and areas of disagreement. They must also provide practical and effective ways for professionals to confront difficult situations encountered each day.

The process begins with the APSAC membership as a whole. The Board will be distributing a survey this summer, asking you to give us your ideas on areas of practice you think need to be addressed in comprehensive Guidelines. We ask you to give this serious thought. The most obvious topics might be those involving your own field of practice. But think beyond that. What areas of child maltreatment prevention, investigation, or treatment seem to be particularly problematic in your community? In what areas of practice do you see the greatest confusion, or encounter poor or questionable practice? In what situations do you find yourself asking, "What is the best way to handle this?" Which areas would profit from practical, concise guidelines that could be used to train professionals working in those areas? Perhaps your county is struggling with the concept of multidisciplinary teams. It may be that there is disagreement and/or confusion surrounding the issue of how best to approach cases of child neglect. There may be a lack of knowledge of how to identify and intervene in cases of emotional abuse. We want to develop Guidelines that will help our membership in the greatest way possible, so we need to know what you want.

The APSAC Board will be surveyed for potential Guideline topics, as well. A committee of the Board will nominate a given number of topics (selecting from the membership and Board suggestions), and the Board will choose from these. The next step will involve appointing APSAC members (these people may or may not be serving on the Board) to chair individual committees ("expert panels") charged with developing each set of Guidelines. After Guideline topics are identified, they will be announced on the APSAC Web page (www.apsac.org), and volunteers will be nominated to serve on the expert panel. Members are encouraged to volunteer to serve on these panels. Each expert panel will participate in a three-part development process, which will include completing a survey regarding appropriate Guideline content, drafting Guidelines for comment, and revising the draft for final Board approval.

This is clearly no small task, and we expect each set of Guidelines to require many months of preparation. To develop truly useful and effective Guidelines requires participation from all of our members. We start by asking you to give us your ideas. If you are an expert in your field, you may be asked to participate, or you may volunteer to serve on one of the expert panels. Whatever your contribution, your participation is valued and will aid in advancing the field of child maltreatment. It will help the daily efforts of your colleagues and may change the lives of the families we serve.

The survey will be distributed in the upcoming months. Please watch for it on the APSAC Web site or in your E-mail! For more information, don't hesitate to contact either Daphne Wright (apsac@comcast.net) or me (Jordan.greenbaum@choa.org).

Jordan Greenbaum, MD
APSAC President

Message From the Board

Dear Colleagues,

As a nonprofit organization, APSAC depends on the support of members and friends to continue its mission of ensuring that everyone affected by child abuse and neglect receives the best possible professional response. Revenue from membership dues covers less than 40% of our annual operating budget—the balance comes from the Colloquium and other sources such as training, registrations, publications, and the generous support of donors who believe in the work we are doing together.

A big THANK YOU to the following members and supporters who have made financial contributions during 2004 and 2005:

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June 21–24, 2006
2006 APSAC 14th Annual Colloquium
Nashville, TN
Visit: www.apsac.org or
E-mail: apsaccolloquium@charter.net

July 9–11, 2006
22nd Annual Symposium:
The Power of Prevention
Atlanta, GA
Call: 404-870-6588

July 9–12, 2006
International Family Violence and Child Victimization Research Conference
Crimes Against Children Research Center
Portsmouth, NH
Call: 603-862-0767 or
E-mail: fri.conference@unh.edu

July 17–19, 2006
National Institute of Justice Conference 2006
Washington, DC
Visit: www.ojp.usdoj.gov/nij/events/nij_conference2006.html

July 18, 2006
Spanish Speaking Forensic Interviewing of Children
National Advocacy Center
Arlington, VA
Call: 703-228-1134

July 19, 2006
Advanced Domestic Violence and Sexual Assault Workshop
National Institute of Crime Prevention
Las Vegas, NV
Visit: www.nicp.net

July 12–15, 2006
Georgetown University Institute
Orlando, FL
Visit: www.gucchd.Georgetown.edu

July 25, 2006
Children as Crime Victims
Pennsylvania Commission on Crime and Delinquency
State College, PA
Visit: www.pccd.state.pa.us

August 14-18, 2006
OJJP 2006 Regional Training Program
Protecting Children Online
Rochester, NY
Call: 800-648-4966

August 21, 2006
18th Annual Crimes Against Children Conference
Dallas Children's Advocacy Center
Dallas, TX
Visit: www.dcac.org/pages/cacc.aspx

September 3, 2006
16th ISPCAN International Congress on Child Abuse and Neglect
York, United Kingdom
Visit: www.ispcan.org/congress2006

September 13-16, 2006
6th North American Conference on Shaken Baby Syndrome
The National Center on Shaken Baby Syndrome
Park City, Utah
Visit: www.dontshake.com

September 27– October 1, 2006
International Association of Forensic Nurses
14th Annual Scientific Assembly
Vancouver, BC
Visit: www.iafn.org

October 12–15, 2006
NACC National Children's Law Conference
National Association of Counsel for Children
Louisville, KY
Call: 888-828-NACC or
E-mail: advocate@nacchildlaw.org

January 22, 2007
APSAC Advanced Training Institute
San Diego, CA
Visit: www.apsac.org or
E-mail: apsac@comcast.net

APSAC ADVISOR

ISSN 108R-3R19

Save these dates!!!!!

APSAC Advanced Training Institute
San Diego, California, January 22, 2007

15th APSAC Annual Colloquium
Boston, Massachusetts, July 11-14, 2007

For more information Visit: www.apsac.org

APSAC Important Contact Information

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