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Motivational Interviewing and Child Welfare: What Have We Learned?

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Introduction

It has been a decade since motivational interviewing (MI) has been proposed as a promising approach that could be used in child welfare practice (Hohman, 1998). MI was originally developed as an alternative counseling style for use in the substance abuse treatment field, using a collaborative and nonjudgmental approach to clients. The goal of MI in any field of social work is to enable clients to resolve their ambivalence about change and to begin to take steps in a positive direction.

MI is directive in that the social worker strategically chooses what to reflect, clarify, and summarize in a nonjudgmental, empathic manner. Key questions are posed to elicit what is known as "change talk" in an attempt to have clients verbalize how they will solve their problems, instead of the social worker directing them (Miller & Rollnick, 2002). The MI approach may be well-suited for child welfare work as clients are involuntary and are often very resistant to working with social workers (Forrester, McCambridge, Waissbein, Emlyn-Jones, & Rollnick, 2007). Use of MI skills reduces resistance and enables the social worker to work as a partner with clients (Shaffer & Simoneau, 2001).

Motivational interviewing has received a great deal of attention as an evidence-based practice, particularly in the substance abuse field. The California Evidence-Based Clearinghouse for Child Welfare (2006–2007) has evaluated MI to be a "1" or a "well-supported effective practice" for parental substance abuse. MI has also been expanded, applied, and studied in areas other than substance abuse treatment, including co-occurring disorders (Martino, Carroll, O'Malley, & Rounsaville, 2000), smoking cessation (Soria, Legido, Escolano, Yeste, & Montoya, 2006), cardiac care (Brodie & Inoue, 2005), weight management (Resnicow, Jackson, Wang, De, McCarty, Dudley, et al., 2001), HIV prevention (Carey, Braaten, Maisto, Gleason, Forsyth, Durant, et al., 2000), criminal justice (Harper & Hardy, 2000), and homeless adolescents (Peterson, Baer, Wells, Ginzler, & Garrett, 2006). A systematic review of MI found that MI was an efficacious intervention to engage and retain noncoerced clients in drug treatment (Dunn, Deroo, & Rivara, 2001).

Trainers who have gone through the MI Training for Trainers represent 24 countries plus most states in the United States (Rollnick, Miller, & Butler, 2008), indicating the wide interest in MI. With the explosion of knowledge and interest in MI as an evidence-based practice, many agencies and public service systems have had social workers and other helping professionals participate in one- to two-day workshops or more of training. Thus, the purpose of this article is as follows: (1) define and describe concepts of motivational interviewing, (2) review research studies where MI has been applied to child welfare populations, including cases where there is substance abuse and domestic violence, (3) describe what is known about training professionals to become competent in MI, and (4) discuss how child welfare systems and social service agencies can move forward regarding integration of the MI approach.

What Is Motivational Interviewing (MI)?

Motivational interviewing, a client-centered but directive counseling style, was developed in the 1980s as an alternative approach to the confrontational methods typically used in alcoholism-drug dependence treatment. Dr. William Miller, one of the developers of MI, indicated,

> Knowing nothing about alcoholism, I did what came naturally to me—Carl Rogers—and in essence asked patients to teach me about alcoholism and tell me about themselves: how they got to where they were, what they planned to do, etc. I mostly listened with accurate empathy. There was an immediate chemistry—I loved talking to them and they seemed to enjoy talking to me. Then I began reading about the alleged nature of alcoholics as lying, conniving, defensive, denying, slippery, and incapable of seeing reality. "Gee, these aren't the same patients I have been talking to," I thought. The experience of listening empathically to alcoholics stayed with me and became the basis for motivational interviewing. (Miller in Ashton, 2005, p. 26)

In MI, the counselor or social worker works to understand and activate the clients' own internal motivators for change. It is directive in that the social worker, while working toward specific goals, uses communication skills to evoke from clients their own goals, desires, and ways of solving problems. Also important to the "spirit" of MI is to honor the clients' autonomy because clients are ultimately the ones who have to make their own decisions (Miller & Rollnick, 2002; Rollnick et al., 2008).

MI involves a strategic use of specific skills and pays particular attention to how clients engage in "change talk" or discussions around their desire, ability, reasons, or need to change. Using an empathic style, the practitioner works to develop discrepancy between the clients' goals or motivators (such as being a good parent) and the clients' current behavior (leaving children alone to go drinking) and to explore and resolve ambivalence that emerges from the discrepancy. MI builds on the strengths perspective to a "competence" perspective, which assumes that most clients know what they need to do and that they have the skills, strengths, and capabilities to achieve their goals (G. Corbett, personal communication, October 2007). The social worker functions more as a collaborator in the process than as a director (Rollnick et al., 2008). Her job is to support the self-efficacy of the client to make changes and, if she is met with resistance from the client, to "roll" with the resistance and use it as a signal that the social worker needs to change the way she is communicating with the client.

Resistance is not uncommon in child welfare work. Clients are often angry, disagreeable, noncooperative, or threatening. MI is particularly well-suited to engaging reluctant clients. Through reflective listening and empathy, the social worker can connect with clients; however, he is not condoning or agreeing with their

behavior. Of course, it is important to also maintain the focus on the needs of the child and to address the reasons why the social worker is involved with the family (Forrester et al., 2007).

Research of the Use of MI in Child Welfare

MI has been studied in about 180 clinical trials to date (Rollnick et al., 2008). In the area of child welfare, specifically, there have been relatively few studies of the application of MI. A few conceptual articles have indicated that MI fits well with engaging child welfare clients (Hohman, 1998; Hohman, Kleinpeter, & Loughran, 2005; Wahab, 2005a). Rullo-Cooney (1995) provided a detailed description of the goals and services made possible through an Intensive Family Preservation Program (IFPP) that integrated the use of MI. The following section reviews studies regarding the use of MI in the child welfare system and in domestic violence work, since these areas interface greatly with child welfare (Edleson, 1999).

Child Welfare, Substance Abuse, and MI

We found only two studies that have investigated the effect of using MI with parents involved with child welfare, and these were in regard to their initiation and continuation of substance abuse treatment. No studies to date have examined if MI is effective in increasing child safety, well-being, or permanency.

Carroll and colleagues (2001) conducted a randomized control trial to investigate if a single session of MI would increase participants' seeking of substance abuse treatment. The participants of this study were referred from Project SAFE (Substance Abuse Family Evaluation), a partner of Connecticut's Department of Children and Families. A total of 60 participants were randomly assigned to either a control group that received a standard intake assessment of Project SAFE, or to an intervention group that received a standard intake assessment plus a 20-minute MI session. The results of this study indicated that the single, short MI session significantly increased substance abuse treatment initiation at a rate of 59.3% compared with only 29.2% in the control group. Participants of the intervention group also continued to attend treatment at a higher rate, although both groups decreased in treatment attendance over time (Carroll, Libby, Sheehan, & Hyland, 2001).

Mullins, Suarez, Ondersma, and Page (2004) studied the impact of MI interviews on engagement and retention in substance abuse treatment of women who identified having used illicit substances during pregnancy. Participants in this study were under the supervision of Child Protective Services; they had self-reported use of cocaine (40%), marijuana (28%), and methamphetamine (25%). Sixty participants were randomly assigned to three 1-hour sessions of MI (intervention group) or to a control group, which received educational information through videotapes. Both groups also received a 1-hour home visit. Results of this study indicated that all participants followed through with the first session, and more participants of the control group complied with attending the second session at a rate of 64% versus only 49% of the MI intervention group. Participation at the third session decreased in both groups at 42% (control) and 46% (MI group). Thus, this study did not find that MI increased substance abuse treatment engagement or retention of coerced clients. The authors speculated that this may be due to the fact that clients were mandated to treatment and appeared to be hesitant to discuss ambivalence regarding drug use with the therapists. They may have believed that this could be used against them for child removal.

Child Abuse, Domestic Violence, and MI

Wahab (2005a; 2005b) has written conceptual analyses of how MI can be applied to work with domestic violence survivors, indicating that it fits well with the domestic violence field's emphasis on client empowerment. At this time, there have been few studies of MI as an intervention in domestic violence. Kistenmacher (2000) studied 33 male batterers, half of whom were randomly assigned to receive two sessions of MI in addition to court mandated treatment. Results indicated that while there was no change in their self-reported motivation to alter abusive behavior, those who received the MI sessions were less likely to blame external factors for their behavior compared with the control group.

Ogle and Baer (2003) studied the impact of using MI techniques to increase substance abuse treatment participation with survivors of domestic violence (DV). Participants (n=147) of a residential DV shelter were randomly assigned either to a control group, whose members received a substance abuse assessment with written feedback, or to the intervention group, whose members received the same assessment feedback provided in a 45-minute face-to-face interview using MI. The feedback contained information about participants' own substance use compared with that of an average American female, the negative consequences due to their use, their motivation to change substance use, and their psychological symptoms related to substance use. Results showed that applications of MI feedback significantly increased participants' attendance at one substance abuse treatment session, at a rate of 60% for the feedback group versus 0% for the control group.

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Studies of Training in MI

Motivational interviewing is a complex counseling style to learn (Miller, Yahne, Moyers, Martinez, & Pirritano, 2004). Based on research and training experience, Miller and Moyers (2006) propose eight stages that practitioners experience while learning MI. They are as follows: (1) developing a collaborative relationship, with openness to the clients' own expertise or grasping the "spirit" of MI, (2) developing proficiency in client-centered counseling skills, (3) recognition of "change talk" or clients' expressions of their desires, reasons, ability, and need to change, (4) developing the ability to elicit "change talk" or clients' discussions of their desires, abilities, reasons, and need for change, (5) recognizing and "rolling" with client resistance, (6) helping clients develop plans regarding change, (7) consolidating clients' commitment to change, and (8) being able to use MI with other intervention therapies. So, the question arises, what is the best way to learn all of this?

Early studies of training in motivational interviewing focused on evaluating knowledge and skill acquisition after 2 days of training. Rubel, Sobell, and Miller (2000) found that substance abuse counselors were able to make knowledge and skill gains, based on written measures, one of which included the *Helpful Responses Questionnaire* (*HRQ*). This is a series of client statements to which the trainee writes a response, which is scored for adherence to MI (Miller, Hedrick, & Orlofsky, 1991).

Another study of probation officers who had received a 2-day training found that the trainees self-rated their skills in using MI quite high at the end of the workshop. Coded audiotapes of pretraining interviews with clients, posttraining interviews with simulated clients, and a 4-month follow-up of taped interviews with clients indicated that the trainees did make skill gains and maintained them, but that they were not as proficient as their own self-rating suggested. Further, they still continued to utilize non-MI-adherent interviewing methods as well, such as persuading or directing. Qualitative interviews of the probation officers at the 4-month interview found that they felt that they were competent in MI and did not need any more training. The coded tapes also indicated that there were no differences in client responses from pre- to posttesting. Overall, it was found that using the one-shot training was insufficient to make significant enough gains to change client response, although the trainees saw themselves as proficient (Miller & Mount, 2001).

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Baer, Rosengren, Dunn, Wells, Ogle, & Hartzler (2004) conducted a similar study of a 2-day training for substance abuse and mental health clinicians, utilizing a pen-and-paper skills measure, including the *HRQ*, and audiotapes with clients' (real and simulated) pre-, post-, and 2-month follow-up reports. Results indicated that the trainees became proficient in MI skills at posttesting, and 8 of the 19 trainees were able to maintain their proficiency in most areas at follow-up.

Miller, Yahne, Moyers, Martinez, and Pirritano (2004) conducted a clinical trial of training conditions for learning MI. In the EMMEE Trial (Evaluating Methods for Motivational Enhancement Education), 140 social workers, psychologists, addiction counselors, and nurses who had volunteered for a 2-day training were randomly assigned to one of five conditions: (1) workshop only, (2) workshop with coaching, (3) workshop with feedback, (4) workshop with feedback and coaching, and (5) a waiting list, where the trainees received a therapist manual and videotapes. Personal feedback using a standard reporting form was E-mailed or mailed to trainees. It contained scores from coded tapes provided by the participants. Coaching involved six individual 30-minute sessions that were conducted over the telephone.

Participants were asked to provide sample tapes of interviews with clients at pretraining as well as at 4, 8, and 12 months posttraining. All participants were taped interviewing a simulated client posttraining. Tapes were coded using the *Motivational Interviewing Skills Code* (*MISC*) (Moyers, Martin, Catley, Harris, & Ahluwalia, 2003). This measure requires three passes by coders, who first rate global scores of the interaction, follow this with behavior counts of both client and counselor speech, and finally, measure "talk time" by both the counselor and client. Trainees were also asked to provide self-assessment of MI skill, complete the *HRQ*, and undergo several measures of personality characteristics.

Results indicated that all participants were able to make a substantial gain in MI skill proficiency by the end of the workshop. Miller et al. (2004) suggested that this was due to the voluntary nature of the training (versus being required by the probation service as in the Miller and Mount (2001) study). They also speculated that the gains may be more related to the increased emphasis on the "spirit" of MI and decreased emphasis on techniques. Non-MI methods, such as confrontation, declined after training. The MI skill proficiency, however, declined at follow-up measures for the workshop-only group, whose members returned to baseline levels at the 4-month measure. Self-assessment of skills had no correlation with skill level as coded by the *MISC*. No personality characteristics were related to acquisition of MI-skill level. Those who received either feedback or coaching or both were able to sustain proficiency levels at the follow-up measures; those who received both the feedback and coaching showed the most improvement on client responses (decreased resistance, more talk about change) as measured by the *MISC*. Those in the control wait-list group that received a manual and videotapes showed no improvement in their skills. The researchers had difficulty with compliance of the sample in submitting tapes of clients at the follow-up time points (Miller et al., 2004).

Training of Child Welfare Social Workers in MI

Forrester and colleagues (2007) in the United Kingdom investigated the communication skills of child protection social workers and explored whether their being trained in MI and receiving coaching resulted in increased MI-adherent skills. The study recruited 42 social workers who attended 4 days of training on alcohol misuse, with 2 of those days emphasizing MI training. The study consisted of a pretraining interview and 3-month posttraining follow-up. The pretraining assessment included audiotapes of interviews with a standardized client, completing the *HRQ* adapted for social work, clinical vignettes to assess child risk, and responses to a resistant parent scenario that measured empathy and whether the social worker set the agenda or allowed the parent to set the agenda, the latter being consistent with MI.

Trainees were randomly assigned to one of two workshops. The control group received the workshop only, and the intervention group received the workshop plus additional telephone coaching over 3 months. Tapes were also collected with standardized clients at 3 months posttraining and were coded using the *MISC*.

Initial preworkshop results indicated that the social workers used aggressive and confrontational communication styles, had low levels of listening and empathy, and typically set their own agenda instead of allowing the client to do so (Forrester, McCambridge, Waissbein, & Rollnick, 2008). Results at follow-up showed that according to the *HRQ* and the parental resistance scenario, the social workers used more empathy and less confrontation and were less likely to impose their own agenda; however, only 10 out of 35 in the final sample achieved minimal competence in MI. Those who were competent in MI were still able to accurately assess child risk, meaning that they could engage the parent while remaining focused on the child.

In this study, there was low participation in telephone coaching due to time constraints, thus there were no differences among the groups in their level of MI skills. Qualitatively, the social workers reported that they felt better able to handle resistant clients and increase parental engagement; they also felt little support from their agency for MI skill development.

In a somewhat similar study, Owen and Hohman (2007) trained seven domestic violence counselors over 2 days. These counselors also received 2 half-day booster sessions at 4 and 8 weeks posttraining. Three months later they were interviewed regarding their use of MI. Qualitative analysis indicated that the counselors had grasped the "spirit" of MI, felt more confident in their work, and felt better equipped to handle resistant clients. Clients appeared to respond and engage more quickly when they used MI skills. Limitations of this study include lack of taped interviews to determine how proficient the counselors actually were in MI.

Implications for Child Welfare Agencies

MI has been demonstrated to be an effective practice to engage resistant clients in behavioral and medical treatments, particularly in the area of substance misuse treatment. This review found that the initial studies of MI with child welfare clients in the context of drug treatment provided mixed results. MI may be useful for working with the kinds of resistance often seen in parents who are involved with the child welfare system (Forrester et al., 2007; Hohman, 1998); however, more research in the use of MI in child welfare work needs to be conducted. No studies have been conducted at this point to determine if MI, as utilized by child welfare social workers, affects client outcomes, such as client engagement, child safety, or permanency. Client engagement needs to be studied to determine if it, in turn, could influence children being maintained in their own homes, leading to fewer child removals and lower costs.

The review of training studies of MI has indicated that participating in a one-shot training session is not enough to sustain skills, and some social workers may have a difficult time even learning these skills, particularly if they have entrenched non-MI-adherent skills, or they work for a system that does not support learning and practicing MI, or both. The best way to learn MI appears to be through training and ongoing coaching and supervision. Unfortunately, audio- or videotaping client interviews and coding them is an expensive and labor-intensive process. As an alternative, peer-support groups that meet regularly to practice and provide feedback regarding MI skills may be one helpful way to increase and sustain skill development. Busy schedules and large caseloads can make learning MI difficult, as was seen in the training studies; however, if administration at an agency makes learning and incorporating MI skills a priority, individuals may be more likely to take the time and invest energy in learning.

Agencies are sending their social workers to learn MI despite lack of research on how the use of MI may impact child welfare clients. For instance, the State of Washington, in an effort to make its child welfare system more effective, client-focused, and evidence-based, has a new policy initiative focused on strength-based case-management that includes a focus on client engagement and working with clients in a more collaborative manner. Currently, all Child Protective Service and contracted child welfare program professionals (e.g., family preservation services, family reconciliation services, and visiting nurses) are now required to attend a one-day introduction to MI. They are also offered an opportunity to return for a second day of MI training, but this is not required (D. Rosengren, personal communication, December 2008).

Summary

Research has supported the benefits of using MI in contexts other than child welfare. Despite mixed findings in initial studies, MI intuitively appears to be a promising approach for social workers in child welfare practice because many of its tenets are similar to social work values, such as self-determination, client empowerment, and respect for the client. Social workers have reported less resistance from clients when they use MI; the time and commitment to learning MI may be beneficial for clients, social workers, and the agencies in which they work. Although there is little evidence at this time to support this, what we do know is that to truly learn and utilize MI takes more than attending a one-day workshop. Support from agency administration and in supervision and small, peer skill-development groups may help maintain initial skills gained from workshops.

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Interviewing Immigrant Children and Families for Suspected Child Maltreatment[1]

Lisa A. Fontes, PhD

Interviews with children and their families concerning child maltreatment may influence a host of important decisions, including the child's placement, the caretaker's criminal guilt or innocence, and termination of parental rights. When the alleged offenders in question are noncitizen immigrants, a finding of child maltreatment that is followed by criminal prosecution may also result in a parent's deportation. This article aims to help professionals conduct productive interviews, investigations, assessments, evaluations, and medical exams related to child abuse in ways that are empowering to immigrant interviewees from a variety of cultures. For the sake of simplicity, the word *interview* is used to describe the various information-gathering conversations, and the word *interviewer* is used to describe the many professionals who gather information.

Professionals who interview children and families in a variety of settings share the same goal—just to get the facts. However, this process is usually stressful and challenging, particularly when the children are culturally different from the interviewer. Approximately 12.5% of people in the United States are foreign born, and one in five Americans speaks a language other than English at home (U.S. Census, 2005–07). As the number of children in the United States who are immigrants or offspring of immigrants increases, it becomes essential for professionals to acquire skills in competently interviewing children and families from diverse cultures.

Biases, cultural differences, and linguistic misunderstandings have the potential to exert a powerful influence in interviews with immigrants—even when interviewers have the best intentions. This article discusses some of the challenges of interviewing children who are immigrants themselves or who are children of immigrants, and suggests practices for making these interviews more effective. This article also discusses interviewing family members of suspected abuse victims.

Immigrants' concerns vary greatly, depending on whether they are the first generation (born outside the country where they currently live), second generation (born in their current country of residence, but with at least one parent foreign-born), or third generation or greater (person and both parents born in their current country of residence). For interviewees who have emigrated themselves, the age when they moved, the number of years in the new country, and their ability to speak the new language will partly determine their level of acculturation.

This article focuses on interviewees who are less acculturated and whose native culture is quite different from that of the United States, because these are the interviewees who may require the most alteration of the standard interviewing process. An interviewee from a family that has recently immigrated to the United States from El Salvador or the Sudan and speaks no English would require numerous adjustments to the standard interviewing process, whereas an interviewee whose parents emigrated two decades earlier from England probably can be interviewed similarly to other U.S. interviewees.

Despite extensive research on child abuse interviewing, little research is available on interviewing immigrants about suspected child maltreatment. The following suggestions, therefore, are based on the little literature that does exist, on my own professional experience working with immigrant families, and on twenty years of exploring issues of child abuse and culture. I eagerly await published research that would cast further light on relevant issues.

Interviewing People for Whom English Is Not a First Language

The value of allowing people to be interviewed in their native language—whether through an interpreter or through a bilingual assessor—cannot be overemphasized. This interview is too important, and its consequences too far reaching, to force interviewees to give only approximate answers because they cannot find the right word in English. In addition, memory and presentation are both affected by the language chosen for the interview. Interviewees are apt to provide more details, look less depressed, and demonstrate the full range of their competence when they speak in their preferred language (see Fontes, 2008; Perez Foster, 1999).

We should remember that bilingual people may know differing words in each of their two languages. For instance, children may know "school words" such as *ruler*, *blackboard*, *cafeteria*, and *recess* in English, while knowing "home words" such as *sofa*, *closet*, and the names of family relationships in their first language. For this reason, bilingual children who are assessed in just one language may not be able to express their full vocabulary or full conceptual knowledge. They may, therefore, appear less advanced intellectually or developmentally than they really are.

Children who are not native speakers of English may have even more difficulty than other children with complex verb forms such as *would have*, *should have*, *may have*, *might have once wanted*, and so on. And imagine their discomfort with constructions such as, "Where were you when you first told someone that something had happened to you in the alley behind your aunt's building?" Interviewers should keep their questions short and direct, using no embedded clauses. Every so often, interviewers should ask if the interviewee understands the questions. If the interviewer has the sense that the interviewee does not understand, the interviewer should pause and try to ascertain what is happening. Interviews with young children, and with people who are nonnative speakers of English, can move especially slowly, requiring a great deal of time and patience.

Where needed, foreign language interpreters should be secured in advance of interviews. Caretakers who bring children to interviews, and the children themselves, may have differing levels of English language fluency. Minor children should never be expected to interpret for their parents. Otherwise, they might be blamed if the outcome is not as the parents wish, they might not have the

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technical vocabulary required to interpret correctly, they might be confused as to whether they should be interpreting accurately or protecting their parents, and/or the interpreting situation might expose them to material they should not hear. In addition, it is exceptionally disempowering for parents to have to speak through their children.

Interpreters make it possible to listen to people who otherwise would be voiceless in our interviews. High-quality interpretation allows us to obtain information, gain interviewees' confidence, reduce their isolation, understand their worldview, and convey information as needed. Poor-quality interpretation leads to frustration for all involved and can leave children even more vulnerable than before we interviewed them. Similarly, when interpreters are untrained or used inappropriately, problems often abound (Fontes, 2005; Fontes, 2008).

Interpreters do not simply convey the spoken word from both sides, although this is their primary stated function. They also serve as the agents of exchange and negotiation between the worlds of the interviewer and the interviewee (Davidson, 2000). It is not possible to interpret perfectly, since subtleties of meaning and context do differ across cultures. At best, an interpreter can convey what each party says and means in a "good enough" fashion to facilitate mutual understanding. For instance, there is no exact equivalent in Spanish for the concept of *foster parent* or *foster care*. Similarly, the concept of *confidentiality* is unknown in many cultures and there may be no exact term to render such a complicated idea. To translate accurately such ubiquitous terms, interpreters must explain these concepts in some detail.

We usually think of interpreters as conduits rather than participants in conversations. However, research shows that interpreters regularly edit, delete, emphasize, de-emphasize, and embellish statements from both parties. "Interpreters do not merely convey messages; they shape and, in some real sense, create those messages in the name of those for whom they speak" (Davidson, 2000, p. 382). Interpreters not only shape the content that is conveyed but they also make choices about when to speak, whom to interrupt when they speak, and which comments they will "let pass" without interpreting. For these reasons, interviewers are encouraged to read further to learn when and how to use interpreters, and how to make optimum use of interpreting services in child abuse interviews (Fontes, 2005; Fontes, 2008).

Professionals who speak a bit of a language that an interviewee speaks may be tempted to conduct interviews in that language, thus obviating the need for an interpreter. While this may save time and money, it is not advisable unless the interviewer is truly proficient in the language and culture of the interviewee. Clearly, conducting interviews without thoroughly dominating the language increases the likelihood of errors. Knowing the basics of a language is not sufficient to conduct an important and sensitive interview in that language. If an interviewer begins using the interviewee's language but does not speak it adequately, this places the interviewee in the awkward position of not wanting to insult the interviewer by requesting an interpreter. Also, the interviewee may be reluctant to correct the interviewer's faulty understanding.

Building Rapport and Conveying Respect

Interviewers set the foundation for a successful interview by making clear the process and goals of the interview at the very beginning. Remember, children and their caretakers may have little or no idea about the purpose of the interview and may mistakenly think it pertains to healthcare, housing, immigration, employment, or school. The more information that is provided about the context of the communication, the better it will be for the interviewee. In simple terms, interviewees need to know about the role and position of the interviewer and how the information will be used. Interviewers should convey as much as they can about the procedures governing the conversation, such as the time frame and expectations. Interviewees need to know if this is a one-time interview or the beginning of a longstanding relationship. Interviewees should be given time to ask questions themselves at various points in an interview. Since many interviewees are hesitant to ask questions of authorities such as interviewers, it can be helpful for an interviewer to say something like, "Now it's your turn to ask me questions," and to allow silence. If the interviewee still hesitates to ask a question, the interviewer can say something like, "Some people want to know X. Would it be helpful if I spoke about that?"

If the caretaker or child is coming into the interview situation with incorrect assumptions about what is going to take place, this could distort the interview or make it difficult to complete. Often children are uncooperative or overly frightened because they think the interviewer is trying to discover something crazy or evil within them or their histories, which might have potentially disastrous consequences if the badness is discovered. This may be especially true for children who have internalized a sense of blame or shame regarding abuse.

Subtleties in the interviewer's tone, attitude, and word choice can make the interviewee feel ashamed, victimized, accused, bullied, humiliated, encouraged, empowered, exonerated, confirmed, or supported. Child abuse interviewers should minimize any possible aura of invasion or intrusion by paying special attention to their voice, phrasing, and a host of nonverbal elements (see Fontes, 2008). As much as possible, the inquiry should affirm the interviewee's worth and value as a human being, even as the interviewer is especially careful not to reward specific responses.

Experiences with discrimination lead many immigrants to be acutely sensitive to possible demonstrations of disrespect. After multiple experiences of being overlooked or discriminated against, some people from minority groups alternate between feeling weary, angry, determined, defensive, amused, and paranoid. They bring these feelings with them to subsequent encounters, including our interviews. Becoming involved with the child welfare system is often embarrassing and even humiliating for clients. By doing our utmost to convey respect, we can thwart these shameful feelings and help clients maintain and recover their dignity.

How do we know if we are behaving in a way that is respectful? We pay careful attention to what we say and how we present ourselves, and then we try to figure out how the interviewees hear us. To be able to try on the interviewees' shoes, we need to accept the idea of a mismatch between the way we want to be seen and heard and the image we are actually conveying. We must examine our demeanor

when we pose questions, explain procedures, observe interactions, examine injuries, review transcripts, and fill out forms—and we should explore how these activities may feel from the perspective of the interviewees. As we catch ourselves conveying any trace of disrespect, we must have the courage to try something new. In our professional roles, we may still need to do things that interviewees would rather we did not do, but a respectful manner will make these actions easier to accept.

We should also check in regularly with the people we are interviewing, asking versions of, "How are you doing?" "How is it going?" "Are you okay?" "Is there anything else you'd like to tell me at this point?"

Demeanor

The set of nonverbal behaviors that communicates an interviewer's interest in the interviewee has been termed *attending behaviors*. These behaviors include making appropriate eye contact, nodding, and leaning forward. But if these actions are imposed too mechanically from the outside without inner feelings, they will be insufficient. Interviewers should do more than simply demonstrate certain actions to look "as if" they care. I encourage them, rather, to try their best to open their hearts and their humanity to the interviewees so they actually *do* care about their well-being. Whether the interviewee is someone who attracts or repulses an interviewer, the quantity and quality of the information garnered will be improved if the interviewer can connect on a level of true feeling.

Rapport continues to build throughout an interview as new topics are raised and the relationship deepens. Many professionals become cold and distant when they step into their interviewer roles. In fact, some misguided district attorneys protest when interviewers appear warm and kind. This is a mistake. Research has found that when interviewers are warm and friendly, their interviews will be more likely to produce correct information, and the interviewees will be more willing to correct the interviewer's mistakes if necessary (Davis & Bottoms, 2002). Interviewers would do well to appear warm, relaxed, supportive, and nonjudgmental, particularly in cross-cultural interviews, where the interviewee may need substantial reassurance. Interviewers will want to communicate that they care, they are interested in what the interviewee has to say, and they can be trusted. Interviewers should try to show interviewees a personal and specific caring for them as individuals, not merely a generalized empathy. This can be achieved through asking about personal likes and dislikes, inquiring about hobbies, truly listening, and repeating details provided by interviewees about their specific situation.

A fascinating but disturbing study found that in interviews with children who had made a prior disclosure but had declined to disclose in the context of a forensic interview, the forensic interviewers gave *less* support to these reluctant children than to children who made allegations during the interview (Hershkowitz et al., 2007). The authors wrote, "This finding suggests that interviewers reacted to their own frustration rather than to the children's needs. Whether nondisclosers were affected by feelings of guilt, shame, commitment, or fear, reluctant children are likely to experience forensic interviews as stressful and to perceive the interviewers as threatening (p. 109)." Support and human warmth are especially important in interviews with immigrant children and families, who may feel especially threatened in the official kinds of settings where interviews typically take place, and who may be nervous around people from outside their culture.

The personal relationship is key to interviewing people from most cultures. In Korean, the concept *jeong* expresses a "combination of empathy, sympathy, compassion, emotional attachment, and tenderness, in varying degrees, according to the social context" (Kim & Ryu, 2005, p. 353). A Korean will be observing an interviewer for signs of *jeong*, which may be demonstrated by showing concern for another person's comfort and by revealing one's own humanity. English has no word that is the exact equivalent of *jeong*. Regardless, interviewees sense this quality and respond well when it is present.

How rare it is for people to listen to each other with full attention! So often, especially when children speak, adults are doing other tasks as they listen, whether driving, doing household chores, or attending to other children. The formal interview presents the requirement, and opportunity, to pay full attention to the interviewee. When they have the interviewer's full attention, children are more likely to speak openly. (The exception to this rule concerns young children and adolescents, who sometimes prefer if an interviewer doodles or in some other way helps them feel less "on the spot.")

Voice Quality in the Interviewer and Interviewee

In people who are right-handed, the left hemisphere of the brain hears words while the right side hears the melody of the words (Givens, 2005). Therefore, when we speak, we are literally speaking to two different aspects of the listener's brain—one that processes our word meanings and the other that processes our voice quality and nonverbal signals. A pleasantly pitched and modulated voice communicates kindliness to one side of the interviewee's brain, while our words communicate it to the other side.

Around the world, people tend to use higher-pitched voices and speak in a sweet, sing-song manner with children when they are not angry. This language, which has been called "motherese," is considered friendly and would be appropriate with a young child. A sweet voice with a varying tone suggests that the interviewer does not have aggressive intentions. However, interviewers should be careful not to speak in this way to teens and adults—it could be considered condescending.

Interviewers who speak in a dry, steady monotone may be perceived as unfriendly, cold, and intimidating. How interviewers use their voices goes a long way to convey caring in a professional relationship. In most circumstances, interviewers will want to use a gentle but firm voice, responding matter-of-factly to even painful material. If an interviewee is extremely anxious, the interviewer may choose to use a soothing voice.

Interviewers should review video or audiotapes of their work from time to time and pay attention to what they really sound like during the process. Did the interviewee have to strain to hear because the interviewer was speaking so quietly? Was the interviewer speaking so loudly that the interviewee seemed frightened

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or intimidated? Was it hard to make out the interviewer's words because the interviewer was mumbling or was chewing gum? Was the interviewer's voice kind and sympathetic? Did it convey support? If the interviewee hesitated to talk, did the interviewer respond patiently so as to encourage more responsiveness; or was the interviewer impatient, threatening, pushy, or dismissive? If the interviewee was not a native speaker of English, was an interpreter used? A supportive tone of voice will encourage the interviewee to reveal sensitive information and cooperate with official systems. A critical or impatient tone can make an interviewee shut down emotionally and close the door to further intervention.

Interviewers should be careful not to read too much into the way an interviewee uses his or her voice. Interviewees may seem to be speaking unusually quickly, or quietly, or loudly, or to be using an aggressive or evasive tone of voice. However, these ways of speaking are probably imported from the interviewees' native language and are not apt to mean the same thing as they might with a person from the same culture as the interviewer.

For instance, languages that are more guttural (such as Arabic, German, Dutch, and some East Asian tongues) can sound harsh or unpleasant to the unaccustomed ear (Giles & Niedzielski, 1998). Some languages, such as Chinese and Vietnamese, are tonal; the meaning of the word varies with its pitch. Speakers of guttural and tonal languages are often misperceived by English speakers to be angry because of the way they use their voices, even when they speak English. Similarly, male speakers of Arabic and some African languages often tend to speak loudly. This may be true whether they are speaking in their first language or in English, because many people import the intonation and volume of their first language into the other languages they learn. An interviewer who is not accustomed to these language habits may respond to an Arabic-speaking person as if he is angry, out of control, or aggressive, when that may not be the case. Ethiopians, East Indians, Filipinos, Bangladeshis, Pakistanis, and many American Indians—and especially women from these cultures—are apt to speak softly and interpret as rude a person who uses a loud voice or who issues a loud direct command.

Pace and Time

As much as possible, interviewees should be allowed to set the pace. Often people need more time to answer questions than interviewers might expect. People who are not native speakers of English but who are being interviewed in English may take longer than usual to respond as they search for the right words. This is likely to be true even if the interviewees have been speaking English for years, especially if they still use their first language more often than English (Heredia & Brown, 2004).

For some people, the quality of an interaction is partly determined by the amount of time spent together. Southern Europeans, Africans, and Latin Americans who are less acculturated may spend quite a while in an interview telling stories and elaborating at length. They are apt to be angered by professionals who show impatience. While an interviewer may impatiently wish an interviewee would "get to the point," the interviewee may be heading in just that direction—but in a more roundabout way than is habitual in the dominant U.S. culture.

It is difficult for interviewers to avoid rushing or appear rushed if they are constrained by large caseloads, deadlines, productivity quotas, or busy schedules or if their supervisor has told them they have only one interview in which to "get all the facts" about alleged abuse. Taking one's time at the beginning of an interview to establish the relationship may help build the sense of trust that will make a bit of rushing later on seem less problematic. To accommodate the more relaxed sense of time of people from a variety of cultures, many professionals schedule longer sessions with their immigrant clients, particularly early in the course of their work together. Additionally, research shows that children are more likely to disclose, and to disclose more information, if they are interviewed more than once (Faller, 2007). Developing rapport with an immigrant child may take more time and effort than usual, and this might easily require extra interview sessions.

Trauma Symptoms in Children That May Not Stem From Caretaker Abuse

Refugee children commonly face traumas prior to migration, during the migration process, and after migration. These damaging traumas may include the "disappearance" of family members, hunger, thirst, illness, homelessness, sexual assaults, seeing dead bodies, being wounded, physical threats and beatings, confinement, torture, rape, seeing relatives killed, witnessing atrocities, being forced to violate their own moral code, and/or living for prolonged periods in fear for their lives (Delgado, Jones, & Rohani, 2005). Also, life in the refugee camps is often tenuous, traumatic, and overcrowded. Immigrants who are not formally refugees but who have come from countries with repressive governments may also have experienced trauma in their countries of origin or during an arduous voyage to their new lands, or both. Life in the new country may still not be safe or secure for immigrant children, who may observe that their parents are unable to communicate, uncertain of how to proceed, and subject to the vagaries of bosses, landlords, social service providers, and others. Additionally, it is traumatic for children to live as undocumented aliens or to know that their loved ones are undocumented and risk deportation on a daily basis.

Sometimes professionals assume that a child who was very young during traumatic experiences was somehow shielded from them. However, research suggests that when children have experienced trauma before they developed language skills, they actually have a more difficult time healing than older children who transformed their experiences into words as the events occurred (Pynoos, Steinberg, & Goenjian, 1996).

Children may demonstrate traumatic symptoms that do not stem from caretaker abuse, but these symptoms can easily be misinterpreted as stemming from abuse. For instance, a child who has been traumatized for whatever reason may suffer from any combination of separation anxiety, school phobia, bedwetting, encopresis, depression, anxiety, poor concentration, mood disorders, anger, substance abuse, suicidality, nightmares, and/or compulsive behaviors, including masturbation. A child who has been traumatized may be afraid of loud noises, sirens, yelling, airplanes, and fire alarms and may startle easily. Conversely, a child who has been traumatized may seem to seek out frightening situations, appear to be afraid of nothing, and respond violently to minor incidents. A traumatized child may have to be coaxed into eating or may bolt down food

quickly and sloppily, looking as if this is his or her last meal. These symptoms present a confusing picture to professionals.

When possible, professionals should take a full trauma history and inquire about the child's behavioral changes over time. Sometimes children seem to "fall apart" when they are finally safe from the source of the trauma, whether it is war, a natural disaster, or a violent caretaker. When working with children who were adopted, who come from extremely chaotic environments, or whose caretakers are themselves traumatized, such a thorough history may not be possible. Parents from some cultures will not want to rehash the past, believing it is unlucky or simply unwise to discuss horrific incidents. Parents may feel shame due to incidents that they and their children have endured. Parents may also fail to see a connection between these past incidents and the child's current behavior, believing instead that the child is willfully misbehaving, is possessed by spirits, or is physically ill. Remember, also, that refugees sometimes take in others' children and claim them as their own so the children can be raised safely. In these situations, the people acting as parents may be hesitant to discuss a child's history because they do not know that early history. Sometimes interviewers can learn through readings or consultations that a child who is being interviewed is a member of a group that is likely to have undergone certain traumatic experiences, even if there is no specific documentation of these experiences for this particular child.

When interviewers note symptoms that often indicate an abuse history in children but are unable to determine the source of the trauma, it is important not to assume these traumas are inflicted by caretakers. Immigrant children may have been subjected to traumas that are not inflicted by caretakers and that may be less familiar to the interviewers.

The process of immigration itself has been found to be traumatizing for many children and families, as are chronic experiences of racism, discrimination, and exclusion (Bryant-Davis & Ocampo, 2005). Consider the ongoing trauma of children who are thrust into an unfamiliar school filled with people who speak another language and who have different sets of behavioral norms. The children are apt to feel isolated, confused, and perhaps invisible for hours every day without end. Children whose caretakers are unable to serve as a bridge to the school system are apt to feel particularly lost without a guide in their new environment.

Conclusion

When an interviewer meets with an interviewee only one time and in one location, the interviewer obtains a snapshot of the person at that time and in that place. It is necessarily just one limited picture, and the interviewer's ability to draw inferences about the person and likelihood of child maltreatment is severely limited. When the interviewer is from a different culture than the interviewee, it can be especially difficult for that interviewer to know how to interpret what he or she is seeing and hearing. This article is a brief outline of some of the issues faced by professionals who interview, interrogate, examine, assess, and evaluate immigrant children and their families when there is a suspicion of child maltreatment. Professionals are encouraged to read further in this area, to learn about other important issues, such as nonverbal behavior, the use of silence, biases, boundaries, phrasing questions, and more, particularly as these pertain to interviewing immigrant children and their families (see Fontes, 2005; Fontes, 2008). When interviewers take positive steps to improve their cultural competence and when they give careful thought to their interviews with immigrants, they will be able to improve the accuracy and fairness of their work. This is especially critical when there is a suspicion of child maltreatment and there is so very much at stake.

Note

1. Portions of this article are adapted from: Fontes, L. A. (2008). *Interviewing clients across cultures: A practitioner's guide*. New York: Guilford. Used by permission.

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Journal Highlights

Patti A. Beekman, Susan Yingling, and Judith S. Rycus

Internet-Based Preventive Training for Parents

This article describes Infant Net, an interactive, Internet-delivered program aimed at improving parenting skills and reducing the risk for child maltreatment among mothers of young infants. The project was adapted from Playing and Learning Strategies (PALS), an empirically supported infant parenting program.

The Infant Net curriculum was designed to increase parents' ability to interact with their infants using behaviors that support optimal social, emotional, and cognitive development. Participants create and share videos of parent-infant interactions. Through weekly phone contact with treatment providers, participants receive feedback and get help in planning treatment, based on the providers' behavioral assessment of parenting skills. Video-recorded, parent-child skill practices are also reviewed in monthly individual and group supervision.

An important program element is the electronic bulletin board that mothers can use to communicate with peers and professional program staff. Participants' ability to chat with other participants provides a virtual community that offers social support and networking for the mothers, reduces feelings of isolation, and promotes learning and engagement.

The authors describe how this Internet-based, parent-education intervention can promote healthy and protective parent-infant interactions in families that have limited access to traditional services. Transferring in-home programs such as PALS to Internet-based interventions eliminates the need for service providers to travel to remote areas, allowing a single coach to work with multiple families in a single day. The authors suggest that issues concerning limited Internet access, outdated equipment, and the absence of technology in many rural families merit ongoing attention.

Feil, E., Baggett, K., Davis, B., Sheeber, L., Landry, S., Carta, J., & Buzhardt, J. (2008). Expanding the reach of preventive interventions: Development of an Internet-based training for parents of infants. *Child Maltreatment*, *13*(4), 334–346.

The Paradox of Father Presence and Absence in Child Welfare

The authors conducted a 3-year research project in Canada to examine the potential risks and benefits for both mothers and their children when child welfare professionals excluded fathers. The authors examined 116 randomly selected child protection files from a midsize Canadian city to determine if workers referenced and/or engaged with fathers. Although a father's contact with children was not commonly mentioned, when it did occur it was most often when the father was seen as an asset to the children. The authors noted that in North America and the United Kingdom, fathers were only occasionally mentioned, and case files were set up in either the mother's or child's name only.

The authors chose the word *ghost* to describe fathers who were not acknowledged, were purposely excluded, or were not viewed as relevant by child welfare personnel. The authors contend that ghost fathers are created as a result of deeply held personal biases, agency policies, and administrative and professional practices. By not having face-to-face contact with fathers, workers are more able to ignore possible dangers that fathers may pose to their families, or in contrast, they may ignore fathers who have the potential to be valuable resources to their families. The authors found that it is rare that workers actually engaged fathers in any meaningful way.

While the emphasis on involvement of fathers in their children's lives persists in popular media, child welfare policies, practices, and education seem to promote father absence. In a review of 32 undergraduate social work programs in Canada, fewer than 5% of the courses offered content related to fathers and fathering. In child welfare, emphasis on standardization, efficiency, and outcome measures appears to take precedence over father inclusion. One social worker participating in the study stated that her caseload "would be doubled if she had to contact fathers."

Social workers lacking in cultural awareness may feel particularly unwilling and unable to confront men of cultures other than their own about their roles as fathers. Social workers may fear that they will simply make things worse by applying standards of fathering, or that they will jeopardize the mother and sometimes the children by allowing the father to know that they are under scrutiny.

For change to occur, the authors suggest that we first examine our biases about gender roles and our fear of fathers' presence and absence in child welfare. Fathers should be routinely included in protection and supervision orders, parenting assessments, appointments, and family conferences, except when to do so would endanger mothers or children.

Brown, L., Callahan, M., Strega, S., Walmsley, C., & Dominelli, L. (2009). Manufacturing ghost fathers: The paradox of father presence and absence in child welfare. *Child & Family Social Work*, *14*(1), 25–34.

Predictors of Mothers' Use of Spanking Their Infants

This study explored the issue of spanking infants, based on concerns regarding the risk of escalation and injury to infants from physical punishment and the fact that infants developmentally cannot understand the relationship between their own behavior and a painful punishment. This study provides data to identify and describe mothers who are more likely to spank their infants (age 13 months and younger), thereby providing an opportunity to enhance the mothers' parenting knowledge and skills.

Over a 9-month period, 246 new mothers were interviewed before leaving the hospital in a large southeastern U.S. city; over 90% were then reinterviewed when their infants were between 6 and 13 months of age. Interviewers gathered demographic information and explored with the mothers issues of parenting stress, developmental expectations, perception of their infant's behavior, empathy for the child's needs, and views on corporal punishment. Spanking was measured by response to the following question: "In the last week, have you spanked [your baby] for misbehaving?"

Data indicate that mothers who approved of corporal punishment were more likely to spank their infants. Further, mothers who spanked were typically younger, reported more life stress and parenting stress, and perceived their infant to be "difficult." They also reported less empathy for their infants, more approval of corporal punishment, and more expectations that their children would meet their own needs. Spanking was not significantly related to education or income level, partnership status, or other psychosocial variables. Notably, over one third of all mothers surveyed indicated that their infants were too young to misbehave.

Limitations of the study included the following: not defining the term *spanking* in the context of other forms of physical discipline; excluding measures of frequency, type, and intensity of spanking; and parental motivation. Further, the study was confined to mothers living in a midsized city in the southern United States and others from a more Appalachian outlying area, and it did not consider how attitudes of spanking infants might be related to geographic and cultural factors.

The authors conclude by highlighting research that depicts the perinatal period as a time of high risk for parenting problems, but also a time of opportunity, when new parents are most receptive to advice and information about infant development before inappropriate responses to their child's behavior become habitual.

Combs-Orme, T., & Cain, D. (2008). Predictors of mothers' use of spanking with their infants. *Child Abuse & Neglect*, *32*(6), 649–657.

Attention-Deficit/Hyperactivity Disorder and Child Maltreatment

This article investigates the relative associations between child maltreatment and attention-deficit/hyperactivity disorder (ADHD) in childhood, specifically between inattentive type and/or hyperactive/impulsive types of ADHD and various types of maltreatment. Authors' findings demonstrate that the presence of ADHD symptoms could be useful for identifying children at elevated risk of maltreatment.

The 14,322 adolescents in this longitudinal study were interviewed in the 1994–1995 and 2001–2002 school years. In the first school year, a parent of the surveyed adolescent, usually the mother, also completed an interviewer-assisted questionnaire. Findings determined that inattentive-type ADHD was associated with substantially elevated risks of supervision neglect, physical neglect, physical abuse, and sexual abuse. In contrast, the hyperactive/impulsive type is associated with only an increased likelihood of supervision neglect and physical abuse. The association between the hyperactive type and physical neglect or sexual abuse is not significant. The combined type (inattentive and hyperactive/impulsive) is associated with substantially elevated risks of physical neglect and sexual abuse, as well as a significant risk of supervision neglect. The linkage of physical abuse and ADHD symptoms is consistent with research findings that corporal punishment is greater in families with children who have ADHD. The authors also investigated associations between the number of ADHD symptoms and the severity of child maltreatment. They found that each additional ADHD symptom reported significantly increased risk for elevated severity of all related types of maltreatment.

The current findings have implications for families and health care providers of children with ADHD symptoms. The stronger association between inattentive symptoms and child maltreatment could reflect less diagnosis and treatment for children with inattentive symptoms, increasing risk if caregivers are unaware of the underlying condition and punishing the child through neglect or physical abuse. In addition, research on parent-child interactions of children with ADHD reports prevalence of a more stressful and conflicted family environment. Child maltreatment may also produce posttraumatic symptoms paralleling those of ADHD or exacerbating existing ADHD symptoms. Finally, ADHD symptoms and child maltreatment might share common etiologic factors, particularly genetic factors associated with ADHD.

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In conclusion, the authors urge preventive strategies for families and health care providers of children with ADHD symptoms, including increasing parenting skill in supervision and injury prevention. They also advocate that pediatricians be alerted that underdiagnosis and undertreatment of ADHD symptoms might be either a risk factor or a marker for child maltreatment. By raising their awareness of the inattention dimension of ADHD, early detection and prevention are possible.

Ouyang, L., Fang, X., Mercy, J., Perou, R., & Grosse, S. (2008), Attention-deficit/hypeactivity disorder symptoms and child maltreatment: A population-based study. *Journal of Pediatrics, 153*(6), 851–856.

Examining Mandated Reporting of Child Maltreatment

Mandated reporting laws in the United States have been successful in increasing the number of reports made to CPS. However, the degree to which the laws reduce the incidence of child maltreatment has not been determined. This article describes reporting practices of four different mandated reporter groups: the legal system, medicine, education, and social services/mental health.

The authors analyzed data from the National Child Abuse and Neglect Data System (NCANDS) of maltreatment reports by the four mandated groups in three states for three consecutive years. They found the majority of substantiated cases by mandated reporters involved neglect, followed by physical abuse, other maltreatment, sexual abuse, psychological abuse, and medical neglect. Educators reported twice the number of physical abuse cases as other mandated reporter groups and the lowest percentage of neglect cases. Medical and legal personnel reported the highest percentage of neglect cases.

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Reports made by each mandated reporter group have unique characteristics. Some differences can be attributed to the ways that reporters come into contact and interact with children. For example, younger children are more likely to see a doctor, whereas educators have contact with school-aged children, resulting in a higher percentage of reports concerning younger children by medical practitioners and older children by teachers. Similarly, although the percentage of cases that involved medical neglect was relatively small (less than 10%), medical personnel had the highest percentage of reported cases. Psychological abuse was also reported in a relatively small number of cases, and social service/mental health personnel reported the highest percentage of cases.

The authors found that differences in substantiation rates among the groups were more difficult to explain and potentially more problematic. CPS substantiated reports made by legal personnel at a significantly higher rate than did other mandated reporter groups. The two mandated groups with the lowest substantiation rates (educational and social service/mental health) also reported the majority of maltreatment cases, suggesting that mandated reporting laws may not be as effective at stopping child maltreatment as expected. Failure to substantiate could be the result of many factors including an unfounded report, lack of sufficient and credible evidence, or inadequate investigation by CPS. Degree of training may partially explain the differences in substantiation rates, also. Child maltreatment is defined legally, thus it is logical that those trained in the law and law enforcement would have the most success in having their maltreatment cases substantiated.

This study was first to examine the actual reporting practices of all four mandated reporting groups. The authors found significant differences among the groups related to type of maltreatment reported and rate of report substantiation. While some differences can be easily explained, others require more research and have broad implications for professional education and training of mandated reporters.

Kesner, J. (2008, December). Child protection in the United States: An examination of mandated reporting of child maltreatment. *Child Indicators Research, 1*(4), 397–410.

Using TeleCAM for Child Maltreatment Assessment

Investigation, assessment, and treatment of child maltreatment require a multidisciplinary approach involving medical professionals, legal and law enforcement representatives, child protective workers, and mental health counselors. Together, they provide observational data, photo and imagery documentation, and narrative text (case notes, scanned legal documents, and medical diagnoses); audio/video tapes of psychosocial interviews; and measurement data for the case record. Existing mechanisms for collaborative assessment (in-person meetings, telephone and video conferencing, mail, E-mail, and CDs) can sometimes limit aggregate data analyses, delay case reviews, and risk the loss of documentation.

This article describes application features of TeleCAM, a Web-based application for remote sharing of assessment information among professionals at different sites. Data used in evidentiary settings must be above reproach, and security and incorruptibility

must be guaranteed. Collaboration tools need to support access to empirical data for accurate diagnosis and treatment of the victim, and to prepare an evidence-based case for child protection or criminal proceedings. Misinterpretation of evidence can lead to the failure to protect a child and society from an abuser or a wrongful prosecution and disruption of families.

The authors believe that TeleCAM will fulfill these requirements. The application creates an integrated case record, which requires input of patient data and uploading of images from user sites. The application can (a) provide immediate transfer of data in all forms (e.g., electronic data, photos, radiological images, laboratory results); (b) enable peer consultation and appropriate sharing of information; (c) establish a site-specific and aggregate site database for future research and development, and (d) document user review and communication exchanges.

The authors conducted a usability evaluation by medical personnel at three Utah Children's Advocacy Centers (CACs) and one children's hospital in Salt Lake City. Participants gave positive feedback on ease of use, quality of photographs, ability to enter and access extensive information and generate reports; rapid collection and comprehensiveness of case information; and security of text and images. However, set-up problems, need for technical support, and time needed to complete a case and download images were challenging. Although only limited generalizations can be drawn from the evaluation due to small numbers, the survey data demonstrated average to above-average agreement on the user-friendliness of the application.

In conclusion, the authors recommended further evaluation, increasing the number of participants and targeting nonmedical personnel, including child protection workers, mental health professionals, and legal advocates.

Thraen, I., Frasier, L., Cochella, C., Yaffe, J., & Goode, P. (2008). The use of Tele-CAM as a remote Web-based application for child maltreatment assessment, peer review, and case documentation. *Child Maltreatment, 13*(4), 368-376.

Social Support and the Effects of Childhood Abuse and Depression

This article explored the relationships between childhood maltreatment, adult depression, and perceived social support from family and friends. Previous data show that child maltreatment is linked to higher rates of depression in adulthood. However, because emotional abuse and neglect are the least researched types of childhood maltreatment, the authors conducted this study to examine emotional abuse and neglect more closely in relation to depression and perceived social support in adulthood.

This effort was part of a National Institutes of Health-funded study at a public urban hospital serving low-income and homeless individuals in Atlanta. Men and women from clinic waiting areas (N=378) were interviewed about their history of childhood maltreatment, depressive symptoms, and perception of social support. The sample was overwhelmingly minority (more than 85% African American and Hispanic) and predominately poor, having monthly income of less than $1,000. This is also a highly traumatized population, with over 30% of individuals reporting

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at least one type of childhood maltreatment (e.g., abuse, sexual abuse, emotional abuse and neglect). It is notable that because child neglect in this population is confounded by poverty, neglect is not included in this study.

In summary, study results demonstrated how adult depression is related to childhood maltreatment, particularly emotional maltreatment, and how perceived family and friend support can help mitigate depression, especially for women. The authors found that childhood emotional abuse and neglect were more predictive of adult depression than were sexual or physical abuse. Perceived friend support, more than family support, was associated with mitigating depression symptoms for all four types of childhood maltreatment. For women, perceived friend support was significantly related to mitigating depression associated with emotional abuse and neglect.

The authors conclude that for this target population, an understanding of the importance of strong support systems as mitigating symptoms of adult depression associated with child maltreatment is of significant public health importance. They further suggest that because emotional abuse and neglect are not as researched as abuse and physical neglect, studies need to focus more on these types of maltreatment.

Powers, A., Ressler, K., & Bradley, R. (2009). The protective role of friendship on the effects of childhood abuse and depression. *Depression and Anxiety 26*(1), 46–53.

Thomas L. Birch, JD
National Child Abuse Coalition

Congress Takes up Obama's Legislative Agenda

The 111th Congress broke for spring recess in April after 3 months of the 2009 legislative session, which was marked by the passage of significant legislative measures with positive implications for the welfare of children. Enabled by Democratic majorities in the House and Senate and empowered by a supportive President, federal legislators in February sent to the White House for final enactment an economic stimulus legislation–the American Recovery and Reinvestment Act, which had been proposed by President Barack Obama to address the nation's job losses and the worsening economic recession. They also passed legislation to reauthorize and expand the State Children's Health Insurance Program (SCHIP). In early April, each chamber passed its version of the fiscal year 2010 budget resolution, reflecting many of Obama's spending priorities for the coming year, including a new initiative to support home visiting services for new parents.

Economic Stimulus Package

On February 17, President Obama signed into law the final version of the American Recovery and Reinvestment Act (H.R.1), including tax breaks and spending that total $789 billion. As proposed initially by the House, the measure includes $1 billion for Head Start for comprehensive development services to help 110,000 additional children and $1.1 billion for Early Head Start. Only about half of all eligible preschoolers and fewer than 3% of eligible infants and toddlers participate in Head Start and Early Head Start.

In addition, the Child Care and Development Block Grant received $2 billion for childcare assistance for low-income families, provided in both the House and Senate bills. The new childcare funding would provide care for 300,000 additional children from low-income families. Currently, only one out of seven eligible children receives care.

Child welfare advocates also scored a victory in the economic stimulus package with inclusion of a temporary increase of an estimated $1 billion for foster care payments to states, including an increase of 6.2% for the Medicaid matching rate to extend to children in foster care. Grants for Temporary Assistance for Needy Families (TANF) were set at $3 billion in the final legislation, which was also for block grants "to help states deal with the surge in families needing help during the recession and to prevent them from cutting work programs and services to abused and neglected children." Unfortunately, funding for the Social Services Block Grant stipulated in the Senate's bill at $400 million was dropped in the final agreement.

Formula grants under the Individuals with Disabilities Education Act (IDEA) Part C to help states serve children age 2 and younger with disabilities and special needs received $500 million in the stimulus bill. The Child Abuse Prevention and Treatment Act (CAPTA) requires states to refer all children under age 3 involved in a substantiated case of abuse or neglect to Part C-funded early intervention services. These CAPTA-mandated procedures have been hampered by a shortage of funding.

State Children's Health Insurance

On February 4, the President signed legislation to reauthorize and expand the State Children's Health Insurance Program (SCHIP) to provide health insurance to lower-income children whose families earn too much to qualify for Medicaid, but who still struggle to afford health insurance.

The legislation approved by the House and Senate would expand coverage to an additional 4 million children through fiscal year 2013 at a cost of $33 billion, bringing the total number of children covered under the program to around 11 million. The costs of the SCHIP bill would be paid for largely by an increase of 62 cents in the federal cigarette tax.

Over the objections of some Republican Senators, Senate Democrats added a provision to the bill already in the House-passed measure that would extend coverage to legal immigrant children who must wait 5 years before becoming eligible for the program. Nine Republican Senators joined all the Senate Democrats voting in favor of the SCHIP expansion legislation: Sens. Lamar Alexander (R-TN), Susan Collins (R-ME), Bob Corker (R-TN), Kay Bailey Hutchison (R-TX), Richard Lugar (R-IN), Mel Martinez (R-FL), Lisa Murkowski (R-AK), Olympia Snowe (R-ME), and Arlen Specter (R-PA). The SCHIP bill first passed the House with 2 Democrats voting against the bill and 40 Republican House members voting in favor.

Congress twice passed an enlargement of the children's health program in 2007, and former President George W. Bush vetoed it both times. President Obama had expressed the wish that the SCHIP measure be among the first he would sign into law on becoming President. During the presidential election campaign, Obama pledged to expand SCHIP eligibility to cover more children.

FY2009 Omnibus Spending Measure

Five months into the 2009 fiscal year, with the economic stimulus package completed, House and Senate legislators agreed upon an omnibus spending measure designed to carry nine unfinished 2009 appropriations bills through the remainder of the current fiscal year. The bill provides about $31 billion more than was spent on the nine bills in fiscal 2008, an 8% increase. President Obama signed the spending bill into law on March 11.

Important sources of federal funding for child welfare services to protect children and prevent maltreatment—including the Social Services Block Grant, Title IV-B child welfare services and child welfare training, and the Promoting Safe and Stable Families program—were all left with funds at the 2008 level. Programs singled out for funding increases include the Child Care and Development Block Grant and Head Start, both with slightly over a 3% increase, and family violence shelters, with a 4% gain over last year.

The bill includes an increase of $4.6 million for the Child Abuse Prevention and Treatment Act (CAPTA) discretionary grants, totaling $41.757 million to support "evidence-based home visitation models," which are now in the second year of funding. The home

visiting grant support would increase from $10 million to $13.5 million in the current fiscal year to allow for new grants in addition to the continuing grants. The new money for home visitation was not a part of the FY09 budget proposal President Bush sent to Congress a year ago.

Since the 2009 fiscal year began in October, the federal government had been operating under a continuing resolution holding spending to the FY08 levels. The $410 billion omnibus appropriations package marks the end of the spending disputes Democrats had with President George Bush, who had threatened to veto the unfinished appropriations bills in disagreement over their funding levels.

Overall, the spending in the omnibus package would provide about $19 billion more than President Bush had requested when he proposed his budget for the nine bills a year ago. Details of the bill were worked out under wraps late last year. Democratic leaders in the House and Senate decided to hold back on bringing the bill forward because it might have slowed down work on the stimulus bill.

Budget Proposals for FY2010

On February 26, the Obama administration published an outline of its intended spending priorities for the 2010 fiscal year, which will be presented in a fully articulated budget proposal sometime in May. More about spending directions than dollars proposed, the budget for the Department of Health and Human Services (HHS) focuses most of its discussion on reforming the nation's health care system.

In addition, the budget would propose expanded funding for Head Start and the Child Care and Development Block Grant. The administration also proposes the creation of a Nurse Home Visitation program, with "funds to states to provide home visits by trained nurses to first-time low-income mothers and mothers-to-be." According to the budget outline, the funding "builds the foundation for a program that could ultimately serve all eligible mothers who seek services."

Reflecting many of the themes outlined in the Obama administration's budget priorities, the House and Senate, before adjourning for 2 weeks of spring recess, each passed budget resolutions reserving funds for home visiting programs. The measure approved by the House identifies a program of home visiting "to low-income mothers-to-be" to produce "sizeable, sustained improvements in the health and well-being of children and their parents."

The Senate budget bill, amended by a provision sponsored by Sens. Patty Murray (D-WA) and Christopher Bond (R-MO) and adopted on the Senate floor by unanimous consent, would provide funds "to establish or expand programs of early childhood visitation that increase school readiness, child abuse and neglect prevention, and early identification of developmental and health delays."

The report of the House Budget Committee, which accompanies the House-passed resolution, explains that its home visiting provision would provide mandatory funding for "evidence-based programs that have been tested in well-designed randomized controlled trials and are likely to produce future budget savings by improving child and family health and well-being." It cites research studies documenting cost savings realized from "nurse home visiting services to low-income families." A final version of the budget resolution to be worked out by a House-Senate conference committee will identify the requirements of a home visiting initiative.

In advance of President Obama's fully detailed budget proposal for fiscal year 2010, which is expected in May, Congress has passed its own budget resolution, including a provision to support states with the expansion or development of home visitation services to low-income families.

On April 29, both the House and Senate approved the final version of the congressional budget resolution—in the House by a vote of 233 to 193, followed by the Senate's vote of 53 to 43. The measure, which does not require the President's signature, creates a blueprint for Congress in drafting the appropriations bills to come next.

The final agreement from the House-Senate conference committee on the budget resolution includes a "revenue-neutral reserve fund" to provide "funds to states for a program of home visits to low-income mothers-to-be and low-income families which will produce sizeable, sustained improvements in the health, well-being, or school readiness of children or their parents."

The budget provision would allow participation of a broad range of home visiting models, not limited to the nurse home visitor model proposed in the President's February budget outline or in an earlier version of the budget resolution passed by the House. The home visiting program anticipated by the budget resolution must next be embodied in authorizing legislation.

Teen Residential Protection

On February 23, 2009, the House passed H.R. 911, the Stop Child Abuse in Residential Programs for Teens Act, by a vote of 295–102. The bill, introduced by Rep. George Miller (D-CA), now moves to the Senate, where no similar legislation has been introduced. In June 2008, the House voted 318–103 to pass the identical measure.

The bill would set standards, with enforcement provisions, to prevent child abuse and neglect in teen residential programs, including therapeutic boarding schools, wilderness camps, boot camps, and behavior modification facilities. While residential treatment facilities designed to help children with extreme behavioral problems, including substance abuse and mental health problems, may provide safe and effective services to children and their families, many exist without any state monitoring or regulation.

The legislation would create new national safety standards for private residential programs that would be enforced by HHS and the states, prevent deceptive marketing by residential programs, and hold programs accountable for violating the law. Through provisions added to the Child Abuse Prevention and Treatment Act (CAPTA), states would be required to set similar standards of protection and investigate reports of maltreatment in these facilities. The bill increases the authorization for CAPTA to $235 million for each of fiscal years 2010–2014 in order to accommodate state responsibilities.

At Issue: Do Child Protection Workers Deserve Immunity When They Misrepresent or Fabricate Evidence?

Daniel Pollack, JD, MSW

The critics and plaintiffs' attorneys are out there. They seethe with frustration in their assertion that there are child protection workers who are as dysfunctional and flawed as some of the abusive and neglectful parents they investigate. They feel mistreated, ambushed, and without recourse to a neutral oversight authority and fume that the courts will believe the word of child protection workers over their clients. And yet, when there is a credible allegation that a child protection worker has knowingly made misleading or false statements that resulted in the wrongful removal of a child, their criticism and anger seem justified. Such misrepresentations may involve highly contested issues of material fact that more properly should be examined by an agency supervisor or in court on the merits. The supervisor or court, inadvertently giving credence to the worker's misrepresentation, may thereby be swayed in favor of the worker's recommendations.

Legal Aspects of Immunity for Government Social Workers

It is an accepted principle that a parent has a constitutionally protected interest in the custody and care of his or her child. This interest does have exceptions, especially when the child may be in immediate or apparent danger. This is when child protection services gets involved. Crucial to every child protection investigation is to establish the facts and circumstances of the case. When these are presented to the court at a dependency hearing, the evidence may become proof.

The best professional judgment of child protection workers may, in hindsight, be wrong. For this and other reasons, child protection workers usually have some level of immunity from prosecution.[1] When individual government officials are sued for monetary damages, they generally are granted either absolute or qualified immunity. The U.S. Supreme Court has stated that qualified immunity is the norm and absolute immunity is the exception.[2]

Should that immunity disappear when, in their official capacities as child protection workers, they make knowingly inaccurate or false statements that result in the wrongful removal of a child? California law provides for public employee immunity from liability for an injury caused by the employee instituting or prosecuting any judicial or administrative proceeding within the scope of one's employment, even if one acts maliciously and without probable cause.[3] However, a public employee has no such immunity if she acted with malice in committing perjury, fabricating evidence, failing to disclose exculpatory evidence, or obtaining evidence by duress.

Generally, whether an employee is acting within the scope of his employment is ordinarily a question of fact to be determined in light of the evidence of the particular case. Some courts hold that immunity for child protective workers exists as long as they act responsibly in the performance of their duties. The immunity applies even where a complaint alleges caseworker misconduct or intentional wrongdoing.[4] Others hold that the worker must be involved in a function critical to the judicial process itself. In either case, the more outrageous the employee's alleged tortuous conduct, the less likely it could be described as foreseeable, and the less likely the social service agency could be required to assume responsibility for the act as a general risk of doing business.

Recent Cases

In *Doe v. Lebbos*, the Ninth Circuit held that a social worker was entitled to absolute immunity for allegedly failing to investigate adequately the allegations of abuse and neglect against a father and in allegedly fabricating evidence in a child dependency petition because those actions had the "'requisite connection to the judicial process' to be protected by absolute immunity (at 826)." In *Van Emrik v. Chemung County Dep't*

of Soc. Servs.,[5] the court found that child protective caseworkers were entitled to qualified immunity in connection with the removal of a child from the custody of her parents during a child abuse investigation. In the Sixth Circuit and the District of Columbia Circuit, the type of immunity depends on the particular task the worker is doing. In *Gray v. Poole*,[6] the court held that qualified immunity covers social workers acting as investigators, while social workers testifying as witnesses are protected by absolute immunity. In *Rippy ex rel. Rippy v. Hattaway*,[7] the court ruled that absolute immunity protects social workers who initiate proceedings on behalf of a child. In *Austin v. Borel*,[8] the court ruled that child protection workers were not entitled to absolute immunity when they filed an "allegedly false verified complaint seeking the removal of two children" from the family home (at 1363).

Ethical Considerations

There is, of course, a difference between misrepresentation of a piece of physical or verbal evidence and the actual creation of false evidence. Misrepresentation involves the willful giving of a misleading representation of the facts. Creation of false evidence involves the act of improperly causing a "fact" to exist. More often, critics and attorneys accuse workers of a willingness to misrepresent, selectively quote, and misconstrue information to support their claims and therefore to present an entirely misleading case. Rather than sticking to agency protocols and training, the workers sensationalize their documentation and findings in a misleading fashion.

To what extent are such allegations true? Do workers consciously or unconsciously misrepresent evidence and selectively engage in systematic distortion? How often do they make deliberate efforts to mislead, deceive, or confuse their own supervisor or the court to promote their own personal or ideological objectives? How frequently are workers omitting or concealing material facts? Under the guise of vigilance, are there child protection workers whose adherence to rules and procedures is purposely excessive?

From a social work, legal, or judicial perspective, making a knowing misrepresentation in a child protection case is a serious ethical breach. The NASW *Code of Ethics,* 4.01(c), notes the following: "Social workers should base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics." At 4.04 the *Code* goes on to state: "Social workers should not participate in, condone, or be associated with dishonesty, fraud, or deception." Dishonesty, shading the truth, or lack of candor cannot be tolerated in child protection services, a field of endeavor built upon trust and respect for the law. Whether or not child protection workers deserve immunity from prosecution when they misrepresent or fabricate evidence is a question each states' courts are dealing with. Similarly, each court must decide whether such misconduct warrants setting aside the decision to remove the child from his or her home. In the final analysis, the question might soon find itself before the U.S. Supreme Court.

A worker's misrepresentation or fabrication of evidence is particularly pernicious because it puts the whole field of child protection in a negative light. Whether or not immunity is granted, there is simply no excuse for this kind of willful and egregious conduct.

Notes

[1] See, e.g., *Abdouch v. Burger*, 426 F.3d 982 (8th Cir. 2005) and *Babcock v. Tyler* (884 F.2d 497 (9th Cir. 1989) (absolute immunity shields social workers to the extent that their role is functionally equivalent to that of a prosecutor); but, see *Burton v. Richmond*, 276 F.3d 973 (2002) (when a state department of human services affirmatively places children in an abusive foster care setting, the state may be liable for damages): *Gray v. Poole*, 275 F.3d 1113, (D.C. Cir. 2002) (qualified immunity covers social service workers acting as investigators, but when testifying as witnesses they are protected by absolute immunity). Qualified immunity is often afforded if the social worker is involved in a "discretionary function" unless his or her conduct is clearly a violation of a statute or constitutional principle (*Snell v. Tunnell*, 698 F. Supp. 1542 (W.D. Okla. 1988).

[2] *Harlow v. Fitzgerald*, 457 U.S. (1982) (absolute immunity is appropriate in limited circumstances—judicial, prosecutorial, and legislative function—whereas executive officials usually receive qualified immunity).

[3] Cal. Gov't Code § 821.6.

[4] *Cunningham v. Wenatchee*, 214 F. Supp. 2d 1103 (E.D. Wash. 2002).

[5] 348 F.3d 820 (9th Cir. 2003).

[6] 911 F.2d 863, (2d Cir. 1990).

[7] 275 F.3d 1113 (D.C. Cir 2002).

[8] 270 F.3d 416 (6th Cir. 2001).

[9] 830 F.2d 1356, 1363 (5th Cir. 1987).

About the Author

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Register Now for APSAC's Atlanta Colloquium in June

APSAC will host its 17th Annual Colloquium June 17–20, 2009, at the Omni at CNN Center, Atlanta, Georgia. The Colloquium will feature Advanced Training Institutes, the Cultural Institute, and nearly 100 seminars from which to choose. The Colloquium also offers ample networking opportunities, poster presentations, exhibits, and an awards ceremony.

The educational goal of APSAC's Colloquium is to foster professional excellence in the field of child maltreatment by providing interdisciplinary professional education. Upon completion of this activity, participants should be able to:

- Apply state of the art treatment methods when working with abused and neglected children.
- Identify the most up-to-date information concerning working with abused and neglected children.
- Prepare and report quality testimony in court cases, both as experts and as witnesses.
- Identify physical abuse, sexual abuse, and neglect in children.
- Apply model examination and treatment techniques for abused and neglected children.

Seminars are designed primarily for professionals in mental health, medicine and nursing, law, law enforcement, education, prevention, research, advocacy, child protection services, and allied fields. All aspects of child maltreatment will be addressed, including prevention, assessment, intervention, and treatment with victims, perpetrators, and families affected by physical, sexual, and psychological abuse and neglect. Cultural considerations will also be addressed.

To help attendees select their seminars, the Colloquium is divided into convenient tracks: Administration, Cultural Diversity, Child Protection, Interdisciplinary, Interviewing, Law, Mental Health, Medicine and Nursing, Prevention, and Research. This Colloquium is cosponsored by APSAC and The Institute for Continuing Education. Continuing education credit is offered for a variety of disciplines and is awarded on a session-by-session basis with full attendance required at the sessions attended. Representatives from The Institute will be on site to accept applications for continuing education credit and to assist conference attendees. A separate processing fee is required.

Complete details and registration forms are available on the APSAC Web site at www.apsac.org. The site also features a downloadable and printable PDF version of the conference brochure.

OMNI HOTEL AT CNN CENTER

APSAC Involved in Strategic Planning Process

The APSAC Board of Directors has engaged Executive Service Corps of Chicago, Illinois, to work with the organization in developing a comprehensive strategic plan. Executive Service Corps works with nonprofits to assist them in several areas, including management, governance, and leadership.

Work on the project has begun, with several ASPAC members providing crucial feedback through phone surveys and online interviews. A Board strategic planning session is scheduled prior to this year's colloquium. A final plan is expected late fall/early winter in 2009. The project is being overseen by the organization's Long Range Planning Committee, which is chaired by Viola Vaughan-Eden, PhD, of Child and Family Resources, Newport News, Virginia.

APSAC Working on Membership Development

APSAC is working to recruit new members into the association's community. In addition to a direct mail campaign, the organization has participated in several conferences as an exhibitor, including the 17th National Conference on Child Abuse and Neglect in Atlanta, Georgia, the 25th National Symposium on Child Abuse in Huntsville, Alabama, and the Children's Justice Conference in Seattle, Washington. If you know of individuals who would benefit from APSAC membership, please refer them to the Web site, www.apsac.org, or to the office, 877.402.7722. More than 150 new members have joined to date in 2009.

Forensic Interview Training Clinic This June

Consistent with its mission, APSAC presents the Forensic Interview Training Clinics, which are focused on the needs of professionals responsible for conducting investigative interviews with children in suspected abuse cases. Interviewing alleged victims of child abuse has received intense scrutiny in recent years and increasingly requires specialized training and expertise.

This comprehensive clinic offers a unique opportunity to participate in an intensive 40-hour training experience and have personal interaction with leading experts in the field of child forensic interviewing. Developed by top national experts, APSAC's curriculum emphasizes state-of-the-art principles of forensically sound interviewing, including a balanced review of several models.

Training topics include the following:

- How investigative interviews differ from therapeutic interviews.
- Overview of various interview models and introduction to forensic interview methods and techniques.
- Child development considerations and linguistic issues.
- Cultural considerations in interviewing.
- Techniques for interviewing adolescents, reluctant children, and children with disabilities.
- Being an effective witness.

You can still register for the June 1–5 clinic in Seattle. Details and registration are available on the Web site at www.apsac.org.

APSAC Supports Regional Training; Chapter Grants Provided

APSAC's Board recently approved logistical and trainer support for two regional programs in Ohio and North Carolina. The organization is supporting these programs to help determine whether or not it can play a more active role in regional and chapter programming. Additionally, the organization reviewed and approved grant requests from the following APSAC chapters: California, Florida, Ohio, and Wisconsin.

APSAC Endorses Research Report on Physical Punishment

At its April meeting, the APSAC Executive Committee voted unanimously to endorse the *Report on Physical Punishment of Children in the U.S.: What Research Tells Us About Its Effects on Children*.

The Report summarizes for a lay audience findings from research on physical punishment of children, the legal status in various settings across the states, the international effort to recognize physical punishment as a human rights violation, and the growing number of countries that have banned physical punishment of children in schools or homes, or both.

Other endorsing organizations include the following: The American Academy of Pediatrics, the American Medical Association, the American College of Emergency Physicians, the National Association of Counsel for Children, and the National Association for Regulatory Administration. The full report can be viewed at www.phoenixchildrens.com/discipline.

CONFERENCE CALENDAR

APSAC-Sponsored Training Events

June 1–5, 2009
APSAC Child Forensic Interview Clinics
Seattle, WA
Call: 877.402.7722, or
Visit: www.apsac.org, or
E-mail: apsac@apsac.org

June 17–20, 2009
17th Annual APSAC Colloquium
Atlanta, GA
Call: 877.402.7722, or
Visit: www.apsac.org, or
E-mail: apsaccolloquium@charter.net

September 26–29, 2010
ISPCAN International Congress on Child Abuse and Neglect
Honolulu, HI
Call: 630.876.6913, or
Visit: www.ispcan.org, or
E-mail: congress2010@ispcan.org

June 2–5, 2009
The National Summit: Intersection of Domestic Violence and Child Welfare
National Council of Juvenile and Family Court Judges and the Family Violence Prevention Fund
Jackson Hole, WY
Visit: http://endabuse.org/content/features/detail/1081, or E-mail: llitton@ispconsults.com

June 2–5, 2009
American Humane's 2009 Family Group Decision Making Conference
Pittsburgh , PA
Visit: www.americanhumane.org, or
E-mail: info@americanhumane.org

June 4–5, 2009
Shared Child Welfare Decision Making: Partnering With Families and Children
The National Center for Adoption Law & Policy
Columbus, OH
Visit: www.law.capital.edu/adoption/symposium, or
E-mail: adoptionctr@law.capital.edu

June 17–20, 2009
17th Annual APSAC Colloquium
Atlanta, GA
Call: 877.402.7722, or
Visit: www.apsac.org, or
E-mail: apsaccolloquium@charter.net

June 23–23, 2009
12th National Child Welfare Data and Technology Conference: Making IT Work for Children: Improving Data for Agencies, Tribes, and Courts
Washington, DC
Visit: www.nrccwdt.org/conferences/our_conf.html, or E-mail: nrccwdt@cwla.org

August 2–5, 2009
23rd Annual Conference on Treatment Foster Care
Foster Family-Based Treatment Association
Atlanta, GA
Visit: www.ffta.org, or
E-mail: shorowitz@ffta.org

August 13–15, 2009
35th Annual NACAC Conference
North American Council on Adoptable Children
Columbus, OH
Visit: www.nacac.org/conference/conference.html, or E-mail: info@nacac.org

CONFERENCE CALENDAR

August 17–20, 2009
21st Annual Crimes Against Children Conference
Dallas Children's Advocacy Center
Dallas, TX
Visit: https://cacconference.org, or
E-mail: conference@dcac.org

August 19–22, 2009
32nd NAAC National Juvenile and Family Law Conference
National Association of Counsel for Children
Brooklyn, NY
Visit: www.naccchildlaw.org/?page=National_Conference

September 3–4, 2009
A New Direction for a Safer Tomorrow: A National Conference on Supervised Visitation and Safe Exchange
The National Council of Juvenile and Family Court Judges
San Diego, CA
Visit: www.ncjfcj.org/content/view/1197/315/, or E-mail: mrobinson@ncjfcj.org

September 21–24, 2009
Strategies for Justice: Advanced Investigation and Prosecution of Child Abuse and Exploitation
National District Attorneys Association/ National Advocacy Center
Columbia, SC
Visit: www.ndaa.org/apri/programs/ncpca/ncpca_home.html, or
E-mail:suzanna.tiapula@ndaa.org

September 26–29, 2010
ISPCAN International Congress on Child Abuse and Neglect
Honolulu, HI
Call: 630.876.6913, or
Visit: www.ispcan.org, or
E-mail: congress2010@ispcan.org

October 17–20, 2009
Midwest Conference on Child Sexual Abuse
University of Wisconsin-Madison
Madison, WI
Visit: www.dcs.wisc.edu/pda/midwest/index.html, or
E-mail: jcampbell@dcs.wisc.edu

November 14–17, 2009
21st Annual NAEHCY Conference
National Association for the Education of Homeless Children and Youth
Denver, CO
Visit: www.naehcy.org/conf/conf_2009.html, or E-mail: info@naehcy.org

January 25–29, 2010
San Diego International Conference on Child and Family Maltreatment.
The Chadwick Center for Children and Families
San Diego, CA
Visit: www.chadwickcenter.org, or
E-mail: sdconference@rchsd.org

APSAC ADVISOR

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APSAC Important Information

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