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AT ISSUE:

The Questionable Legitimacy of Pediatric Bipolar Disorder

Janet Cahill, PhD

Until relatively recently, a diagnosis of bipolar disorder in children under the age of 12 was extremely rare. Before the 1990s, it was generally accepted that bipolar disorder was typically first expressed in the late teens or early 20s. In the past 20 years, there has been a 40-fold increase in the number of children and adolescents diagnosed with bipolar disorder. This diagnosis is varyingly referred to as juvenile bipolar disorder, pediatric bipolar disorder, or childhood bipolar disorder. There are inconsistencies in the age range of children who are included under this diagnosis, as some researchers and clinicians include adolescents in these diagnostic categories, and others include only prepubertal children (up to ages 10–12). In this article, I focus on diagnosing bipolar disorder in prepubertal and very young children, and I use the term *pediatric bipolar disorder* (PBD).

Assigning a diagnosis of bipolar disorder to children has been the subject of great controversy and debate (Carlson et al., 2003). However, consensus exists that the documented rates of PBD have increased exponentially. Harris (2005) reported that 25% of children between the ages of 3–13 who were seen at an inpatient child assessment unit had been diagnosed by their outpatient therapists as having pediatric bipolar disorder, and these children had routinely been prescribed mood stabilizers or antipsychotic drugs, or both. Harris also noted that the parents of another 25% of the children on her unit believed that their children had pediatric bipolar disorder and had asked that their children be medicated for this condition. In my own clinical practice, I have seen children as young as age 3 who entered our clinic with a prior diagnosis of PBD. Again, all of these children had been prescribed antipsychotic or mood stabilizing drugs.

Clinicians agree that we know less about bipolar disorder in children than in adults, and the diagnosis of pediatric bipolar disorder has been referred to as a *high-stakes decision* (Youngstrom, Findling, & Feeny, 2004). If a child actually has bipolar disorder and the diagnosis is missed (a false negative), the developmental consequences for the child are unclear. We do know that in adults, bipolar disorder tends to be progressive, and there is evidence that intervening in the early stages of the disorder can be beneficial. Moreover, giving stimulant or antidepressant medications to adults with bipolar disorder can trigger or exacerbate manic episodes (DelBello et al., 2001). These points suggest that

there might be better outcomes for individuals who develop bipolar disorder if we intervened earlier, even if we are not completely sure of the diagnosis.

However, the consequences of making a false positive diagnosis—that is, diagnosing a child with bipolar disorder and subsequently determining he or she does not meet the criteria for the condition—can have negative consequences. Children diagnosed as having PBD are almost always medicated with drugs such as lithium, Seroquel, Geodon, Risperdal, and Abilify, among others, that have serious side effects. Indeed, the drugs typically used for the treatment of bipolar disorder have far more serious side effects than do medications used for other childhood disorders (Findling, Feeny, Stansbrey, Delpuerto-Bedoya, & Demeter, 2002). Even more concerning is the fact that none of these medications have been well studied in young children. A core question in this debate, then, is How accurately can bipolar disorder be diagnosed in young children? Moreover, if children are given this diagnosis, how confident are we that they will continue to meet the criteria as adults?

Bipolar Disorder in Adults

Bipolar disorder has long been a common diagnosis for adults, and it is often seen in adults who are involved in the child welfare system. It is a debilitating and chronic mental illness that frequently interferes with parents' or caregivers' ability to safely and effectively care for their children. We have well-established and well-researched criteria for the diagnosis of bipolar disorder in adults and adolescents ages 15 and older. Careful adherence to the diagnostic criteria in the DSM-IV-TR, particularly around the presence of manic episodes, allows for an accurate differential diagnosis of bipolar disorder in these populations. Most clinicians can clearly articulate the characteristics of adult bipolar disorder and can confidently identify it.

We also have a good understanding of the etiology of the disorder. Adult bipolar disorder is clearly understood to be a genetic disorder; it is estimated that in 93% of cases, the etiology of bipolar disorder can be identified as inherited (Kieseppa et al., 2004). The mean age when bipolar disorder expresses in adults is the mid-20s. The inherited genes express in a clear pattern of changes in neurotransmitters that lead to cyclical disruptions of mood. Bipolar disorder in adults is a very stable and debilitating condition. Its characteristic mood

instability tends to reoccur over the life span and is best viewed as a chronic and persistent mental illness. It is associated with high rates of hospitalization, unemployment, and suicide (Harrow et al., 1990; Angst et al., 2002). From a child welfare perspective, many parents who meet the criteria for bipolar disorder struggle to provide safe and adequate care for their children.

A primary component of bipolar disorder in adults is the presence of episodic and significant mood changes. The DSM-IV-TR indicates that these mood states must be significantly different from a normal mood state, and they must last from several days to many months. Most, but not all, adults with bipolar disorder exhibit mood shifts between depressive and manic or hypomanic states (Johnson & Leahy, 2004) and display typically neutral mood states in between. The cardinal characteristics of true manic episodes in adults are a decreased need for sleep, pressured speech, racing thoughts, and a high level of distractibility.

There is a robust literature supporting the use of psychotropic medications as a first line of treatment for adults diagnosed with bipolar disorder. As mentioned above, adult bipolar disorder is a strongly genetic disorder that results from an imbalance of neurotransmitters. Most clinicians endorse the use of mood stabilizers as a core component of treatment. Several psychosocial treatments, such as cognitive behavioral therapy or social rhythm therapy, are commonly used in conjunction with appropriate medications.

Broad consensus exists, then, about the existence, diagnostic criteria, and recommended treatment for adult bipolar disorder. When it comes to pediatric bipolar disorder, however, no consensus exists on these points.

Bipolar Disorder in Children—Shifting the Diagnostic Rules

We can trace back the staggering increase in the diagnosis of bipolar disorder in children to the mid-1990s, when Dr. Janet Wozniak joined a research lab at Massachusetts General Hospital. The lab was headed by Dr. Joseph Biederman. Dr. Wozniak became interested in children with attention deficit hyperactivity disorder (ADHD) who were very difficult to treat. She noticed a subgroup of her young clients who had periodic rages. She felt their behaviors, including kicking, biting, and screaming, were extreme. Dr. Wozniak decided these extreme behavioral outbursts were not the result of the impulsive aspects of ADHD. She made a conceptual leap and concluded that the aggressive behaviors she was observing were the result of undiagnosed bipolar disorder. She and Dr. Biederman, along with other colleagues, wrote a series of articles positing that many children who were diagnosed with ADHD actually met the criteria for bipolar disorder. In particular, they argued that the behavioral outbursts seen in some children were actually symptoms of mania (Biederman et al., 2000).

A major diagnostic sticking point accompanied this new diagnosis. As mentioned, the DSM describes bipolar disorder as episodic in nature, specifying that affected individuals display episodes of depression, mania, and intervening neutral mood states that are different from each other and should last a week or more. The children described by Wozniak and Biederman rarely had these long and discrete mood states. Instead they exhibited brief and frequent rages that could occur many times during a single day. To resolve this problem, Biederman's group, along with other researchers, suggested that bipolar disorder had a different presentation in children and that it included rapid or ultradian cycling. Instead of the sustained mood states observed in adults, children could exhibit many mood shifts within a single day and experience quick and extreme bursts of anger or rage. Biederman and colleagues suggested that children with bipolar disorder therefore presented with a different phenotype and labeled this disorder bipolar NOS, or *not otherwise specified*. To treat these mood states, Biederman and colleagues recommended adult mood stabilizers and antipsychotic medications.

Biederman and colleagues' articles had a tremendous impact on how oppositional behavior in children was conceptualized and treated. From that point forward, there was an exponential increase in the diagnosis of bipolar disorder in children and a concurrent increase in the use of mood stabilizers and antipsychotic medications to treat them. These medications were a sharp divergence from the well-researched and well-understood medications for ADHD. A number of researchers subsequently advocated that these medications be used for children as young as age 3 (National Institute of Mental Health [NIMH], 2001).

Opponents to Biederman's research raised a number of objections, many of which had to do with assessment assumptions and with methodology. These concerns will be addressed subsequently in more detail. One less commonly cited criticism is related to money. A 2008 *New York Times* article contended that Dr. Biederman earned at least \$1.6 million dollars in consulting fees from drug companies from 2000 to 2007 and had failed to disclose this income to Harvard University, where he had an academic appointment. He was allegedly paid this money during the years he advocated the expanded use of psychotropic medications in children (Harris & Carey, 2008). Later allegations reported that Biederman told the pharmaceutical company funding his research that a set of future studies would have results that would benefit the company (Harris, 2009). The proposed study was to test the efficacy of Risperdal (risperidone), a powerful, atypical antipsychotic drug, on preschool children. During his presentation to the company, one of his slides read that the proposed trial "...will support the safety and effectiveness of risperidone with this age group" (Harris, 2009, p. A-16). In other words, Dr. Biederman appeared to be promising positive results to the funders of his research before the study was actually conducted. Currently, Biederman is under investigation on several fronts for alleged conflicts of interest.

Certainly, Biederman's group is not alone in accepting research funding from drug companies—an alarming trend in and of itself. But it is important to note that Biederman's work was the cornerstone of both the increased diagnosis of bipolar disorder in children and the greatly increased use of psychotropic and mood stabilizing medications to treat children who supposedly had this disorder. For example, a roundtable discussion sponsored by the National Institute for Mental Health (NIMH) concluded that that prepubertal bipolar disorder existed and could be reliably diagnosed with existing diagnostic instruments (NIMH, 2001). More striking still, the roundtable concluded that bipolar disorder in young children did not have to meet the full diagnosis from the DSM. Children seen in clinics could fall into one of two categories: (1) those who clearly had bipolar disorder because they met DSM-IV criteria for bipolar I or II, and (2) those who *may have* bipolar disorder but did not meet DSM-IV criteria (NIMH, 2001, p. 871).

The work group proposed that a third phenotype for bipolar disorder be developed—bipolar not otherwise specified (NOS). The group suggested that this third diagnostic expression of bipolar disorder did not need to have episodic mood states. Rather, "... the most frequent course is a long-duration episode with rapid cycling (ultradian or continuous cycling as the predominant type) and mixed mania (i.e., co-occurring mania and depression)" (NIMH,

2001, p. 871). The roundtable suggested that screening and diagnosis for bipolar disorder should be done for children as young as age 3 or 4.

The recommendations from this roundtable are frequently cited in textbooks to support the existence of prepubertal bipolar disorder. Of the 19 members of this roundtable, 14 were psychiatrists. Joseph Biederman was a member of the group as were several of his colleagues, including Janet Wozniak. The intent here is simply to suggest that a small group of researchers had a disproportionate influence on the research into pediatric bipolar disorder, and a substantial portion of the research used to justify the broad expansion of the disorder came from Biederman's and colleagues' work.

Frances (2010) has directly argued that a major impetus for the widespread expansion of the use of this diagnosis with children came from researchers such as Biederman, whom he refers to as "thought leading." Frances asserts that these researchers fundamentally changed the way we diagnose bipolar disorder in an overinclusive manner that does not allow for strong fidelity to a diagnostic protocol. Moreover, he has charged that members of the pharmaceutical industry played a major role in this expansion. It allowed them to greatly increase the use of their existing drugs for a large and previously unaccessed population (Frances, 2010).



The Problem of Differential Diagnosis

Funding issues aside, researchers and clinicians have challenged some of the assumptions upon which the diagnosis of pediatric bipolar disorder are based. First is the assumption that children diagnosed with pediatric bipolar disorder will go on to develop the adult-onset type. This is a critical question. If we can identify this often-devastating disorder at a younger age and somehow improve the prognosis, then the use of such powerful drugs may have some justification. However, the few prospective and longitudinal studies that have addressed this question did not support this assumption. For example, Lewinsohn, Klein, and Seeley (2000) completed a longitudinal study of adolescents and reported that about 5% of the sample had what was referred to as subsyndromal bipolar disorder. This group did not meet the full adult characteristics of bipolar disorder, but they had symptoms of the mood elevations suggestive of the disorder. The members of this group were reevaluated at age 24 and were found to have significantly high rates of impaired psychosocial functioning, as well as elevated rates of depression, anxiety, antisocial personality disorder, and borderline personality disorder. However, they did not have increased rates of bipolar disorder. This study suggested that elevated moods in adolescents were transitory. Further, elevated moods were predictive of adult problems but not a specific expression of bipolar disorder.

In another study by Hazell, Carr, Lewin, and Sly (2003), 203 boys aged 9–13 were evaluated for psychological disorders. Of this sample, 124 were diagnosed with ADHD, and 25% of the ADHD

group were said to meet the criteria for mania. However, 6 years later, only one of the children diagnosed with mania continued to meet the criteria. These results suggest that even if children exhibit symptoms consistent with mania, these symptoms are transient. The study did not support a link between early mania and ADHD and subsequent adult bipolar disorder.

In another prospective study by Kim-Cohen et al. (2003), the same subjects were carefully evaluated several times between the ages of 11 and 26. Some were reported to meet the criteria for mania at younger ages. However, none of the individuals who had been diagnosed with mania at a younger age still met the criteria at age 26. The most common precursors of adult problems were oppositional or conduct problems.

Proponents of pediatric bipolar disorder posit that the core symptom of mania is much more common in children than previously thought (Biederman et al., 2000). Yet, high rates of mania in community samples have not been supported. The Great Smokey Mountain study (Costello et al., 1996) evaluated a sample of 4,500 children aged 9 to 13 and found no cases of mania and only .1% of hypomania.

These studies fail to provide clear evidence that older children and adolescents who exhibit symptoms that could be interpreted as mania go on to develop adult bipolar disorder, nor do the studies support a clear path between pediatric bipolar disorder and adult onset bipolar disorder. Further, none of the studies included children younger than age 9. Harris (2005), among others, argues that these findings point to the danger of using a loose definition of *mania* as a core symptom of bipolar disorder in children.

Another challenge to the stability of pediatric bipolar disorder is lack of valid and reliable measures. The most commonly used assessment tools to diagnose PBD are versions of the Kiddie Schedule for Affective Disorders and Schizophrenia (KSADS), and in particular the version developed at Washington University (WASH-U-KSADS). The WASH-U-KSADS has been found to have good inter-rater reliability (Geller, Zimmerman, Williams, Bolhofner, Craney, DelBello, & Soutullo, 2001); however, these instruments rely on a high level of training in their use and a good bit of clinical judgment (Youngstrom, Findling, & Feeny, 2004). Because they rely heavily on clinical judgment, the possibility of assessor bias exists. Moreover, they have not yet been shown to consistently predict adult bipolar disorder (Youngstrom, Findling, & Feeny, 2004).

Another commonly used tool is a profile from the Child Behavior Checklist (CBCL), one of the most commonly used multidimensional assessment tools for children and adolescents (Achenback, 1991). Proponents of the diagnosis of childhood bipolar disorder have developed an algorithm from the CBCL that has been labeled juvenile bipolar disorder phenotype (CBCL-JBD). This profile consists of clinically significant elevations (T scores >70) on the Anxious/Depressed, Aggression, and Attention Problems subscales

(Halperin et al., in press). Some researchers argue that this profile can discriminate PBD from ADHD and can predict adult onset of the disorder (Biederman et al., 2009). However, other research has not supported these conclusions. Halperin et al. (in press) followed a group of children whose parents completed the CBCL when their children were aged 7–11. The same checklist was re-administered 9 years later. Results indicated that while 31% of the children met the criteria for PBD at pretesting, only 4.9% did at posttesting. More important, only two individuals from the study sample actually developed bipolar disorder as adults. Of the two, only one had an elevation on the CBCL-JBD scale. The authors concluded that an elevation on this scale did not predict specific Axis I disorders in late adolescence (Halperin et al., in press). This research, along with other studies (Ayer et al., 2009), suggests that we do not have a clear set of diagnostic tools that identify symptoms in children that lead to adult-onset bipolar disorder. Ayer et al. (2009) concluded that the CBCL-JBD should not be used in the diagnosis of juvenile bipolar disorder.

Some researchers have attempted to identify specific symptoms or behaviors that could be seen as unique or cardinal symptoms of PBD. Biederman et al. (2000) argued that irritability, distractibility, and rages are the core symptoms of pediatric bipolar disorder. However, these symptoms also occur within a number of other more clearly established diagnostic categories for children.

The Issue of Comorbidity

Even the strongest proponents of the existence of PBD acknowledge that it is highly comorbid with other childhood disorders (Youngstrom, Findling, & Feeny, 2004). The most common comorbid diagnoses are attention deficit hyperactivity disorder (ADHD), conduct disorder (CD), oppositional defiant disorder (ODD), anxiety disorders, and substance abuse (Biederman et al., 2000). These researchers argue that bipolar disorder is comorbid or co-occurring with these other diagnoses. The proposed comorbidity rates for ADHD are extremely high at 60%–90%. With a comorbidity rate as high as 90%, isn't it reasonable to ask how the symptoms of bipolar disorder can be differentiated from those of ADHD? Proponents of PBD argue that this disorder is often mistakenly diagnosed as ADHD. But the reverse is also quite possible—ADHD is often mistakenly diagnosed as pediatric bipolar disorder. Given that we have clear and agreed upon criteria for ADHD and we do not for pediatric bipolar disorder, it is more credible that pediatric bipolar disorder is the more questionable diagnosis. Many other childhood disorders are reported to have high comorbidity rates with bipolar disorder, including oppositional defiant disorder, conduct disorder, substance abuse, autistic spectrum disorders, and symptoms of trauma (Biederman et al., 2000).

Harris (2005) completed a careful secondary diagnosis of the children coming to her with a prior diagnosis of pediatric bipolar disorder. She found that many of them actually met the criteria for pervasive developmental disorders, reactive attachment disorder

(although this diagnosis is also controversial) (Chaffin et al., 2006), posttraumatic stress disorder (PTSD), fetal alcohol syndrome (FAS), and mild delirium from overmedication. These alternative diagnoses have many symptoms that overlap with the proposed bipolar disorder NOS. These include aggression, oppositional behavior, anxiety, irritability, impulsivity, and mood changes.

From the perspective of child maltreatment, differentiating bipolar disorder from symptoms of trauma is particularly problematic. Traumatized children can be moody, irritable, distractible, aggressive, and sexually inappropriate. It is very difficult to distinguish these symptoms from symptoms purported to be indicative of PBD. Commonly used measures are not successful in differentiating these diagnoses. For example, Ayer et al. (2009) concluded that the CBCL cannot distinguish between PBD and PTSD. They hypothesized that these scales might actually measure an overall pattern of self-regulation.

Issues Specific to Child Welfare

The diagnosis of PBD has other ramifications for professionals involved in the child welfare and child protection field. Our field is inundated with children who are traumatized, distractible, anxious, and depressed and who display acting-out behaviors. We also deal with families under stress and parents who may themselves have psychological difficulties. In this environment, children as young as age 2 are being diagnosed with pediatric bipolar disorder. Since these children cannot accurately self-report their own mood states (imagine asking a 2-year-old if she has been manic lately), the diagnosis is often based upon information received from a parent. Many of the parents involved in child welfare systems have their own difficulties, and they may overpathologize their children and present them in an overly negative manner. Some parents also fail to acknowledge or understand the contribution of poor or inconsistent parenting to their children's difficulties. It is often simpler to request medication for a child than to change their parenting interactions.

Giving any child powerful mood stabilizers or antipsychotic drugs, or both, will certainly calm a child down, and some parents are satisfied with that. Most of these parents are rightfully frustrated and upset by their children's behavior. They often feel they cannot control their children, and in some cases, the children are very aggressive. The prospect of a pill that will calm the child, with no other changes needed, can be most attractive. Especially in child welfare cases, the possibility exists that parents' behaviors are contributing to a child's instability, either through abuse and neglect or by having unrealistic developmental expectations for their children's behavior.

Rebecca Riley presents an extreme example of this concern. She died at the age of 4 from a lethal dose of Clonidine prescribed by a psychiatrist who had diagnosed her at the age of 2 with bipolar

disorder. The psychiatrist had also diagnosed Rebecca with ADHD and had prescribed Seroquel and Depakote in addition to Clonidine, none of which are FDA-approved for use with children. Rebecca's parents, Michael and Carolyn Riley, had a history of involvement in the child protection system. They reportedly had asked repeatedly for more medication to calm Rebecca and their other two children. They were later convicted of her murder. The psychiatrist reached a \$2.5 million settlement with the family. She was reported as saying she relied on the information given to her by the parents as a major part of her diagnosis. She has resumed her practice as a psychiatrist (Wen, 2010).

If It Isn't Bipolar, What Else Could It Be?

Proponents of PBD describe these children as extremely irritable, explosive, distractible, impulsive, and oppositional, and they argue that ADHD alone cannot account for these symptoms. However, the combination of ADHD and oppositional defiant disorder (ODD) or conduct disorder (CD) can easily account for these symptoms. The diagnosis of ADHD explains the impulsivity, distractibility, and hyperactivity, while ODD or CD can account for aggressive and oppositional behaviors. The combination of ADHD and ODD is extremely common in children in the child protection system. Making a distinction between PBD and the combination of ADHD and either ODD or CD has profound implications for both the etiology and treatment of children receiving these diagnoses.

ADHD is a condition which, based on our best understanding of the etiology, has a neurological component. Medication is commonly used to treat this disorder. However, the efficacy and side effects of ADHD medications for children are much better researched and understood than the efficacy and side effects of adult mood stabilizers and antipsychotic drugs when given to children.

As for oppositional behavior, social learning theorists have developed another, well-researched explanation for oppositional behaviors in children. McNeil & Hembree-Kigin (2010) asserted that the core cause is an impaired parent-child relationship. Simply put, parents do not attend to their children when they are exhibiting desired behaviors, do attend to them when they are misbehaving, and thus inadvertently reinforce the acting-out behavior. Patterson, Reid, & Dishion (1994) described a coercive cycle that occurs when children escalate their negative behavior and parents simply give in. If the oppositional behavior we often see is the result of problems in the parent-child relationship, then that is a logical place to intervene. Several well-supported interventions have demonstrated that oppositional behavior can be reduced through behavioral intervention (Eyeberg et al., 2001; Kazdin, 2005). One prominent example is parent-child interaction therapy (PCIT), which has been demonstrated to be effective in reducing acting out behaviors in a wide variety of child populations. Of course, there are no medical side effects to PCIT.

As stated, it is also possible that the children we are seeing in child protective services are exhibiting symptoms of trauma. Here again, we have excellent, evidenced-based psychosocial approaches to address and resolve these symptoms, such as trauma-focused cognitive-behavioral therapy (Cohen, Mannarino, & Deblinger, 2006).

The Importance of Good Assessments

Throughout this article, I have discussed both the challenges and the importance of obtaining an accurate differential diagnosis for the children in our care. In practice, many of the younger children diagnosed with pediatric bipolar disorder were given this diagnosis after only a short interview with the child's parents. One critical component to diagnosing these children effectively is the use of multimodal, multiple-method assessments that rely on several sources of data (parents, teachers, other collaterals, and the children themselves) and a variety of assessment methods (interviews, structured observations, and standardized testing). All diagnoses should be based on a careful assessment protocol, but it is of particular importance for children suspected of having bipolar disorder.

A case example from my clinic will underscore this point. A referral was received for an 8-year-old boy we'll call Matthew. At the age of 3, he was diagnosed by his pediatrician as having bipolar disorder. The initial diagnosis was based upon his mother's report of extreme and sudden rages, oppositional behavior, lack of peer relationships, and difficulties transitioning in school. His pediatrician then referred him to a psychiatrist who prescribed Seroquel. Matthew was subsequently seen by several other mental health professionals, including two psychiatrists, a neurologist, a licensed clinical social worker, and two psychologists. Several gave Matthew the same diagnosis *by history*, meaning the clinicians took the diagnosis from the prior medical records. By the time he came to our clinic, Matthew had been on 14 different medications including Seroquel, Depakote, lithium, Prozac, Abilify, and Strattera. He had been in psychotherapy with four therapists, had been hospitalized twice, and had been involved with crisis and mobile responses four times. At the time of his referral, he was in a partial care program, and he continued to be diagnosed as having bipolar disorder. After all of these services, his mother reported no improvements in his behavior, and she said he was getting worse. She described him as having temper tantrums that lasted for hours. She reported that he had no friends and was refusing to go to school. She was desperate and thinking she might have to send Matthew to a long-term residential program.

Matthew was given a thorough, multimodal, multimethod assessment that included instruments specific to autistic spectrum disorder, based upon his history and his overall presentation at the clinic. He was ultimately diagnosed with Asperger's disorder. With his mother's permission, he was weaned off all his medications. His mother participated in a slightly modified PCIT intervention (McNeil & Hembree-Kigin, 2010), and he was enrolled in a social

skills training program designed for children with Asperger's disorder. Within 16 weeks, his mother reported a decrease in oppositional behavior to within normal limits, and Matthew was functioning well in school. He was not on any medications.

Of course, this is just one example from the million or so children who are being medicated for pediatric bipolar disorder. But it is a cautionary tale about the consequences of misdiagnosis, especially in young children.

Conclusions and Future Directions

Many research and treatment considerations need to be addressed before the controversy surrounding pediatric bipolar disorder is resolved. This article has attempted to illuminate the considerable challenges to the widespread use of this diagnostic category in young children. There is little agreement about the core characteristics of PBD, the ages at which it manifests, and its relationship to adult bipolar disorder (Halperin et al., 2010). For children under age 12 who do not meet the criteria of adult bipolar disorder, there is not even consistent proof that the disorder exists, except as a poorly supported proposed phenotype. Many other well-established and common problems can explain the behaviors attributed to pediatric bipolar disorder. Most, but not all, of the evidence-based treatments for these more typical disorders do not involve the use of powerful psychotropic medications. As indicated, these medications include antipsychotics that have not been well tested in children and adolescents. We have limited understanding of the effects of antipsychotic medications on the developing brain. We do know that even short-term use of antipsychotics can cause significant weight gain in children and adolescents—along with other significant side effects. One group of children placed on antipsychotics had a weight gain of 9–18 lbs in 10 weeks (Olfson, 2010). This type of weight gain can have significant health implications. In the absence of a robust literature that supports the clinical effectiveness of these medications, the side effects may well outweigh any benefits. This is especially true since the antipsychotics are often prescribed for aggressive behaviors, for which we have other, evidenced-based psychosocial alternatives.

One other point of interest is that recent studies have found poor children are more likely to receive antipsychotic drugs. Children who are covered by Medicaid are 4 times more likely to be given antipsychotic medications than are children with parents who have private insurance (Wilson, 2009).

From a child welfare perspective, we should advocate for the use of thorough assessments of children in our care and remain skeptical of the diagnosis of bipolar disorder in young children. Even if such a diagnosis is suspected, the symptoms of oppositional behavior should first be treated with psychosocial treatments. In particular, adult psychotropic or mood stabilizing drugs should be used with extreme caution in young children.

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Working With Undocumented Latino Youth Who Have Been Sexually Abused

April Dirks-Bihun, PhD

Introduction

Anna is a young Latina female whose parents entered the United States illegally from Northern Mexico when she was 3 years old. She is now 11 and in sixth grade at a rural school in the Midwest. She lives with her father, her brother (age 7), and her maternal uncle in a house owned by the uncle. Anna's mother left Anna and her younger brother several times during their childhood, and Anna has not seen her mother for 3 years. Anna's father parents the two children while working double shifts at the local meat processing plant.

One month ago, Anna disclosed to her father that her uncle was touching her sexually in the evenings when the father was at work. Anna was told not to lie about such serious things and that if she told anyone about her lie, they would all be deported back to Mexico. Anna was devastated that her father did not believe her, and she made plans to run away from home. In the meantime, her father requested a shift change at the packing plant so he could be home in the evenings, but he was denied this request. He also began to look for other housing arrangements and even considered sending Anna back to Mexico to live with relatives. The county Department of Human Services became aware of the sexual abuse situation when Anna's younger brother told his teacher that he had to sleep on the living room floor because his uncle was in bed with his sister at night. There has been an extensive investigation, and the uncle has been found guilty of sexual abuse, which had continued over the course of 4 years.

In my days as a school social worker, I encountered many situations that required the intervention of the local child welfare agency. Anna's case is a composite of cases that required the attention of helping professionals working with Latino children who have experienced sexual abuse. Located in the rural Midwest, the school district in which I worked was over 70% Latino, and it was estimated that half of the families were undocumented immigrants. As a professional working with this diverse population, I constantly struggled to find ways to identify the needs of undocumented children such as Anna. I was also concerned about the children who were not attending the local schools, who were essentially "off the radar," and whose condition was unknown.

While childhood sexual abuse exists in all facets of society, there are undoubtedly some particular barriers to child protection services for undocumented children who are at risk or who have been abused. It is critical to raise awareness of sexual abuse among undocumented

Latino children living in the United States in order to identify victims of abuse and the barriers in identifying and serving these children. A review of the literature will offer insight into the topic of sexual abuse among Latino children and will increase knowledge for practitioners working with an at-risk population that, until now, has been virtually invisible.

Sexual Abuse Among Latino Children Living in the U.S.

The Latino immigrant population is the fastest growing in the United States, and it is growing at an astounding rate. Latinos now represent over 15% of the population and are projected to increase to 24.4% by the year 2050 (U.S. Census Bureau, 2010). The rate of immigration and growth in the Latino population is more than 3 times the growth rate of the nation's population as a whole. Between 2000 and 2006, this group alone accounted for one half of the nation's growth, and the trend is expected to continue. Professionals working in the area of child welfare will increasingly work with this group as the population numbers continue to multiply.

Latino children are also the fastest growing group in the child welfare system (Dettlaff & Cardoso, 2010; Rivera, 2002). Even with this rapid growth, there is surprisingly little conclusive data on the prevalence of child sexual abuse within this population. There is conflicting data in the literature about the rates of child and adolescent sexual abuse in Latino populations in comparison to other ethnic groups (Ulibarri, Ulloa, & Camacho, 2009). Multiple studies show that Latino children are more likely to experience childhood sexual abuse when compared with non-Latino children (Finkelhor, Ormrod, Turner, & Hamby, 2005; Newcomb, Munoz, & Carmona, 2009), and some data indicate that children of Latino immigrants are 5 times more likely to be confirmed as victims of childhood sexual abuse (Dettlaff, Earner, & Phillips, 2009). Other sources state that there is no significant difference in the rate of sexual abuse between Latino and non-Latino children (Katerndahl, Burge, Kellogg, & Parra, 2005; Sedlak & Broadhurst, 1996). It is possible that social scientists do not have a good understanding of the rate of sexual abuse among Latino children and adolescents, because only the most serious incidents of abuse are even reported, and most of the cases are managed within the Latino community and family system because of the potential consequences of reporting abuse



Sexual Abuse Among Undocumented Latino Children Living in the U.S.

Very little is known about the need for child protection services for undocumented Latino children and how this need differs from Latino children who are citizens of the United States. The research on child sexual abuse among Latinos is scarce and contradictory, but research on sexual abuse among undocumented children is virtually nonexistent. According to the Pew Hispanic Center, in 2008 there were an estimated 11.9 million unauthorized immigrants living in the United States and an estimated 500,000 to 800,000 additional immigrants arriving each year (Passel & Cohn, 2008). These undocumented immigrants include children coming across the border either with or without

(Vericker, Kuehn, & Capps, 2007). Especially in communities with a high percentage of undocumented families and children, the risk of deportation due to an interaction with authority figures may deter reporting even the most serious allegations of abuse.

According to the National Child Traumatic Stress Network (2007), 29% of Latino children reported sexual abuse in a national sample of traumatized children. However, it is ultimately difficult to determine how many Latino children are victims of abuse both because only a small percentage of abuse instances are reported and because the samples of children in most studies have been predominantly Caucasian (Sledjeski, Dierker, Bird, & Canino, 2009). In a recent study, Newcomb, Munoz, and Carmona (2009) sampled a group of 223 Latino and European American students between the ages of 16 and 19 in Southern California to examine the impact of child sexual abuse among ethnically diverse high school students. The researchers found that the prevalence of child sexual abuse among Latinas, in particular, was much higher than the existing research would suggest. Latinas in the study were much more likely to report being a child abuse victim than their male Latino or European American classmates, and over half of the Latinas in the study reported childhood sexual abuse. The study also determined that female perpetrators and male victims were more prevalent than research would indicate. In general, these findings suggest that childhood sexual abuse among Latino males and females is more common than has been demonstrated by previous research on the topic.

parents. The Pew Hispanic Center has not determined exactly how many of the undocumented immigrants are children. However, they have determined that approximately 1.5 million children were undocumented in 2008 and made up about 6.8% of the students enrolled in the nation's elementary and secondary schools. In other words, there are a significant number of children living in the United States illegally who may be at risk for sexual abuse.

Many children experience some form of sexual assault when they immigrate to the United States. According to Pulitzer Prize-winning author Sonia Nazario (2006), over 48,000 children enter the United States from Mexico and Central America each year. These children are not accompanied by a parent or guardian, and they are exposed to the most extreme forms of sexual violence and trauma. In her book *Enrique's Journey*, Nazario provides accounts of children who experience sexual assault while journeying to the border to cross into the United States. As well, countless children experience traumatic events related to adult sexual assault, such as witnessing gang rapes of women while riding in train cars on their journey toward the U.S.-Mexico border. Violence against children is also addressed in the HBO documentary *Which Way Home*. Filmmaker Rebecca Camissa portrays the risks that children endure as they leave their homes in Central America to travel by train in an attempt to enter the United States illegally. Like Nazario's work, this documentary also explores the dangers that children face, including disabling injury, sexual assault, robbery, and death. Ethnographic studies in the form of documentary seem to be the only data available to study the prevalence of sexual assault experienced by children who enter the United States illegally.

Undocumented Latino children also fall victim to human trafficking. Arriving in Mexico from South and Central America, an untold number of children are then illegally smuggled into the United States. Fueled by a Western demand for prostitution and pornography, many of these children fall victim to human traffickers for factors such as economic necessity. However, children and adolescents can also fall victim to human traffickers due to a history of physical and sexual abuse, or they may actually be abducted and placed into the trade. According to Langberg (2005), who researches data on human trafficking across borders, governments are very reluctant to address this issue, and the Latin American and Caribbean regions are two of the most under-researched and underfunded regions when it comes to resources to counteract trafficking. Trafficking remains a daily occurrence. As of today, no adequate intervention exists from government on either side of the border to protect against this practice (Langberg, 2005).

Even undocumented children living in the United States who are not victims of human trafficking, or who have not crossed the border alone, are at risk of sexual abuse. Significantly, there are no data on the numbers of undocumented children who are abused because these children often fall through the cracks of legal and child welfare services (Jean-Baptiste, 2009). I estimate that the percentage of undocumented children who are sexually abused is at the same rate or higher than documented Latino children living in the States. Due to the difficult nature of acquiring quantitative data on a large number of undocumented children living in the U.S. combined with the barriers of collecting accurate data to address risk of childhood sexual abuse, it is extremely difficult to find empirical research on this topic. Research is needed to quantify the risk of sexual abuse of undocumented children and to address this issue in the human rights and child maltreatment literature.

Barriers to Child Protective Services for Latino Children

The invisible issue of sexual abuse among the undocumented population is of particular concern. Considered invisible because it often goes unreported and unseen, sexual abuse also can be considered invisible because it is a taboo topic within many traditional Latino families and is, therefore, not openly discussed. Unlike physical abuse, which may be identified by marks such as bruises or burns, sexual abuse of children is difficult to identify unless children disclose the abuse to another person who is in a position to help them. Children face many barriers when reporting sexual abuse, but there are also unique barriers that affect the ability of children in undocumented populations to report the abuse. Language may be the first and most critical barrier for those in need of child protection services. Additional obstacles to reporting abuse include social and cultural barriers, a limited understanding of the legal system, and limited access to public facilities where reporting may take place, such as medical facilities and schools.

The fear of deportation is a special issue that affects both undocumented children who have been sexually abused and their families. According to Perez-Foster (2005), immigrants who enter the U.S. without proper documentation often live in constant fear of deportation. I have worked with children who had been told that their parents, siblings, aunts, and uncles would all be deported if the child told anyone about the abuse. Many parents are terrified about deportation if their children become involved in the child protection system, and this fear deters them from taking appropriate action to protect their children and to prosecute the offenders. Unfortunately, the fear of deportation and insecurity regarding involvement in the child welfare process prevent many children and families from getting appropriate child sexual abuse services.

Based on my own work with undocumented child victims of abuse, it is not uncommon for an abuser to threaten a child with deportation if the child discloses the abuse. These threats were very effective in protecting the abuser because the children feared serious, negative consequences for the entire family if they reported the abuse. I frequently needed to reassure families that deportation was not standard protocol for the department of human services. However, families had learned from experience that any involvement in government services, and especially police matters, was surely a potential threat to the family's remaining in the United States. This point is illustrated in a legal case discussed in a Sapelo Foundation white paper that documented an incident of an underage undocumented immigrant who was subjected to repeated sexual abuse because of her immigration status (Shore, 2010). She was the sister-in-law of a U.S. citizen businessman and was threatened with deportation if she disclosed the abuse. In addition, these immigrants are at constant risk for exploitation and physical and sexual assault due to their illegal status, and they may be unable or unwilling to seek proper protection from local officials.

Individuals who live in constant anxiety related to immigration status may also be less likely to report suspected child sexual abuse in any circumstances, because any interaction with legal authorities or child protection services may seem extremely risky to a person who has worked hard to go unnoticed. Abused children often come to the attention of service providers at medical facilities and public schools, but children of Latino immigrants are more likely to be uninsured when compared with documented children and may not come to the attention of medical professionals (Capps, Ost, Reardon-Anderson, & Passel, 2004). Further, undocumented children may or may not attend school. The dropout rate for Latino teens in middle and high school is alarming (Brammer, 2004). The high rate of school dropout may be related to low academic achievement and lower school engagement than adolescents of other ethnic groups. In many Latino families, children are considered important economic contributors, and they are often given responsibility for childcare, or they find employment to supplement the family income. Due to the reliance on Latino teens for economic support, a child or adolescent may drop out of school to acquire the low-

paying and nontechnical jobs that are offered to them (Locke & Newcomb, 2005). Because they do not attend school, these children are less likely to come to the attention of service providers.

There may be other factors within undocumented Latino communities that limit the reporting of sexual abuse to authorities. Cultural values of shame, *familismo*, and *respeto* may affect the reporting of abuse. According to Fontes (2007), shame is a prevalent concept in Latino cultures, and members of a child's family who were not responsible for the sexual abuse may still feel a deep sense of guilt and shame for not having protected the child. The family may feel that it is in the child's and family's best interest to keep the assault a secret and to pretend as if it did not happen.

Familismo is a term widely used in the Spanish language to describe the importance of the extended family. According to Coohy (2001), "Familism, or *familismo*, refers to attitudes, behaviors, and family structures operating within an extended family system and is believed to be the most important factor influencing the lives of Latinos" (p. 130). *Familismo* is thought to promote healthy emotional and psychological growth in children, and Latino families often have strong family networks to protect their children from external physical and emotional stressors (Sabogal, Marin, & Otero-Sabogal, 1987). In general, interpersonal closeness and support within Latino families may be very helpful to survivors of sexual assault, and the family support and closeness that result from *familismo* can be a positive factor in a child's life. However, when the abuse is perpetrated by a hierarchical member from within the close-knit family structure, the family may not be a safe place for the victim to reside. Therefore, *familismo* can influence a victim's experience of childhood sexual abuse either positively or negatively.

Some children may not be willing to seek help for abuse because they understand the concept of *familismo* and the value of placing the needs of the family above their own need to be safe. Further, children may be unwilling to expose a respected member of the family, such as a father or an uncle, because of *respeto*, the internalized value of respect. To disrespect the authority of a family member may be seen as damaging to the entire family system. While this dynamic is not unique to Latino families, the strong adherence to *familismo* and *respeto* might further reinforce the disincentives to disclose and report the abuse.

Finally, the concept of female virginity before marriage is also very important among some Latino families. At times, the importance of maintaining a child's virginity can be a deterrent to contacting police authorities and getting the proper care for a victim of sexual assault. It is not uncommon for families to demand to know whether there was penetration from sexual assault because the family may be concerned by the implications of loss of virginity. Of course, all children who have been sexually assaulted may be in need of help to recover from the assault, regardless of whether penetration occurred.

How Can We Help?

In the United States, child welfare services, including foster care and protective services, are available to all children regardless of their immigration status (Jean-Baptiste, 2009). However, a great deal of confusion exists on the part of practitioners about how exactly to treat undocumented immigrant children. There is no known research on the topic of practitioner responses to serving undocumented children who are victims of child sexual abuse. As the undocumented immigrant population and the Latino population in general continue to increase, there will inevitably be an increased demand for competent helping professionals to work with children and adolescents who have experienced sexual abuse. Helping undocumented immigrants obtain child protection services is complicated, especially when the risks of accessing services (such as shame and a fear of deportation) may outweigh the benefits for some families of seeking services. There is a significant gap in the literature on the topic of sexual abuse among undocumented children and, therefore, we know little about how to best serve this population.

There are a number of best practice behaviors stemming from core values of cultural competence, trust, confidentiality, and a strengths perspective that practitioners can implement while working with undocumented immigrants who may be at risk for childhood sexual abuse. First, practitioners in both public agencies and private practice settings should strive for cultural competence when working with this population. The topic of childhood sexual abuse can be an especially sensitive area when a practitioner may also be struggling to grasp the unique cultural attributes of population they are serving. According to Dettlaff and Cardoso (2010), becoming a culturally competent practitioner requires more than understanding the basics of Latino culture. Culturally competent practice develops over time and is increased through experience with members of a cultural group. It requires understanding a whole host of complex issues such as immigration law, deportation risk, cultural norms and values, family structure, language, history of violence, and experiences with acculturation within each family system. In particular, understanding acculturation is essential when working with undocumented immigrant families, because high levels of acculturation stress have been related to increased child maltreatment (Hovey & King, 1996). Cultural competence can be demonstrated for Latino families by showing respect to family members, and by placing bilingual helping professionals in diverse population centers where children and their families can feel more comfortable communicating their needs.

Second, when working with Latino families, it is important to create a climate of trust, in which families and helping professionals can report suspected child abuse without fear of negative consequences or deportation. It is important to keep in mind that "child welfare systems have a responsibility to address the well-being of children who come to the attention of their system, without regard to citizenship status" (Dettlaff & Cardoso, 2009, p. 6). Not only should child protection workers and other helping professionals serve

undocumented children, they should also routinely assess the risk of deportation of the immigrant families with whom they are working (Dettlaff, Earner, & Phillips, 2009). Helping professionals could work with undocumented Latino families to see if they are eligible for services and also help the families make guardianship plans in the event that the parents would come to the attention of immigration officials. If child protection services could work with families to create safety nets for children, it is possible that more families would turn to child protection services if their children were in danger.

Undocumented individuals will be more likely to seek out services if they are allowed a degree of anonymity at the onset of services. A third strategy is to create a climate of anonymity and forego acquiring a detailed social history and citizenship information, such as social security number, at a first meeting. However, even if detailed citizenship information is not collected, it is essential for a culturally competent practitioner to assess risks associated with immigrant families at all times. Latino families should also be educated about their legal rights and child protection issues. Community agencies and child protection services should inform Latino community members about child sexual abuse and methods of prevention (Dettlaff et al., 2009). Even with a climate of anonymity, it is essential that practitioners work diligently to create a climate of trust when working with undocumented Latino families so that individuals feel comfortable protecting their children and reporting suspected abuse without fear of deportation. Additionally, it is essential in this process that practitioners be sensitive to the importance of *familismo* and respect the family system when attempting to break through the fear of reporting and using services.

Finally, it is important to use a strengths perspective when working with undocumented immigrants and to build on the strengths found in immigrant families. For example, the strength it takes to illegally cross the border into the United States is a motivating factor that can be utilized and built on when working with the family and child involved in a sexual abuse case (Dettlaff et al., 2009). However, it may be challenging to utilize the strengths perspective when there are so many problems affecting Latino families that originate from outside the family unit that may affect service provision (Dettlaff & Cardoso, 2010). Problems occur at the social and economic levels in the community, which can present huge obstacles



to families in need of services. For example, some of the anti-immigration policies generated at the state and federal levels targeting undocumented Latino immigrants have actually resulted in a decrease of supportive programs for the children of Latino immigrant families. With anti-immigration politics and prejudice, it is no wonder that families and practitioners are unsure of how to proceed when a child victim has disclosed abuse.

Identifying barriers to child protection services for undocumented Latino children is an important area for future research. Despite the overwhelming challenges facing the Latino community and the evidence of sexual abuse in the Latino community, little attention has been devoted to researching abuse among the undocumented population. Research is needed on the effects of growing anti-immigration policies on children and adolescents in need of services. At a time when immigration is increasingly becoming an issue, policy makers may be so concerned about whether or not families and children should be crossing the border that they fail to consider the child protection needs of the children who are already residing in the United States. These children often go unnoticed and do not get the services that are their basic human right.

This article raises several issues that are clearly on the radar screen but are not often discussed. How do we serve sexual assault victims who are undocumented immigrants and are not even supposed to be living in the United States? Whose responsibility is it to serve these children, and how do we most effectively serve them? What kind of legal, ethical, and moral responsibility do we have to serve undocumented children? We need a better understanding of the relationship between ethnicity and child maltreatment, especially

childhood sexual abuse, in order to identify children at risk and understand the needs of undocumented children. While this article does not offer solutions to these impending questions involving responsibility and human rights, it hopefully will open the door to a discussion of the issue and create an environment for scientific inquiry on the very important topic of sexual abuse among children who are at risk of falling through the cracks of the child welfare system.

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Ethnic Differences in How Domestic Violence Affects Mothers' View of Their Infants

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Introduction

Research has consistently found that adolescents, young children, and infants are likely to experience many adverse outcomes in homes where domestic violence occurs (Kitzmann, Gaylord, Holt, & Kenny, 2003; Mahony & Campbell, 1998; McGuigan, 2007), including a higher likelihood of child abuse and neglect (Appel & Holden, 1998; McGuigan & Pratt, 2001). There is an absence of research examining differences in how domestic violence impacts child abuse potential in Hispanic and white non-Hispanic mothers, and little consistency in how Hispanic and white non-Hispanic mothers reportedly differ in their reactions to domestic violence (Aguilar Hass, Dutton, & Orloff, 2000; Edelson, Hokoda, & Ramos-Lira, 2007).

Examining the impact of domestic violence on the child abuse potential of Hispanic mothers is important because in the United States, one fourth of the children younger than 5 years of age are Hispanic (Latino, 2009, citing U.S. Census Bureau). Research on this question may contribute timely knowledge and direction to child abuse prevention and intervention efforts.

To better understand parent-child relationships in Hispanic families, most human service professionals would agree that it is important to consider how traditional Hispanic culture may influence family roles. Hispanic individuals represent a diverse group of people with varying national origins, from Mexico (64%), Puerto Rico (10%), Cuba (4%), and other Central and South American countries (U.S. Census Bureau, 2009). But despite their diverse nationalities, a majority of Hispanic families express similar cultural values regarding the importance of family, distinct gender roles, and parenting practices (Galanti, 2003).

For Hispanic people as a group, *familismo* (loyalty and solidarity shared by family members) is a central concept, and gender roles may be more rigidly defined and influenced by the cultural concepts of *machismo* and *marianismo*. *Machismo* dictates that Hispanic fathers have an obligation to the family and should be courageous, honorable, dominant, authoritarian, and aggressive. *Marianismo* expects Hispanic women to be good mothers, submissive to their

husbands, self-sacrificing, and tireless caregivers who nurture their husbands and children before themselves (Bauer, Rodriguez, Quiroga, & Florez-Ortiz, 2000; Perilla, Bakeman, & Norris, 1994). Husbands may provide discipline and direction to older children; however, for infants and children under age 3, nurturing (e.g., hugging, kissing) and mastery of developmental tasks (e.g., toileting, learning to speak) are primarily the mother's duty (Cabrera, Shannon, Mitchell, & West, 2009; Solis-Camara & Fox, 1995). These gender roles and parenting practices may influence how domestic violence impacts child abuse risk and may also contribute to a lack of help seeking among Hispanic women who have been victimized by their male partners (Bauer et al., 2000; West, Kantor, & Jasinski, 1998).

In the United States, the lifetime prevalence of violence against women by a domestic partner is 22%, and worldwide rates reach 69% (Kapoor, 2000). Sadly, the majority of female victims of partner violence live in households with young children (Tjaden & Thoennes, 2000). Studies in Mexico have found prevalence rates within that same range, reporting that between 34% to 46% of adult women have experienced partner violence (Edelson et al., 2007; Natera, Tiburcio, Berenzon, & Lopez, 1997).

A review of the domestic violence literature reveals a paucity of empirical studies examining the effects of domestic violence on infants, and particularly the effect of domestic violence on mothers' view of their infant. (For an exception, see McGuigan, Vuchinich, & Pratt, 2000.) More research is needed on the relationship between domestic violence and mothers' cognitions about their infant, since it is during pregnancy or immediately after childbirth that many women first experience domestic violence (Saltzman, Johnson, Gilbert, & Goodwin, 2003; Tjaden & Thoennes, 2000). It is well known that couple relationships are usually the most discordant during the first years of child rearing. Likewise, domestic violence during a child's first year can have a profound influence on the child's future psychological development (Bogat, DeJonghe, Levendosky, Davidson, & von Eye, 2006) and on physical health (McGuigan, 2007).



Since the seminal study by Fauber and Long (1991), researchers have demonstrated that conflict in the parents' relationship indirectly affects children through negative changes in the quality of the parent-child relationship and can also increase parents' negative cognitions about their child. Violent interactions between parents have spillover effects that influence children both within and outside the family (Carrell & Hoekstra, 2008; Fincham, Bradbury, & Scott, 1990). Parents with unrealistic expectations regarding their child's behavior show increases in their negative attributions toward their child (Azar, 1997). Other parenting characteristics correlated with negative outcomes for children include the perception of the child as difficult or demanding (McGuigan et al., 2000) and diminished parental acceptance of the child (Krishnakumar & Buehler, 2000). However, studies are lacking that directly examine the relationship between domestic violence and mothers' negative view of their infant.

One study that directly addressed the effect of domestic violence on parents' view of their infant found that both mothers and fathers who experienced domestic violence showed a more negative view of their infant than did parents who had not experienced domestic violence (McGuigan et al., 2000). However, the study did not examine whether the impact of domestic violence on maternal attributions varied across ethnic groups.

Together, these studies prompt a more detailed investigation of how domestic violence influences mothers' perception of their infant in two major ethnic groups in the United States, white non-Hispanics and Hispanics. Information regarding Hispanic mothers is particularly relevant considering that the proportion of Hispanic children born in the United States has increased faster than that of any other racial or ethnic group (Federal Interagency Forum on Child and Family Statistics, 2003).

Method

The current exploratory study reviewed 5 years of archived data (1997–2001) from the Oregon Healthy Start (OHS) program. Oregon Healthy Start continues to be a voluntary home-visiting program designed to help families at risk of poor family functioning to give their firstborn infants a healthy start in life. The OHS program was modeled after the Healthy Families America program, which is sponsored by Prevent Child Abuse America. The OHS program addresses family dysfunction and child abuse prevention by promoting positive parenting practices. At the time of this study, OHS was serving 19 Oregon counties.

To identify at-risk families, OHS used an extensive two-stage screening and assessment process. The screening was initially completed by hospital nurses or trained Family Assessment Workers (FAWs) in the hospital shortly before or shortly after a child's birth. Mothers provided yes-no answers to the 15-item Hawaii Risk Indicator (HRI) checklist (Hawaii Family Stress Center, 1994). Mothers who were unmarried, who had inadequate or no prenatal care, or who showed any two other risk characteristics (i.e., history of substance abuse, fewer than 12 years of education, inadequate income) were further assessed using the Kempe Family Stress Inventory (KFSI). The KFSI is an in-depth interview that assesses 10 psychosocial factors related to poor family functioning and the risk of child abuse (Korfmacher, 2000). Healthy Start FAWs conducted KFSI interviews after receiving extensive training in the interview protocols. Interviews took one hour and were conducted in the hospital or in the home shortly after the child's birth as part of a "welcome baby" visit. Based on KFSI scores, families considered at-risk for poor family functioning were offered weekly home visiting services.

Family Support Workers (FSWs) provided weekly visits to participating families for the first few months and gradually reduced these

to bi-weekly or monthly visits, depending on the family's needs. Family Support Workers received at least 96 hours of initial training and over half (58%) had college degrees in health or human service-related fields (e.g., nursing, public health, social work, human services). The FSWs who provided home visits to Hispanic families were fluent in Spanish, with the majority being second-generation immigrants from Mexico. Home visits focused on child abuse prevention by providing parenting education, child development information, and referrals to needed social services.

The 1,447 mothers in the current study sample resided in semi-rural or small metropolitan areas, and the majority (75%) had never been married. This study included only mothers who had volunteered to receive home visiting services for one year and who were either white non-Hispanic (72.5%) or Hispanic (26.5%). On average, the mothers were 21.1 years of age ($SD = 4.7$) when their child was born, and most (79%) did not work outside the home. Over half (51%) of the mothers had less than a high school education, and 89% were enrolled in the Oregon Health Plan, a state medical plan for low-income families. The majority (58%) lived independently with their husband or partner; one third (34%) lived with parents, relatives, or friends (and might also include their husband or partner); and the remaining 8% lived alone with their newborn child.

Measures

Self-reports on how mothers viewed their children would be susceptible to social desirability bias. To avoid this, FSWs took detailed notes of family interactions during the home visits, including notes on the mothers' view of their child. On alternate weeks, the FSW would meet with a multidisciplinary team to review each family's progress. The assessments of the mothers' view of their child were based on the assessments completed by FSWs and multidisciplinary teams at 6 and 12 months. Mothers' view of their child was measured with the following five items (rated yes = 1 and no = 0): (a) "Mother has rigid or unrealistic expectations of the child's behavior," (b) "Mother sees child as difficult," (c) "Mother sees child as deserving of punishment," (d) "Mother sees child as deliberately disobeying and annoying," and (e) "Mother shows a lack of bonding with child." Scores were summed to produce a total index score ranging from 0 to 5 with higher scores indicating a more negative view of the child. Factor analysis showed all items consistently loaded on one dimension with good internal reliabilities at both the 6-month (Cronbachs alpha = .59) and 12-month (Cronbachs alpha = .79) assessments.

For this study, *domestic violence* was strictly defined as "any act of physical aggression between partners with

the intent to do harm during the first year of child rearing." Research has established that while different types of domestic violence exist, the majority involves the male partner as the perpetrator or both partners in mutual couple violence (Johnson & Ferraro, 2000). In the current study, no distinctions were made regarding the frequency or typology of the violence. The conceptual basis of this study focused on how any type of physical aggression between partners confirmed during the first year of child rearing would affect the mothers' view of their child.

The FSWs were trained to recognize signs of relationship volatility. The frequent home visits with observations of family interactions increased the likelihood that domestic violence would be detected. To insure the mothers' safety and to promote open disclosure when violence was suspected, mothers were asked in private if their spouse or partner had been physically aggressive toward them. Victims were informed of their options regarding shelter services, legal action, and counseling.

Results

Of the 1,447 mothers in this study, 140 (10%) were assessed as having experienced domestic violence. There was no significant association between domestic violence and the mothers' race or ethnicity. Specifically, of the 1,063 white non-Hispanic mothers, 109 (10%) experienced domestic violence, and of the 384 Hispanic mothers, 31 (8%) were assessed as having experienced domestic violence.

Separate t-tests were conducted to examine the effect of domestic violence on the mothers' view of their child. Table 1 shows the effect of domestic violence on mothers' negative view of their child at 6 and 12 months for all mothers in the study sample. Table 2 includes only white non-Hispanic mothers, and Table 3 shows the effect of domestic violence on Hispanic mothers' negative view of their child. While scores on the mothers' negative view index were low, there was variation at the lower levels.

Table 1 shows that for all mothers ($n=1,477$), those who were assessed as experiencing domestic violence during the first year of their child's life developed a significantly more negative view of their

Table 1. All Mothers' Negative View of Their Child ($n = 1,447$)

Group	6 months		12 months		<i>t-value</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
DV parents	.30	.64	.60	1.12	4.15	.000
Non-DV parents	.13	.44	.14	0.48	0.42	.673

Table 2. White Non-Hispanic Mothers' Negative View of Their Child (n = 1,063)

Group	6 months		12 months		<i>t-value</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
DV parents	.35	.68	.72	1.22	4.36	.000
Non-DV parents	.15	.45	.16	0.51	0.41	.679

Table 3. Hispanic Mothers' Negative View of Their Child (n = 384)

Group	6 months		12 months		<i>t-value</i>	<i>p</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
DV parents	.13	.43	.16	.52	0.30	.768
Non-DV parents	.10	.39	.10	.39	.115	.908

child ($p < .001$) from the 6-month assessment ($m = .30$) to the 12-month assessment ($m = .60$). There was no significant change in the view of the child for mothers who had not experienced domestic violence.

Table 2 shows that for white non-Hispanic mothers ($n=1,063$), those who were assessed as experiencing domestic violence during the first year of their child's life developed a significantly more negative view of their child ($p < .001$) from the 6-month assessment ($m = .35$) to the 12-month assessment ($m = .72$). There was no significant change in the view of their child for white non-Hispanic mothers who had not experienced domestic violence.

Table 3 shows that for Hispanic mothers ($n=384$), there was no significant change in the mothers' view of their child regardless of whether or not the mother had been assessed as experiencing domestic violence. Domestic violence during the first year of child rearing had no significant effect on the Hispanic mothers' view of their infant.

Discussion

This exploratory study revealed some important findings for programs seeking to improve family relations and reduce the risk of child abuse in violent families. A continuing challenge when researching the connection between domestic violence and child abuse is why only a small proportion of mothers in violent homes go on to commit child abuse. Changes in mothers' view of their

infant is one way domestic violence could influence child abuse potential. It follows that an increase in negative maternal cognitions would lead to a higher likelihood of the child becoming an eventual target for abuse.

This is one of the first studies to illustrate variation in the impact of domestic violence on maternal cognitions by comparing white non-Hispanic and Hispanic mothers. The results extend previous research and show that for white non-Hispanic mothers, domestic violence increased the negative cognitions about their infant children. Despite the assessment of domestic violence, Hispanic mothers showed no significant change in the view of their infant from 6 months to 12 months.

Exploring the causes of ethnic differences in the impact of

domestic violence will be an important next step for researchers. We speculate that differences in Hispanic and white non-Hispanic mothers' view of their child may be related to the families' cultural values. Studies have found higher levels of *familism* in Hispanic families (Losada et al., 2006; Shaull & Gramann, 1998). It is well known that motherhood (*marianismo*) is seen as the most culturally accepted identity for Hispanic women. A recent study of a home visiting program found that parent-child interactions improved over the child's first year for Hispanic mothers to a significantly greater degree than white non-Hispanic mothers (Middlemiss & McGuigan, 2005). These findings suggest the need for more exploration of ethnic differences in parenting in both violent and nonviolent households.

Generalizability of this study is limited to white non-Hispanic and Hispanic mothers who voluntarily participated in a home visiting program in one state. Statistical limitations must also be acknowledged. No measures of interrater reliability were available in the archived data. However, home visitor training emphasized independent assessment of each family's characteristics, and visitors were unaware that items would be combined to form the negative view of the child index. Having the input of the county's multidisciplinary teams on all of the 6- and 12-month assessments minimized the extent to which any associations between constructs may have been due to shared method variance. Future studies should include more rigorous designs to tease out the causal linkages among domestic violence, mothers' negative view of their infant, and confirmed child abuse.

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Service Use by Parents in Child Welfare: Current Knowledge and Future Needs

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A number of studies have documented that parent mental health and substance abuse problems are associated with child abuse and neglect (e.g., Brown, Cohen, Johnson, & Salzinger, 1998; Chaffin, Kelleher, & Hollenberg, 1996; Dinwiddie & Bucholz, 1993; Kelleher, Chaffin, Hollenberg, & Fischer, 1994). In addition, parents involved with the child welfare system typically have higher rates of poverty, stress, and unemployment than do parents not involved with child welfare (Epstein et al., 1998; Whipple & Webster-Stratton, 1991), and families with more risk factors have higher rates of child maltreatment (Wu et al., 2004). Despite the needs of these parents, there is evidence to suggest they do not always receive appropriate or adequate services and treatments.

Francis and Wolfe (2008) found that none of the abusive fathers in their study had received services other than Child Protective Services (CPS), despite having elevated scores on mental health, anger, and parenting stress measures. Smith and Marsh (2002) identified the unmet service needs among mothers involved with the child welfare system who were also receiving substance abuse treatment. These were especially high for legal help, housing assistance, medical check-ups, and job training. Yet, there is evidence that the receipt of needed services is positively related to outcomes (Choi & Ryan, 2007), and research also supports the effectiveness of specific treatments for parents. Thus, it is important to better understand patterns of service utilization by parents involved with child welfare. The literature on service utilization by parents in child welfare is scant, but it is timely to summarize what is known and to make suggestions for future research.

This article summarizes the findings from studies on service utilization by parents involved with the child welfare system, and it makes recommendations for future research. Services are defined broadly to include mental health and substance use treatment, as well as other social services. The studies included in this review were identified by searching primary databases (e.g., PsychLit, Social Work Abstracts) with keywords (e.g., parents, child welfare, service use, parents, child maltreatment). Reference lists included in these articles were also examined for relevant articles. Studies were included in this review if they examined the use of services by parents who were referred to or involved with child welfare. Studies that examined use of services by children were included if parent service use was also included.

Current Knowledge

Existing studies can be categorized by one of three broad purposes: (1) to describe the services used and the percentage of parents who used services, (2) to examine the correlates of service use, or (3) to examine the impact on case outcomes of matching services to needs.

Services Used and Percentage of Parents Using Services

Kolko, Seleyo, and Brown (1999) examined the past treatment histories and current service use of 86 youth and their parents when there had been an allegation of physical or sexual abuse. The study found that the most frequent prior treatment used by parents had been inpatient treatment (32.9%) followed by outpatient treatment (22.4%), with no significant differences by type of abuse. Of potential parent services, including group therapy, marital therapy, and parent education, the most frequently used service was individual therapy (37.7%). No significant changes were found in the services used at a second interview, which occurred 4–8 months after receiving an initial service. Drug and alcohol services were used infrequently.

Staudt and Cherry (2009) used data from the *1994 National Study of Protective, Preventive, and Reunification Services Delivered to Children and Their Families* to examine whether once child welfare caseworkers had identified a mental health or substance use problem, they subsequently offered services, and whether these services were then provided. Among parents with mental health problems, 77.9% were offered mental health services, and 84% of these received services. Approximately 66% of parents with substance use problems were offered services, and services were provided to 67.5% of persons offered services. Caregivers who had both substance use and mental health problems were more likely to be offered substance abuse services than parents identified with only a substance use problem. This study highlighted that the services were not always well targeted. For example, mental health services were offered to 26.8% of parents with no identification of mental health problems, parenting services were offered to 24.4% of parents with no identification of parenting problems, and some parents with identified problems were not offered services.

Correlates of Service Use

Most of the studies that have examined the correlates of service use have consisted of secondary analyses of data from the National

Survey of Child and Adolescent Well-being (NSCAW). Anne Libby and colleagues (2006 and 2007) studied disparities in the use of specialty mental health and drug-alcohol treatment, specifically whether American Indian caregivers received needed services. Among caregivers with mental health or substance use problems, American Indian caregivers were significantly less likely to receive mental health treatment than were whites, blacks, or Hispanics, but they were not less likely to receive substance abuse treatment (Libby et al., 2007). Caregivers of preschool children were more likely to receive mental health treatment compared with caregivers of adolescents. Caregivers with children in the home (compared with children in out-of-home placement) were less likely to receive substance abuse treatment. Other analyses of the NSCAW data examined the relationship between child and family characteristics and use of services by caregivers with mental health or substance abuse problems (Libby, Orton, Barth, & Burns, 2007). Caregivers of children with externalizing problems were significantly more likely to receive mental health services than were parents of children with internalizing problems. Caregivers of neglected children were more likely to receive substance abuse and mental health treatment than were caregivers of abused children. When children were in the home, caregivers were less likely to receive substance abuse treatment, and caregivers of children aged 2–5 were less likely to receive substance abuse treatment. Hispanic caregivers were more likely than other ethnic groups to receive substance abuse services and blacks were less likely to receive mental health services.

In a study of 27 Medicaid-eligible children with substantiated physical abuse and their caregivers, those maltreating caregivers who acknowledged the abuse were significantly more likely to be in treatment than were caregivers who denied the abuse (Swenson, Brown, & Sheidow, 2003). Among maltreating caregivers, 60% received mental health treatment, and for most, this treatment focused on the abuse; at a 6-month follow-up, only 16% of the maltreating caregivers were receiving treatment. Fifty-one percent of the children had at least one caregiver receiving mental health treatment, but by the 6-month follow-up, only four children had at least one caregiver in treatment.

Matching Services to Need and the Relationship to Outcomes

Illinois researchers examined whether matching services to needs had an impact on reunification (Choi & Ryan, 2007; Marsh, Ryan, Choi, & Testa, 2006). These studies consisted of mothers with substance abuse problems whose children were placed out of the home. Most of the mothers were African American with limited resources and multiple needs. Mothers were described as “chronic substance abusers” (Choi & Ryan, 2007, p. 1400). Mothers who had services matched to their needs ($n=354$) had a significantly higher likelihood of being reunified with their children (Choi & Ryan, 2007). Specifically, the need-service match included mental health treatment, substance abuse treatment, housing, and family counseling. The study also documented high levels of unmet service needs. Moreover, it is not only the provision of individualized ser-



ices that is important but also progress in meeting goals for those services. More progress toward meeting goals in matched services (as rated by caseworkers in the areas of domestic violence, mental health, substance abuse, and housing) was related to a higher likelihood of reunification (Marsh et al., 2006). Notably, of 724 mothers, only 18% had achieved complete progress toward goals in substance abuse treatment, with limited progress in the other areas, as well (Marsh et al., 2006). In family preservation services, Ryan and Schuerman (2004) documented that families with the problem “difficulty paying bills” who received financial services had decreased maltreatment and out-of-home placement rates, though there was no significant change in family functioning.

Summary of Current Studies

Despite lack of studies and various study limitations, the findings suggest that parents involved with the child welfare system have significant unmet needs, and that parents with substance use problems may be especially likely not to receive services. Parents of children living at home may be less likely to receive needed services when compared with parents whose children were placed out of the



home. This is problematic because services to parents may improve their well-being and prevent out-of-home placement of children (Libby et al., 2007). Findings to date point to disparities in service use by race/ethnicity for parents involved with child welfare, just as for the general population. Matching services to needs has a positive impact on outcomes, but little is known about how

frequently this occurs, or how caseworkers make decisions about which services are needed. The next section highlights some possible future directions for continued study of service use by parents.

Research Needs

First, more comprehensive data are needed about parental needs. Marcenko, Lyons, and Courtney (2011) stated that “the changing policy and economic landscape requires periodic studies of sufficient breadth and rigor to detect changes in the needs of the population as a basis for more effectively targeting services” (p. 431). More studies such as theirs, which incorporated standardized measures and examined multiple need domains of parents in one state, would inform the field about what services are needed to address the issues and problems of parents in child welfare. The researchers were able to compare needs of parents whose children were still at home with the needs of parents whose children had been placed out of the home. Knowledge gaps exist about how needs and service use vary by different groups of parents, such as by mothers and fathers, by the maltreating parent and other caregivers in the home, by parents who acknowledge and parents who deny the abuse, and by the reason for referral to child welfare. The focus needs to extend beyond parent or child needs to include family need for services, such as family counseling (Marcenko et al., 2011). More information is also needed to understand the impact of parent and family functioning on parenting behaviors and children’s well-being.

Second, little is currently known about how child welfare workers conduct parent and family assessments, intervene with parents and families, or make referrals for services, and more research is needed. This should include a focus on the degree to which services match needs and how these services are subsequently related to outcomes. Some work has been done on the role of child welfare

workers in helping youth access specialty mental health services (Stiffman, Pescosolido, & Cabassa, 2004). This work needs to extend to how child welfare workers facilitate access to and use of a variety of services by parents. Moreover, the quality of caseworker-parent collaboration and agreement in assessing needs and making decisions about service use may ultimately determine whether parents actually receive or use the recommended services. Yet, the working relationship between child welfare workers and parents has not been a research priority. Whether parents are court ordered to receive services or receive them in response to an expressed need should also be considered.

Third, it is important to know whether services are actually accessed and used after referrals are made. Research questions might include the following: What are the factors that influence service access and continued use? Does access and use vary by service type, geographic region, and characteristics of parents and helping professionals? Also, little is known about how parents experience services and the factors that contribute to treatment satisfaction, motivation, and adherence. Alpert (2005, p. 362) noted that studies to date have focused on variables related to what a parent “is or does,” but these are static variables that are generally not amenable to change. Knowing whether and how demographic variables are related to service use sensitizes us to groups that may be underserved. Understanding how parents experience and perceive services may lead to increased understanding of parental motivation and adherence to service plans. Research could illuminate both the barriers to service use and the factors that increase the likelihood of service utilization. Of course, once parents access and use services, it is important to know what factors lead to progress in attaining desired outcomes.

Fourth, the field needs a more complete understanding of service effectiveness. Research has often focused on the effects of a package of services (e.g., family preservation services) on child welfare outcomes, such as recurrence, reunification, or re-entry into care. More information is needed on individual components of the service package, such as the specific treatments or interventions provided and how they are related to parent and child outcomes, including improvements in parent functioning. Further, the child welfare literature tends to oversimplify the complexity of services, and the quality of services has not been a focus. Prior research often utilized a dichotomous measure of services—received, or not. A next step is to examine the specific treatments or interventions provided. It is one thing to know a parent received services from a behavioral health agency; it is quite another to know what treatments were provided, the treatment intensity and dosage, how closely the treatment matched the need, the quality and integrity of treatment, and so on. Moreover, because parents may receive services from multiple providers, the coordination of services and collaboration among providers may influence how parents experience services as well as their effectiveness.

Although these are presented as discrete research aims, they are all part and parcel of the process of service usage. Understanding how the process unfolds—from identification of need, to service referral, to service usage, to whether intended outcomes are achieved—could substantially increase knowledge that drives improvements in policies and programs. A broad research agenda that includes many conceptual and methodological challenges is in order. For example, parents may not recall the types of services used or the agency names (Kolko et al., 1999); secondary data are unlikely to include information on service quality or specific treatments provided. Quantifying and assessing the quality of services is a complex and challenging process, yet such efforts will help to define practice standards and expectations across the states and agencies. It is well worth the effort to begin dialogue and collaboration across disciplines and research teams to increase the knowledge related to the service needs and use by parents involved with the child welfare system. Such knowledge may ultimately improve the well-being of children and families served by child welfare.

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SEEING Beyond Abuse

Jessica L. Young, OD

Many may think that visiting an eye doctor would be the last place for an abuse victim to go. After reading this article, you may disagree. One day, a 49-year-old woman came to see me for a routine eye examination. Her vision was getting a little worse, and she thought she might need new glasses. During the examination, I noticed a tear in the iris of her right eye. I checked her eye pressure and found it to be elevated in her right eye. I asked if she had ever sustained any injuries to her eyes. She confirmed that she had, in fact, been hit many times in her eyes and face many years prior by a former boyfriend. I explained how the trauma had damaged her eye, and that the increased eye pressure could lead to optic nerve damage and vision loss if left untreated. We decided to begin medicated eye drops to lower the eye pressure. So far the drops are successfully keeping the pressure down, reducing her chances of vision loss. This woman very well may have lost her eyesight had she not happened to come for a regular eye exam.

Physical assault resulting in trauma to the eye can have both immediate and lasting effects. If trauma to the eye occurs, urgent medical attention should be sought to treat any immediate damage. Visiting an eye doctor is prudent for anyone who has ever sustained trauma to the eye because a condition called traumatic or angle recession glaucoma can occur months, or even years, after an eye injury.

Glaucoma is the second-leading cause of blindness in the United States. The eye contains fluid that is constantly being produced and drained. This fluid creates pressure inside the eye (intraocular pressure), which helps the eye keep its shape. In glaucoma, this pressure becomes too high, which can damage the optic nerve inside the eye and lead to permanent vision loss.

Damage to the eye from traumatic injury can lead to angle recession or traumatic glaucoma. The fluid in the eye is drained at the *angle*, which is where the cornea (the front clear window of the eye) meets the iris (the colored part of the eye). This drainage angle can be damaged during a traumatic event such as a strike to the eye. When the angle is damaged, the fluid may not drain properly, which can cause the eye pressure to increase and lead to glaucoma.

In the United States, over 1 million Americans experience eye injuries each year. Blunt eye injuries account for over 60% of these injuries, and over 10% of all eye traumas are due to assault.¹ Damage to the eye angle is one of the most common complications after a strike to the eye.² Though infrequent, damage to the eye

angle can lead to angle recession glaucoma weeks, months, or even many years after the trauma to the eye has occurred. As with most other forms of glaucoma, symptoms of vision loss are not noticed until the glaucoma is advanced and the damage is extensive. In fact, glaucoma is often called the “sneak thief of sight.” Since traumatic glaucoma can occur long after the eye has been injured, it is important not only to have an initial eye examination at the time of an injury but also regular visits to an eye doctor thereafter.

At the first visit to an eye doctor, it is necessary to mention any previous eye or head trauma so the eye can be properly evaluated for angle recession and glaucoma. The doctor will check the eye angle with a special lens, measure the eye pressure, and evaluate the optic nerves for any signs of damage. If angle recession is found, regular follow-up visits will be needed to monitor the eye for angle recession glaucoma. If glaucoma is detected, the doctor will likely start prescription eye drops to lower the eye pressure and try to prevent further damage to the optic nerve.

In 2007, the U.S. Department of Health and Human Services found that 794,000 children were victims of maltreatment.³ Nearly 11% of these children were physically abused. Child abuse is a serious concern that has extensive short- and long-term health consequences. Monitoring eye injuries must be an important part of intervention.

I urge anyone who has ever sustained an eye injury, especially victims of domestic violence or child abuse, to schedule an examination with an eye doctor. Professionals who work with abuse victims should include eye examinations as a regular part of ongoing medical care. Victims should mention their history of eye trauma so the eyes can be properly evaluated.

About the Author

Dr. Jessica Young is a 2007 graduate of the Pennsylvania College of Optometry. She currently practices at Ophthalmic Associates in Johnstown, Pennsylvania. The Pennsylvania Optometric Association named Dr. Young the 2010 Young Optometrist of the Year. She hopes that this article will help to promote awareness of the importance of screening for traumatic glaucoma in victims of abuse. Contact: JLY017@yahoo.com

¹ American Academy of Ophthalmology. (2011). *2009 Eye Injury Snapshot Project results*. Retrieved from: http://www.aao.org/practice_mgmt/eyesmart/snapshot_2009_results.cfm.

² Sullivan, Brian R. (2004, March 11). *Angle recession glaucoma*. Retrieved from: http://www.emedicinehealth.com/angle_recession_glaucoma/article_em.htm.

³ U.S. Department of Health and Human Services. (2007). *Child Maltreatment 2007*. Retrieved from: <http://www.acf.hhs.gov/programs/cb/pubs/cm07/chapter3.htm>.

An Interview With Bryan Samuels, Commissioner, ACYF

Ronald C. Hughes, PhD

Bryan Samuels is the Commissioner of the Administration on Children, Youth and Families (ACYF) of the U.S. Department of Health and Human Services. He was appointed to this position by President Obama in June, 2009. Among his many responsibilities as Commissioner, Mr. Samuels is responsible for federal activities related to the development, management, and oversight of the country's public child welfare system.

Prior to his appointment as Commissioner, Mr. Samuels held a variety of leadership positions in various systems serving children, including as the Chief of Staff of Chicago's public schools, the third largest public school system in the country. His vetting in the field of child welfare has included serving as Deputy Director of Health and Human Services in the State of Nebraska, and a 4-year stint as Director of the Illinois Department of Children and Family Services, the nation's third largest child welfare system.

For those looking at Mr. Samuels' accomplishments, reading his writings, listening to his public discourse, and especially being a part of his private conversations, it becomes clear that he is an especially intelligent and thoughtful man. It also becomes clear that he is, in final measure, committed to two things: public service and rational process.

His commitment to public service may be, in large part, a result of his early history. He spent 12 years in a residential placement for disadvantaged children, Glenwood School for Boys in Chicago. His memories and feelings regarding his early years are mixed. Even the best of dependency institutions is still an institution. But he remains cognizant of the support and opportunities provided by even a less-than-perfect public system of substitute care. With that support, he thrived and took advantage of the opportunities made available to an intellectually curious and resilient young man. Mr. Samuels graduated from Notre Dame with a degree in economics in 1989 and from the Harris School of Public Policy in 1992.

Mr. Samuels explained that the genesis of his commitment to science, empiricism, and rational process is the combined result of his developmental experiences and opportunities, plus the mentorship of a few important people along the way, including Judy Langford and Paula Wolf. Whatever the source, this commitment defines his work.

When Mr. Samuels assumed leadership of the Illinois Department of Children and Family Services in 2003, he found himself in a unique position with unique opportunities. His predecessor, Mr. Jess McDonald, had begun a major reform of the state's child welfare system, resulting in a significant

reduction in the number of children placed in residential treatment, an increased number of children maintained in their homes, and foster care being used as a placement resource for children with more serious issues than had been true previously. At the same time, additional financial resources became available by reducing costly residential treatment placements...resources that could be used instead to develop services and programs for children in care. For Mr. Samuels, the question was how to take advantage of this opportunity to best use limited resources to meet the needs of the children in care. Mr. Samuels acknowledged, "Everybody says they want to develop and implement program policy and practice that works. But I wanted to do more than talk the talk. Science had to be brought to bear on providing services to this in-home population."

Mr. Samuels also wanted to change the CPS culture from concentrating on the *residential* part of residential treatment to a focus on the *treatment* part. He said, "We really did move away from thinking of residential and group homes as primarily placement options and, instead, we thought of them as treatment options. We wanted residential treatment to be just that—treatment. We had an expectation that the child would go to the most appropriate treatment program, and the child would get better and get stabilized, and then we would be looking for a family placement rather than a residential placement." This required sophisticated and comprehensive assessments of both the child's needs and the treatment facility's capacities and willingness to meet those needs. Mr. Samuels said, "We went through an elaborate process of looking at the clinical needs of children" and did an analysis of the residential programs to "develop profiles of children who were best served by each of these residential programs." He explained that this information guided placements that weren't ends in themselves, but rather, were made with "the expectation that the child would ultimately go home, or to a relative foster placement, because the residential placement did its job" to prepare the child for a less restrictive placement.



Mr. Samuels explained that research shows us that whatever trauma a child has suffered as a result of maltreatment, it will only be exacerbated if we cause further disruption in his life and if we don't make every effort to maintain as much stability as possible. Thus, he said, within 6 months of the adoption of his reforms in Illinois, the agency had gone "from an average placement of 20 miles to an average placement of 6 miles" from a child's home community. "One goal," he said, "was, whenever possible and appropriate, to keep the child in the same school, close to relatives and close to things and places he is familiar with, to reduce the trauma" of separation and placement.

Mr. Samuels stressed that an important change was the implementation of comprehensive assessment, used, as he said, "up front, so that you had a baseline for all the kids as they entered the front door." He was particularly proud of the use of this data to improve statewide efforts to "rethink the independent living and transitional programs we were operating." Using developmental and assessment data, they were able to place children into one of four different categories of transitional and independent living, based on each child's particular needs and strengths.

Mr. Samuels reported that the program was a success. "We could really target a group of children based upon their assessment needs rather than treating all kids the same." The common thread running through Mr. Samuels' reform success in Illinois was better collection and better use of information—in other words, an evidence-based approach to assessment and service delivery. A phrase Mr. Samuels often uses in conversation is "mining the data." Underpinning his remarkable success were better assessments of the children and families, better assessment of the capacities of residential treatment programs, and most important, a commitment to analyzing and using that information in a rational decision-making process to develop policy and deliver services.

Mr. Samuels has carried his evidence-based approach to solving systemic issues from his earlier work in state government to the national stage as Commissioner of ACYF. He stated, "Just about every child who enters care, his family's parenting skills are weak, and we know our kids enter care with high rates of anxiety or depression...or with developmental or mental health problems, and yet we do not have a set of common go-to strategies to address these problems. We know our kids and our families enter the system with some pretty predictable challenges in front of them, and we need to develop some core competencies around being able to effectively address those issues. That really is the big thing I want to get done."

Mr. Samuels believes there are empirically supported programs and models that have substantial scientific merit, but, for a variety of reasons, they are not being implemented. He sees a three-step process based upon his commitment to good service. He claims we need to, first, find the evidence-informed practices, then identify the critical core competencies that are needed for training, and third,

help the states by supporting implementation to ensure fidelity to each of the models that are introduced.

Bryan Samuels also believes that these efforts at identifying and implementing evidence-based practices will not, by themselves, get the job done. He would like to see his commitment to rationality extended to fiscal management as well. He says, "The second thing I would like to get done is to realign the outcomes that we ask of states with the financing we make available to states. We want an incentive system that reinforces good performance and discourages bad performance. The way the system works today is there is actually a perverse incentive. If you don't run your system well, we end up giving you more money, and if you run your system well, we take money away. We are working to have the financial system reward desired outcomes so that we have a coherent and reinforcing system. We don't have that today."

Mr. Samuels is optimistic and excited about the next several years. He feels those with whom he works in the present administration are very knowledgeable and supportive. That has not always been the case. He tells, with considerable anguish, how he believed he had to leave his job as Child Welfare Director in Illinois prematurely, because the political leadership was so caught up in its own personal and political issues that Mr. Samuels could not count on support in his efforts to reform the child welfare system. However, in spite of the present constricting financial environment, Mr. Samuels believes that with the energy and commitment that is available, a lot can be done to improve the lives of the children and families we all serve.

Mr. Samuels was so excited about the many developmental activities in the Administration for Children, Youth and Families that when asked about a desired legacy, it was difficult for him to narrow it down. Finally, he replied, "I would say my legacy, I hope, would be of the children and families that we serve, being able to look at the system and the way the system treated them, and have them be able to say that there was at least one guy who understood what they needed."

I think he will succeed, because I've never met a person who has tried harder to identify those needs.

Mr. Bryan Samuels will receive the *Pro Humanitate Distinguished Service in Public Child Welfare Administration Award* at the 19th APSAC Annual Colloquium in Philadelphia, July 13–16, 2011.

About the Author

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Journal Highlights

Patti A. Beekman, BS

Protective Supervision in Public Child Welfare and Juvenile Courts

In Minnesota statute, Protective Supervision grants the child protection agency authority to supervise a child, while granting a parent permission to retain custody under certain conditions. Protective Supervision allows the state to fulfill the federal mandate of maintaining children safely in their own homes whenever possible and appropriate. Further, Protective Supervision reinforces the goal of providing the least restrictive, most appropriate service a child needs at any point during intensive case management.

A research study on services to young children had brought critical attention to Protective Supervision, reporting that children living at home under the agency's legal supervision were less likely to receive services for developmental or behavioral problems than children in foster placement. After the first round of federal Child and Family Services Reviews (CFSR), summary findings cited similar discrepancies. As a result, the Minnesota Department of Human Services (MDHS) funded an exploratory study on Protective Supervision in Minnesota. Researchers conducted separate focus groups and interviews with child protection and judicial personnel throughout the state to assess both systems' knowledge of Protective Supervision and its use. Respondents also shared observations about the relationship between child protection and the court system in their counties. After compiling data, authors determined that personnel in both systems lacked a common understanding of the concept, definition, or use of Protective Supervision. Vague wording in the Minnesota statute complicates things further by failing to provide guidelines for implementation, and the court system and child protection agency have used the intervention quite differently.

This article offers insight into a complicated partnership between two complex systems. Notwithstanding the inherent stressors between the two systems, county child protection and judicial systems in Minnesota are together exploring the potential and experiencing limitations of Protective Supervision. In conclusion, the authors noted growing recognition that collaboration between child welfare and the courts requires attention, probably in all states.

Wattenberg, E., Troy, K., & Beuch, A. (2011, February). Protective supervision: An inquiry into the relationship between child welfare and the court system. *Children and Youth Services Review*, 33, 346–350.

Substance-Exposed Infants, Mothers, and Family Reunification

Substance-exposed infants experience a range of negative outcomes including physical and mental health problems, poor parenting, risk of maltreatment, and low rates of achieving permanency. Substance-abusing mothers face serious co-occurring problems that include mental health issues, inadequate housing, domestic violence, and low reunification rates.

This study examines the association between substance abuse treatment components, treatment progress, and family reunification. The authors focused on services for mothers who had a substance-exposed infant and investigated the association between types of intervention and the likelihood of making progress in treatment and achieving family reunification. The study focuses on transitional services after traditional substance abuse treatment to determine whether mothers could achieve better outcomes when community-based services followed more structured services. Using a subset of data from the 2000–2009 Illinois Title IV-E Alcohol and Other Drug Abuse (AODA) Waiver demonstration, the authors gathered data on 160 mothers with substance-exposed infants living in Cook County, Illinois. The longitudinal design of this smaller study follows families over time, analyzing data in placement records, medical invoices, and caseworkers' quarterly reports.

Treatment variables included the following: (1) receiving treatment services other than residential, (2) receiving residential treatment only, and (3) receiving residential treatment combined with other community-based transitional services. The authors found that the type of intervention not only affected the probability of treatment progress but also influenced the rate of reunification. This study clearly identifies the combination of residential and transitional treatment components as having significant and positive effects on treatment progress (directly) and family reunification (indirectly). In contrast, residential services provided without a transitional component had no significant effect on treatment progress.

Regarding practice application, it is critical to refer mothers with substance abuse problems to both residential and community-based transitional services. The order and length of each specific treatment component should correspond with severity of mothers' substance use and pace of treatment progress.

Huang, H., & Ryan, J. (2011, February). Trying to come home: Substance exposed infants, mothers, and family reunification. *Children and Youth Services Review*, 33, 322–329.

A Peer-to-Peer Approach to Supporting Kinship Caregivers

Relatives are caring for almost a quarter of the 510,000 children in the U.S. child welfare system; however, new kinship caregivers frequently do not receive the support and services they need. This article highlights a 5-year U.S. Children's Bureau demonstration project in Clark County, Nevada, that utilized a peer-to-peer approach to services for caregivers. The program paired new kinship caregivers with full-time, paid kinship liaisons who were current or former caregivers. The liaisons augmented primary casework services by mentoring and supporting relative caregivers, participating in case staffings and child and family team meetings, and copresenting training workshops.

The study examined the effects of services to 74 kinship families during 2008, the final year of the demonstration project. Researchers conducted baseline telephone interviews with caregivers within 30 days of initial liaison contact and again 90 days later, and they analyzed service logs that detailed liaison services provided to each caregiver. Participants were administered two instruments, Relative Caregiver Self-Assessment Scale and Peer-to-Peer Measure, in advance of scheduled interviews.

The most requested service by kinship caregivers was an explanation of their rights and responsibilities. Other services used by at least

half of sample families included information and referral, explanation of permanency options, and assistance with foster care licensure. The responses of kinship caregivers were positive; findings showed that (1) kinship caregivers who felt engaged with their liaisons were more likely request help for safety concerns, and (2) as caregivers reported greater satisfaction with their liaison, safety conditions improved.

The study highlights a direct relationship between the degree of information and referral provided by liaisons and an increase in caregivers' overall coping abilities, knowledge of permanency, and ability to access needed services. Moreover, caregivers' reported satisfaction with their liaison also significantly increased their willingness to become a permanent resource for children in their care. Kinship caregivers expressed a high degree of trust and acceptance from their liaison and reported that the personal experiences shared by their liaison helped them transition into the caregiver role. However, despite their satisfaction with kinship liaison services and supports, many caregivers reported high stress levels at both baseline and follow-up, expressing their concerns about kinship parenting and dealing with children's emotional needs. This finding is consistent with previous studies citing kinship caregivers' tendency to experience long-term and ongoing stress.

Denby, R. W. (2011, February). Kinship liaisons: A peer-to-peer approach to supporting kinship caregivers. *Children and Youth Services Review*, 33, 217–225.



Intergenerational Continuity in Child Maltreatment

Previous research confirms that parents' history of abuse or neglect in childhood elevates their risk of maltreating their own children. To stop this cycle of intergenerational continuity in maltreatment, prevention and protective interventions must address the associations between parents' childhood abuse and neglect and victimization of their children.

This prospective, longitudinal study was intended to improve prevention strategies by examining two factors: (a) direct associations between the mothers' history of childhood abuse and neglect and maltreatment of their infant or toddler, and (b) mothers' mental health problems, social isolation, and social information processing patterns. The study participants included 499 mothers recruited by health clinics and obstetric medical practices during their pregnancy, and their infants from birth to 26 months of age. Participants completed a face-to-face interview to assess their history of childhood maltreatment and mediating conditions. Participants consented to reviews of county protective service records up to 7 years after their child's birth. Researchers reviewed county records through 2006 for allegations and substantiations of maltreatment of participants' infants.

Study findings indicated that mothers' childhood physical abuse significantly predicted victimization of their own child, but was mediated by mothers' social isolation and tendencies to respond with aggression when stressed. In contrast, there was no direct association between a mothers' experience of childhood neglect and her own child's maltreatment. The mothers' experience of maltreatment in childhood also predicts problematic adult relationships, while problematic adult relationships and social isolation were also predictors of their child's maltreatment. Isolated mothers may perceive they would not have help in times of need, mediating the association between physical abuse and child victimization. This study is the first to examine social isolation as a mediator of intergenerational continuity in child maltreatment.

Finally, the authors examined two aspects of mothers' social information processing, hostile attributions and aggressive response biases. A mother's hostile attribution bias was not significant as a mediator associated with her child's maltreatment; but aggressive response biases were significant and predicted mothers' adult aggression. For mothers who had been physically abused, aggressive response biases also predicted aggressive parenting, thus indicating these mothers may be intergenerationally not only repeating maltreatment but also modeling the harsh behavior of their own abusers.

The authors recommend future research on moderators as well as mediators of intergenerational continuity in child maltreatment to identify factors that will help physically abused women to develop supportive friendships and reduce their isolation.

Berlin, L., Appleyard, K., & Dodge, K. (2011, February). Intergenerational continuity in child maltreatment: Mediating mechanisms and implications for prevention. *Child Development*, 82(1), 162–176.

Worker Confidence and Judgment in Assessing Risk

Although actuarial risk assessment instruments with strong empirical backing are available, assessing risk still involves subjective judgment by the worker. Research has not adequately investigated the influence of specific context or caseworker variables on professional judgment. The goal of this study was to examine consistency in risk assessment decisions, worker confidence when assessing risk, and subjective factors that influenced both confidence and judgment.

In the research simulation, 96 participants read two case scenarios, completed risk assessment forms, and then conducted two interviews based on the scenarios. The simulated interviews used trained actors and were acutely stressful clinical encounters, one with a cooperative client and the other, a confrontational client. Participants had completed a series of questionnaires

related to prior work history and emotional state. After the simulation, they completed an anxiety assessment scale, and they discussed their performance with a researcher. The study demonstrated high variability in participants' assessment of risk, confirming that workers assess risk differently, even when using validated measures to assess the same two families.

The level of confidence felt by individual workers was related to one's age, acute levels of stress, and perceived ability to engage family members. The level of perceived confidence in judgment and clinical ability was consistent between interviews and risk assessments but did not relate to the appraised level of risk. The participants felt equally confident whether they appraised the child to be at high risk or low risk. Older participants expressed more confidence in their performance and assessment of risk, and experienced lower stress. Participants felt that their ability to engage parents influenced their confidence level, and more confident participants reported that a parent's confrontational behavior did not affect their confidence. They attributed high levels of confidence to training, past supervision, and length of experience. In contrast, participants with lower confidence levels experienced higher anxiety and a further eroding of confidence when the parent was confrontational.

In conclusion, the authors highlighted the variation in levels of appraised risk in this study, even with high levels of worker confidence. They feel these results indicate a need for ongoing consultation with workers and more attention to critical thinking skills. They further contend that policy makers and managers must recognize the limitations of risk assessment tools and understand the importance of training workers in engagement and assessment process.

Regehr, C., Bogo, M., Shlonsky, A., & LeBlanc, V. (2010, November). Confidence and professional judgment in assessing children's risk of abuse. *Research on Social Work Practice*, 20(6), 621–628.



Adapting Child Welfare Practice With Immigrant Latino Children

Immigrant Latino children and families represent the largest and fastest-growing ethnic group in the United States. This article describes the application of an existing evidence-based framework, “systems of care,” to child welfare practice with immigrant Latino children and families. A system of care is a family-focused, community-based, and culturally competent practice framework, implemented by multiple-partner agencies in a community in a team approach to serving families. It involves developing individualized, culturally relevant service plans to address family issues, and it considers extended family as team members and potential placement resources, including those who still reside in the country of origin.

Culturally competent practice requires that child welfare practitioners understand the effects of immigration and acculturation on immigrant families, and that services are provided in families’ native language using interpreters where needed. Caseworkers should address concerns about immigration status, clearly stating that their work with families is independent of immigration status and that staff do not report information on immigration status to other governmental authorities, and that practitioners must understand how federal and state immigration policies may affect service delivery. Agencies should also recruit bilingual caseworkers and create policies to promote interagency collaboration in immigrant communities. When undocumented children enter the system, agencies should be able to access potential forms of immigration

relief, such as Special Immigrant Juvenile Status, when reunification is not an option.

The authors review specific engagement and practice guidelines for culturally competent interaction with Latino families, such as using a conversational approach with the family and involving the family in deciding how to share information. Reciprocity is important, and families may ask caseworkers questions about their own families as part of relationship development. Latino families may offer small gifts of food, religious articles, or mementos from their home country in appreciation of services. Caseworkers should be respectful of elders and acknowledge the importance of extended family, understand the role of gender in family relationships, and understand how a family handles decision making. Workers should also understand that many Latino cultures view physical discipline as an appropriate form of punishment by parents who care about the welfare of their children.

The authors stress that administrators must ensure adequate training for practitioners on issues and experiences affecting immigrant populations. A systems of care framework is effective with children and families facing multiple challenges and involved in multiple systems. It must be responsive to cultural values and differences and emphasize individualized and strengths-based service planning. Research is needed evaluate outcomes of this framework in child welfare agencies and with immigrant children and families.

Dettlaff, A. J., & Rycraft, J. R. (2011, August). Adapting systems of care for child welfare practice with immigrant Latino children and families. *Evaluation and Program Planning*, 33, 303–310.



Service Use Among Immigrant Families

This study investigated demographic, individual, and organizational factors associated with service use among immigrant families in the child welfare system. Families with mixed immigration status are a growing demographic group in the U.S. population; currently, 16% of U.S. children below 6 years, and 11% of 6–17-year-olds, live in mixed-status families. This study is first to use a nationally representative longitudinal data set (National Survey of Child and Adolescent Well-being) to examine multiple predictors of Family Support (FS) services by immigrant families in the child welfare system. The

present study used data collected from caregiver and caseworker reports at baseline (11/1999 to 4/2001) and during the 12-month follow-up. The final sample consisted of 5,501 children from 97 countries living in 36 states. Selected children were from families in which either the primary or secondary caregiver or the child was not born in the U.S.

Caregivers reported services used by their families over a 12-month period. Data showed that FS service use by immigrants is multi-determined by demographic, individual, and organizational factors; thus, future strategies to promote service use must consider factors from this research that may hinder access to services. Caregiver characteristics such as prior history of maltreatment, mental health problems, domestic violence, cognitive impairments, and history of arrests were significantly associated with heavy FS service use, but substance abuse was not associated with FS service use, suggesting a need for services for substance-abusing caregivers.

Among child factors, behavior problems and a history of neglect were associated with greater Family Support service use. The absence of a significant association between physical abuse, sexual abuse, and FS service use suggests an unmet need for services among these families.

This research highlights the important role of child welfare workers in enabling access to FS services among immigrants. Caseworker training on cultural issues, their concerns related to bureaucracy, and advocacy for clients was also associated with increased service use among immigrant families. These findings suggest that policy planners and child welfare supervisors need to consider child welfare workers' perception of organizational problems and work out innovative methods to help caseworkers cope with bureaucratic obstacles.

Rajendran, K., & Chemtob, C. (2010, August). Factors associated with service use among immigrants in the child welfare system. *Evaluation and Program Planning*, 33, 317–323.

Understanding Chronically Reported Families

Child welfare agencies are increasingly concerned with multiple re-reports of child maltreatment. Current research cites negative outcomes of chronic maltreatment (now set at 5 reports), but most studies stop at the first re-report. Given the negative outcomes of chronic child maltreatment and the cost of providing services, understanding dynamics and predictors of recurrence is a priority.

This study continues a previous longitudinal analysis of case characteristics predicting first re-reports of maltreatment. The authors analyzed case data for child, family, services, and community variables found to predict a first re-report, and then compared characteristics of recurring cases. The original study sampled 6,412 children under age 12 in a Midwestern metropolitan area at the time of sampling in 1993–1994. For the current analyses, the authors followed children through 2006 or age 18.

Findings demonstrated that some factors (e.g., tract poverty) that predicted initial recurrence lose their predictive value for later re-reports, whereas others (e.g., Aid to Families with Dependent Children history) remain predictive. One of the most significant findings was that characteristics of a first re-report of maltreatment are helpful but not sufficient to understand the nature of cases that become chronic. For example, children older at the first report were less likely to have a second one, but increased child age was not protective for subsequent reports.

Child characteristics affecting first re-report included child mental health or substance abuse, child disability, special education, younger children in the home, and being a female victim of sexual abuse. Families receiving four or more re-referrals were more likely to have an emotionally disturbed, mentally ill, or developmentally disabled child. Developmental delay and special education status were not significant after the second recurrence, even when both these conditions were associated with higher maltreatment risk. Such cases may reflect services the child received from time of first referral.

Family characteristics varied during subsequent recurrences, with the exception of parents lacking a high-school education, which is a consistent risk factor for re-reports, and no AFDC/TANF history, which is a consistent protective factor. Chronic characteristics included a caregiver with a history in foster care, families with low social support, younger-age parents, and higher rates of domestic violence and mental illness. Substantiation of maltreatment consistently increased the risk of re-report; however, dynamics of chronically re-reported families may not clearly indicate a specific type of maltreatment. For example, both physical and sexual abuse cases were less likely to recur than neglect; but after the second report, there was little relationship between the type of report and subsequent risk.

There is controversy over whether provision of services by child welfare agencies increases or decreases risk for maltreatment recurrence. In this study, in-home child welfare, mental health, and education services emerged as consistent predictors of reduced recurrence. The authors suggest that understanding how the broader social service system is helping chronic families is key to understanding recurrence over time, and they suggest further study to examine how poverty, partner violence, neighborhood factors, and informal supports relate to chronic re-reporting of maltreatment.

Jonson-Reid, M., Emery, C., Drake, B., & Stahlschidt, M. (2010, November). Understanding chronically reported families. *Child Maltreatment*, 15(4), 271–281.

About the Author

Patti A. Beekman is Senior Training Manager at the Institute for Human Services, Columbus, Ohio.

Washington Update

Thomas L. Birch, JD

Congress Looks to Take Deep Cuts in 2011 Funds

Almost halfway into the 2011 fiscal year, the U.S. House of Representatives and the Senate continue to negotiate funding for the year. During the first week in March, both chambers passed yet another short-term continuing resolution to extend funding for the current fiscal year until March 18. This measure essentially continues appropriations at 2010 levels as well as specifies \$4 billion in cuts (demanded by the House) from the current fiscal year's spending. The mid-year reduction eliminates all funds that would have gone for earmarks, including a loss of \$3.175 million from the \$29 million in Child Abuse Prevention and Treatment Act (CAPTA) discretionary funds.

In the meantime, legislators still need to reach final agreement on a continuing resolution until the September 30 end of the 2011 fiscal year. On February 19, the House passed H.R. 1, the continuing resolution for funding the remainder of the 2011 fiscal year. The bill passed on a near party-line vote, 235–189, with all Democrats and three Republicans voting in opposition. The funding measure, which contains more than \$60 billion in cuts to current funding, would reduce 2011 appropriations for scores of programs.

For the most part, child welfare funding—the largest portion of which is mandated, not discretionary, spending for foster care and adoption placement subsidies—was spared in the House-passed measure. There were some notable exceptions, such as spending reductions made in Head Start and the Child Care and Development Block Grant. Cuts were also taken from 2011 funds for the Women, Infants and Children (WIC) nutrition program, family planning, Maternal and Child Health Block Grants, and the Community Services Block Grants. The National Institutes of Health and the Centers for Disease Control suffered cuts as well. Harold Rogers (R-KY), chair of the House Appropriations Committee, indicated that the cuts in 2011 would mark the beginning of a new trend of reductions to take place throughout the next year.

The bill's reach was broad in what Republican leaders referred to as the largest single discretionary spending cut in the history of the country. During floor debate in the House, among the dozens of amendments that passed were nine amendments to defund various aspects of the health care reform law, effectively blocking the

Department of Health and Human Services from implementing the law. Presumably, such provisions would negatively affect administration of the evidence-based home visiting grants to states. Much depends on the final outcome, with Senate Democrats taking their turn and the President holding the veto over the bill, if he chooses.

The Senate continues to buy negotiating time with the passage of each short-term funding bill. Because the two chambers differ significantly on funding levels, the task of reconciling the two bills into one is a complex assignment. Congress probably will pass yet another short-term funding resolution lasting until April 18 to gain even more negotiating time before arriving at the final agreement. Once done with 2011 funding, legislators on Capitol Hill will turn their attention to the 2012 budget proposed by President Obama on February 14.

There is disagreement between Democrats and Republicans, between the House and the Senate, and also from the “bean counters” over what is driving the spending debt. On the day after the House voted to reduce the current fiscal year's spending to 2008 levels, the nonpartisan Congressional Budget Office forecast the largest federal budget gap in history—\$1.5 trillion this year—and laid the blame not on spending but on the tax package negotiated by President Obama in December to extend the Bush-era tax cuts.

Obama Submits 2012 Budget to Congress

On February 14, amid the House debate over the 2011 budget, President Obama sent to Congress his budget proposal for fiscal year 2012. The funding request embodies a freeze on discretionary spending at the 2010 level and includes adjustments made in programs throughout the government. By proposing cuts in some programs to allow increases in others, the administration hopes to realize its pledge of an overall freeze in domestic spending.

The 2012 discretionary budget for the Department of Health and Human Services (HHS) Administration for Children and Families (ACF) proposes a decrease of \$1.2 billion from 2010, a total request in 2012 of \$16.2 billion. Included are significant cuts in programs such as the Community Services Block Grant and the Low-Income Home Energy Assistance Program (LIHEAP), although additional funding is proposed for Head Start and child care.

Funds for the Child Abuse Prevention and Treatment Act (CAPTA) basic state grants, discretionary grants, and community-based prevention grants would all be held at current funding levels. The Obama budget would reduce funding for the Promoting Safe and Stable Families grants to states by \$20 million, with that amount applied as an increase in funding for state court improvement activities. Support would increase slightly for family violence prevention programs to expand shelter capacity and services.

HHS 2012 Budget Proposes Child Welfare Reform Initiative

The President's 2012 budget for HHS includes an increase of \$250 million to support an agenda that provides incentives to states to reform foster care. Funds would be available, presumably on a competitive basis, to decrease the rates of maltreatment recurrence and the rates of re-entry into foster care. States could also use the funds to improve outcomes for children in foster care by reducing their length of stay in foster care and increasing permanency through reunification, adoption, and guardianship.

The new program aims to help states at the front end of the child welfare system. The initiative would seek to help states achieve declines in the numbers of children who need to enter foster care and to improve services to families with more complex issues. States

would receive support for demonstrations to test innovative strategies that improve outcomes for children and reward states for the efficient use of federal and state resources.

Few details are available yet from the Administration for Children and Families beyond what was laid out in the ACF budget documents. Apparently, ACF leadership is interested in further discussions to more fully develop the proposal. It is encouraging that the administration chooses in this way to signal its attention to child welfare services as a policy priority.

CAPTA Reauthorization Bill Signed Into Law in 2010

After numerous delays and 2 years overdue, the Child Abuse Prevention and Treatment Act (CAPTA) Reauthorization Act of 2010 (S.3817) renewing the federal child abuse statute passed both the House and the Senate in December during the lame duck session. President Obama signed the legislation into law on December 20.

In a press release from the White House following final passage of the bill, President Obama expressed appreciation to Sen. Christopher Dodd (D-CT) for his leadership in drafting the bill. Dodd retired at the end of the 2010 legislative session; he was deter-



mined to finish the CAPTA work before leaving the Senate. Dodd succeeded in drafting a bipartisan bill that would continue authorized funding for CAPTA's discretionary programs, as well as the basic state grants and the community-based prevention grants. As a result of the desire to arrive at a bipartisan agreement, the bill introduced by Dodd last September is modest in scope.

The CAPTA Reauthorization Act addresses such themes as promoting differential response in child protective services, addressing the co-occurrence of child maltreatment and domestic violence, and sharpening the prevention focus of the community-based child abuse prevention grants. The bill includes provisions that reference an alternative approach to protecting children from harm, with a charge to HHS to address best practices in differential response through dissemination of information, research, and training of personnel. These are considered an eligible use of basic state grant funds for improving child protective services and are included as a state grant eligibility requirement to identify "as applicable" policies and procedures around differential response. The bill also would require state policies and procedures encouraging the involvement of families in decision making in cases of abuse and neglect of children.

The bill incorporates a new provision recognizing the co-occurrence of child maltreatment and domestic violence in up to 60% of the families in which either is present, and it calls for the adoption of procedures aimed at enhancing the safety both of children and the victims of domestic violence. Other provisions follow this theme, with directions to HHS to disseminate information on effective programs and best practices in collaborations between child protective services and domestic violence services; in research, technical assistance, and training; and through support for development of collaborative practice. Attention to services for children exposed to domestic violence would be an eligible expenditure of basic state grant funds, and states would be required to have procedures in place to address the co-occurrence of child maltreatment and domestic violence.

The Dodd bill sharpens the prevention focus of CAPTA Title II with a broad mandate to support the range of community-based and prevention-focused activities that include a variety of services and strategies. The focus is on recognizing respite care and home visiting as "core services" for support of the Title II grants, with optional services such as supports to parents with disabilities, domestic violence services, child care, and early childhood education and care. The bill also seeks to enhance the involvement of parents in planning and implementing prevention services.

Finally, in recognition of the relationship between child maltreatment and substance abuse, the Senate bill, in a number of provisions, seeks to address this issue through research, technical assistance, program innovation, policies promoting collaborations with substance abuse treatment services, and preventive services to improve the ability of the child welfare system to intervene effectively in child maltreatment cases where substance abuse is a factor.

U.S. Signs Child Protection Convention

On October 22, the United States signed the Convention on Jurisdiction, Applicable Law, Recognition, Enforcement and Cooperation in Respect of Parental Responsibility and Measures for the Protection of Children. The agreement ensures international recognition and enforcement of custody and visitation orders. It contains provisions addressing cooperation on key issues such as runaway children and the cross-border placement of children in foster families or institutional care. Secretary of State Hillary Rodham Clinton indicated that signing this convention reaffirmed the United States' deep commitment to protecting rights and welfare of children around the world. The U.S. Senate must approve this document. Clinton said that the State Department would work closely with Congress, other federal agencies, and state and local officials to address implementation of the convention in the United States. The Senate recently approved the Hague Convention on the International Recovery of Child Support and Other Forms of Family Maintenance. The convention for the protection of children is meant to complement and reinforce the Hague Convention on the Civil Aspects of International Child Abduction.

About the Author

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

APSAC News

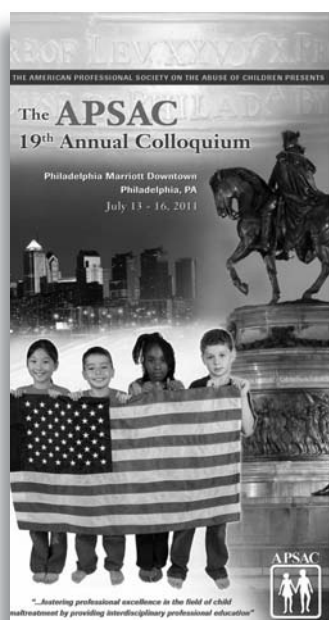
Register Today for APSAC's Colloquium in Philadelphia

APSAC will host its 19th Annual Colloquium from July 13–16, 2011, at the Philadelphia Marriott, Philadelphia, Pennsylvania.

The Colloquium will feature Advanced Training Institutes, the Cultural Institute, and nearly 100 seminars from which to choose. In addition, the Colloquium 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.

The training objectives of seminars this year include the following:



- Identifying physical abuse, sexual abuse, and neglect in children
- Treating abused and neglected children
- Applying model examination techniques for assessment of abused/neglected children
- Describing and utilizing the most up-to-date information concerning working with abused and neglected children to improve care and well-being
- Preparing and delivering quality testimony in court cases, both as experts and as witnesses

Seminars are designed primarily for professionals in mental health, social work, 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, and Prevention.

The 19th Annual Colloquium is supported by 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 are available at www.apsac.org. The site also features a downloadable/printable PDF version of the conference brochure.

New Directors and Officers Take Office at San Diego Board Meeting

The American Professional Society on the Abuse of Children's Board of Directors met Jan. 24 in San Diego, California. During the meeting, new Board members were seated, and 2011 officers were elected.

The following officers were elected to serve:

President **Ronald C. Hughes**, PhD, MScSA, Director, Institute for Human Services, Columbus, Ohio;

President-Elect **Viola Vaughan-Eden**, PhD, LCSW, Child and Family Resources, Newport News, Virginia;

Vice President **Tricia Gardner**, JD, Assistant Professor, Center on Child Abuse & Neglect, Oklahoma City, Oklahoma;

Treasurer **Vincent J. Palusci**, MD, MS, Loeb Child Abuse Center, New York, New York;

Secretary **William Marshall**, Detective, Spokane Police Department, Spokane, Washington;

Board Member at Large to the Executive Committee **Julie Kenniston**, LSW, Director of Training and Education, Butler County Children Services, Mason, Ohio; and

Immediate Past President **Michael L. Haney**, PhD, Consultant, Tallahassee, Florida.

New Board members elected or appointed to 3-year terms:

Bill S. Forcade, JD, Attorney at Law, Chicago, Illinois;

Michael V. Johnson, Director, Detective (ret), Boy Scouts of America, Irving, Texas; and

Frank Vandervort, JD, Clinical Assistant Professor at Law, Child Advocacy Law Clinic, University of Michigan Law School, Ann Arbor, Michigan.

Board members elected to a second term:

Viola Vaughan-Eden, PhD, LCSW, Child and Family Resources, Newport News, Virginia; and

Vincent J. Palusci, MD, MS, Loeb Child Abuse Center, New York, New York.

Additional APSAC Board members who are currently completing their terms: **Elissa J. Brown**, PhD, St. John's University, Partners Program/Psychology, Jamaica, New York; **Monica Fitzgerald**, PhD, Assistant Professor, Medical University of South Carolina, Charleston, South Carolina; **Lori Frasier**, MD, Professor of Pediatrics University of Utah/Primary Children's Medical Center, Salt Lake City, Utah; **Robert Parrish**, JD, Deputy District Attorney, Salt Lake County District Attorney's Office, Bountiful, Utah; and **Susan Samuel**, Trainer/Consultant, Cloudcroft, New Mexico.

A complete list of APSAC Board members is available on the web site at www.apsac.org.

Haney Named Special Assistant to President

At its recent Board meeting in San Diego, California, APSAC's Board approved the hiring of **Michael L. Haney**, PhD, Consultant, Tallahassee, Florida, as Special Assistant to the President of APSAC. The position will last 6 months.

Specific duties will include the following:

- Coordinate with APSAC's President, assist with developing retreat agendas, and when directed, represent APSAC at national meetings, workgroups, or specialty projects
- Attend all regular and special meetings of APSAC's Board of Directors, including the monthly Executive Committee calls
- Reformulate APSAC's infrastructure to reflect appropriate lines of authority, supervision, oversight, and management, and facilitate the introduction of professional staff

- Reformulate the Table of Organization to include product development oversight of APSAC committees by the Executive Director
- Implementation of oversight responsibilities of APSAC committees responsible for product development
- Reformulation of the By-laws to reflect necessary changes and adaptations
- Serve as Chair of new fundraising and contract procurement committee
- Develop new Board member evaluation process to include performance evaluation of product development committee chairs
- Perform other activities identified by the President and Special Assistant necessary to adapt APSAC infrastructure and function to empower Executive Director in the performance of his or her duties.

Dr. Haney has 28 years of experience in child protection, child welfare, and mental health. He has been an active member of APSAC since 1995 and has served on the Board of Directors since 2006, both as Vice President and President. He currently serves as Immediate Past President. He brings a vast knowledge of APSAC's operations and shares the Board's vision to keep APSAC as the premiere organization to support child welfare and child protection professionals.

Haney said, "I am humbled by the Board of Directors' confidence in me and very excited about opportunities to increase our membership and to help APSAC grow, prosper, and seek new opportunities to better serve child protection and child welfare professionals."

APSAC Forensic Interview Training Clinic in Seattle

Consistent with its mission, APSAC presents the Forensic Interview Training Clinic, 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 viewing, with 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.

The 2011 Seattle clinic will take place June 20–24. Details and registration are available at www.apsac.org.

Successful Institutes Offered by APSAC in San Diego

Nearly 160 individuals participated in APSAC Advanced Training Institutes on January 23 in San Diego, California. The programs were a part of the annual San Diego International Conference on Child and Family Maltreatment sponsored by the Chadwick Center. Three APSAC programs were featured:

Teaching Caregivers to Talk With Children About Feelings: Implications for Treating Child Trauma

Monica Fitzgerald, PhD, and Kimberly Shipman, PhD

Advanced Sexual Abuse Evaluation for Medical Providers

Lori D. Frasier, MD, and Suzanne Starling, MD

Advanced Forensic Interviewing

Lynda Davies, BA, Michael Haney, PhD, Dr. Tom Lyon, JD, PhD, and Julie Kenniston, LSW

In addition to offering the educational programs, APSAC exhibited at the conference, and many of its members served as conference faculty. APSAC's Board of Directors held a meeting January 24 in conjunction with the conference.

Katie Toth Memorial Education Fund

A special fund was established in April 1997 in memory of Mary Katherine (Katie) Toth, daughter of Patricia Toth, JD, one of APSAC's earliest Board members and APSAC's fifth President. Mary Katherine died on April 21, 1997, at 20 months of age.

The fund supports the training and education of new child maltreatment professionals, thereby promoting APSAC's mission of supporting professionals who serve children and families affected by child maltreatment and violence. This year, in its ongoing commitment to support law enforcement, APSAC awarded a "Katie" Scholarship to **Detective Scott S. Renalds** of the Louisa County, Virginia, Sheriff's Office to attend the 2011 Child Forensic Interview Clinic in Virginia Beach.

Patti Toth's generosity with her time, energy, and expertise has contributed greatly to APSAC's success. Over the years, Patti has devoted considerable effort to improving APSAC's professional education and training programs. Patti served as chairperson of APSAC's First National Colloquium, and she has taught numerous APSAC Institutes and Colloquium seminars. She is also program manager for APSAC's Child Forensic Interview Clinics.

Contributions to the Katie Toth fund are welcome. They may be made payable to "APSAC/Katie Toth Memorial Education Fund." All contributions are tax deductible and will be acknowledged both with a letter from APSAC and through publication in the *APSAC Advisor*.

APSAC Advisor Has a New Editor

After 6 years as both Associate and Executive Editor of the *APSAC Advisor*, Dr. Judith Rycus has resigned from this position. Dr. Vincent Palusci has been appointed to succeed her. Dr. Palusci, who has authored several articles for the *Advisor*, is a pediatrician and Professor in the Department of Pediatrics at Langone Medical Center at New York University. Dr. Palusci is also an APSAC Board member and Board Treasurer. APSAC welcomes Dr. Palusci to this position.

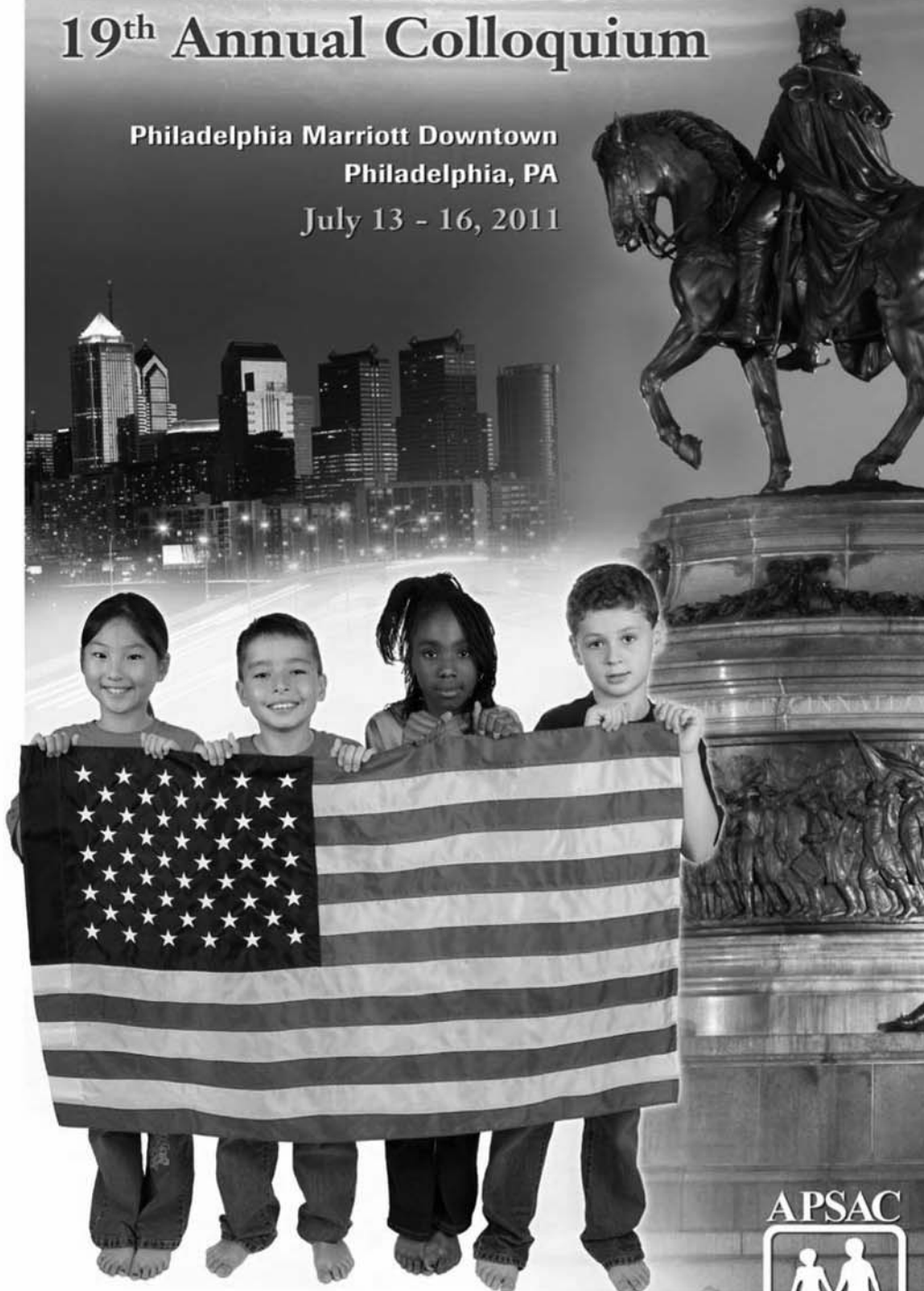
The APSAC Board also wishes to thank Dr. Rycus for her commitment to good science, innovation, and the translation of research into practice. The quality and relevance of her work will serve as benchmarks for future *Advisor* editors.

Learn more by visiting: www.apsac.org

THE AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN PRESENTS

The APSAC 19th Annual Colloquium

Philadelphia Marriott Downtown
Philadelphia, PA
July 13 - 16, 2011



"...fostering professional excellence in the field of child maltreatment by providing interdisciplinary professional education"

APSAC



Conference Calendar

May 18-20, 2011

18th Annual National Foster Care Conference

Daniel Memorial
Daytona Beach, FL
904.296.1055
swaugerman@danielkids.org
www.danielkids.org

June 1-4, 2011

48th AFCC Annual Conference

Association of Family and Conciliation Courts (AFCC)
Orlando, FL
608.664.3750
afcc@afccnet.org
www.afccnet.org/conferences/afcc_conferences.asp

June 8-10, 2011

One Child, Many Hands: A Multidisciplinary Conference on Child Welfare

Children's Hospital of Philadelphia/
Penn School of Social Policy and Practice
Philadelphia, PA
215.573.9779
fieldctr@sp2.upenn.edu
www.onechildmanyhands.org

June 8-11, 2011

American Humane Conference on Family Group Decision Making (FGDM) and Other Family Engagement Approaches

American Humane Association (AHA)
Henderson, NV
303.792.5333
info@americanhumane.org
www.americanhumane.org

June 20-24, 2011

APSAC's Child Forensic Interview Clinic

American Professional Society on the Abuse of Children (APSAC)
Seattle, WA
877.402.7722
apsac@apsac.org
www.apsac.org

July 13-16, 2011

19th APSAC Annual Colloquium

American Professional Society on the Abuse of Children (APSAC)
Philadelphia, PA
877.402.7722
apsac@apsac.org
www.apsac.org

July 15-16, 2011

14th Bi-annual American Bar Association National Conference on Children and the Law

ABA Center on Children and the Law
Washington, DC
202.662.1740
davidsonha@staff.abanet.org
www.abanet.org/child

July 19-21, 2011

4th National Research Conference on Child and Family Programs and Policy

Bridgewater State University
Bridgewater, MA
508.531.1000
mmanning@bridgew.edu
www.nrcfpp.org external link

August 25-27, 2011

11th National Conference on Child Sexual Abuse and Exploitation Prevention

National Children's Advocacy Center (NCAC)
New Orleans, LA
256.533.KIDS (5437)
mgrundy@nationalcac.org
www.nationalcac.org

August 29-31, 2011

National Child Welfare Evaluation Summit

Children's Bureau, Administration for Children and Families
Washington, DC
301.495.1080
cw-evaluationsummit@jbsinternational.com
www.ncwes2011.jbsinternational.com

September 14-16, 2011

Putting the Pieces Together for Children and Families: The National Conference on Substance Abuse, Child Welfare, and the Courts

Children and Family Futures
714.505.3525
mlujan@cffutures.org
www.cffutures.org/conference2011 external link

October 16-19, 2011

National Staff Development and Training Association Institute

American Public Human Services Association (APHSA)
Madison, WI
202.682.0100
DGross@aphsa.org
www.nsdta.aphsa.org



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