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Regular Features

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APSAC

Enhancing the ability of professionals to respond to children and their families affected by abuse and violence.

From the Editor

Vincent J. Palusci, MD, MS

The ***APSAC Advisor*** is a quarterly news journal for professionals in the field of child abuse and neglect. It has been the most popular benefit of APSAC membership for years. The *APSAC Advisor* provides succinct, data-based, practice-oriented articles that keep interdisciplinary professionals informed of the latest developments in policy and practice the field of child maltreatment. It is designed to highlight best practices in the field and publish original articles and current information about child maltreatment for professionals from a variety of backgrounds, including medicine, law, law enforcement, social work, child protective services, psychology, public health, and prevention in the United States.

The ***APSAC Advisor*** has been so successful because of the dedication and hard work of its outstanding editors and contributors. Beginning in 1988 with Jon Conte and continuing through this year with Judith Rycus, the *Advisor* has been blessed with Editors in Chief who have committed significant time and talent to its excellence. We wish to also thank our departing Consulting Editors Patti Beekman, Neil Guterman, Steve Ondersma, and Bea Yorker and Editorial Assistant Susan Yingling, who have all given many years of work to the publication. Welcome to Howard Fischer, Colleen Friend, Michael Haney, Cheryl Lanktree, and Saribel Garcia Quinones, who are joining as new Consulting Editors! Thank you, other colleagues—Michael Bandy, Ilene Berson, Lisa Aronson Fontes, Thomas Birch, David Finkelhor, Lori Frasier, Thomas Lyon, Maria Scannapieco, and Ann West—for joining in making the *Advisor* a continuing success.

The ***APSAC Advisor*** regularly publishes information about the organization, APSAC statements, highlights from journals, conference information, and Washington updates. In addition, the *APSAC Advisor* welcomes manuscripts addressing important topics in practice, policy, and theory, including empirical research articles, review articles, and program evaluations. Regular articles should be 4,000–6,000 words, inclusive of tables, figures, and references. Controversial topics can be addressed by an "At Issue" article. Brief program descriptions for the "What's New and Who's Doing It" section will also be accepted, limited to no more than 1,000–2,000 words including tables, figures, and references. Other submissions not meeting these requirements will also be considered.

With the support of the APSAC Officers and Board, publications committee chair Elissa Brown, and the APSAC membership, we look forward to continuing excellence in the ***APSAC Advisor***. Your submissions should be prepared according to the guidelines in the *Publication Manual of the American Psychological Association* (6th edition). All submissions should have all of the authors' names, degrees, and contact information on the first page and brief biographies (50 words) at the end. All submissions and questions should be sent to the Editor in Chief of the *APSAC Advisor* at: advisor@apsac.org.

Do Evidence-Based and Effective Programs for Abused and Traumatized Children Address the Issue of Psychological Maltreatment? A Survey of Program Developers

Amy J. L. Baker, PhD, Mel Schneiderman, PhD, and David Pelcovitz, PhD

During 2008, over 770,000 children were deemed to be victims of child abuse or neglect (U.S. Department of Health and Human Services, 2010). Because a portion of maltreated children goes undetected, the actual rates are likely to be even higher. Decades of research have documented the short- and long-term harm of maltreatment to children's cognitive, social-emotional, and physical development (Cicchetti & Toth, 2000). Costs also accrue to society in the form of juvenile delinquency and adult criminality, both of which are associated with childhood maltreatment (Luntz & Widom, 1994), as well as the intergenerational transmission of abuse (Kaufman & Zigler, 1987). More immediate costs also include out-of-home placement, prevention, emergency room and other medical care, and related social services.

In response to the need to provide treatment to victims of child maltreatment, interdisciplinary professionals of the last 3 decades have contributed to the development and validation of evidenced-based and best practice treatments for physically abused and sexually abused children, including the development of "abuse-specific" treatments as an alternative to generic-eclectic psychotherapeutic interventions (Cohen, Mannarino, & Deblinger, 2006). Abuse-specific treatment is based on theory and clinical experience regarding the impact of various forms of abuse on social, emotional, and cognitive functioning over the course of an individual's development (Deblinger & Heflin, 1996; Friedrich, 2002; Herman, 1997; Kolko, 1996; Pearce & Pezzot-Pearce, 1997; Urquiza & Winn, 1994).

These models share an acknowledgment that developing rapport with the abused child is particularly challenging because issues of trust and betrayal are paramount. Also key is the recognition that early abuse affects memory and information processing and can cause emotion dysregulation and distorted cognitions and relational styles (Perry, 2000). Common to many abuse-specific treatments are a planned incremental exposure to and discussion of the abuse event(s) in the context of the therapeutic relationship (i.e., the narrative) as a way of integrating the memories and making new meaning of the abuse experience.

Another innovation in the field has been the articulation of "trauma-informed" therapeutic interventions that aim to address the specific needs of a traumatized child without making assumptions about the specific abuse or trauma experienced. An underlying belief of these treatments is that there are common responses children have to a range of *traumatic events* (defined as "sudden or unexpected shocking events; death or threat to life or bodily integrity; and/or the subjective feeling of intense terror, horror, or helplessness" [APA, 2000, p. 463]).

Trauma-informed interventions focus on trauma symptoms: the behavioral, cognitive, physical, and emotional difficulties that are directly related to traumatic experiences. Trauma-informed treatment represents an approach to engaging clients with histories of trauma that starts with the recognition of the impact of trauma-related symptoms on their lives. Currently, a number of these trauma-informed as well as abuse-specific treatments have been deemed evidence-based or best practice in the field (e.g., California Clearinghouse for Child Welfare, National Child Traumatic Stress Network).

The purpose of the current study was to consider whether and how these programs address a child's experience of psychological maltreatment (PM), which has been shown to have a high incidence of co-occurrence with physical and sexual abuse (Claussen & Crittenden, 1991; Trickett, Mennen, Kim, & Sang, 2009). To perpetrate physical or sexual abuse, some nonphysical and nonsexual attitudes and behaviors typically take place that constitute psychological maltreatment. For example, the harsh, demeaning, and

threatening words spoken to a child prior to the infliction of physical injury and the quiet seduction of the child into the secret and exploitive world of the sexual abuser both reflect aspects of PM that accompany physical and sexual abuse. Psychological maltreatment is also likely to co-occur with physical abuse because the ineffectual parenting practices that can culminate in physical abuse can also lead to psychologically maltreating parenting practices as preliminary attempts at control and discipline, such as humiliation, singling out, shaming, threatening to abandon, and so forth. Thus, children who are referred for treatment to abuse-specific or trauma-informed interventions because of physical or sexual abuse are likely to have also experienced psychological maltreatment (although children referred to trauma-informed treatments for traumatic events unrelated to childhood maltreatment—such as illness, natural disaster, or random community violence—may not have also experienced psychological maltreatment).

Psychological maltreatment is widespread and has been found to be harmful to children's development even at relatively low levels (see Binggeli, Hart, & Brassard, 2001; Brassard & Donovan, 2006; Barnett, Manly, & Cicchetti, 1993; Kairys & Johnson, 2002; English & LONGSCAN Investigators, 1997; Portwood, 1999; Trickett, Mennen, Kim, & Sang, 2009; Wright, 2007, for recent reviews). Evidence of damage has been found in a range of behavioral and emotional domains of children's development, including problems of intrapersonal thoughts, feelings, and behaviors (e.g., depression, low self-esteem, suicidal ideation); emotional problems (e.g., emotional instability, impulse control problems, substance abuse); social competency problems and antisocial functioning (e.g., self-isolating behavior, social phobia, aggression, and violent behavior); learning problems (e.g., decline in mental competence, academic problems); and physical health problems (e.g., asthma, hypertension; somatic complaints). Retrospective studies with adults have found associations between various forms of psychological maltreatment and a range of negative outcomes including eating disorders (Allison, Grilo, Masheb, & Stunkard, 2007; Grilo & Masheb, 2002; Bardone-Cone et al., 2008), substance abuse (Eiden, Foote, & Schuetze, 2007; Hyman, Paliwal, & Sinha, 2007; Klein, Elifson, & Sterk, 2006; Medrano, Hatch, Zule, & Desmond, 2003; Medrano & Hatch, 2005; Minnes et al., 2008; Surratt, Kurtz, Weaver, & Inciardi, 2005), and psychiatric conditions (Garno, Gunawardane, & Goldberg, 2008; Simeon, Knutelska, Yehuda, Putnam, Schmeidler, & Smith, 2007).

In light of the prevalence of PM, its co-occurrence with other forms of childhood maltreatment, and its adverse and pervasive impact on the child's development and psychological functioning, we designed this study to investigate whether and how current treatment approaches in the field were addressing children's experiences of PM. It was our understanding that most abuse-specific interventions focus on sexual abuse and physical abuse rather than psychological maltreatment. Further, our clinical experience led us to question whether psychological maltreatment was being adequately addressed in trauma-informed interventions. To that end, we identified 11 evidence-based and best practice abuse-specific or trauma-informed treatment programs and interviewed the program developers or other relevant authority of 10 of them to learn about their perspective on whether and how their programs address children's experiences of psychological. Five main issues were explored in these interviews.

The first issue we addressed was whether the program developers had a working definition of PM that could then be used as the basis for therapeutic interventions for children with experiences of PM. Of particular interest here was whether the American Professional Society on the Abuse of Children (APSAC) definition was mentioned. To define PM, we used the definitional framework published by APSAC (Binggeli, Hart, & Brassard, 2001; Hart & Brassard, 1995) as *Guidelines for Psychosocial Evaluation of Suspected Psychological Maltreatment of Children and Adolescents*. The guidelines begin with a broad definition: "Psychological maltreatment means a repeated pattern of caregiver behavior or extreme incident(s) that conveys to children that they are worthless, flawed, unloved, unwanted, endangered, or only of value in meeting another's needs" (Binggeli, Hart, & Brassard, 2001, p. 2). Six categories of PM are offered: (1) spurning, (2) terrorizing, (3) isolating, (4) exploiting/corrupting, (5) denying emotional responsiveness, and (6) mental health, medical, and educational neglect.

We chose the APSAC framework for several reasons: It was developed with input from many of the leading scholars in the field and has been subject to modification based on empirical evidence (Bingelli, Hart, & Brasard, 2001; Brassard, Hart, & Hardy, 1993; Garbarino, Guttman, & Seely, 1986; Hart & Brassard, 1991); there is a high degree of agreement between the APSAC definition and other major definitional systems of PM (e.g., National Incidence Study II, Modified Maltreatment Classification System; McGee & Wolfe, 1991; see Brassard & Donovan, 2006, for a review); there are now many research studies demonstrating the damage caused during (or correlated with) specific developmental periods by each of the subtypes of PM (see Binggeli, Hart, & Brassard, 2001; Brassard & Donovan, 2006; Hart, Binggeli, & Brassard, 1998, for reviews); there is strong evidence for the cross-cultural validity for many of the PM subtypes (Dunne et al. 2009; Rohner, 1975; Rohner & Rohner, 1981; Runyan, Dunne, et al., 2009); and major governments and professional organizations have adopted definitions that are very similar (e.g., Singapore, American Academy of Pediatrics, American Humane Association).

After exploring a working definition of PM, other questions we addressed in this study were as follows: (1) What is the estimated prevalence of PM in the population served by the programs? (2) How is the issue of PM addressed in the written program materials? (3) How well do the interviewees believe that the program addresses the issue of PM? and (4) What role do the interviewees believe psychologically maltreating parents should play in the treatment of the child?

Program Selection

We conducted a comprehensive Internet search to identify programs for inclusion in this analysis. Criteria included the following: (1) group or individual child therapy program, (2) aimed at addressing childhood abuse or traumatic experiences, (3) with manuals written in the English language, (4) manualized with materials available for review, and (5) deemed evidence-based or best practice (e.g., included in the SAMHSA or a comparable model program registry). Each program registry uses different criteria for determining whether a program is deemed effective or evidence-based. For example, acceptance into the SAMHSA model program registry is based on staff discussions with program developers and an independent review of research evidence that culminates in a decision to include the program or not in the model registry. Factors taken into account include the quality of research (reliability and validity of measures, intervention fidelity, handling of missing data and attrition, presence of potential confounding variables, and appropriateness of analysis) and the program's readiness for dissemination (availability of implementation materials, quality and availability of training and support resources, and quality assurance procedures). Other registries employ different approaches but share the feature of reviewing the ability of the program to be disseminated and the quality of the evidence of the effectiveness of the program. Six sources were examined for possible programs to include. They represent the only sources that we were aware of. Table 1 provides an overview of these sources and which programs that we identified from each.

Table 1. Overview of Program Selection Search Results

Source	Search Criteria	Have Met Study Criteria
Office of Juvenile Justice and Delinquency Prevention http://www.ojjdp.gov/programs/ProgResults.asp	Searchable database. Keywords used: all ages, both genders, all problem types, all settings, all program types, ratings of exemplary or effective, which resulted in 100 programs.	CB-ITS PE TF-CBT
Substance Abuse and Mental Health Services National Registry of Evidence-Based Programs and Practices (NREPP). http://www.nrepp.samhsa.gov/	Searchable database. Keywords used: mental health treatment for children 0–17 years of age, which resulted in 25 programs.	RLH TF-CBT
Kauffman Best Practices Project to Help Children Heal From Child Abuse (2004) http://www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTAbrochure.pdf	Nonsearchable list of 3 programs.	TF-CBT AF-CBT
Saunders, B. E., Berliner, L., & Hanson, R. F. (Eds.) (2004). http://www.musc.edu/ncvc/resources_prof/OVC_guidelines04-26-04.pdf	Nonsearchable list of 9 programs.	EMDR AF-CBT TF-CBT Trauma-Focused Play Therapy
California Evidence-Based Clearinghouse for Child Welfare http://www.cebc4cw.org/	Searchable database. Criteria = Levels 1 and 2, which resulted in 52 programs.	AF-CBT EMDR SITCAP-ART TF-CBT
National Child Traumatic Stress Network http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_trmnt_prom	Nonsearchable listing of 38 programs.	AF-CBT CB-ITS, Integrated Treatment for Complex Trauma (ITCT) RLH SPARCS TF-CBT TST

CB-ITS: Cognitive Behavioral Intervention for Trauma in Schools, PE: Prolonged Exposure Therapy, TF-CBT: Trauma Focused Cognitive Behavioral Therapy, RLH: Real Life Heroes, AF-CBT: Abuse-Focused Cognitive Behavioral Therapy, EMDR: Eye Movement Desensitization and Reprocessing, SICAP-ART: Trauma Intervention Program for Adjudicated and At-Risk Youth, SPARCS: Structured Psychotherapy for Adolescents Responding to Chronic Stress, TST: Trauma Systems Therapy

In all, 11 programs met the criteria for inclusion: (1) Cognitive Behavioral Intervention for Trauma—in the schools (Jaycox, 2003); (2) Trauma-Focused Cognitive Behavioral Therapy (Cohen, Mannarino, & Deblinger, 2006); (3) Real Life Heroes (Kagan, 2007); (4) Abuse-Focused CBT (Kolko & Swenson, 2002); (5) EMDR for children (Adler-Tapia & Settle, 2008); (6) Trauma-Focused Play Therapy (Gil, 1991); (7) SITCAP-ART (Raider, Steele, Delillo-Storey, Jacobs, & Kuban, 2008); (8) Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) (DeRosa et al., 2006); (9) Integrated Treatment of Complex Trauma–C (Lanktree & Briere, 2008); (10) Trauma Systems Therapy (Saxe, 2007); and (11) Prolonged Exposure Therapy (Foa, Hembree, & Rothbaum, 2007). See Table 2 for program information.

The Interview Protocol

Each author conducted from three to four semi-structured interviews, each of which lasted between 30 and 45 minutes. Informed consent was obtained prior to the interview proper. The developer of one program declined to participate because the term *psychological maltreatment* was deemed to be too vague to be discussed. The interviewees were assured confidentiality and anonymity of their responses. The protocol comprised a series of open-ended and closed-ended questions designed to address the following five topics:

1. Definition of Psychological Maltreatment

This was assessed with a single open-ended question about which definition of PM the person relied on in his or her work.

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Table 2. Program Information

Program	Duration	Core Elements	Evidence of Effectiveness
Abuse-Focused CBT Kolko & Swenson (2002)	12–16 weekly individual sessions	Socialization to models of stress and CBT, Understanding and cognitive processing of the child's exposure to hostility /violence and abusive experience(s), Psychoeducation about child abuse laws, child safety/welfare, and common abuse-related reactions/attributions, Training in affect identification, expression, and management skills, Coping skills, Training to address everyday problems, Development of social support plans, and Interpersonal skills training to enhance social competence.	1. OJJDP = not included 2. SAMHSA = not included 3. Saunders = not included 4. CA. Clear = 3 (promising) 5. NCTSN = included 6. Kauffman = included
CB-ITS Jaycox (2003)	10 group sessions	Imaginal exposure to stress or trauma, introduction to cognitive therapy, combating negative thoughts, introduction to real life exposure, exposure to stress or trauma memory, introduction to social problem solving, practice with social problem solving, relapse prevention, and graduation.	1. OJJDP = exemplary 2. SAMHSA quality ratings of research = 3.4 and dissemination 3.8 3. Saunders = not included 4. CA clear = not included 5. NCTSN = included 6. Kaufman = not included
EMDR Greenwald (1993)	2–3 sessions	Preparation, assessment, desensitization and reprocessing, installation of positive cognition, body scan, closure, re-evaluation.	1. OJJDP = not included 2. SAMHSA = not included 3. Saunders = 3 4. CA Clear. = 1 5. NCTSN = not included 6. Kaufman = not included
Integrated Treatment of Complex Trauma–C. Lanktree & Briere (2008)	variable	Assessment of complex trauma, Advocacy and systems interventions, Client-therapist relationship, Developing and enhancing a safe therapy environment, Distress reduction and the development of affect regulation skills, Facilitating positive identity, Psychoeducation, Cognitive and emotional processing, Relational/attachment processing, Behavior self-control.	1. OJJDP = not included 2. SAMHSA = not included 3. Saunders = not included 4. CA Clear. = not included 5. NCTSN = included 6. Kaufman = not included

Table 2 Program Information *continued*

Program	Duration	Core Elements	Evidence of Effectiveness
Prolonged Exposure Therapy Foa, Hembree, & Rothbaum (2007)	9–12 90-minute sessions	The program consists of four treatment components: (a) clinical interview including assessment of PTSD symptomatology, psychoeducation about common reactions to trauma, and construction of client's troublesome thoughts and avoided situations, (b) training in controlled breathing to help clients manage anxiety, (c) imaginal exposure to the memory of the traumatic event, both in session, and as homework, (d) in-vivo exposure to trauma reminders that are avoided and feared.	1. OJJDP = exemplary 2 = SAMHSA quality of research = 2.9 to 3.7 readiness to disseminate = 3.1 3. Saunders = not included 4. CA clear = not included 5. NCTSN = not included 6. Kaufman = not included
Real-Life Heroes Kagan (2007)	6–18 months of weekly individual sessions	Safety planning, trauma psychoeducation, skill building in affect regulation and problem solving, cognitive restructuring of beliefs, nonverbal processing of events, and enhanced social support.	1. OJJDP = not included 2. SAMHSA quality of research = 3.7 and dissemination = 4.0 3. Saunders = not included 4. CA clear. = not included 5. NCTSN = included 6. Kaufman = not included
SITCAP-ART Raider, Steele, Delillo-Storey, Jacobs, & Kuban (2008)	10 sessions of 6 youth	Education, debriefing, focusing on themes, drawing, details, trauma-specific questions, cognitive reframing.	1. OJJDP = not included 2. SAMHSA = not included 3. Saunders = not included 4. CA Clear. = 3 5. NCTSN = not included 6. Kaufman = not included
SPARCS DeRosa, Habib, Pelcovitz, Rathus, Sonnenklar, Ford, et al. (2006)	16 1-hour groups for 12–19-year-olds	Mindfulness, problem solving, meaning making, relationship building/communication skills, distress tolerance. Also includes psychoeducation regarding stress and trauma.	1. OJJDP = not included 2. SAMHSA = not included 3. Saunders = not included 4. CA Clear. = NR 5. NCTSN = included 6. Kaufman = not included
Trauma-Focused CBT Cohen, Mannarino, & Deblinger (2006)	12 individual sessions or more plus parent component	Psychoeducation, relaxation, affective expression and modulation, cognitive coping and processing I, trauma narrative, cognitive coping and processing II, in-vivo mastery, conjoint parent-child sessions, enhancing future safety, grief psychoeducation, grieving the loss, preserving positive memories, redefining the relationship.	1. OJJDP = exemplary 2. SAMHSA quality ratings research 3.7 and dissemination 3.7 3. Saunders = 1 4. CA. clear. = 1 5. NCTSN = included 6. Kaufman = included

Table 2 Program Information *continued*

Program	Duration	Core Elements	Evidence of Effectiveness
Trauma-Focused Play Therapy Gil (1991)		Selection and display of appropriate toys and miniatures based on the particular child's traumatic situation; Giving therapeutic permission and encouragement to move at the child's own pace; Observation and recording of the child's post-trauma play and accompanying affect; Reflective commenting on the child's posttrauma play or therapeutic questions that ask the child to expand on narrative already provided of play; Assisting with clarification, processing of idiosyncratic meaning, affect discharge, sequential organization and integrating of difficult cognitions and affect; Helping the child manage anxiety, develop new coping strategies, and identify external resources; Providing parental support and education as well as guidelines for observing and participating in child's everyday play without overinterpreting and/or becoming intrusive; Collateral individual therapy for parents, particularly if prior abuse issues interfere with current abilities to address their child's needs for safety and support.	1. OJJDP = not included 2. SAMHSA = not included 3. Saunders = 4 4. CA Clear. = not rated 5. NCTSN = not included 6. Kaufman = not included
Trauma Systems Therapy Saxe, Ellis, & Kaplow (2007)	variable	Key components: Trauma Systems Therapy can be seen as a framework for organizing a series of empirically validated interventions to address the real-world needs of children facing considerable adversity. It is designed to help children and families where there is ongoing stress in the social environment. Traumatic stress and the intervention involve two elements: • a child with difficulty regulating his or her emotional state, and • a system of care that cannot effectively regulate the child's response to his or her social environment. In this program, social context includes family, school, and neighborhood. Services are tailored to the child/family using a 3 X 3 matrix with stability of social environment on one axis and the child's ability to regulate emotions on the other.	1. OJJDP = not included 2. SAMHSA = not included 3. Saunders = not included 4. CA Clear. = not included 5. NCTSN = included 6. Kaufman = not included

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2. Estimate of Prevalence of Psychological Maltreatment
This was assessed with a single closed-ended question about how many child clients were perceived to have experienced PM, however it was defined (0 = not at all, 1 = a few, 2 = some, 3 = many, 4 = most, 5 = all, 6 = don't know).

3. How the Issue of PM Is Covered in the Curriculum and Training Materials
Five questions were asked within this general topic, three of which used the same closed-ended response options (0 = not at all, 1 = in passing, 2 = somewhat, 3 = in-depth): How, if at all, is the concept of psychological maltreatment addressed in the portion of the book or manual that presents the background and theoretical underpinnings of the program? How, if at all, is the concept addressed in the portion of the book or manual that presents the content of the sessions? And how, if at all, is the concept addressed in the training materials for therapists? We also asked two open-ended questions: How does the program aim to address the psychological maltreatment experiences of children; and, if the program uses a trauma narrative, how is PM dealt with when it comes up in that context?

4. How Well the Program Addresses PM and Need for Improvement
We asked six questions, all but one using the following response options: (0 = not at all, a little bit, 2 = somewhat, 3 = much, 4 = very much). The questions were (1) Do you believe that the program as it stands allows children to adequately process/acknowledge any PM they might have experienced? (2) Do you believe that any modifications in the program would allow a therapist using it to work more productively with children

who have been psychologically maltreated? (3) Do you think therapists using the program could benefit from being training to understand and recognize the 18 types of psychological maltreatment as defined by APSAC? (4) Do you see any need for a standalone program for children who have been both psychologically maltreated in addition to some other form of maltreatment as well? (5) Do you see any need for a standalone program for children who have been psychologically maltreated without also having been maltreated in some other way as well? and (6) Are you aware of any programs that specifically address PM experiences of children (0 = no, 1 = yes).

5. How Psychologically Maltreating Parents Should Be Involved in Treatment

We asked two open-ended questions about what role, if any, the interviewee believed that psychologically maltreating parents should play in an intervention for psychologically maltreated children and what services, if any, should be provided to psychologically maltreating parents.

Results

Definition of Prevalence of Psychological Maltreatment

Interviewees were not familiar with the APSAC definition. Not one mentioned the definition by name or by its 18 components. Three interviewees said that they had not defined PM, or did not use the term, or both. Four said that it was "abuse or neglect" in general, two defined it as "psychological aggression," and one referenced Garbarino's (1986) definition.

Estimate of Prevalence of Psychological Maltreatment

Interviewees all acknowledged that at least some children served by their program had experienced PM, although they cited a range of prevalence. One interviewee said that this was true of "some" clients; two interviewees said that this was true of "many" clients; five said that this was true of "most" clients, and two said that this was true of "all" clients. Three interviewees commented that it is hard to disentangle PM from other forms of abuse or neglect: "I think that PM is pervasive, and I think it overlaps with other types of maltreatment out there. I know it sometimes happens only on its own, but mostly it does not happen on its own but it occurs with other types of maltreatment."

How the Issue of PM Is Covered in the Curriculum and Training Materials

Table 3 presents these data.

Five of the ten interviewees reported that their programs covered content related to psychological maltreatment in an "in-depth manner." This was true for the background materials of the manual, the curriculum of the program, and the program training materials. Comments made by the interviewees regarding the intent of their program to address PM are illustrative of the general difficulty in defining the term and disentangling it from other forms of abuse: for example, "This is tricky. What we try to do is create a safe environment, not specific to PM," and "This therapy is generic, not specific to any particular trauma."

Eight of the ten interviewees reported that their programs utilized a trauma narrative. When asked how PM would be incorporated into that, the developers generally made the point that whatever came up in the narrative would be addressed in treatment, including but not limited to any kind of maltreatment, such as psychological maltreatment.

How Well the Program Addresses PM and Need for Improvement

These data are presented in Table 4.

Table 3. How the Issue of PM Is Covered in the Curriculum and Training Materials

	None	Somewhat	In-Depth
Background	2	3	5
Curriculum	1	5	4
Training	1	3	5

Table 4. How Well the Program Addresses PM and Need for Improvement

	No	A Little/Somewhat	Much/Very Much
Program as It Stands	0	2	8
Would Modifications Help?	3	6	1
Would Therapist Training Help?	1	4	5
Need for Standalone for Children Multiabused	6	3	1
Need for Standalone for Children PM Only	6	3	1

Our data show that 8 of the 10 interviewees felt their program, as it stands now, can "much" or "very much" adequately address the needs of a child who has experienced psychological maltreatment. Most, however, thought that modifications would be "a little bit" or "somewhat" useful. All but one thought that additional therapist training in the APSAC definition of psychological maltreatment would be helpful. The interviewees were divided as to whether a new program would be beneficial for children who had experienced PM in addition to other forms of trauma/abuse or had experienced it as the only form of trauma and abuse.

Regarding awareness of any programs specifically for children who have been psychologically maltreated, interviewees were unanimous in saying that they were not aware of any such programs.

How Psychologically Maltreating Parents Should Be Involved in Treatment

Each of the interviewees responded affirmatively that the parents of maltreated children should be involved in their children's treatment, with many considering it "critical" or a "central role." In general, they reported that the parents needed support and therapy to address their own unmet needs and "ghosts in the nursery" as well as to understand the damage they are causing to their children in order to support the child's treatment and to prevent relapse of psychologically maltreating behaviors.

Discussion

The purpose of this study was to determine whether and how evidence-based and best practice trauma-informed and abuse-specific therapeutic programs address children's experience of psychological maltreatment. Eleven programs were identified and ten program developers and authorities agreed to be interviewed. Before discussing the data, we mention a few limitations at the outset. First, individual therapists bring their own knowledge base and skill set into the therapeutic session with abused and traumatized children. It is quite likely that some of them are knowledgeable about the topic of psychological maltreatment and engage child clients specifically on dimensions of PM identified by APSAC (i.e., spurning, terrorizing, and so forth).

Needless to say, there was no way to assess the content of these discussions. However, it is likely that some clinicians are not knowledgeable about the topic of PM and do not engage the child clients on this experience. For the purposes of this study, we inferred that if the interviewees (who were for the most part the program developers) intended that a concept be routinely covered in the program, they would reflect on it in their comments during the interview and in their survey reports regarding program materials. It is also worth noting that these programs are all well established and highly regarded, which is the reason they were selected for this review. Nothing written in this article is intended to be critical of the programs. Our only intention is to assess whether and how they address the issue of PM.

Turning to the current study, we found that in general the interviewees did not have sufficient knowledge and were unable to articulate a coherent description of any recognized definition of PM in the field. In particular, they appeared to be unfamiliar with the definition of psychological maltreatment endorsed by APSAC. They did not spontaneously offer it when given an opportunity to do so and generally expressed unfamiliarity with it when told that it involved 18 subtypes of PM. This suggests that the topic of PM is not yet as prominent as it needs to be. Reasons for this abound. As Baker (2009) noted, there is no uniform legal definition of this form of maltreatment, and there is ongoing conceptual and definitional confusion in the research literature, including multiple terms for the same general issue (e.g., emotional abuse, verbal abuse, psychological abuse, and so forth). While the APSAC definition could be a helpful rubric for the creation of measures of psychological maltreatment, most measures of the construct do not yet incorporate it, and thus, most research published is not grounded in the theory and research underlying its development (Baker, 2009). Further, it appears that the APSAC definition in particular might not be as well disseminated as it needs to be. Thus, it appears that the program developers and authorities interviewed for this study are not clear about the definition of PM and the many forms it can take, which suggests that issues related to PM if not raised by the child may not be addressed in treatment.

Consistent with this is the fact that only half of the interviewees believed that their program (i.e., background materials, curriculum, training) covered "in-depth" the issue of psychological maltreatment. Some of those who reported that it was less than in-depth coverage responded that this was not problematic because their program was designed to address traumatic events as identified by the client. In that sense, the program is "generic" in being able to address the resulting thoughts and feelings of any and all precipitating events. This belief is exemplified in the following quote from one interviewee, "Trauma program is general, doesn't matter what the person has experienced. We focus on their perception of their trauma not how we believe it was traumatic. Start from the person's perception. Even something we believe might have been very traumatizing, if they don't see it that way, that is what we work with."

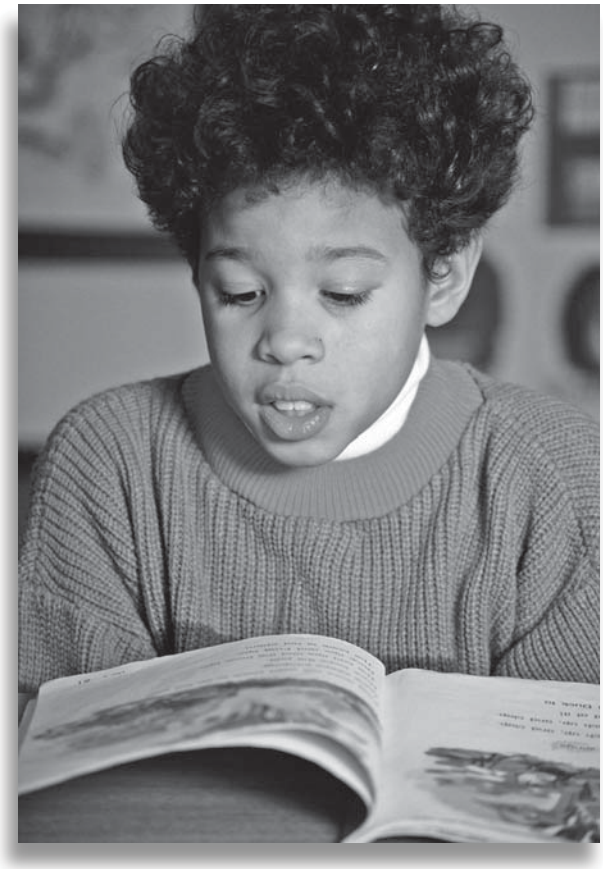
However, we believe that many children do not spontaneously talk about their trauma experience (nor do adults or children consider PM experiences as traumatizing) and that many children may not be "traumatized" by PM experiences but may be suffering nevertheless. If the clinician does not have a clear definition of PM, then it may be likely that the issue may never surface since neither the child nor clinician may consider it a treatment issue. For example, children may not report that a parent threatens to kill them or kick

them out of the home, and if the therapist does not ask questions about this, the issue may never arise. Thus, even for trauma-informed as opposed to abuse-specific treatment, awareness about PM on the part of the clinician with information provided by the program could potentially be useful for the treatment of children who have been psychologically maltreated. In the absence of clear direction on the part of the program and knowledge on the part of the clinician, it is possible that the child's PM experiences will go unreported and hence untreated.

A second response to the question about whether program materials covered psychological maltreatment in-depth was made by interviewees regarding abuse specific programs who stated that their materials did attend to the concepts of verbal aggression and verbal rejection, which can co-occur with physical abuse, and thus PM is at least in part addressed in the program. This idea was captured in the following statement: "We do not refer to it as PM but what children experience by adults that is a trauma. We are interested in what the child experiences. We do not use the term PM that much, but we certainly recognize and deal with it more than we deal with physical abuse. In a way, PM is the psychological underpinning that children carry into adolescence and adulthood." However, according to the APSAC definition, psychological maltreatment consists of 18 types (including but not limited to verbal aggression), and unless the clinician is aware of these other types and can probe for them and or respond appropriately when the child shares information related to them, the experience might go unaddressed in treatment.

Nonetheless, not one of the interviewees expressed the belief that a standalone program specifically for children who experienced psychological maltreatment would be warranted. The reason offered was that their programs were not specific to any one form of abuse, and thus while not intended specifically for children who have experienced PM, the program would work well with that population. Thus, while it was generally believed that abused children could benefit from therapy especially designed for abused children, there was no perceived benefit to having a treatment be specific to psychological maltreatment per se. They shared the belief that their program would be able to adequately address the treatment needs of children who experienced psychological maltreatment.

How well these programs address the PM experience of child clients is something we consider to be an unresolved issue that requires further empirical exploration. It appears relevant to us to determine how well these programs are addressing children's experiences with psychological maltreatment, in the absence of a working definition that captures many of the specific types of PM that can occur. What is clear is that unless a frontline mental health provider implementing one of these programs receives training on PM from some other source, he or she will



most likely be uninformed about it (beyond a general idea that it is verbal abuse). The question remains whether the clinician—in the absence of specific training—can effectively recognize and treat it. It seems possible that in the absence of training, therapists might not elicit information about psychological maltreatment from a client, or not recognize it as PM when a client discusses a behavior that is considered PM in the APSAC definition (which the therapist is unfamiliar with), or both. Thus, therapists might overlook and minimize clients' PM experiences, in the absence of specific training or direction in the treatment program materials. In addition, it is unclear how these programs would treat children who have been psychologically maltreated but are not exhibiting signs of traumatic stress or symptoms. The quote from the 1927 Nobel Prize in literature winner, Henri Bergson, appears apt. "The eye sees only what the mind is prepared to comprehend."

It is interesting that interviewees generally agreed that training for therapists about psychological maltreatment would be helpful. Most of the interviewees endorsed this item. Presumably this is because training could lead to greater awareness of the different types of PM identified by APSAC and could inform the work that the clinicians do. This suggests that despite believing that their programs could adequately address PM, they also believe that it could be helpful to alert frontline staff about the many

forms that PM can take. This suggests that without explicitly saying so, the program developers acknowledge that their programs may not be fully addressing issues related to PM and that if therapists were more trained, they would be more attuned to this issue in their interventions with children. The implication is that with greater training, clinicians would better be able to identify the issue of PM and then address it. Hence, once PM is identified, the program can address it adequately and, therefore, a standalone program is not needed to address PM. Again, this is an empirical question that should be addressed.

Despite the general agreement among the interviewees, some areas met with disagreement. A notable one pertains to whether the child is the level of the intervention and sole recipient of the treatment or whether the program aims to treat or modify the social ecology within which the child is living. A natural implication flowing from these different orientations is how to address the ongoing abusive experiences of the child who may still be in the stressful, traumatizing environment.

When asked about the role and services of the psychologically maltreating parents, there was consensus that as long as parents are not dangerous to the child, they should be involved in therapy. Comments included, "Yes, should be involved. Psychoeducation component for parents, parents should have adjunct therapists to address ghosts in nursery, and they all need a witness to what their child's perception and experience is like so that they can understand it as child does. A lot of parents don't know the damage they are doing. They are practicing what they experienced; matter of ignorance rather than intent to harm." And, "Critical. Trying to do anything without the parents' involvement, doesn't work as well. In our experience when we don't have access to parents, kids idealize them. Lots of opportunities to work with parents who are really harsh with their kids. Can alter how they perceive and interact with them. Optimistic about changing in parents [*sic*]. Worth making investment in, but some parents cannot be helped."

While sharing this vision, programs varied as to how much third parties (especially parents) were involved in the treatment. At one end of the spectrum are programs like EMDR, in which the child is the client and the services are provided to that client in the office; and at the other end of the spectrum is Trauma Systems Therapy, in which the child's ecology is considered holistically and services are provided in a range of locations and settings.

The set of findings that resulted from the interviews suggests a number of important next steps for research and practice. One critical direction for future research is to document the extent of psychological maltreatment experienced by children in abuse-specific and trauma-informed treatment programs. If high levels are established (and there is every reason to believe that they will be), then studies should be conducted to determine the differential effectiveness of abuse-specific vs. trauma-informed programs for addressing the psychological maltreatment experiences of children in treatment.

Since PM often co-occurs with other forms of abuse, another direction for research is to explore whether addressing the trauma of sexual abuse or physical abuse also reduces the adverse impact of PM. This raises the issue of how the programs aim and actually address multiple abuse experiences. Is each form of abuse mentioned by the child included in the trauma narrative or just the primary one? What about children for whom the sole maltreatment experience is psychological maltreatment? How well do these programs help those children, or would a standalone program focused exclusively on PM be more appropriate and effective? Surveys of frontline mental health clinicians could ascertain what level, if any, of training they have in psychological maltreatment and whether that training per se is associated with improved outcomes. Based on the findings from these suggested research directions, the development of specific training modules might be indicated, which could lead to a new round of evaluation investigations. In light of the prevalence of psychological maltreatment coupled with the lack of specific information about the concept and inconsistency with which the best practice treatments incorporate information about it in their curricula, these next steps represent a path forward in the field of abuse and trauma treatment, practice, and research.

References

Allison, K., Grilo, C., Masheb, R., & Stunkard, A. (2007). Association of FKBP5 polymorphisms and childhood abuse with risk of posttraumatic stress disorder symptoms in adults. *Behaviour Research and Therapy, 45*(12), 2874–2883.

Adler-Tapia, R., & Settle, C. (2008). EMDR and the art of psychotherapy with children treatment manual. New York: Springer.

Baker, A. J. L. (2009). Adult recall of psychological maltreatment: Definitional strategies and challenges. *Children and Youth Services Review, 31*, 207–714.

Bardone-Cone, A. M., Maldonado, C. R., Crosby, R. D., Mitchell, J. E., Wonderlich, S. A., Joiner, T. E., Crow, S. J., Peterson, C. B., Klein, M. H., & le Grange, D. (2008). Revisiting differences in individuals with bulimia nervosa with and without a history of anorexia nervosa: Eating pathology, personality, and maltreatment. *International Journal of Eating Disorders, 41*(8)*,* 697–704.

Barnett, D., Manley, J. T., & Cicchetti, D. (1993). Defining child maltreatment: The interface between policy and research. In D. Cicchetti & S. L. Toth (Eds.), *Child abuse, child development, and social policy* (pp. 7–73). Norwood, NJ: Ablex.

Bingelli, N. J., Hart, S. N., & Brassard, M. R. (2001). *Psychological maltreatment of children: The APSAC Study Guides, 4.* Thousand Oaks, CA: Sage.

Brassard, M. R., & Donovan, K. L. (2006). Defining psychological maltreatment. In M. M. Freerick, J. F. Knutson, P. K. Trickett, & S. M. Flanzer (Eds.), *Child abuse and neglect: Definitions, classifications, and a framework for research* (pp. 151–197). Baltimore, MD: Paul H. Brookes Publishing.

Brassad, M., Hart, S., & Hardy, D. (1993). The Psychological Maltreatment Rating Scales. *Child Abuse & Neglect*, *17*(4), 715–729.

Cicchetti, D., & Toth, S. L. (2000). Developmental processes in maltreated children. In D. J. Hansen (Ed.), *Nebraska symposium on motivation: Child maltreatment*, *46* (pp. 85–160). Lincoln: University of Nebraska Press.

Cohen, J., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents.* New York: Guilford Press.

Deblinger, E., & Heflin, A.H. (1996). *Treating sexually abused children and their non-offending parents: A cognitive behavioral approach.* Thousand Oaks, CA: Sage.

DeRosa, R., Habib, M., Pelcovitz, D., Rathus, J., Sonnenklar, J., Ford, J., Sunday, S., Layne, C., Saltzman, W., Turnbull, A., Labruna, V., & Kaplan, S. (2006). *Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS): A trauma-focused guide*. Manhasset, NY: North Shore–Long Island Jewish Health System.

Dunne, M. P. et al. (2009). ISPCAN Child Abuse Screening Tools–Retrospective version (ICAST-R): Delphi study and field testing in seven countries. *Child Abuse & Neglect, 33*, 815–825.

Eiden, R. D., Foote, A., & Schuetze, P. (2007). Maternal cocaine use and caregiving status: Group differences in caregiver and infant risk variables. *Addictive Behaviors, 32*(3), 465–476.

English, D. G., & LONGSCAN Investigators. (1997). *Modified Maltreatment Classification System (MMCS).* Available at: http://www.iprc.unc.edu/longscan/

Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). *Prolonged exposure therapy for PTSD: Therapist guide*. New York: Oxford University Press.

Friedrich, W. (2002). An integrated model of psychotherapy for abused children. In J. E. B. Myers, L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, & T. A. Reid (Eds.). *The APSAC handbook of child maltreatment, second edition* (pp. 141–157). Thousand Oaks: Sage.

Garbarino, J., Guttman, E., & Seely, J. W. (1986). *The psychologically battered child.* San Francisco: Jossey-Bass.

Garno, J., Gunawardane, N., & Goldberg, J. F. (2008). Predictors of trait aggression in bipolar disorder. *Bipolar Disorders, 10*, 285–292.

Gil, E. (1991). *The healing power of play.* New York: Guilford Press.

Greenwald, R. (1993). *Using EMDR with children.* Pacific Grove, CA: EMDR Institute.

Grilo, C. M., & Masheb, R. M. (2002). Childhood maltreatment and personality disorders in adult patients with binge eating disorder. *Acta Psychiatrica Scandinavica, 106*(3), 183–188.

Hart, S. N., & Brassard, M. R. (1991). *Definition of psychological maltreatment.* Indianapolis: Office for the Study of the Psychological Rights of the Child; Indiana University School of Education.

Hart, S. N., & Brassard, M. R. (Cochairs). (1995). *Guidelines for the psychosocial evaluation of suspected psychological maltreatment of children and youth.* Chicago: APSAC.

Herman, J. (1997). *Trauma and recovery.* New York: Basic Books.

Hyman, S. M., Paliwal, P., & Sinha, R. (2007). Childhood maltreatment, perceived stress, and stress-related coping in recently abstinent cocaine dependent adults. *Psychology of Addictive Behaviors, 21*(2), 233–238.

Jaycox, L. (2003). *Cognitive behavioral intervention for trauma in the schools*. Longmont, CO: Sopris West Educational Services.

Kagan, R. (2007). *Real-Life Heroes: A practitioner's manual.* New York: Haworth Press.

Kairys, S. W., Johnson, C. F., & Committee on Child Abuse and Neglect. (2002). The psychological maltreatment of children: Technical report. *Pediatrics*, *109*(4), e68. doi: 10.1542/peds.109.4.e68.

Kaufman, J., & Zigler, E. (1987). Do abused children become abusive parents? *American Journal of Orthopsychiatry, 57*, 186–192.

Klein, H., Elifson, K., & Sterk, C. (2006). Predictors of suicidal ideation among 'at-risk' cocaine-using African American women. *Suicide and Life-Threatening Behavior, 36*(3), 336–348.

Kolko, D. J. (1996). Individual cognitive behavioral treatment and family therapy for physically abused children and their offending parents: A comparison of clinical outcomes. *Child Maltreatment, 1*(4), 322–342.

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

Lanktree, C., & Briere, J. (2008). *Integrative treatment of complex trauma for children (ITCT–C): A guide for the treatment of multiply-traumatized children aged eight to twelve years.* Retrieved from: http://www.johnbriere.com/Child%20Trauma%20Tx%20Manual%20(LC%20PDF).pdf

Luntz, B. K., & Widom, C. S. (2004). Antisocial personality disorder in abused and neglected children grown up. *American Journal of Psychiatry, 151*, 670–674.

McGee, R. A., & Wolfe, D. A. (1991). Psychological maltreatment: Toward an operational definition. *Development and Psychopathology, 3*(1), 3–18.

Medrano, M. A., & Hatch, J. P. (2005). Childhood trauma, sexually transmitted diseases, and the perceived risk of contracting HIV in a drug using population. *American Journal of Drug and Alcohol Abuse, 31*, 403–416.

Medrano, M., Hatch, J. P., Zule, W. A., & Desmond, D. P. (2003). Childhood trauma and adult prostitution behavior in a multiethnic heterosexual drug-using population. *American Journal of Drug and Alcohol Abuse, 29*(2), 463–486.

Minnes, S., Singer, L. T., Kirchner, H. L., Satayathum, S., Short, E. J., Min, M., Eisengart, S., & Mack, J. P. (2008). The association of prenatal cocaine use and childhood trauma with psychological symptoms over 6 years. *Archives of Women's Mental Health, 11*(3), 181–192.

Pearce, J. W., & Pezzot-Pearce, T. D. (1997). Psychotherapy of abused and neglected children. New York: Guilford Press.

Perry, B. D. (2000). The neurodevelopmental impact of violence in childhood. In D. Schetky & E. Benedek (Eds.), *Textbook of child and adolescent forensic psychiatry.* Washington, DC: American Psychiatric Press.

Portwood, S. G. (1999). Coming to terms with a consensual definitional of psychological maltreatment. *Child Maltreatment, 4*(1), 56–68.

Raider, M. C., Steele, W., Delillo-Storey, M., Jacobs, J. & Kuban, C. (2008). Structured sensory therapy (SITCAP-ART) for traumatized adjudicated adolescents in residential treatment. *Residential Treatment for Children & Youth, 25*(2), 167–185.

Rohner, R (1975). *They love me, they love me not: A worldwide study of the effects of parental acceptance and rejection.* New Haven, CT: HRAF Press.

Rohner, R., & Rohner, E. C. (1981). Parental acceptance-rejection and parental control: Cross-cultural codes. *Ethnology, 20*, 245–260.

Runyan, D. K., Dunne, M. P., et al. (2009). The development and piloting of the ISPCAN Child Abuse Screening Tool–Parent version (ICAST-P). *Child Abuse & Neglect, 33*, 826–832.

Saxe, G. N., Ellis, B. H., & Kaplow, J. B. (2007). *Collaborative treatment of traumatized children and teens: The trauma systems therapy approach.* New York: Guilford Press.

Simeon, D., Knutelska, M., Yehuda, R., Putnam, F., Schmeidler, J., & Smith, L. M. (2007). Hypothalamic-pituitary-adrenal axis function in dissociative disorders, post-traumatic stress disorder, and healthy volunteers. *Biological Psychiatry* [Special issue*: Stress and PTSD: Neural mechanisms and treatment*]*, 61*(8), 966–973.

Surratt, H. L., Kurtz, S. P., Weaver, J. C., & Inciardi, J. A. (2005). The connections of mental health problems, violent life experiences, and the social milieu of the 'stroll' with the HIV risk behaviors of female street sex workers. *Journal of Psychology and Human Sexuality, 17*(1/2), 23–44.

Trickett, P., Mennen, F. E., Kim, K., & Sang, J. (2009). Emotional abuse in a sample of multiply maltreated, urban young adolescents: Issues of definition and identification. *Child Abuse & Neglect, 33*, 27–35.

Urquiza, A., & Winn, C. (1994). *Treatment for abused and neglected children: Infancy to age 18.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, National Center on Child Abuse and Neglect.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2010). Retrieved from: http://www.acf.hhs.gov/programs/cb/stats_research/

Wright, M. O. (2007). The long-term impact of emotional abuse in childhood: Identifying mediating and moderating processes. *Journal of Emotional Abuse, 7*(2), 1–8.

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AT ISSUE:

Clergy Sexual Abuse in the U.S. Roman Catholic Church: Exploring the Church's Response

Jack F. Coyne MD, FAAP

> Some people brought children to Jesus for him to place his hands on them, but the disciples scolded the people. When Jesus noticed this, he was angry and said to his disciples, "Let the children come to me, and do not stop them, because the Kingdom of God belongs to such as these. I assure you that whoever does not receive the Kingdom of God like a child will never enter it." Then He took the children in his arms, placed his hands on each of them, and blessed them. (Mark 10:14–16, Good News Translation, Second Edition, 1992)

Personal Insight

This is a story of constant betrayal by self-indulged pillars of our community who through time have created a sacrilegious code of supremacy and secrecy that has left, in its path, personalized horror, carnage, and hopelessness. As a forensic pediatrician, medical director of three child advocacy centers, and an ordained Roman Catholic priest since 1971, I have a unique perspective on the topic of religion and sexual abuse. This statement is meant both as a disclaimer for the injection of my personal opinions and as an explanation for why this article may appear to be particularly critical of the Catholic Church. It is not my intention to suggest that the abuse of children is unique to the Catholic clergy, or indeed, any other institution where the powerful have access to the less powerful. However, it is my profound belief that the sacred process of ordination and consecration of the men who become the shepherds of the Church necessarily means that the perversion of that power is a greater atrocity than when the same acts are committed outside the walls of the sanctuary. It is not meant to minimize in any way the impact on the child, regardless of the background or authority of the perpetrator. It is meant to maximize the sacrilege of the offender. In my capacities as both an ordained Catholic priest and a pediatrician, I have seen the devastation firsthand. I have also lived that trauma in my own extended family. Those involved either have committed suicide or live with depression, addiction, hopelessness, and self-imposed loneliness.

We have all heard and seen the physical and psychological effects of child sexual abuse. Many of these children were hurt by someone who "loved them," resulting in not only physical trauma but also issues of betrayal of a personal relationship. When a member of the clergy abuses a child, it is both a betrayal of a human relationship as well as a relationship with God. When the Church hierarchy is actively protecting itself along with the predators within its fold, expected issues of secrecy and delayed disclosures are intensified.

It is my spiritual belief that these crimes can be compared with no others and can be forgiven only by Him. It is my secular hope that the practitioners reading this will come away with some understanding of the magnitude of the priest sexual abuse scandal, including and especially the massive cover-up perpetrated by the Church, and some insights into the issues involved in treating the victims of this abuse.

History of Sexual Abuse in the Catholic Church

It is not surprising that the history of child sexual abuse by representatives of the Church is nearly as old as the history of the Church itself. What may be surprising, given the current state of affairs, is that "very early on the abuse of minors was considered a heinous crime, so much so that guilty clerics have been, at various times, excommunicated, removed from the clerical state and/or cut off from all financial assistance" (Doyle, 2003, p. 191). At the Council of Elvira in Spain, circa AD 309, four canons, or laws promulgated by the Catholic Church, were passed that confronted the sexual behaviors of clerics and delineated the consequences of their child molestation. These sanctions included no communion, excommunication, fasting, and lengthy penances. The penance for priests and bishops was considerably longer—10 to 12 years of fasting (Doyle, 2003). The Third Latern Council of AD 1179 decided that clergymen who "commit sins against nature" should be forced out of the Church or given a life sentence of detention in a monastery (Doyle, 2003, p. 195). In 1570, a priest who sodomized a boy was defrocked and turned over to secular

authorities, who then decapitated him (Rosetti, Anthony, Cimbolic, & Wright, 1996).

Some 1800 years after the first pedophile priests were excommunicated, things have both changed dramatically and remained the same. The sexual abuse has continued. Priests' ordained power and, therefore, perceived trustworthiness have allowed them almost unlimited access to children. Father John Goeghan—who brought clergy sexual abuse to center stage, leading to the subsequent public downfall of Cardinal Law of Boston—and Father Oliver O'Grady—object of the documentary *Deliver Us From Evil* (Baldwin, Brown, Ortenberg, & Berg, 2006) and the one to expose Cardinal Mahony, then a bishop, who knowingly reassigned him to numerous parishes throughout California—among others, used their positions as well as their charm to rape and abuse members of dozens of Catholic families over at least a 20-year period. Father Goeghan allegedly raped or fondled 150 children throughout his career. Father O'Grady's victims ranged from a 9-month-old infant to a middle-aged mother of another adolescent victim.

Astonishingly, despite ample signs and warnings as to their proclivities, the bishops of the Church have moved numerous priests (O'Grady and others) from one parish to another, covering up the reality of what was going on from both the unsuspecting members of each new community and from the police. Church documents show that beginning in 1973, these alarming deeds were done with the Church's full knowledge (U.S. Conference of Catholic Bishops, 2002). It wasn't until 1998 that O'Grady was tried, convicted, and imprisoned for 7 years and then deported to Ireland. He lives there now through the generous retirement package given to him by the Archdiocese of Los Angeles in return for not implicating the LA bishop (Baldwin et al., 2006). Father Goeghan was tried in 2003 and convicted of one count of indecent touching. He was sentenced to prison, where in 2004 he was murdered by a fellow inmate who had allegedly been molested as a child.

It is well documented that cases such as these occurred consistently throughout the history of the Church, but it wasn't until the 1980s that the rampant abuse started becoming public knowledge. This code of secrecy was a dramatic departure from the manner in which the early Church made a public spectacle of its discipline of child molesters. How did this change happen?

One explanation lies in the legal authority of the Church itself. Canon law encourages—even requires—Church leaders to engage in secrecy to prevent scandal. If a bishop suspects a cleric has committed sexual abuse, for instance, canon law mandates the bishop to conduct (or delegate) an investigation and then place the results into a secret archive. It is clear that those aware of such investigations were sworn to secrecy and risked excommunication if they spoke out (Doyle, Sipe, & Wall, 2006).

The oath a Pope receives from a bishop when he becomes a cardinal includes the promise to "never reveal to anyone whatever has been confided in me to keep secret and the revelation of which could cause damage or dishonor to the Holy Church" (Doyle et al., 2006, p. 205). With a vow such as this, it is easy to understand how the Church became so secretive, even in the face of the egregious behavior of its clergy.

The Church has also been successful in obtaining the continued secrecy of the victims by financially coercing them into believing it was best to remain silent (Doyle, 2003). Once again, the Catholic Church leaders' primary concern was the public perception of the Church, not the welfare of the innocent victims.

The basic Christian tenet of forgiveness may have also unwittingly contributed to the prevalent silence of the Church. The abusive priest often went for "treatment" at a retreat or alcoholic treatment center, came back forgiven, and was placed in another parish where no one knew of his past. The sacrament of confession was similarly used to the molester's advantage (U.S. Conference of Catholic Bishops, 2002).

In the January 6, 2002, edition of the *Boston Globe*, reporters broke the story of how the archbishop of Boston, Bernard Cardinal Law, and his predecessors had effectively allowed priests to sexually abuse children by perpetuating an elaborate and secretive damage control system that protected the Church's position in the community instead of protecting the welfare of the child victims (Rezendes, 2002). Our children were "abused twice: once by the physical assault, and then by deflection and denial tied to the holy powers of the priesthood and the needs of the clerical culture around it. Priests raped children, and the bishops protected the priests, allowing rape to happen again. And much of this occurred in the name of God" (Carroll, 2002, p. 6).

In response to the *Boston Globe*'s exposé, American bishops met in Dallas in June 2002 and again in November 2002. The reports generated from those meetings highlighted the gaps in criminal and child protection laws (U.S. Conference of Catholic Bishops, 2002). Those laws

> made it difficult, and in some instances impossible, to hold priests and their superiors accountable. The criminal laws have statutes of limitations that make it impossible to prosecute many crimes of sexual abuse because the victims do not come forward until they reach adulthood and the statute of limitations has passed. Furthermore, the child protection law only requires the reporting of abuse perpetrated by family or household members. This means that adding the position of clergy or clergy administrators to the list of person mandated to report abuse would only require

> clergy to report abuse by family or household members and would not reach the problem of abusive clergy. (Mangold, 2003, pp. 162–163)

To include abuse by clergy in the mandated reporting laws would require a much greater expansion of the reporting laws to encompass abuse perpetrated by those outside of the family structure, and outside the current authority of public child protective agencies. The child protection system has no prosecutorial authority. Moreover, "state laws are explicit as to when reports made to child protection can be shared with law enforcement." (Mangold, 2003, p. 163)

One hopes that widespread expansion of the mandatory reporting laws will be forthcoming as a result of the Catholic Church sexual abuse scandal:

> To address the problem of hidden abuse by priests (remembering almost never is there a third party to corroborate what the child says), states are examining their criminal laws and their civil child protection laws to discover what gaps can be filled. Abuse by teachers, day care providers, clergy from other religions, and others in authoritative positions (boy scouts) and private settings are examples of similar problem areas. (Mangold, 2003, p. 163)

These national efforts have delved into some of the shortcomings of secular institutions. They have not, however, translated into meaningful reform within the Church on a local level. For example, in my own community, the chancery created a board to address the allegations of abuse by the clergy. Unfortunately, they staffed it with a psychiatrist who, in my opinion, believes that sexual abuse of a child is simply inappropriate behavior and with a judge well known for his lenient treatment of rapists and child molesters, among others. These were the people handpicked by the chancery without assistance from child advocacy centers in two counties. It was clear that the Church was more interested in creating a board that would protect itself rather than creating a body of independent, highly-trained child abuse professionals who could fashion ways in which the perpetrators would be held accountable and the children would be protected.

In fact, the Vatican has recently declared new abuse guidelines and, last June during a homily in St. Peter's Square, Pope Benedict begged forgiveness from God and from the victims of child abuse by priests. He vowed that the Church would do everything in its power to ensure that it never happens again. But the guidelines and the Pontiff himself have not required the bishops to call the police when they know of or suspect a child sex crime, perhaps the single most important step a bishop could take to protect kids.

Why Priests Sexually Abuse Children

Until the mid-1960s, the Church actively recruited boys as young as 12 years for "the calling," or a vocation to the priesthood. As one of the last attendees of the minor seminary, having been schooled at the Montfort Seminary until my graduation in 1964, I believe that the institutional Church of that time created a living hypocrisy through its irrational and unrealistic views of human sexuality. How could young seminarians hope to be fully human when the Church labeled sex as evil? It was sometimes tragically impossible for them to reconcile their God-given urges with the Church's teachings. These young boys were immaturely locked within themselves, failing to develop a healthy sense of human sexuality.

The Church's stance on sexuality is hardly new. "From the earliest days, when priests were allowed to marry, we find laws telling them to avoid sex" (Doyle et al., 2006, p. 4). During the Council of Elvira, canon law (Canon 33) was enacted to prohibit married priests from having sexual relations with their wives. (Doyle et al., 2006, p. 14)

Not surprisingly, as news of the depth of the sex abuse scandal continued to spread throughout the 1990s, many academic writings on the priest abuse scandal saw the celibacy mandate at the center of the problem. While celibacy does not cause priests to abuse children, it can, especially when imposed at a tender age, stunt the normal sexual and psychological development of the young men so instructed.

Pope John Paul II did not agree. He instead blamed the scandal on the presence of evil and moral decay in America. Despite the Church's doctrine of infallibility, which states that in areas of faith and morals the Pope's words are final and cannot be challenged, it is difficult to fathom Pope John Paul II's request for forgiveness for his abusing priests, suggesting that they were the true victims, not the children (Dale & Alpert, 2007). The Church has found ways not only to protect itself but also to lead its shepherds to other untouched children. In reality, there are plenty of appropriate targets for blame, including

> …the thousands of priests who knew that others were abusing children and did nothing…the thousands who looked the other way and failed to speak out in support of the victims…the many priests who stood by in silence while their bishops ran roughshod over victims, lying to them, lying to the public and lying to the clergy because of their obsession with their image and their power…. The regiment is dishonored by those priests who have spoken out but only to voice their self-centered concern about priests' rights and the tarnished image of the priesthood brought on by "a few". (Doyle, 2008, para. 3–4)

The Church and all of these children have been "dishonored by those priests and bishops who keep trying to shift the blame to anyone but themselves with idiotic claims such as that of Madison's Bishop Morlino, who recently announced that the whole problem was caused because people didn't obey the 1968 anti-birth control encyclical Humanae Vitae" (Doyle, 2008, para. 5).

In April 2008, Pope Benedict XVI traveled to the United States and orchestrated closed meetings with five children and their families who had been abused by his priests. A far cry from Pope John Paul II's plea on behalf of the "victim" priests, it was a moving and compassionate acknowledgement of the trauma suffered by these children. There was even a sense of forgiveness in the air. Nevertheless, the process was not open enough, and absolutely no plan existed to make the bishops responsible or, more importantly, accountable. In Australia in July of 2008, the Pontiff said, "I am deeply sorry for the pain and suffering the victims have endured and I assure them and their parents that I share in their suffering" (Wooden, 2008, para. 14; Simpson, 2008). His apology was stronger in Australia than his comments in the United States, but he did not address the victims' future, and either their financial or, more importantly, psychological needs. Anthony Foster, the father of two Australian girls who were allegedly raped by a Catholic Priest during their childhood, expressed his disapproval of the Pope's actions to the press: "What we haven't had is an unequivocal, unlimited practical response that provides for all the victims for their lifetimes…. The practical response needs to include both financial help…and psychological help" (Sullivan, 2008, para. 9).

Regardless of why the sexual abuse occurred, it is clear that the "Church must change its perspective and deal with the perpetrators as child abusers who happen to be priests instead of as priests who happen to be child abusers" (Dale & Alpert, 2007, p. 71). In other words, it must focus on the criminal nature of the abuse and allow the full and open secular investigation of the allegations.

On March 19, 2010, in his Pastoral Letter of the Holy Father Pope Benedict XVI to the Catholics of Ireland, the Pope delivered what I believe to be his most powerful expression of remorse, decrying the "sinful and criminal acts and the way Church authorities in Ireland dealt with them." He stated,

> No one imagines that this painful situation will be resolved swiftly. Real progress has been made, yet much more remains to be done. Perseverance and prayer are needed, with great trust in the healing power of God's grace. At the same time, I must also express my conviction that, in order to recover from this grievous wound, the Church in Ireland must first acknowledge before the Lord and *before others* the serious sins committed against defenseless children. Such an acknowledgement, accompanied by sincere sorrow for the damage caused to these victims and their families, must lead to a concerted effort to ensure the protection of children from similar crimes in the future. (Benedictus PP. XVI, 2010, para. 4)

The Pontiff alluded to the importance of reporting abuse to civil authorities, urging the bishops to "continue to cooperate with the civil authorities" and telling abusers to "submit yourselves to the demands of justice" (Benedictus PP. XVI, 2010, para. 17), but he did not and has not since required it. As strong as this statement is, it failed to acknowledge the Vatican's failures in the manner in which it handled and continues to handle the scandal. Many believe, as I do, that he again did not address the victims' real financial and psychological needs.

While I believe in personal growth and transformation, it is hard to accept the sincerity of the Pope's words when he, as Joseph Cardinal Ratzinger, wrote and cosigned a letter to all bishops in May 2001 that asserted the Church's right to hold its child abuse inquiries behind closed doors and keep evidence confidential for up to 10 years after the victims reached adulthood. His cosignor, Archbishop Tarcisio Bertone, had previously been quoted as saying, "In my opinion, the demand that a bishop be obligated to contact the police in order to denounce a priest who has admitted the offence of pedophilia is unfounded," a position which has only recently been repudiated (Hagerty, 2010, para. 8).

In addition, it appears to me that the real impetus for the change in the Church's response to child abuse allegations has come from the increasing number of lawsuits, both civil and criminal, against both the Church and the abusing clerics as well as the media's substantially increased coverage of the scandal. According to a research study conducted by the John Jay College of Criminal Justice and authorized and paid for by the U.S. Conference of Catholic Bishops, as a conservative estimate, the Church has paid out over $500,000,000 relative to the child abuse allegations. These funds have gone to victims for the treatment of priests and for legal expenses. The study did not delineate how much the Church paid to each of these groups. Further grounds for skepticism come from the fact that during the Vatican's news conference regarding its pedophilia scandal in July 2010, it cited the movement for the ordination of women as offensive as the scandal of priests who sexually assault children (Donadio, 2010).

Professional Response

We are obliged not only to help heal the trauma of our child patients' abuse but also to protect them from disease and violence. We do this by conducting thorough and forensically sensitive evaluations, which in the medical world involve the SOAP (S-subjective, O-objective, A-assessment, P-plan) process. Often the objective portion of the physical examination is unremarkable, especially if the child is seen many years after the abuse or after he or she has become sexually active. Probably the most critical portion of that exam is the subjective portion because it is often

here that the diagnosis of sexual abuse is more evident. It is essential that one ask the correct questions. These include, among others, "Why are you here today? What can we do to help you? Has anyone touched you in any place that they shouldn't? Where are those places? Has anyone asked you to keep it secret? Are you worried about yourself or your body?" These open-ended questions are helpful to the child's healing process and when asked for the purpose of making a diagnosis may be admitted in a court of law as an exception to the hearsay law.

As professionals responding to child maltreatment, we routinely see children who have been victimized by the more powerful. We know that the detection and investigation of child abuse is typically hindered by secrecy and delayed, incomplete disclosures. These are often the direct result of the child and parents' feelings of fear, denial, and betrayal. How does the victim of sexual abuse by a priest differ from a victim of abuse by another? Should our responses differ? Abuse by a member of the clergy is not only a personal and emotional betrayal, but a spiritual betrayal as well. The secrecy typically seen in child abuse cases is amplified by the unprecedented and systemic cover-up committed by the Church hierarchy. This includes every type of tactic from public attacks on the credibility of the child victim to the payment of hush money to the child's family. The need for sensitivity and thoroughness during the evaluation is particularly keen. The need for mental health treatment must be carefully determined. The mutlidisciplinary teams created to protect children in each county should take an active, compassionate, nonjudgmental role in assisting the diocese and their community through this difficult time. Child advocacy centers are well positioned to act in that capacity. There are now 746 child advocacy centers the United States. Not long ago, there was none.

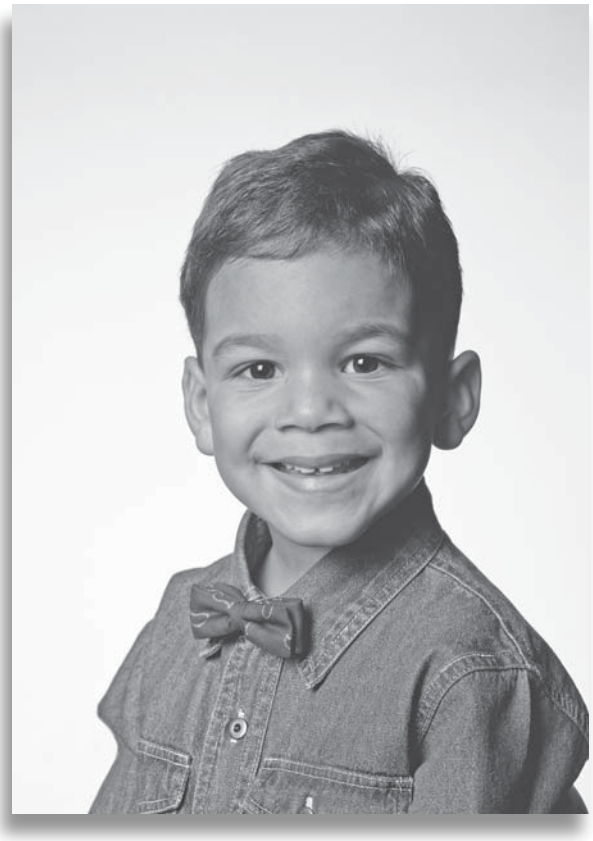
We anticipate that collaborative teams such as child advocacy centers will motivate and mobilize federal activity as happened in the 1960s when all 50 states passed reporting laws before federal action created the Child Abuse Prevention and Treatment Act {CAPTA) of 1974. No matter what the basic framework, collaboration must be employed to protect our children. There can be no more secrets on any level.

Susan Vivian Mangold suggested four points to guide the reform. I believe it is the mandate of the collaborative team (district attorney, child protection system, police, and medical, mental health, and crisis services) to make this happen, and the physicians' response should be loud and clear:

> First, the mandated reporting system must be expanded not only to require clergy to be mandated reporters but to require that all mandated reporters to report abuse by those in professional positions over children, such as teachers, day care providers, camp counselors, and clergy. Second, reports of abuse by perpetrators outside of the family or household should be referred to law enforcement, not just child protective services, for investigation, but only after the child's parents have been notified. Third, criminal records involving child abuse should be maintained by statewide central registries, just as with records of abuse perpetrated by family or household members. Finally, penalties for failure to report abuse must be enforced and should include civil as well as criminal penalties. This already applies to physicians, but seldom do we see the District Attorney charging those physicians who do not report abuse. When this changes, so will their behavior. (Mangold, 2003, pp. 176–177)

The Catholic Church child sexual abuse scandal has actually given us a window of opportunity. With the reforms generated by our multidisciplinary teams and, we hope, spearheaded by child abuse professionals, we can create a more protective environment for children without further overtaxing the child protection system or harming parents or families already suffering due to the abuse of a child.

Since the 1960s, our child protective laws have taken the side of protecting children, requiring that reports be made to authorities whenever there is a *reasonable cause* to suspect abuse. The current system places the names of individuals in state registries whenever



there is *credible evidence* that they have committed abuse against a child. This system is duplicated in all 50 states. Concerned citizens must alert their legislatures that they want their state laws to protect all children. Only with such laws in place will Church policies, which require bishops to follow canon law, have any meaning. Such laws will afford priests the same due process rights that we all receive. Such laws will better protect children and thereby begin to put an end to this tragic chapter in the history of the Catholic Church.

Conclusions

So much has gone unseen—such pain, trauma, and loss of innocence. The church has kept secrets, lied, and made children wrong, guilty, and hopeless. It has created such horrendous, adverse childhood experiences that even the money and forgiveness (which have been short in coming) will likely make no difference in their lives now.

I believe we have a unique opportunity here. Every week, I see up to 12 children in our community who have been sexually abused by a trusted or loved one. As an ordained Roman Catholic priest, I believe our spiritual leaders cannot be allowed to investigate themselves. They need to be held responsible by more than just words, and under no circumstances are they to be moved somewhere else. While secretive boards and tribunals can declare abusers forgiven, these bodies cannot and should not be allowed to declare their fellow priests no longer a threat to the children of their parishes. I find it reprehensible that our priests need a law ordering them to allow civil authorities to do their job. Open investigation should be the Church's innate response so we will have no more adult survivors, but children who can begin to heal because our society and our church have become therapeutic, not secretive.

The Church needs to show compassionate leadership, not only by asking for forgiveness and taking responsibility for the pain their priests have caused but also by assuring us that those who have sexually abused children will never do it again. I believe that the Church is obliged to strip these people of their authority and properly utilize our civil authorities to prosecute accordingly. It's time to devote our energies to the healing process and psychological needs of the victims. The Church needs to embrace a "No Tolerance" philosophy for any form of abuse. That posture alone will bring moral leadership to the Church and to its many charismatic and dedicated priests who have devoted their lives to help us all to better love and serve each other.

Christ asked the children to come to Him. What pain He must have endured to realize His representatives (priests and bishops) would hurt them so. The Catholic Church needs our help. We are uniquely poised, by virtue of our experience and training, to assist the Church in this process. The reward is nothing less than the future health and happiness of the children we serve.

References

Baldwin, R., Brown M., Ortenberg, T. (Producers), & Berg, A. (Director). (2006). *Deliver us from evil* [Motion picture]. New York: Lionsgate.

Benedictus PP. XVI. (2010). Pastoral letter of the Holy Father Pope Benedict XVI to the Catholics of Ireland. Retrieved from: http://www.vatican.va/holy_father/benedict_xvi/letters/2010/documents/hf_ben-xvi_let_20100319_church-ireland_en.html

Carroll, J. (2002). *Toward a new Catholic Church: Promise of reform*. New York: Houghton Mifflin.

Dale, K., & Alpert, J. (2007). Hiding behind the cloth: Child sexual abuse and the Catholic Church. *Journal of Child Sexual Abuse, 16*(3), 59–74.

Donadio, R. (2010, July 15). Vatican revises abuse process, but causes stir. *New York Times*. Retrieved from: http://www.nytimes.com/2010/07/16/world/europe/16vatican.html

Doyle, T. (2003). Roman Catholic clericalism, religious duress, and clergy sexual abuse. *Pastoral Psychology, 51*(3), 189–231.

Doyle, T. (2008, August 16). *Dishonoring my regiment: A response and reflection*. Retrieved from: http://reform-network.net/?p=1919

Doyle, T., Sipe, A., & Wall, P. (2006). *Sex, priests, and secret codes*. Los Angeles: Volt Press.

Hagerty, B. (2010, April 12). Vatican: Bishops must report alleged abuse to police [National Public Radio]. Retrieved from: http://www.npr.org/templates/story/story.php?storyId=125866557

Investigative Staff of the *Boston Globe*. (2002). *Betrayal: The crisis in the Catholic Church*. Boston: Little, Brown.

Mangold, S. (2003). Reforming child protection in response to the Catholic Church child sexual abuse scandal. *University of Florida Journal of Law and Public Policy, 14*(2), 155–178.

Rezendes, M. (2002, January 6). Church allowed abuse by priests for years. *Boston Globe*. Retrieved from: http://www.boston.com/globe/spotlight/abuse/stories/010602_geoghan.htm

Rosetti, S., Anthony, P., Cimbolic, P., & Wright, T. (1996). Development and preliminary validation of the MMPI–2 scale for same-sex priest child molesters. *Sexual Addiction & Compulsivity, 3*(4), 341–356.

Sullivan, R. (2008, July 20). Pope 'sorry' for child abuse by Australian clergy. *Scotland on Sunday*. Retrieved from: http://scotlandonsunday.scotsman.com/abuseinthecatholicchurch/Pope-39sorry39-for-child-abuse.4306234.jp

U.S. Conference of Catholic Bishops. (2002). *The nature and scope of the problems of sexual abuse of minors by Catholic priests and deacons in the United States*. Washington, DC: John Jay College Research Team. Retrieved from: http://www.usccb.org/nrb/johnjaystudy/

Wooden, C. (2008, July 20). Pope apologizes to Australians for 'betrayal' of clergy sex abuse. *Catholic News Service*. Retrieved from: http://www.catholicnews.com/data/stories/cns/0803761.htm

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The Case for the Credentialing of Forensic Interviewers

Michael L. Haney, PhD, Victor I. Vieth, JD, Hector M. Campos, MSW, LCSW

Introduction

A number of child protection leaders and organizations have held discussions or even offered proposals for the credentialing or certification of forensic interviewers. For example, the American Professional Society on the Abuse of Children (APSAC) has recently issued a statement on the development of a Diplomate status for forensic interviewers (APSAC, 2010). APSAC has worked with national partners who provide training and research in the discipline of forensic interviewing and with a number of state forensic interview training programs.

In 2007, with the assistance of the American Prosecutors Research Institute, APSAC conducted a national survey of front-line child protection professionals. Of the 589 professionals responding to the survey, 88.9% agreed or strongly agreed that the "creation of a Diplomate program in child forensic interviewing is beneficial to the field" (Haney, Conte, Berson, & MacFarlane, 2008). Only 8.7% of the respondents were neutral to the idea, and only 2.4% disagreed or strongly disagreed. A solid majority of the respondents believed that a Diplomate program should recognize the achievement of advanced standards (77.9%), should be based on years of experience (58.1%), and should require continuing education (91.8%). Nearly 90% of the child protection professionals expressed confidence that if front-line forensic interviewers are involved in the development of the Diplomate program, and if the program develops gradually and is based on research that it "is a good idea for the field." However, 60% of the respondents expressed the view that a Diplomate status, standing alone, "would negatively impact the perceived competence of interviewers who do not have Diplomate status."

In keeping with these results and myriad discussions, Dr. Mike Haney gave several national presentations suggesting the development of a national organization of forensic interviewers that will establish a base floor for all forensic interviewers but will support these professionals in reaching much more advanced standards (Haney et al., 2008). Dr. Haney suggested this membership organization be affiliated with APSAC and that it develop a code of ethics for forensic interviewers. Although APSAC has not yet formally endorsed this concept, it is one of several possibilities being considered in the long term.

At an APSAC forum on credentialing held in San Diego in January of 2008, the National Child Protection Training Center (NCPTC) distributed a paper proposing a multi-tiered credentialing process with Diplomate status as the top tier (Vieth, 2010). In that paper, NCPTC also proposed that front-line forensic interviewers be responsible for developing standards in the field, including the development of an ethical code. In a letter to APSAC in 2009, 13 of the 16 *ChildFirst/Finding Words* state forensic interview training courses expressed support for a multi-tiered credentialing process as proposed by NCPTC.

The National Association of Certified Child Forensic Interviewers (NACCFI) is another organization that has proposed the development of standards for the field of forensic interviewing. Specifically, NACCFI has proposed a certification of forensic interviewers who have completed recognized forensic interview training programs, who are actively engaged in the work of forensic interviewing, who are participating in peer review, who agree to adhere to a code of ethics, and who pass a competency examination.

There are many similarities among the NCPTC, NACCFI, and Haney proposals. Accordingly, Dr. Haney and leaders from NCPTC and NACCFI worked together to harmonize these ideas and develop a multi-tiered credentialing proposal that recognizes basic standards for the field but also allows forensic interviewers to grow professionally. The multi-tiered credentialing proposal was later presented at two national conferences: the "When Words Matter" conference in Savannah, Georgia, and at the "Dallas Crimes Against Children" conference in 2010. For the forensic interviewers and child protection professionals who could not attend these presentations, the workshop was also offered online to approximately 500 child protection professionals. NACCFI also developed an online survey which NCPTC distributed to an e-mail list of over 9,000 front-line child protection professionals.

This paper provides an outline of the multi-tiered credentialing process NACCFI proposes, summarizes the response from front-line professionals who responded to the NACCFI survey on credentialing, offers some thoughts on the benefits of a credentialing process, and responds to some of the concerns raised by several national leaders as well as front-line professionals.

The NACCFI Multi-tiered Credentialing Process

As a starting point for the discussion, we present the outline of the multi-tiered credentialing process, which is similar to what NCPTC proposed at an ASPAC forum and which has largely been adopted by NACCFI. This outline is not necessarily the final proposal because, at the time of this writing, NACCFI continues to receive input from the field. However, the proposal is offered here simply to give some context to the discussion and to otherwise facilitate a more meaningful dialogue. Readers are advised to visit the NACCFI web site for details of the proposal and for updates on the process.

1. Basic forensic interviewing credential

To create uniformity in the field, the basic credential should be compatible with the forensic interviewing credentials currently in place for Children's Advocacy Centers (CAC) accredited by the National Children's Alliance (NCA). NCA requires that forensic interviewers working at a CAC successfully complete 40 hours of state or nationally recognized forensic interview training or, at the very least, that these interviewers document "satisfactory completion of competency-based child abuse forensic interview training that includes child development" (NCA, 2008). Moreover, other MDT members must be "routinely present" for the interviews, and interviewers must participate in a "formalized peer review process." NACCFI proposes a compatible standard for all forensic interviewers, whether or not they conduct their work in a CAC. In addition, interviewers must also adhere to an ethical code developed for the field of forensic interviewers by the forensic interviewers themselves. Finally, these interviewers must have three letters of endorsement from multi-disciplinary team members.

2. Intermediate forensic interviewing credential

In addition to the completion of a state or nationally recognized forensic interviewing course, a forensic interviewer applying for this credential must complete an additional 40 hours of advanced course work on forensic interviewing, have conducted at least 25 forensic interviews, and have participated in at least one peer review process in which one or more of the applicants' interviews were critiqued. The forensic interviewer must again sign an acknowledgment of ethical guidelines pertaining to this work, and his or her agreement to abide by these guidelines. Finally, the interviewer must take and complete a nationally accepted examination documenting that the interviewer has acquired basic knowledge relevant to forensic interviewing.

3. Advanced forensic interviewing credential

In addition to the basic forensic interview training, an applicant for this credential must have completed a minimum of 80 hours of advanced course work on forensic interviewing, have conducted at least 100 forensic interviews, and participate in a quarterly peer review process. The forensic interviewer must again sign the acknowledgment pertaining to ethical standards.

4. Diplomate in forensic interviewing

In addition to the completion of basic forensic interview training, an applicant for Diplomate status must have completed a minimum of 160 hours of advanced training on forensic interviewing. The applicant must have conducted a minimum of 500 forensic interviews and must document continued participation in a quarterly peer review process. The forensic interviewer must continue to acknowledge an understanding of and adherence to ethical guidelines. Finally, and most important, the applicant must submit three transcripts or videotapes of forensic interviews conducted in at least 3 different years, for blind review by an expert panel. The panel, appointed by the body overseeing the credentialing process, must consist of practicing forensic interviewers who have conducted a minimum of 500 forensic interviews and who utilize different forensic interviewing protocols. The reason for a panel of experts utilizing different protocols is to avoid a process that endorses primarily one model over another but adopt one that instead focuses on acceptable practices in the field of forensic interviewing. The reason that the three transcripts or videotapes be from different years is to provide some evidence that the applicant has maintained excellence over an extended period of time.

The NACCFI Survey

To assist front-line child protection professionals in offering input on the credentialing process, NACCFI developed an online survey and e-mailed a link to the survey to approximately 9,500 front-line child protection professionals from all 50 states. Approximately 2,500 recipients clicked on the link to survey and, of these, 720 professionals took the full survey. There were several important findings:

1. The vast majority of respondents were front-line professionals, most of them actively practicing as forensic interviewers

Specifically, 79.6% of the respondents were currently practicing as forensic interviewers, and only 4.8% of the respondents had never practiced. Since front-line forensic interviewers are the subject of a credentialing process, the large response from current professionals may be the best data we have thus far in assessing support for credentialing from those in the field.

2. The respondents came from all regions of the country

Respondents came from 48 states plus the District of Columbia and Puerto Rico and closely paralleled the number of accredited children's advocacy centers in each region. The federal government funds four regional children's advocacy centers to oversee the growth of CACs in the United States (Chandler, 2006). The correlation between the percentages of respondents from each region of the country and the percentages of CACs in those regions strongly suggests the survey was dominated by forensic interviewers and other multidisciplinary team members affiliated with or otherwise influenced by the growth of CACs in their regions.

3. Forensic interviewers taking the survey came from CACs, law enforcement agencies, and child protection agencies

Of the respondents to the survey who stated they were actively practicing forensic interviewers or had done so in the past, 60.4% said this work was done as part of a CAC, 19.1% as a part of a CPS agency, and 16.9% as part of a law enforcement agency. Approximately 40% of the respondents were conducting forensic interviews as part of another agency.

4. Forensic interviewers taking the survey had diverse levels of experience

To be widely accepted in the field, a credentialing system will need to generate support from interviewers with various levels of experience. The respondents to this survey did, indeed, have diverse levels of experience. Specifically, 41.2% had conducted 0–100 forensic interviews, 41.2% had conducted 100–1000 forensic interviews, and 17.6% had conducted more than 1,000 forensic interviews.

5. Survey respondents had diverse educational backgrounds

Again, to gauge whether or not there is widespread support in the field, it is critical to get input from professionals with diverse backgrounds. In terms of educational background, 10.8% had a high school or associate of arts degree, 36.3% had a bachelor's degree, 44.4% had a master's degree, and 7.3% had a doctoral degree.

6. More than 90% of the respondents to the survey could meet basic or advanced credentialing standards pertaining to training

One of the concerns about credentialing is that the proposed standards on training would not be attainable for many in the field. The vast majority of respondents to this survey had the experience and training levels necessary to meet the proposed standards. Specifically, 6% had no FI training, 44.2% had 40 hours, 24.5% had 50–80 hours, 14.3% had 90–160 hours, and 9.5% had more than 160 hours.

7. The vast majority of respondents support credentialing and basic tenets of the credentialing process proposed by NACCFI

The following percentages of respondents agreed with these statements:

- Credentialing would benefit the field (81.1%)
- Credentialing should be only for practitioners (79.8%)
- There should be an "Inactive" status for those who have not practiced for more than 2 years (75.1%)
- That experience as a forensic interviewer and participation in peer review "stand out as being more equated" to effective practice than "higher levels of education" (75.7%)
- That participation in a formalized peer review process should be a requirement for credentialing (80.8%)
- That there should be an ethical code for forensic interviewers (93.8%), that applicants should have no felony convictions within the past 10 years, and any conviction or arrest history related to crimes against children or any substantiation by a CPS agency for child maltreatment automatically disqualifies an applicant (92.1%)
- That all categories of credentialing should require three professional endorsements by colleagues (84.5%)
- That passing a competency examination should be required even for the basic credential (70.9%)
- That the initial 40 hours of training should be received from a "nationally recognized training organization, agency, or trainer," and that advanced training should also meet this criteria (88.7%).

8. A large percentage of respondents supported the number of training hours and actual forensic interviews required for each of the four credentialing tiers

In terms of the actual number of training hours needed to meet each credential, the largest percentage for each credential matched our original recommendation of 40 hours for the basic credential (52.7%), 80 for the intermediate (56.9%), 120 for the advanced (51.4%), and 160 for the Diplomate status (40.2%, although a solid 26.6% said it should be 240 or more hours of forensic inter-

view training). In terms of the actual number of forensic interviews conducted for each credential, the largest percentage of approval for each credential matched our original recommendation of 0 for the basic credential (35.9%), 25 for the intermediate (29.3%), 100 for the advanced (38.6%), and 1,000 for the Diplomate status (35.5%, although a solid 25.7% said 500 or more forensic interviews would be sufficient for this credential). NACCFI has subsequently lowered the number of interviews for its Diplomate status to 500. Although there is some aspect of arbitrariness to setting numbers of training hours or actual interviews, the response to the survey suggests that the NACCFI proposal is within the range of what will be widely accepted in the field.

The Case for the Credentialing of Forensic Interviewers

Whatever the final credentialing process looks like, there are at least ten strong arguments for moving in this direction:

1. In cases of child sexual abuse, the competence of forensic interviewers may be more important than the competence of any other member of the multidisciplinary team

Although the taking of a child's statement is important in all cases of child abuse, the taking of the child's statement is critical in cases of sexual abuse. In a case of physical abuse or a homicide, the child's brain, eyes, bones, and skin provide the crucial evidence. In sexual abuse, the child's body rarely produces evidence (Heger et al., 2002). Instead, the child's words are most critical. It is from these words that police officers can search for corroborating evidence, child protection workers can better assess the risks the child is facing, medical professionals can assure the child that his or her body is intact, mental health professionals can help a child cope with the emotions associated with child maltreatment, and prosecutors can prove an allegation in a court of law (Johnson, 2009; Vieth 2009a). Without the child's words, the work of every other member of the team is muted, if not wholly irrelevant. In the event the case results in civil or criminal proceedings, the child's words and the collection of these words are closely scrutinized by court and counsel and by thousands of jurors old enough to remember the high-profile day-care cases of the mid-1980s and who are worried that little has changed (Hechler, 1988).

Moreover, there is little dispute that it is possible to taint a child's memory (Ceci, 1999). For the sake of the accused, the forensic interviewer must be competent—and then some. It is also not disputed that some children, no matter how poorly they were interviewed, may be truthfully and accurately recounting a history of child sexual abuse (Russell, 2009). The statements of these children should not be tossed out of prosecutors' offices or from courts of law, and their abusers should not be set free simply because the child had the misfortune of being interviewed by an investigator poorly trained or otherwise poorly equipped to collect this evidence. A national credentialing of forensic interviewers—a credentialing that requires a base level of training, ongoing training, actual work in the field, peer review of that work, and a testing of knowledge does not eliminate incompetence in the field, but it will ensure every maltreated child that the person who interviews him or her at least meets minimal standards.

2. Credentialing will establish not only minimal standards for entry into the profession of forensic interviewing—but also minimal continuing education standards for remaining in the profession

Credentialing is also a mechanism to ensure that practitioners not only meet minimal standards but also continue to receive training or otherwise access resources that will help them grow professionally. To meet the intermediate, advanced, or Diplomate status, forensic interviewers must attend continuing education specifically pertaining to forensic interviewing, as well as ongoing peer review and adherence to an ethical code. The requirement of ongoing training is a characteristic of most of the members of MDTs, including prosecutors (Minnesota Board of Continuing Legal Education, 2011), social workers, and law enforcement officers. Given the critical nature of remaining current in this field, forensic interviewers should also develop and adhere to continuing education standards.

3. Credentialing will not only assist in establishing minimal standards for entering or remaining in the field—but it will also assist in developing an ethical code for the profession

If forensic interviewers are also psychologists or members of some other profession, they have some national standards, many of them strictly enforced, governing their ethical behavior. However, there are not any national ethical standards specifically pertaining to the work of forensic interviewers. Standards designed for a psychologist, social worker, or some other profession may be of assistance to the forensic interviewer, but they will not help the interviewer in many instances. In developing an ethical code for forensic interviewers, it will not be necessary to start from scratch. Forensic interviewers who are members of the American Professional Society on the Abuse of Children (APSAC) must adhere to the APSAC *Code of Ethics* (Conte & APSAC, 1997). This code requires APSAC members to "routinely receive supervision, consultation, or counsel with more experienced colleagues or peers" and to have their work "subjected to periodic review, evaluation, or consultation." APSAC members are also prohibited from representing themselves to "hold expertise, knowledge, or qualifications which they do not in fact possess, including when providing expert testimony, writing, or providing education to professionals or lay persons alike." Moreover, APSAC members must act in compliance with applicable laws and regulations and "will participate at least annually in high-quality professional education" (Everson & APSAC, 1995).

The NACCFI has an ethical code that requires its members to participate in "ongoing training, supervision, and peer review of their interviews." The ethical code also addresses the usage of foreign language interpreters, interview aids, the security of the forensic interview tape, and handling conflicts of interest. The ethical code promotes the interviewing of children in child friendly environments, to conduct forensic interviews in the language the "child knows best," and to avoid "stereotyping, profiling, or discriminating" against children or others on the basis of "gender, age, handicap, ability, economic status, family structure, lifestyle, ethnicity, religion, language, culture, national origin, or sexual orientation" (NACCFI, 2011). The ethical code prohibits forensic interviewers from becoming "sexually, physically, or romantically involved" with the children or families they work with even if the child or family member is of legal age. An NACCFI forensic interviewer is not allowed to "withhold, alter, influence, coerce, or falsify information for the purposes of affecting the outcome of an interview or a case" (Russell, 2010). The NACCFI code also provides interviewers guidance on what to do when a fellow team member is engaging in unethical conduct.

The existing APSAC code of ethics and the proposed NACCFI code of ethics provide the basis for at least developing a minimal code of ethics for front-line forensic interviewers. As the field grows, the code of ethics can expand or otherwise adapt to emerging ethical issues the field faces. In our judgment, the key is for front-line interviewers themselves, those who actually do the work and who confront these issues, to take a leadership role in the ongoing development of this code of ethics.

4. Credentialing that includes the development of an ethical code may also assist in removing unethical practitioners from the field

The development of an ethical code will not only assist those practitioners actively seeking to maintain high ethical standards, but it may also provide a mechanism for sanctioning or revoking the credentials of those who consciously choose to engage in unethical behavior. Although this sort of conduct is rare—as is egregious conduct for most professions—the point is that other professions have a mechanism for revoking the credentials of those who insist on engaging in unethical behavior. It is in the best interests of children for the field of forensic interviewing to follow the lead of the other professions who make up our MDTs and to develop an ethical code. An ethical code, combined with some mechanism for enforcement, will also assist in reigning in less egregious but equally troubling behavior—such as by those who refuse to interview children in a child friendly, neutral environment or who claim that peer review is pointless and simply choose not to participate. Although removing these individuals from the ranks of those interviewers who are credentialed may not necessarily cause their behavior to stop, it will allow those who maintain the standard to clearly distinguish themselves from those whose conduct is concerning, if not blatantly unethical.

5. Credentialing will extend the minimal standards in place at CACs to all interviewers and will provide recognition for forensic interviewers who exceed minimal standards

The National Children's Alliance, the body that accredits children's advocacy centers, recognizes the critical role of the forensic interview, especially in cases of sexual abuse. Specifically, the NCA accreditation standards provide the following:

> Forensic interviews are typically the cornerstone of a child abuse investigation, effective child protection, and subsequent prosecution, and they may be the beginning of the road toward healing for many children and families. The manner in which a child is treated during the initial forensic interview may significantly impact the child's understanding of, and ability to respond to, the intervention process or criminal justice system, or both. Quality interviewing involves

> an appropriate, neutral setting; effective communication among MDT members; employment of legally sound interviewing techniques; and the selection, training, and supervision of interviewers.

Interviews must be conducted in a manner that is "legally-sound, non-duplicative, non-leading, and neutral," other MDT members must be "routinely present," the interviews should be "routinely conducted" at the CAC, and forensic interviewers must receive at least 3 hours of continuing education every 2 years and participate in a "formalized peer review process." Moreover, a multi-tiered credentialing program will also recognize those forensic interviewers both in and outside of CACs who have far surpassed these minimal standards.

6. A credentialing association made up of practicing forensic interviewers will ensure that standards for the field are determined by those who actually do the work

The prosecutors, law enforcement officers, social workers, psychologists, and medical professionals serving on our MDTs have developed independent credentialing or licensure standards, including an ethical code for their respective professions. These professions publish journals specifically related to their work and otherwise grow their respective fields separate and apart from the other disciplines with which they work. These and other medical, mental health, and legal professions do not allow others from outside their disciplines to determine the standards for their respective professions. This is not the case in the field of forensic interviewing. In the field of forensic interviewing, we routinely have doctors, lawyers, psychologists, researchers, linguists, and college professors—most of whom have never conducted a forensic interview—routinely publishing articles, offering workshops, or even testifying in court as to what are the best practices in the field of forensic interviewing (Vieth, 2009b).

This is not to say that other disciplines do not play an important role in the forensic interview process as a great many disciplines have a role in the forensic interview process and their input is critical. Although forensic interviewers must draw upon the expertise of these and many other professionals, and they must ensure that the forensic interview meets the needs of the team members, it is the forensic interviewers themselves who should determine the minimal credentials for beginning or continuing to work in this field. If not, they run the risk that the standards for their field will be dictated by those who do not actually work as forensic interviewers.

7. Credentialing may be helpful to the prosecutor in qualifying a forensic interviewer as an expert witness

A decade ago, the idea of having a forensic interviewer testify as an expert witness in a court of law was simply unheard of. Largely as a result of the growth of national and state forensic interviewing courses, appellate courts from at least ten different states have considered this issue for the first time and, with only a handful of exceptions, these courts have ruled that forensic interviewers meeting certain standards can testify as an expert. For those prosecutors who want the option of qualifying the forensic interviewer as an expert witness, a credible credentialing process will help make the case. Although the process of qualifying a forensic interviewer as an expert witness is complicated and varies from state to state, essentially the prosecutor has to prove that forensic interviewing techniques have been published and subjected to peer review, that the techniques have been tested, that forensic interviewing is widely accepted in the field, that there is a known or potential error rate, that there is some commonality among interviewing protocols*, and that there are national standards or guidelines governing forensic interviewing.*

Of course, even without these standards, prosecutors and interviewers have a lot of options. Forensic interviewers working in a CAC can and should cite the NCA standards and members of APSAC can cite that organization's forensic interviewing guidelines (Everson et al. & APSAC, 2002) as well as the ASPAC guidelines on the usage of anatomical dolls (Everson & APSAC, 1995).

8. Credentialing may assist the prosecutor in limiting or excluding the testimony of defense experts

A credible credentialing process will aid the prosecutor in arguing to trial and appellate courts for the exclusion or at least limiting of the testimony of defense "experts" who have never conducted a forensic interview. If defense attorneys still wish to call various psychologists, researchers. or other academics to the witness stand, their testimony should be limited to their field of expertise. In other words, a psychologist may be able to talk about how memory is coded, retained, or retrieved or any other issue pertaining to a child's statement provided it is within the professional's expertise. However, the psychologist should not be testifying as to best practices or even current practices in a field he or she is not part of. If forensic interviewing evolves into its own profession, complete with ethical and other standards, this may limit if not exclude the testimony of many defense experts. There is some indication that appellate courts are willing to limit the testimony of experts if the case can be made that an expert is not directly involved in the work of forensic interviewing or is otherwise unfamiliar with specific interviewing protocols or other specific tools or work conducted for an interviewer.

9. Credentialing is as important to the children of tomorrow as it is to the children of today

In considering the issue of credentialing, it is important to think not only about the children we are currently working with or may be working with in the immediate future. It is also critical to think of children who may be referred for a forensic interview decades from now. If credentialing had been developed 20 years ago, we would have a much better sense of what does or doesn't work in terms of establishing minimal standards or reigning in negligent or even unethical behavior. Although any credentialing process we begin today will be flawed, it will nonetheless allow us

to discern these flaws and improve the system for the next wave of maltreated children. If we wait until that next generation is upon us, we may be largely starting from scratch again.

10. This is the generation ideally qualified to develop a credentialing process

We still have in our field professionals old enough to remember the day care cases of the mid-1980s and who were on the forefront of developing children's advocacy centers, multidisciplinary teams, and national and state forensic interviewing courses (Hechler, 1988; Chandler, 2006). A large body of the research on forensic interviewing, including most of the best research, has been conducted by researchers who are currently still with us. This is an ideal time to draw upon our shared experiences and seize this moment in history. We may not get it exactly right, but surely we have the capacity to develop the field of forensic interviewing as a profession or at least a very unique skill that requires the development and adherence to minimal standards.

Addressing Concerns About Credentialing

As the debate about credentialing has unfolded, child protection professionals have raised a number of valid concerns. Two of the most commonly raised concerns are as follows:

1. Will a credentialing process hurt those forensic interviewers who cannot meet the standards?

This is a valid concern, particularly if the only tier of the credentialing process were the Diplomate status we have discussed. However, in establishing an initial tier that is compatible with the existing NCA standards, this is something that can be obtained by nearly every child protection professional in the United States. Indeed, in a recent survey of CACs, *all* of the forensic interviewers responding to this survey had been trained through at least one of the major national or state forensic interviewing courses, and more than 80% were participating in peer review (Regional Children's Advocacy Center, 2009). If the concern is that interviewers who fail to meet even the minimal standards set by the NCA will be attacked, this issue is already upon us. Since the NCA standards are already in place, these standards can be used to attack forensic interviewers both in and outside of CACs who fail to receive quality forensic interview training, who fail to participate in peer review, or who otherwise fail to adhere to better practices in the field. In other words, the multi-tiered credentialing process outlined in this paper does not give attorneys an attack they don't already have.

It is also important to make a distinction between those who cannot meet minimal standards and those who choose not to. Although we can and should do everything possible to expand training options for those who cannot currently take advantage of these opportunities, we should not be protective of those forensic interviewers who have these opportunities available to them but choose not to take advantage of them. Finally, and most important, MDTs need to recognize that attorneys will attack the field of forensic interviewing no matter what decisions the field makes. Those who oppose credentialing because they fear a defense attack may be surprised when they are cross examined for being part of a field that currently has no national association, no ethical code, and no minimal standards applicable to all who call themselves forensic interviewers. It is true that forensic interviewers who meet only minimal standards will be attacked by defense counsel for not having met intermediate or advanced standards. This, though, is true for every profession. A treating physician may be attacked for not being board certified in a certain field. A pediatrician may be attacked for not meeting the criteria for certification as a child abuse subspecialist. Each of these professionals, though, is still able to meet enough national standards to have some measure of credibility in courts of law. Similarly, a forensic interviewer who has not yet had enough experience or training to be recognized as a Diplomate in the field will nonetheless be able to say he or she meets national standards to work in this field.

2. For MDTs that have limited resources, is it not better to put money into training and peer review as opposed to a credentialing process?

MDTS can and should put their dollars into high-quality forensic interview training and peer review. Having said this, teams that make this investment should be recognized for having put more resources into the growth of their forensic interviewers. Simply put, a team that sends its forensic interviewer to a 2-hour workshop should not be placed in the same category as a team that has sent its forensic interviewer through hundreds of hours of basic and advanced training and that has participated in dozens of peer reviews. Moreover, a national association of forensic interviewers that collects a modest fee from its members may actually save these teams money, provided that some of this money can be used to develop more training options and to lower the costs associated with existing trainings. NACCFI is very much aware of limited resources in the field and, working with each of you, is committed to developing a credentialing process that does not unfairly burden front-line professionals. Consistent with what APSAC has done for its members, a sliding fee scale may be appropriate.

Conclusion

In recent decades, forensic interviewing has dramatically improved in the United States. The growth of Child Advocacy Centers and the development of numerous national and state forensic interviewing courses incorporating pertinent research have made a significant difference in the quality of these interviews and in the lives of the children for whom this is all about. It is for this reason that many forensic interviewers believe the field is ready to take the next step in developing forensic interviewing as a profession, complete with an ethical code and other standards for the field. If this is, indeed, the consensus of forensic interviewers, then it is important to develop an infrastructure that will give these interviewers the opportunity to take this next step.

References

American Professional Society on the Abuse of Children (APSAC). (2010, Fall). APSAC's position on forensic interviewer certification. *APSAC Advisor, 22*(4), 31.

Ceci, S. J. (1999). *Jeopardy in the courtroom: A scientific analysis of children's testimony*. Washington, DC: APA.

Chandler, N. (2006). Children's advocacy centers: Making a difference one child at a time. *Hamline Journal of Public Law & Policy, 28*(1), 315–337.

Conte, J., & American Professional Society on the Abuse of Children (APSAC). (1997). *Code of ethics* [Practice Guidelines]. Elmhurst, IL: APSAC.

Everson, M., & American Professional Society on the Abuse of Children (APSAC). (1995). *Use of anatomical dolls in child sexual abuse assessments* [Practice Guidelines]. Elmhurst, IL: APSAC.

Everson, M. et al., & American Professional Society on the Abuse of Children (APSAC). (2002). *Investigative interviewing in cases of alleged child abuse* [Practice Guidelines]. Elmhust, IL: APSAC.

Haney, M. L., Conte, J., Berson, I., & MacFarlane, K. (2008, June). *Diplomate in forensic interviewing*. Paper presented at APSAC Colloquium, Phoenix, AZ.

Hechler, D. (1988). *The battle and the backlash*. New York: Macmillian.

Heger, A. H., Ticson, L., Velasquez, O., & Bernier, R. (2002). Children referred for possible sexual abuse: Medical finding in 2384 children. *Child Abuse & Neglect, 26*(6–7), 645–659.

Johnson, M. (2009). The investigative windows of opportunity: The vital link to corroboration in child sexual abuse cases. *CenterPiece, 2*(9), 1–4.

Minnsota Board of Continuing Legal Education. (2011). *Rules of the Minnesota State Board of Continuing Education.* Retrieved from: www.mbcle.state.mn.us

National Association of Certified Child Forensic Interviewers (NACCFI). (2011). *Code of practice principles, standards, and ethical conduct*. Retrieved from: www.naccfi.com

National Children's Alliance (NCA). (2008). *Standards for accredited members* (Revised). Available at: http://www.nationalchildrensalliance.org

Regional Children's Advocacy Centers. (2009). *Forensic interviewing practice survey*. Huntsville, AL: Author. For a copy, contact the National Child Protection Training Center at: www.ncptc.org

Russell, A. (2009). Assessing children's statements for investigative and court purposes. *CenterPiece, 1*(6), 1–6. Retrieved from: www.ncptc.org

Russell, A. (2010). Finding equilibrium: *Greene v. Camreta*. *CenterPiece, 2*(1), 1–6.

Vieth, V. I. (2009a). Picture this: Photographing a child sexual abuse crime scene. *CenterPiece, 1*(5), 1–4.

Vieth, V. I. (2009b). The forensic interviewer at trial: Guidelines for the admission and scope of expert witness testimony concerning an investigative interview in a case of child abuse. *William Mitchell Law Review, 36*(1), 186–219.

Vieth, V. I. (2010). *It's time to swim: A proposal for developing a multi-tiered approach to the credentialing of forensic interviewers.* Retrieved from the National Child Protection Training Center (see "publications"): www.ncptc.org

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Journal Highlights

Howard Fischer, MD

Anonymity and Disclosure of Child Maltreatment

Child maltreatment is a highly stigmatized behavior. Researching this behavior is therefore difficult, and investigators must use imperfect, insensitive methods. Child welfare reports are specific but insensitive in that most cases of maltreatment do not get reported. Risk factors in parents or caregivers (mental illness, physical punishment, substance abuse, domestic violence) may be underreported and may not be firmly associated with maltreatment. Professionals can obtain parental reports of maltreatment by self-report instruments such as the Conflict Tactics Scale—Parent-Child (CTS-PC), which explores physical abuse, psychological abuse, and neglect. Again, the stigma and potential consequences of these disclosures (including Child Protective Services [CPS] reports) may make for underendorsing.

Most child maltreatment (CM) research therefore is done under conditions of confidentiality. Investigators agree not to share the subjects' answers unless there is possible danger to participants or their children, and they pledge to keep information collected separate from identifying data, except for a table kept in a locked drawer. This degree of confidentiality is often not considered very reassuring or protective by study participants.

The study authors sought to determine, by randomly assigning three different degrees of anonymity promised to study participants, the extent of disclosure of CM and CM-risk behaviors. Three degrees of protection of participants were possible in this study: (1) Anonymity, in which the researcher did not know or record participants' names, and in which their answers could not be traced to them in any fashion, (2) Quasi Anonymity, in which participants' names were recorded, but could not be connected to their answers, and (3) the Traditional Confidential Consent form, in which answers could be connected to names only via a table kept in a locked file cabinet. Participants were told in this condition that Institutional Review Board requirements made the researchers potential reporters of information about CM. The researchers in this study attempted to discern any explanation for potentially different patterns of disclosure as a function of the three protection conditions offered to participants.

Study subjects were 150 women in an obstetric hospital who had recently given birth. They were at least 18 years old and had at least one other child. Most were African American. The postpartum period was chosen because it is a period in which women may be reluctant to reveal CM and CM risk factors. Study subjects had to understand English, not be in pain at the time of study participation, and have slept since delivery. Each mother's and her child's medical condition had to be stable. Informed consent was obtained.

Researchers obtained three data sets: (1) Five items from the CTS-PC were used to inquire about stigmatized or harsh acts toward children: swearing or cursing at a child, slapping a child, pinching a child, shaking a child, calling the child dumb or lazy; (2) the Child Abuse Potential Inventory (CAPI) was used to look for risk factors for CM: rigidity, emotional distress, and social isolation—the authors called these "indirect items"; and (3) previous involvement with CPS was sought by questioning participants. This included CPS investigation (even for a false report) as well as removal of a child from parental custody for any time period.

After data collection, the women were informed that in reality the entire study was anonymous (for all three protection conditions) and that the random assignment to the three conditions was a needed fiction to see how self-reporting varied under various conditions of anonymity. None of the participants was "troubled by the deception."

Women in all three protection conditions were similar regarding race, age, education, number of children, and marital and financial status. There were significant differences between protection conditions and disclosures. Endorsement of harsh parenting behaviors (on the CTS-PC) was 2.7 times higher under complete anonymity versus traditional confidentiality and 2 times higher in the quasi anonymous condition. Risk factors (the CAPI responses) were endorsed 1.8 times more in the anonymous condition than traditional confidentiality, and 1.9 times more in the quasi anonymous condition. CPS involvement was endorsed 3 times more frequently in the anonymous condition than in the traditional confidentiality condition. The quasi anonymous condition degree of disclosures generally fell between those of anonymity and traditional confidentiality.

Thus, it was clear that disclosure increases when participants do not think that they could be connected to their responses, with full anonymity leading to much more disclosure than traditional confidentiality. The authors point out that the data from fully anonymous participants could not be used for longitudinal research, that is, on follow-up studies of such women since they are not identifiable. They suggest that the quasi anonymous approach to data collection might produce data that could be linked by nonidentifying personal cues (such as the first initial of a parent's first name

or "a favorite flavor of ice cream") to a participant and used in follow-up studies without revealing identities.

Chase, S. K., Beatty, J. R., & Ondersma, S. J. (2011). A randomized trial of the effects of anonymity and quasi anonymity on disclosure of child maltreatment-related outcomes among postpartum women. *Child Maltreatment, 16*(1), 33–40.

Change Trajectories During Home-Based Services

As reported physical and sexual abuse declines, chronic child neglect comprises a larger proportion of cases in the child welfare system. Families with neglect are more likely to have multiple substantiated cases with multiple service episodes, potentially receiving the same services repeatedly and using increasing resources in the community over time. It is important to understand patterns of repeated maltreatment over time so we can better understand which services have the potential for the greatest improvements and whether different "change trajectories" in families require different interventions at different points during their involvement with child welfare services.

The authors studied 2,175 families receiving home-based family preservation and support services provided by community-based agencies in six districts across one state. Families were referred for these services by child welfare authorities because of physical abuse or neglect, with specific exclusion of sexual abuse. The authors then tested hypotheses about five basic change trajectories: (1) "untreatable families," who have substantial and intractable problems that respond little to services, (2) "relapsing families," who improve during services but lose or fail to sustain improvement over time, (3) "paradoxical" patterns, in which families get worse over the course of child welfare services, sometimes with improvement only after the withdrawal of services, (4) "probabilistic" patterns, for which high-problem families have a modest but stable probability of improving during any given service episode and might require multiple episodes to eventually improve in a dose-dependent manner, and (5) other change trajectories.

Audio computer assisted self-interview was used for families around service entry, the end of services (means 205 days later), and again 6 months later (means 405 days from entry). The population was thought to be representative demographically of service participants across the state, 72% of families who were approached for the study enrolled, and approximately one third completed all three phases of data collection. Four constructs associated with maltreatment were measured to assess change over time: depression (Beck Depression Inventory), concrete resources (Family Resources Scale), social support (Social Provisions Scale), and abuse risk (Child Abuse Potential Inventory). A discrete-time recurrent event survival model was used to test child welfare recidivism patterns over 3 years.

When applied to latent problem factor scores, the five change trajectories hypothesized essentially duplicated the trajectory patterns that emerged, although there were important but variable effects from missing data. Data from independently collected home visitor reports and clinician ratings also confirmed these trajectory assignments. Recidivism rates also followed predicted patterns based on change trajectory, with some important limitations. The most strongly supported prediction was the idea that chronic cases enter services with high problem levels and often show limited and insufficient improvement during services. As the number of reports increased, families were also more likely to be in "stable high" rather than "stable low" patterns. Little support was found for the hypotheses that families actually worsen over the course of services or relapse, with few families having relapsing or paradoxical trajectories identified.

The study's findings raise a number of questions about the child welfare service system structure. Traditional reactive and episodic service models may be a "mismatch" for families with change trajectories that are better suited to chronic care services. Chronic care service models appear better adapted to the needs of "untreatable families" or for probabilistic and relapsing change trajectories. Many high-problem chronic cases in child welfare show limited but important sustained change with current services that can be associated with decreased recidivism risk, and while current reactive periodic services efforts are not wasted on chronic families, their change trajectories suggest that chronic care models are potentially a better fit with better long-term outcomes.

Chaffin, M., Bart, D., Hecht, D., & Silosvky, J. (2011). Change trajectories during home-based services with chronic child welfare cases. *Child Maltreatment, 16*(2), 114–125.

Investigations Involving Parents With Cognitive Impairments

Parents with cognitive impairments (CI) make up between 2.5% and 5.4% of the population. They are overrepresented in child welfare cases, and many of their children are removed from parental care. More than 10% of all cases investigated for child maltreatment (CM) in Canada involve parents with CI. In these cases, there is greater likelihood of CM substantiation, a greater chance of a case staying open for protective services (PS) even if it is not substantiated, and a greater chance of a child being removed. Studies show that when parents have CI, more than 27% of children are removed. Studies in the United States, Australia, and England have shown that children of CI parents are nearly 4 times more likely to be removed from the home. Parents with CI may be automatically presumed to be incompetent, and PS systems may not be constructed to support such parents. Little research has been done on the factors that influence PS decision-making in cases that involve parents with CI.

The authors studied the relationship between CM investigation outcomes (substantiation, case kept open, child removal) for children of parents with CI and child, case, parent, household, and PS worker variables. They used data taken from the Canadian Incidence Study of Reported Child Abuse and Neglect (CIS-2003), a database consisting of CM investigations across Canada. They randomly selected 55 child welfare service areas from the total of 382 such areas, and they excluded cases involving children >15 years old. The sample contained 1,170 investigations of children of parents with CI. Parents were considered to have CI based on PS worker judgment, whether or not psychometric testing results were available. The independent variables were (1) child characteristics: age, problems in functioning (physical, cognitive, emotional, and behavioral), (2) case characteristics: maltreatment type, severity, and chronicity, (3) parent and household characteristics: number of parents in the home, parental education, employment, income, housing type, history of maltreatment as a child, social supports, mental health, substance abuse, and perceived noncooperation, and (4) characteristics of the investigating PS worker: years in the field and current caseload.

Three fourths of cases involved a mother with CI. Mean age of the child was 7 years. Most referrals to PS were from schools (22%), police (16%), and health professionals (10%). Neglect was the most common form of CM. Allegations of sexual abuse were rare. One third of the children had had previous substantiated CM investigations. Investigating PS workers had an average of 7 years (SD=7.22) experience. They had an average caseload of about 15 (SD=10.88). CM type and severity were the strongest predictors of substantiation. The chance of substantiation increased threefold when exposure to domestic violence was present. The likelihood of substantiation decreased with increasing investigator caseload.

Of the 715 cases for which CM was substantiated, 70% were kept open for ongoing services. When a parent had been maltreated as a child, the chance that their child's case would remain open was increased fourfold. Of cases that were not substantiated, 30% were kept open for ongoing PS involvement. These cases were more likely to remain open for younger children, children with problems functioning, and when the parent was unemployed, using substances, or socially isolated. Less experienced PS workers were more likely to keep unsubstantiated cases open. Nearly 10% of cases of substantiated CM by parents with CI resulted in removal (or "court application" in Canadian terminology). Perceived parental noncooperation was strongly associated with removal as was the severity of the CM.

The perception of parental noncooperation, according to the authors, derives from the fact that parents with CI may be unreliable timekeepers, make more than one appointment for the same time slot, and make spur-of-the-moment decisions. PS workers interpret missed appointments as noncooperation. They may not have the time or skills to develop rapport with CI parents. Such parents may agree to comply with PS suggestions without fully understanding what has been asked. When they don't follow through, they are considered noncooperative. PS workers made few referrals for services to relieve parental poverty, despite the well-known association between poverty and the risk of neglect. Some PS decisions regarding parents with CI were related to investigator experience and caseload and not within parents' control.

Limitations of the study included the fact that the level of parental CI was not ascertained. This may be important, as parenting ability is known to be very poor with an IQ <60. In addition, the study data looked at case characteristics and outcomes for a single point in time, and long-term outcomes were not examined. The authors call for increased training for PS workers in helping parents with CI to increase worker comfort and reduce possible worker biases and misconceptions.

McConnell, D., Feldman, M., Aunos, M., & Prasad, M. (2011). Child maltreatment investigations involving parents with cognitive impairments in Canada. *Child Maltreatment, 16*(1), 21–32.

Abusive Versus Noninflicted Abdominal Trauma

Abusive head trauma is the leading cause of child abuse death, followed by abusive abdominal trauma (AAT). Previous outcome studies of AAT used data from single hospitals or trauma centers. This study looked at children hospitalized for abdominal trauma at all types of acute care hospitals in the United States using a national database.

The Kids' Inpatient Database (KID) is a database of inpatient hospital stays developed by the U.S. Agency for Healthcare Research and Quality. Datasets, released every 3 years, contain a

sample of 80% of all acute care hospitalizations, with three million hospitalizations in 36 states. Because the majority of abusive injuries are found in young children, the authors analyzed only children 0–9 years old. The 2003 and 2006 databases —the most recent available—were combined for this study. Outcomes studied were mortality, length of hospital stay, and total hospital charges incurred. Confounders and covariates included in the analysis were child's age, gender, race/ethnicity, payer type, urban or rural residence, and income quartile of residence by zip code. Injury severity was also considered.

The combined database had 234 children with AAT and 4,200 with noninflicted abdominal injury. Children with AAT were younger than those with accidental injury (mean age of 2 years versus 5.4 years) ($p<.01$), more likely to be in a minority group, and more likely to live in a zip code with the lowest median income ($p<.01$ for both). The percentage of boys was similar for both groups. The mortality rate for children with AAT was 9% versus 3.4% for noninflicted abdominal injury ($p<.01$). Length of hospital stay was 6 days versus 4 days for noninflicted injury ($p<.01$). The mortality rate among infants (0–1 year) was not significantly different for abusive versus noninflicted abdominal injuries.

This study is the first to provide data on children hospitalized with abdominal injuries at a group of acute care hospitals and not just at trauma centers. Children were included who did not have injuries severe enough to justify trauma center admission, and a large sample size was used. The authors have confirmed the impression of many of us in the field that children with AAT have worse outcomes than those with noninflicted abdominal injuries.

Lane, W. G., Lotwin, I., Dubowitz, H., Langenberg, P., & Dischinger, P. (2011). Outcomes for children hospitalized with abusive versus noninflicted abdominal trauma. *Pediatrics, 127*(5), e1400–e1405.

Vitamin D Status in Abused and Nonabused Children

It has been proposed that suboptimal vitamin D levels can account for bone fractures in children in whom there is no other explanation for the fracture(s). That is, low vitamin D levels are an alternative explanation to inflicted injuries causing fractures. If this is so, abusive injury may be misdiagnosed. Severe vitamin D deficiency is associated with clinical rickets (a bone disease with bone deformity and fragility), but no studies have shown that vitamin D insufficiency—in the absence of rickets—leads to increased fracture susceptibility. The authors evaluated children younger than 2 years of age with fractures to compare vitamin D status (1) between children with accidental and abusive fractures, (2) between children with single and multiple fractures, and (3) among children with metaphyseal (growing end of a bone) and rib fractures, which are highly specific for abuse.

The investigators studied 118 children admitted to a children's hospital with fractures over a 1-year period. Patients were excluded from the study if they had a known pre-existing disease that predisposed them to fractures or if they were taking medications that affected bone metabolism. A diagnosis of abuse was made using history, physical examination, laboratory and radiologic findings, as well as consultation with child abuse experts based on published American Academy of Pediatrics guidelines. Serum vitamin D levels were classified as either vitamin D deficient (<20 ng/ml), vitamin D insufficient (20 - <30 ng/ml), or vitamin D sufficient (at least 30 ng/ml). Eight percent of the study population was vitamin D deficient, 31% vitamin D insufficient, and 61% vitamin D sufficient, levels very similar to the distribution of vitamin D levels found in another study of healthy 8–24-month-old children without fractures. None of the children in the present study had radiographic evidence of rickets. Some had evidence of demineralization (5% of the vitamin D-insufficient group, 7% of the vitamin D-sufficient group). This was not a statistically significant difference.

Accidental injuries as the cause of fractures was diagnosed in 60% of the children, abuse in 31%, and cause not determined in 9%. The prevalence of vitamin D deficiency and insufficiency did not differ between abused and nonabused children with fractures. Vitamin D status did not differ between children with single or multiple fractures. In addition, vitamin D status did not differ between children with rib or metaphyseal fractures and those without these lesions. The authors note that they did not have a control group of children without fractures but state that the study already mentioned (of vitamin D levels in healthy children) supports the correctness of their findings of the distribution of vitamin D levels in their population. They also indicate that the small sample size decreases the power of their study to detect small differences.

This paper concludes that a low-vitamin D level should not discourage clinicians from considering abuse when a child has unexplained fractures. This study seems to have successfully refuted the hypothesis advanced that low-serum vitamin D levels, in the absence of clinical or radiographic rickets, can account for otherwise unexplained fractures.

Schilling, S., Wood, J. N., Levine, M. A., Langdon, D., & Christian, C. W. (2011). Vitamin D status in abused and nonabused children younger than 2 years old with fractures. *Pediatrics, 127*(5), 835–841.

Child Abuse and Neglect and Cognitive Function

It is understood that child abuse and neglect (CAN) have harmful effects on brain growth and child development. Although neglect is the more commonly substantiated form of child maltreatment, less research has been done on neglect outcomes. Most studies combine abused and neglected children into one group. One

prospective longitudinal follow-up study looked at neglect and cognitive outcome at age 5 in extremely low-birth-weight infants. The present authors looked at the cognitive outcomes of maltreated children (abuse, neglect, or both) using a population-based longitudinal sample at age 14, with adjustment for relevant social and familial factors.

The database was a longitudinal birth-cohort study of over 7,000 mothers-child pairs in Queensland, Australia, who had enrolled at their first prenatal visit during 1981–1983. Information was collected at that first visit, 5 days after delivery, and when the child was 6 months old, 5 years old, and 14 years old. At age 14, children were administered the Wide Range Achievement Test (WRAT) reading test and Raven's Standard Progressive Matrices (RSPM) to test abstract reasoning. Reports of suspected maltreatment during 1981–2000 were collected from the appropriate agency in Queensland. The researchers considered 18 variables relating to the mothers' demographic, educational, substance use, and peripartum emotional status.

Data from the child protection agency were available for 7,214 children in this cohort. Nearly 11% (789) had been reported for suspected CAN, and maltreatment had been substantiated in 506 children. Nearly 3,800 of the 14-year-olds in this birth cohort completed the WRAT and the RSPM. In this group, 298 had a history of being reported for suspected CAN (7.9%). Thirty-eight percent had been reported for abuse and neglect, the rest for abuse or neglect.

Reporting ("notification") for child maltreatment (abuse, neglect, or both) was associated with a lower score on reading ability (WRAT). Perceptual reasoning, as measured by the RSPM, was also lower. Results were similar when the analysis was done using only substantiated CAN as the predictor, and the association was the same when abuse or neglect was looked at separately after adjustment for a range of potentially confounding variables. Neglect is at least as harmful as abuse in this respect. Interventions need to be devised that are effective in preventing neglect.

Mills, R., Alati, R., O'Callaghan, M., Najman, J. M., Williams, G. M., Bor, W., & Strathearn, L. (2011). Child abuse and neglect and cognitive function at 14 years of age: Findings from a birth cohort. *Pediatrics, 127*(1), 4–10.

Abusive Head Trauma by Male and Female Perpetrators

Abusive head trauma (AHT) is estimated to occur annually in 15–40 children per 100,000 children younger than 1 year of age. Male perpetrators of AHT outnumber females in most studies, but no studies before this one have examined the effect of perpetrator gender on victim presentation, clinical outcome, or perpetrator legal outcomes. The authors reviewed 48 cases of children with AHT presenting to a tertiary care children's hospital. They defined AHT as injury occurring in a child < 5 years of age with intracranial injury on neuroimaging and no adequate history to explain the injuries. The presence of retinal hemorrhages or noncranial injuries was not necessary to define AHT. Of the 48 cases of AHT, perpetrators were identified for 34 (17 men and 17 women).

The mean age of the 34 children was 9.4 months; time to seek medical care ranged from 0–48 hours (mean 4.5); days of hospitalization ranged from 2–43 (mean 12). Thirty-one children presented with acute symptoms (cardiopulmonary arrest, respiratory arrest, seizures). Fourteen children had neurosurgical interventions (41%). Six children died (17%). All 6 children at autopsy showed evidence of rotational acceleration-deceleration injury (which is considered to be shaking-specific). Retinal hemorrhage was present in 82% of the 34 patients. The severity of retinal hemorrhage was associated with the severity of the intracranial injury.

The perpetrators were between 16–60 years old. The median age of female perpetrators was 34 years, versus 27 years for males (p=.001). Biologic parents were most common followed by mothers' boyfriends. The following variables were significantly associated with male perpetrators: acute presenting findings of cardiopulmonary or respiratory arrest (p=.025), severe clinical outcome (p=.012), neurosurgical intervention (p=.037), death (p=.018), perpetrator confession (p=.0001), and conviction (p=.005). The six children who died did so at the hands of male abusers. Fourteen of the 15 men who confessed described shaking the victim. Of the 3 women who confessed, 2 described shaking, and one both shaking and impact; 82% of male abusers were convicted, and 2 were awaiting trial; 29% of female abusers were convicted.

The authors question whether the outcomes for males' victims are different because of perpetrator gender differences or rather because of the greater upper body muscle mass of men. They also call for research to clarify if gender bias exists in prosecuting AHT perpetrators.

Esernio-Jenssen, D., Tai, J., & Kodsi, S. (2011). Abusive head trauma in children: A comparison of male and female perpetrators. *Pediatrics, 12*(7), 649–657.

About the Author
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Washington Update

Thomas L. Birch, JD

Fiscal Woes Dominate Congressional Summer

The major distractions in Congress at mid-summer have been the unremitting debate over raising the debt ceiling and its fiscal companion, reducing the size of the federal budget deficit. In the background, appropriations bills for the 2012 fiscal year are moving out of committee and onto the floor of the House of Representatives for passage. Despite that forward motion, there is no guarantee that the House and Senate will finish up the 2012 funding scheme before the start of the new fiscal year on October 1. Indeed, appropriations committee staffers predict another year with one or more continuing resolutions carrying funding along while the two chambers and the White House look for a way to resolve their partisan differences.

House Speaker John Boehner (R-OH) has indicated that he plans to get all dozen appropriations bills passed before the August recess starts. Last year, only 2 of the 12 went to the House floor for a vote. Not a single appropriations bill was taken up in the Senate last year, and there is little evidence so far for the situation this year to be different.

As usual, the funding measure for the Labor, Health and Human Services (HHS), and Education Departments is expected to come toward the end of the process. In May, the House Appropriations Committee announced the FY-2012 spending allocations for each of its subcommittees, cutting total federal discretionary spending by approximately $30 billion in the next fiscal year compared with FY-2011. The plan presented by House Appropriations Committee chair Harold Rogers (R-KY) would cut combined spending for Labor, HHS, and Education by more than $18 billion. The Department of Defense would receive an increase of $17 billion.

The allocations represent the level of spending each appropriations subcommittee is given to work with in drawing up its funding legislation. Rogers warned that appropriations this year would include double-digit reductions in almost all areas of nonsecurity spending. The reduced spending allocations set by Rogers would cut $41.5 billion from President Obama's budget request for the Labor, HHS, and Education appropriations bill.

The 2012 budget resolution passed by the House in April offers some clues to directions the House might take in drafting its appropriations bills. House Budget Committee chair Paul Ryan (R-WI) crafted the spending blueprint, which lays out budget policy to guide decisions that appropriators will make for the coming fiscal year. Damage done to the nation's social safety net would be significant.

Many of the spending assumptions set forth in this House-passed budget resolution assume the same level of budget cuts proposed by the House in its plan for 2011 spending. Those cuts included $1 billion in reduced spending for Head Start and further cuts in child care assistance. In the House-passed plan for 2012, nonsecurity discretionary spending—including the full range of funding for child and family services—would be cut back to FY-2006 levels next year and then frozen at those amounts for 5 years, with any growth thereafter held at the rate of inflation. According to the Center on Budget and Policy Priorities, the Ryan budget plan would achieve almost two thirds of the proposed budget cuts from programs for lower-income Americans.

The Ryan budget takes a swipe at the Title XX Social Services Block Grant, which funds a range of social services programs, including significant support for child maltreatment prevention and protection services. Funds for SSBG would be eliminated as a case of "duplicative spending." The report from the House Budget Committee acknowledges that SSBG goes to states "to help achieve a range of social goals, including child care, health services, and employment services." The report asserts that these are services funded by other federal programs as well and contain no requirements "to demonstrate the outcomes of this spending, so there is no evidence of its effectiveness" (U.S. Congress, 2011, p. 97). That lack of concrete information on SSBG spending has long challenged advocates' efforts to justify appropriations for the social services funds.

In health care spending, the Ryan budget would repeal all new Medicaid spending enacted under the health care reform law. This would convert the Medicaid program into a block grant to the states and end the federal guarantee of coverage for all eligible children. Millions of new enrollees offered the benefits of Medicaid and the State Children's Health Insurance Program in the Affordable Care Act would be denied coverage, and states would find themselves dropping coverage for current beneficiaries and reducing benefits currently received because the federal share of funding would be locked in with no increase over time. States already facing big budget shortfalls would have to bear all the costs if they wanted to provide more assistance to people during tough economic times once they had spent their block grants. The Senate has rejected the Ryan budget. Still, it continues to

inform budget positions put forward by the House in this summer's spending negotiations.

Child Welfare Waiver Bill Passes House, Introduced in Senate

On May 17, Sen. Max Baucus (D-MT), Finance Committee chair, and Sen. Orrin Hatch (R-UT), ranking Republican on the committee, introduced the State Child Welfare Innovation Act, S.1013, to renew authority for HHS to extend waivers of federal foster care regulations through 2014. This would enable states to use funds flexibly to develop innovative strategies for serving children in the child welfare system as alternatives to traditional foster care.

States that apply for a waiver to use federal foster care funds would be required to address one of three goals listed in the legislation: (1) to increase permanency for children and promote the successful transition to adulthood, (2) to increase efforts to better serve children and families being served at home or in placement by improving safety, and (3) to prevent abuse and neglect and the re-entry of children into foster care with a special focus on in-home and community services.

The bill focuses on enabling states to make changes in their policies, procedures, or other aspects of the state child welfare program to achieve the goal of the project funded under the legislation. Specific child welfare program improvement policies related to prevention identified by the bill include the following: providing family counseling, family group decision-making, and in-home peer support for families; developing family-based substance abuse treatment programs; and addressing domestic violence, which puts children at risk of entering foster care.

The bill aims to reduce the number of children and youth who enter foster care, while also improving the circumstances for children in the child welfare system and keeping families together. In a statement made upon introduction of the bill, Baucus credited a drop in the number of children in the system (by more than 80,000 over the last 10 years and by nearly 40,000 over the last 2 years) in part to success achieved by the states' use of the type of waiver the bill would provide.

The Finance Committee leadership considers the legislation to be cost-neutral and free of controversy, which should enable the bill to move expeditiously. In addition to Baucus and Hatch, Senators Jay Rockefeller (D-WV) and Michael Enzi (R-WY) are cosponsors of S.1013.

A similar, pared-down version of the child welfare waiver measure passed the House by voice vote on May 31. Reps. Geoff Davis (R-KY) and Jim McDermott (D-WA), the chairman and ranking member, respectively, of the House Ways and Means Subcommittee on Human Resources, introduced this legislation. It would renew through FY-2016 the authority of the HHS secretary to authorize waivers for states to conduct child welfare program demonstration projects likely to promote the objectives of Title IV Part B (Child and Family Services) or Part E (Foster Care and Adoption Assistance) of the Social Security Act.

Included among the demonstration projects that may be approved would be those designed to (1) identify and address barriers that result in delays to kinship guardianship for children in foster care, (2) provide early intervention and crisis intervention services that safely reduce out-of-home placements and improve child outcomes, or (3) identify and address domestic violence that endangers children and results in the placement of children in foster care.

Reference

U.S. Congress, House of Representatives, Committee on the Budget. (2011). *Concurrent Resolution on the Budget: Fiscal Year 2012* [Report]. Washington, DC: Government Printing Office.

Forensic Interviewer Special Interest Groups

Julie Kenniston, MSW, LSW

The questions are many. The answers are few. Is forensic interviewing a profession or a skill set? Is there one model that is better than another? Should interviewers be certified or credentialed? Should evidence be used in interviews with children? Is forensic interviewing an evidence-based practice? These are but a few of the questions that have been generated.

The world of forensic interviewing has had some incredible debates over the course of the last few years, and many of these debates did not include the voices of the interviewers themselves. From certification to training models, interviewers have had to find their answers by attending conferences and trainings or putting out questions on multidisciplinary list servs. Each interviewer then had to come up with his or her own individual understanding of what is best practice. Until now, there has not been a way to gather these interviewers in one place to allow for the dialogue among them that would support their work. Given the number of years that APSAC has worked toward creating a diplomate status and exploring whether certification for forensic interviewers is in the best interest of the field, it made sense for APSAC to begin the special interest group (SIG) venture with a forensic interviewer SIG.

A SIG is an online community for members of an organization with an interest in one area of the overall mission. The SIG provides a format for interested members to communicate. In an effort to create this forum for forensic interviewing, APSAC is offering two special interest groups for its members. The first group will be targeted for forensic interview practitioners. As debates rage over hot topics that impact interviewers, it has become crucial that professionals conducting forensic interviews have a place to share their views and seek support from one another. This SIG has the potential of being a starting point for researchers or others needing to gather information from a large group of practitioners.

However, APSAC recognizes that many professionals have an interest in what is happening with forensic interviewing. With such a variety of professions contributing to the field, APSAC decided to offer a second SIG that will include the interviewers, trainers, researchers, multidisciplinary team members, and supervisors. APSAC is creating this online community as a means of supporting dialogue on specific topics in which both groups can communicate about relevant issues.

As the leading national organization supporting professionals who serve children and families affected by child maltreatment and violence, APSAC is committed to providing the resources needed to enhance skills and improve the field. The SIG provides an opportunity for national and international professionals to access one another. The service is free to APSAC members. Once the SIGs are available, members will receive announcements to join. We look forward to the growth and development of this field to best serve the children and families we care for.

About the Author
Julie Kenniston, MSW, LSW, is Director of Training and Education at Butler County Children Services in Hamilton, Ohio, and Executive Director of the Center for Family Solutions (CFS), Butler County's developing child advocacy center. She is also an independent contractor and trainer who presents nationally and internationally on forensic interviewing and is a member of the APSAC Board of Directors.
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APSAC News

Pictured above are several of this year's award winners.

APSAC Colloquium Provided Outstanding Education and Networking

Nearly 650 professionals attended the 19th Annual APSAC Colloquium, sponsored by the American Professional Society on the Abuse of Children (APSAC), which was held July 13–16, 2011, in Philadelphia, Pennsylvania. A strong program, coupled with the multidisciplinary support of professionals who serve children and families affected by child maltreatment and violence, attributed to the Colloquium's success.

APSAC's Colloquium offered nearly 100 institutes and workshops that addressed all aspects of child maltreatment, including prevention, assessment, intervention, and treatment with victims, perpetrators, and families affected by physical, sexual, and psychological abuse and neglect. The lineup provided several special programs that attracted strong attendance from law enforcement personnel, as well as the U.S. Air Force. The sessions also addressed cultural considerations.

APSAC's Annual Colloquium is a major source of education and research for professionals in the field of child maltreatment, including mental health, medicine and nursing, law, law enforcement, education, prevention, research, child protective services, advocacy, and related fields. The educational goal of APSAC's Colloquium is to foster professional excellence in the field of child maltreatment by providing interdisciplinary professional education.

The 20th APSAC Annual Colloquium will take place in Chicago, Illinois, June 27–30, 2012.

Awards Presented by APSAC During Its Annual Colloquium

The American Professional Society on the Abuse of Children recognized outstanding service and commitment within the field of child maltreatment during its Annual Colloquium in Philadelphia. Awards were presented at the Awards Ceremony and William Friedrich Memorial Lecture. Following is a list of awards presented and the recipients.

Outstanding Professional The Award recognizes a member who has made outstanding contributions to the field of child maltreatment and the advancement of APSAC's goals.

- **Mary L. Pulido, PhD**, The New York Society for the Prevention of Cruelty to Children

Outstanding Front-Line Professional The Award recognizes a front-line professional (e.g., child protection worker, law enforcement personnel, mental health counselor, or medical professional) who demonstrates extraordinary dedication and skill in his or her direct care efforts on behalf of children and families.

- **Deborah Shropshire, MD**, University of Oklahoma College of Medicine

Outstanding Media Coverage The Award recognizes a reporter or team of reporters in newsprint or broadcast journalism whose coverage of child maltreatment issues shows exceptional knowledge, insight, and sensitivity.

- **Barbara Bradley Hagerty**, National Public Radio

Outstanding Research Article The Award recognizes the authors of a research article judged to be a significant advancement to the field of child maltreatment.

- **Chantal Cyr, PhD**, University of Quebec at Montreal, Department of Psychology; **Eveline Euser, PhD**, Centre for Child and Family Studies, Leiden University; **Marian Bakermans-Kranenburg, PhD**, Centre for Child and Family Studies, Leiden University; and **Marinus Van Ijzendoorna, PhD**, Centre for Child and Family Studies, Leiden University (2010). Attachment security and disorganization in maltreating and high-risk families: A series of meta-analyses. *Development and Psychopathology*, *22*(1), 87–108.

Outstanding Doctoral Dissertation The Award recognizes an individual whose dissertation has the greatest potential for making a significant contribution to the child maltreatment theoretical and applied knowledge base.

- **Marina Lalayants, PhD**, Lois J. and Samuel V. Silberman School of Social Work at Hunter College

Outstanding Article in the Journal Child Maltreatment The Award recognizing the authors of a research article judged to be a significant advancement to the field of child maltreatment.

- **Janet Currie, PhD**, Columbia University & National Bureau of Economic Research; and **Cathy Spatz Widom, PhD**, John Jay College, City University of New York (2010). Long-term consequences of child abuse and neglect on adult economic well-being. *Child Maltreatment, 15*(2), 111–120.

Ronald C. Laney Distinguished Service Award The Award is presented on a periodic and exceptional basis by the APSAC Board of Directors to an individual who has exhibited a life time of service to others as exemplified by Ron C. Laney.

- **Donald C. Bross, JD, PhD**, University of Colorado School of Medicine & Kempe Children's Center

William Friedrich Memorial Award The Award is presented by the APSAC Board of Directors to an individual who has demonstrated a career that exemplifies the achievements and character of the late William Friedrich.

- **Anthony J. Urquiza, PhD**, UC Davis Health System/Children's Hospital & CAARE Diagnostic and Treatment Center

APSAC Names Dr. Michael Haney Its Executive Director

Michael L. Haney, PhD, a forensic and mental health consultant, was named Executive Director of the American Professional Society on the Abuse of Children when its Board of Directors met July 12 in Philadelphia, Pennsylvania.

Dr. Haney has extensive background in child abuse and disaster behavioral and mental health response (28 years), including working for the Florida Department of Children and Family Services as Bureau Chief for Family Safety and Preservation and the Florida Department of Health as the Director for Prevention and Intervention. He is a Nationally Certified Counselor, a Certified Critical Incident Stress Manager, and a Licensed Mental Health Counselor. Dr. Haney graduated from the University of North Florida with a BA in psychology, received an MEd and EdS in mental health counseling from the University of Florida. He holds a PhD in psychology from Lacrosse University.

Haney's duties as Executive Director 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.
- Facilitate the work of all Board of Director Committees (keeping work projects on task and timely).
- In collaboration with the Operations Managers, keep the Board of Directors informed by timely reports deemed necessary by the Executive Director, required by the Board, required by the by-laws, and/or required by law.
- Identify and research issues for the Board of Directors.
- Plan and execute the operations of APSAC in accordance with the by-laws and policies of the Board.
- Serve as primary contact for Information and Communications/Public Relations, including serving as a primary point of contact or spokesperson as appropriate.
- In concert with APSAC's legal counsel, maintain a personal understanding of local, state, and federal laws and regulations as they apply to the mission and operations of the organization.
- Research grant opportunities; pursue grants as directed by the Board of Directors.
- Work with the Board to develop corporate, governmental, and organizational partners.
- Membership development.

Commenting on his selection, Haney said, "I'm deeply appreciative and excited by the Board's confidence in me, and I look forward to working with the APSAC Board and our membership to continue and improve our services to child welfare professionals."

APSAC Offers Three Advanced Training Institutes in January

The APSAC Advanced Training Institutes are being held in conjunction with the 26th Annual San Diego International Conference on Child and Family Maltreatment, January 22–23, 2012. APSAC's Advanced Training Institutes offer in-depth training on selected topics. Taught by nationally recognized leaders in the field of child maltreatment, these seminars offer hands-on, skills-based training grounded in the latest empirical research. Participants are invited to take part by asking questions and providing examples from their own experience. The 2012 Institutes include the following:

APSAC Pre-Conference Institute #1:
Advanced Medical Evaluation of Child Sexual Abuse
Sunday, Jan. 22, 8 am–4 pm, lunch break on your own, continuing on Monday, Jan. 23, 8 am–Noon (11 Hours) *Lori D. Frasier, MD, Suzanne Starling, MD, and Karen Farst, MD*

APSAC Pre-Conference Institute #2:
Advanced Forensic Interview Training
Sunday, Jan. 22, 8 am–4 pm, lunch break on your own (7 Hours) *Julie Kenniston, MSW, LSW, and Chris Ragsdale*

APSAC Pre-Conference Institute #3:
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for Young Children/Preschoolers
Sunday, Jan. 22, 8 am–4 pm, lunch break on your own (7 Hours) *Monica Fitzgerald, PhD, and Shannon Dorsey, PhD*

Details and registration are available on the APSAC Web site under the Events tab, Event List.

Call for Abstracts

APSAC is now accepting abstracts for its 2012 Colloquium, June 27–30, Chicago, Illinois. Details on responding to the Call for Abstracts are available on the association's Web site, www.apsac.org.

Conference Calendar

September 11-14, 2011
16th International Conference on Violence, Abuse and Trauma
Institute on Violence, Abuse and Trauma at Alliance International University
San Diego, CA
858.527.1860, x4030
IVATconf@alliant.edu
www.ivatcenters.org

September 14-16, 2011
Putting the Pieces Together for Children and Families: National Conference on Substance Abuse, Child Welfare and the Courts
Children and Family Futures
714.505.3525
mlujan@cffutures.org
www.cffutures.org/conference2011

October 16-19, 2011
National Staff Development and Training Association Institute
American Public Human Services Association
Madison, WI
202.682.0100
DGross@aphsa.org
www.nsdta.aphsa.org

October 17-18, 2011
30th Annual Michigan Statewide Conference Child Abuse and Neglect: Prevention, Assessment and Treatment
University of Michigan Health System's Child Protection Team, University of Michigan Medical School and University of Michigan Mott Children's Hospital
Plymouth , MI
734.615.0387
zellerj@med.umich.edu
http://cme.med.umich.edu/childconference

October 24-25, 2011
11th Annual Child Abuse and Neglect Conference
Children's Healthcare of Atlanta Child Protection Center, the Georgia's Governor's Office for Children and Families
Atlanta, GA
404.785.7694
elizabeth.williams@choa.org
www.choa.org/annualconference

January 22 & 23, 2012
APSAC Advanced Training Institutes
American Professional Society on the Abuse of Children
San Diego, CA
877.402.7722
apsac@apsac.org
www.apsac.org

January 23-26, 2012
The 26th Annual San Diego International Conference on Child and Family Maltreatment
Chadwick Center for Children and Families
San Diego, CA
858.966.4972
SDConference@rchsd.org
www.sandiegoconference.org

March 19-23, 2012
28th National Symposium on Child Abuse
National Children's Advocacy Center
Huntsville, AL
256.327.3863
mgrundy@nationalcac.org
www.nationalcac.org

April 16-20, 2012
18th National Conference on Child Abuse and Neglect
Office on Child Abuse and Neglect, Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services
Washington, DC
18conf@pal-tech.com
www.pal-tech.com/web/OCAN

April 23-27, 2012
APSAC's Child Forensic Interview Clinic
American Professional Society on the Abuse of Children
Chicago, IL
877.402.7722
apsac@apsac.org
www.apsac.org

June 27-30, 2012
20th APSAC Annual Colloquium
American Professional Society on the Abuse of Children
Chicago, IL
877.402.7722
apsac@apsac.org
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