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

PRESIDENT'S MESSAGE

APSAC and the First Russian-American Child Welfare Forum

Ronald C. Hughes, President, APSAC

> *We not only need a "reset" button between the American and Russian governments, but we [also] need a fresh start between our societies—more dialogue, more listening, more cooperation in confronting common challenges.*
>
> Barack Obama, President of the United States of America, the U.S.-Russia Civil Society Summit (Moscow, July 7, 2009)

> *One can judge a society's maturity and developmental level from the way it treats its children. We need a standardized system for the protection of children in all senses of the word.*
>
> Dmitry Medvedev, President of the Russian Federation

Recognizing the need to make a fresh start in relations between the United States and Russia, President Dmitri Medvedev and President Barack Obama created the U.S.-Russia Bilateral Presidential Commission in July 2009 to address shared challenges, explore opportunities for partnership in areas of mutual interest, and coordinate activities to solve joint concerns.

Seventeen committees have been formed under the Bilateral Commission to address the highest priority needs. One of these is the Civil Society Committee and its four sub-working groups–migration, prison reform, anticorruption, and child protection. Dr. Ronald Hughes was appointed as a delegate to the Committee specifically to work within the Child Protection Sub-Working Group, which meets twice a year (once in Russia and once in the United States). Its members represent both governmental and nongovernmental organizations involved in protecting children's rights and interests.

An outgrowth of discussions among delegates of the Child Protection Sub-Working Group was the decision to organize the First Russian-American Child Welfare Forum. This Forum was held August 2–6, 2011, in Ulan Ude, capital of the Republic of Buryatia, and in Sukhaya, a small village on the shores of Lake Baikal. More than 200 delegates from Russia and the United States spent 5 days together in dialogue and presenting plenary sessions, workshops, and discussion platforms. The format enabled child protection specialists from both countries to identify common concerns and showcase approaches to prevention and intervention in situations of child maltreatment. The Forum was a first step to address their mutual challenges, needs, capacities, and willingness to collaborate to improve children's safety and well-being. A primary conference goal was to strengthen relationships and communication among participants to facilitate ongoing collaboration in solving problems, such as child pornography, child sex trafficking, intrafamilial child abuse and neglect, and promoting early recognition of at-risk children and families to prevent child maltreatment.

The Forum was a joint effort at many levels. Russian contributors included the Government of the Republic of Buryatia, with special involvement of the President of the Republic, Mr. Vyacheslav Nagovitsyn, and his staff. Other contributors were the Office of the Children's Rights Commissioner for the President of the Russian Federation, the Gorbachev Foundation, the Presidential Plenipotentiary Envoy to the Siberian Federal District, and the National Foundation for the

Prevention of Cruelty to Children, a nongovernmental organization located in Moscow.

Among the American contributors and coorganizers of the Forum were the United States Department of Justice, the American Professional Society on the Abuse of Children (APSAC), and the Institute for Human Services (IHS).

During the opening plenary, videotaped welcomes were shared from the cochairs of the Child Protection Sub-Working Group, Mr. Andrew Oosterbaan, Chief of the Child Exploitation and Obsenity Section of the U.S. Department of Justice, and Mr. Pavel A. Astakhov, Children's Rights Ombudsman of the Russian Federation. A meeting of the Child Protection Sub-Working Group was subsequently held during the Forum, cochaired by Mr. Luke Dembosky, U.S. Department of Justice resident legal advisor at the U.S. Embassy in Moscow, and Mr. Anton P. Astakhov, Assistant Presidential Commissioner for Children's Rights for the Russian Federation. At this meeting, Dr. Vincent Palusci had the opportunity to present remarks regarding the involvement of physicians in child maltreatment practice.

More than 200 child welfare professionals from Russia and the United States participated in wide-ranging dialogue regarding identification and intervention in a host of child welfare topic areas, such as child pornography, child sex trafficking, alcohol abuse and fetal alcohol syndrome, chronic neglect and poverty, medical diagnosis of child maltreatment, child abuse prevention, risk assessment and safety planning, the civil society infrastructure necessary for child protection, child fatalities, working with families, and the role of training and education in building a competent child protection work force. The issues of child sex trafficking and child pornography were a follow-up to initiatives begun in a previous meeting in Moscow of the Civil Society Committee.

In addition, delegates covered much new ground at the Forum. One area emphasized in presentations and discussions was prevention in all areas of child maltreatment, including physical abuse and neglect as well as sexual abuse. Another emphasis was the introduction of treatment intervention models that have substantial empirical support. Delegates spent considerable time on issues related to alcohol abuse and its effects on neonates, which cause serious problems in both Russia and the United States.

Several APSAC members were among the American attendees. Board President Ronald C. Hughes led a team with Dr. Vincent Palusci, Dr. Lori Frasier, Dr. Viola Vaughan-Eden, Dr. Michael Haney, Ms. Tricia Gardner, Dr. Raelene Freitag, and Dr. Tatiana Balachova, all of whom conducted workshops, led plenary sessions, and moderated discussion platforms on a wide range of topics. The APSAC team was joined by three participants representing the U.S. Department of Justice (DOJ). They were Ms. Lou Ann Holland, Ms. Sandra Marchenko, and Mr. Luke Dembosky, who all spoke on issues related to child sex trafficking and child pornography. APSAC members Dr. Judith Rycus and Ms. Ruby Johnston from the Institute for Human Services conducted sessions on the technology of competency-based training and its role in promoting large-scale system change.

Another APSAC member, Mr. Chris Newlin, a delegate to both the Civil Society Committee and the Child Protection Sub-Working Group, was a leader in previous meetings that forged new ground in U.S.-Russian collaboration to combat child pornography and child sex trafficking, including coordination of plans for identification, intervention, and interdiction. Although Mr. Newlin did not attend the Forum, he has been an essential contributor to the planning process and will provide continued leadership in future meetings.

Planning, presenting, and participating in the First Russian-American Child Welfare Forum was an interesting and productive experience for the U.S. participants. All of us were overwhelmed by the generosity and hospitality of our Russian hosts and by the personal and professional respect that was shown in response to our time and effort. Clearly, there are substantial needs related to improving the safety and well-being of children in Russia, and there is much we can offer. Even small and measured investment has the potential to produce significant gains for children and families, and Russian child welfare professionals can learn not only from our successes but also from our mistakes. We have much to gain by participating in Russian child welfare reform efforts, particularly in assessing the utility and transferability of American standards and practices to very different political and cultural contexts.

Because the Forum was intended to be the first of an ongoing Russian-American collaboration, the conference organizers are already planning next year's meeting, which will likely be held in the United States. APSAC members interested in participating should contact members of the APSAC Board.

APSAC representatives Dr. Ronald Hughes, Dr. Judith Rycus, and Dr. Vincent Palusci gave presentations at the opening plenary sessions or during the on-site meeting of the recent Child Protection Sub-Working Group. Transcriptions of their presentations are included in this issue.

APSAC Presentations at the First Russian-American Child Welfare Forum

Ronald C. Hughes, PhD, MScSA, Judith S. Rycus, PhD, MSW, and Vincent J. Palusci, MD, MS

Presentation by Dr. Ronald C. Hughes at the opening plenary session of the First Russian-American Child Welfare Forum in Ulan-Ude, capital of the Republic of Buryatia, Russian Federation, August 2, 2011. The presentation was televised throughout the Republic and in school classrooms.

A civil society is a society that recognizes, supports, and is guided by fundamental and essential ethical principles of moral discourse. These principles are liberty, justice, human dignity, and a fourth, which I will explain shortly.

These three principles … liberty, justice, and human dignity … are transcendental principles. By this we mean that their recognition, justification, and acceptance are not dependent on any particular human experience, similar or disparate histories, or their utility, although their normative power is paramount. Their justification transcends these things. Their legitimacy and power are derived from their logical necessity. It is impossible to engage in any moral discourse, any discussion of ethical practice, without a recognition that such a discussion must concern these basic moral concepts and the recognition that the conceptualization of any one of these transcending moral concepts requires a conceptualization of the others.

How does the recognition and acceptance of the essential nature of these defining characteristics of a civil society translate to child welfare?

For children, the concept of freedom must be put into a developmental perspective. Children do not have all the same freedoms, right to self-determination, privacy, or the concordant responsibilities of adults. Freedom for children means to be free to grow and develop, to be free from environmental assault, coercion, and deprivation that can undermine their development as healthy, productive, and moral social beings. Thus, it means the right to be free from abuse and exploitation, to be free from neglect. To be set free to grow and develop requires that children have safe and stable families who will provide basic care and nurturance. Freedom and liberty are about the right to choose from possibilities, and possibilities can only exist for children in a safe and nurturing environment, free from abuse, neglect, and exploitation.

Any conceptualization of justice for children must take into consideration their special developmental needs and vulnerabilities. Children have relatively little capacity to obtain needed resources or to assure their own safety. They do not choose their circumstance and have little power to change them. Justice for children requires that certain developmental rights be universally applied to children, such as the right to a safe and stable family and the right to basic care and nurturance.

In our respective societies, we have often come up short in our responsibility to treat children with inherent respect and dignity. Our institutions have often failed to protect them from exploitation and dehumanizing conditions, or worse, have been the source of such abuse. The human trafficking of children for sex [and] their exploitation in child pornography are graphic examples of the treatment of children as dehumanized commodities. Their worth as human beings is discounted when we do not redress the failures of those with responsibility to nurture and protect them; when we allow those who abuse or neglect them to do so with impunity, when we turn a deaf ear to their needs and our moral responsibilities because they do not have voice.

To these fundamental and transcending moral principles of a civil society—human dignity, liberty, and justice—I would add a fourth: beneficence, or in its universal conceptualization, altruism. It is logical to conceive of a normative moral order that includes liberty, human integrity, and justice without normative sentiments regarding benevolent intent or behavior. In fact, justice is most often conceived as the balancing of selfish interests, not benevolent intent. There are no laws requiring good Samaritans. Benevolence is often referred to as supererogatory … in other words, it is not a moral prerequisite of a normative ethical system; it is beyond moral duty. Yet, it is considered by nearly all ethicists to be the highest moral good. To quote Emmanuel Kant, "The only thing good, in and of itself, is goodwill." We cause children to be. They cannot choose their circumstances. Their needs are great. Their vulnerability is complete. They have little power or influence to pursue their interests. Children are totally dependent upon the goodwill of others. Our society's responsibility to its children is its most fundamental moral obligation.

For this reason I include it as a fourth moral foundation of a civil society. I believe it is a profoundly necessary moral imperative, one that cannot be legislated, but the one most important in informing the general will of a civil society if the other principles of liberty, justice, and human dignity are to sustain.

Finally, there is one additional instrumental ethical requirement recognized by all mature civil societies: the normative conceptualization of the rule of law. Constitutional and legislative codification of liberty, human dignity, and justice, applied equally to all, both sustains and informs a civil society. Thus, I include it as the final

Dr. Ronald Hughes, APSAC President

fundamental moral concept in our discussion of the ethical foundations of civil societies and moral basis for our fight against child abuse. Armed with this combination of duty and goodwill, we will work together over the next few days and hopefully, long into the future, to better the lives of children and families in our two great countries.

Additional comments from Dr. Hughes regarding the role of nongovernmental organizations (NGOs) in civil society's efforts to prevent child abuse and neglect.

Dr. Michael Haney

NGOs are a natural evolutionary expression of group of individuals with similar interests, concerns, hopes, and commitment within an open, liberal democracy, that is, a civil society. The mission, goals, and objectives of an NGO can be as varied and diverse as the individual interests, concerns, hopes, and civil commitment of the individuals within a society. NGOs play an important, even essential, part in the moral and just development of a liberal democracy. They provide the means for like-minded members of civil society to combine their resources, their energy, their strategic efforts, and thus their influence and effectiveness in seeking shared goals. In the early twentieth century in the United States, NGOs evolved into a powerful moral and political phenomenon for both advocacy and service delivery to marginalized and disenfranchised populations. One subgroup was children.

Children are an existentially dependent and powerless group in any society, who, by this reality, are inherently susceptible to many kinds of individual, institutional, and social abuse, neglect, and exploitation. Thus we, in all our histories, have seen times when children were exploited in labor, discounted in law and legislation, treated as social commodities, rather than with human dignity and human rights, whose well-being was not assured by civil institutions or [who] were actually exploited by these same institutions; and whose families were sometimes the source of unchecked exploitation, abuse, and neglect.

NGOs are the most significant social and political advocacy structure for identifying, developing and sustaining our efforts as a civil society to meet the needs of maltreated children. NGOs are the primary source for research and program development of new and effective models of intervention and service.

I think it is safe to say that the history of progress and improvement in the services to maltreated children in the United States over the last 100 years has been a history of the development, growth, sophistication, and effectiveness of nongovernmental organizations whose moral and scientific missions have been to improve the safety and welfare of children.

Presentation by Dr. Judith S. Rycus at the opening plenary session of the First Russian-American Child Welfare Forum in Ulan-Ude, capital of the Republic of Buryatia, Russian Federation, August 2, 2011

I have been asked to talk with you about the importance of training in an effective system of child protection. To do this, I would like to present and explain some fundamental principles about training.

Few people would dispute that training is important to job success. However, in the child protection field, training is far more than "important" … it is *absolutely essential* to effective child protection work.

Let me start with an analogy.

Let's suppose you were just diagnosed with a brain tumor. Fortunately, you're told that it can be surgically removed. You checked your surgeon's background and credentials and learned that he had taken three classes on brain surgery and, on a few occasions, he had watched an experienced surgeon perform the surgical procedure that you need.

Would you allow this surgeon to operate on your tumor?

The analogy may seem far-fetched because child protection workers don't cut out brain tumors. But all too often, we do cut children out of their families to ensure their safety, and the trauma and loss can be just as great … and the long-term consequences equally devastating for children, and for their families.

Child protection is an extremely complicated field of practice, and it requires high levels of professional knowledge and skills—or as we call them, competencies. Therefore, training is essential to prepare and sustain a skilled child protection work force, and a training program will be most effective if it follows several fundamental principles.

First, training is a *process*, not an *event*. We often think of training as attending classes on selected topics, and we generally think of training as most important for newly hired staff members. However, effective training is an ongoing process that makes training available and easily accessible to staff throughout their careers.

Initially, training helps staff learn the fundamental and essential competencies to do their jobs. We call these "core" competencies, because they are equally important for everyone who performs that same job. But Core is only the beginning. We must also help staff [members] become proficient in more specialized and advanced skill areas, some of which cannot be mastered without considerable training, practice, and feedback over longer periods of time. To be most effective, training should be included in an ongoing professional development plan for each staff person in the organization.

The second principle is that in healthy organizations, *training is a part of management*, and arranging training is the responsibility of the organization. Managers who hire staff who lack the ability to do their assigned job are essentially shooting themselves in the foot; if staff cannot perform their jobs, the organization cannot achieve its mission and goals. Effective managers rely on training to build their staff's capacity, thus helping the organization to be successful.

The third principle is that *all staff* need training —not just the staff who work directly with families and children. Most organizations make the same mistake; they put considerable energy into training direct service staff and tend to ignore other staff groups, including supervisors and managers. Or, they train direct service staff first, and only then do they provide training to others, as an afterthought.

This presents several problems. An organization must be well managed in order to achieve its mission. Further, in order for direct service specialists to apply what they've learned to their jobs, the organization must create an environment that *facilitates* and *supports* them. Creating such an environment is the responsibility of managers and supervisors. If managers and supervisors cannot effectively manage, or if they lack a thorough understanding of child protection work, it doesn't matter how much training we provide to direct service staff—they won't use what they've learned in training because their work environment doesn't allow it.

An effective training system always trains managers and supervisors first or at the same time as direct service staff. And sometimes, it is most effective to train direct service staff and their managers together, so they learn the same principles at the same time. This can generate a commitment for both to apply what they have learned back in the workplace.

The final principle is that organizations need a *system* for training. It is not enough for staff to attend random training events that they might find interesting or valuable. The goal is to establish a training system that allows staff to attend the training they most need in order to do their jobs—*when* they need it.

To do this, a training system must have several components. One is the capacity to assess the individual training needs of each staff

Dr. Viola Vaughn-Eden, Ms. Tricia Gardner, Ms. Sandra Marchenko, and Dr. Vincent Palusci

member and to provide training that meets individual needs. It's true that some knowledge and skills are needed by all staff. We referred [to] these "core" skills earlier. These need to be trained in a standardized way to promote a common understanding of the work and a common approach to achieving it.

An effective training system must also offer a continuum of learning activities with a variety of delivery strategies. Classroom training is an effective means of learning, but it is not the only one. Distance learning enables staff to access training through the Internet, or to use self-instructional techniques, without having to travel anywhere. Coaching and on-the-job training are essential to help staff master complicated skills and use them effectively in their natural work environment. Most important, supervisors must be skilled in educational supervision, using everyday activities as "learning moments" to help their staff strengthen their skills. It is the training system's to ensure that supervisors have the ability, and the tools, to do this. Educational supervision is the best means of promoting what we call "transfer of learning," which is essential if newly learned knowledge and skills are ever to be used on the job.

Ultimately, our goal is to set up a comprehensive system for training, one that is integrated within the management structure of the organization, one that is sustainable and that stays relevant and current over time. We want a training system that does more than simply build the capacity of specialists and managers. We want a training system that exerts continuous pressure toward excellence and pushes the service system toward achieving best practice for children and their families.

Presentation by Dr. Vincent J. Palusci to the Child Protection Workgroup of the Bilateral Presidential Commission (Obama-Medvedev) in Ulan-Ude, capital of the Republic of Buryatia, Russian Federation, August 2, 2011.

Mr. President, Madame Chairwomen, distinguished Ministers and Members, and Guests of the Child Protection Workgroup: I am proud and honored to be here today representing the American Professional Society on the Abuse of Children and American physicians. I am a pediatrician and epidemiologist specializing in care and research for abused children at the New York University School of Medicine. I work at Bellevue Hospital in New York City treating children and also work with the City's Administration for Children's Services. I will be attending the First Russian-American Child Welfare Forum presenting information on medical issues with Dr. Lori Frasier and on prevention with Dr. Michael Haney.

It is important to put medicine's contribution to the care of abused and neglected children into historical context. While physicians have always cared for children with injuries after maltreatment, our formal involvement is more recent.

- It has been 350 years since Buryatia joined Russia,
- It has been 275 years since Bellevue Hospital was founded,
- Last month, we celebrated 235 years of American independence,
- It has been 136 years since the founding of the New York Society for the Prevention of Cruelty to Children in New York City,
- It is just 50 years ago that child abuse and neglect was officially recognized in medicine with the publication of C. Henry Kempe's landmark article, "The Battered Child,"
- But only during the last 25 years have we had an organization such as APSAC and scientific studies to understand child abuse and neglect in its many forms.

We now know that, from before birth through adulthood, there are certain basic needs that, if not met, will negatively affect child and adult health and development throughout the lifespan. As you develop your social and professional responses to child abuse and neglect in Russia, I want you to learn from our successes and failures from the perspectives of medicine and public health.

Dr. Judith Rycus, Mr. Luke Dembosky, and Mr. Dimitry Grigoriev (NFPCC).

Keep in mind:

- The response to child abuse and neglect should be approached as a medical and public health issue. Child welfare in the U.S. was first left to social workers and government, but we now realize that violence in families must be addressed by all members of civil society and its professionals.
- Physicians and public health practitioners need to be included in the systems of care you design. We as physicians can do more that just treat the physical and mental injuries after child abuse and neglect, and we can help lead your efforts to develop a truly encompassing care system.
- Physicians and public health practitioners need your help to understand child welfare issues beyond our clinical care for children and families. We need your assistance but can bring the strength of our scientific knowledge to design, implement, and measure the outcome of your programs. I am pleased that the Minister of Health is here today, and you must be sure to include medical and public health professionals in this ongoing discussion.

So how does this look in practice? On any given day at Bellevue Hospital, I may be asked to provide care to a young sexual abuse victim seen in the general pediatric clinic, an infant with a head injury being cared for in the intensive care unit, a runaway teen with psychiatric needs who also may have been abused and who is being seen in the emergency department, or an abandoned child referred from a foster care agency where there are additional concerns of abuse and neglect. All of these children need a comprehensive medical assessment in addition to services and evaluation from our governmental and private child welfare agencies, law enforcement, and judiciary systems. All these children need specialized care provided in a child-friendly environment that will not further traumatize them. And all of these children can benefit from our services to prevent further injury and to maximize their health and development.

Dr. Lori Frasier and Dr. Judith Rycus

This background supports the following recommendations based on our experiences:

1. Include physicians and public health professionals in your policy making groups, advisory boards, nonprofit organizations and multidisciplinary teams,
2. Include training on an ongoing basis for everyone in your child welfare system on the medical and public health issues facing children and families,
3. Include training for medical and public health professionals on child abuse and neglect issues both during initial professional training and ongoing,
4. Provide support for professional development for all the roles in your child welfare system you create. This includes respect and financial support for professional growth, specialization, and certification as appropriate to recognize the special roles and competence needed to perform these critical tasks for children and families in your system.

Thank you for inviting us as the representatives of APSAC, the American people, and the professionals who care for abused and neglected children and their families in the U.S. We are proud to join you in your efforts at this First Russian-American Child Welfare Forum to improve your systems of care. Your warm welcome and the opportunity to share our experiences with you have been gratifying and life-affirming. We are excited and pleased to join you in this important work and look forward to continued cooperation between our countries to address these important issues for children and families in both Russia and the United States of America.

What Is My Next Question? Using Question Frameworks to Improve Children's Narrative Accounts of Abuse

Scott M. Snider, LCSW, and Mark D. Everson, PhD

> Do I have to answer? I mean . . . it was only that one time. We were playing outside, and Mommy had to go to the store. He always does stuff when she goes to the store. I think she knows something because she keeps taking my baby brother with her. Daddy said to come inside, but Brandon had to stay outside. Daddy said, "Come here," and he . . . he started doing that. I went to my room, and then Mommy came home.

What is the next question in this forensic interview of an 8-year-old girl?

The field of child forensic interviewing draws upon accepted practices in the areas of question formation (Faller, 2007), knowledge of children's language development (Walker, 1999), and the development of interview protocols such as the National Institutes of Child Health and Human Development (NICHD) and CornerHouse's Rapport, Anatomy Identification, Touch Inquiry, Abuse, and Closure (RATAC) protocols (Brown & Lamb, 2009). Building upon these foundations, how can the interviewer's question framework maximize children's ability to report their experience? This article offers practical strategies to improve the clarity, accuracy, and level of detail children provide by emphasizing the need to structure interview question frameworks in response to children's narrative accounts of abuse.

Although some differences exist among researchers, Faller (2007) noted that the field generally recommends open-ended questions over close-ended questions because of their likely greater accuracy and acceptance in court. Child interviewers are often directed to utilize invitational phrases such as "Tell me about [an event]" to obtain detailed narrative accounts in the child's own words. Interview protocols such as NICHD also advise a "narrative training phase" to teach children to provide descriptive details about an event (Lamb, Hershkowitz, Orbach, & Esplin, 2008, p. 88). If children disclose abuse, ideally they will generalize the practice narrative lesson and provide initial narrative accounts of their abuse experience in response to "Tell me everything about that." As seen in the previous example, however, children's initial narratives are rarely, if ever, a complete history of their experience. Further questioning is required to clarify the events described in the initial narrative, along with other potential events and concerns.

Interview protocols offer some guidance on the framework and types of questions to ask after the child provides the initial narrative account. For example, NICHD recommends techniques such as referencing events, people, or actions using the child's words ("contextual cueing"), and asking the child about blocks of time based on the child's account of the event ("time segmentation"). Interviewers can clarify aspects of the child's narrative account by posing, "You said something about X; tell me everything about X." (Lamb et al., 2008). However, interviewers

may *target different aspects of the child's narrative account* depending on their individual style, level of training, and agency role. Without an overarching framework to structure and organize questions, the risk of confusing the child and interviewer increases, and the quality and inter-reliability among interviewers may decline.

The Initial Narrative Account

The example of the 8-year-old girl's statement contains several characteristics typically found in children's initial narrative accounts. The child provides multiple details about the alleged event but skips information regarding what sexual acts may have occurred, referring only to her father "doing that." The child provides what appears to be a relatively linear timeline of the event from beginning to end as instructed by the interviewer, but there are gaps in the timeline, such as whether Brandon stayed outside and exactly what happened in the house.

Note that the child provides significant levels of detail through the use of a single, open-ended invitational request, which supports the use of these questioning techniques within interview protocols. From the simple "Tell me about that" instruction the interviewer learns that (1) this may have occurred one time, although the child strongly alludes to possible other incidents, (2) it likely occurred at the child's home, (3) her mother went to the store, (4) her brother Brandon was home but likely not present during the alleged abuse, (5) there appeared to be purposeful isolation of the girl from her brother, (6) her father told her to "come here," (7) her father did something, and (8) she went to her room after this alleged incident. The efficacy of eliciting narrative details through open-ended questioning is self-evident, particularly *when considering how many directed, focused questions would be required to obtain this same level of information.* It is also possible that the interviewer would not glean this information using directed focused questions. For example, the interviewer may not have known to ask about her brother's whereabouts or her father's possible attempts to isolate the child from her brother.

While children can provide significant levels of information from these techniques, children and adolescents should not be expected to provide a clear, complete, and detailed account of an event when presented with a single "Tell me about that" request. Other fields of practice do not expect this level of reporting ability from children. For example, pediatricians do not expect children to offer a cogent, organized, and complete history of symptoms using the single phrase "Tell me about your health." Walker (1999, p. 19) advised that children's narrative accounts might appear "incomplete and disorganized" until sometime in the teenage years. Given this premise, the interviewer's task is not only to obtain accurate information but also to organize the flow of information with a question framework, providing that the questions are not leading or overly suggestive.

A well-organized question framework maximizes the child's ability to accurately describe his or her experience, and the interviewer and interview observers ideally obtain a clear understanding of the child's experience. The child's overall outcome improves when one's service and treatment plans are based on the clearest, most accurate information from the child. Conversely, a poorly structured, disorganized interview framework risks confusing the child and yielding inaccurate information by repeatedly switching subjects and time references. The child may be perceived as less credible by professionals and the court system, even though the interviewer, not the child, may be responsible for the lack of clarity.

Event Versus Scripted Memory

The field of child forensic interviewing recognizes the importance of determining the frequency of abuse to guide interview questions. Failure to match the question framework to the child's description of a single episode versus a combination of multiple episodes typically leads to interviewer errors and the perception that the child is not credible. Therefore, interviewers must be intentional in formulating questions based on whether they are seeking to access event memory or scripted memory. *Event* or *episodic* memory involves recall of a single, distinct event. This type of memory recall is critical for child abuse assessments, as professionals most often seek specific details of a particular event rather than a generalized account of abuse (Klemfuss & Ceci, 2009). In contrast, *scripted* memory involves an averaging of events over time. Scripted memory typically does not contain the same level of detail regarding specific events, but the generic script may be recalled better and may be more resistant to suggestive questioning than event memory (Olafson, 2007). As a frame of reference, an adult may recall idiosyncratic details of an anniversary dinner at his favorite restaurant (event/episodic memory). The same adult would have difficulty recounting details of every specific visit to the same restaurant over time and would resort to describing what usually occurred at the restaurant, such as what food he usually ordered or where he would usually sit (scripted memory).

Single-Event Interview Strategy

For single event interviews, the interviewer accesses episodic memory by asking the child to tell about the specific event from the beginning to end. The child responds with an initial narrative account of the event. As seen in the opening example, children often incorporate both the narrative practice experience and the instruction to describe the event from beginning to end, and their account roughly follows a linear timeline of the event. At that point, a simple and effective strategy is to address the child's initial narrative statements from the start of the narrative account, working through the narrative from beginning to end. Because the interviewer asks the child to report completely about an event from the beginning to the end, it follows logically to organize interview questions in this same manner.

Based on the example, the interviewer should first ask the child to describe more about her statement that they were "playing outside." Following invitational questioning techniques and "contextual cueing" (Lamb et al., 2008, p. 94), the interviewer may pose, "Let's start at the beginning to make sure I get everything right. You said that you were playing outside. Tell me everything about playing outside." When the child satisfactorily describes playing outside, the interviewer may inquire about her mother going to the store, and subsequently ask the child to tell more about her father telling her to "come inside" while Brandon stayed outside. The interviewer can then address the critical issue by asking, "You said your father said, 'Come here.' Tell me everything that happened when your father said, 'Come here.'" The child may provide details about the alleged abuse or may still demonstrate avoidance about what occurred. If the child does not respond to this invitational question, the interviewer may pose a focused question, such as "He told you to come where?" Once the child responds, good practice dictates that the interviewer should pair this focused question with an open-ended invitational request, such as "Tell me about what happened then" (Lamb et al., 2008).

Note that the interviewer avoids the temptation to immediately ask about her father "doing that" in response to the child's initial narrative account. Whether the child was sexually abused is obviously a critical issue. However, transitioning directly to questions about her father "doing that" is problematic in this example, and in most cases, for three reasons. First, the interview will likely fail to clarify contextual details surrounding the abuse event and will often miss critical information. Second, the interviewer risks losing track of which details the child has or has not provided, and must switch time references repeatedly to obtain a complete picture of what happened from beginning to end. Last, the interviewer also risks increasing the child's avoidance by quickly initiating questions most likely to produce reluctance and anxiety.

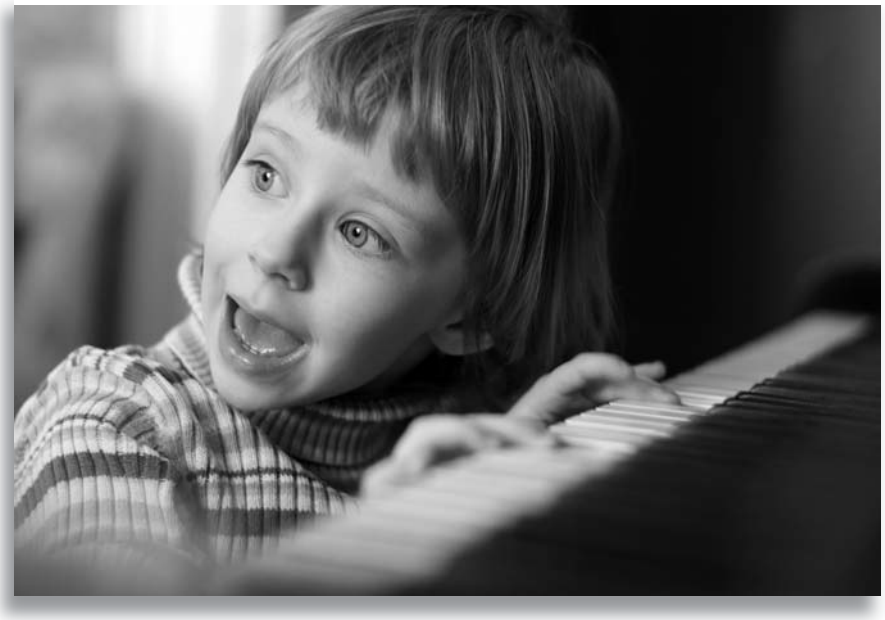
Using a practical, linear question framework to explore a single event from the beginning to the end of the child's initial narrative has several benefits. First, utilizing questions formulated from the child's own language minimizes potential interviewer errors and assumptions while simultaneously increasing the child's capacity to provide relevant details (Lamb et al., 2008). Second, the interviewer is less likely to become disorganized, since the children themselves provide the road map for organizing questions. Third, the interviewer clearly conveys that the interviewer is listening carefully to the child's statements, creating the prospect of effective reciprocal communication throughout the interview. Fourth, questions designed to clarify the beginning of the episode often give children the running start they need to subsequently describe traumatic events. Finally, children often provide information the interviewer would not have obtained otherwise through focused questioning. The end result is more likely to be a clear, detailed account of the alleged event in the child's own words.

Multiple-Event Interview Strategy

Multiple-event interviews tend to be complex, given the need to clarify several events over the course of time. For abuse that occurred more than one time, accepted practice recommends attempting to access event or episodic memory by asking the child to isolate one specific event, such as the first, last, or worst time abuse occurred (Lamb et al., 2008; Olafson, 2007). If the child recalls a specific incident, the interviewer structures questions about this specific single event using the single event strategy previously outlined. After the child describes the single event in sufficient detail, the interviewer may opt either to ask about another recalled specific incident (event memory) or shift questioning to what "would" occur over time (scripted memory).

Multiple-event interviews differ depending on case circumstances such as the frequency and duration of abuse. In the authors' experience, however, until around age 8, children should generally not be expected to provide event memory details on more than one to two episodes within a single interview. The authors also find that the younger the child and the more numerous the

abusive events, the more likely the interviewer may need to switch to scripted memory questions to clarify what "would" happen during additional events after the child provides a single episode description. Once the interviewer chooses to switch to a scripted memory framework, the evaluator's questions should match the child's scripted memory responses and be phrased as what "would" or "usually" happen, such as "Would your father ever touch you with other parts of his body?" after the child disclosed one episode of touching.



Some children cannot recall a specific event when abuse occurred more than one time. For example, young children tend to have more difficulty than older children in isolating and reporting details of specific episodes within multiple events (Poole & Lamb, 1998). If the child cannot isolate a specific episode such as the first, last, or worst time, the interviewer has case-specific options. The interviewer may ask the child to "Tell me what happened," recognizing that the child's account will likely contain both episodic and script memory details. After the child provides their account, the interviewer may ask whether the alleged abuse happened in a different way or a different place to obtain a more complete history. Alternatively, the interviewer could exclusively utilize scripted memory questions and ask what "would" occur. This strategy attempts to strictly access scripted memory to avoid confusion between single and multiple events. However, the interviewer of young children should be cautious before assuming the child understands and can use scripted recall at will when asked what "would" occur. Furthermore, the interviewer should document any difficulty discriminating between episodic and scripted memory, and note that the child's account may contain both episodic and scripted details.

Note that scripted memory questions are often focused or yes-no questions, in which any positive response should be paired with an invitational question to "Tell me more about that" (Lamb et al., 2008). By matching scripted memory questions to the child's scripted recall, the interviewer can glean critical information such as different locations, types of touching, and other idiosyncratic details without confusing the child and risking inaccurate reporting. After exhausting questioning about the alleged offender, the interviewer should ask whether the child was sexually abused by any other individual, and follow up any positive response either within the interview or through additional interviews.

Shifts Between Episodic and Scripted Memory

Even when children start to report a single incident using episodic memory, they may shift between episodic and scripted memory responses. This phenomenon occurred in the sample narrative statement. The child initially stated that abuse occurred one time, but she alluded to the possibility of more than one incident by stating, "He *always* does stuff when she goes to the store." She then reverted back to episodic memory and described the one incident when her father called her inside. Interviewers must recognize children's subtle language changes, marking their switch from event to scripted memory (or vice versa) and formulate questions accordingly. Key words such as *always*, *would*, or *usually* and the use of the present tense indicate a child's shift to scripted memory. When these switches occur, the interviewer should gently redirect the child back to episodic memory to describe the single recalled event. After the child fully describes this single event in detail, the interviewer should revisit whether events occurred more than once through statements such as "You said before that he always does stuff when your mother goes to the store. Tell me everything about that."

In increasingly complicated interviews, the child may initially report no clear recall of a specific event, forcing the interviewer to match the child's scripted memory to a scripted-memory-question framework. As the child reports what would occur, the discussion may spark memories of a specific event. Depending on factors such as the age of the child and the salience of the event, the interviewer can opt to pose episodic memory questions if the child is able to detail this single event. The key point is that the interviewer must identify these shifts wherever they occur and respond accordingly by matching the question framework to the child's episodic or scripted memory recall.

Pitfalls

Even in relatively straightforward single-event cases, child interviews are replete with choice points when the child's statements challenge the interviewer's questioning framework. Children may spontaneously offer information about concerns such as domestic violence, substance abuse, or even abuse by other individuals. These choice points create decision trees within the child interview. The method through which the interviewer navigates these decision trees defines variations between interviewers, as individual interviewers may follow different paths within the interview.

Consistent with the narrative in our example, the child may next describe sexual touching by her father and then spontaneously state that her uncle did the "same thing." The interviewer's dilemma is whether to abandon the original line of questioning about her father and ask about the uncle, or to flag this issue and delay asking about the uncle until later in the interview. Interviewers must use their clinical knowledge and experience to inform their decision based on the individual child, but in the authors' experience, the best strategy is generally to avoid repeatedly switching subjects. The interviewer will most likely improve accuracy by exhausting questions about a particular subject on the decision tree before moving to the next. Once the subject is completely explored, the interviewer can move to the next subject.

If the child in the example spontaneously discloses abuse by her uncle as well, the best approach would likely be to advise the child that the interviewer wants to understand better what happened with her father and will ask about her uncle later in the interview (or during an additional interview). The interviewer can cue the child and direct the conversation by simply stating, "If I ask about too many things at once, I get very confused. I'll ask about your uncle a little later, but let's finish talking about your father."

Conclusion

Our experiences support the use of narrative interview techniques to obtain vastly improved quality and quantity of information from children. The use of such techniques can be further enhanced when interviewers structure their question framework to maximize the child's capacity to verbalize a clear, linear, detailed description of his or her experiences. By using simple strategies to address single-event and multiple-event interviews, interviewers can avoid pitfalls, such as shifts between subjects and between episodic and scripted memory. Ideally, the end results are more accurate and detailed information from children; a forensically defensible interview that maintains the integrity of interview protocols; and improved medical, mental health, child protection, and legal outcomes for children as well as their families.

References

Brown, D., & Lamb, M. E. (2009). Forensic interviews with children: Supporting interviewers in adhering to best practice recommendations and enhancing children's capabilities in forensic interviews. In K. Kuehnle & M. Connell (Eds.), *The evaluation of child sexual abuse allegations: A comprehensive guide to assessment and testimony* (pp. 299–325). Hoboken, NJ: Wiley.

Faller, K. C. (2007). Questioning techniques. In K. Faller (Ed.), *Interviewing children about sexual abuse* (pp. 90–109). New York: Oxford University Press.

Klemfuss, J. Z., & Ceci, S. (2009). Normative memory development and the child witness. In K. Kuehnle & M. Connell (Eds.), *The evaluation of child sexual abuse allegations: A comprehensive guide to assessment and testimony* (pp. 153–180). Hoboken, NJ: Wiley.

Lamb, M. E., Hershkowitz, I., Orbach, Y., & Esplin, P. W. (2008). *Tell me what happened: Structured investigative interviews of child victims and witnesses.* Chichester, U.K.: Wiley.

Olafson, E. (2007). Children's memory and suggestibility. In K. Faller (Ed.), *Interviewing children about sexual abuse* (pp. 10–34). New York: Oxford University Press.

Poole, D. A., & Lamb, M. E. (1998). *Investigative interviews of children: A guide for helping professionals.* Washington, DC: American Psychological Association.

Walker, A. G. (1999). *Handbook on questioning children: A linguistic perspective* (2nd ed.). Washington, DC: ABA Center on Children and the Law.

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Comparing the NICHD and RATAC Child Forensic Interview Approaches—Do the Differences Matter?

Patti Toth, JD

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"It's simple, but not easy. Ask more open-ended questions and fewer closed-ended questions." This is how Tom Lyon (professor of Law and Psychology at the University of Southern California and an expert on child interviewing) describes the task of conducting a child forensic interview that maximizes reliability while minimizing suggestibility. For the child being interviewed, it's easy to guess when asked a focused question that can be answered with just one or two words, which increases the likelihood of being wrong. For the interviewer, the challenge is to increase the use of open-ended prompts to successfully elicit more accurate narrative responses from children.

Throughout the world, professionals from a variety of backgrounds (including social work, law enforcement, and others) are now specially trained in child-sensitive "forensic" interviewing. These training programs are likely to mirror one of two popular approaches—a structured "narrative" interview that emphasizes eliciting verbal narratives in response to open-ended invitations (similar to or based on the **NICHD protocol**), or an interview that incorporates early use of media, such as anatomical drawings, along with specific questions regarding "touch" (similar to or following the **RATAC protocol**). For interviewers trying to enhance their skills and utilize best practices, it is important to recognize both the similarities and differences in these two approaches.

Background

By definition, forensic interviews are investigative in nature and aimed at gathering reliable information that can serve as evidence in civil and criminal courts to help protect children and/or hold offenders accountable. Concerns about inappropriately suggestive interview techniques in high-profile child abuse cases around the globe during the 1980s and 1990s resulted in greater emphasis on open-ended interview techniques most likely to elicit free recall narratives and accurate information. At the same time, it was recommended that the use of more focused, closed-ended "recognition" prompts be minimized, especially with children under age 6, since research clearly demonstrated the risk they pose of producing unreliable answers.

RATAC Protocol

Developed by Minnesota's "CornerHouse" Children's Advocacy Center (CAC) in 1989, the RATAC protocol includes five elements:

- *Rapport*
- *Anatomy Identification*
- *Touch Inquiry*
- *Abuse Scenario*
- *Closure*

The RATAC protocol promotes the use of media, including easel pads and drawing of a "face picture" and "family circles" by the interviewer during the rapport stage. This is followed by asking young children to provide names for body parts using anatomically detailed drawings, and discussing touches as the primary method for introducing the topic of suspected abuse with children under age 10. RATAC instructors encourage interviewers to consider the appropriateness of using anatomical dolls as demonstration aids following a child's verbal disclosure of sexual abuse. In the one published study involving the use of the RATAC protocol in 500 real-life interviews for suspected child sexual abuse taking place in 2003 and 2004, interviewers at the CornerHouse CAC introduced anatomical dolls in 49% of their interviews. The RATAC protocol reflects several practices common in the United States at the time it was developed, such as anatomy identification (sometimes also called "body parts inventory") and the use of anatomical dolls. The RATAC protocol has been taught in 17 states, as well as in Japan.

NICHD Protocol

The NICHD Investigative Interview Protocol was developed by a group of researchers (led by Michael Lamb) at the National Institute of Child Health and Human Development (NICHD) to encourage the use of open-ended prompts to elicit verbal

narrative responses and thus translate widely supported research-based recommendations into operational guidelines. It was first published in 2000. Since then, the NICHD protocol has been utilized in several countries and has inspired adaptations in a number of jurisdictions that integrate and endorse its key components.

Among the approaches based on, or more similar to, the NICHD protocol are (partial list): Tom Lyon's (2005) "Ten Step Investigative Interview," "Achieving Best Evidence in Criminal Proceedings: Guidance on Interviewing Victims and Witnesses, and Using Special Measures" from the United Kingdom (2011), Michigan's Forensic Interviewing Protocol, Washington State's Child Interview Guide, Ohio's Childhood Trust Flexible Interview Guidelines (Erna Olafson and Julie Kenniston), the National Children's Advocacy Center's (NCAC) Flexible Interview Model (Linda Cordisco-Steele and colleagues), and North Carolina's RADAR Adaptation of NICHD Protocol (Mark Everson and Chris Ragsdale).

The NICHD protocol is supported by extensive field research involving over 40,000 real-life interviews in the United States, the United Kingdom, Israel, and Canada, and it is described in numerous articles published in many peer-reviewed scientific journals. Phases of the NICHD protocol include the following: *Introductory phase:* explaining the purpose and ground rules; eliciting a promise to tell the truth

- *Rapport-building phase*
- *Training in episodic memory* and narrative event practice
- *Transition to substantive issues:* using open-ended, nonsuggestive verbal prompts
- *Free recall phase:* investigating the incidents using a variety of open-ended prompts
- *Closure*

Approaches based on the NICHD protocol tend to discourage the use of props such as dolls and drawings (or recommend their use only late in the interview if necessary for clarification) due to concerns that they may unnecessarily raise the risk of eliciting inaccurate information.

Similarities

Creators of both the RATAC and NICHD protocols were motivated by the desire to improve interview practice and be sensitive to the needs of children. Consequently, there is agreement about a number of guiding principles and interview characteristics, some of which are described next.

Flexibility – Although the RATAC protocol is described as "semi-structured" and the NICHD as "structured," both approaches allow interviewers to modify their approach to adapt to the individual child and circumstances. For example, if a child immediately starts to disclose abuse at the beginning of the interview process before all initial stages have taken place, both approaches would agree that the interviewer should follow the child's lead rather than postpone discussion of the abuse experience(s).

Interview as only part of the investigation – No matter what protocol is utilized, there is agreement that a forensic interview is only one part of a complete investigation.

Necessity of peer review and ongoing training to reinforce and maintain interviewer skills –
Consistent with the results of research conducted by the developers of the NICHD protocol, proponents of both RATAC and NICHD agree that interview training alone is insufficient to maintain and improve interviewer performance. Ongoing training to reinforce skills along with regular support and feedback (including review of interviews with peers) are necessary.

Setting – There is widespread agreement that the interview setting should be private, free from distractions, child-friendly, and neutral. Whenever possible, the interviewer should be the only person present during the interview with the child.

Documentation – Everyone concurs that video recording is the best and most accurate way to document interviews and should be utilized whenever possible. In addition, there is apparent agreement that the child should be informed when the interview is being recorded.

Timing – No matter the preferred protocol, interviewers agree that it is preferable to interview a child as soon as possible after the alleged event(s), while considering the child's mental and physical state and ability to provide information (such as whether it is naptime or the child is otherwise tired or distracted).

Interviewer demeanor – Both approaches endorse an interviewer demeanor that is supportive, warm, and friendly while maintaining objectivity. Interviewers should be open-minded and unbiased and should de-emphasize authority.

Importance of building rapport – Both approaches teach that it is critical for interviewers to engage the child, establish a relationship, and make him or her comfortable before initiating questions about substantive allegations.

Developmental appropriateness – Being developmentally appropriate during an interview is crucial. Both approaches stress that interviewers must pay careful attention to the child's understanding and use of language, and adjust to his or her developmental level. This includes making sure the child understands the interviewer (and vice-versa) and keeping sentences short and simple.

Importance of adapting to the individual child – Consistent with other interview approaches, the NICHD and RATAC protocols are in agreement that interviewers should recognize and respect the uniqueness of each child. In addition to adapting to the child's cognitive developmental level, interviewers should consider the child's physical age, cultural background and experiences, mindset, level of support, physical or other disabilities if any, and other unique characteristics if any and adapt accordingly.

Differences

Table 1 indicates some of the differences between the NICHD and RATAC protocols. Discussion of three of the key differences follows.

Table 1. Comparison of Interview Approaches*

Components/ Techniques	NICHD-Based Approaches (emphasizing verbal narratives)	RATAC-Based Approaches (CornerHouse/Finding Words/ChildFirst)
Introductory Instructions (or "ground rules")	Routine—interviewer explains expectations (such as *"Correct me if I make a mistake*") and acceptable responses (such as *"I don't know*") early in the interview, and includes practice examples with young children	Instructions not included at beginning but reinforced throughout the interview "when opportunity presents itself"
Promise to tell truth; *with or without* Assessment of Truth/Lie Testimonial Competency	Child is usually asked to promise to tell truth in developmentally appropriate language; Truth/Lie competency of young children *may* be assessed using examples	Not included —Truth/Lie discussions at beginning of interview are discouraged by RATAC instructors
Narrative Event Practice (or "training in episodic memory")	Important interview stage used to build rapport and to assess child's use and understanding of language—open-ended invitations are used to elicit neutral or positive event narratives	Not specifically designated as a separate stage or component of the interview
Use of Drawings	Drawings (usually gender-neutral) are used sparingly and generally only after a disclosure when attempts to elicit verbal narratives during substantive questioning have been insufficient	Use of drawings in various ways is encouraged, starting with "'face pictures,'" "'family circles,'" and anatomically detailed drawings at beginning of interview (see descriptions that follow)
Face Picture	Not included	When younger than age 8, and child's choice if 8–10 years—interviewer uses easel pad to draw picture of child's face and ask questions; part of rapport stage along with family circles
Family Circles	Not included	When younger than age 11 (and older if interviewer chooses), questions about and draws circles to represent who child lives with and help structure child's report

Table 1. Comparison of Interview Approaches* *continued*

Components/ Techniques	NICHD-Based Approaches (emphasizing verbal narratives)	RATAC-Based Approaches (CornerHouse/Finding Words/ChildFirst)
Anatomy Identification	Not included	Anatomically detailed drawings used to see if children younger than 6 years can differentiate gender, and w/children younger than 10 years to name body parts
Touch Inquiry (to introduce topic of concern)	Not included	Yes/No questions (and follow-up) about positive and negative touch for children younger than 10 years
Nonsuggestive Transition (to introduce topic of concern)	Starts with *"Tell me why you're here today*" for all children and, as needed, uses question progression that becomes gradually more direct (see, for example, Lyon's "Ten Step Interview")	*"What do you know about coming here today?"* can be used w/children ages 10 and over, but not usually w/younger children
Substantive Questioning (called "Abuse Scenario" in RATAC protocol)	Emphasis on: • Inviting narratives (such as *"Tell me about …," "Tell me more,"* and *"What happened next?"*) • Nonsuggestive open-ended inquiries for all ages (and minimizing use of forced choice questions) • Gradual progression as needed to more direct questions • "Pairing" open-ended follow-up requests for more info following direct questions or short answers • More focused open-ended techniques such as cued recall and time segmentation to elicit details	"Process of Inquiry" model favors fewer free recall/indirect questions and more direct questions (including Yes/No and multiple choice) w/younger children and those w/more emotional trauma; considers more indirect questions (free and focused recall) most appropriate w/older children and those who are less emotionally traumatized; misleading questions should not be asked
Use of Anatomical Dolls	Generally not used	Interviewers are encouraged to use dolls under appropriate circumstances

*This comparison is a brief and partial list of the author's general impressions of some of the components and techniques and areas of emphasis that may *differ* in these two approaches. Individual practice or specific approaches can vary and often blend different aspects of both approaches.

There are a number of similarities in these approaches not reflected in this chart.

The most significant differences between the NICHD and RATAC protocols involve children under the age of 10. Consideration of the differences should take into account that young children, especially preschoolers, are the age group most susceptible to suggestion.

Interview Instructions

Interview instructions or "ground rules" have research support and are specifically included as part of the introductory phase of an NICHD-based forensic interview in order to orient the child to interview expectations, discourage guessing, and increase resistance to suggestion. Recommended instructions incorporated in many approaches based on the NICHD protocol include the following:

1. *"Don't guess"*
   The child is given permission to say *"I don't know"* and is told not to guess, accompanied by a practice example (for young children) such as *"What's my dog's name?"* Assuming the child says *"I don't know,"* the interviewer reinforces the answer and asks that the child not guess when answering other questions. Adaptations such as Tom Lyon's (2005) "Ten Step Investigative Interview" recommend also using an example where the child *does* know the answer, such as *"Do you have a dog?"* and pointing out that the child *should* answer when he or she knows the answer.
2. *"Don't understand"*
   The child is given permission to say he or she doesn't know what the interviewer means when a question is not understood, accompanied by a practice example (for young children) such as *"What's your gender?"* Assuming the child says he or she doesn't know what that means, the interviewer acknowledges that's a hard word and says, *"What I mean is, 'Are you a boy or a girl?'"*
3. *"Correct interviewer mistakes"*
   The child is encouraged to correct interviewer mistakes, accompanied by a practice example (for young children) such as *"What would you say if I said you were 30 years old?"* Assuming the child corrects the interviewer with his or her actual age, the interviewer thanks the child and asks the child to correct any other mistakes by the interviewer.
4. *Interviewer lack of knowledge*
   The child is clearly told that, because the interviewer wasn't there, he or she doesn't know what happened and can't help answer interview questions.
5. *Promise to tell the truth*
   The interviewer asks for a commitment from the child to tell the truth. This can be done by asking the child *"Do you promise that you will tell me the truth today?"* Tom Lyon's (2005) "Ten Step Investigative Interview" adds the question *"Will you tell me any lies?"* Additional discussion regarding the child's understanding of the difference between telling the truth and telling a lie is optional.

Tom Lyon points out (and demonstrates in interviews he has conducted) that an interviewer should be able to cover the above-listed instructions at the outset of the interview in 2 minutes or less. After providing instructions at the beginning, an interviewer should continue to offer reinforcement of these ground rules throughout the interview whenever appropriate.

Proponents of the RATAC protocol recommend incorporating interview instructions into the body of the interview as the opportunity presents itself (for example, when the child corrects the interviewer or answers *"I don't know"* on his or her own) rather than reviewing instructions at the beginning of the interview. They argue that "extensive pre-interview instructions" are not necessarily effective and that immediate and positive reinforcement when the situation arises is more helpful. The drawback with omitting instructions at the beginning and waiting until the opportunity presents itself is that reticent or very deferential children, who most need practice and encouragement to apply these instructions, are the least likely to provide the opportunity for reinforcement on their own during the interview.

Narrative Event Practice

Although RATAC trainers encourage interviewers to invite children to provide a narrative statement about life experiences during the rapport stage, neutral narrative event practice or "training in episodic memory" is given much greater emphasis as a separate and important interview phase in the NICHD protocol. It recommends that interviewers identify a recent innocuous event experienced by the child and then use a series of open-ended questions and prompts to encourage the child to provide detailed narrative responses and elaboration about that event from episodic and recall memory. Having children "practice" responding to open-ended prompts about neutral experienced events has been shown to increase the amount of information produced from recall memory during the substantive phase of the interview, regardless of their ages. Based on the extensive body of research regarding the use of the NICHD protocol in the field, it is clear that even preschoolers are capable of providing informative narrative responses (albeit shorter than those provided by older children) to open-ended prompts. This is especially important given the greater suggestibility of preschool age children. But since open-ended invitations and narrative free recall responses are a departure from the usual way adults communicate with young children, it takes practice and training of both the child and interviewer with narrative event practice to maximize the child's ability to provide narratives.

In contrast, RATAC's "Process of Inquiry" teaches interviewers that narrative responses are less likely and that direct and focused questions are more appropriate with young children. Because there is not yet any published research examining the question types and responses elicited by RATAC interviewers in real-life interviews, it is not clear how the RATAC protocol compares with

the NICHD protocol with regard to the use of direct and focused questions in interviews with young children.

Transition to Topic of Concern

For young children (under age 10), the RATAC protocol utilizes "touch inquiry" as the primary means of introducing the topic of suspected sexual abuse. Children are asked to identify touches they like and touches they don't like or consider confusing, followed by questions about where on the body they are touched and by whom. The question *"What do you know about coming here today?"* can be used with children 10 and over but has generally been considered developmentally inappropriate with younger children under the RATAC protocol.

The NICHD protocol adopts a much different approach, taking advantage of the fact that in most cases of suspected abuse, the child has made a previous disclosure that is the basis for conducting the forensic interview. The topic of suspected abuse is introduced for **all** ages by posing an extremely open-ended invitation, for example *"Now that I know you better, tell me why you came to see me today,"* or *"Tell me why I came to talk to you today."* If the child doesn't immediately respond with information about the topic of concern, the interviewer can use other open-ended nonsuggestive prompts, for example *"It's really important for me to know why you came to see me today," "I understand something may have happened to you—tell me what happened," "What did ____ tell you about coming to talk to me today?" "Why do you think ____ brought you here to talk to me today?"*

In research involving real-life interviews, interviewers utilizing the NICHD protocol have had impressive success with these prompts—over 80% of initial disclosures of sexual abuse by preschoolers were made in response to such free-recall prompts. If these are not productive, the NICHD protocol gives the interviewer the option to use a series of general prompts, or prompts based on background information, that are as nonsuggestive as possible but become gradually more focused, for example *"I heard you talked to _____ about something that happened—tell me what happened," "I see you have* [a bruise, a broken arm, etc.]*—tell me what happened," "I heard you saw* [the doctor, a policeman, etc.] *last week— tell me how come/what you talked about," "Is* [your mom, another person] *worried about something that happened to you? Tell me what she's worried about," "I understand someone might have bothered you— tell me what happened," "I understand someone may have done something that wasn't right— tell me what happened," "I understand something may have happened at* [location]*—tell me what happened."*

Conclusion

A great deal of time and attention has been devoted to improving interviews with children regarding suspected abuse over the last 30 years. We now know that using open-ended prompts to elicit free recall narrative responses is critical in order to maximize reliable information from children. This is especially true with young children who are more likely to respond with inaccurate information to direct and focused recognition prompts. Tom Lyon's admonition that interviewers should *"ask more open-ended questions and fewer closed-ended questions"* is indeed a simple concept, but it can be very challenging to implement on a consistent basis. Interviewers should be as knowledgeable as possible about available options, should regularly seek review of their work, and should strive to incorporate evidence-based best practice techniques in their interviews so that children's voices are heard. As research continues and our experience grows, we will continue to learn more about how to do a better job of protecting children and holding offenders accountable.

References

Anderson, J., Ellefson, J., Lashley, J., Lukas Miller, A., Olinger, S., Russell, A., Stauffer, J., & Weigman, J. (2010). The CornerHouse Forensic Interview Protocol: RATAC. *Thomas M. Cooley Journal of Practical and Clinical Law, 12*(2), 193–331.

Hlavka, H. R., Olinger, S. D., & Lashley, J. (2010). The use of anatomical dolls as a demonstration aid in child sexual abuse interviews: A study of forensic interviewers' perceptions. *Journal of Child Sexual Abuse*, *19*(5), 519–553. doi:10.1080/10538712.2010.511988

Lamb, M. E., Hershkowitz, I., Orbach, Y., & Esplin, P. W. (2008). *Tell me what happened: Structured investigative interviews of child victims and witnesses*. West Sussex, England: Wiley.

Lamb, M. E., Orbach, Y., Hershkowitz, I., Esplin, P.W., & Horowitz, D. (2007). A structured forensic interview protocol improves the quality and informativeness of investigative interviews with children: A review of research using the NICHD Investigative Interview Protocol, *Child Abuse & Neglect, 31*(11–12), 1201–1231. doi: 10.1016/j.chiabu.2007.03.021

Lyon, T. D. (2005, version 2). Ten step investigative interview. In *Selected Works of Thomas D. Lyon*. Retrieved October 6, 2011, from http://works.bepress.com/thomaslyon/5/

Saywitz, K. J., Lyon, T. D., & Goodman G. S. (2011). Interviewing children. In J. E .B. Myers (Ed.), *The APSAC handbook on child maltreatment (3rd ed.).* (pp. 337–360). Thousand Oaks, CA: Sage.

U.K. Home Office, Ministry of Justice. (2011). Achieving best evidence in criminal proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures. Retrieved October 10, 2011, from http://www.justice.gov.uk/guidance/docs/achieving-best-evidence-criminal-proceedings.pdf

About the Author

Patti Toth manages APSAC's Child Forensic Interview Clinics and is a former APSAC Board member and President. She is coauthor of Washington State's Child Interview Guide and also manages Washington's statewide child interview training. Patti was a prosecutor and first Director of NDAA's National Center for Prosecution of Child Abuse. Contact: *ptoth@cjtc.state.wa.us*

Journal Highlights

Howard Fischer, MD

Gender, Child Maltreatment, and Adult Depression

Compared with nonabused children, children who are maltreated have a higher risk of major depressive disorder (MDD) in adulthood. Studies show that sexual abuse, physical abuse, emotional abuse, and child neglect may lead to adult depression in both men and women. Since depression, in general, is more common in women than in men, it has been asked whether the risk of depression resulting from child maltreatment (CM) differs according to the child victim's gender. Reasons have been proposed for a possible greater vulnerability to depression in such women. Women hold themselves more accountable for the quality of relationships than do men. They suffer more self-blame and shame after experiencing CM. Women may have different coping strategies, may focus on the causes and consequences of their depression, and may be more likely to get diagnosed with MDD.

The few studies that examined the role of gender as a moderator of risk for depression after CM have produced inconsistent results: Some showed no role for gender, others that women were at greater risk. Most of these studies have looked at only one or two types of CM; they have also used CM measures "with unknown psychometric properties" (p. 176). The authors of the present study looked at the influence of gender on the association between CM and depression using a large sample of primary care patients at an HMO. They used a validated measure of CM—the Childhood Trauma Questionnaire (CTQ), an instrument specifically created for retrospective analyses—and measured depression with the Patient Health Questionnaire (PHQ).

Study patients came from various communities in California. They were between 21 and 75 years old and literate in English. Patients with psychosis, bipolar disorder, dementia, or postpartum depression were excluded. Twelve thousand Kaiser Permanente primary care patients were randomly selected for participation in the study; about 5,700 participated and returned completed questionnaires.

Depression was measured with the PHQ, which inquired about the presence of eight symptoms and their frequencies during the previous two weeks. CM was measured by the CTQ, which assesses physical abuse, sexual abuse, emotional abuse, and emotional and physical neglect. There are five items that may be endorsed for each of the five CM types. They are rated on a five-point frequency of occurrence scale. Mean age of study participants with MDD (50.5 y) was younger than those not depressed (53.3 y). Women participants were more likely to be African American and less likely to be married. More women than men reported histories of sexual abuse (26% v 13%) and emotional abuse (34% v 24%). Proportions were not significantly different by gender for physical abuse (~23%), emotional neglect (~35%), or physical neglect (~29%). The prevalence of depression was 8.5% in women and 5.2% in men. More depression was seen in more severe CM.

Logistic regression models were used to test the effects of gender on CM and MDD. Adjustments were made for marital status, age, educational level, and ethnicity. None of the models indicated a gender effect. The correlation between abuse history and current depression was the same for men and women. Of course, because more women reported childhood sexual abuse and emotional abuse, there was a higher proportion of depressed women. Stated plainly, abused women do not have a greater vulnerability to depression than men, but there are more of them.

The authors point out that their cross-sectional study does not permit one to infer causality between CM and MDD. The retrospective nature of the CM assessment runs the risk of faulty recall. They do not know how generalizable their results with HMO members are to other populations. They conclude by stating that men as well as women with histories of CM should be assessed for depression. In addition, some studies show that depressed patients with histories of CM respond better to psychotherapy than to pharmacotherapy. Knowing about a CM history may thus influence the mode of treatment.

Arnow, B. A., Blasey, C. M., Hunkeler, E. M., Lee, J., & Hayward, C. (2011). Does gender moderate the relationship between childhood maltreatment and adult depression? *Child Maltreatment, 16*(3), 175–183.

Screening Tool for Sexual Assaults

About 67,000 children in the U.S. were sexually abused in 2009. Often, these children are taken to an Emergency Department (ED) for evaluation of the alleged sexual abuse. EDs may be busy, noisy places—settings that are not the best for an initial evaluation of a distressing problem. Studies show that even in pediatric EDs there is sometimes no documentation of the genital examination and no testing and prophylaxis of sexually transmitted diseases (STD) or pregnancy. However, children who are evaluated for sexual assault at a child advocacy center (CAC) are more likely to have a complete physical examination, a genital examination, tests and prophylaxis for STDs, and referral for counseling. Thus, EDs provide immediate evaluation, but the evaluation may not be optimal when established guidelines are used as a standard.

The rationale for an ED visit is the need for rapid evaluation of injuries and STDs, the need to recover forensic evidence, to assure the child's safety, and to evaluate emotional problems resulting from the assault, including suicidal ideation or plan. The study authors devised a screening questionnaire that sought to determine which prepubertal children with a complaint of sexual assault could have their initial evaluation in a place other than an ED, that is, in a CAC. They evaluated 2 years of medical records from two pediatric EDs and a CAC, all part of one healthcare system, looking at children 12 years old and younger. The record was reviewed to answer these questions: (1) Did the incident occur in the last 72 hours with oral, genital to genital, or genital to anal contact? (2) Did the patient have genital or rectal pain, bleeding or discharge, or known genital injury? (3) Was there an immediate concern for the child's safety? and (4) Was there an unrelated emergency medical condition present? Data were collected from all contributors to the medical record: triage nurses, sexual assault nurse examiners, social workers, and ED and CAC physicians. An answer of "yes" to any of these questions was a positive screen, requiring immediate evaluation. A high-risk patient (not synonymous with a screen-positive patient) had physical examination findings (trauma or infection), a change in custody or institution of a safety plan by child protection or law enforcement authorities, or an emergency medical condition requiring intervention.

The charts of 163 patients were reviewed and 90 (55%) had a positive screen. More than two thirds of these 90 were positive because of genital or rectal pain, bleeding, or discharge; 44% because of time <72 h and mucosal contact; 22% for a safety concern; and 9% for an emergency medical condition. Screen-positive and screen-negative patients were similar in age, gender, and ethnicity. Medical records after CAC evaluation showed that 56 of the 90 screen-positive patients were classified as high risk. No negative-screen patients were ultimately found to be high risk.

Thus, the screening tool had a sensitivity of 100%, a specificity of 68%, a negative predictive value of 100%, and a positive predictive value of 62%. The authors suggest that patients with a negative screen might benefit from "timely evaluation" in the less stressful, more thorough CAC, since there is no medical emergency requiring them to have an ED visit. This will also lighten the load on EDs (while increasing the load on CACs—editor). EDs and general pediatric clinics might use the screening tool for triage, to determine who needs immediate evaluation and who can be referred to a CAC on a nonemergent basis. The authors indicate that their screening questionnaire needs prospective evaluation to confirm its utility.

Floyed, R. L., Hirsch, D. A., Greenbaum, V. J., & Simon, H. K. (2011). Development of a screening tool for pediatric sexual assault may reduce emergency-department visits. *Pediatrics, 128*(2), 221–226.

Estimating the Probability of Abusive Head Trauma

The most common type of fatal child abuse is abusive head trauma (AHT). Usually infants are the victims. These children have an intracranial injury (ICI) without an adequate explanation for the injury. The physician must in such cases determine which children with ICI need investigation and then attempt to distinguish between abusive and nonabusive head trauma (nAHT). In addition to the medical evaluation, a multidisciplinary team must gather and synthesize all pertinent information to determine the likelihood that the ICI is the result of abuse. The consequences of mistaking AHT for nAHT, or vice versa, may be enormous and irrevocable.

Recently, articles in the lay press, as well as in legal and medical journals, have questioned the validity of the clinical diagnosis of AHT. There is, then, a need for a valid, agreed-upon scientific basis to aid in making a diagnosis of AHT. The authors performed this study to propose a method of estimating the probability of AHT given different clinical findings in a child with ICI.

The authors based their work on six published studies of head injury (both nAHT and AHT) describing a total of 1,053 children, of whom 348 had AHT. They contacted the authors of the six papers for additional needed details not included in the articles. The six studies included children younger than 3 years old with any combination of subdural, subarachnoid, or extradural hemorrhage, intraparenchymal injury, cerebral contusion, diffuse axonal injury, hypoxic ischemic injury, and/or associated cerebral edema. The study authors looked for the presence of the following clinical features in these children with ICI: apnea, retinal hemorrhages, rib fractures, long bone fractures, skull fractures, seizures, and head/neck bruising. Skull fracture was found to have no predictive value and was omitted from the final analyses.

Using strict definitions, a diagnosis of AHT was considered valid after "comprehensive evaluation of all medical and social features, after a multidisciplinary assessment of the full case details and, in many cases, by 'finding of fact' in care or criminal legal proceedings or a perpetrator admission" (p. e558). Cases that were indeterminate or "suspected abuse" were not included in the AHT category. The authors performed sophisticated statistical analyses of the data with a five-page appendix describing the statistical methods used.

The study showed that when a child younger than 3 years had an ICI without any of the other clinical features (apnea, fractures, etc.), the probability of AHT was about 4%. The authors then describe probabilities and odds ratios (OR) for AHT in the presence of ICI and one clinical feature: the OR is ~45 with a rib fracture (probability of AHT of 65%), the OR is ~35 with retinal hemorrhages (probability of AHT of 58%). Apnea with ICI had about a 25% probability of indicating AHT.

When multiple clinical feature are present along with ICI, the probability of AHT depends very much on the specific features present. If, for example, a child with ICI had apnea and retinal hemorrhages, the probability of AHT was 90%. If a child with ICI had apnea and head or neck bruising, the probability of AHT was about 54%. When rib fractures or retinal hemorrhages were present with any one of the other features, the OR for AHT was >100 and the probability of AHT was >90%. When three or more of the clinical features were present, ORs were >100 and the probability of AHT was >85%. The authors present tables showing the 64 possible combinations of clinical features and the ORs and probabilities for each combination.

These estimates of probability may provide a valid foundation with which to support clinical opinion. In this way, they may help in deciding whether (and how much of) a work-up is needed for a given child. They may help the clinician explain in court why certain combinations of findings have a lesser or greater chance of predicting abuse.

Maguire, S. A., Kemp, A. M., Lumb, R. C., & Farewell, D. M. (2011). Estimating the probability of abusive head trauma: A pooled analysis. *Pediatrics, 128*(3), e550–e564.

Detection of Human Papillomavirus in Sexually Abused and Nonabused Children

Genital infection with human papillomavirus (HPV) is the most common sexually transmitted infection (STI) in the United States. The infection may be asymptomatic, produce genital warts, or lead to genital cancers. If perinatal transmission can be excluded, the presence of an STI in a child is considered evidence of child sexual abuse (CSA). By the age of 18 years, 12%–25% of girls and 8%–10% of boys in the U.S. will have been sexually abused. Not enough is known about the epidemiology of HPV transmission in children, and it is not currently possible to equate HPV detection with CSA. Studies have found the prevalence of genital HPV detection in children to vary 5%–33%. There is also some belief that much childhood HPV infection is the result of nonsexual transmission (e.g., parents with warts on their hands transmit the infection to infants during diaper changes, or children with warts on their hands inoculate their own genitals). The study authors attempted to characterize the epidemiology of HPV genital infection in children without previous consensual sexual activity by studying children being evaluated for CSA. They compared HPV prevalence with certainty of CSA, maternal and child history of genital and nongenital warts, and demographic factors.

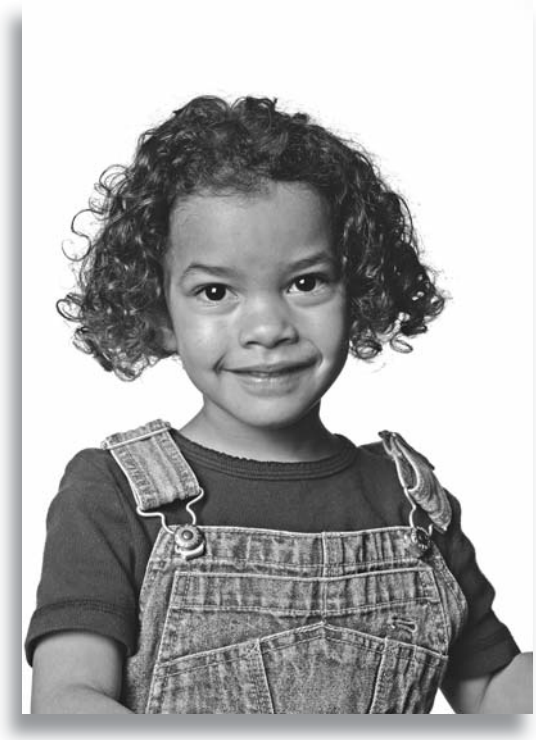
Study subjects were recruited from eight sites in four states. One site was a pediatric emergency room and the rest were child advo-

cacy centers. Histories, physical examinations, and STI testing (for Chlamydia, gonorrhea, syphilis, HIV, and hepatitis B) were done. Both boys and girls were recruited from one site; the other seven recruited girls only. Maternal STI history, including the presence of genital warts before, during, and after the pregnancy, was obtained. A history of nongenital warts in caregivers and in the child was also obtained. A comparison group of children presenting for reasons unrelated to CSA was recruited to ensure the presence of adequate numbers of nonabused children for data analysis. Physicians skilled in diagnosing CSA determined the likelihood of abuse on the basis of history, physical examination, and the presences of STIs (not including HPV). CSA certainty was considered "definite," "probable," "possible," or "no evidence of CSA," using published criteria. HPV genital infection was positive if HPV DNA was found by polymerase chain reaction testing in participant urine sample or genital swab.

The study population included 534 children evaluated for CSA, and 14 had genital warts. The comparison (control) group had 42 children. The age range of the patients was 6 months to 13 years. Girls were more likely to have evidence of CSA than boys (87% v 75%; p=.051). Subjects aged 10 years or older were more likely to have evidence of CSA than younger ones (92% v 82%; p=.002). Most subjects (83%) had urine and genital swab specimens analyzed for HPV. Some had only a genital swab or a urine specimen. There were 517 subjects with adequate specimens, of whom 438 were considered to have some evidence of abuse and 79 were considered to have no evidence of CSA. HPV was detected in 12% of subjects (and in 11% of those without genital warts).

HPV detection did not differ if the mother had had either genital warts or hand warts or not. Children with evidence of CSA were 10 times more likely to have genital HPV (13.7%) than those without evidence of CSA (1.3%). HPV detection rates varied with the certainty of the CSA classification: 8.4% in possible CSA, 15.6% in probable CSA, and 14.5% in definite CSA. These findings did not change when patients with genital warts were excluded. CSA was the strongest predictor of HPV detection. Older age was also independently associated with HPV detection.

The authors indicate that increasing HPV detection in the older children and lack of association of maternal history of genital warts do not support the notion of perinatal transmission in children older than 2 years, although they wish they had more younger children in the study. They also make the observation "that there is no gold standard for the determination of CSA" (p. e683) which leads to some uncertainty in evaluating results. They conclude by stating that their goal was to characterize the epidemiology of HPV infection in children without previous consensual sexual activity, not to assess the utility of HPV detection in diagnosing CSA.



Unger, E. R., Fajman, N. N., Maloney, E. M., Onyekwuluje, J., Swan, D. C., Howard, L., Beck-Sague, C. M., Sawyer, M. K., Girardet, R. G., Hammerschlag, M. R., & Black, C. M. (2011, September). Anogenital human papillomavirus in sexually abused and nonabused children: A multicenter study. *Pediatrics, 128*(3), e658–e665.

About the Author
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Washington Update

Thomas L. Birch, JD

Congress Resumes Budget Battles on Multiple Fronts

Since returning from the August recess, Congress has focused attention—again—on the issues of spending and revenues. The Joint Select Committee on Deficit Reduction—the so-called supercommittee of six Democrats and six Republicans from the House and Senate created by the Budget Control Act to settle the debt ceiling controversy—is charged with identifying $1.5 trillion in spending cuts by Thanksgiving this year. Congress must enact the cuts, or tax increases, by December 23.

There can be little doubt that discretionary spending will suffer mightily. President Obama has said that the deal will result in the lowest level of domestic spending since the Eisenhower administration in the 1950s. Everything in discretionary spending is on the table, and the debt ceiling compromise bill does not include any immediate revenue additions or tax increases. That initiative is left to the supercommittee.

For the 15th straight year—what gets to look like business as usual—Congress has allowed a new fiscal year to begin on October 1 without having enacted all of the regular appropriations bills needed to keep the government running. Almost none of the dozen regular appropriations bills for fiscal 2012 are ready for enactment. Instead, Congress has passed a continuing resolution to keep the government operating until mid-November while the appropriations process advances. Typically, the continuing resolution allows agencies to operate at their prior year level. That has not been the case in the current congressional session because House Republicans have forced specific spending cuts in the process of continuing federal funding on a stop-gap measure. Federal agencies are operating now in FY-2012 with 98.5% of their FY-2011 allocations.

In the meantime, work on individual appropriations has picked up momentum, in part to signal preferred funding levels to the members of the supercommittee. In the Senate, the Subcommittee on Labor-HHS-Education Appropriations on September 20 approved its version of the 2012 spending bill, holding most child welfare funding at current levels.

In the House, Rep. Denny Rehberg (R-MT), chair of the Labor-HHS-Education Appropriations Subcommittee, has released a draft plan of his proposals for a House version of the 2012 spending bill. However, Rehberg's document was not approved or even reviewed by his subcommittee, so it carries only quasi-official status. The move clearly represents the Republican approach to spending decisions for 2012 and aims at advising the deficit reduction supercommittee on where to reduce the size of the federal deficit.

In a sweeping action reflecting hostility among many congressional Republicans toward Obama's health care reform, the Rehberg plan eliminates most of such reform enacted in the Affordable Care Act, including funds for home visiting, and has allocated no money to the program in 2012. The spending plan also cuts almost $8 million dollars from discretionary spending for the Child Abuse Prevention and Treatment Act (CAPTA) with no explanation. The Senate bill maintains 2011 spending levels for all CAPTA programs.

On the other side of the ledger, the House bill would increase funding for Head Start and the Community Services Block Grant (long on the elimination list for fiscally conservative House Republicans) and maintain current spending levels for the Child Care and Development Block Grant.

Congress Votes Extension of Safe and Stable Families

On September 27, Congress approved legislation to extend spending authority for Title IV-B(1) Child Welfare Services and Title IV-B(2) Promoting Safe and Stable Families through 2016. The bill also extends the authority of the Department of Health and Human Services (HHS) to grant waivers to states for innovative uses of federal foster care funds.

The Child and Family Services Improvement and Innovation Act (S.1542, H.R. 2883) passed the Senate by voice vote on September 23 after September 21 approval in the House by a 395 to 25 vote. The legislation extends the funding authority for the regional partnership grants originally focused on protecting children in families exposed to the use of methamphetamine, as well as other drugs. The new legislation eliminates the methampheta-

mine emphasis in the program, recognizing the variety and multiplicity of substance abuse risks for children. Support is also extended for the court improvement program.

GAO Report Certifies Undercount of Child Fatalities

More children are likely to have died of maltreatment than are reflected in the estimated 1,770 child fatalities reported in *Child Maltreatment 2009*,[1] the most recent study of the annual analysis of the National Child Abuse and Neglect Data System (NCANDS) issued by the U.S Department of Health and Human Services (HHS). According to testimony presented by Kay E. Brown, Director of Education, Workforce and Income Security at the U.S. Government Accountability Office (GAO), at a hearing on July 12 before the House of Representatives Ways and Means Subcommittee on Human Resources,[2] the undercounting of child maltreatment fatalities (as explained in the GAO's report *Child Fatalities From Maltreatment: National Data Could Be Strengthened*) is reflected by the fact that nearly half the states report their data to NCANDS based solely on children already known to child protective services (CPS) agencies.

However, not all children who die from abuse or neglect were previously known to protective services. While HHS has encouraged states to obtain information on child maltreatment fatalities from other, non-CPS sources of information, 24 states reported to GAO that their 2009 NCANDS data did not include child fatality information from any non-CPS sources.

Rep. Dave Camp (R-MI), chair of the Ways and Means Committee who commissioned the GAO study, opened the hearing before turning the gavel over to the subcommittee chair, Rep. Geoff Davis (R-KY). Davis emphasized the importance of focusing on improving counts of child maltreatment fatalities to better protect children.

In her testimony on behalf of GAO, Brown advised that a synthesis of information about child fatalities from multiple sources such as death certificates, state child welfare agency records, or law enforcement reports—not currently linked in the NCANDS data—could produce a more comprehensive picture of the extent of child deaths than reliance only on CPS data. She cited a study finding that by linking any two of the data sources,

1 *Child Maltreatment 2009* is available on the Children's Bureau Web site at http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can
2 Find the full GAO report at http://www.gao.gov/new.items/d11811t.pdf

more than 90% of child fatality cases could be identified. Brown told the subcommittee that the undercount of fatalities currently ranges from 55% to 76% by using multiple reporting sources.

Brown cited further barriers to collecting accurate counts, including inconsistent state definitions of maltreatment, differing state legal standards for substantiating maltreatment, and missing state data. In addition, local child death investigators, such as law enforcement officials, coroners and medical examiners, and CPS staff, are often unable to determine, without definitive medical evidence, that a child's death was caused by abuse or neglect rather than natural causes. GAO's survey found that in 43 states medical issues were a challenge in determining child maltreatment, exacerbated by significant variations in the level of skill and training for coroners and medical examiners from state to state. Brown also explained that the sharing of reporting data across jurisdictions (county or state) is often hindered by confidentiality rules governing child abuse reporting information.

In responding to requests from the states for additional HHS assistance in collecting data on child fatalities and near fatalities from maltreatment and using this information for prevention efforts, GAO recommends in its report that the Secretary of HHS

- take steps to further strengthen data quality, such as identifying and sharing states' best practices and helping address differences in state definitions and interpretation of maltreatment,
- expand available information on the circumstances surrounding child fatalities from maltreatment,
- improve information sharing on the circumstances surrounding fatalities from maltreatment, and
- estimate the costs and benefits of collecting national data on near fatalities.

Other witnesses at the hearing included the following:

Theresa Covington, director of the National Center for Child Death Review, who testified that child deaths from neglect are especially underreported, which is significant in understanding that the majority of all child maltreatment cases are attributed to neglect. She also identified differing state definitions and varying capacity for investigation as challenges to an accurate understanding of the scope of child fatalities and recommended developing national standards on definitions and reporting criteria.

Dr. Carole Jenny, director of the child protection program at Hasbro Children's Hospital in Providence, Rhode Island, urged federal support for training more doctors in child-abuse pediatrics to help police, forensic, and social service agencies in making correct diagnoses of child deaths from abuse or neglect and by ruling out conditions that mimic abuse or neglect.

Michael Petit, president of the Every Child Matters Education Fund, pointed to the findings and recommendations in the fund's report *We Can Do Better: Child Abuse and Neglect Deaths in America* (October 2009 & September 2010), asserting that child protective services are stretched too thin.

Jane Burstain, senior policy analyst at the Austin, Texas, Center for Public Policy Priorities, urged the subcommittee panel to be mindful of the implications for protecting children and preventing maltreatment and related fatalities in their current deliberations over reducing federal spending.

Rep. Jim McDermott (D-WA) struck a similar theme when asking about states with the best systems to predict and prevent abuse or neglect. Petit identified Vermont with its extensive safety net that includes comprehensive health care and home visiting services.

Other members of the subcommittee expressed differing concerns. Rep. Rick Berg (R-ND), a freshman member of the subcommittee, spoke of the importance of improving communication among agencies to achieve a more complete picture of the problem. Rep. Tom Reed (R-NY), another first-term member, proposed requiring drug and alcohol testing for all parents on public assistance.

About the Author
Thomas L. Birch, JD, is director of the policy and advocacy work of the National Child Abuse Coalition. An attorney by training, he came to this work from Congress, having served as legislative counsel to members of the United States Senate and House of Representatives on issues of domestic policy.

APSAC News

The American Professional Society on the Abuse of Children Participates in Historic Event in Russia

A joint venture between the Administration of the President of the Russian Federation, the American Professional Society on the Abuse of Children (APSAC), the Institute for Human Services (IHS), the U.S. Department of Justice (DOJ), the National Foundation for Prevention of Cruelty to Children in Russia (NFPCC), and the Republic of Buryatia resulted in the First Russian-American Child Welfare Forum being held at Ulan-Ude and Lake Baikal in the Republic of Buryatia August 1–6, 2011.

The initiative was a result of discussions conducted by President Obama and President Medvedev's Bilateral Commission's Civil Society Subcommittee on Child Protection. The APSAC, IHS, and DOJ contingent consisted of 16 members along with those from other organizations who provided consultation with a panel of Russian officials and child welfare professionals on a variety of issues critical to improving Russia's child welfare system.

Over 150 Russian government and nongovernmental organization (NGO) officials attended the First Russian American Child Welfare Forum. The Forum is designed to be an annual event pairing local child welfare service providers with leading Russian and American specialists to tackle the most serious issues facing the child protection and welfare field today. The goal is to further the development of Russian-American dialogue and partnership in resolving pressing national and international child protection-related issues.

A complete summary of the event by APSAC President Ron Hughes and our delegates' presentations are available in this issue of the *Advisor*. Additional information is available at **www.racwf.org**.

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. The 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.

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

APSAC Pre-Conference Institute #2:
Advanced Forensic Interview Training
Sunday, January 22, 8 a.m.–4 p.m, 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, January 22, 8 a.m.–4 p.m., 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.

Mark the Dates: 2012 APSAC Advanced Forensic Interview Clinics

Consistent with its mission, APSAC pioneered the Forensic Interview Training Clinic model to focus on the needs of professionals responsible for conducting forensic-investigative interviews with children in suspected abuse cases. Interviews with children have received intense scrutiny in recent years and increasingly require specialized training and expertise. These comprehensive Clinics offer a unique opportunity to participate in an intensive 40-hour training experience and have personal interaction with leading experts in the field of child forensic interviewing. Developed by top experts, APSAC's curriculum teaches a structured narrative interview approach that emphasizes best practices based on research and is guided by best interests of the child. Attendees will receive a balanced review of several protocols and will develop their own customized narrative interview approach based on the principles taught during the Clinics.

The first clinic will be held April 23–27, 2012, in Norfolk, Virginia. A second clinic is being offered July 30–August 3, 2012, in Seattle, Washington. Details and registration are available on the APSAC Web site, www.apsac.org.

APSAC to Celebrate 25 Years at Colloquium

APSAC will be celebrating its 25th anniversary at the upcoming 20th Annual Colloquium, which takes place June 27–30, 2012, in Chicago, Illinois. Keep an eye on the APSAC Web site and your e-mail regarding plans for this celebration. Colloquium details will be posted on the Web as they become available.

APSAC

The American Professional Society on the Abuse of Children

Celebrates A Quarter Century of Progress

The 20th Annual Colloquium

June 27–30, 2012
Sheraton Chicago Hotel and Towers
301 East North Water Street | Chicago, Illinois 60611

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

The American Professional Society on the Abuse of Children is returning home to celebrate our 25th Anniversary in the city and state that gave birth to our organization: Chicago, Illinois. In 1987, a visionary group of professionals wondered what might be possible if they developed a multidisciplinary membership organization supporting those working to end child abuse. Over the next 25 years, an involved and committed membership provided the answer: the development of an organization unique in its capacity to provide education, training, guidance, and leadership in the field of child maltreatment.

Come join us in the celebration of their vision and commitment to supporting and training professionals who serve children and families affected by child maltreatment and violence. Through the hard work and dedication of our members, APSAC has grown into a multidisciplinary group of professionals who also are our friends, family, colleagues, and the leading experts on the prevention and intervention of child abuse in the United States.

Our vision is for a world where all maltreated or at-risk children and their families have access to the highest level of professional commitment and service. Our mission is achieved in a number of ways, most notably through expert training and educational activities, policy leadership and collaboration, and consultation that emphasizes theoretically sound, evidence-based principles.

Please join us in Chicago June 27–30, 2012. Our anniversary colloquium is hailed to be the premier training event of the century, including child abuse professionals from around the world. Be a part of making this dream come true and making new friendships, as well as renewing old ones. APSAC exists because of you, and we hope you celebrate with us—A Quarter Century of Progress in Service to Children and Families!

Helping Professionals Protect Children and Families for a Better Tomorrow

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

Colleagues connecting for kids.

APSAC SERVICES BRING VALUE TO MEMBERS

APSAC is dedicated to bringing the very best in services to its members. We're all about providing you with the tools you need to help you, your colleagues and the people you help. Here are just a few of our powerful services.

APSAC Education

Each year, APSAC delivers the very best in education through its Advanced Training Institutes, Colloquium, and Forensic Interview Clinics. Details on these APSAC events are available on the web.

- 2012 Advanced Training Institutes, January 22-23, San Diego, CA
- 2012 20th Annual Colloquium, June 27-30, Chicago, IL
- 2012 Forensic Interview Clinics, April 23-27, Norfolk, VA and July 30-August 3, Seattle, WA

APSAC delivers value!

APSAC Online Resources

APSAC provides valuable online tools to enhance the membership experience, including:

- APSAC Library
- Career Center
- Searchable Membership Directory

APSAC Publications

APSAC publications provide members with knowledge, news and updates to help them with their profession. These publications include:

- Child Maltreatment Journal
- APSAC Advisor
- Practice Guidelines
- The APSAC Handbook on Child Maltreatment

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

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Elmhurst, IL 60126

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Fax: 630.359.4274
E-mail: apsac@apsac.org
www.apsac.org

Conference Calendar

January 22, 2012
APSAC Advance Training Institutes
American Professional Society
on the Abuse of Children
San Diego, CA, 807.402.7722
apsac@apsac.org
www.apsac.org

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

February 26-29, 2012
2012 National Conference—Making Children a Priority: Leading Change!
Child Welfare League of America (CWLA)
Washington, DC, 202.688.4200
www.cwla.org/conferences/conferences.htm

March 8, 2012
8th Annual Wells Conference on Adoption Law
Capital University Law Review and the National Center for Adoption Law & Policy
Columbus, OH, 920.366.4344
cdiedrick@law.capital.edu

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

March 21-25, 2012
2012 Annual Conference and Exposition
American Counseling Association
San Francisco, CA, 800.347.6647
www.counseling.org/Convention

March 21-24, 2012
National Conference on Juvenile and Family Law
National Council of Juvenile and Family Court Judges
Las Vegas, NV, 775.784.6920
ckelley@ncjfcj.org
www.ncjfcj.org/content/view/1471/315

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 23-25, 2012
Together for Children: 25th Annual Wisconsin Conference on Child Abuse and Neglect
Children's Service Society of Wisconsin and Prevent Child Abuse Wisconsin
Lake Geneva, WI
pcaw@cssw.org
www.preventchildabusewi.org

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

May 23-25, 2012
European Conference on Child Abuse and Neglect in Amsterdam (EUccan)
Emma Children's Hospital, the Netherlands Forensic Institute (NFI), and the Academic Medical Centre /Amsterdam (AMC)
Amsterdam
www.euccan.eu

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

July 8-10, 2012
International Family Violence and Child Victimization Research Conference
UNH Family Research Laboratory & Crimes Against Children Research Center
Portsmouth, NH, 603.862.1888
doreen.cole@unh.edu
www.unh.edu/frl

July 30-August 3, 2012
APSAC's Child Forensic Interview Clinic
American Professional Society
on the Abuse of Children
Seattle, WA, 877.402.7722
apsac@apsac.org
www.apsac.org

September 29-October 1, 2012
12th International Conference on Shaken Baby Syndrome/Abusive Head Trauma
National Center on Shaken Baby Syndrome
Boston/Cambridge, MA, 801.447.9360
mail@dontshake.org
www.dontshake.org

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on the Abuse of Children
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