APSAC ADVISOR

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Regular Features

Also in This Issue

This special issue of the *APSAC Advisor* highlights changes in the professional response to child maltreatment and the contribution of APSAC and its members on our organization's **25th anniversary.**

APSAC

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

President's Message

This has been an exciting, even exhilarating, 2 years as President of APSAC. Through its 25-year history, APSAC has earned a well-deserved reputation for providing products and services of the highest quality and significance. This is a result of the unique character of its professional multidisciplinary membership and a long a history of special commitment of that membership in governance and development. Partially by design and partially by necessity, the APSAC Board of Directors and its subcommittee infrastructure have historically not been only the nexus of governance for the organization, but have also in a unique way been the professional staff of the organization. This continues to be a unique and powerful aspect of APSAC's history and character. However, it became clear to the present Board that if APSAC is to maximize its potential in providing more comprehensive leadership in the development of policy, programs, and services to help professionals throughout the country to provide the highest quality services to maltreated children and their families, then APSAC would have to increase its professional staffing capacity and infrastructure.

In the past 2 years, the Board of Directors has committed to a two-pronged strategic initiative; first, to strengthen APSAC's historical areas of activity and, second, to begin the process of extending APSAC's capacity to act more planfully, proactively, comprehensively, and consistently in efforts to secure our organization's mission.

To address our commitment to strengthening APSAC's established areas of activity, we have undertaken and completed several initiatives. A third edition of the *Child Maltreatment Handbook* has been published, with John Meyers providing editorial leadership. Two sets of APSAC Guidelines were developed; "Integrating Prevention Into the Work of Child Maltreatment Professionals" was published in 2010, and "Forensic Interviewing in Cases of Suspected Child Abuse" will be published over the next few months. Board member Julie Kenniston oversaw the development of APSAC-hosted Internet special interest groups regarding investigative interviewing.

After a comprehensive national search, Candice Feiring, PhD, was selected as the new Editor in Chief of *Child Maltreatment.* APSAC's renowned research journal continues to thrive with Dr. Feiring's leadership. The *APSAC Advisor*, through the leadership of two Editors in Chief, Dr. Judith Rycus and Dr. Vincent Palusci, has made great strides in enhancing its creativity and relevance. The *Advisor* not only is the essential "connection" between membership and organization, it has proven the venue for debate and education on many important issues facing us as a field of practice.

APSAC's last two Annual Colloquiums have been financial and programmatic successes, even in times of significant economic challenge. The outlook for our upcoming 25-year celebration at our 20th Colloquium in June promises to be a truly seminal event. Our Child Forensic Interview clinics around the country, under the leadership of Patti Toth, continue to be an exemplar of progressive evolution in service to best practice. This excellence was highlighted by a recent invitation to travel to Singapore for a 2-week training for child welfare professionals. These are but a few examples of our commitment to maintain the highest levels of quality to APSAC's historical areas of development and activity.

The second prong of the Board's strategy was to identify and address the development of organizational infrastructure areas that could allow the expansion of APSAC's effectiveness in meeting its mission. Primary to any such development is the need to secure additional financial support. APSAC has succeeded in acquiring over $120,000 in additional grants and donations to support both targeted and unrestricted development. In addition, it has set a goal for an additional $500,000 in grant donations for the next 2-year period, and work has begun to reach or exceed this goal.

Past board President Dr. Michael Haney has been hired half time as Executive Director in the first substantive move toward increasing APSAC's professional staffing and capacity. Board membership participation has been developed to include specially targeted members with essential professional expertise. Board Committees, such as the new Amicus Legal Committee, have been appointed to grow into permanent ongoing infrastructures with ongoing capacity to influence national policy. Target funding has been obtained to support this growth. Board members Frank Vandevort and Bill Forcade provide leadership in this effort.

APSAC has been working with the Obama/Medvedev U.S.-Russian Bilateral Presidential Commission's Civil Society Committee, the American Embassy in Russia, and the Departments of Justice and State to facilitate child welfare reform efforts in Russia. This resulted in APSAC co-sponsoring the first Russian-American Child Welfare Forum, held last August in Ulan Ude in the Republic of Buryatia in the Russian Federation. As a result, the APSAC Chicago Colloquium will play host to the Second Russian-American Child Welfare Forum and a meeting of the Bilateral Presidential Commission Civil Society Committee's Child Welfare Working Group. APSAC member Christopher Newlin and I serve as members. The U.S. Department of Justice and the American Embassy in Moscow are sponsoring a party of Russian delegates and child welfare professionals to attend the conference as part of a learning tour. The activities have been cost neutral for APSAC through targeted fundraising efforts and have helped to expand APSAC's effectiveness in shaping policy and practice within the United States and around the world.

These are some of the positive things that have happened over the last 2 years. In the near future, APSAC has some significant choices to make regarding its development. President-Elect Dr. Viola Vaughan-Eden, Executive Director Dr. Mike Haney, Vice President Tricia Gardner, and our present and prospective Board members are more than up to the task. Our administrative staff, Michael and Dee Dee Bandy and Dr. Jim Campbell and his wife, Jane, are without peer. Their commitment and excellence are everywhere present in all that we do. And whatever level of growth and development is decided to best meet APSAC's mission and objectives, the organization has proven its capacity to provide the needed leadership and service. I look forward to continuing to make a contribution in any way I can.

Ronald C. Hughes, PhD, MScSA
President, APSAC

APSAC Presidential Memories

Tricia D. Gardner, JD

In honor of APSAC's 25th anniversary, some of our founders and former presidents have shared their memories from their time of leadership. Some have served during times of prosperity and others during times of strife, but all have provided undeniable leadership and vision for APSAC. It is because of their great dedication and sacrifice that APSAC is still a strong and thriving organization today.

Jon Conte, PhD, President, 1987–1989 and 2001–2003

Professor, University of Washington School of Social Work

When I think back to the beginnings of APSAC, I recall more the feelings than the events. It was a time not all that long after the rediscovery of childhood sexual abuse in the late 1970s. There was a strong feeling of discovery and the excitement that each new research finding or professional collaboration seemed to generate in professionals meeting each other for the first time and brought together by a common purpose. There was a keen awareness of the need for new knowledge and a real sense of multidisciplinary collaboration and mutual support. While there was some resentment from colleagues who had been working in physical abuse with this new emphasis, over time this gave way.

Now I am struck with how what was originally our sole interest has become widespread among the public and in virtually every social and behavioral science and, indeed, much of the humanities as well. Virtually every discipline claims an interest and specialization in child abuse. Child maltreatment professionals have become increasing fragmented. APSAC is hardly the only national or global organization committed to child abuse, and public more than professional interests define policy concerns dealing with child maltreatment.

Yet I am also struck with how important our mission remains. Multidisciplinary collaboration, dissemination of new knowledge, other supports for professionals, and most of all, a central focus on the victim of child maltreatment and the adults who influence their lives remain an urgent need here in the United States and around the globe.

David Corwin, MD, Founding Member

Professor and Chief of the Pediatrics Child Protection and Family Health Division, Primary Children's Center for Safe and Healthy Families, University of Utah School of Medicine

I've always hoped that APSAC would become the professional organization for those at the front lines in the effort to confront child maltreatment and to promote the best possible response to those affected by child maltreatment. Many people think I was an early APSAC President, but actually I chaired the National Summit Conference on Diagnosing Child Sexual Abuse in October of 1985, where the first mandate for a new multidisciplinary professional society focused on child sexual abuse emerged. After that, the organizing meeting for APSAC was held at the Chicago O'Hare Airport Hyatt Hotel in September of 1986. Although there was originally an interest to focus mainly on sexual abuse (as indicated by the mandate), the final decision was to support the broader focus on all child abuse and neglect. While never President, I was the first Editor in Chief of the *APSAC Advisor* and the first Chair of the Professional Guidelines Committee that oversaw the creation of the first sets of professional guidelines.

The original name of the organization was APSVOC, American Professional Society on the Victimization of Children. When I returned to California after the organization meeting and met with Neal Snyder and others who had helped me found CAPSAC (originally the California Association of Professionals on the Sexual Abuse of Children, which was actually founded before APSAC and quickly grew to more than a 1,000 members), we decided that if APSVOC would agree to become APSAC then we could change the name of CAPSAC to the California Professional Society on the Abuse of Children, keeping it in parallel mission with APSAC. The new APSAC Board accepted that proposal and APSVOC became APSAC.

David L. Chadwick, MD, President, 1989–1990

Director Emeritus, Chadwick Center for Children and Families, Rady Children's Hospital, San Diego, California

I don't recall that anything very interesting happened during my year as President. I made my most important contribution at the meeting in New Orleans, where we defined the mission of APSAC. A substantial number of those attending wanted an organization that would concern itself only with sexual abuse. I argued that if that were adopted, we would need separate organizations for each of the recognized maltreatment forms and the organizations would then compete with each other. Perhaps the "March for Munchausen's Syndrome by Proxy" would garner all the supporters. This argument prevailed, and APSAC's mission includes all maltreatment forms.

Joyce Thomas, RN, MPH, PNP, FAAN

President, 1990–1991

President and CEO, Center for Child Protection and Family Support, Washington, DC

As one of the founding members of APSAC in 1989–1990, it was my distinct honor to serve as an early President of this newly established multidisciplinary professional organization. The seed idea to form APSAC grew out of an organizing meeting that was held May 14–17, 1986, in New Orleans, Louisiana, during the Fourth National Conference on Child Sexual Victimization, and this greatly influenced my involvement as one of the early leaders. I remember that in the 1980s, several high-profile child sexual abuse cases hit the national media, and we all recognized the need to establish greater credibility in the field of child maltreatment. I specifically recall that social workers and others involved in the investigation and treatment of young children from the McMartin preschool in Manhattan Beach, California, came under attack, and the creation of APSAC was critical for quality assurance in practice and research.

Two key efforts stand out in my mind from the time I served as President. First was my role to engage APSAC in addressing cultural competency in the field; second was my job of creating an environment for the formation of state chapters. In both situations, APSAC was entering uncharted territories, and our approach on how to proceed was not always clear. For example, in 1989, through firsthand practice experience and publications of early research articles from many professionals, the field began to uncover the problems of racial disparity in maltreatment rates and overrepresentation of African American and Native American children in out-of-home placement. During those days, almost every major child abuse institution began to dialogue about the gaps and need for ethnic-minority leadership development and training of child welfare providers, as well as the importance of increased public awareness and the implications of research on cultural factors. In 1990, the first major federal grant on cultural competency in child welfare was awarded to the Center for Child Protection and Family Support (CCPFS) in Washington, D.C., and the People of Color Leadership Institute (POCLI) was established.

As the first African American President of APSAC, I believe that one of my most significant accomplishments occurred when the APSAC Board established working groups to address issues of cultural competency in both the organization and the field. I remember being extremely active in partnering with others to motivate, encourage, and strengthen systems intervention for African American, Latino, Native American, and Asian-American children and their families. This was a conscious choice—one that continued long after my presidency ended.

State chapter formation was another major effort that began while I was President. I recall that following the highly visible Manhattan Beach child abuse case, California became the first state to organize and form a state chapter. This was known as the California Professional Society on the Abuse of Children (CAPSAC). APSAC Board agendas focused on matters related to formation of structures, state by-laws, fiscal issues, and relationship of state chapters to the national organization. This dialogue continued well into the future of APSAC.

Charles Wilson, MSSW, President, 1992–1993

Senior Director and Sam and Rose Stein Endowed Chair in Child Protection, Chadwick Center for Children and Families, Rady Children's Hospital, San Diego, California

My days in APSAC had a profound impact on my professional identity and my vision of a nation of professionals working together on behalf of children and families. I have been involved in many efforts in my 40-year career, but I don't think I have ever been prouder than with my small role in helping build the foundation of APSAC and my association with a fine group of leaders.

I must admit to being a bit overwhelmed and quite frankly flattered to be asked to join the Board of APSAC in 1987. APSAC was still very young and still being incubated by its founders from Jon Conte to David Chadwick. I was directing child welfare in Tennessee at the time, and the APSAC Board was composed of genuine heroes of the child abuse field. The rest of the Board lived on an intellectual plane far above my world, and I was honored to be among them. I listened a lot and learned. On the Board and at the early APSAC gatherings in San Diego, I found a rich intellectual engine that was feeding upon the mutual energy. The collective influence of APSAC permeated all my work in Tennessee and across the nation. By 1989, I was drafted to serve on the APSAC Executive Committee as we really began to chart a course to independence, struggling with the wisdom of launching our own journal and conference. We had to weigh mighty decisions—from the danger of financial disaster to what to call the conference, settling on the term *colloquium* as "a gathering of professionals" to set us apart.

By 1991, I was in line to follow Joyce Thomas as APSAC President. I must admit that John Briere and I tended to cut up in the back of the Board meetings that year, like a couple of sixth graders, trying Joyce's patience at times. But she managed to focus us all to really propel the organization and field forward. In 1992, I moved to the President's role and found an incredible partner in Theresa Reid, our Executive Director. In fact, my term of presidency was comparatively easy, highlighted by outstanding staff leadership in Chicago, a growing membership, and being surrounded by really smart people. We sought to further expand not only the membership but also the impact of APSAC, and we succeeded.

I can look back on those days with pride because we not only laid a solid foundation for APSAC but, as the organization emerged, also true national leadership that was stronger and more influential than any of us could possibly be alone.

Barbara Bonner, PhD, President, 1993–1994

Professor of Pediatrics and CMRI/Jean Gumerson Endowed Chair Director, Center on Child Abuse and Neglect
University of Oklahoma Health Sciences Center

My first inkling that there was going to be a new national organization for professionals involved in child abuse and neglect was at the National Conference on Child Abuse and Neglect sponsored by the Children's Bureau in New Orleans in 1988. Everyone was abuzz with rumors about a special group that was meeting at the conference to plan the new organization, recruit members, and establish an organization for the multiple disciplines involved in maltreatment cases. When I received information about the American Professional Society on the Abuse of Children, I immediately joined in 1989. I joined the Board of Directors in 1989 and was President from 1993 to 1994.

These years were during the height of the discovery, frenzy, and backlash of child sexual abuse. APSAC was to make significant contributions to managing the fire storm that arose during the next 10 years. Thousands of mental health professionals leapt to provide services to victims, some of whom had minimal symptoms; medical information was published that was later retracted due to a lack of research; statements by professionals were made such as "If you think you've been sexually abused, then you've probably been sexually abused"; forensic interviewing of children came under increasing scrutiny and criticism; cases were prosecuted and then overturned at the appeals level; accused adults were forming organizations to denounce the accusers, often their own children or grandchildren; ritual abuse was reported to be at epidemic levels; and slogans such as "Believe the children" were promulgated in an effort to support children's reports of sexual abuse.

It was a time of high controversy and few answers that had any empirical basis. Prosecutors didn't know whom to prosecute, judges and juries didn't know whom to believe, professionals didn't know how to properly interview children, mental health professionals were being charged for mishandling cases—it was a turbulent, unsettling period in the history of this very young field.

APSAC was an emerging resource during this difficult time. While working rapidly to establish a Board of Directors, raise finances to fund much needed research, and provide information to the field, the new organization had massive requests and responsibilities. APSAC responded through providing guidelines, holding open meetings at conferences to discuss current controversies, publishing a newsletter, responding to the media, and setting organizational policies to maintain independence and objectivity in the maelstrom. Professionals began using their membership in APSAC to establish their credibility in court cases. State chapters were established to organize training at the state level. The organization matured, the membership increased, an annual conference was scheduled, a journal was initiated, and the professionals settled in with a strong commitment for the long haul to intervene and prevent the maltreatment of our children. APSAC brought the level of professionalism to the field that was direly needed at the time.

Professionals in the child abuse field tend to be committed, have a great sense of humor, and work with a sense of urgency. The members I served with on the APSAC Board are still working in the field, still committed to protecting children, still training the next generation, and still members of APSAC. I am honored to have served and to have the life-long colleagues and friends that I met through my association with APSAC.

Patti Toth, JD, President, 1994–1995

Program Manager, Child Abuse Training
Washington State Criminal Justice Training Commission

I had recently moved from the west coast to the east coast and started my job at the National Center for Prosecution of Child Abuse in 1987 when I heard about APSAC—this brand new organization dedicated to multidisciplinary collaboration. *"What a great idea!"* I thought and rushed to join as a charter member. At that time, I knew the founders only by reputation, but I knew that this was something I wanted to be a part of. Little did I realize how important APSAC would become to me.

Despite the fact that I was not a PhD, a researcher, or a professor, I was welcomed and quickly came to know the smartest and most caring people in the field as both colleagues and friends. Being part of APSAC challenged me to work harder, to open my mind, and to learn more about other disciplines and how important it was for all of us to find ways to work together more effectively. I was fortunate to be elected to the Board and then chosen as President during a time when APSAC was just starting to hold its annual Colloquium and was contemplating publishing its own journal. I made it my mission to try to increase law enforcement involvement in APSAC and to continue APSAC's leadership in educating child interviewers, passions I continue to pursue on behalf of APSAC.

My APSAC colleagues were there to throw me a baby shower at the Colloquium held in Tucson a month before my daughter Katie was born, then a year later to welcome Katie as the youngest attendee at the Colloquium held in Chicago. When Katie died following heart surgery at 20 months of age, APSAC established the Katie Toth Memorial Education Fund, which means the world to me. Through this memorial, APSAC is now able to offer scholarships for law enforcement officers from small communities to attend its Child Forensic Interviewing Clinic.

My involvement with APSAC has impacted me in a profound way and provided immeasurable support, both personally and professionally. The friends I've made and the lessons I've learned will be with me for life.

Linda Williams, PhD, President, 1995–1996

Professor of Criminal Justice and Criminology
University of Massachusetts—Lowell

APSAC had a critical impact on my career as a researcher in the field of child maltreatment. From the time of the early formative meetings of the organization, I was keenly aware of how much APSAC was needed in our field. Of course, there was the need for a professional organization dedicated to addressing child abuse and neglect in the United States. However, many of us, whatever our specialty, were marginalized in our own disciplines (e.g., there was little attention to child maltreatment in my field of criminology and sociology in the late 1980s, and colleagues representing other disciplines shared the same experiences). Happily, due to the work of APSAC members, this is not as true today, and there is significant attention to child abuse in our disciplines and sub-specialties. In the 1980–1990s, we knew that if we were to find effective ways to address child abuse, then interdisciplinary collaborations, professional-peer support, and rigor in research and practice were needed. Soon it became clear that for many who have found a home at APSAC, work on child abuse issues is not something on the margins of our existence but in the center of what we do.

There are numerous ways in which APSAC has supported this work. One of the highlights is the peer-reviewed journal *Child Maltreatment* (*CM*), which in the years since it was inaugurated in 1995 has become an authoritative voice in the field. I have been fortunate in my career to have had an opportunity to provide service to APSAC and was honored in 2001 to receive the APSAC Award for Outstanding Service. I have been a member since 1987 and on the Board of Directors in 1991–1997. In 1995–1996 I served an 18-month term as President and was Vice President in 1993 and 1994. Critical to the research that has been the focus of my work, I cochaired the research committee with Ben Saunders in 1992 and 1993. I was fortunate to have the opportunity to coedit two special issues of *CM* and was honored to serve with Patti Toth as cochair of the First National Colloquium in June 1993 in Chicago and to chair of the Second National Colloquium in May 1994 in Cambridge, Massachusetts.

One of the proudest moments of my career was when I was received APSAC's Research Career Achievement Award. While the award recognizes repeated, significant, and outstanding contributions to research on child maltreatment, the support of APSAC and APSAC colleagues deserves much credit for my success as a researcher. Indeed, APSAC has supported the contributions of many in our field today. I have been privileged to serve APSAC and to work with so many smart and dedicated colleagues. I applaud APSAC for encouraging research and building a knowledge base for professional practice designed to help children and families affected by child abuse and neglect. APSAC provides important support for those working in the field, and I urge all professionals concerned about the issue of child abuse and neglect to support APSAC by becoming a member and working for the organization.

Deborah Daro, PhD, President, 1996–1997

Senior Fellow, Chapin Hall at the University of Chicago

When asked to describe the factors that went into establishing program evaluation as a "field of practice," one scholar suggested three things were key—a set of instructional courses that could be offered to students outlining the underlying theories and skills needed to conduct evaluations, a professional society in which like-minded individuals could gather to share their experiences, and an academic journal that provided a peer-reviewed, written record of what was being accomplished as well as highlighted outstanding questions and concerns. Although child maltreatment as both a field of practice and a focal point of public policy predated APSAC by some 20 years, the new organization played a central role in solidifying the practice and the professional identity of those of us confronting child abuse. We were not just social workers, psychologists, physicians, or lawyers. We also were engaged in building a new area of practice and research, one which would improve the public and societal response to a serious threat to child well-being.

APSAC provided a forum where we could learn to do our work better. Since its inception, the organization has provided high-quality training through its symposia and advanced training institutes; it has built learning networks among those engaged in this work through its conferences, listserv, and state affiliate organizations; and it has fostered new thinking through its publications, including the *APSAC Handbook*, *APSAC Advisor*, and *Child Maltreatment*. On many fronts, APSAC serves as an important catalyst in better understanding the underlying causes of maltreatment, its consequences, and most importantly, how to mediate its impacts and reduce its incidence.

I have always considered membership in APSAC is being akin to voting—it is simply what you do if you want to be an active, informed citizen. I joined APSAC in 1988 because it was the price of admission to a field I was committed to shaping. By the time I became President in 1996, child abuse was a visible and salient public policy concern and APSAC membership topped 5,000. During my presidency, we promoted a bold goal for the organization—"10,000 by 2000" or "Bring a Friend to APSAC." While we had good intentions in setting this numerical goal, we clearly lacked a viable implementation plan.

Today, APSAC faces more competition for a professional's "membership dollar" than it faced in the late 1990s. Those working in this field are often drawn to other interdisciplinary groups that target important but broader issues than child maltreatment—trauma for some, positive child development for others. One challenge APSAC faces is reminding those working with victims as well as those who focus on preventing maltreatment that we have more in common than we sometimes think. Strengthening the professional response to child abuse and neglect remains a function of skill development, shared experiences, and new learning. APSAC continues to be well-positioned to do all three. So, "10,000 by 2020" anyone?

Harry Elias, JD, President, 1997–1998

Judge of the San Diego Superior Court

APSAC has been a great organization that brings together parties from all fields who care about the welfare and safety of children. The mid- to late '90s was squarely in the midst of another "backlash" movement in the field of child abuse. APSAC was continuing to pursue best practices and try to provide additional education, through conferences or publications, to practitioners in the field.

Working with the Board was an exciting time for me. I was able to try and take what we discussed at meetings and conferences and bring these into the courtroom, both in criminal cases and, more importantly, child welfare cases. Even though some of us had been around for a while, the organization and exchange of ideas was exciting. I remember most the efforts to try to make APSAC more open and inviting. I developed a number of friendships that exist and are strong to this day.

Diane DePanfilis, PhD, MSW

President, 1998–1999

Professor and Associate Dean for Research
Director, Ruth H. Young Center for Families & Children
University of Maryland School of Social Work

I joined APSAC close to the beginning of its launch and am still a member because I firmly believe that every child and family affected by child maltreatment deserves the best possible professional response. APSAC has been at the cutting edge of establishing and promoting the best interdisciplinary practices, disseminating innovative research findings through its journal, *Child Maltreatment*, and providing training for professionals at all stages of their careers. As President, I particularly worked to increase APSAC's presence within CPS agencies—something that is still needed because this system affects more maltreated children and their families than any other service system. I also believe in the importance of bridging the gap between policy, practice, and research. By speaking to all of us through the *APSAC Advisor*, I do believe that we are all in a better position to collaboratively practice more effectively. Congratulations to the current leadership for this celebration of APSAC's birthday!!

Veronica Abney, PhD, President, 1999–2000

Private Practice, Santa Monica, California

When I think about APSAC, many, many memories arise—some good and some not so good. I really loved being part of APSAC. The 10 plus years of my involvement with the organization were probably the most exciting of my career. I learned so much about child abuse and about running a nonprofit organization. I think the memory that sticks out the most is the year that we had the first Colloquium's Cultural Institute. We were meeting in Miami where we did not know many professionals of color, which made it difficult to advertise on the level we may have liked. If I remember correctly, we needed 100 people to attend, and we did not think we were going to come close to that. Those of us on the cultural diversity committee wanted the larger organization to see the importance of cultural issues and that "if we build it, they will come."

The morning of the Cultural Institute, I was very anxious. I went down to the conference room where the Institute was being held. Participants were starting to arrive, and we soon had a long line of professionals wanting to register on site. I was amazed! We had to add chairs, and at some point there was standing room only. In short, the Cultural Institute was a tremendous success. Each year when I look at the Colloquium brochure and see that the Cultural Institute continues, I feel pleasantly surprised and proud.

Sandra Alexander, MEd, President, 2000–2001

Child Maltreatment Expert Consultant,
Division of Violence Prevention, U.S. Centers for Disease Control and Prevention (CDC), Atlanta, Georgia

I was recently introduced by a colleague with "She knows everyone in the field of child maltreatment." While this is a tremendous exaggeration, it did make me think about how my network of professional colleagues and contacts has been greatly expanded due to my participation in APSAC over the years. Through APSAC, I have been able to meet, learn from, and work with most of the key contributors to child maltreatment prevention, intervention, and treatment work in the country. This has not only enhanced my knowledge but also facilitated access to experts for conference faculty and other professional endeavors over the years. APSAC's multidisciplinary focus and commitment to training for a diverse field of professionals has made a significant contribution to the field of child maltreatment. And although "match-making" is not listed in APSAC's mission, through my participation on the APSAC Board I had an opportunity to get better acquainted with someone I had previously known only casually as an "expert" in the field and a colleague of some of my friends. Now, we have been married for over 10 years.

I was APSAC President during what was probably one of the most difficult periods in APSAC's history. Within a very short period of time, the organization had to lay off staff, close the

Chicago office, and develop a plan for how to keep the organization alive and responsive to members while sorting out multiple financial issues and developing an organization and sustainability plan. This basically meant that a handful of extremely dedicated Board members stored files in their homes and offices and assumed the role of day-to-day operations of the organization in addition to their full-time jobs. That the organization came through this period and continued to get stronger over the next few years is due to the passion and commitment of those Board members and the support of many members who just refused to let it die. They brought the same dedication to "saving APSAC" as they brought to their work in child maltreatment.

Tony Mannarino, PhD, President, 2004–2005

Professor of Psychiatry and Vice Chair
Department of Psychiatry, Drexel University College of Medicine.
Director of the Center for Traumatic Stress, Allegheny General Hospital, Pennsylvania

Having been involved with APSAC from the very start of the organization, I have so many wonderful memories. First and foremost, most of the dear friends and colleagues that I have in the child trauma field have come through APSAC. Through the years, we have all participated together in meetings, dinners, and informal get-togethers, and these experiences have enriched my life in more ways than I could have ever imagined. Now that we are the "senior" group in APSAC, it is fun to look back and see how it all started.

I was President of APSAC during the years 2004–2005 and was on the Board for a total of 5 years. These were challenging times as APSAC's financial situation was less than stellar, and we were faced with trying to right the ship. It was gratifying that we were able to do some things to improve the financial situation.

I believe that the greatest asset of APSAC is its true interdisciplinary nature. There is no other organization in our country dedicated to improving the lives of children and families affected by maltreatment, trauma, and violence that brings together professionals from the legal, medical, and mental health arenas the way that APSAC does. And APSAC does a wonderful job in promoting a deep respect between all of these groups that has ultimately contributed to major strides in the child maltreatment field.

Jordan Greenbaum, MD, President, 2006–2007

Medical Director, Stephanie V. Blank Center for Safe and Healthy Children, Children's Healthcare of Atlanta, Georgia

What I remember most about being on the Executive Board of APSAC (2003–2008) is the sense of camaraderie. There we were—a group of professionals of all types, from all parts of the country, with all sorts of backgrounds—trying to work together to build the organization and to push it to the next level: lots of good ideas and very little money; lots of projects and very little time to devote to them. It was a microcosm of our work in child maltreatment. But despite the challenges, we learned from each other and made good progress. As a team, we pulled APSAC through a crisis and came out the other side a bit battered, but stronger and better able to meet future challenges. The Bandy's helped us to bring order to APSAC management and paved the way for major changes.

I'm proud to be a member of APSAC and truly believe the organization plays a critical role in the professional lives of those of us working in child maltreatment. A multidisciplinary organization is the natural leader of a multidisciplinary field. The more we learn from each other through APSAC activities, the better we'll collaborate in the field.

Michael Haney, PhD, NCC, CISM, LMHC

President, 2008–2009
Executive Director, APSAC

The American Professional Society on the Abuse of Children is one of the most outstanding groups of professionals that I've ever had the privilege and honor of participating with. I joined APSAC in 1995 and then was elected to the Board in 2005. I served two terms as Vice President and then a term as President for 2008 and 2009. More recently, I was overwhelmed by the Board's support when they asked me to serve as Executive Director.

This organization has so much to offer and is made up of the finest individuals in the United States—all dedicated to serving children and, in particular, the professionals who serve children and their families. Serving as a Board member, President, and now Executive Director constantly reminds me of how this organization makes a difference in the lives of children. The quality individuals whom I've met and who have served on the Board have made an even greater impact on me as professional colleagues and much more as my friends.

About the Author
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APSAC, Social Work, and Child Welfare

Colleen Friend, PhD, LCSW

Social work and child welfare professionals have been the backbone of APSAC's membership since its inception. This article considers their intersection with APSAC and traces where they have journeyed together since 1987, starting with the Title IV-E Child Welfare Training Partnerships, then moving to other child welfare accomplishments related to Title IV-E as well as other legislation and lawsuits. Finally, the article explores more areas of joint accomplishment along with APSAC's role in (a) responding to child sexual abuse, (b) emphasizing the need for evidence-based practice (EBP), (c) sharing membership and evidence with other EBP organizations, (d) recognizing the role of culture in working with consumers of child welfare and social work services, and (e) taking on the importance of workable caseloads.

Many professionals consider social work the basic orientation of most child welfare workers. In fact, many such workers call themselves social workers, yet fewer than 30% of child welfare workers have professional social work degrees (BSW/MSW), according to a report by the Social Work Policy Institute (2010). The same report noted that child welfare agencies have had long-standing difficulties in recruiting and retaining professionally trained staff. In an attempt to remedy this, since the late 1980s, states and public agencies have partnered with university social work programs to draw down a specific training provision of federal Title IV-E funds to stipend both bachelor- and master-level social work students, preparing them for careers in child welfare.

It should be noted that the bulk of Title IV-E funds goes to the states to support services for children who have been removed from their homes. This is one of the last federal entitlements to the states; rather than risk the dismantling of it, many states and communities have sought what has become known as Title IV-E waivers to obtain permission to use these funds for services to assist children in their own homes. Several waivers have demonstrated promising success, and cost savings have been applied to local discretionary programs, including large-scale prevention efforts (Casey Family Programs, 2009). APSAC members have been involved in crafting waivers and evaluating their outcomes.

Different Title IV-E training partnership models emerged across the states, many of which provided or coordinated agency-based, state-of-the-art training programs and funded additional practice-based research or curriculum development. The largest among them is the California Social Work Education Center (CalSWEC), which has grown to include 20 schools of social work. As of June 2011, nearly 4,400 graduates have started work in California's child welfare system since the program began in 1990 (CalSWEC, 2011). In California—as well as in Arkansas, Kentucky, Michigan, Pennsylvania, New York, Ohio, Washington, Oklahoma, and other states—APSAC members have been engaged with Title IV-E Training Partnerships as deans, program coordinators, curriculum developers, trainers, and contractors (NASW, 2003; NASW, 2004).

Nationally, Title IV-E Training Partnerships have been found to improve both worker retention and worker competence; they are considered key to addressing deficiencies in the child welfare workforce as well as meeting the goals of child safety, permanence, and well-being (NASW, 2003). The last three goals are the mantra and central focus of the Adoptions and Safe Families Act (ASFA), which became law in 1997. This groundbreaking legislation drives the current child welfare system's shortened timelines to establishing a permanent home for each child, insistence on safety first, and facilitation of the child being seen in a more holistic way: happy, thriving, and nurtured rather than simply abuse free. ASFA also mandated that states report specific data and be held accountable in program reviews. APSAC member Richard Gelles took a congressional sabbatical from his university position in 1996 and was instrumental in the crafting and the passage of this Act. In recognition of this and his other research, APSAC gave him its Career Achievement Award in 1999.

The ASFA legislation, Title IV-E Training Partnerships, and Title IV-E waivers have combined to dramatically lower the number of children in foster care. For example, only 408,000 of our nation's children were in foster care in 2010 compared with 662,000 during the previous fiscal year (AFCARS data as cited in Casey Family Programs, 2010). This one-year drop is so dramatic that it is hard to believe it was the result of legislation passed more than 10 years earlier, but the cumulative effects, coupled with other initiatives, have coincided with many fewer children remaining in out-of-home care.

APSAC has served as a crucible for ideas that have launched important changes leading to this impressive achievement. APSAC has also provided a home base for child welfare and social work practitioners since its beginning, with conference sessions and *APSAC Advisor* articles consistently focusing on topics related to their practice. Moreover, the *Advisor* was consciously conceived to be useful to the practitioner: short articles, interviews, and commentaries without an abundance of footnotes and citations. APSAC membership rates were tied to income levels to specifically encourage child welfare and social work participation. The initial APSAC Board

meetings reflected this focus on needing to target the organization to meet the interests of direct service professionals, widely recognized as child welfare and social work practitioners (David Corwin, personal communication, January 25, 1988).

As a measure of this success, the two largest categories of APSAC membership (self-identified) are Child Protective Services (241) and Social Work (561) (APSAC, 2012). Through its early publication of practice guidelines, APSAC has promulgated concise, interdisciplinary, peer-reviewed assistance that is at the heart of the child welfare worker's daily practice—from *Psychosocial Evaluation of Suspected Sexual Abuse in Children* to *Psychosocial Evaluation of Suspected Psychological Maltreatment in Children and Adolescents*. Lucy Berliner, MSW, took the leadership role in chairing both editions of APSAC's guidelines on child sexual abuse.

As APSAC expanded its role in encouraging and expanding evidence-based multidisciplinary practice, child welfare and social work have also moved in this direction, but the process has not been without challenges. For example, a colleague and I presented "Training the Trainers on Evidence-Based Interviewing Techniques" at the APSAC Colloquium in Hollywood in 2004. As we went around the room for introductions and to determine why participants were there, we noted sadly that the majority thought we were going to help them gather fact-pattern evidence to build a better case in criminal or dependency courts. At the 2010 APSAC Colloquium in New Orleans, a team of social workers and expert interviewers (Kathleen Faller, Linda Cordesco Steel, and Debra Nelson Gardell) presented the "Evidence Base for Extended Forensic Evaluations in Child Sexual Abuse Cases"; every seat was taken and no such confusion arose.

Since the late 1980s and probably at the behest of lawsuits and liability issues, child welfare has moved, albeit slowly at first, into this new territory of evidence-based and multidisciplinary practice. For example, multivictim, multiperpetrator child sexual abuse allegations in that decade led child welfare to move into collaborative arrangements that the emerging Child Advocacy Center (CAC) movement provided. Today, every state has at least one CAC and many communities have several; all require child welfare representation for full membership (NCA, 2008). Many APSAC members were integral to the success of this CAC movement.

APSAC members have taken leadership positions in other innovative child welfare practice trends as well. The largest public child welfare agency in the country, the Los Angeles County Department of Children and Family Services (DCFS), has become a more trauma-informed child welfare and evidence-based system, partially due to a number of local and national initiatives, including the grantees, affiliates, and learning communities developed from the National Children's Traumatic Stress Network (NCTSN) funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) grants at four sites in the Los Angeles area (Friend, 2009). The NCTSN has raised the standard of care and services provided to traumatized children, adolescents, and their families. DCFS has recently settled a lawsuit and has taken a leadership role in retooling its training, practice, and quality assurance to ensure that it is meeting the mental health needs of children and families under its protection. This new practice will stand as a model for the many states facing lawsuits concerning child welfare's ability to meet children's mental health needs. This agency has integrated the use of the California Evidence-Based Clearinghouse for child welfare (CEBC) into its new mental health training, using this Web-based resource that allows child welfare (and other) practitioners to access the latest research on effective interventions. APSAC members have anchored the successful NCTSN, participated in its grant network, created the CEBC, and provided training to meet DCFS clients' mental health needs.

Social work has also struggled with the quest toward evidence-based and multidisciplinary practice. The profession was long immersed in theory, unresolvable ethical debates, and an obsession with social work-specific interventions (Thyer, 2008). With the establishment of the Society for Social Work and Research (SSWAR) in 1994, the profession and its educators have reflected a new nexus of understanding that, because social problems are not discipline-specific, interdisciplinary evidence-based approaches are the likely solutions. Members of SSWAR have served as editorial review board members of *Child Maltreatment* and the *APSAC Advisor* and have published in both venues. Indeed, social workers in the United States and Canada who are also members of APSAC and SSWAR have played an important role in the leadership and membership of the Campbell Collaboration, an organization dedicated to transparent, systematic evidence reviews that we hope will bridge the research-to-practice chasm.

APSAC's presidents have included five social workers: Jon Conte, Charles Wilson, Diane De Panfillis, Veronica Abney, and currently, Ronald Hughes. Hughes and APSAC member (and former *APSAC Advisor* editor in chief) Judith Rycus are coauthors of the *Field Guide to Child Welfare,* the most widely published child welfare textbook in the history of the social work profession. In addition, they have developed the Pro Humanitate Literary Awards, recognizing outstanding books and scholarly articles with subject matter important to child welfare or social work practice. Hughes and Rycus were among several APSAC leaders who were invited to attend the first Russian-American Child Welfare Forum in August 2011, where the Russians collaborated with Americans to develop their child welfare system.

APSAC has called upon its experts to contribute to three editions of the *APSAC Handbook on Child Maltreatment*. Both a textbook and *New York Times* bestseller, it covers all aspects of child maltreatment. It has been described on Amazon.com as the most comprehensive resource for individuals working within the child welfare system and for students preparing to work in that field. This handbook has probably been one of APSAC's greatest accomplishments and recruitment tools because it has launched social work and child welfare students into an appreciation of interdisciplinary and research-based practice.

Future directions for APSAC in meeting the needs of child welfare and social work professionals include doing more to raise the importance of culture and workable caseloads. Social work and child welfare professionals without exception respond that these are important areas to explore. Please see the article by Lisa Fontes (this issue) for more details about APSAC's efforts that have given this issue the prominence it has today. One of the most important dilemmas facing child welfare and social work today is the overrepresentation of African American and Native American children on child welfare caseloads. APSAC has done more than any other organization to raise the flag of culture when dealing with consumers of child welfare or social work services. We will need a concerted campaign to unravel this further, but the ball started rolling with APSAC. Regarding worker caseloads, the Council on Accreditation (COA, 2008) has guidelines for human services organizations in both public and private sectors. Accreditation is designed to be a framework within which an organization can reliably measure a variety of its outcomes and achievements—with confidence that the results are valid. Undergoing the accreditation process and abiding by its recommendations does result in lowering caseloads.

Given serious client needs and these difficult economic times, workable caseloads may seem like an impossible goal. Could a solution be within reach utilizing cost savings from Title IV-E waivers? Might this build on the work of the Title IV-E Training Partnerships? Would APSAC be able to bring its focus on evidence-based multidisciplinary practice to a cost benefit analysis? Could APSAC do for this issue what it did for cultural diversity? With APSAC's increased recognition as the leading national organization supporting professionals who serve children and families affected by child maltreatment and violence, it may be able to take this on. The real question is: Can we afford not to?

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Twenty-five Years of APSAC—The Medical Perspective

Lori D. Frasier, MD

This past quarter-century almost precisely parallels my career as a child abuse pediatrician. I ended my pediatric residency in 1986 and approached Dr. Carole Jenny, who had become the medical director of Harborview's Sexual Assault Center, to ask about specialized training in child abuse. She had been my continuity clinic director at Harborview's general pediatric clinic. As I struggled with the direction of my pediatric career, the field of child abuse interested me. In 1988, I became a fellow at the Harborview Sexual Assault Center. No one could have been more surprised than I as to what would happen over the next 25 years.

The Medical Professionals

The publication of "The Battered-Child Syndrome" in 1962 (*JAMA*) by Dr. C. Henry Kempe et al. formed the core focus that would become child abuse pediatrics. This was solidified by Dr. Kempe's partner article in the 1970s about child sexual abuse. However, it was in the 1980s that the field grew from a handful of interested physicians to many more who began seeing and evaluating abused children as a referral specialty. Many pediatricians were recognizing patterns of physical abuse and head trauma. Fewer were involved in the evaluation of child sexual abuse. Some physicians were beginning to be involved in all aspects of child abuse and neglect. It was a tough world with little guidance, few mentors, and no roadmap.

Dr. Carole Jenny recalls, in the mid-1980s, being asked in court, "Aren't girls born without hymens?" Realizing there was really no research on this, she looked at over 1,100 newborns and wrote a seminal paper. Even today, a misconception remains that girls can be born without hymens, despite 25 years of knowledge that this does not occur. The medical professionals (mostly pediatricians, although not exclusively) who were evaluating these children realized that there was a distinct, but not always accurate, body of knowledge and expertise in child sexual abuse. The Cantwell studies of the 1980s, although now no longer valid, were important in recognizing that physicians needed to understand not only normal anatomy but also sequelae of sexual abuse trauma in children.

Although I cringe at my recollections of telling physicians about the "4mm rule," I now realize that we were very much pioneers and had little "evidence-based" knowledge to rely upon. The pediatricians who were really at the frontline of the field were instrumental in training the next generation of child abuse pediatricians such as me. I asked Dr. Jenny in 1988 if I could train as a fellow in her program for a year. No one could believe that I wanted to specialize in this very strange area. Twenty-five years later, there are accredited 3-year fellowships in child abuse pediatrics and a child abuse subboard examination. Each generation of newly trained child abuse physicians has been amazingly intelligent and insightful. Our colleagues from family medicine, radiology, ophthalmology, neurosurgery, pathology, and psychiatry, to name just a few, are increasingly partnering with pediatricians to ask important questions and to find answers through well-designed research. Dr. Jenny is responsible for training the largest number of physicians to be child abuse specialists.

Technology

Colposcopy

The colposcope equipped with a camera was the first tool medical providers had in the area of child sexual abuse to really share and research genital findings in children. There were no studies (except the prescient book by Ambroise Tardieu in 1846) that really described children's anogenital anatomy. The reality is that "normal" was completely misunderstood if not unknown. Providers began taking magnified photos and carefully trying to analyze and understand what various findings meant. The colposcopic and other macro-camera photos became the basis for early study in this area. Teaching sessions developed in which actual cases could be shared. I recall the workshops and case review sessions at the San Diego conference in the 1990s where many people brought their slides and Kodak prints for viewing by colleagues. There were many questions and not so many answers. We became, for want of a better term, *hymenologists*.

During this period, Dr. Joyce Adams was attempting to organize the findings we were seeing into a tool that became the Adams Classification System. Later, it became apparent that medical providers were misusing such systems as a checklist or cookbook for findings. These systems morphed into a consensus-based guidelines statement. We are now at a stage where abnormal findings are considered rare. Photodocumentation with digital systems and distance peer review are the norm. Sexually transmitted infection (STI) assessment has been revolutionized by DNA amplification technologies, and forensic assessment of acute rape victims is changing rapidly as new technologies come online.

Imaging
Recognition of physical abuse, especially serious forms of battered children, had long been known. Caffey, for example, described the concept of shaking babies in the early 1970s. However, the importance of earlier recognition and prevention were concepts that evolved over the past 25 years. These advancements parallel improvements in neuroimaging that have been so critical to our field. CT scans improved and MRIs became standard imaging tools in determining injuries, bleeding, and aging of blood products. Improved understanding of pathophysiology and biomechanics enabled physicians to more accurately diagnose abuse.

The Horizon
Proteomics, serum markers of neurologic injury, may enable us to detect early and prevent more serious injury and even deaths. Primary prevention of infant abuse, primarily head trauma, has become the focus of many advocates and researchers.

Other Healthcare Professionals (SANES, NPs)

The involvement of other health professionals in child abuse and neglect has also been a force for change for the better. Using nurse practitioners as physician extenders and ultimately as experts in their own right with specialist practices has expanded the scope of child abuse services both in tertiary institutions and in rural communities. Sexual Assault Nurse Examiners (who may be RNs or additionally NPs) have provided forensic services to victims of sexual assault in the absence of skilled physicians.

The Child Advocacy Center Model and the Medical Profession
The first child advocacy center (CAC) was formed in Huntsville, Alabama, in the mid-1980s as a response to the treatment of children as victims in the criminal justice system. CACs spread throughout the U.S., becoming accredited by the National Children's Alliance. CACs were envisioned to be community-based agencies that were child friendly, where all members of the investigative and treatment teams were able to meet and discuss cases of child abuse in a collaborative manner. There are now over 900 CACs in the U.S., each reflecting an individual community's needs. Medical providers, long part of this multidisciplinary team, often provide on-site medical care for children and have become a voice for medical issues at team meetings.

Medico-Legal Advancements
Research, clinical care, and forensic practice evolved at the same time for medical providers. The unique role of a clinician (whether physician or nurse) in the court system has advanced significantly. Judges and juries weigh the medical experience of specialty child abuse practitioners heavily. Prosecutors and defense attorneys rely on such expertise. Court testimony has become a skill that these providers have developed and ongoing training programs assist medical practitioners in the development and refining of such skills.

However, some of the legal issues are not supportive of the work of the child abuse researchers over the last 25 years. A backlash against the concept of shaking infants has permeated the courts. The media have taken this up as a significant medical controversy, which it is not. It is a legal controversy. However, the need for additional research has never been more acute.

Where Are We Going in the Next 25 Years?

The major goal of all organizations such as APSAC should be to NOT exist in 25 years. Child abuse should be eradicated through primary prevention efforts combined with earlier detection and intervention with at-risk families. Ideally, children would be wanted and raised in loving homes. Parents would have resources and support from their communities, and their government would have a priority to raise stable and happy children. All families, no matter how they are configured, would have support for raising their children. Beam me up, Scotty!!!!

Short of these laudable, and perhaps unattainable, goals, an emphasis on primary prevention must be the future in order to reduce child abuse in our society and around the world. Governments and health care organizations must realize that preventing child abuse is the single best way to reduce many health consequences in adults, and also a way to reduce prison populations and criminality. This will result in heightened productivity of our work force, an improved standard of living, and a more civil society. A critical issue is the prevention of neglect, which is so deeply rooted in poverty in even in the richest country in the world. I expect APSAC will be around in 25 years, and I hope it asks me as I approach my 82nd birthday what was accomplished in that 25 years and what the future may bring. I will look back fondly at our failures and our successes. I hope to write about how much we have accomplished in the half-century since APSAC was founded and how important APSAC was in achieving those goals.

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Twenty-five Years of Interviewing Research and Practice: Dolls, Diagrams, and the Dynamics of Abuse Disclosure

Thomas D. Lyon, JD, PhD

A great deal of research in the past 25 years has contributed to our understanding of how best to interview children about suspected maltreatment. The disastrous failures of the highly publicized day care abuse cases led to a flood of research, initially emphasizing the failures of conventional approaches, and more recently highlighting the potential for eliciting complete and accurate reports. If a child has disclosed abuse, and is willing to disclose again, we know what to do. Research supports the use of interview instructions, narrative practice rapport building, and the use of open-ended questions to elicit and to elaborate on the child's report (Saywitz et al., 2011). These elements are found in an increasing number of interview protocols, most notably the NICHD structured protocol (Lamb et al., 2008).

However, prior disclosure is a big if. The likelihood that abused children will refuse to acknowledge abuse has long been recognized (Pollack, 1909). The problem of reluctance is recognized by proponents of the NICHD protocol (Lyon et al., 2009), and researchers continue to seek means of overcoming reluctance through improvements (Hershkowitz, 2011). It is fair to say that whereas the focus since the 1980s has been on reducing false allegations, researchers have increasingly turned to means of increasing true allegations.

Nevertheless, tensions within the field exist among both interviewers and researchers regarding the best next steps for interviewing. An enduring debate that nicely captures these tensions concerns the use of anatomical dolls and diagrams. Dolls were developed in the 1970s (Koocher et al., 1995), and their use was widespread in many jurisdictions by the mid-1980s (Boat & Everson, 1988; *In re Rinesmith*, 1985). In the 1980s, Groth (1984) developed anatomically detailed diagrams of children for use in sexual abuse interviews. The theory was that young children might better describe their abuse through use of the dolls and diagrams, overcoming developmental and motivational difficulties in disclosing.

When APSAC was founded in 1987, researchers had only just begun to examine anatomical dolls. The first study examining the use of dolls in interviewing was published in 1986 (White et al., 1986), and the results were reassuring: Children with other evidence of abuse responded differently to questioning than children for whom there were no suspicions. However, studies observing free play had raised red flags regarding interpretation of children's free play with the dolls (Gabriel, 1985; Jampole & Weber, 1987), and experts had made questionable interpretations of behaviors, such as digital insertion (*In re Cheryl H.,* 1994), that were later found to be quite common among children who played with the dolls (Cohn, 1991). Diagrams received less attention; their use was not systematically studied until the 1990s (Steward et al., 1996).

Twenty-five years later, the disagreements continue. Although observations of children's free play with the dolls have fallen out of vogue, the use of dolls and diagrams to elicit disclosures or to clarify reports is still popular. On the one hand, many interviewers support their use (Anderson et al., 2010; Hlavka et al., 2010), and Faller (2005, 2007) reviewed the research favorably. On the other hand, the experimental work published since 2000 has been uniformly critical (Brown et al., 2007; Bruck, 2009; Bruck et al., 1995, 2000; Otgaar et al., in press; Poole & Dickinson, 2011; Willcock et al., 2006), and most research reviews have been similarly negative (Brown, 2011; Dickinson et al., 2005; Pipe & Salmon, 2009; Poole et al., 2011; Salmon, 2001).

The difference is attributable to unspoken value judgments and a lacking appreciation of the dynamics of sexual abuse disclosure. It is not enough to prove that dolls and diagrams elicit more details; one must have some means of determining whether those details are true. It is also insufficient to limit one's focus to false allegations: one must always weigh the costs against the potential benefits. The best studies examine genital touch in medical contexts, because this provides the closest analog to sexual touch, enables one to assess accuracy, and allows one to assess the effects of dolls and diagrams on children who have and have not been touched. This research warns against doll and diagram use in very young children and counsels caution in their use with older children. But the risks have been exaggerated by some research, and reasonable minds still disagree about the potential utility of dolls and diagrams when nondirect questions fail to elicit disclosures

Field Research on Dolls and Diagrams

Interviewers are likely to be most impressed with results in the field, because field research has the advantage of external validity; these are real cases of alleged sexual abuse. Ironically, that is also its disadvantage; the accuracy of any additional details elicited by dolls or drawings often cannot be ascertained. Some field research appears to provide support for dolls and diagrams; early doll studies were positive (e.g., Leventhal et al., 1989; White et al., 1986), and two recent studies utilizing body diagrams (with the genitalia obscured) found that diagrams elicited new details when introduced at the end of an interview (Aldridge et al., 2004; Teoh et al., 2010). However, two recent studies examining doll interviews found that they were no more productive than interviews without dolls (Lamb et al., 1996; Thierry et al., 2005).

Skeptics can discount either positive or negative findings. The studies examining non-NICHD interviews can be criticized for the failure of the interviewers to utilize all available means of eliciting complete reports through open-ended questions. When additional details are elicited, it is often not clear if the dolls or diagrams are responsible, unless the researchers compared introduction of dolls and diagrams with a separate condition in which children are simply asked to recall the abuse a second time (Salmon et al., 2011). Furthermore, studies finding the elicitation of additional details do not tell us whether dolls or diagrams are useful in eliciting disclosures from children who fail to disclose in response to other prompts.

When additional details are *not* elicited, it is sometimes questionable whether children who received and did not receive the dolls or diagrams are comparable. For example, if interviewers chose when and whether to use dolls, they may have selectively done so with less productive children, which would make dolls and diagrams look less productive than they really are (Faller, 2005). In technical terms, unless children are randomly assigned to the doll condition and the no-doll condition, one doesn't know what to make of any differences. Notably, these methodological difficulties can be overcome with more carefully controlled research, but field research is extremely difficult: It is very difficult to obtain the necessary consents, and it is time-consuming and expensive (e.g., one has to train and carefully monitor the interviewers). Furthermore, even if other methodological concerns are met, the accuracy issue almost always remains, because of the lack of clear corroborative evidence in most abuse cases.

Medical Exam Studies With Dolls and Diagrams

It thus seems likely that the debates over the utility of dolls must look to experimental evidence, but then the question is: What is the appropriate analog to sexual abuse? The initial wave of research on dolls and diagrams turned to medical examinations, which had a number of advantages.

First, there could be conditions in which children either had or had not experienced genital touch. This allows one to calculate both true positive and false positive rates for any technique, which in turn enables one to assess the probative value of a disclosure under different circumstances. It is essential to be able to calculate both rates. Imagine a study that included only children who had been touched. A method might increase disclosures, but be essentially worthless if it increased false disclosures by the same amount. But we wouldn't know its effects on false disclosures if all the children had been touched. But by the same token, any study that includes only children who haven't been touched is equally incomplete. A method might increase false disclosures, but be valuable if it increased true disclosures by a much larger amount.

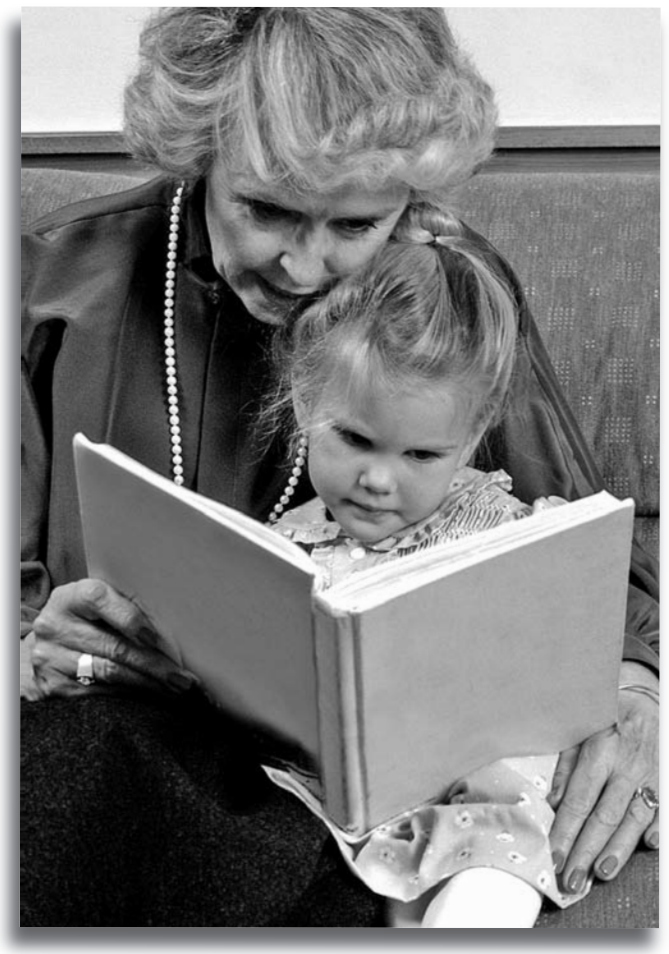
Second, medical examinations specifically enable one to inquire into genital touch. Researchers examining genital touch in medical examinations understood that genital touch is different than other types of touch; once children are out of diapers, toilet-trained, and can bathe themselves, their genitals are less likely to be touched by adults as part of caretaking. When they *are* touched on their genitals, and particularly if the touch is invasive, they are likely to experience it as unpleasant: It is salient, often embarrassing, and sometimes disgusting to the child. An obvious limitation to studying medical examinations is that when a doctor touches a child's genitalia, he or she does so for a valid medical purpose. The child's parent is likely to be present, and the doctor will not say or do anything to suggest that the touching is secretive or in some way wrong. Hence, the dynamics of sexually abusive genital touch are likely to be perceived as more wrongful and more embarrassing.

A series of studies examined children's reports of genital touching as part of well-child examinations, and the findings can be summarized quite easily (Bruck et al., 1995, 2000; Saywitz et al., 1991; Steward et al., 1996). When 3–7-year-old children are asked free recall questions about the medical examination, they only rarely disclose genital touch if they have been touched, and never disclose genital touch if they haven't been touched (Saywitz et al., 1991; Steward et al., 1996). When the interviewer moves to direct questions utilizing a doll or drawing, the likelihood that children disclose touch increases. Bruck and colleagues (1995, 2000) found that 2–4-year-old children exhibited relatively low true positive rates (only about 50% of those who were touched said that they had been touched), and high false positive rates (about 50% of those who were not touched claimed that they had). The fact that the true positive and false positive rates were almost equal suggested that children were responding randomly, and it meant that a disclosure of touch in response to a direct question was not probative. Steward and colleagues (1996) found that 3–6-year-old children exhibited higher true positive rates than false positive rates, such that a disclosure of touching was weak to moderate evidence of touching. Saywitz and colleagues

(1991) found that 5–7-year-old children also exhibited higher true positive rates than false positive rates, and the rates of false positives were so low that a disclosure constituted strong evidence that the child had been touched. (For a more complete discussion, see Lyon et al., 2012.)

A significant finding by Saywitz and colleagues (1991) was that among the children who were touched, 7-year-olds were less likely than 5-year-olds to disclose such touch in their free recall. This illustrates the importance of reluctance in assessing children's disclosures. If it were simply a matter of memory, then one should expect the 7-year-olds to be more likely to recall the touch than 5-year-olds. The fact that they performed worse supports the conclusion that they were reluctant to disclose.

Subsequent reviews of the literature have evaluated these studies differently. Faller (2005) interprets Steward's and colleagues' study as supporting doll and diagram use; whereas, others (e.g., Poole & Dickinson, 2011) emphasize the increase in false positives. There may be implicit value judgments being made here (Ceci & Friedman, 2000). Is the increase in error justifiable, given the increase in true disclosures? When Poole and Dickinson (2011) conclude that diagrams should not be used to elicit disclosures unless there is evidence of abuse akin to "images or a definitive medical finding," they are assuming that a conclusion that abuse occurred requires an extremely high standard of proof (p. 668). I suspect that Faller would put more emphasis on the need to utilize sensitive measures in order to avoid missing true cases. Of course, other considerations must come into play. Is this a criminal case? Is the child potentially at risk of further abuse?



The four medical examination studies leave a number of questions unanswered. None of the studies considered whether improved methods of eliciting free recall might increase true disclosures; none utilized narrative practice rapport building before recall or cued invitations after. None provided more than brief follow-up to disclosures to determine whether elaboration might make true and false disclosures distinguishable. Finally, none compared questioning with a doll or diagram with direct questions about genital touch alone. It might be the case that dolls and diagrams are less necessary with improved interviewing, because children who are more comfortable with the interviewer and more talkative are more likely to disclose. However, for children who fail to disclose despite improved interviewing, dolls and diagrams might be less dangerous to use as a backup, because the accuracy of the disclosures can be tested through testing the child's ability to elaborate on an acknowledgement of touch.

Recent Research on Dolls and Diagrams: No More Genital Touching

Sadly, these questions have remained unanswered, in part because the research conducted in the last decade has failed to utilize the medical examination paradigm. Instead, children experience nongenital touch and are asked questions with the assistance of diagrams that fail to depict the genitalia. The touching that children experience is typically not very salient and certainly not embarrassing. The fact that none of the children experience genital touch means that the true positive rate of the diagrams cannot be determined—the research can calculate only the rate of false allegations. The fact that the touch is not embarrassing means that there is no reason to assume that children are reluctant to disclose touch. Despite these limitations, the researchers often conclude in very strong terms that the diagrams are not useful to questioning children about suspected sexual abuse (e.g., Willcock et al., 2006).

In the subsequent studies, body diagrams led to some false reports of touch, though not always claims of genital touch. Willcock and colleagues (2006) found that one month after interacting with a man who touched them in five innocent places, 11% of 5–6-year-olds disclosed genital touch when questioned with a clothed body diagram. Brown and colleagues (2007) found that 4 to 6 weeks after experiencing seven innocent touches (e.g., tickling the feet, squeezing the wrist), 4% of 5–7-year-olds disclosed genital touch

either when directly asked or when questioned with an unclothed body diagram. In free recall, none of the children mentioned any touching, and a large percentage failed to report touching in response to direct questions (with or without the diagrams). Poole and Dickinson (2011) found that 4 months after being touched on the wrist (a wrist band) and shoulder (a sticker), 0% of 4–9-year-olds disclosed genital touch when questioned with an unclothed body diagram. Without the diagrams, only 1% of children mentioned the touch that did occur; in the diagram condition, 8% did so. Poole and Dickinson also included a group in which children received suggestions from their parents that they did in fact receive touches that they had not experienced; the rates of false reports of those touches were similar in the no-diagram and diagram conditions. In all three studies, children falsely reported other types of touch, although Brown and colleagues (2007) found similar rates regardless of whether a direct question was asked or the body diagrams were used.

Unfortunately, the studies are not terribly useful in helping us assess the potential utility of diagrams in questioning children about genital touch. Because there was no condition in which children *were* touched on their genitalia, one cannot calculate the percentage of children who were touched who revealed with or without the diagrams. Children often showed very low rates of touch disclosure, but there is no reason to assume that children were reluctant to disclose any of the touches that occurred. It is more likely that they simply forgot the touching or found it unremarkable. (Cf. Bruck, 2009, who found that children underreported touching immediately after a staged event.)

With respect to the false reports of genital touch, the problem is that the diagrams omitted the genitalia. Poole and Dickinson (2011) assert that this explains why they *didn't* obtain any false reports of genital touch, but they provide no support for their apparent belief that explicit depiction would increase the likelihood of error. Rather, the opposite problem might be at work: When the genitalia are not depicted, this increases the risk of misunderstanding. This is a possible explanation for the higher rate of false reports of genital touch in Willcock and colleagues' study, in which clothed diagrams were used; Brown and colleagues suggest that the clothed drawings made it "more difficult to specify where touches occurred" (Brown et al., 2007, p. 40). Indeed, a recent study comparing clothed with unclothed diagrams found that younger children produced more accurate details in response to the unclothed diagrams, and it speculated that the lack of clothing facilitated children's recognition of the parts of the body (Otgaar et al., in press).

The Importance of Studying Reluctant Disclosure

Despite these limitations, the researchers conclude that body diagrams are not useful for eliciting reports of genital touch in sexual abuse investigations. With respect to the argument that one ought to be studying touch that is analogous to sexual abuse—probably genital touch, at least touch that children find embarrassing—they make different arguments. Poole and Dickinson (2011) acknowledge that abuse may be "embarrassing or traumatic," but argue that this is irrelevant if one is interested in examining false allegations, because those involve children who have not been abused (p. 668). This argument misses two points.

First, embarrassment affects not only children who have been touched but also children who haven't. Children who are aware that genital touch is unusual and embarrassing will be less inclined to false alarm to suggestions of genital touch than to suggestions of innocuous touch. Steward and colleagues, for example, found that whereas 42% of children falsely reported touches to the ears in free recall 6 months after a medical exam, 0% falsely recalled genital touch.

Second, false allegations cannot be assessed in a vacuum, unless one adopts the value judgment that any increase in false positives is unacceptable. The question is always how often children who were touched disclose compared with how often children who weren't touched false alarm. (Even with respect to the touches they did study, Poole and Dickinson (2011) couldn't provide this analysis: Children who were touched and children who weren't touched were not comparable, because all of the children who weren't touched were subjected to repeated suggestions of touching before being questioned.)

Salmon and colleagues (2011) make the point that that reports of incidental touch may be relevant because abuse "in the early phases" is often initiated through purportedly accidental touch during daily activities (General Discussion section, para. 3). This is true, and their results (which concern the ability of diagrams to clarify reports of touching) suggest that diagrams don't facilitate disclosure of touching that the child found unremarkable. It is not clear, however, why this is a disadvantage; it would be dangerous to characterize touch as abusive if it could have been accidental. Furthermore, the argument implicitly recognizes that if one is investigating overt abuse that *is* recognized as such by the child being questioned, studies examining children's reports of incidental touching are less relevant.

Most remarkably, some researchers argue that sexually abused children are not reluctant to disclose. Bruck and Ceci (2009), for example, discuss a study in which they found that large percentages of children were initially reluctant to acknowledge misbehavior at school. Asserting that the study has no relevance for understanding possible denial of sexual abuse, they explained that "the motives to deny an actual punishment are quite different from denying sexual abuse. The former involve protecting oneself from revealing an embarrassing wrongdoing" (p. 158). Ironically, this is a concise description of how many (if not most) abused children perceive abuse: an embarrassing wrongdoing. Indeed, when adult survey respondents are asked why they never disclosed

abuse as a child, two of the most common reasons are embarrassment and a fear that they would be blamed for the abuse (Anderson et al., 1993; Fleming, 1997).

Until researchers acknowledge the importance of understanding the dynamics of sexual abuse disclosure, their research will have limited applicability to abuse investigation. Even if they cannot obtain permission to study contexts in which genital touch occurs, they should take account of motivational barriers to disclosure, and design their studies accordingly. Indeed, fear of punishment provides a promising laboratory analog to disclosure reluctance. Lab studies examining children's concealment of transgressions, and means of encouraging them to disclose, have revealed the advantages of eliciting a promise to tell the truth and the limited advantages of reassurance (Evans & Lee, 2010; Lyon & Dorado, 2008; Lyon et al., 2008; Talwar et al., 2002, 2004).

Conclusion: Dolls, Diagrams, and the Future

Ultimately, I don't have any easy answers for practitioners who are considering whether to use dolls and diagrams in questioning children about abuse. My personal view is that they should be used only as a last resort and avoided altogether with children under 4 years of age. After one has worked through the disclosure questions that are provided by the NICHD protocol, then direct questions about genital touch could be used with caution and only when a subsequent interview is not practical (or when delay may endanger the child). But I would stress that my view is based on limited knowledge, on value judgments, and primarily on the research that best applies: studies examining children's true and false reports of genital touch.

Child interviewing research has enabled interviewers to make great strides in the past 25 years. We can now point to evidence-based approaches to interviewing that increase the productivity of children's reports without increasing the likelihood of false reports. The next step is to identify the best means of eliciting disclosures from children who are reluctant to reveal abuse, whether because of fear, embarrassment, guilt, shame, or other motivational barriers. The most progress will be made if researchers learn as much as they can about the dynamics of sexual abuse and the principles of cognitive, social, and language development and if they are as open as they can be about the methodological strengths and weaknesses of their work. Moreover, we must all be mindful of the devastation wreaked by both false allegations and false denials of abuse.

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APSAC's Role in Developing the Field of Cultural Competence in Child Maltreatment Prevention, Intervention, and Research

Lisa Aronson Fontes, PhD

APSAC's impact over 25 years far exceeds other organizations in spreading the word about the importance of culture on child maltreatment—and in shaping our interventions accordingly. In this article, I outline the many ways APSAC as an organization and its leaders have defined and highlighted the issue of cultural competence in child maltreatment, virtually from the organization's inception, and how it continues to break ground in this field. Additionally, I describe the state of our understanding of culture in child maltreatment when APSAC first began and some of the major concerns that remain today.

Attention to Culture at APSAC's Founding and Shortly After

When APSAC was founded in 1987, most research articles in child maltreatment did not mention the race or ethnicity of the participants, and those that did rarely analyzed group differences. Cultural groups were poorly defined. A study that included Mexican Americans would be described only as referring to Hispanics more broadly, and studies that might include disparate groups such as Pakistani and Japanese Americans might not distinguish between these two groups, calling them all "Asians." This failure to name groups properly in professional writing came to be known as "ethnic lumping" (Hayano, 1981; Fontes, 1993). Similar problems with research design contributed to inaccuracies and overgeneralizing in those few publications that did begin to acknowledge cultural influences in child maltreatment. The lack of attention to culture in research meant that we simply did not know which research findings pertained to members of which groups. In the *Advisor*, APSAC leaders critiqued research in the field for its failure to attend to culturally diverse children and families and made recommendations to improve the cultural competence of investigations (Urquiza & Wyatt, 1994; Fontes, 1997).

The eye-opening 1981 book *Child Abuse and Culture: Cross-Cultural Perspectives,* edited by an early APSAC member, anthropologist Jill Korbin, provided some of the theoretical background for examining cultural issues in child maltreatment through its focus on children in various nations. However, the situation of cultural minority families within the United States remained largely unexplored in the research and professional literature.

If the field's research attended inadequately to culture back in 1987, theoretical ideas, recommendations for prevention and intervention, and related trainings about culturally competent practice were even more limited. APSAC stepped in to fill the vacuum with a series of initiatives that helped put cultural issues and competence on the map and sped the development of a new generation of leaders in this field. APSAC's mark in cultural competence in child welfare is without a doubt one of its most outstanding achievements.

Joyce Thomas, a pioneer in racial justice in child welfare, was an early APSAC president. In 1990, Thomas founded and became director of the People of Color Leadership Institute (POCLI), which was a 4-year NCCAN-funded project marking a collaborative effort among four major national organizations in child maltreatment, including APSAC. POCLI provided trainings and a mentorship program, including a full-day training just before APSAC's 1993 colloquium. In 1991, Thomas began editing a column in the *APSAC Advisor* under the banner of POCLI, in which she profiled, interviewed, and coaxed articles out of researchers, mentors, and leaders who were intervening to prevent and reduce the effects of child abuse in ethnic minority communities. These leaders included Amy Okamura, Gayle Wyatt, Terry Cross, Luis Zayas, and others. Since that time, the *Advisor* has maintained an editorial Board member with a focus on cultural issues and has published innovative articles in this area.

In 1993, I presented a proposal for a book that became *Sexual Abuse in Nine North American Cultures* (1995) to Charles Terry Hendrix, a vice president at Sage Publications who would later become an APSAC Board member. Terry passed it on to APSAC founding president Jon Conte, who was editing a series of books

on child maltreatment. Jon supported the book's publication. I turned to copies of the *APSAC Advisor* for information about experts who could potentially write the chapters on child sexual abuse in their cultural groups, and in this way I met Veronica Abney who served on the APSAC Board for 9 years and later would serve as president. Abney has long presented first-rate workshops on providing services for African American children affected by child maltreatment and a range of other topics at the APSAC colloquia and in other venues.

The APSAC Board, the Cultural Diversity Committee, and the Cultural Institutes

Abney describes her initial contact with APSAC as following from her involvement in the California State Chapter of APSAC, CAPSAC:

> I remember being at a CAPSAC luncheon during one of the conferences sponsored by the San Diego Children's Hospital. I was the only African American in the room. I decided that this was not okay, and that I needed to become involved because these professionals were influencing policies that were impacting the lives of the many African Americans in the child welfare system. I quickly became a member of the CAPSAC Board of Directors, which naturally led me to APSAC. (Personal communication, January 11, 2012)

Prior to her presidency, Abney served as APSAC Board secretary and head of the Nominating Committee, where she recruited Board members who shared her commitment to cultural competence. Indeed, most APSAC Board members who have been active in issues of cultural and racial fairness were recruited personally by others who also emphasized this area. This personal chain has assured APSAC's continual focus on issues of cultural competence.

The Board of Directors established a Cultural Diversity Committee within the Board around 1991, which Veronica Abney guided during its early years. This committee consisted of Board and other APSAC members and tasked itself with several challenges: ensuring the cultural diversity of the Board and of the organization, assuring that the colloquia attend to cultural issues, ensuring that APSAC policies and guidelines adequately address issues of cultural competence, and raising awareness of cultural issues in the organization and society, while raising APSAC's profile in these issues nationally. These steps are in the interest of seeing that *all* children and families receive the best possible professional response to child maltreatment. To its credit, the Cultural Diversity Committee has pushed a social justice agenda within the organization, obligating the Board to examine its own internal workings as well as its professional work in the world, most notably in an organizational process audit that was undertaken 4 years ago. The Cultural Diversity Committee has reminded other Board members of the importance of having diversity represented in the makeup of the Board, recognizing that this identity and history is one of the strengths people bring to the Board and strengthens its ongoing work. To its credit, APSAC has never restricted the activities of Board members "of color" to the Cultural Diversity Committee, nor has it restricted the Cultural Diversity Committee to people of color, recognizing that professionals of color have strengths to bring to all discussions of child maltreatment, and that people from all cultural groups must have an investment in improving the field's ability to address the needs of cultural minority communities. Work related to cultural diversity has not always been easy and has, at times, stirred up controversy; but, it has been a central thread of APSAC's mission from its inception—never relegated to the margins.

Veronica Abney asked me to present on cultural issues in child sexual abuse at the 1996 colloquium in Chicago and put forward my name as a possible APSAC Board member based on our contact through my 1995 book. The Nominating Committee asked me to dedicate more time to the organization, and so I looked for ways to move from being a passive to an active APSAC member. At the 1996 APSAC colloquium, APSAC president Diane DePanfilis presented such an opportunity when she asked members to suggest ways they would like to get involved. At this meeting, I suggested an annual APSAC Cultural Institute; and Diane DePanfilis, Veronica Abney, Robert Pierce, and I took this on as our project and midwived it into reality. We held the first Cultural Institute at the 1997 colloquium in Miami on the day prior to APSAC's annual meeting. There was no additional charge for attending the first cultural institutes, they were the only major events held by APSAC on that day, and they were publicized independently to local organizations that might be interested, which facilitated a large attendance.

The Cultural Institute was conceived as a way to reach out to people from diverse cultural communities and call attention to the particular issues that might be relevant to immigrant and minority cultural communities. The Cultural Diversity Committee worked to elicit proposals for and include sessions on a range of topics, including a variety of ethnic-cultural and racial groups as well as issues of disability, sexual orientation, religion, racism, gender oppression, and social class. The cultural institutes have typically included a full day of activities, beginning with a panel on a topic of general interest and moving to breakout sessions exploring a range of issues. In the evening of each Cultural Institute, an open cultural diversity networking meeting is held to make a space where people with a strong interest in cultural issues in child maltreatment—and particularly members of cultural minority groups—would be able to find and bond with each other, and connect with the organization.

This same format has been used at every APSAC colloquium since, fostering untold training and networking opportunities for diverse professionals in many cities. The open meeting of members with an interest in cultural issues on the day of the colloquium has led to the increased repeated colloquium attendance, presentations, and even eventual Board membership of a variety of people with an interest in cultural issues. In this way, I recruited Viola Vaughan-Eden, current APSAC president-elect, at the 2001–2002 meeting in Washington, DC.

The Cultural Diversity Committee has attempted to be responsive to local needs and to benefit from the strengths of the communities where the colloquia are held. For instance, at the first Cultural Institute in Miami, Cuban American pediatrician and child abuse expert Walter Lambert participated in a panel on culture in child discipline. He eventually became an APSAC Board member. At APSAC's tenth colloquium in 2002 in New Orleans, Ivy Duong, a social worker of Vietnamese descent from California, conducted sessions on working with Vietnamese families at the request of local providers who desired training on this topic. They also requested training on military and religious issues in child sexual abuse; Board members Sarah Maiter, who has roots in both South Africa and Toronto, and Walter Lambert jointly provided the latter. The 2008 APSAC colloquium was held in Phoenix, Arizona. Since it took place on an Indian reservation, the Cultural Diversity Committee took advantage of the opportunity to "share, participate in, and experience Indian culture"

(Sarah Maiter, personal communication, January 8, 2012). At the impetus of the Cultural Diversity Committee in the mid-1990s, APSAC began to require that every colloquium submission describe how the presentation would address cultural issues. While clearly some presentations achieved this purpose more effectively than others and the role of culture was not equally central in all presentations, this requirement was evidence of APSAC's recognition of the importance of addressing cultural issues in discussions of practice and research. At that time, no other national conference was requiring this in its call for presentations; now it is fairly standard practice in professional conferences that address child maltreatment and family violence. Around the same time, APSAC began scheduling additional presentations with an explicit focus on culture throughout the various days of the colloquium in a culture track. The Cultural Diversity Committee worked closely with the Colloquium Committee to make sure geographic needs and new avenues of research as well as practice were included.

APSAC Leaders in Cultural Competence: Beyond Their Work in APSAC

A number of APSAC leaders have advanced cultural analyses and commitments in their work outside the organization. For instance, Deborah Daro added questions about race and culture to the annual National Committee to Prevent Child Abuse America's 50-state survey, which vastly increased available information. In 2000, APSAC founder and former president, and then director of the National Children's Advocacy Center, Charles Wilson and I discussed ways to help expand the training of forensic interviewers to include culturally and linguistically competent practice in more meaningful ways. We decided to reach the United States' largest linguistic minority first; and I developed the Spanish Language Forensic Interviewer Training, which I implemented through NCAC in the following 2 years. At the first Spanish Language Forensic Interviewer training, which I conducted at the National Children's Advocacy Center in Huntsville, Alabama, I met an outstanding Cuban American forensic interviewer, Toni Cárdenas, whom I recruited to facilitate the training with me the following year and attend the APSAC colloquium. Toni eventually became an APSAC Board member.

Former APSAC Board member Kathleen Faller has long recognized the importance of cultural issues in forensic interviews with children and coauthored with me a chapter on this topic (Fontes & Faller, 2007). The APSAC Forensic Interviewer Trainings have included a unit on cultural competence from their inception. I remember piloting this curriculum with 65 police officers in Kentucky and learning rather quickly that I needed to adjust my Northeastern liberal perspective to be able to reach a wider audience—while not sacrificing the important principles of justice, respect, and accuracy that lie at the core of culturally competent interviewing practice. I have subsequently

conducted trainings on cultural issues in forensic interviewing at a variety of venues throughout the United States, and on forensic interviewing more broadly in Spanish in Latin America. In 2008, my book *Interviewing Clients Across Cultures* was published. Although this book does not focus solely on child maltreatment, it includes chapters highly relevant to that area, including one on nonverbal behavior, one on using interpreters, and one on speaking with people whose native language is not English—all in the context of interviews.

Brenda Mirabal, a pediatrician whom many consider the godmother of everything having to do with child abuse prevention and intervention in Puerto Rico, has brought a team of Puerto Rican child abuse professionals to APSAC colloquia for several years. Mirabal enlisted me to help train Puerto Rican forensic interviewers (in Spanish). I brought in Maria Gallagher, then Northeast regional training assistant director for the National Children's Advocacy Centers. Gallagher arranged for important support for the children's advocacy centers in Puerto Rico and subsequently served on the APSAC Board of Directors. I am proud to say that APSAC has acted with integrity and resisted efforts to be co-opted into trainings that would have disempowered local social workers and other professionals in Puerto Rico—opportunities that have sprung up more than once when the island government has changed hands.

In 2001, APSAC established the award for Outstanding Service in the Advancement of Cultural Competency in Child Maltreatment Prevention and Intervention (see Table 1). The award was established to recognize individuals, organizations, and agencies that have made outstanding contributions to the advancement of cultural competency in child maltreatment prevention and intervention. The recognition of their pioneering work by our national organization has not only provided recipients with the opportunity to sustain their agenda with their own organizations but in some instances it has also facilitated the continuation of their direct practice work. For example, Bridging Refugees Youth and Children's Services (BRYCS), which provides information and training on child maltreatment to those who work in immigrant and refugee populations, through the United States Conference of Catholic Bishops (USCCB), was strengthened and its reach extended as a result of receiving the APSAC cultural competence award in 2008.

The first two editions of the *APSAC Handbook on Child Maltreatment* included chapters by Veronica Abney on cultural competence in child maltreatment. Although this chapter is missing from the third edition, I hope it will be included in the future. *Child Maltreatment* has published quite a few important articles over the years on cultural issues in child maltreatment, with a special issue on this topic, which I edited in 2001, with Behl, Crouch, May, Valente, and Conyngham's 2001 analysis of ethnicity in child maltreatment research, which was replicated by Miller and Cross in 2006. My book *Child Abuse and Culture: Working With Diverse Families* (2005) has become a central text in many professional training programs, and it has become the centerpiece of brown bag lunch discussion groups at many agencies.

APSAC Awards for Outstanding Service in the Advancement of Cultural Competency in Child Maltreatment Prevention and Intervention

Veronica D. Abney, PhD, LCSW
(2001)

Children's Advocacy Center of SW Florida, Inc.
(2003)

Lisa Fontes, PhD
(2004)

Dorothy Roberts, JD
(2005)

National Children's Alliance
(Nancy Chandler, Executive Director)
(2005)

Delores BigFoot, PhD
(2006)

Toni Cardenas, MSW
(2007)

BRYCS—Bridging Refugee Youth and Children's Services
(2008)

Michael A. de Arellano, PhD
(2009)

Cultural Competence in Child Maltreatment Today

Since APSAC's founding, a variety of other organizations have come to address specific and broad questions of culture and child maltreatment. This list is necessarily incomplete. The American Humane Association has projects on child welfare and migration. In 2004, the Casey-CSSP Alliance for Racial Equity in Child Welfare was established to develop and implement a national, multiyear campaign to address racial disparities and reduce the disproportionate representation of children from certain racial and ethnic communities in the nation's child welfare system. The National Children's Alliance

(NCA), the national support, training, and technical assistance organization for hundreds of children's advocacy centers nationwide, has included cultural competence as a criterion in its accrediting of child advocacy centers. This has obligated local centers to improve the ability of their agencies to reach children from all cultural groups. Bridging Refugee Youth and Children's Services (BRYCS) has extensive resources aimed at immigrants and refugees, and those who work with them, to help them avoid child maltreatment.

Clearly, the landscape in terms of race, ethnicity, and culture in child welfare has changed considerably since APSAC was founded; and APSAC as an organization and through its members can take some, but not all of, the credit for those changes. Many of the most important questions remain in dispute. For instance, professionals within and outside APSAC still debate the causes and solutions to racial disproportionality within child welfare. How much of this disproportionality is due to racism, and how much is due to the impoverished conditions afflicting many Native and African American families? What is the possible importance of ethnically similar providers? How can we best overcome the challenges of working with people whose first language is not English? Where bilingual providers are not available, is it better to use interpreters or cultural bridges? What are the most effective and compassionate ways to help Native American families overcome child maltreatment, especially in the context of complicated jurisdictional issues? Is family group decision making more culturally competent than other approaches or does it leave children at risk? Does structured decision making help social workers assess culturally diverse families more accurately and, therefore, avoid bias? How applicable are standard prevention and intervention ideas to members of cultural minority groups and how can we test these? What ideas about child maltreatment prevention and intervention currently exist in cultural minority communities that might be expanded and even tested with members of other cultural groups? And, most importantly in my opinion, how can we change the structural factors such as poverty and economic disempowerment that create the contexts in which child maltreatment typically thrives? Some of these more complex questions have arisen only after APSAC set the stage for inclusion of cultural considerations in all its venues.

In this brief review, I have undoubtedly neglected to mention important people, events, and achievements, although I have consulted with several colleagues during the writing process and have strived for accuracy. This review is meant to be illustrative rather than comprehensive, and I have written it in the context of inadequate records and occasionally failing memories. I sincerely ask that those who detect omissions or mistakes to please contact me. This area of knowledge in child maltreatment requires a great deal of additional exploration. From its early days, APSAC began shining its light on this relatively unfamiliar aspect of child maltreatment; and it continues to do so importantly today. Through publications, institutional practices, trainings, personal mentoring, and professional networking, I hope APSAC will continue to provide leadership and a community to all who care that every child and family—regardless of background—should grow up safe from violence.

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When the Call Comes: APSAC's Historic Recognition of Law Enforcement Officers and Prosecutors as Professionals

Michael Johnson and Victor Vieth, JD

> We so easily overestimate our own work and action in its importance in comparison with what we have become only through others. (Matthews, 2005, p. xiv)

The American Professional Society on the Abuse of Children (APSAC) has had a profound impact on the fields of law enforcement and prosecution. This essay includes a discussion on the benefits APSAC has brought to the nation's law enforcement officers and prosecutors, and also the role APSAC has played in helping other professionals understand the critical role of criminal justice professionals in addressing child maltreatment. In addition to looking at these accomplishments, the authors suggest challenges facing APSAC and the child protection field in the years to come.

APSAC's Recognition of Criminal Justice Professionals

Twenty-five years ago, there was an open debate in the field of child protection as to whether or not law enforcement officers and prosecutors should be considered as professionals on par with professors, researchers, physicians, and mental health professionals with multiple initials attached to their professional titles. Although this was not discussed in journals, it was a water cooler discussion that many in the criminal justice field vividly recall and that, even today, persists in some circles.

Since many law enforcement officers had only an associate's or bachelor's degree and most will not be writing treatises, some in the field of child protection believed that the men and women in blue or brown could learn a lot from the field, but couldn't teach the field anything. Although prosecutors had the degree of juris doctor, many similarly regarded them as having attended no better than a trade school and thus had much to learn and little to offer.

Even today, some of the discussion surrounding research or evidence-based practice by academics and researchers fails to even casually acknowledge the day-to-day successes achieved by law enforcement officers, child protection workers, and prosecutors. No better example of this success exists than the multidisciplinary initiatives of David Chadwick and the professionals of the San Diego Children's Hospital or prosecutor Bud Cramer's discussion of the importance of multidisciplinary teams (Chandler, 2006) that led to the development of Children's Advocacy Centers (Cramer, 1985). Field-driven efforts such as those of prosecutor Cramer typically precipitate the research that, eventually, supports the field-driven practices (Faller & Palusci, 2007). The reason for this is that frontline professionals lack the luxury of waiting for research to catch up with emerging issues.

In focusing more on children and less on degrees and titles, the founders of APSAC recognized that law enforcement officers had as much, if not more, to offer the field than any other discipline and that while research can guide the criminal justice field, the vast and rich experiences of criminal justices professionals can and should influence researchers and others working in the child protection field. In extending a hand to law enforcement officers and prosecutors handling child abuse cases, APSAC accorded these criminal justice professionals much needed benefit in several distinct areas.

First, in allowing police and prosecutors to join the American *Professional* Society on the Abuse of Children, APSAC boldly recognized these men and women as the professionals they are. In other words, APSAC recognized that a profession is more than an advanced degree but also includes advanced knowledge, skills, training, and *experience* in a specialized discipline.

Second, APSAC not only recognized law enforcement officers and prosecutors as professionals but gave them the tools to become professionally-recognized experts in the field of child protection**.** Through membership in APSAC, many criminal justice professionals are accessing peer-reviewed journals, attending conferences designed specifically for child protection professionals, and now have access to many leading child protection professionals they can call for advice or assistance in their work. Simply stated, APSAC has raised the level of professional expertise of criminal justice professionals and has influenced their work.

Third, APSAC accorded criminal justice professionals an ethical code for working cases of child abuse. Although prosecutors have multiple ethical codes, none of these specifically address cases of child maltreatment. Law enforcement officers must adhere to and enforce constitutional and statutory provisions. However, they do not have a national ethical code, much less an ethical code pertaining to the handling of child abuse cases. Upon membership in APSAC, criminal justice professionals agreed to review and adhere to the APSAC ethical code (APSAC, 1997). Suddenly, the standards of the criminal justice field were elevated.

Fourth, APSAC gave the field investigative guidelines. Although some today debate the purposes of a forensic interview, criminal justice professionals who have been in the field for more than a quarter of a century recall the high-profile day care cases that imploded and left investigators and prosecutors holding the bag (Hechler, 1988). Accordingly, the purpose of a forensic interview was to acquire legally defensible information in a reliable manner. Through the development of national forensic interviewing guidelines (APSAC, 2002) as well as guidelines for the usage of anatomical dolls (APSAC, 1995), APSAC helped investigators and prosecutors develop standards for this critical component of an investigation. The APSAC forensic interviewing clinic also became the model for other forensic interviewing courses—most of which follow the APSAC pattern of 5-day courses rooted in research and practical application.

Contributions of Criminal Justice Professionals to APSAC and the Field

The trust APSAC placed in criminal justice professionals has been rewarded throughout the past 25 years. These contributions include the following:

The Shaping of APSAC

According to Herman Stasse, it is a sign of deep sickness when an organization forgets its forefathers and mothers (Harrison, 2011). In the case of APSAC, law enforcement legends such as Ken Lanning, Bill Walsh, Mike Hertica, Dana Gassaway, and Rick Cage published articles, conducted trainings, and served in leadership roles. In the field of prosecution, pioneers including Patti Toth, Robert Parrish, and Brian Holmgren labored to ensure that the work of prosecutors reflected relevant research and was worthy of the professional status APSAC accorded them. Even today, APSAC continues to draw strength from the criminal justice field with two current or past law enforcement officers and one prosecutor serving on the Board. These and other criminal justice professionals did not make APSAC what it is, but APSAC wouldn't be the same without them.

The Shaping of Other Disciplines

In giving law enforcement officers and prosecutors a significant role in APSAC, these professionals not only shaped the organization but they also shaped other disciplines. To a greater extent, medical professionals realized that diagnosis of abusive head trauma or other forms of maltreatment could not be made without a comprehensive investigation and that it was the primary province of law enforcement officers to collect the evidence the medical community needed in making definitive findings. Mental health professionals began to realize that although they could diagnose PTSD and any number of other mental health conditions, it was the work of law enforcement officers and prosecutors that detailed the victim's pain and that procured the court orders to get victims, families, and even perpetrators into the psychologist's office. Child protection workers and child protection attorneys also gained a deeper appreciation of the fact that when law enforcement officers excel in proving a criminal case of abuse, proving a civil child protection case becomes much easier.

The Shaping of Research

There is also a growing awareness that the best researchers, those whose work actually impacts and improves the lives of children and is applicable to first responders and intervenors, are those researchers who regularly share a cup of coffee with law enforcement officers and prosecutors. Simply stated, many researchers have come to value the practical experience of frontline professionals who, in the course of their careers, interact with thousands of child abuse victims, extended family members, and survivors. To the extent this wealth of experience contributes or drives the research, the research will also drive the work of frontline criminal justice professionals. In other words, researchers realize more than ever that the only research that impacts the field of child protection is research that is actually relevant to the work of frontline professionals.

The Shaping of the Law

Criminal justice professionals working closely with leading medical, mental health, and other professionals from APSAC have also influenced the law. Twenty-five years ago, the field was struggling with interviewing children in a manner that did not contaminate the process. Today, a number of appellate courts recognize the concept of forensic interviewing as an emerging discipline that many members of the MDT, including law enforcement officers, are qualified to conduct (Vieth, 2009). Prosecutors have also worked with the medical and mental health community in limiting the scope of questionable practices of some defense experts. Recently, APSAC expanded its involvement with the legal community and is expediting a review of possible amicus (friend of the court) briefs in child protection cases that will significantly impact the field.

This is not to say that criminal justice professionals have also spoken with a unified voice or that our field always got it right. Twenty-five years ago, many prosecutors and law enforcement officers expressed concern about videotaping forensic interviews

(Stern, 1992). Today, recording forensic interviews is widely practiced, and the research to date shows this practice generates more evidence and is more likely to produce convictions, including guilty pleas (Vandervort, 2006). Even when criminal justice professionals have erred, we all learned, and the stronger alliance with researchers and other disciplines has helped the criminal justice community chart a new course—as has largely been the case with recording forensic interviews.

Future Challenges for APSAC and the Field

In the decades ahead, the child protection field will face many new challenges. If the past is prologue, APSAC will play a significant, even deciding, role in meeting these challenges. As vital members of APSAC, law enforcement officers and prosecutors will be critical in addressing emerging issues. From the perspective of the authors, there are at least six emerging issues that warrant the attention of the field and of APSAC.

First, there is a critical need to address child maltreatment in Indian Country. Native American children suffer higher rates of abuse than children in the general United States population (US DHHS, 2009). The distrust of federal authorities likely results in underreporting of abuse in Indian Country (Fox, 2003). APSAC must continue to value the unique culture of Indian Country and devote more resources to empowering child protection professionals to better serve Native American children. APSAC should also expand its collaborations with organizations serving Indian Country, including the Native American Children's Alliance (see www.nativechildrensalliance.org).

Second, the field needs to more fully assess the benefits and limitations of the alternative or differential response system. Although this system has shown some promising results, many prosecutors and law enforcement officers are worried that critical child protection decisions are now made unilaterally without the involvement of criminal justice professionals, and many times without the involvement of medical and mental health professionals. In 85% of the states using this model, the decision of whether or not to forward a child into the alternative response system was made by the assigned social worker with approval or other involvement from a supervisor (US DHHS, 2003). If this trend continues, traditional MDT/CAC investigations will be relevant to only about 25% of the child abuse cases reported to the child protection system (those cases involving child sexual abuse and severe physical abuse). APSAC needs to be a leader in assessing the strengths and weaknesses of the differential response system and the wisdom of excluding so many members of the multidisciplinary team from assessing these cases.

Third, there is a need to expand CAC and MDT work beyond sexual abuse cases. APSAC has played an important role in expanding multidisciplinary and child protection teams and Children's Advocacy Centers throughout the United States. However, many CACs and MDTs continue to serve primarily sexually abused children (Chandler, 2006)—the smallest percentage of maltreated cases reported to the child protection system (US DHHS, 2011). In the years ahead, APSAC members can play a critical role in the expansion of CACs and MDTs in addressing other forms of maltreatment. As one example, most states have civil and criminal laws prohibiting emotional abuse, and a large body of research exists documenting that this form of maltreatment is just as harmful as other forms of abuse (Vieth, 2004). Unfortunately, most cases of emotional abuse are not investigated, much less investigated by a multidisciplinary team.

Fourth, child protection professionals need to more fully address the role of spirituality in the abuse of children. Law enforcement officers often lament how often child abusers use religious or spiritual themes in the abuse of children (Vieth, 2012). Prosecutors have often faced the spectacle of theologians and church leaders who fill a courtroom in support of an accused offender, and in implicit opposition to a child alleging abuse. There is a growing body of research that offenders not only wound their victims physically and emotionally but also spiritually (Eshuys & Smallbone, 2006; Firestone, Moulden, & Wexler, 2009). This is critical because more than one study finds that, for many victims, their ability to cope with abuse may depend on their ability to cope spiritually (Gall, 2006). MDTs need to devote more attention to this issue, and APSAC should also recognize this growing body of evidence and involve members of the faith community in the organization to a greater extent.

Fifth, the recent events at Penn State University and other institutions have focused the attention of a number of leading professionals to the woeful undergraduate and graduate preparation of future child protection professionals (Vieth, 2012). This poor preparation is a problem for medical schools, law schools, and for undergraduate and graduate psychology, social work, and criminal justice programs (Vieth, 2006). APSAC is well represented in academia and, in the years to come, this representation needs to result in far better training of future child protection professionals at the undergraduate and graduate levels.

Sixth, there is a need to grow APSAC membership among nurses. Law enforcement officers and prosecutors have long recognized the critical role of nurses in documenting behaviors or actions indicative of abuse (Canaff, 2010). Generally speaking, nurses at hospitals and clinics spend as much if not more time with patients and families and are in a better position to document evidence that may be critical in proving abuse, protecting a child, and repairing a family impacted by maltreatment. In child abuse trials, it is not unusual for the prosecutor to call many more nurses than doctors to the witness stand. In recognition of this fact, there is a need to involve more nursing professionals in APSAC.

Conclusion

A lot has happened in 25 years. In the past quarter century, the child protection field has improved markedly—in no small part thanks to leadership of APSAC. This has translated into hundreds of thousands of maltreated children receiving better medical and mental health care, and in more humane treatment from the social service and criminal justice systems. If it is true that child abuse is declining, the vast improvement in our child protection system, and the critical role APSAC played in that improvement, should bring a great deal of pride. As we celebrate these accomplishments, it is also important to remember the millions of children and adults still suffering under the weight of abuse. In focusing on their needs, APSAC is poised to say to hurting children, in the words of Aeschylus: "Take heart. Suffering when it climbs highest lasts but a little time" (Kennedy, 1998, p. 145).

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AT ISSUE:

25 Years of APSAC—A Personal Historical, Law Enforcement Perspective

Kenneth V. Lanning, MS

In May 1970, I began my 30-year career as a special agent with the FBI. Early in that career, I also became involved as an instructor in the FBI's field police training program. After 10 years as a field investigator and part-time police instructor and getting my Master's degree, I was transferred to the FBI Behavioral Science Unit (BSU) at the FBI Academy in Quantico. I was assigned to this Unit from January 1981 until I retired from the FBI in September 2000. Although the BSU was part of the FBI's Training Division, its work involved more and more research and operational case consultation as well as training.

As a junior member of the BSU, I was at first given a wide variety of miscellaneous assignments. Soon fellow unit member Roy Hazelwood approached me. Roy was the unit expert in what was then referred to as sex crimes. He explained that the key to success was to have a unique and important specialty. He suggested we team together in the area of sexual crimes—a topic I had been teaching since 1973 as a field police instructor. We would divide up the sexual crimes; he would specialize primarily in adult victim cases, and I would specialize primarily in child victim cases. This made sense. "Crimes against children" was an area that I thought was important and rewarding. I believe that this conversation and my resulting decision is one of the keys to understanding a central point of my involvement with APSAC and my ability to maintain professional objectivity.

I quickly tried to do everything possible to improve and expand my expertise in the specific area of the sexual victimization of children. I was soon regularly interacting not only with criminal justice professionals but also with social workers, doctors, nurses, and mental health professionals. I learned a great deal from this interaction and developed a greater appreciation and understanding of other perspectives. I came to recognize the importance of and need for a multidisciplinary response to the problem of child sexual abuse. As my expertise and reputation grew, I consulted on an ever-growing number of cases and was frequently invited to do presentations at national and regional training conferences on the topic.

My focus on the sexual victimization of children intensified during the 1980s, and I soon recognized the changing and evolving attitudes about the issue. During this time, most of the new training materials, articles, and books on the topic referred to child sexual victimization primarily in terms of intrafamilial father-daughter incest. From my work, however, I knew that the sexual victimization of children included far more than this. Intrafamilial sexual abuse between an adult and child may be a common form of child sexual victimization, but it is not the only form. This emphasis on intrafamilial child sexual abuse by many professionals is still common today. Many of the policies, protocols, and procedures developed to deal with one-on-one intrafamilial sexual abuse, however, may have limited application to cases involving sexual molestation by acquaintances, such as in the recent allegations at Penn State University or sexually motivated child abduction. These variations and differences were often not adequately understood or addressed by interveners or at training conferences.

It was important for professionals dealing with child sexual abuse to recognize and learn to manage the common denial associated with this serious problem and to encourage society to deal with, report, and prevent the sexual victimization of children. Some professionals, however, in their zeal to overcome denial and increase awareness tended to exaggerate and misrepresent the problem. It seemed to me that true professionals should cite reputable and scientific studies and note the sources of information. If they did not, their credibility and the credibility of the issue could be damaged.

At many of the conferences I attended in the 1980s, I also recognized what seemed to be a zealous aspect to many of the presentations and discussions. The need to believe the children and eliminate laws requiring corroboration was often communicated as part of an impassioned crusade. At one child abuse conference, a nationally known keynote speaker, when asked why she always referred to victims as "she" and offenders as "he," responded that she was concerned about the forest and couldn't worry about a few trees. At conferences, shopping bags with crayon drawings by young children were distributed to carry handout material. These are just a few small examples of what I came to sense about the emotional nature of much of the response to child abuse, even on the part of so-called professionals.

I also remember hearing from the experts that most child molesters were victims themselves. This was essentially presented as a documented fact. The only thing that varied was the exact percentage. I wondered how this had been determined. As time went on, I got up the courage and confidence to ask these experts, whom I then held in awe, and was told that the percentage had been determined by research studies in which such offenders were asked about their victimization. I then asked how these responses were verified or corroborated. The most common answer I got was, "Why would they lie?" Few in law enforcement would ask such a question. These experts should have more accurately stated that most offenders *claim* to be victims. Interestingly, there is now some research suggesting that when sex offenders are confronted with the use of a polygraph and real consequences for their answers, the percentage claiming to be victims drops to about the same as that in the general population.

My skepticism has only increased for research concerning human behavior that is overly reliant on self-reported information. It began with my doubts about the claim that most sex offenders are victims themselves. This skepticism may be due in part to a professional lifetime spent interviewing and talking with individuals who repeatedly lie about, misrepresent, and rationalize their behavior for a wide variety of reasons. Although behavioral research is highly regarded in some circles, my opinions and analysis were not based on such uncorroborated, self-reported information. I typically operated from a law enforcement bias that tends to assume people are lying unless you know otherwise.

Because I was simultaneously doing training, research, and case consultation, I increasingly began to recognize the importance of defining terms. This recognition was reinforced through my interaction with academic researchers such as Dr. David Finkelhor. When we use basic or common terms (e.g., *child, sex*), we rarely define them. Apparent disagreements are often due to the confusion created by calling different things by the same name and the same thing by different names. A dictionary or layperson's definition of *mental disorder* (e.g., "pedophilia") may not be the same as a psychiatric or mental health definition. Legal definitions of *sexual assault* may not be the same as societal attitudes or religious beliefs.

There was also a problem with the consistent use of definitions. When case volume was wanted, *children* were more likely to be defined as '"anyone younger than 18 years old." When impact was wanted or specific examples were needed, *children* quickly became "anyone younger than 12 years old." The definition problem seemed most acute when professionals from different disciplines came together to work or communicate about the sexual victimization of children. I realized that definitions are especially important whenever discussing, researching, and writing about the nature and scope of the problem.

The most significant occurrence that changed my professional perspective concerning allegations of sexual victimization of children was the claim of what came to be called Satanic Ritual Abuse (SRA). In early 1983, when I first began to hear about cases involving what sounded like satanic or occult activity in connection with allegations of extreme sexual victimization of children, I tended to believe that they had occurred. Soon I was dealing with hundreds of victims alleging that thousands of offenders were severely abusing and even murdering tens of thousands of people as part of well-organized groups, and there was little or no corroborative evidence. A few of these cases could have been well-founded, but not all or even most of them were. The very reason many experts cited for believing these allegations— many victims, who had never met each other, reporting the same events—was the primary reason I began to question at least some aspects of these allegations.

As more and more of these cases came to my attention, I progressively became more concerned about the lack of physical evidence and corroboration for many of the more serious allegations. There was a lack of corroborative evidence when there should have been

corroborative evidence. Many of the unsubstantiated allegations just did not seem to have occurred, or in some cases, could not have occurred. These cases appeared to call into question the credibility of victims and raised controversies over complex topics such as the reality or reliability of recovered repressed memories and the suggestibility of children. This included debates over how the human brain stores and recovers memories, how easily children of different ages can be led and influenced by questioners, and confirmation bias.

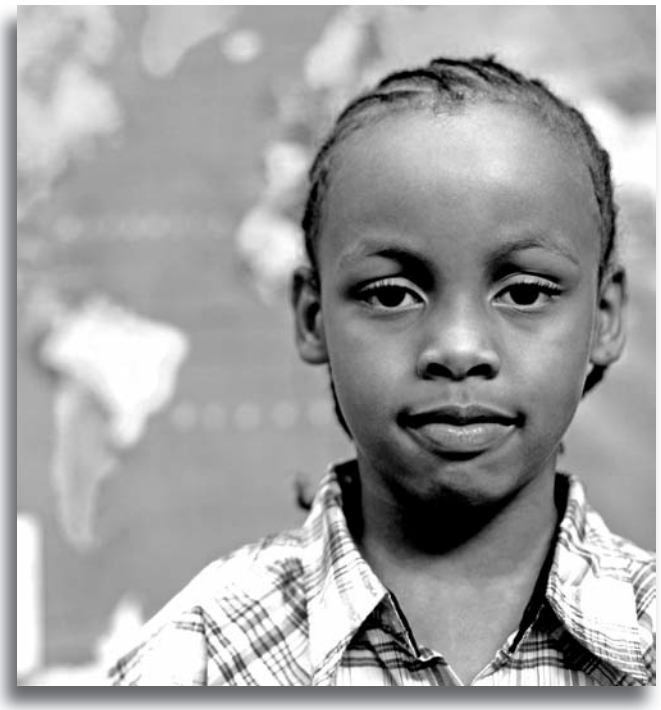
When I decided to publicly communicate my concerns and doubts about these cases, some claimed I had gone to the "dark side." I did not anticipate the antagonistic reaction of some of my professional colleagues, such as those who believed the allegations couldn't produce any real evidence while offering ever-expanding explanations for why there was no evidence. When I began to consider alternative explanations for some of the allegations, I found that many child abuse experts had no real answers. They seemed more concerned that questioning some allegations might mean one had to question all allegations.

I spoke out and published on this issue because I was concerned about the credibility of the sexual victimization of children. I was certainly troubled that innocent people might be falsely accused. But I was also concerned that guilty people might be getting away with molesting children because we could not prove they were satanic devil worshipers. I did not want the controversy over these extreme, overzealous cases to cast a shadow upon and fuel the backlash against the validity and reality of child sexual victimization and the need for objective investigation.

Many of these anecdotal but repeated experiences suggested to me that the field I had chosen to specialize in often had an excess of emotion and a deficiency of professionalism. This emotionalism seemed to have the potential to increase the motivation of interveners but decrease their ability to be objective.

In May of 1986, I attended and presented at the National Conference on Sexual Victimization of Children in New Orleans, Louisiana. While there, several of my new colleagues from different disciplines approached me. They inquired about my interest in being a founding member of a new organization to be called the American Professional Society on the Abuse of Children (APSAC). This was to be a multidisciplinary organization that would encourage and support professionalism and interaction in the field. I remember that one of the early debates back then was whether this new organization would address primarily sexual abuse of children or child abuse in general. The eventual decision to address the broader issues seems to have been the right one.

The word that was most appealing to me in the name of this new organization was *professional*. I therefore enthusiastically agreed to join and become a founding member of the Board of Directors of



APSAC and later a member of its Advisory Board. I tried my best to represent a professional law enforcement perspective during many APSAC discussions and meetings concerning controversial issues such as allegations of SRA, forensic interviewing, repressed memory, Internet exploitation of children, compliant child victims, and the focus and nature of publications.

I eventually authored four articles published in the *APSAC Advisor*: "Sexual Homicide of Children" (1994); "The 'Witch Hunt,' the 'Backlash,' and Professionalism" (1996); "Cyber 'Pedophiles': A Behavioral Perspective" (1998); and "A Law Enforcement Perspective on the Compliant Child Victim" (2002). I was a guest coeditor with Lucy Berliner for a special issue of the *APSAC Advisor* on the topic of Compliant Child Victims from five different professional perspectives in 2002. The *Advisor* agreed to publish these articles when other child advocacy groups did not want to confront this uncomfortable reality. I also authored chapters titled "Criminal Investigation of Sexual Victimization of Children" in the first (1996) and second (2002) editions of *The APSAC Handbook on Child Maltreatment* and presented at seven of the early APSAC Colloquiums between 1993 and 2001.

I consider my article on "The 'Witch Hunt,' the 'Backlash,' and Professionalism" to be one of the most significant of my 36 publications. In this article, I set forth ten characteristics that the seemingly opposite perspectives of the "witch hunt" and "backlash" have in common. They are in fact two sides of the same coin of emotional zealotry. I then made some recommendations for a more professional response.

I also discussed my realization that complex problems such as the sexual victimization of children are typically addressed from three major perspectives: personal, political, and professional. The personal perspective encompasses the emotional: how the issues affect individual needs and wants. The political perspective encompasses the practical: how the issues affect getting elected, obtaining funding or pay, and attaining status and power. The professional perspective encompasses the rational and objective: how the issues affect the problem and what are the most effective ways to address it. I found that the personal and political perspectives tended to dominate emotional issues such as child sexual abuse. In this article, I expressed my opinion that sexually victimized children need more people addressing their needs from the professional perspective and fewer from the personal and political perspectives.

Two of the personal highlights of my professional career involve APSAC. In 1996, I received the APSAC Outstanding Professional Award. The dedication by the editors of *The APSAC Handbook on Child Maltreatment, 2nd edition* (2002) stated: "This book is dedicated to Kenneth V. Lanning. Ken, you are one of the pioneers. You led the way. You opened our eyes. You taught us. You were always one step ahead. You're the coolest FBI agent we know. You've done more than we can count to protect kids. Thanks."

I am proud of my involvement with APSAC and support its efforts to advance professionalism and interdisciplinary cooperation. Although my experience with APSAC was generally a positive one, there were times when I felt that the law enforcement perspective was not equally respected. For example, I once worked with other law enforcement members on a subcommittee to develop the law enforcement track for that year's APSAC Colloquium. After completing our work, however, we were told that APSAC Board members from other disciplines would have to approve our decisions concerning law enforcement training. As far as I knew, nobody in law enforcement got to approve the training track for other disciplines. Law enforcement members who then succeeded me on the APSAC Board of Directors communicated to me similar experiences, which suggested that what they sometimes felt indicated a lack of equal consideration and recognition for their views. I assume this concern has by now been addressed.

In my opinion, working together as part of a multidisciplinary team means coordination, not abdication. Each discipline performs a function for which it has specific resources, training, and experience. Although each discipline must understand how its role contributes to the team approach, it is equally important that it understands the respective responsibilities and limitations of that role. The team approach is therefore a two-way street. Just as medical and psychological professionals are charged with evaluating and treating the victimized child, law-enforcement investigators are responsible for conducting criminal investigations. Just as law-enforcement officers need to be concerned that their investigation might further traumatize a child victim, therapists and physicians need to be concerned that their treatment techniques might hinder the investigation.

In striving for professionalism, I often have considered why, when I evaluated cases of sexual victimization of children, I was usually able to maintain my objectivity as a professional fact-finder. Why was I so often able to maximize the professional perspective and minimize the political and personal perspective when dealing with such emotional topics? I came to the conclusion that the two biggest factors are (1) how I came to my job and expertise and (2) my basic background and personality.

As I mentioned, I came to specialize in cases involving the sexual victimization of children for somewhat practical and selfish reasons. My work was rewarding, important, and fulfilling, but I was not drawn to it for sentimental or altruistic reasons. I had no agenda. I was just an FBI agent doing his job. The FBI paid me the same salary every two weeks. It made no difference to me financially in which direction the evidence led. In addition, I had been a well-trained and experienced investigator for 10 years before I ever came to the BSU. My work experience had taught me to be skeptical and desensitized me to many aspects of these cases. My threshold of bizarre was different from that of most people. I am proud of this objective law enforcement perspective and believe it has an important role to play in society's response to child abuse.

APSAC was part of my effort to strive for professionalism in my work, communicate my opinions, and learn from others. I congratulate the organization on its 25th anniversary. I would also like to recognize the other law enforcement APSAC Board members with whom I have worked—Rick Cage, Mike Hertica, Dana Gassaway, Bill Walsh, Donna Pence, and Mike Johnson—and to thank Theresa Reid, the first APSAC Executive Director from 1988 to 1997, for her support of my participation.

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Kenneth V. Lanning was a special agent with the FBI for more than 30 years and was assigned to the FBI Behavioral Science Unit at the FBI Academy for 20 years. He received the 1996 APSAC Outstanding Professional Award, the 1997 FBI Director's Annual Award for Special Achievement for career accomplishments in connection with missing and exploited children, and the 2009 Lifetime Achievement Award for Outstanding Service from the National Children's Advocacy Center. He has consulted on thousands of cases and lectured and trained tens of thousands of criminal justice professionals. Contact: caconsultants@earthlink.net

Prosecuting Child Physical Abuse and Homicide Cases: How Things Have Changed Since the Creation of APSAC

Robert N. Parrish, JD

Criminal prosecution of cases involving the physical abuse of young children or in which children have passed away as a result of inflicted injuries continues to present challenges not often encountered in other forms of criminal prosecution. It has always been accepted that almost all acts of child abuse occur in secrecy, with no other eyewitnesses unless the witness is also involved in the abuse or is too young to provide reliable testimony.

> Where there is child abuse, there will invariably be secrecy. The great disparity of power and control between the abuser and the child assures that there will be little, if any, direct evidence. Even in cases where the victim survives, the child's age and vulnerability make it unlikely that he or she could be expected to testify competently. In these cases, it is probable that evidence of prior abusive conduct by a caretaker may be the only available link between the specific nature of the child's injuries and the caretaker who has offered either no explanation or an inadequate explanation for those injuries. (*State v. Tanner,* 1983, p. 547)

Almost without exception, this leaves prosecuting attorneys with the difficult task of proving what happened, who did it, and when it happened through circumstantial evidence. In some cases it is clear that someone inflicted an injury or set of injuries upon the child; however, in other cases the injuries may have been the result of accident or may have been inflicted by another person and only thorough investigation allow proof beyond a reasonable doubt that they were caused by abuse.

Since the formation of the American Professional Society on the Abuse of Children (APSAC) in 1987, the process of criminal investigation and prosecution of child abuse cases has undergone a dramatic transformation for the better. During the 1980s, prosecutors were limited in the tools available to illustrate expert witness testimony in the courtroom, and most were just beginning to learn about complex medical entities such as subdural and retinal hemorrhages in young children. Through providing increases in opportunities for interdisciplinary training, networking, and professional cross-training, APSAC has played a tangible role in improving the way the criminal justice system handles child abuse cases. Although much has been accomplished, the future presents tremendous challenges as well.

The key to successful prosecution is twofold. First, expert witnesses provide their opinions concerning what most likely caused the entire collection of injuries suffered by the victim and when they were most likely caused. Such expert opinions are not formed or expressed in a factual vacuum but rather must be informed by the history provided by the caregivers of the child surrounding the time the child went from "fine" to "symptomatic." Such history is often collected by the medical professionals involved as a normal part of their diagnostic process, but often that history changes over several tellings or when the caregivers are interviewed by social services workers or law enforcement investigators. Discrepant accounts that don't adequately explain the nature and severity of a child's entire collection of injuries have always been considered the "cardinal sign" of abuse, both in the medical profession and in the justice system.

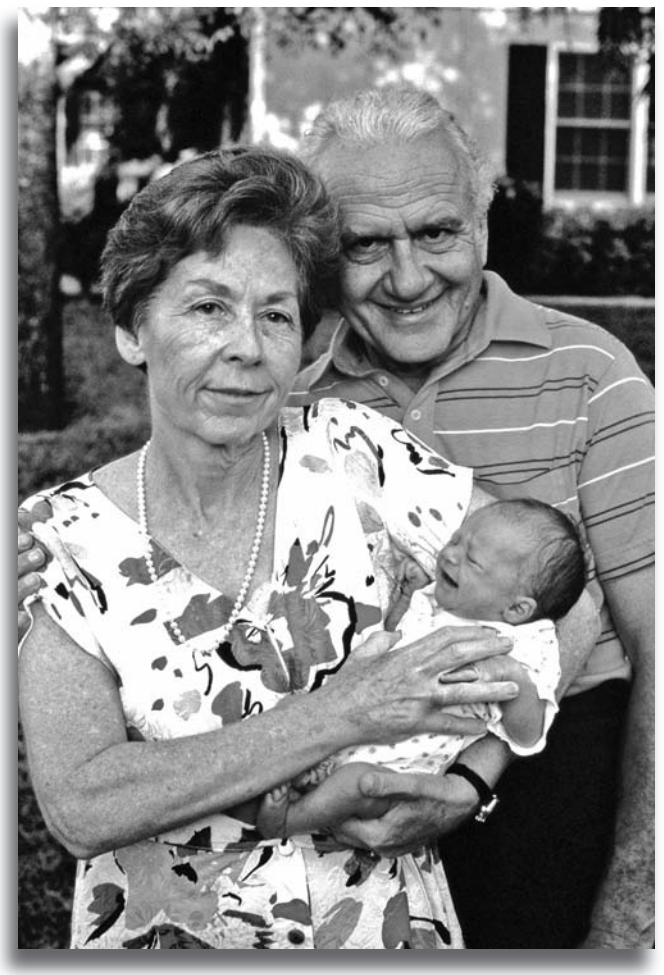
> A significant discrepancy between the physical findings and the history is the *cardinal sign* of abuse. The evaluator must remember that an explanation for an injury should not change when it is questioned or challenged. If the history differs from parent to parent, or when challenged, it is very likely fabricated. (Monteleone & Brodeur, 1998, pp. 8, 20)

Though this was written specifically for medical evaluators, it applies directly to criminal justice professionals, who realize that insufficient histories provided by perpetrators help to show not only that the victim was abused but also the identity of the abuser.

Prosecutors have learned over the last several decades how important the offering of those stories can be to a successful prosecution, especially in sorting between potential perpetrators of the abuse. Expert medical opinions are much stronger if they are informed by the entirety of investigative facts discovered by both the child protective services workers and the law enforcement investigators in the case. Thus, open sharing of information is essential to a successful prosecution.

Second, the prosecutor must prove beyond any reasonable doubt who it was that committed the acts of child abuse that resulted in the collection of the child victim's injuries and what mental state they were acting with at that time. When the proof is almost completely circumstantial, this can be the most difficult part of such criminal cases in the courtroom. Just as medical expert opinion is strengthened by sharing of all information, so the prosecutor's task of proving the "whodunit" of the case is simplified by learning from the medical experts what the likely nature and onset of symptoms would be for the injured child. While abusive caregivers generally don't tell the truth as to exactly how the child was injured, they lack understanding of the significance of the onset and progression of the symptoms and thus usually *do* tell the truth about when the child first became symptomatic and what symptoms were observed after the child's health or welfare changed. Timing the cause of the injuries is primarily informed by the history of symptoms provided by all caregivers for the child (Alexander, Levitt, & Smith, 2001).

To prove both essential parts of their criminal case, prosecutors must be well informed about the medical issues involved in each case. That means they must obtain training concerning the cause of childhood injuries provided by medical experts who have training and experience in the field of child maltreatment. In each case, that general knowledge must be enhanced by detailed discussions with the medical experts involved in that case. As Brian Holmgren, an expert prosecutor who has handled these cases for several decades has noted, the "child abuse prosecutor's paradox" involves the simple truth that the more severely the child abuse victim is injured the easier it will be for the prosecutor to prove both what happened and who committed the abuse beyond a reasonable doubt. The more difficult cases to prove involve children who although injured by another person, have fully recovered from those injuries and whose initial symptoms were less than clear as to their cause. For example, young children with milder closed head injuries may be described as "fussy, lethargic, didn't want to eat as much, or vomiting." Since these symptoms can be caused by a long list of other things, they are considered nonspecific symptoms of abuse, although they certainly might be the result of inflicted injury. In addition, the timing of the onset of those symptoms can be over hours or even days, making it difficult to pinpoint when the injuries were first caused. A child with a severe closed head injury, on the other hand, will almost invariably develop some type of symptoms very soon after the neurologic insult and those symptoms will progress along a fairly predictable path until the child is brought for medical care.



One of the most important advances in the prosecution of child physical abuse and homicide cases in the last two and a half decades is the improvement in technology that allows prosecutors to more thoroughly explain complicated medical concepts and terminology to a jury of laypersons or to judges untrained in such medical issues. Courtroom practice has evolved from the relative "dark ages" when we would circulate 8"x10" photographs of the victim's injuries among the members of a jury while the expert witness had already moved on in her testimony to some other topic. Sometimes we all would wait while each juror slowly consideredeach photo. Later, we used of slides or overhead projectors so that at least everyone in the courtroom was seeing the same thing contemporaneously with the expert's explanation of the injuries. Now we use computers and projectors to not only allow simultaneous showing of the photographs of the child's injuries but also to illustrate internal anatomy and to put into motion the expert's opinion as to the likely mechanism that resulted in injury (Lauridson & Parrish, 2006). Given the fact that modern society has evolved into a group of visually-oriented learners, technology has provided indispensable tools for courtroom proof and persuasion. Almost all of these tools were developed as a direct result of the professional connections created through cross-training and networking.

While prosecutors have vastly improved the way they handle these cases in court, the medical profession has also made great strides in understanding the underlying scientific basis for expert medical opinions as to all forms of child maltreatment. It remains vital for

the two groups of professionals to train each other as to what expert opinions are supported by sound medical science and what legal restrictions are placed on such expert opinions. The American Board of Pediatrics recently formulated a set of subboard certification criteria and certified a new group of subspecialists in Child Abuse Pediatrics, an important stride toward recognition of those who truly specialize in the field of child maltreatment (Block & Palusci, 2006). Defense challenges to the scientific reliability of medical opinions about the meaning of certain diagnostic entities have also accelerated, and an increasing number of "irresponsible experts" are more than willing to express opinions in a courtroom on behalf of criminal defendants who reflect the views of a small minority (Chadwick & Krous, 1997). Unfortunately, that group of individuals has recently been effective in convincing an uninformed and questionably-motivated law professor to write several specious articles concerning the diagnostic entity known as the shaken baby syndrome which in turn have been picked up by certain media to influence the general public to believe that there is no such thing as a collection of injuries that allows well-qualified experts to identify that closed head injuries in young children were inflicted by some other person (Tuerkheimer, 2009; Tuerkheimer, 2010). Prosecutors must not be scared away by ill-informed and poorly written and researched articles, because Dr. Sandeep Narang has recently refuted everything written by Professor Tuerkheimer and the underlying bases for her conclusions. Dr. Narang, a pediatrician with the University of Texas Health Sciences Center at San Antonio, Texas, does an excellent job putting Tuerkheimer's misinformation into proper context and exposes the complete lack of credibility of the authors and writings upon which Tuerkheimer's articles and assumptions were based (Narang, 2011).

As the field of medicine has become more and more specialized, one of the biggest challenges to successful criminal prosecution of child physical abuse and homicide cases is the problem of "reinventing the wheel." Even prosecutors in large metropolitan areas may not have the experience or training to handle a complicated case and may be assigned only one or two child physical abuse or homicide cases within their career as a prosecutor. Some prosecutors' offices have specialists who are well-trained and highly experienced to handle child abuse crimes, but even in special victim units, the likelihood is that most of the experience prosecutors gain will be in the sexual abuse of children with only occasional cases of child physical abuse or homicide by abuse. The problem in rural jurisdictions, where the prosecutor must handle criminal cases of all kinds, may be even more pronounced. There is a solution provided by agencies such as the National Center on Prosecution of Child Abuse (www.ndaa.org/apri) and by professional associations such as APSAC (www.apsac.org). Both have developed significant bodies of information available to handle these cases, lists of prosecutors with significant experience who are willing to consult with others, and even training materials, transcripts of frequently-encountered defense experts, and lists of medical experts available for consultation.

Thanks to the networking and training efforts of the American Professional Society on the Abuse of Children and many other allied groups and agencies, there will never be a need for a prosecutor handling her first case to "reinvent the wheel." No substitute exists for the hard work of learning every detail of every case to prosecute it effectively in court. However, there are resources available so that the learning process does not have to be unreasonably arduous and many professionals willing to be a sounding board for any issues unique to individual cases.

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Evidence-Based Mental Health Treatment: A 25-Year Glance at Past, Present, and Future

Monica M. Fitzgerald, PhD, and Lucy Berliner, MSW

The 25th anniversary of the American Professional Society for the Abuse of Children (APSAC) calls us to reflect on how far mental health treatment for abused and neglected children and their families has come over this quarter century and the role of APSAC in shifting traditional thinking about children's mental health needs.

Advances in Treating Trauma

One of the most significant advances that has occurred over this time is the gradual move away from studying different types of abuse, trauma, and violence separately. It is now far more common for studies to assess a range of trauma and abuse experiences and the consequences of "polyvictimization" for child well-being (Turner, Finkelhor, & Ormrod, 2010). This shift has produced two of the key findings regarding trauma and its impact on children. First, trauma and abuse experiences are very common in the general population and even more common in clinical samples (Finkelhor, Hamby, Ormrod, & Turner, 2009; Copeland, Keeler, Angold, & Costello, 2007). Second, it is the accumulated burden of multiple traumas and adversities that is most predictive of negative outcomes, not the specific type or number of trauma experiences (Felitti et al., 1998). On the one hand, the good news is that not all children who have been exposed to trauma and abuse develop persisting mental health conditions (Bonanno, 2004; Bonanno, Westphal, & Mancini, 2011; Bonanno, Brewin, Kaniasty, & LaGreca, 2010; Copeland et al., 2007; Masten, 2001). On the other hand, there is a subset of children characterized by exposure to multiple forms of abuse and trauma and multiple adversities (e.g., insecure attachment, changes in living situation, parental incarceration, parental mental illness, and foster placement). These children are at the highest risk to develop persistent and severe behavioral and mental health problems, including trauma distress and depression (Felitti et al., 1998; Dube, Anda, Felitti, Chapman, Williamson, & Giles, 2001; Danielson, de Arellano, Kilpatrick, Saunders, & Resnick, 2005).

Twenty-five years ago there was scant empirical knowledge about the specific types of mental health interventions that would be most beneficial for children and families affected by abuse, violence, and neglect. Mental health professionals treating maltreated children would use their best judgment and clinical skills based on their training and experience in the field. They tended to use treatment approaches that were familiar and comfortable. For example, "treatment as usual" for abused children and their families in the late 1980s was not evidence-based (Chadwick Center for Children and Families, 2004). Sexual abuse treatment approaches originally developed out of the rape crisis movement that emerged in the early 1970s and established the conceptualization that the children were innocent victims who would likely suffer negative impacts. Mental health professionals who were active in APSAC during the early years were mostly involved with treating child sexual abuse (CSA) victims and their nonoffending parents. These treatments contained what we now consider the key elements of trauma-focused therapies, such as directly focusing on the CSA and addressing maladaptive cognitions. APSAC's interdisciplinary mission that promoted the coordinated system response emphasized child protection and holding offenders accountable through criminal prosecution. These two perspectives were highly compatible and likely related to the fact that CSA does not just involve parents as offenders.

In the past, physical abuse was not traditionally considered victimization but was viewed as a family problem and a failure of parenting. Physical abuse victims were not usually referred for mental health treatments because the impact of their experiences was not recognized. There was widespread recognition that the key for helping physically abused families was improving parenting. Consequently, interventions tended to be parenting programs that did not attend directly to the children's mental health. The treatment approaches were primarily didactic, involved voluntary support groups for parents, and rarely addressed the possibility that the child may have developed posttraumatic stress or depression. Again, it is likely that the interdisciplinary nature of APSAC helped promote the shift toward perceiving physical abuse as victimization, without abandoning the recognition that a focus on parenting is important.

The Role of APSAC Members

There has been tremendous growth in our field over the past 25 years developing and testing interventions for children and families affected by CAN. Treatment approaches are now conceptualized in terms of the target for clinical intervention and are based on well-accepted principles for bringing about change. Currently, we have sophisticated randomized clinical trials and proven interventions for the impact of traumatization (e.g., posttraumatic stress, depression), behavior problems in abused children, bonding-attachment disruptions, physically abusive families, and neglecting families. Some of the seminal empirical studies of trauma-specific and abuse-specific treatments were published in *Child Maltreatment* and other scientific journals in the mid-1990s and involved APSAC members (Cohen & Mannarino, 1996; Cohen & Mannarino, 1998; Lanktree & Briere, 1995; Berliner & Saunders, 1996; Kolko, 1996b), many of whom had served on the Board and as prior Presidents. A new generation of APSAC-affiliated researchers is now refining evidence-based treatments (EBTs) for this population and evaluating enhancements to EBTs (e.g., Rochelle Hanson, Monica Fitzgerald, Shannon Dorsey, Michael deArellano, Elissa Brown).

APSAC has clearly played a key role in the evolution of the field. Many of the most influential researchers in this area have been active APSAC members and Board members, such as David Finkelhor, Ben Saunders, Judy Cohen, Tony Mannarino, Esther Deblinger, Howard Dubowitz, Diane DePanfilis, Des Runyan, David Kolko, Elissa Brown, Rochelle Hanson, Mark Chaffin, Beverly Funderburk, Dee BigFoot, Anthony Urquiza, Cindy Swenson, Barbara Bonner, John Briere, Steven Ondersma, and many others. APSAC efforts to advance knowledge of CAN and skills have been achieved through product development and dissemination for its publications, educational colloquiums, and training and consultation activities. The annual APSAC Colloquium provides a platform for disseminating knowledge to an interdisciplinary audience. *The APSAC Handbook,* which is in its third edition, has summarized the empirical research on prevalence, impact, and interventions and is a widely used and highly regarded text. *Child Maltreatment* is a scientific journal for CAN-related research and is now the premier journal in the field. The *APSAC Advisor* is a quarterly news journal that provides data-based, practice-oriented articles that keep professionals informed of the latest developments in policy and practice, and APSAC's interdisciplinary guidelines task forces regularly develop data-based Practice Guidelines on key areas of the field. APSAC's cross-disciplinary approach affords the opportunity for other key professionals such as medical providers, child advocates, child protection, law enforcement, and prosecution to become aware of effective interventions for the children and families and to serve as brokers with their communities for policy changes to increase availability of evidence-based treatments.

Current State of the Field

In 2012, the prevalence and negative impact of child abuse and neglect (CAN) on children's mental health and behavioral, cognitive, and interpersonal functioning is better understood by professionals serving children in medical, community, and mental health child-service setting than it was 25 years ago. This is due to a large body of empirical knowledge based on increasingly rigorous methodologies that has accumulated over this period. We now have general population epidemiological surveys of the children, their caregivers, and adults (Finkelhor et al., 2009; Finkelhor, Turner, Ormrod, & Hamby, 2010; Copeland et al., 2007; Felitti et al., 1998). Prospective studies of birth cohorts (Jaffe, Caspi, Moffit, Taylor, Polo-Thomas, & Arsenault, 2007; Briggs-Gowan, Carter, & Ford, 2012) and samples of abused children and carefully matched controls (Widom, 1999) have allowed conclusions to be drawn about abuse-specific impacts. Prospective investigations with high-risk and abused samples, such as *Longitudinal Studies of Child Abuse and Neglect* (*LONGSCAN*; http:www.irpc.unc.edu/longscan), have provided the opportunity to measure impacts over time (Widom, Dumont, & Czaja, 2007; Putnam & Trickett, 1993). In addition, there have been many studies conducted examining the effects of CAN and various aspects of child welfare system intervention on children. Numerous studies have documented the high rates of mental health and behavioral problems in child-welfare-involved children (Leslie, Hurlburt, James, Landsverk, Slymen, & Zhang, 2005), and the lack of mental health services delivered to this high-need population (Landsverk, Burns, Stambaugh, & Reutz, 2009).

As knowledge has clarified the variability in the effects of CAN on children and families, the need for standardized methods of assessing impacts has emerged. APSAC has played an important role in bringing attention to the dearth of, and need for, evidence-based standardized assessments in the field to carefully assess abuse and trauma-related consequences to guide case conceptualization, treatment planning, and monitoring of treatment progress. Several of the first measures that advanced the field were developed by APSAC members 20 years ago, such as the *Trauma Symptom Checklist for Children* (*TSCC*) by John Briere, PhD (a former APSAC Board member), was published in 1988 to evaluate posttraumatic symptomatology and other symptom clusters found in abused and traumatized children and adolescents. He continued working throughout the 1990s and developed a parent report assessment tool to learn about younger children's posttraumatic stress symptomatology (ages 3-12), the *Trauma Symptom Checklist for Young Children* (*TSCYC*, Briere, 2005). Another example of APSAC members' leadership in advancing mental health assessment is the work of Bill Friedrich, PhD, ABPP (prior Board member) who began developing the *Child Sexual Behavior Inventory* (*CSBI*) in the 1990s. The *CSBI* was published in 1997 and became the first psychometrically sound measure of sexual

behavior problems (e.g., boundary issues, sexual interest, self-stimulation, exhibitionism, sexual intrusiveness) in 2–12-year-old children (Friedrich, 1997). All of these measures continue to be widely used by practitioners today and have been translated into several other languages. An important use of these measures has been to assess treatment outcomes in treatment trials with abused and trauma-exposed children.

While the idea that standardized assessment of child and family problems is an essential first step for mental health treatment has taken hold, routine screening for trauma exposure and abuse-related conditions (e.g., posttraumatic stress, depression, anxiety, behavior problems) is uncommon in most mental health, medical, social service, and school settings (Farmer, Burns, Phillips, Angold, & Costello, 2003; Costello, Pescosolido, Angold, & Burns, 1998; Jaycox, Morse, Tanielian, & Stein, 2006). This is problematic because children tend not to report trauma or abuse experiences unless they are directly asked using specific questions. The high rates of polyvictimization in childhood (Finkelhor et al., 2010; Finkelhor et al., 2009) call for professionals to ask about several common types of victimization (beyond the primary referral abuse-trauma type) when assessing trauma exposure, including physical abuse by caregivers, sexual assaults and victimization, violence witnessed inside and/or outside of the home, death of a family member, natural disasters, and accidents. The evidence is strong that children and families respond to routine screening, especially when it is accompanied by strategies including normalizing exposure and associated symptoms, addressing common misconceptions, and providing validation and support. This approach to assessment facilitates open communication about trauma, communicates clinician comfort in discussing difficult events, minimizes child avoidance, and incorporates gradual exposure to talking about the trauma in a safe environment.

Beyond learning whether children have experienced trauma or abuse, it is a necessary prerequisite for effective treatment to determine the specific psychological impact so that treatment can be matched to the individual child and family situation. In addition to conducting a clinical interview, it is now recommended that clinicians consider using psychometrically sound assessment checklists. According to Kazak et al. (2010), standardized assessment achieves three critical aims: (1) accurate identification of children's problems and disorders, (2) ongoing monitoring of response to interventions, and (3) evaluation of outcomes.

Mental Health Treatment in an Evidence-Based Era

One of the major movements that has taken place with regard to mental health treatments in the past 2 decades is the advent of evidence-based interventions (EBT) as the recommended standard of care. EBT are intervention programs that have been shown to have overall better results compared to nonspecific or alternative interventions. Interventions may have varying levels of evidence and it may be useful to consider evidence-based outcomes from a dimensional continuum versus a categorical perspective (Weisz & Kazdin, 2010).

In addition to its role in helping develop sound assessment measures, APSAC has been a key player in the development of evidence-based mental health practice (EBP) for children affected by CAN. APSAC members were among the first researchers to rigorously test treatments targeting mental health and behavioral problems commonly displayed by abused and neglected children using sophisticated randomized control designs. As a national organization, APSAC has emphasized the importance of an evidence-based-practice approach to serving children in the varied settings we work within (e.g., social service, mental health, legal, and medical) to support APSAC's vision of "a world where all maltreated or at-risk children and their families have access to the highest level of professional commitment and service."

This principle applies to all aspects of CAN intervention from child abuse medical evaluations to forensic interviews to mental health interventions. In 2010, we refined our mission statement to reflect our evidence-based values: APSAC's mission is to "support professionals who serve children and families affected by child maltreatment and violence through providing expert training and educational activities, policy leadership and collaboration, and consultation that **emphasizes theoretically sound, evidence-based principles"** (www.apsac.org).

There have been substantive advances in developing and testing psychosocial treatments improving CAN-related child and family outcomes. There are three primary targets for mental health interventions: (a) child psychological-mental health difficulties (e.g., posttraumatic stress, depression, and anxiety), (b) child behavioral problems (e.g., oppositionality, defiance, and sexual behaviors), and (c) ineffective and harmful parenting behaviors and parent-child interaction (e.g., emotionally and physically harsh, coercive, abusive, and/or neglectful). In some cases all three targets may be addressed by a single intervention, whereas in other cases, separate interventions may be necessary. Determining the priority target and intervention approach is based on a systematic, abuse-focused assessment process.

Many organizations and other resources provide information on effective interventions. The best known Web resource that enumerates evidence-based interventions and provides detailed descriptions of their research outcomes and readiness for dissemination is the National Registry of Evidenced-Based Programs and Practices (NREPP) (www.nationalregistry.samhsa.gov), supported by the Substance Abuse and Mental Health Services Administration. Another such resource is the California Evidence-Based Clearinghouse for Child Welfare (CEBC) (www.cebc4cw.org/), a Web site providing child welfare professionals a forum where information and research data regarding evidence-based practices (EBP) relevant to child welfare are available. The National Child Traumatic Stress Network (http://www.nctsn.org/) is a specific resource for trauma-focused interventions.

Interventions for the Impact of Traumatic Events (Posttraumatic Stress, Depression, Anxiety)

Interventions that directly target the trauma or abuse experience and are based on the principles or contain the components of cognitive behavioral treatments have the greatest evidence for effectiveness. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006; Deblinger & Heflin, 1996; www.musc.edu/tfcbt) is a specific version of trauma-focused therapy that has been subjected to extensive empirical testing. It has been found effective with children of all ages (3–18 years), multiple types of trauma experiences, both genders, and various ethnic and racial backgrounds and is currently the most widely disseminated trauma-specific intervention in the field (Silverman et al., 2008). TF-CBT is a family-focused approach, as nonoffending caregivers and children are included equally in this intervention. Briere and Lanktree (2011) have recently published a description of a comparable approach targeting adolescents with complex trauma. This model pays specific attention to addressing the context and safety considerations for adolescents. There is also an effective school-based intervention available called Cognitive Behavioral Intervention for Trauma in Schools (CBITS; Jaycox, 2004; http://cbitspro gram.org/). CBITS is a skill-oriented, structured group-based trauma-focused intervention delivered in schools that incorporates educators and other school staff.

The primary components of CBT for CAN focus on (a) providing corrective information about CAN/trauma, (b) building child and parent coping skills to manage stress and regulate emotional distress effectively, (c) improving caregiver understanding of the child's CAN/trauma experiences and responses and the caregiver's optimal response to these, (d) achieving mastery over trauma-related memories and reminders reducing traumatic avoidance through the use of gradual exposure throughout treatment and specific exposure to the trauma memory, (e) cognitive processing to help children and families make meaning and contextualize the traumatic experiences through cognitive restructuring, and (f) enhancing safety to optimize future developmental outcomes.

Interventions for Disruptive Behavior and Parenting Problems

Effective interventions for child behavior problems are primarily behavioral and cognitive behavioral. They target changing environmental contingencies and teach parents and caregivers to respond to child behavior in more effective ways. The same principles apply to addressing the coercive, ineffective, and violent parenting practices that are associated with CAN. In addition, parenting interventions enhance parent-child relationships, promote secure attachment and bonding, and lower parental distress. Many of these interventions are brand named, which means that they have a particular packaged version of delivering the standard treatment elements. All of them contain common basic ingredients: increasing positive one-on-one time with children, selective attention that involves attending to positive behaviors and ignoring minor negative behaviors, setting reasonable expectations, and consistently following through using rewards and nonviolent consequences. Some interventions are fully parent-mediated, whereas others may involve parents and children together learning the new skills.

Parent-Child Interaction Therapy (http://pcit.phhp.ufl.edu/) is a well-established intervention that has been used extensively in CAN situations (Timmer, Urquiza, Zebell, & McGrath, 2005; Chaffin, Funderburk, Bark, Valle, & Gurwitch, 2011) and has specific evidence for its effectiveness in reducing subsequent child

maltreatment reports (Chaffin et al., 2004; Chaffin et al., 2011). PCIT has a unique delivery vehicle in that parents receive live coaching via a bug in the ear to practice their new skills. It is designed for younger children, although it is effective in reducing future child abuse reports for children up to age 12 who do not have serious behavior problems. Triple P (http://www.triplep-america.com) is another well-established parent management intervention that has been found to reduce child abuse reports. Triple P has levels of intensity of intervention from community awareness campaigns to brief focused behavior management to standard individual and group versions. The Incredible Years and the Parent Management Training—Oregon Model (PMTO) (www.incredibleyears.com; http://www.isii.net/index.html) are also well-established parent management interventions that have been used with CAN.

Multidimensional Treatment Foster Care–Adolescent (MTFC–A) (www.mtfc.com) and the young child version Multidimensional Treatment Foster Care–Preschool (MTFC–P) (Fisher, Kim, & Pears, 2009) are intensive parent management interventions for severely disturbed children and adolescents who require out of home placement due to behavior problems and/or severe delinquency. The foster parent serves as the therapeutic agent and is supported by a consultant who helps develop the behavior management plan and provides support and consultation carrying out the plan as well as additional therapies that may be needed. This intervention has been proven effective reducing outcomes such as runaways, criminal referrals, self-reported criminal acts, and fewer days in locked settings and associations with delinquent peers.

There are two tested interventions for young children that are primarily based on attachment theory and use a more reflective and interpretive approach than parent management training. Child Parent Psychotherapy (CPP) (Lieberman & Van Horn, 2005) was developed for situations in which young children (ages 0–5) were exposed to domestic violence. CPP emphasizes the importance of treating mental health problems within the context of the parent-child relationship to enhance parental responsiveness, attunement and consistency to their children. The trauma experience is directly addressed and processed jointly. Attachment and Bio-behavioral Catch-up (ABC) (Dozier, Lindhiem, & Ackerman, 2005) takes a similar approach to promoting secure attachment and nurturance via increasing parental or caregiver responsiveness in physically neglectful families with young children (ages 0–5), and also has a component increasing children's regulatory capabilities. Both have growing evidence supporting their effectiveness.

Combined Interventions

There are several interventions that are designed specifically to address child physical abuse situations that involve both children and parents. These interventions are cognitive behavioral or incorporate cognitive behavioral principles. Alternatives for Families Cognitive Behavioral Therapy (AF-CBT; www.afcbt.org) is a short-term intervention for physically abusive parents and children ages 5–15 years; some sessions are child only, some parent only, and others are conjoint. Because there has been violence in the relationship, safety planning and routine assessment of the use of force, hostility, and coercion are incorporated. It includes the standard CBT components of psychoeducation, including information about violence, teaching both children and parents skills for emotional regulation (especially anger), teaching positive parenting, and teaching both parents and children useful skills such as problem solving and communication. A unique component is the clarification process in which the parents explicitly take responsibility for the abuse and make amends to the child for the abuse. AF-CBT has shown to improve family functioning and reduce child-to-parent aggression, child behavior problems, parental abuse risk, and re-abuse among physically abusive parents (see Kolko, 1996a, 1996b, 2002; Chalk & King, 1998). A group version called Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT) (http://www.caresinstitute.org/services_parent-child.php) has also been tested for physically abusive parents and at-risk parents (Runyon, Deblinger, & Steer, 2010). In this model, the children and parents meet in separate groups initially and then later conjointly. This intervention also includes the children doing a trauma narrative as part of the clarification process. It has been shown to decrease posttraumatic stress as well improve behavior problems and reduce later violence.

Multisystemic Therapy for Childhood Abuse and Neglect (MST-CAN) (Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew, 2010) is a child abuse specific version of MST, a multi-component intervention for treating youth ages 6–17 with serious behavior and conduct problems. It is a structured package of specific strategies based on a functional analysis of the child abuse behavior. Some of the intervention strategies involve environmental interventions (e.g., school, separation from deviant peers), whereas others are based on CBT and parent management training principles. MST-CAN has been shown to be effective in reducing behavior problems, improving child functioning and reducing future child abuse reports (http://www.mstcan.com/).

The Science–Practice Gap

Clearly, there have been substantive advances in psychosocial treatments for youth affected by child maltreatment and trauma over the past 25 years. However, despite the fact that effective EBTs exist for maltreated and trauma-exposed children, few children receive these treatments (Chadwick Center for Children and Families, 2004). The wide gap between science and practice is not unique to the CAN/child trauma field. For example, the Institute of Medicine (2001) found that there is a 17-year lag for scientific knowledge generated in randomized clinical trials to be routinely incorporated into everyday medical practices across the nation, and other research has highlighted the limited effective-

ness of services delivered "as usual" in community mental health settings (McLennan, Wathen, Macmillan, & Lavis, 2006; Weiss, Catton, & Harris, 2000; Weisz, Donenberg, Han, & Weiss, 1995). In 2004, the Kauffman Foundation and the Chadwick Center initiated the Kauffman Best Practices Project, and leading researchers and clinicians in the child abuse field joined a working group led by Ben Saunders, PhD (APSAC member and former Board member), to brainstorm ways to address the fundamental systems changes needed to close the chasm between best care and everyday care (Chadwick Center for Children and Families, 2004).

Some of the leading reasons for the lack of EBT adoption include the following: mental health providers' misconceptions about the applicability of practices; inertia and resistance to change; lack of effective training and ongoing education in EBT; lack of support, resources, and infrastructure; and lack of leadership among administrators, program managers, and supervisors in championing the use of ESTs and working to overcome administrative barriers (Chadwick Center for Children and Families, 2004; Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005; Torrey et al., 2001). In addition, "brokers" of service (e.g., child welfare staff, Guardian ad Litems, victim advocates, and medical and educational service staff) also play a critical role in adoption of EBT because they identify and refer trauma-exposed children to treatment and ensure that they receive needed services. Unfortunately, brokers of service are often unfamiliar with EBTs and often view all mental health approaches as the same (Chadwick Center for Children and Families, 2004).

APSAC: Looking Forward in Mental Health

In the past 25 years, we have made incredible gains in our ability to identify and effectively treat the impact of child abuse and trauma. Recent clinical research on evidence-based assessment and treatment offers child service providers from multiple disciplines the tools needed to ensure children and their families are identified and provided the highest quality of mental health services. We now have well-developed, low-cost, or free standardized screening and assessment tools that provide comprehensive information about both trauma exposure and trauma-related mental health difficulties as well as research based clinical strategies for talking to children about abuse and trauma exposure.

Additionally, we have many highly effective, short-term psychosocial treatments that work for improving CAN-related child and family outcomes (child psychological–mental health difficulties, child behavioral problems, and ineffective and harmful parenting behaviors and parent-child interaction. Web-based resources provided by the CEBC, NREPP, and NCTSN help clinicians stay abreast of new treatments and development of promising practices in the field, and innovative clinical decision-making tools are now available to help clinicians select EBPs and track clinical progress (www.practicewise.com; Chorpita & Weisz, 2009; Weisz et al., 2011).

APSAC has led in the past and will continue to lead to improve the lives of children and families affected by abuse and violence and to increase workforce effectiveness and confidence in engaging and serving these families. APSAC has the opportunity to help lead and facilitate effective supportive implementation efforts in this country, such as by conducting learning collaboratives (http://www.nctsn.org/resources/training-and-education/learning-collaboratives; *The Breakthrough Series…,* 2003) to improve multidisciplinary professionals' ability to build community capacity to deliver high-quality mental health services to youth and families affected by abuse and trauma. APSAC also has a role in increasing awareness, knowledge, and training in evidence-based service planning for professionals working in child welfare, which begins first with favoring evidence-based interventions or services, evidence-based principles, and evidence-based service models (Stambaugh, Burns, Landsverk, & Reutz, 2007). Given the choice between selecting a well-supported evidence-based service (e.g., specific parent training programs) and relying on less supported models, service plans should favor the evidence-based service. The APSAC Task Force on Evidence-Based Service Planning in Child Welfare is currently developing Practice Guidelines for a new service planning perspective that we have called "evidence-based service planning" with families involved in the child welfare system. Other recent national efforts to pilot broker implementation models (e.g., Project FOCUS, Dorsey, Kerns, Trupin, Conover, & Berliner, 2012; Project BEST,

www.musc.edu/projectbest) have focused on improving the awareness of child trauma and evidence-based practice (EBP) among brokers (child welfare caseworkers, GALs) and brokers' ability to identify appropriate EBP referrals, and engage children and families with appropriate, evidence-based services. APSAC has an important opportunity to lead wide-scale efforts in raising awareness about the mental health impact of child abuse and trauma on children and their families, and in overcoming barriers to children and families receiving effective, evidence-based mental health interventions.

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The Promise of Prevention: Expanding With Quality

Deborah Daro, PhD

Despite recent declines in substantiated cases of physical abuse and neglect, child maltreatment remains a substantial threat to a child's well-being and healthy development. In 2009, over 3 million children were reported as potential victims of maltreatment. The risk for harm is particularly high for children living in the most disadvantaged communities, including those living in extreme poverty or those living with caretakers who are unable or unwilling to care for them due to chronic problems of substance abuse, mental health disorders, or domestic violence. In 2009, an estimated 1,770 children—or over 4.8 children a day were identified as fatal victims of maltreatment. As in the past, the majority of these children—over 80%—were under the age of 4 (US DHHS, 2011). While child maltreatment is neither inevitable nor intractable, protecting children remains challenging.

Promising Prevention Strategies

Several reviewers suggest that the more universal or broadly targeted prevention efforts have greater success in strengthening a parent's or child's protective factors than in eliminating risk factors, particularly for parents or children at highest risk (Harrell, Cavanagh, & Sridharan, 1999; Chaffin, Bonner, & Hill, 2001; MacLeod & Nelson, 2000). Others argue that prevention strategies are most effective when they focus on a clearly defined target population with identifiable risk factors (Guterman, 2001; Olds, Sadler, & Kitzman, 2007). In truth, a wide range of prevention strategies has demonstrated an ability to reduce child abuse and neglect reports as well as other child safety outcomes, such as reported injuries and accidents. In other cases, prevention efforts have strengthened key protective factors associated with a reduced incidence of child maltreatment, such as improved parental resilience, stronger social connections, positive child development, better access to concrete supports such as housing, transportation and nutrition, and improved parenting skills and knowledge of child development (Horton, 2003).

Public Awareness Efforts

In the years immediately following Henry Kempe et al.'s 1962 (*JAMA*) article, "The Battered-Child Syndrome," public awareness campaigns were developed to raise awareness about child abuse and to generate political support for legislation to address the problem. Notably, the nonprofit organization Prevent Child Abuse America (PCA America, formerly the National Committee to Prevent Child Abuse) joined forces with the Ad Council to develop and distribute nationwide a series of public service announcements on TV, radio, print, and billboards.

Between 1975 and 1985, repeated public opinion polls documented a sharp increase in public recognition of child abuse as an important social problem and steady declines in the use of corporal punishment and verbal forms of aggression in disciplining children (Daro & Gelles, 1992). More recently, broadly targeted prevention campaigns have been used to alter parental behavior. For example, the U.S. Public Health Service, in partnership with the American Academy of Pediatrics (AAP) and the Association of SIDS and Infant Mortality Programs, launched its "Back to Sleep" campaign in 1994, which was designed to educate parents and caretakers about the importance of placing infants on their back to sleep as a strategy to reduce the rate of sudden infant death syndrome (SIDS). Notable gains also have been achieved with universal education programs to prevent shaken baby syndrome (SBS) (Dias et al., 2005; Barr et al., 2009).

Child Sexual Assault Prevention Classes

In contrast to efforts designed to alter the behavior of adults who might commit maltreatment, a category of prevention programs emerged in the 1980s designed to alter the behavior of potential victims. Often referred to as child assault prevention or safety education programs, these efforts present children with information on the topic of physical abuse and sexual assault, how to avoid risky situations, and, if abused, how to respond. A key feature of these programs is their introduction by universal service delivery systems, often being integrated into school curricula or primary support opportunities for children (e.g., Boy Scouts, youth groups, recreation programs). Although certain concerns have been raised regarding the appropriateness of such efforts (Reppucci & Haugaard, 1989), the strategy continues to be widely available.

Parent Education and Support Groups

Educational and support services delivered to parents through center-based programs and group settings are used in a variety of ways to address risk factors associated with child abuse and neglect. Although the primary focus of these interventions is typically the parent, quite a few programs include opportunities for structured parent–child interactions, and many programs incorporate parallel interventions for children. For instance, programs may include the following:

- Weekly discussions for 8 to 14 weeks with parents around topics such as discipline, cognitive development, and parent–child communication,
- Group-based sessions at which parents and children can discuss issues and share feelings,
- Opportunities for parents to model the parenting skills they are learning,
- Time for participants to share meals and important family celebrations such as birthdays and graduations.

Educational and support services range from education and information sharing to general support to therapeutic interventions. Many of the programs are delivered under the direction of social workers or health care providers.

A meta-analysis conducted by the U.S. Centers for Disease Control and Prevention (2009) on training programs for parents of children ages birth to 7 years identified components of programs that have a positive impact on acquiring parenting skills and decreasing children's externalizing behaviors. These components included the following:

- Teaching parents emotional communication skills,
- Helping parents acquire positive parent-child interaction skills,
- Providing parents opportunities to demonstrate and practice these skills while observed by a service provider.

Home Visitation

As noted before, home visitation has become a major strategy for supporting new parents. Services are one-on-one and are provided by staff with professional training (e.g., nursing, social work, child development, family support) or by paraprofessionals who receive training in the model's approach and curricula. The primary issues addressed during visits include the following:

- The mother's personal health and life choices,
- Child health and development,
- Environmental concerns such as income, housing, and community violence,
- Family functioning, including adult and child relationships,
- Access to services.

Specific activities to address these issues may include the following:

- Modeling parent–child interactions and child management strategies,
- Providing observation and feedback,
- Offering general parenting and child development information,
- Conducting formal assessments and screenings,
- Providing structured counseling.

In addition to working with participants around a set of parenting and child development issues, home visitors often serve as gatekeepers to the broader array of services that families may need to address various economic and personal needs. Critical reviews of the model's growing research base have reached different conclusions. In some cases, reviewers conclude that the strategy, when well implemented, does produce significant and meaningful reduction in child-abuse risk and improves child and family functioning (AAP Council on Child and Adolescent Health, 1998; Geeraert, Van den Noorgate, Grietens, & Onghena, 2004; Guterman, 2001; Hahn et al., 2003; Stoltz & Lynch, 2009). Others are more sobering in their conclusions, noting the limitations outlined earlier (Chaffin, 2004; Gomby, 2005).

Community Prevention Efforts

The strategies previously outlined focus on individual parents and children. Recently, increased attention is being paid to prevention efforts designed to improve the community environment in which children are raised. Among other things, these efforts institute new services, streamline service delivery processes, and foster greater collaboration among local service providers. This emerging generation of "community child abuse prevention strategies" focuses on creating supportive residential communities where neighbors share a belief in collective responsibility to protect children from harm and where professionals work to expand services and support for parents (Chaloupka & Johnson, 2007; Doll, Mercy, Hammond, Sleet, & Bonzo, 2007; Farrow, 1997; Mannes, Roehlkepartain, & Benson, 2005).

In 2009, Daro and Dodge examined five community child abuse prevention programs that seek to reduce child abuse and neglect. Their review concluded that the case for community prevention is promising. At least some of the models reviewed show the ability to reduce reported rates of child abuse, reduce injury to young children, improve parent–child interactions, reduce parental stress, and improve parental efficacy. Focusing on community building, such programs can mobilize volunteers and engage diverse sectors within the community, including first responders, the faith community, local businesses, and civic groups. This mobilization exerts a synergistic impact on other desired community outcomes, such as economic development and better health care.

Looking Toward the Future

Achieving stronger impacts with young children and their families will require continued efforts at developing and testing a broad array of prevention programs and systemic reforms. No one program or one approach can guarantee success. Although compelling evidence exists to support early intervention efforts, beginning at the time a woman becomes pregnant or gives birth, the absolute "best way" to provide this support is not self-evident. The most salient protective factors or risk factors will vary across populations as well as communities. Finding the correct leverage point or pathway for change for a specific family, community, or state requires careful assessment in which the final prevention plan is best suited to the needs and challenges presented by each situation.

As the prevention field moves forward, current strategies, institutional alignments, and strategic partnerships need to be reevaluated and, in some cases, altered to better address current demographic and fiscal realities. Key challenges and the opportunities they present include the following:

- **Improving the ability to reach all those at risk:** The most common factors used to identify populations at risk for maltreatment include young maternal age, poverty, single parent status, and severe personal challenges such as domestic violence, substance abuse, and mental health issues. Although such factors are often associated with elevated stress and reduced capacity to meet the needs of the developing child, no one of these factors is consistently predictive of poor parenting or poor child outcomes. In addition, families that present none of these risk factors may find themselves in need of preventive services as the result of a family health emergency, job loss, or other economic uncertainties. In short, our ability to accurately identify those who will benefit from preventive services is limited and fraught with the dual problems of overidentification and underidentification. Building on a public health model of integrated services, child abuse prevention strategies may be more efficiently allocated by embedding such services within a universal system of assessment and support.

- **Determining how best to intervene with diverse ethnic and cultural groups**: Much has been written about the importance of designing parenting and early intervention programs that are respectful of the participant's culture. For the most part, program planners have responded to this concern by delivering services in a participant's primary language, matching participants and providers on the basis of race and ethnicity, and incorporating traditional child rearing practices into a program's curriculum. Far less emphasis has been placed on testing the differential effects of evidence-based prevention programs on specific racial or cultural groups or the specific ways in which the concept of prevention is viewed by various groups and supported by their existing systems of informal support. Better understanding of these diverse perspectives is key to building a prevention system that is relevant for the full range of American families.

- **Identifying ways to use technology to expand provider–participant contact and service access**: The majority of prevention programs involve face-to-face contact between a provider and program participant. Indeed, the strength and quality of the participant–provider relationship is often viewed as one of the most, if not the most, important determinant of proximate and distal outcomes. Although not a replacement for personal contact, the judicial use of technology can help direct-service providers offer assistance to families on their caseload. For example, home visitors use cell phones to maintain regular communication with parents between intervention visits; parent education and support programs use videotaping to provide feedback to parents on the quality of their interactions with their children; and community-based initiatives use the Internet to link families with an array of resources in the community. Expanding the use of these technologies and documenting their relative costs and benefits for both providers and program participants offer both potential costs savings as well as ways to reach families living in rural and frontier communities.

- **Achieving a balance between enhancing formal services and strengthening informal supports**: Families draw on a combination of formal services (e.g., health care, education, public welfare, neighborhood associations, and primary supports) and informal support (e.g., assistance from family members, friends, and neighbors) in caring for their children. Relying too much on informal relationships and community support may be insufficient for families unable to draw on available informal supports or who live in communities where such supports are insufficient to address their complex needs. In contrast, focusing only on formal services may ignore the limitations to public resources and the importance of creating a culture in which seeking assistance in meeting one's parenting responsibilities is normative. Those engaged in developing and implementing comprehensive, prevention systems need to consider how they might best draw on both of these resources.

Identifying and testing a range of innovations that address all of these concerns and alternatives is important. Equally challenging, however, is how these efforts are woven together into effective prevention systems at local, state, and national levels. Just as the appropriate service focus will vary across families, the appropriate collaborative partnerships and institutional alignments will differ across communities. In some cases, public health services will provide the most fruitful foundation for crafting effective outreach to new parents. In other communities, the education system or faith community will offer the most promising approach. And once innovations are established, they will require new partnerships, systemic reforms, or continuous refinement if they are to remain viable and relevant to each subsequent cohort of new parents and their children.

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Journal Highlights

Howard Fischer, MD

Each year since 1998, the editors of APSAC's *Child Maltreatment* journal have selected an article of the year. These articles offer a glimpse of important research findings and best practices through the years, and their abstracts are reprinted here with permission of Sage Publications, Inc.

Interventions for Sexually Abused Children

This study evaluated treatment outcome for 49 recently sexually abused children aged 7–14, who were randomly assigned to receive either sexual abuse-specific cognitive behavioral therapy (SAS-CBT) or nondirective supportive therapy (NST). Respondents and their nonoffending parent were provided with 12 individual treatment sessions, which were closely monitored for adherence to the assigned treatment modality. Participants and parents completed several standardized assessment instruments pre- and post-treatment. Results indicated that there was a significant group-by-time interaction on the Children's Depression Inventory and the Child Behavior Checklist Social Competence Scale, with the SAS-CBT group improving more than the NST group on both of these instruments. Clinical findings also suggested that SAS-CBT was more effective than NST in treating sexually inappropriate behaviors. Implications for clinical practice and future research are discussed.

Cohen, J. A., & Mannarino, A. P. (1998). Interventions for sexually abused children: Initial treatment outcome findings. *Child Maltreatment, 3*(1), 17–26.

Prevalence, Case Characteristics, and Long-Term Psychological Correlates of Child Rape Among Women

Using telephone interview methods, a national probability sample of adult women was screened for a history of completed rape in childhood, and characteristics of child rape incidents were assessed. All respondents were evaluated for a history of major depressive episode, posttraumatic stress disorder (PTSD), and substance use problems. Implications of the results for prevention, intervention, and future research are discussed.

Saunders, B. E., Kilpatrick, D. G., Hanson, R. F., Resnick, H. S., & Walker, M. E. (1999). Prevalence, case characteristics, and long-term psychological correlates of child rape among women: A national survey. *Child Maltreatment, 4*(3), 187–200.

Reactive Attachment Disorder

In recent years, there has been an increase in the number of children diagnosed with Reactive Attachment Disorder (RAD). There is considerable disagreement about what this entity actually entails and, in particular, what types of assessments and interventions to use with these children and families. Children with a history of maltreatment (i.e., physical, sexual, emotional abuse, and/or severe neglect) are particularly likely to receive this diagnosis, because the behavior problems often seen in these children are presumed to stem from the maladaptive relationships they have had with abusive caregivers. However, many children are receiving this diagnosis because of behavior problems that clearly extend beyond the DSM-IV criteria for RAD. Perhaps the most concerning consequence of the RAD diagnosis is the emergence of novel treatments that lack a sound theoretical basis or empirical support and may potentially be traumatizing and dangerous to the child. Thus, the purpose of this article is to review and synthesize what is known about RAD and attachment disorders and to discuss implications for treatment.

Hanson, R. F., & Spratt, E. G. (2000). Reactive attachment disorder: What we know about the disorder and implications for treatment. *Child Maltreatment, 5*(2), 137–145.

Child Sexual Behavior Inventory

A normative sample of 1,114 children was contrasted with a sample of 620 sexually abused children and 577 psychiatric outpatients on the Child Sexual Behavior Inventory (CSBI), a 38-item behavior checklist assessing sexual behavior in children 2–12 years old. The CSBI total score and each individual item differed significantly among the three groups after controlling for age, sex, maternal education, and family income. Sexually abused children exhibited a greater frequency of sexual behaviors than either the normative or psychiatric outpatient samples. Test-retest reliability and interitem correlation were satisfactory. Sexual behavior problems were related to other generic behavior problems. This contributed to the reduced discrimination between psychiatric outpatients and sexually abused children when compared with the normative/sexually abused discrimination.

Friedrich, W. N., Fisher, J. L., Dittner, C. A., Acton, R., Berliner, L., Butler, J., Damon, L., Davies, W. H., Gray, A., & Wright, J. (2001). Child Sexual Behavior Inventory: Normative, psychiatric, and sexual abuse comparisons. *Child Maltreatment, 6*(1), 37–49.

Trying to Understand Why Horrible Things Happen

This study concerns the nature of specific attributions for sexual abuse and their relation to psychological distress over time. Participants (80 children and 57 adolescents) were seen within 8 weeks of discovery of the abuse and 1 year later. They described why they believed the abuse happened, rated the extent to which internal and external attributions for the abuse event applied to them, and completed measures of general attribution style for everyday events, shame for the abuse, and symptoms of depression, PTSD, and self-esteem. Parents and teachers rated behavior problems. Abuse-specific internal attributions were consistently related to higher levels of psychopathology and were particularly important for predicting PTSD symptoms and parent and teacher reports of internalizing behavior problems, even after controlling for age, gender, abuse events, and general attributional style. Shame also was an important predictor of symptom level and mediated the relation between abuse-specific internal attributions and PTSD symptoms.

Feiring, C., Taska, L., & Chen, K. (2002). Trying to understand why horrible things happen: Attribution, shame, and symptom development following sexual abuse. *Child Maltreatment, 7*(1), 25–39.

A Multilevel Study of Neighborhoods and Parent-to-Child Physical Aggression

The majority of children in the United States experience parent-to-child physical aggression (PCPA), a disciplinary strategy out of favor with many experts. Several decades of research have documented a link between community characteristics and severe child maltreatment. No one has taken a multilevel approach to study whether neighborhoods affect the amount of corporal punishment and/or physical abuse used by individual families. Data for this article come from the Project on Human Development in Chicago Neighborhoods and were analyzed using hierarchical linear modeling. An interval scale of PCPA was developed. Values obtained show that several neighborhood characteristics were associated with PCPA. Immigrant concentration remained significant after controlling for family composition. A cross-level interaction was found between neighborhood social networks and Hispanic race/ethnicity. The article's conclusion is that neighborhood characteristics may influence the amount of PCPA used by families. Neighborhood intervention strategies hold promise.

Molnar, B. E., Buka, S. L., Brennan, R. T., Holton, J. K., & Earls, F. (2003). A multilevel study of neighborhoods and parent-to-child physical aggression: Results from the project on human development in Chicago neighborhoods. *Child Maltreatment, 8*(2), 84–97.

How Does Trauma Beget Trauma?

This study examined the associations between perceived risks and benefits of drug use, unsafe sexual behavior, alcohol consumption, and aggressive-illegal behavior and reports of expected involvement in those behaviors in a sample of 340 college women with and without histories of interpersonal victimization (i.e., child sexual abuse, child physical abuse, adult sexual assault, and aggravated assault). Trauma victims reported greater perceived benefits and lower perceived risks associated with risky sexual behavior, illicit drug use, and heavy drinking, but not aggressive-illegal behavior than nonvictims. Victims also reported greater expected involvement in risky sex behavior, drug use, and heavy drinking. Regression analyses revealed that the relationship between victim status and expected involvement in risky behaviors was mediated by cognitions about risks and benefits of risky behavior, controlling for trauma-related symptoms. Implications of the findings for the understanding of repeat victimization are discussed.

Smith, D. W., Davis, J. L., & Fricker-Elhai, A. E. (2004). How does trauma beget trauma? Cognitions about risk in women with abuse histories. *Child Maltreatment, 9*(3), 292–303.

The Victimization of Children and Youth

This study examined a large spectrum of violence, crime, and victimization experiences in a nationally representative sample of children and youth ages 2–17 years. More than one half (530 per 1,000) of the children and youth had experienced a physical assault in the study year, more than 1 in 4 (273 per 1,000) a property offense, more than 1 in 8 (136 per 1,000) a form of child maltreatment, 1 in 12 (82 per 1,000) a sexual victimization, and more than 1 in 3 (357 per 1,000) had been a witness to violence or experienced another form of indirect victimization. Only a minority (29%) had no direct or indirect victimization. The mean number of victimizations for a child or youth with any victimization was 3.0, and a child or youth with one victimization had a 69% chance of experiencing another during a single year.

Finkelhor, D., Ormrod, R., Turner, H., & Hamby, S. L. (2005). The victimization of children and youth: A comprehensive, national survey. *Child Maltreatment, 10*(1), 5–25.

Report of the APSAC Task Force on Attachment Therapy, Reactive Attachment Disorder, and Attachment Problems

Although the term *attachment disorder* is ambiguous, attachment therapies are increasingly used with children who are maltreated, particularly those in foster care or adoptive homes. Some children described as having attachment disorders show extreme disturbances. The needs of these children and their caretakers are real. How to meet their needs is less clear. A number of attachment-based treatment and parenting approaches purport to help children described as attachment disordered. Attachment therapy is a young and diverse field, and the benefits and risks of many treatments remain scientifically undetermined. Controversies have arisen about potentially harmful attachment therapy techniques used by a subset of attachment therapists. In this report, the Task Force reviews the controversy and makes recommendations for assessment, treatment, and practices.

Chaffin, M., Hanson, R., Saunders, B., Nichols, T., Barnett, D., Zeanah, C., Berliner, L., Egeland, B., Newman, E., Lyon, T., Letourneau, E., & Miller-Perrin, C. (2006). Report of the APSAC Task Force on attachment therapy, reactive attachment disorder, and attachment problems. *Child Maltreatment, 11*(1), 76–89.

Early Physical Abuse and Later Violent Delinquency

In this prospective longitudinal study of 574 children followed from age 5 to age 21, the authors examine the links between early physical abuse and violent delinquency and other socially relevant outcomes during late adolescence or early adulthood and the extent to which the child's race and gender moderate these links. Analyses of covariance indicated that individuals who had been physically abused in the first 5 years of life were at greater risk for being arrested as juveniles for violent, nonviolent, and status offenses. Moreover, physically abused youth were less likely to have graduated from high school and more likely to have been fired in the past year, to have been a teen parent, and to have been pregnant or impregnated someone in the past year while not married. These effects were more pronounced for African American than for European American youth and somewhat more pronounced for females than for males.

Lansford, J. E., Miller-Johnson, S., Berlin, L. J., Dodge, K. A., Bates, J. E., Pettit, & G. S. (2007). Early physical abuse and later violent delinquency: A prospective longitudinal study. *Child Maltreatment, 12*(3), 233–245.

Effects of Foster Parent Training Intervention on Placement Changes of Children in Foster Care

Placement disruptions undermine efforts of child welfare agencies to promote safety, permanency, and child well-being. Child behavior problems significantly contribute to placement changes. The aims of this investigation were to examine the impact of a foster parent training and support intervention (KEEP) on placement changes and to determine whether the intervention mitigates placement disruption risks associated with children's placement histories. The sample included 700 families with children between ages 5 and 12 years, from a variety of ethnic backgrounds. Families were randomly assigned to the intervention or control condition. The number of prior placements was predictive of negative exits from current foster placements. The intervention increased chances of a positive exit (e.g., parent-child reunification) and mitigated the risk-enhancing effect of a history of multiple placements. Incorporating intervention approaches based on a parent management training model into child welfare services may improve placement outcomes for children in foster care.

Price, J. M., Chamberlain, P., Landsverk, J., Reid, J. B., Leve, L. D., & Laurent, H. (2008). Effects of foster parent training intervention on placement changes of children in foster care. *Child Maltreatment, 13*(1), 64–75.

A Motivational Intervention Can Improve Retention in PCIT for Low-Motivation Child Welfare Clients

A motivational orientation intervention designed to improve parenting program retention was field tested versus standard orientation across two parenting programs, Parent–Child Interaction Therapy (PCIT) and a standard didactic parent training group. Both interventions were implemented within a frontline child welfare parenting center by center staff. Participants had an average of six prior child welfare referrals, primarily for neglect. A double-randomized design was used to test main and interaction effects. The motivational intervention improved retention only when combined with PCIT (cumulative survival = 85% vs. around 61% for the three other design cells). Benefits were robust across demographic characteristics and participation barriers but were concentrated among participants whose initial level of motivation was low to moderate. There were negative effects for participants with relatively high initial motivation. The findings suggest that using a motivational intervention combined with PCIT can improve retention when used selectively with relatively low to moderately motivated child welfare clients.

Chaffin, M., Valle, L. A, Funderburk, B. W., Gurwitch, R. H., Silovsky, J. F., Bard, D., McCoy, C., & Kees, M. R. (2009). A motivational intervention can improve retention in PCIT for low-motivation child welfare clients. *Child Maltreatment, 14*(4), 356–368.

Long-Term Consequences of Child Abuse and Neglect on Adult Economic Well-Being

Child abuse and neglect represent major threats to child health and well-being; however, little is known about consequences for adult economic outcomes. Using a prospective cohort design, court substantiated cases of childhood physical and sexual abuse and neglect during 1967–1971 were matched with nonabused and nonneglected children and followed into adulthood (mean age 41). Outcome measures of economic status and productivity were assessed in 2003–2004 (N =807). Results indicate that adults with documented histories of childhood abuse and/or neglect have lower levels of education, employment, and earnings and fewer assets as adults compared with matched control children. There is a 14% gap between individuals with histories of abuse/neglect and controls in the probability of employment in middle age, controlling for background characteristics. Maltreatment appears to affect men and women differently, with larger effects for women than men. These new findings demonstrate that abused and neglected children experience large and enduring economic consequences.

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Washington Update

John Sciamanna

The Changing National Landscape in 25 Years

The 25th anniversary of the American Professional Society on the Abuse of Children (APSAC) gives us a chance to pause and reflect on where we are in this country when it comes to children and families. This column, written from a national perspective, lays out some progress and perils relative to the organization's starting point. In addition, our overview of federal policy and action comes at an unusual time for the country. For one thing, we are still in the shadow of the worst economic decline since the Great Depression. This has raised challenges and general questions about how families are weathering the economic storm. Children are of particular concern, especially those in the most vulnerable families. A second factor that makes our review timely is that issues surrounding child abuse and neglect are receiving new attention by both policymakers and news media. This attention has been brought about due to last year's grand jury indictment of Jerry Sandusky, the former football coach at Penn State University.

Current circumstances make it important to assess where we are today, where we have been, and where the future may take us. Official national data on child abuse, neglect, and foster care have improved overall, though most observers may say we still need to do more. Practice and policy at both the state and local levels have also improved. Going forward, will the challenges of a slowly recovering economy and significant budget cuts at the state and federal level change this narrative? Can we sustain the improvements already made, and if we can, can we continue to make progress in addressing the high rates of child abuse and neglect?

The Last Quarter Century

Over the last quarter century, we have made significant advancements in our approach to child abuse and neglect through improved practices, such as differential response and home visiting to name just two. We have also explored the ever-increasing understanding of brain development and applied it to programs that can impact child maltreatment. In addition, we have decreased the likelihood that foster care will be utilized as a solution for neglect, and policymakers in Washington, DC, are exploring common ground when addressing our nation's most vulnerable families and children. In recent years, members of both parties and houses of Congress have been able to agree, even if decisions often come with limited funding. This has occurred with little of the political gridlock and paralysis that seems to attach to so many other issues. It is certainly not time to declare victory or even to argue that children are better off today than they were 25 years ago; yet, there are notable signs of progress in the areas of child protection and child welfare. Nevertheless, many remain indifferent to the plight of far too many children, as evidenced by rising child poverty and homelessness.

The 1974 Child Abuse Prevention and Treatment Act (CAPTA) was enacted to encourage greater focus and attention by states on Child Protective Services (CPS). One of CAPTA's first great challenges came in 1981 when the Reagan Administration proposed a number of block grants of key child welfare programs, including CAPTA. Although those efforts resulted in converting social services entitlement funding into Title XX, the Social Services Block Grant (SSBG), CAPTA, and Title IV-E foster care and adoption assistance remained in law as separate funding sources and guidance for states.

By 1985, Congress amended the law to create the Community-Based Child Abuse and Neglect Prevention Grant program (ACYF, 2011). This was a significant victory, not just because Congress had moved away from eliminating CAPTA but also because it demonstrated a willingness to focus on the prevention of abuse and neglect. CAPTA was reauthorized and expanded in 1988 as the Child Abuse Prevention, Adoption and Family Services Act and reauthorized again in 1992. However, in 1995, it once again became the target of a child welfare block grant. That attempt was made by the House but was never taken up in the Senate. In fact, CAPTA was instead reauthorized in 1996. Meanwhile, Congress had created a new child welfare-funding source, Title IV-B part 2, which we know today as the Promoting Safe and Stable Families (PSSF) program. Initially enacted in the first year of the Clinton Administration, the program focused on family preservation and family support with particular attention to the most vulnerable families and keeping children out of foster care.

The creation of PSSF was important because it increased funding for family-based services aimed at preventing abuse and addressing the effort to keep children and families together and safe. It was also important because obtaining additional funds for CAPTA through the annual appropriations process was proving difficult. PSSF was created as a mandatory federal fund. This meant that along with foster care and adoption assistance, funding was locked into the federal budget and not dependent on annual debates over appropriations. PSSF had a fixed level of funding, but foster care and adoption assistance were created as entitlements, automatically increasing based on the number of eligible children.

Due to this funding arrangement, PSSF, foster care, and adoption assistance experienced some increases while the appropriation-dependent CAPTA struggled to keep funding levels. In fact, the effort to get more dollars into CAPTA has been difficult since its inception. In 1992, the basic state grant, which helps states to support their CPS system and is the incentive for them to follow the law's various mandates, was at $20.5 million. This rose to $22.9 million in 1994 but decreased to $21 million in 1996. It stayed at that level until Congress accepted a Bush Administration proposal to increase funding to over $27 million in FY-2005 (Stoltzfus, 2009). Since that high point, CAPTA appropriations have drifted downward to just over $26 million. To put this in state budget perspective, California (with its budget shortfalls totaling billions) receives the greatest share of CAPTA funds at $1.8 million, and Wyoming receives the smallest share at $74,786. As a result, states have struggled to find other sources to address the basic needs of child protective services. Much of the funding comes from state and local revenue, and some states have relied heavily on flexible federal block grants such as the Social Services Block Grant (SSBG) to supplement their CPS systems (American Humane Association, 2012). States also tap other resources such as the PSSF program, but it should be noted that only the $26 million in federal CAPTA funds require states to follow various legislative requirements, including mandated reporter laws, the appointment of an appropriately-trained guardian ad litem for children, confidentiality rules, and most recently, the need for a differential or alternate response. Even in good budget times such as the late 1990s and start of this century when the federal budget was in surplus, states have been unsuccessful in obtaining sufficient funding through the annual appropriations process. Looking forward, strong advocacy will be crucial to avoid potential reductions over the next decade as the federal budget is reduced in an effort to eliminate the deficit.

Part of the reason that CAPTA has fared poorly in the annual appropriations process is due to its competition. When Congress decides how to allocate funds, CAPTA is competing with other high-profile programs, including child care, K–12 federal education funding, Head Start, health research through the National Institutes of Health (NIH), behavioral health and higher education funding, and a range of human services, education, and labor programs. The most recent example of Congress' reluctance to invest in CAPTA-related services was highlighted late in 2011 when, in reaction to the allegations of child sexual abuse in Pennsylvania, several bills were introduced to amend CAPTA. A number of these bills directed states to make all adults mandated reporters and to increase penalties for failure to report. One bill (S. 1877) did provide limited funding for training of reporters by authorizing $5 million in the first year of enactment; however, the appropriations committees would need to include the funding in a future federal budget.

The reality of the appropriations process and the limited funding for prevention has caused a number of advocates and child advocacy groups to propose a revision that would modify how the entire child welfare system is funded. One major goal is to allow some of the entitlement funding currently limited to foster care and adoption placements to flow toward prevention programs. This includes programs supporting not only families in crisis or those undergoing investigation by CPS but also programs for vulnerable families that have not yet reached a crisis point. Expanding foster care and adoption assistance funding to prevention services will be a sizeable hurdle due to the new budget ceiling enacted by Congress this past year.

Policy Progress: Prevention and Child Abuse and Neglect

While CAPTA funding was stagnant, some new approaches were emerging, one of which may have a significant impact on the development of prevention and up-front services. In 2008, the Bush administration requested (and Congress supported) the allocation of $10 million (through CAPTA) for the purposes of helping states to create effective home visitation programs. While this was taking place, the incoming Obama Administration was proposing to make such a program permanent and to provide

substantial mandatory funding. The Obama Administration was successful in making the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program a part of the new health care law, the Affordable Care Act (ACA), PL 111-148. This was significant in two ways. For one, a prevention program would receive critical mandatory funding that insured its support for at least the first 5 years. Additionally, states would receive significant funds to implement one or more evidence-based model programs that had been evaluated through well-designed research. In implementing their programs, states are required to have measurable outcomes as a condition of receiving funds. At the same time, a smaller part of funding (25%) allows support for promising approaches that do not yet qualify as evidence-based models (U.S. Department of Health and Human Services [US DHHS], 2010). Both the large funding invested and how the implementation and evaluation process has been structured could highlight the need for prevention initiatives and offer a model for future expansion of prevention programs.

While new and significant funds were arriving through the aforementioned home visitation model, CAPTA was being strengthened with language encouraging CPS models based on a differential response (DR) or alternate response practice. CPS has traditionally approached all families in the same way: A complaint is filed; if it is screened into the system for further review, the CPS worker investigates and then makes a determination whether or not maltreatment occurred. In contrast, DR or alternate response applies a dual approach to the management of child maltreatment, because there are various types of abuse and neglect and some families may require additional services or supports. As the American Humane Association (2011) outlines,

> …[A]n isolated incident of inadequate supervision is not comparable to repeatedly hitting a toddler for misbehaving. Nor is either of these the same as the sexual exploitation of a young person by his parent…. [DR encourages] an approach that allows child protective services to respond in multiple ways to abuse and neglect allegations. For high-risk reports, an investigation ensues, while for low- and moderate-risk cases with no immediate safety concerns, a family assessment is conducted, which gauges the family's needs and strengths. (para. 1, 3)

The American Humane Association began exploring differential response in 2005 to provide the field with comprehensive information and resources. As DR spread, Congress began to take notice with new supportive language inserted into the 2010 CAPTA reauthorization. Unfortunately, additional funds were not a part of the new legislative language, but the practice was spreading under the microscope of evidenced-based research. In states where DR is being implemented in a comprehensive and systematic way (such as Minnesota, Ohio, and New York), families have been able to obtain assistance through a less confrontational approach.

Changing Policy in Child Welfare

Along with achieving important gains in prevention, the fact of real progress in child placements is evident. Although presidential administrations and congresses have not opened the federal funding spigot, policymakers are more closely examining ways to appropriately address the challenges of the most vulnerable families. For example, one could argue that child welfare funding streams are supporting changes that have contributed to a decline in the number of children in foster care.

In 1997, through the enactment of the Adoption and Safe Families Act (PL 105-89, ASFA), more focus was placed on the amount of time a child spends in foster care. Although the ASFA changes did not include large increases in funding, the act underscored the deleterious effects of keeping children in foster care for years on end. It provided some funding to encourage adoptions for children who had experienced prolonged stays in foster care and were not likely to be reunited with their birth families. Congress increased the funding for PSSF and added funding to improve the role that state and local family courts play in the oversight of foster children. Along the way, states simultaneously experimented with waiver authority and examined the use of kinship care as a placement option.

At the same time, Congress began to examine more closely the role that substance abuse plays in placement stability and the ability to reunify families. In 2005 through the PSSF reauthorization, Congress allotted $20 million specifically to target drug treatment programs for families in the foster care system. In 2008, as a result of some of the earlier experiments by states through a federal waiver process, Congress was ready to embrace kinship care as a permanency option for some children. All states are now allowed to use federal foster care funds for kinship care as a result of the 2008 Foster Connections to Success and Increasing Adoptions Act (PL 110-351). That new law was also significant because it represented an effort by policymakers and child advocacy groups to look beyond numbers of children in foster care to actual outcomes. New requirements directed states to focus greater attention on a child's educational placements and health care services when that child is in foster care. As part of the 2011 Child and Family Services Improvement and Innovation Act (PL 112-34), Congress further amended the education provisions to clarify that the new education protections for children in foster care apply to each placement not just the initial placement as was interpreted in the initial HHS instructions. Although both provisions are still being developed, they have encouraged federal policy to consider some of the characteristics and challenges inherent to the foster care placements.

In 2011, Congress renewed PSSF and its companion program Child Welfare Services (CWS), including refinements in substance abuse funding, extension of court funds, and new support for the child welfare workforce. In addition, it added more focus to infants and toddlers in care while strengthening states' health care planning requirements. Finally, congressional action has placed more emphasis on addressing issues related to child trauma.

Child Maltreatment and Child Welfare 2012

In December 2011, the U.S. Department of Health and Human Services (DHHS) released the latest national data on child abuse and neglect. For 2010, the number of substantiated cases was projected to be 695,000 out of more than 3 million reports. Children from birth to 1 year of age had the highest rate of victimization at 20.6 per 1,000. Of the estimated 1,537 child fatalities, more than 47% were under the age of one year. Thirty-two percent were victims of neglect, while 68% suffered from neglect and at least one other form of maltreatment. For all 695,000 substantiated cases, more than 9% were sexually abused, 17% were physically abused, and 78% were victims of neglect (US DHHS, 2011).

Some of these numbers may not be a complete accounting of child maltreatment. Incidents of sexual abuse are likely underreported, as the Pennsylvania indictments have demonstrated with more victims coming forward as a result of the recent news attention. It has also been suggested that the reported number of child deaths does not fully account for all child fatalities. Critics argue that both numbers are undercounted due in part to the way in which data are collected, as states report information gathered only through state CPS systems to the National Child Abuse and Neglect Data System (NCANDS). As a result, additional reports made through other systems such as law enforcement may not be included. In 2011, with the passage of the Child and Family Services Improvement and Innovation Act (PL 112-34), states are required to include child death information from other sources (such as child death review teams, law enforcement, and medical examiners) and to report any failure to include such information on child fatalities.

Looking over 25 years of NCANDS data, child abuse and neglect numbers have improved, particularly over the past 15 years. However, the extent to which they have improved is debatable, as DHHS continues to refine the way in which data are collated. For example, over the last 2 years, the annual report has included unduplicated counts of children substantiated as abused or neglected (i.e., a child is not counted twice if that same child is substantiated a second time the same year). The unduplicated count for 2010 is the 695,000 figure, with the duplicated count being 754,000 (US DHHS, 2011). Similarly, because not all states report complete data, the numbers are adjusted or estimated to reflect totals for all fifty states. National numbers are affected by variations in state reporting, which may be influenced by how the state categorizes child abuse and neglect. For example, there was a dramatic decline in the number of children substantiated as abused and neglected between 2006 and 2007 as national numbers decreased from 905,000 to 794,000, determined through a comparison of annual maltreatment reports for 2006 and 2007 (US DHHS, 2008). Much of this decline was caused by Florida's re-categorization when the state reclassified "some indication" of abuse and neglect into the "other" category instead counting these cases in the substantiated category. Consequently, the total number of child abuse and neglect victims in Florida went from a little more than 134,000 in 2006 to over 53,000 in 2007. In turn, national estimates were altered. That being said, the rate of victimization from 2001 to 2006 decreased from 12.3 to 12.1 per 1,000 children, and after the adjustment in 2007, the rate declined from 10.4 to 10.0 in 2010 (US DHHS, 2008, pp. 37, 130).

Child welfare and foster care have seen even more dramatic declines. In 2010, 408,425 children were in foster care compared with 567,000 children in 1999 (Stoltzfus, 2009; US DHHS, 2011). For the most part, this number reflects both fewer children entering care and more children leaving care. Part of that success in exits from care has been due to an increase in adoptions. In 2010, 52,000 children were adopted from the foster care system (US DHHS, 2011). For the most part, these numbers have increased each year for the past decade and annual placements are well above the 37,000 adoptions in 1998 (US DHHS, 2006). One growing area of concern, however, is the number of youth leaving foster care without a permanent family. In 2010, 27,000 youth left foster care for independence, referred to as "aging out" or being emancipated (US DHHS, 2011). In recent years, these numbers have reached close to 30,000. Although states are collecting new data on this population, more general studies indicate that these young people, once they leave care, face tremendous odds and poor outcomes, including high rates of homelessness, unemployment, limited college experience, and higher teen pregnancy rates.

Where Does That Leave Us 25 Years Later

Statistics and key numbers suggest important progress over the last 25 years. An examination of the data would seem to tell us that as far as the universe of "child protection and child welfare" goes, children are better off.

At the same time, we do have to guard against basing everything on caseload numbers as our only indicator. Washington policymakers and the press tend to gravitate toward caseload statistics, especially when we can't really measure other more important long-term outcomes, such as individual physical health, mental health, income, and education.

As an example, many policymakers have hailed the success of the 1996 welfare reform Temporary Assistance for Needy Families

(TANF) when caseloads declined by half or more within the first 4 or 5 years. In the recession, however, TANF caseloads increased by 13% over a 2-year period despite unemployment doubling and other supports such as nutrition programs increasing more dramatically (US Department of Commerce, 2011). Also, perhaps as a consequence of changes made through TANF, more people than ever are living in what has been labeled "deep poverty," that is, living at incomes that are less than 50% of the poverty income level. The 6.7% of people who were in deep poverty in 2010 represented the highest proportion ever since the statistic was first kept in 1975, and this number is significantly above the 5.4% when TANF was created.

Similarly, we have hailed the reductions in child abuse numbers and decreased foster care placements, but it is unclear how much of this progress is genuine and lasting. It is clear that the deepest economic downturn since the Great Depression has not resulted in higher measured rates of child abuse and foster care placements. To what extent will some of the current negative trends for families impact these numbers in the future? We are experiencing greater homelessness, with 1.6 million children—one in 45—being homeless annually in America. This is an increase of 38% between 2007 and 2010 (National Center on Family Homelessness, 2011). The poverty rate reached 15.1% in 2010, significantly higher than the pre-recession 12.5%, which was up from lower rates in the late 1990s. For all children under the age of 18, the poverty rate hit 22%. For the youngest, children under the age of 6—the group that makes up a disproportionate share of child deaths and of child abuse and, neglect—the rate was 25.3%; one out of every four young children was living in poverty (US Department of Commerce, 2011).

So are the child abuse numbers and foster care statistics the result of better practice and policy? Are long-term real impacts on the most vulnerable families and children being measured? Juxtaposed against these other statistics, we will have to carefully examine the potential influence of current conditions. We may have made significant progress in how we deal with families, how we assist children in foster care, and how we address the needs of families that come to the attention of CPS and child welfare, yet the challenge will be to sustain these improvements in the face of significant headwinds.

Regardless of the answers to our questions, we move into the next 25 years still facing one overall reality: Having over 400,000 children in foster care and more than 700,000 maltreated children annually is still far too many for the United States in the 21st century.

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APSAC News

APSAC—A Quarter Century of Progress

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 with child abuse professionals attending 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!

Details and registration are now available on the Web at www.apsac.org.

APSAC Advanced Forensic Interview Clinics Coming to Norfolk and Seattle

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–Aug. 3, 2012, in Seattle, Washington. Details and registration are available on the APSAC Web site, www.apsac.org.

Forensic Interview Practitioner and Supporter SIGs Now Open

APSAC's Forensic Interview Practitioner (FIP) and Forensic Interview Supporter (FIS) Special Interest Groups (SIGs) are now up and running. APSAC Board member Julie Kenniston, MSW, LSW is coordinating both SIGs.

A SIG is an electronic community for members of an organization with an interest in one area of the overall mission. The SIG provides a format for interested members to communicate. In an effort to create this forum for forensic interviewing, APSAC is offering two special interest groups for its members.

The Forensic Interview Practitioner group targets practitioners. As debates rage over hot topics that impact interviewers, it has become crucial that professionals conducting forensic interviews have a place to share their views and seek support from one another. This SIG has the potential of being a starting point for researchers or others needing to gather information from a large group of practitioners.

However, APSAC recognizes that many other types of professionals also have an interest in what is happening with forensic interviewing. With a variety of professions contributing to the field, APSAC has decided to offer a second SIG (Forensic Interview Supporter) that includes interviewers, trainers, researchers, multidisciplinary team members, and supervisors.

Both SIGs are getting started with two new listservs designed to support their interests. If you are interested in applying for partic-

ipation in a SIG, please visit the Special Interests Group tab in the Members Only area of the Web site at www.apsac.org.

Attendance at APSAC Institutes Increases by 13%

One-hundred eighty individuals participated in APSAC Advanced Training Institutes January 22–23 in San Diego, California. The programs were a part of the Annual San Diego International Conference on Child and Family Maltreatment sponsored by the Chadwick Center.

APSAC programs were as follows:

- Advanced Medical Evaluation of Child Sexual Abuse
  Lori D. Frasier, MD, and Suzanne Starling, MD
- Advanced Forensic Interviewing
  Julie Kenniston, MSW, LSW, and Chris Ragsdale, MSW, LCSW, USN
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for Young Children and Preschoolers
  Monica Fitzgerald, PhD, and Shannon Dorsey, PhD

In addition to offering three educational programs, APSAC exhibited in the conference and many of its members served as conference faculty.

APSAC Board Meets in San Diego

APSAC's Board of Directors met January 24–25 in San Diego, California, during the APSAC Institutes and the Annual San Diego International Conference on Child and Family Maltreatment. The first day was dedicated to association business, while day two focused on strategic planning for the organization.

A broad spectrum of topics was covered, from the 25th Anniversary Celebration planned in conjunction with the Colloquium, to international partnerships, to financial reports and more. Additionally, standing committee reports were heard.

During the meeting, the Board approved a new President Emeritus status for the organization. This would be a nonvoting, elected member of the Board who meets the following qualifications: (1) must be a current APSAC member, (2) must have been a President of APSAC, (3) must have made extraordinary contributions of time, experience, talent, leadership, and fundraising efforts to the organization.

The strategic planning discussion covered staffing, committee and Board structure, financial resources, prioritization of projects, and assigning and tracking responsibility and accountability.

The American Professional Society on the Abuse of Children

APSAC

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

The American Professional Society on the Abuse of Children envisions a world where all maltreated or at-risk children and their families have access to the highest level of professional commitment and service. Child maltreatment is a national public health problem costing children their lives and society billions of dollars.

For 25 years, APSAC has been a multidisciplinary network of child welfare and child maltreatment professionals, many of whom are the leading child abuse experts in the world. The Anniversary Colloquium is an opportunity to honor them for their service to children and families.

APSAC strives to improve the ability of professionals to respond to children and families affected by abuse and violence. We believe that through expert training and educational activities, policy leadership and collaboration, and consultation that emphasizes theoretically sound, evidence-based principles, we can one day live in a world free of child abuse and violence.

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

Our Anniversary Colloquium is hailed to be one of the premier training events of the century, with child abuse professionals attending from around the world. Please join us as we return home to Chicago June 27-30, 2012 and be a part of this historic occasion. APSAC exists and thrives because of your commitment. 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

Conference Calendar

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
emolengraaf@scem.nl
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 and Crimes Against Children Research Center
Portsmouth, NH
603.862.1888
doreen.cole@unh.edu
www.unh.edu/frl

July 22–25, 2012

26th Annual Conference on Treatment Foster Care
Foster Family-Based Treatment Association
Atlanta, GA
800.414.3382
shorowitz@ffta.org
www.ffta.org/conference

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 9–12, 2012

19th ISPCAN International Congress on Child Abuse and Neglect
International Society for the Prevention of Child Abuse and Neglect
Istanbul, Turkey
303.864.5220
info@ispcan2012.org
www.ispcan.org

September 9–12, 2012

17th International Conference on Violence, Abuse and Trauma
Institute on Violence, Abuse and Trauma
San Diego, CA
858.527.1860
ivat@alliant.edu
www.ivatcenters.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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