ADVISOR

December 2018

In This Issue

Trauma after natural disasters, supporting immigrant children, and more

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ADVISOR

Vol. 30 | No. 4

page
3

At Issue: Supporting Our Immigrant Children | *Padma Swamy and Marsha R. Griffin*

As pediatricians, we see in our clinics every day a diverse spectrum of children with unique family structures across all socioeconomic strata and different immigrant statuses. It is our responsibility to promote the health and well-being of all children. Child protection team members also care for all children and know all too well the vulnerability of children. The field of child protection requires professionals to come face-to-face with the unique vulnerability of children every single day. Immigrant children are much the same. Many of them are fleeing their home countries because of prolonged histories of physical, emotional, and sexual abuse, or neglect. Immigrant children would benefit from the expertise and wisdom of providers trained in child abuse and neglect.

page
6

Evidence-Based Assessment in the Aftermath of Disasters: Towards a Best-Practice Model for Evaluating Hurricane-Exposed Youth | *Julie Kaplow, Christopher Layne, and Benjamin Rolon-Arroyo*

Natural disasters, including hurricanes, are expected to increase in intensity and frequency, and have the power to adversely impact millions of children and adolescents worldwide. A growing body of research is shedding light on how youth typically respond to hurricanes, as well as on factors that can exacerbate or mitigate their effects. This work carries important implications for post-disaster risk screening and assessment. In this paper, we propose guidelines for applying evidence-based assessment (EBA) concepts, principles, and practices to four major assessment tasks typically undertaken in the aftermath of a hurricane, including (1) risk screening/situation analysis, (2) mental health needs assessment, (3) in-depth ecological assessment, and (4) treatment planning/monitoring. We discuss the potential that EBA holds for improving mental health assessment among hurricane-exposed youth.

page
21

Improving the Effectiveness of Intimate Partner Violence Screening: Results From a Local Needs Assessment | *Nancy Correa and Ryan Krasnosky*

Intimate partner violence (IPV) is a serious preventable public health problem that negatively impacts millions of Americans. Experts recommend that healthcare providers screen for IPV, but screening and positive disclosure rates remain low. We conducted a needs assessment on IPV screening in Houston, Texas. The needs assessment included a literature review, 26 interviews with organizations that screen for IPV and agencies that provide services to survivors of IPV, and three focus groups with survivors of IPV. The focus group participants shared their experiences in interacting with healthcare providers and identified opportunities for providers to improve how they screen for IPV. Recommendations include asking the patient alone, improving rapport, sharing what will happen if the patient discloses abuse before the screening, asking specific and direct questions that include questions on emotional abuse, and creating individualized follow-up plans.

page
28

Suicide-Related Behaviors Among Abused and Maltreated Youth: A Call to Action and Recommendations for Providers | *Ryan Hill, Angela Hayes, Kimberly Lopez, and Julie Kaplow*

Adolescent suicide-related behaviors are a substantial public health problem in the United States, and youth with a history of child abuse or maltreatment are at elevated risk for suicide. Service providers who work with abused and maltreated youth have a unique opportunity to reach those at highest risk for suicide-related behaviors, provide support, and ensure that youth receive appropriate services. This article provides an overview of risk markers for suicide-related behaviors and the types of prevention services available to at-risk youth. The article also provides suggested action steps to assist service providers in preventing suicide among abused and maltreated youth.

page
42

Bonded to the Abuser: How and Why Children Form and Maintain Attachments With Abusive Caregivers | *Amy Baker and Mel Schneiderman*

It is common knowledge among those working with maltreated children that despite the abuse and/or neglect experienced at the hand of a parent, children generally want to maintain a relationship with the abuser. Although some children—especially older teens—may express their disappointment and anger at maltreating parents, the majority perceive their abusive parent as an attachment figure and desire to repair the relationship and reunite with the parent. Part one of this paper discusses six sources of evidence that support and explain the phenomenon of children being bonded to an abusive caregiver. Part two presents common themes in the writings of adult survivors of different forms of childhood maltreatment as another source of evidence.

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At Issue: Supporting Our Immigrant Children

Key words: immigrant health, child health, unaccompanied immigrant children, asylum seekers

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> *"Give me your tired, your poor, your huddled masses yearning to breathe free, The wretched refuse of your teeming shore. Send these, the homeless, tempest-tossed to me, I lift my lamp beside the golden door!"*
>
> *- Emma Lazarus (1883)*

Fearful, threatened children from across the world are fleeing their home countries seeking the safe haven promised by these words. Whether it be traveling north on the dangerous train, *La Bestia* (the Beast), from Central America or risking treacherous waters in rickety rafts fleeing Myanmar, children are fleeing for their lives trying to escape traumas including violence, extreme poverty, environmental degradation, and persecution.

Researchers have extensively studied trauma in children, and found that it leads to changes in brain function and structure and poor long-term health outcomes (Shonkoff et al., 2012). Many immigrant and refugee children are suffering from accumulated trauma: the underlying pre-migration trauma; the trauma that can occur during migration; and the trauma of acculturation in adjusting to life in a foreign community (Giacco & Priebe, n.d.). Through this process, children may be exposed to violence, sexual abuse, or the death of a parent, and may not be able to share the experience because of their developmental stage or the effects of the trauma. Traumatized children may present with symptoms of recurrent headaches, stomachaches, or behavioral problems, symptoms similar to those seen in children exposed to domestic violence or neglect. Despite the trauma, many children show signs of amazing resilience and strength.

Most children have migrated in the spirit of hope. This hope can be a source of resiliency for recently migrated children. A study done by Cooch et al. (2017) examining the evaluation of a program that involved group therapy in the school setting showed that immigrant children had high levels of resiliency to begin with, and that group therapy in the school setting helped to improve the Pediatric Symptom Checklist (PSC) score. Interventions that aim to improve mental health through utilization of resiliency shift the mindset away from a problem-based focus to a solution-based mentality. Further research needs to be conducted on how to sustain hope and build resiliency in all our children.

In the last few years, the safe havens sought with such hope have become sources of ongoing traumas. New threats seem to be aimed at children and families every day. Both immigrant children and U.S.-born citizen children with immigrant parents are suffering from the fear of parental separation due to deportation. We are seeing more and more children in our clinics exhibiting signs of separation anxiety, afraid to go to school or leave their parent's side. This fear is not an unfounded fear.

This very fear potentially can affect a child's overall health, whether the child has adequate food in the home or is able to access rightfully deserved healthcare. The current administration is considering a policy change in defining what is public charge. The current definition of public charge is "a person who is primarily dependent on the government for more than half of personal income" (Perreira, Yoshikawa, & Oberlander, 2018).

This policy will discourage immigrants and their dependents (including U.S. citizen children) who are seeking permanent residency from using any government-supported health care (National Immigration Law Center (NILC), 2018). This is alarming to us all, and we are already feeling its effects. Under this plan, a lawful immigrant could be denied permanent residency, a "green card," if they use Medicaid, the Women, Infants, and Children (WIC) Nutrition Program, food stamps, tax credits, or other noncash government benefits (NILC, 2018). Already, many of the parents in our clinics are not renewing Medicaid for their children. We are seeing a decrease in the numbers of patients coming into our clinics for appointments. Many families are afraid of seeking services like WIC due to the possible policy change. This results in more children going hungry. While this policy is not yet in place, merely hearing about it is chilling. This is already occurring, with a WIC agency in Beacon, New York reporting that it has lost 20% of its caseload due to this fear (Evich, 2018). These factors have a direct impact on the health of our children. Fear of family separation is behind all of this.

Earlier this year, the Department of Homeland Security (DHS) formalized a policy— "Zero Tolerance" —to remove immigrant children from their parents at the southern border if families enter the United States without presenting at the official ports of entry, the bridges across the Rio Grande River. Officials have turned many families away at the bridges, forcing them to swim the river. Then, they wait on the riverbank to turn themselves into a DHS agent. This is considered an unlawful entry into the United States, subject to the Zero Tolerance Policy. Officials then separated the children from their parents, and placed the parents into a detention facility or deported them. The disastrous results of this separation continue to play out in the lives of children and their families. DHS agents had been informally practicing the separation of children from their parents for many months, even among asylum seekers. An asylum seeker is defined by the United States Citizenship and Immigration Service (USCIS) as someone who is already in the United States, or who is seeking admission at the port of entry due to persecution based upon race, religion, nationality, membership in a particular social group, or political opinion (USCIS, n.d.). Asylum seekers have a lawful right to come to any country to request asylum from dangers that threaten their lives. Child protection team members, perhaps more than anyone in this country, understand the trauma of separating a child from his/her parent. And yet, we as a country are separating children from their parents as punishment for seeking safety at our borders. Many of these separated children continue to be held as "unaccompanied children" in Office of Refugee Resettlement detention centers (shelters), because DHS does not know where their parents are. The American Academy of Pediatrics (AAP) issued a Policy Statement on the Detention of Immigrant Children in March 2017, which included advising that agents should not place immigrant children in detention, and should never separate them from their parents, unless the child is at risk of abuse at the hands of the parent (Linton, Griffin, & Shapiro, 2017). The AAP Policy Statement clearly states that detention is never in the best interest of the child (Linton et al., 2017).

Detention of unaccompanied minors, however, is not a new issue. The Flores Settlement Agreement, which was approved in 1997 after 10 years of legal work, stipulates that unaccompanied minor children should be treated with dignity, respect, placed in the least restrictive environment, released with unnecessary delay to their sponsor, and not held with unrelated adults (Reno v. Flores, 1993). In early September, the Departments of Homeland Security and Health and Human Services proposed regulations regarding the Flores Settlement Agreement that strip vulnerable children of vital protections, jeopardizing their health and safety (Department of Homeland Security & Department of Health and Human Services, 2018). If approved, the proposed regulations pave the way for major expansions of family detention centers where children could be held indefinitely and in conditions that put their health and safety at great risk. This potential change to the Flores Settlement Agreement undermines state child welfare laws regarding licensure for residential child care facilities, and threatens basic protections for children. There is no evidence that any amount of time in detention is "safe" for children. In fact, even short periods of detention can cause psychological trauma and long-term mental health risks for children (Linton et al., 2017). Leaders can change these detrimental policies, and as child health advocates we have a role in facilitating that change.

Pediatricians across the country are standing up for immigrant children. We are training ourselves in trauma-informed care, first recognized and designed for children in foster care. We are advocating in Washington, DC and locally, using social media and writing op-ed articles. Many child maltreatment professionals are already writing and advocating for the protection of immigrant children. As mandatory reporters of child abuse, we cannot sit still and allow administrative abuse to harm our children. We need your continued support. Please lend your voices to the outcry by medical and mental health providers across the country. Standing on the sidelines, remaining quiet, is no longer an option.

About the Authors

Padma Swamy, MD, MPH, *is dedicated to improving the social factors impacting immigrant families. She is part of the Program for Immigrant Refugee Child Health (PIRCH) at Baylor College of Medicine/Texas Children's Hospital. She is also a leader for the Immigrant/Refugee Health Committee of Doctors For Change, a Houston-based non-profit.*

Marsha R. Griffin, MD, *lives and works on the Texas/Mexico border and has spent the last 10 years writing and speaking about her concerns for the trauma inflicted on the children living along the border, as well as those children who are forced to pass through this region in search of safe haven. She continues to help mobilize individuals and institutions to better serve the migrating poor. She is Co-chair of the American Academy of Pediatrics Immigrant Health Special Interest Group.*

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At Issue: Supporting Our Immigrant Children

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Evidence-Based Assessment in the Aftermath of Disasters: Towards a Best-Practice Model for Evaluating Hurricane-Exposed Youth

Key words: hurricane, disaster, evidence-based assessment, risk screening, children, youth

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In 2017 alone, multiple states and territories across the United States, including Texas, Puerto Rico, Florida, and the U.S. Virgin Islands, sustained direct hits from some of the strongest hurricanes on record, impacting millions of children and families. Unfortunately, these devastating events are all too commonplace. In recognition of the inevitability and frequency of natural disasters, the Institute of Medicine (2015) has proposed strategies for building healthy, resilient, and sustainable communities following disasters, including the implementation of community-level disaster impact assessments. Further awareness of the potentially traumatic nature of disasters, including their associated mental health consequences (e.g., posttraumatic stress reactions; Goenjian et al., 2005; Kronenberg et al., 2010; Lai, Lewis, Livings, La Greca, & Esnard, 2017; Pynoos et al., 1993), has led to calls to train health care providers in trauma-informed care, including trauma-informed risk screening and assessment (Courtois & Gold, 2009; Cook & Newman, 2014). Despite these calls to action, the child trauma field has yet to develop best practice models for efficient and effective risk screening and assessment of youth in the wake of natural disasters. The recent hurricanes and associated floods across the United States underscore the pressing need for guidelines that can assist providers and organizations who serve hurricane-exposed youth.

In this paper, we propose that *evidence-based assessment* (EBA) principles and methods can serve as valuable tools for addressing this need, and offer suggestions for how to apply them to help disaster-exposed youth. EBA provides a rigorous yet practical way for clinicians to use assessment tools to guide such activities as risk screening, triage, case conceptualization, diagnosis, and treatment planning/monitoring. EBA carries promise for enhancing the efficiency, accuracy, and effectiveness of youth mental health services (Youngstrom, 2013), and researchers have recently applied EBA to traumatized and bereaved children and adolescents (Layne, Kaplow, & Youngstrom, 2017b). Although beyond the scope of this article, a number of researchers have described an evidence-based stepped-care model of post-disaster child and adolescent mental health services (e.g., Saltzman, Layne, Steinberg, Arslanagic, & Pynoos, 2003; for reviews, see Institute of Medicine, 2014; McDermott & Cobham, 2014).

Accordingly, the present paper has two primary aims. The first is to propose basic guidelines for applying EBA concepts, principles, and practices to the task of assessing youth in the aftermath of a hurricane. These guidelines draw upon multiple sources, including both empirical studies of hurricane exposure-related risk factors and consequences and our clinical experiences in conducting trauma-informed assessments and interventions with youth exposed to Hurricane Harvey, which struck Texas and Louisiana in August 2017. The second aim is to illustrate how EBA can improve both assessment efficiency (e.g., reserving in-depth assessment for decision-making points where it is most useful and accurate) and effectiveness (using appropriately-designed tools to guide specific clinical decisions as they arise) when applied to settings that serve youth exposed to hurricanes and their aftermath (Layne et al., 2017b).

Using Evidence-Based Assessment Procedures in the Aftermath of a Hurricane

One of the greatest challenges associated with disasters is that planning for recovery must be conducted within a limited timeframe that is typically calculated in weeks and months. Making effective decisions in this tightly-compressed context requires coordinated, efficient information-gathering (Johnson & Olshansky, 2013) and the timely synthesis of findings in ways that are clearly comprehensible and clinically actionable. Professionals can use several types of information to support the incorporation of mental health considerations into the recovery process to improve outcomes after a disaster. Ideally, practitioners should identify valid and reliable sources and tools for each type of information in advance of a disaster as part of prior planning. EBA encourages the efficient selection of the best available assessment tools for the specific questions at hand, gathering the best available data using those tools, and judiciously applying assessment data to make informed decisions about individuals and their needs (Hunsley 2015; Hunsley & Mash, 2007).

In the next section, we present a four-stage model for utilizing EBA in post-disaster settings. Readers should view these stages as fluid (adaptable to individual settings) rather than strictly sequential, allowing practitioners and administrators to iterate the procedure as well as "backtrack" to prior steps as additional information becomes available (Layne et al., 2017b).

Overview

Drawing on prior work detailing the roles of situation analysis and needs assessment as complementary information-gathering procedures following war and disasters (Layne, Beck, Rimmasch, Southwick, Moreno, & Hobfoll, 2009), we propose that these types of information include:

1. Situation analysis, which focuses on collecting factual details of what occurred, including prevalence rates of exposure to specific risk types of factors (e.g., percentages of youth who were seriously injured, lost a pet, lost their home). Situation analysis also involves searching for and predicting "chain reaction" cascades of adversities resulting from the original exposure, which assume a life of their own as separate sources of stress (e.g., loss of home leading to forced displacement, change in school, loss of family income, financial strains) that extend beyond, exacerbate, and outlast the initial effects of disaster-related exposures per se.

2. Mental health needs assessment, which aims to address the causal consequences of exposure to risk factors (identified through situation analysis) with the aim of preventing and/or ameliorating longer-term distress and dysfunction. Mental health needs assessment focuses on gathering information regarding mental health problems (e.g., posttraumatic stress reactions, depression, grief reactions) theorized to arise from, or to have been exacerbated by, one's specific exposure profile. Needs assessment can be conducted at the individual (e.g., through in-depth assessment, case formulation, and treatment planning) and/or group level (e.g., by identifying at-risk subgroups that share a common set of mental health needs based on their pattern of exposure/vulnerabilities), and can encompass a range of child caregiving systems (Masten & Obradovic, 2008).

3. In-depth ecological assessment of the recovery environment, including up-to-date information regarding potential vulnerability and protective factors, secondary adversities set in motion or exacerbated by initial risk factors, and trauma reminders (e.g., media coverage). Ecological assessment also includes surveillance, which can be viewed as an abbreviated, ongoing repetition and extension of the initial situation analysis. Surveillance involves a search for recurring or emerging causal risk factors and related threats to safety and well-being (e.g., supply shortages, disease outbreaks, unemployment, increases in domestic violence, scams, people moving back into condemned/unsafe housing) that can exacerbate, prolong, and extend beyond

the short-term effects of hurricane exposure alone.

4. Ongoing assessment of client well-being, including monitoring response over the course of intervention and assessing outcomes at follow-up.

Stage 1: Situation Analysis

Conducting a situation analysis in the aftermath of a hurricane requires a working knowledge of the various exposure-related risk factors that youth are likely to encounter, either during the storm or its aftermath. A number of studies have contributed to a growing evidence base regarding potent risk factors that may predispose youth to developing significant psychological distress, including posttraumatic stress symptoms (PTSS), after a hurricane (see Furr, Comer, Edmunds, & Kendall, 2010 for a meta-analytic review). Identified risk factors include:

- Experiencing the death of a loved one (including pets)
- Being injured or witnessing other people who are injured
- Extensive damage to home and/or belongings
- Being separated from a caregiver
- Being forced to evacuate with little time to prepare
- Requiring rescue by helicopter or boat
- Being trapped or having difficulty escaping
- Being displaced from home for a long period of time (e.g., living in a shelter)
- A history of other trauma(s) or losses
- Being forced to move to a new school
- Lack of social support
- Having a family member who served as a rescue worker
- Financial difficulties prior to or resulting from the storm
- Ongoing threats of recurring disasters

(Kronenberg et al., 2010; LaGreca, Silverman, Vernberg, & Prinstein, 1996; 2010; Martin, Felton, & Cole, 2016; McLaughlin et al., 2009; Overstreet & Mathews, 2011).

Although certain risk factors may be differentially more potent than others in their causal effects, pathways of influence, and the severity of their consequences (Layne et al., 2009), (for example, death of a loved one is associated with the highest levels of distress; Breslau, Peterson, Poisson, Schultz, & Lucia, 2004), there is converging evidence across post-disaster studies of a general dose-response relation. In particular, as exposure to risk factors increases, emotional distress also tends to increase (Overstreet & Mathews, 2011). This finding underscores the value of risk screening (as part of initial situation analysis) for identifying youth who endorse a greater number of exposure-related risk factors and are consequently at greater risk for experiencing persisting mental health difficulties. Those youths with higher levels of exposure could be identified early on as potential recipients of a lower-tier intervention (e.g., a universal, skills-based intervention such as Skills for Psychological Recovery, Berkowitz et al., 2010; or the skills-building modules of multi-module interventions, Saltzman, Layne, Pynoos, Olafson, Kaplow, & Boat, 2018), implemented in schools or community centers as a means of preventing future posttraumatic stress or further exacerbation of symptoms.

Review of post-hurricane risk screening tools. To date, experts have developed few hurricane-specific measures designed to assess exposure-related risks. One of the most widely-used measures of hurricane-related risk exposure (e.g., Brown, Mellman, Alfano, Weems, 2011; Terranova, Boxer, & Morris, 2009; Weems et al., 2010) is the Hurricane-Related Traumatic Experiences Questionnaire (HURTE; Vernberg, La Greca, Silverman, & Prinstein, 1996). Clinical experience gained by interviewing children and adults following Hurricane Andrew in 1992, and inspection of a post-disaster supplement to the Diagnostic Interview Schedule, aided the development of this measure (Robins & Smith, 1993). The HURTE, which was recently updated with additional items and now referred to as the HURTE-II, is designed to be administered to school-age children and assesses exposure-related risk factors across four domains: Before the Hurricane (17 items), During the Hurricane (16 items), After the Hurricane (17 items), and Current Functioning (4 items). Research findings support the reliability and predictive validity of the original HURTE for assessing children's hurricane-related exposure and associated stressors (La Greca, Silverman, & Wasserstein, 1998; Weems et al., 2010; Yelland et al., 2010). Research regarding the HURTE-II's psychometric properties is currently underway (La

Greca, personal communication, January 8, 2018).

The National Child Traumatic Stress Network (NCTSN) Hurricane Assessment and Referral Tool for Children and Adolescents was created to assess both hurricane-related exposure and associated symptoms of PTSD and depression (Hansel, Osofsky, & Osfsky, 2015), thereby collecting information relevant to both situation analysis and mental health needs assessment. Caregivers and/or children/adolescents can complete this measure, although younger school-aged children may need assistance in completing the measure (Kronenberg et al., 2010). Regarding hurricane-related exposure, this measure assesses demographic information, 18 hurricane-related exposure items, as well as six items assessing for a history of psychological/psychiatric problems and treatment. Experts have not formally evaluated the hurricane-related exposure section of the measure. This measure also includes a section designed to assess a total of 22 symptoms of PTSD (derived from the UCLA PTSD Reaction Index; Steinberg, Brymer, Decker, & Pynoos, 2004) and depression, and seven additional parent-report symptoms for young children.

Researchers have created a number of adaptations to the NCTSN Disaster Assessment and Referral Tool for Children and Adolescents to meet the needs of different settings and populations. For example, an adaptation by Osofsky and colleagues (Kronenberg et al., 2010), simplified the language of the measure to make it easier for school-aged students (M*age* = 14.27 years, SD = 2.13) to complete. The resulting measure, the Child/Youth Assessment & Referral Tool, is typically administered via interview format and assesses demographic information, 18 exposure risk categories, 15 symptoms of PTSD and depression, and five additional parent-report symptoms for young children.

The Louisiana State Health Sciences Center Katrina Inspired Disaster Screenings (LSUHSC-KIDS; Hansel et al., 2015) was developed for 9-18 year olds (M*age* = 14.14, SD = 2.41). Designed to be administered to students in a group format, the measure assesses hurricane-related exposure via nine items based on several existing hurricane exposure measures (Kronenberg et al., 2010, NCTSN, 2005; La Greca, Vernberg, & Prinstein, 1996). This measure also assesses PTSS and depressive symptoms. An exploratory factor analysis of the 22-symptom portion revealed a two-factor solution comprised of anxious and depressive reactions (Hansel et al., 2015).

Experts adapted the Hurricane Exposure Questionnaire for Caretakers and Youth (aged 11 to 17 years) from adult measures of hurricane-related exposure (Bravo, Rubio-Stipec, Canino, Woodbury, & Ribera, 1990; Norris & Kaniasty, 1992) as well as the HURTE (La Greca et al., 1996). Items assess the child and family's exposure to the hurricane, perceived safety, loss or damage to their home, life threat/loss (i.e., physical injury to the child or a significant other, loss of a family member or a person close to them), loss of material objects, and child's disruption of everyday life (i.e., separation from family, still living out of home at time of interview). Practitioners have used this measure in multiple studies to examine risk factors associated with hurricane-related exposure (Felix et al., 2011; Felix, Kaniasty, You, & Canino, 2016; Felix, You, Vernberg, & Canino, 2013; Rubens, Vernberg, Felix, & Canino, 2013); however, researchers have not yet conducted a formal psychometric study.

As previously discussed, one of the greatest challenges in conducting a situation analysis in the aftermath of a disaster is the need for both rapid and efficient information-gathering. Post-disaster settings that provide the greatest access to youth, such as schools or hospitals, require developmentally- and culturally-informed self-report tools that children or adolescents can complete quickly and easily by themselves with minimal assistance from teachers or healthcare providers. In addition, a number of existing hurricane-related exposure tools include mental health variables (e.g., PTSS) that can lead to increases in "false positives" in the more immediate aftermath, given that most children demonstrate expectable short-term increases in psychological distress following natural disasters. For example, La Greca and colleagues (1996) found that 29% of youth exposed to Katrina (n = 442) exhibited "severe" or "very severe" PTSS within the first 3 months of the storm; in contrast, only 12% exhibited severe or very severe symptoms 10 months post-Katrina. Thus, although PTSD can be diagnosed as early as 1 month post-event, practitioners may need additional time to discriminate between individuals with more protracted recovery trajectories versus youth at risk for severe persisting distress, functional impairment, and developmental disruption, who stand in need of specialized intervention (Layne et al., 2009).

To address these issues, our Harvey Resiliency and Recovery Program at Texas Children's Hospital created the Hurricane Exposure, Adversity and Recovery Tool (HEART), adapted from the NCTSN Assessment and Referral Tool for Children and Adolescents. The HEART was created explicitly for the purpose of conducting a post-hurricane situation analysis among Houston youth between the ages of 8 and 18 in both medical (including emergency departments, mobile units, outpatient pediatric practices, etc.) and school-based settings. The child self-report version of the HEART consists of 29 yes/no questions pertaining to potential exposure-related risk factors, accompanied by a question inquiring about their desire for mental health support. We also created a parent-report version (available in both English and Spanish). To date, the HEART has been administered to 50 hurricane-exposed children/adolescents and shows excellent acceptability (children report that they understand the questions) and feasibility (children and caregivers are able to complete the measure independently within 5 minutes or less). Studies regarding the HEART's psychometric properties and clinical utility are underway.

Stage 2: Mental Health Needs Assessment

In most post-hurricane situations, referral questions typically center not only on hurricane-related exposures among children and adolescents (an integral part of situation analysis), but also their range of distress reactions to those events (Layne et al., 2009) in the form of a mental health needs assessment. A mental health needs assessment focuses on the expected causal consequences of those exposures—in particular, on the range of youths' distress reactions, life disruptions, and associated mental health needs, including the specific interventions that may be indicated. These may include "Tier 1" general/supportive interventions, "Tier 2" locally-delivered therapeutic treatments for clinically significant problems (e.g., specialized school-based mental health services), "Tier 3" intensive psychiatric treatment, or some combination thereof. (See Saltzman et al., 2018, for an example of a three-tiered school/community-based intervention).

Conducting an evidence-based mental health needs assessment in the aftermath of a hurricane requires that one first consider the most common referral questions and diagnostic issues that exposed youth are likely to manifest. Based on studies of youth exposed to Hurricane Katrina (e.g., Kronenberg et al., 2010), as well as a recent review of post-disaster symptom trajectories in youth (Lai et al., 2017), PTSS are commonly identified after a natural disaster, with some estimates of up to 70% among youth in the immediate aftermath (Küçükoğlu, Yıldırım, & Dursun, 2015). Besides PTSS, other commonly reported mental health issues among youth post-disaster (natural or man-made) include depressive symptoms and maladaptive grief reactions (Claycomb et al., 2016; Lai, La Greca, Auslanders, & Short, 2013; Layne et al., 2001; 2008). It is important to note that not all youth who demonstrate elevated PTSS, depression, or grief within the first 3 to 6 months of the disaster will go on to exhibit persistent symptoms over time. Consequently, stratifying children based on early symptom levels may lead to misclassification errors, such as the referral of "false positive" children (who will recover naturally) to costly intensive services they do not need (Lai et al., 2017). Thus, multiple competing concerns should guide the decision as to when to commence risk-screening. If resources permit, early (between 1 to 3 months post-disaster) brief screening may be useful in identifying youth at high risk for significant distress and functional impairment, for whom timely intervention might prevent developmental disruption (e.g., distress leading to academic problems, school drop-out) or risky behavior (substance use, affiliation with deviant peers). Given the potential risk, however, of over-selection and over-referral, such second-tier interventions could involve general supportive skill-building delivered in classroom settings (e.g., coping skills delivered by a trained counselor; Layne et al., 2008) that carries both low cost and low risk for iatrogenic effects.

Those youth who do exhibit chronically elevated PTSS have often been exposed to a combination of both hurricane-related risk factors and pre-existing environmental and relational risk factors (which exacerbate the adverse effects of hurricane exposure; Kronenberg et al., 2010; Lai et al., 2017). For example, the majority of youth treated for PTSD in the longer-term aftermath of Katrina had experienced other traumas and losses prior to the hurricane (Jaycox et al., 2010). The most common potentially traumatic event reported was "death or serious injury of a loved one" prior to the hurricane, as endorsed by 70% of the sample. This finding underscores the need for assessment tools that encompass a range of potentially traumatic life events endemic to the affected region (e.g., bereavement), as well as common psychological responses to those events (e.g., PTSS, grief reactions; Layne, Kaplow, Oosterhoff, Hill, & Pynoos, 2017a). Elevated prevalence rates of trauma and bereavement reported by underserved populations (who are often hardest hit by hurricane-related adversities) call for the systematic assessment of both trauma exposure/PTSS and bereavement/maladaptive grief (e.g., Layne, Kaplow, & Pynoos, 2014) as common consequences (Breslau et al., 2004; Courtois & Gold, 2009; Kaplow, Saunders, Angold, & Costello, 2010).

A related evidence-based practice involves reviewing assessment tools and protocols to ensure that candidate tools are valid and useful for assessing the most prevalent and common diagnostic conditions in the targeted setting (see Layne et al., 2017b for a review of commonly used measures for Acute Stress Disorder, PTSD, and PCBD in youth). One strategy for locating specialized measures for traumatized or bereaved youth is to review the Measures Review Database compiled by the National Child Traumatic Stress Network. This no-cost service describes measures of potentially traumatic events (including bereavement), PTSS, grief, and associated reactions; summarizes test reliability and validity data; and includes details for obtaining each measure.

When conducting an evidence-based needs assessment, it is also helpful to consider common differential diagnoses or potential comorbid diagnoses. Keeping a list of the most common conditions and comorbidities can help to prevent clinicians from missing diagnoses or underestimating co-occurring psychological problems (Jensen-Doss, Youngstrom, Youngstrom, Feeny, & Findling, 2014; Rettew, Lynch, Achenbach, Dumenci, & Ivanova, 2009). Studies of youth post-disaster have found high comorbidity of PTSS and depressive symptoms (Fan, Zhang, Yang, Mo, & Liu, 2011; Lai et al., 2013). However, PTSS can often be masked by other co-occurring psychological or behavioral difficulties (Layne et al., 2017b). For example, although PTSS can appear as a comorbid condition with ADHD (Cuffe, McCullough, & Pumariega, 1994; Weinstein, Staffelbach, & Biaggio, 2000), and PTSS and dissociative symptoms both predict future attention problems in children (Kaplow, Hall, Koenen, Dodge, & Amaya-Jackson, 2008), PTSS can often be misdiagnosed as ADHD. This diagnostic conflation between ADHD and PTSS may arise from the inherent difficulty in distinguishing between behavioral manifestations of (a) hyperactivity versus hyperarousal, (b) inattention versus avoidance or dissociation, and (c) fidgetiness versus reexperiencing symptoms. The close overlap between these dual sets of symptoms underscores the need to carefully assess whether the onset of possible ADHD symptoms temporally corresponds with the occurrence of the hurricane and/or other potentially traumatic events as precipitating causal risk factors. In such cases, practitioners should evaluate the hypotheses that (1) ADHD is comorbid with and potentially masking underlying PTSD, or, alternatively, (2) ADHD-like symptoms reflect the presence of PTSD and are not actually ADHD, as alternative explanations compared to an ADHD diagnosis alone (Layne et al., 2017b).

In our experience with treating youth in the aftermath of Hurricane Harvey, it is clear that PTSS and grief reactions often co-occur. Symptom presentations may emanate from temporally- and causally-disconnected events, such as PTSS (e.g., hyperarousal) evoked by hurricane exposure that co-occurs with grief reactions (e.g., yearning for the deceased) to a prior death. Alternatively, PTSS and grief reactions may co-occur because they each emanate from the same event (traumatic bereavement; e.g., being killed by natural disaster, murder, suicide) (Layne et al., 2017a). The ensuing interplay between PTSS and grief reactions can powerfully influence the nature and course of children's adjustment (Kaplow, Layne, Pynoos, Cohen, & Lieberman, 2012; Kaplow, Layne, Saltzman, Cozza, & Pynoos, 2013; Layne et al., 2001, 2008; Pynoos, 1992). Although in its early stages, the current literature points to the importance of distinguishing between PTSS and grief reactions, given that the two constructs may have different configurations of causal risk factors, vulnerability factors, protective factors, and sequelae (Layne et al., 2017a; 2017b). Further, evidence that PTS reactions and grief reactions exhibit different treatment response trajectories (e.g., PTS reactions recede significantly more during trauma-focused work than grief reactions) suggests the need for different treatment components (Grassetti et al., 2015). Clinicians' ability to formulate effective treatment plans for traumatized and bereaved youth may thus depend on their ability to accurately assess and discriminate between PTSS versus grief reactions.

Stage 3: In-Depth Ecological Assessment

After evaluating exposure to hurricane-related risk factors and other potentially traumatic events (e.g., bereavement), and commonly observed reactions to these events, clinicians can move toward a systematic in-depth ecological assessment for clinical impairment. By definition, trauma- and stressor-related disorders such as PTSD and Persistent Complex Bereavement Disorder (PCBD) have their primary causal origins located outside the individual (i.e., trauma exposure is the primary causal risk factor for PTSD; bereavement is the primary causal risk factor for PCBD)—within their surrounding ecologies. This basic distinction regarding the primary locus of causation sets these disorders apart from heavily biologically-determined psychiatric disorders such as bipolar disorder and schizophrenia (Layne et al., 2017b) and underscores the need for a thorough ecological assessment that searches for contextual factors theorized to play influential roles in causing, maintaining, worsening, or alleviating clinically significant distress, functional impairment, and risky behavior (Layne et al., 2006; Layne, Steinberg, & Steinberg, 2014). These contextual factors include:

(a) Direct-effect causal contributors to adjustment, including harmful causal risk factors (e.g., life threat, physical injury, bereavement, loss of home); and beneficial promotive factors (e.g., healthy attachment relationships, positive family connectedness; well-resourced schools).

(b) Interactive-effect moderator variables, including vulnerability factors and protective factors:

- Vulnerability factors interact with the causal risk factor to exacerbate its harmful effects on a negative outcome. For example, poor social support (vulnerability factor) after witnessing the injury of a loved one (causal risk factor) can lead to a worsening in PTSS (a negative or undesirable outcome).
- Vulnerability factors can also interact with the causal risk factor to intensify its negative effects on a positive outcome. For example, being forced to enroll in a new school where a child has no friends and feels alienated (a vulnerability factor) can exacerbate the effects of extensive damage to one's home (a risk factor), leading to a diminishment in a child's self-esteem (a positive or desirable outcome).
- In contrast, protective factors interact with the causal risk factor to buffer or mitigate its effects on a negative outcome. For example, a child's use of effective coping strategies such as emotional expression and seeking social support (both protective factors) can mitigate the harmful effects of being trapped in her home during a flood (a causal risk factor) in ways that diminish PTSS (a negative outcome).
- Protective factors can also interact with the causal risk factor to diminish its harmful effects on a positive outcome—for example, positive parent-child communication (a protective factor) regarding the death of a loved one (a causal risk factor) can preserve a child's ability to grieve in comforting, adaptive ways (a positive outcome).

(c) Mediator variables (including trauma reminders, loss reminders, and secondary adversities) are intervening links in causal chains that transmit the prior effects of causal factors (e.g., trauma, bereavement) to subsequent outcomes (e.g., PTSD, PCBD). For example, the loss of one's home during a hurricane can lead to "chain reaction" cascades of subsequent adversities, such as displacement→starting a new school→drop in school grades. Mediators can thus maintain, prolong, and even worsen distress over time (Kaplow et al., 2012; Kaplow & Layne, 2014). Mediator variables can also be conceptualized in the form of pernicious developmental cascades (Masten & Cichetti, 2010). For example, trauma exposure in an earlier developmental period (e.g., physical abuse in childhood) can lead to proximal distress (e.g., PTS reactions) and problems in functioning (e.g., behavior problems at school) within that same developmental period. These childhood school-related problems can act as mediators by cascading forward into subsequent developmental periods (e.g., affiliation with deviant peers in middle adolescence) that carry their own risks (e.g., school dropout, risky behavior such as drug and alcohol use). In turn, these accumulating problems increase one's vulnerability to the effects of subsequent stressors (e.g., hurricane exposure), exacerbating their harmful effects and setting the stage for further developmental disruption (e.g., school dropout, criminal activity in older adolescence) (Layne et al., 2017a). These findings underscore the need to assess for both current and prior trauma exposure, as well as co-occurring psychological and behavioral problems, to create opportunities for early intervention (Layne et al., 2014a).

Evidence of differential relations between theorized causal risk factors and their consequences further illustrates the need for conceptual clarity and measurement precision when assessing the ecologies that surround traumatized and bereaved youth. For example, studies of youth post-disaster have found that unlike the dose-response pattern that consistently emerges for PTSS, neither level of disaster exposure nor proximity to the disaster are consistently associated with depressive symptoms (Kronenberg et al., 2010). Such findings point to the conclusion that disaster-related causal risk factors and their primary consequences (e.g., PTSD, PCBD, depression) are not functionally interchangeable. More specifically, simple summative scoring (i.e., creating a sum of different types of exposure-related risk factors, where a higher total score denotes greater risk), although potentially helpful in initial risk screening, loses theoretically informative and clinically actionable information when applied to needs assessment—that is, in identifying the causal consequences of such exposures and associated needs and targets for intervention. Summative scoring across exposure types during needs assessment can thus impede efforts to identify who is at risk for what, through what causal pathways, and to identify targets for early intervention to prevent cascading effects (Layne et al., 2014c). Summative scoring can thus lead to the erroneous and inefficient conclusion that everyone is at risk for every problematic outcome, and thus everyone requires every mental health service (i.e., indiscriminately prescribing all treatment components) to prevent or reduce those outcomes (Layne et al., 2009).

Compared to Stage 2 assessment, Stage 3 ecological assessment uses more rigorous and comprehensive tools, including semi-structured or structured diagnostic interviews that focus not only on PTSS and related psychological and behavioral conditions, but also environmental vulnerability and protective factors (Sheehan et al., 1998). The reliability of these methods is substantially higher than unstructured interviews (Garb, 1998), increasing the accuracy of diagnosis, case conceptualization, and treatment planning. Semi-structured interviews carry the added value of offering the clinician greater flexibility in addressing pre-existing developmental (Kaplow et al., 2012; Kaplow & Layne, 2014) and cultural factors (Contractor et al., 2015) that can influence the specific ways in which post-disaster posttraumatic stress or grief reactions manifest in children and adolescents (Nader & Layne, 2009). In this stage of evaluation, diagnostic interviews and self-report checklists (utilized in Stage 2) complement one another in guiding and informing clinical diagnosis and treatment planning.

Throughout the process of treatment planning, EBA also calls for the integration of idiographic (client-centered or client-nominated) information, such as asking clients to identify their highest priority or "top" problems, with nomothetic (norm-referenced) information as gathered using standardized tests (Layne et al., 2017b). This integrative approach captures the complementary strengths of both methods, including client engagement and making treatment outcomes transparent and relevant to children and adolescents (Weisz et al., 2011). Being sensitive to clients' values is especially relevant to the assessment of traumatized and/or bereaved youth for whom developmental factors, culture, and personal life experiences may markedly influence how they exhibit distress, impairment, and/or adaptation (Kaplow et al., 2012). Clients' beliefs about the causes of their distress reactions, as well as how to best address them, also vary widely, can change over time, and can influence their willingness to engage in assessment and treatment. For example, in the more immediate aftermath of disaster, children may be focused primarily on the acquisition of basic needs (e.g., finding a new permanent home), but may later be concerned with reducing distress in response to trauma reminders (e.g., experiencing panic when faced with stormy weather). When patient beliefs align with clinicians' line of questioning and use of assessment tools, the chances of rapport building, treatment adherence, and treatment success markedly improve (Yeh et al., 2005). This information, gathered through Stage 3 Ecological Assessment, can be shared (with permission) with other providers and those working closely with the children (e.g., school counselors, case managers), thereby streamlining the acquisition and use of information while avoiding repetition.

Stage 4: Surveillance and Treatment Monitoring

If Stage 3 in-depth ecological assessment identifies the need for treatment, then the goal of assessment shifts to measuring and monitoring therapeutic process and progress (Youngstrom & Frazier, 2013). Process measures can include tracking whether the patient completes homework assignments, such as keeping track of trauma reminders, associated reactions, and consequences. Technology, such as text-messaging, now makes it easier to automatically schedule client reminders for activities and to track completion rates. A variety of brief progress measures are also available that are sensitive to change, allowing clinicians to monitor therapeutic progress (e.g., Wells, Burlingame, Lambert, Hoag, & Hope, 1996; see Beidas et al., 2015, for a review of no-cost measures). Session- by-session progress measures, even though brief, can significantly improve outcomes and provide a valuable cue to revisit treatment planning if the client is not making expected gains. Once clients have reached their goals, termination planning can incorporate monitoring strategies that can trigger a booster session or return to treatment (Lambert, 2010). Identifying disaster-related anniversaries, bereavement anniversaries, developmental milestones, or other reminder-laden situations ahead of time, and developing proactive plans for how to manage them, improves the prospect for maintaining treatment gains (Saltzman et al., 2018).

Conclusions

Unfortunately, experts expect natural disasters, including hurricanes, to increase in intensity and frequency in the foreseeable future (U.S. Global Change Research Program, 2016), and these events can adversely impact significant numbers of children and adolescents worldwide (UNISDR, 2015). A growing body of research is shedding light on how youth typically respond to hurricanes and on factors that can exacerbate or mitigate their effects. EBA principles have the capacity to inform all stages of evaluation necessary in the aftermath of disaster, including risk screening/situation analysis, mental health needs assessment, in-depth ecological assessment, and treatment planning/monitoring (Layne et al., 2009; Youngstrom, 2013). EBA also provides rigorous yet practical strategies to guide the assessment of hurricane-exposed youth in ways that can improve the effectiveness (maximizing the likelihood of successful outcomes), efficiency (matching individuals to the types of services they need), and coherence (adding clarity to assessment tool selection, case formulation, and intervention planning) of mental health intervention efforts. EBA can also assist with the coordination of other services across the post-disaster recovery landscape by providing necessary information (e.g., situation analysis, mental health needs assessment) to other providers, school personnel, and case managers working with hurricane-affected youth. It is our hope that the use of EBA in the aftermath of Hurricane Harvey, and the lessons we continue to learn from its implementation, will help to lay the foundation for future recovery efforts in the years to come.

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Acknowledgements

Grants from SAMHSA (SM-16008 and SM-062111), the Hurricane Harvey Relief Fund of the Greater Houston Community Foundation, and the Children's Health Fund given to the first author supported this work in part. We are especially grateful to the many children and families who shared their experiences with us in the aftermath of Hurricane Harvey.

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General Interest

Improving the Effectiveness of Intimate Partner Violence Screening: Results From a Local Needs Assessment

Key words: intimate partner violence, domestic violence, screening, needs assessment

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Background

Intimate partner violence (IPV) is a serious, preventable public health problem that affects millions of Americans. The term "intimate partner violence" describes physical violence, sexual violence, stalking and psychological aggression by a current or former intimate partner[1]. An intimate partner is a person with whom one has a close personal relationship that can be characterized by emotional connectedness, regular contact, ongoing physical contact and/or sexual behavior, identity as a couple, or familiarity and knowledge about each other's lives (Centers for Disease Control and Prevention, 2015).

IPV has both immediate and long-term physical and mental health effects. Immediate health effects include physical injuries, sexually transmitted diseases, HIV, unintended pregnancies, psychological distress, and even death (Nelson, Bougatsos, & Blazina, 2012). Long-term health impacts include panic attacks, depression, anxiety, post-traumatic stress disorder, substance abuse, gastrointestinal disorders, chronic pain, headaches, difficulty sleeping, activity limitations, asthma, and diabetes (Breiding, Chen, & Black, 2014; Center for Disease Control and Prevention, 2014; Nelson, Bougatsos, & Blazina, 2012). In addition, children who are exposed to IPV are at increased risk for abuse and neglect, mood and anxiety disorders, post-traumatic stress disorder, substance abuse, and school-related problems (Wathen & MacMillan, 2013).

An estimated 36.4% of women and 33.3% of men in the United States experience physical violence, sexual violence, or stalking by an intimate partner at some point in their lives (Centers for Disease Control and Prevention, 2015). Heterosexual women are five to eight times more likely than heterosexual men to be victimized by an intimate partner, and for adolescents, the rates of experiencing some form of dating violence vary from 25-60%. These numbers may underrepresent the true rates of abuse because IPV is often underreported for a variety of reasons, including shame, fear, and reprisal (Catalano, 2012). Consequently, all healthcare settings and professionals providing care are likely treating patients affected by IPV and are in a position to screen, identify, and intervene on behalf of victims.

IPV survivors access health care at higher rates than the

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[1] *Physical violence is defined as the intentional use of physical force with the potential for causing death, disability, injury, or harm. Sexual violence includes: 1) Use of physical force upon someone to engage in a sexual act against his or her will, whether or not the act is completed; 2) Sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act. Psychological or emotional violence involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological or emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources (Centers for Disease Control and Prevention, 2015).*

general public, but IPV screening remains challenging. Major medical organizations recommend screening. In 2013 and again in 2018 the U.S. Preventive Services Task Force recommended providers screen for IPV with moderate evidence. This was a reversal of their previous recommendation not to screen due to insufficient evidence. An effective IPV screening program must include a screening tool with sound psychometric properties. A systematic review conducted to summarize IPV screening tools tested in healthcare settings, and provide a discussion of existing psychometric data and an assessment of study quality, concluded that no single IPV screening tool had well-established psychometric properties (Rabin, Jennings, Campbell, & Bair-Merritt, 2009). Only a small number of studies evaluated even the most common tools. Sensitivities and specificities varied widely within and between screening tools. Further testing and validation are needed.

While most healthcare professionals report that they believe IPV is a healthcare issue (Richardson et al., 2001), providers report many barriers to screening. Barriers include: time constraints, lack of knowledge and training on what to do for the victim, lack of policies and procedures for screening, discomfort with the topic, fear of offending the patient or partner, need for privacy, perceived lack of power to change the problem, belief that the victim will not leave the abusive relationship, misconceptions regarding the patient population's risk of IPV, lack of referral options, different health priorities, and a lack of evidence for effective interventions (Hamberger, Rhodes, & Brown, 2015; Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000; Garcia-Moreno, Jansen, Ellsberg, & Watts, 2014; Hegarty, Feder, & Ramsay, 2006).

These findings coupled with varying levels of commitments to screen for IPV at some institutions have led to inconsistencies in care. While experts have identified that "many research questions remain unanswered regarding the range of optimal approaches to IPV screening," some major healthcare organizations have made recommendations on screening practices (Miller, McCaw, Humphreys, & Mitchell, 2015, p. 94)

For example, the American College of Obstetricians and Gynecologists' recommendations for healthcare providers include:

1. Screen for IPV in a private and safe setting.
2. Prior to screening, offer a framing statement to show that screening is done universally and that the screening will be confidential.
3. Incorporate IPV screening into the routine medical history so all patients are screened regardless of if abuse is suspected.
4. Develop partnerships with agencies that offer IPV services.
5. Regularly offer IPV training to staff.
6. Have printed resource sheets available.
7. Use non-judgmental language that makes the patient comfortable (American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women, 2012).

Methods[2]

Despite widespread recommendations for providers to screen for IPV, screening rates remain low in healthcare settings (Waalen et al., 2000; O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011). To address this gap in practice, we conducted a community needs assessment of IPV screening practices in Houston, Texas (Correa, 2018). The goal of this assessment was to understand current practice and identify opportunities to improve the screening, identification, and referral of survivors of IPV. We interviewed 26 local experts on IPV, agencies that provide IPV services, and organizations that screen for IPV. We consulted with a local agency that convenes organizations that provide services to survivors of IPV to identify organizations and people to interview.

In addition to interviews with key stakeholders, we conducted three focus groups with 17 survivors of IPV to understand how to improve the effectiveness of IPV screening and connect survivors with resources. Three agencies that offer services to survivors of IPV aided in the recruitment of participants. Baylor College of Medicine provided IRB approval. The interview guide is available by request to the authors, and a detailed write-up of the methodology and results is under review by

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[2] *Adopted from Correa, 2018. An assessment of screening for intimate partner violence. Texas Children's Hospital and Baylor College of Medicine. Accessed April 18, 2018. Available at* https://www.texaschildrens.org/sites/default/files/uploads/IPV%20Assessment%20Final.pdf

the *Journal of Interpersonal Violence*.

Results of the Local Assessment

Interviews

The assessment revealed inconsistent practices both between and within institutions. While some institutions had created standard protocols, the screening protocols varied dramatically between the sites with regard to who was screened, who did the screening, how the patient was screened, how often the patient was screened, and which screening tool was used. For example, some practices screened verbally while other practices used a paper screener; some practices used validated screening tools while other practices had developed their own questions.

Most of the local healthcare organizations that the research team interviewed were unable to provide data to determine the number of patients screened, the rate of positive screens, the follow-up to the positive screens, and the outcomes of patients referred to services. Some of the organizations provided estimates, which ranged from just a few positives each year to 5% of the patient population.

However, locally there was consistency in the response to a positive screen, which included: referral to a social worker, nurse, or designated internal IPV advocate; safety assessment; and connection to an IPV agency if the patient consents. IPV agencies reported that they received some referrals from healthcare organizations, but the number of referrals was relatively small.

Focus Groups

We conducted three focus groups with survivors of IPV. The participants ranged from 22 – 70 years of age and 65% were receiving public assistance. The participants were a diverse group of women and 36% identified as white, 29% Hispanic, 29% Black, and 6% American Indian. The focus groups resulted in the identification of five themes. One of the identified themes addressed that screening in health care must be improved to effectively identify and refer survivors. Approximately half of the participants reported they had been screened for IPV by a healthcare professional, but the participants shared many reasons as to why they did not disclose the abuse to a healthcare provider and ways that screening can and should be improved:

- Screen alone. Many of the participants said their abuser was with them when they were screened for IPV so they were unable to answer truthfully.

“It’s hard to fill out forms when they’re right next to you, watching you… Number one, you have to admit to yourself that there’s a problem at home. You know, and you don’t want to do that. Number two, they’re right there next to you and you’re like, ‘Mmmm, no issues!’ You know? So, you just kind of have to just hope for the best.”

“You can’t even, like, signal to them because it’s scary. It’s, it’s like you’re being held hostage. You can’t tell nobody.”

- Tell patients what you will do if they respond “yes” before you screen. Some of the participants expressed fear of not knowing what would happen if they responded truthfully to the screen, and suggested that they would be more likely to disclose if they knew what would happen next. In addition, many participants shared that they did not understand the legal system and were fearful of losing custody of their children if they disclosed.

“Then he finds out you told them and it’s like all like hell broke loose again.”

“You’re always faced with the question of, ‘Should I tell or should I not?’”

“The, ‘Do you feel safe?’ [question]. No, I, because I couldn’t see past that question. If I said yes, ‘No, I don’t feel safe. No.’ Then what happens?”

- Improve rapport. Many of the participants reported that they would be more likely to disclose if the providers had better rapport such as listening, making eye contact, and caring for the patient.

“Early identification of IPV is complicated because there is shame. Screening must be authentic, compassionate, and realistic. Survivors are scared of being reported to authorities. It must be realistic because the available services are limited.”

- Ask more specific questions. Many of the participants did not realize they were in abusive relationships for years because the abuse was not physical. Some participants reported having to sign their paychecks to their abusers and losing their jobs because they weren't allowed to return to work until their bruises healed. The participants recommended asking specific and direct questions that included questions on non-physical abuse.

"Honestly, I didn't know. I really thought it was the norm and I have been dealing with it for a long time. I knew something wasn't right. I just thought it was, 'You know, he has anger because, you know, he is military. He's been deployed,' different things like that… It didn't really, like, really hit me that it was 'abusive.'"

"They, they can control you so well, they don't have to hit you."

- Tailor the referrals and follow-up from a positive disclosure to the individual patient's circumstance to decrease the risk of violence for the patient. The participants had different preferences on the safest mode of communication with the healthcare institution.

In addition to specific recommendation on the role of health care, the participants offered insights to the important role of families and communities in the recognition and response to IPV:

- Families and children are a key driver to a survivor's decision to stay or leave a violent relationship. Many of the participants reported that their family and the family of the abuser were aware of the abuse. Several participants reported that their abuser's family noticed and asked the survivor about the abuse. Many of the survivors disclosed the abuse to their own family and received a wide variety of responses ranging from not believing the survivor to providing tremendous support and a safe place for the survivor and the survivor's children to live. In other cases, it seemed that the families accepted the abuse. The participants were all in agreement that their children were a top priority, but in some cases the children were the reason that the survivor stayed in the abusive relationship, and in other cases the children were the reason the survivor left the relationship. Participants also shared their fears of their children being taken away if they left the relationship or reported the abuse.

"I had a kid so I really didn't want to leave him 'cause kids need their dad."

"It finally started getting to the point where it was leading to physical abuse and that's when I said, 'That's it.' I have two boys and they're, one is a preteen and one is a teen. And I didn't want them to grow up feeling like that, that was normal and that's a relationship."

- Engage with communities. Participants agreed that solely screening in the healthcare setting is not sufficient and a broader community-wide strategy is needed to effectively screen, identify, and connect survivors with community resources. Participants felt that more education and public awareness is needed around IPV, especially non-physical abuse. Participants recommended a variety of venues to educate the community on IPV including public bathrooms, grocery stores, libraries, schools, daycares, hair and nail salons, churches, and pediatric offices. In addition to these venues, several participants shared that their workplace played a critical role in identifying and leaving the violent relationship. Two participants became aware that they were in an abusive relationship from a presentation and research at work. Participants also shared that their workplace played a critical role in leaving the abusive relationship by transferring them to a different office and through the services offered by an employee assistance program (EAP). In addition to increasing education and awareness of IPV in the community, most of the participants shared stories of calling the police to report abuse. A few of the participants shared positive stories about the response from law enforcement, but the majority of participants described negative experiences with law enforcement and the need for more training and better responses.

Discussion

While we applaud providers and institutions that screen for IPV, we must consider *how* we are screening and not just if we are screening for IPV. Screening for IPV cannot merely be part of a checklist sandwiched between questions on eating and sleeping habits. Without attention to how screening is conducted, providers will inevitably receive negative responses from patients and perhaps miss opportunities to offer critical support to families in crisis.

Providers that choose to screen for IPV must screen patients alone since survivors are unable to disclose abuse in the presence of their abuser. Institutions must develop protocols and identify opportunities to isolate the patients, whether it is an institutional policy that patients are always seen by themselves for a part of the healthcare visit to discuss sensitive issues and screen for IPV or having healthcare providers escort patients to the bathroom for a urine sample if the partner refuses to leave the room.

Providers must take steps to show compassion through making eye contact and listening. Prior to screening providers need to provide an explanation as to why they are asking the questions and what they will do if the patient discloses abuse. This can be done verbally or written on a paper or electronic screener. This help builds rapport with patients, decreases perceptions of judgement, and may help alleviate fears. Fear of retaliation, safety, and losing custody of children are the most common barrier to women disclosing abuse across cultures (Montalvo Liendo, 2008). For example, prior to screening providers might state, "We care about the safety and health of all of our patients, so we ask all patients about violence in the home. If you respond yes, I will talk to you privately about your answers and your answers will not be shared with anyone, including your partner."

Providers must also ask specific and direct questions and avoid generic questions such as, "Do you feel safe at home?" or, "Are you in abusive relationship?" Many survivors of IPV, especially survivors that are not experiencing physical violence, may not identify their partner's behavior as abusive, so specific and direct questions that include questions on emotional abuse are needed.

In addition, as practices incorporate IPV screening into their practice, more evaluation and research is needed to improve our understanding of the best methods to both screen and respond to IPV. While the research is clear that IPV is prevalent and providers have an opportunity to identify survivors of IPV, we must be diligent in *how* we are screening and responding to IPV to provide survivors a true opportunity to disclose and seek support.

About the Authors

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Improving the Effectiveness of Intimate Partner Violence Screening: Results From a Local Needs Assessment

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Suicide-Related Behaviors Among Abused and Maltreated Youth: A Call to Action and Recommendations for Providers

Key words: suicide, prevention, youth, adolescence

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Suicide is the second leading cause of death among U.S. adolescents (Centers for Disease Control and Prevention, 2018). Given associations between child abuse and maltreatment and suicide-related behaviors (e.g., Norman et al., 2012), service providers who work with abused and maltreated youth have a unique opportunity to reach those adolescents at high risk for suicide-related behaviors, provide support, and ensure that they receive appropriate services. With increased awareness of risk markers for suicide-related behaviors, knowledge of the types of services available to at-risk youth, and training in identifying and assessing suicide risk, service providers working with abused and maltreated youth can and will save more lives. In support of this mission, we provide a brief overview of suicide-related behaviors, indicators of suicide risk among adolescents, the association between child abuse/maltreatment and suicide, and preventive interventions for reducing suicide risk. Finally, for service providers that wish to actively support suicide prevention among abused and maltreated youth, we provide several suggested action steps for advancing suicide prevention across a variety of disciplines.

Adolescent Suicide Is a Serious Public Health Concern

From 2007-2016, suicide accounted for more than 11,000 deaths among children aged 12-17 years (Centers for Disease Control and Prevention, 2018). While suicide is rare prior to the onset of adolescence, the suicide rate increases from 0.29 per 100,000 to 17.32 per 100,000 between 10-21 years of age, a nearly 60-fold increase, and remains elevated throughout adulthood (Centers for Disease Control and Prevention, 2018). Suicide ideation and attempts are also frequent during adolescence: Data from a nationally-representative survey of U.S. high school students indicate that 17.7% of students reported seriously considering suicide in the past 12 months and 8.6% reported a suicide attempt (Kann et al., 2016a). Suicidal thoughts and attempts are frequent among middle school students as well (Centers for Disease Control and Prevention, 2017). One recent estimate places the economic impact of suicide and suicide attempts among 15-24 year olds at over $15.5 billion in 2013 alone (Shepherd, Gurewich, Lwin, Reed, & Silverman, 2016). The elevated rate of suicide-related behaviors during adolescence indicates the enormity of the unaddressed mental health burden among this population. Further, child and adolescent suicide ideation is associated with negative mental health outcomes and lower socioeconomic status in adulthood (Reinherz, Tanner, Berger, Beardslee, & Fitzmaurice, 2006). Taken together, these data point toward adolescence as a key period for addressing suicide risk and demonstrate a need for awareness, screening, and intervention to effectively prevent suicide-related behaviors.

Risk Markers for Adolescent Suicide-Related Behaviors

In the empirical literature, research has identified a wide array of risk markers and warning signs of adolescent suicide-related behaviors (King, Ewell Foster, & Rogalski, 2013; Gould, Greenberg, Velting, & Shaffer, 2003). A risk marker can be thought of as *indicative of risk* for suicide, but not necessarily *predictive of risk* for suicide. In contrast, warning signs are factors indicative of *immediate* concern and should prompt assessment by a healthcare professional and, potentially, life-saving action. Psychiatric risk markers include a range of psychiatric symptoms and disorders associated with increased suicide ideation, suicide attempts, or suicide, including anxiety (Hill, Castellanos, & Pettit, 2011), depression, behavior problems, substance abuse (Brent et al., 1993; Nock et al., 2013), and post-traumatic stress (Waldrop et al., 2007). Interpersonal and social risk markers include bullying, peer rejection, perceived parental support, parent-child conflict, social isolation (Kim & Leventhal, 2008; King & Merchant, 2008), perceived burdensomeness, and thwarted belongingness (Hill & Pettit, 2014; Van Orden et al., 2010). Cognitive risk markers include hopelessness and low self-esteem (Beautrais, Joyce, & Mulder, 1999), avoidant coping strategies (Kaplow, Gipson, Horwitz, Burch, & King, 2014), and problem-solving difficulties (Speckens & Hawton, 2005). Experiential risk markers include adverse childhood experiences (ACE), such as childhood instability, physical abuse, neglect, sexual abuse, family violence (Thompson et al., 2012), stressful life events (Kaplow et al., 2014), discrimination (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009) and contact with the juvenile justice system (Abram et al., 2008). Demographic indicators of risk include gender, age, race/ethnicity, and sexual orientation (Gould et al., 2003). The presence of risk markers can identify individuals or groups at elevated risk for suicide-related behaviors and, if supported by longitudinal findings, may indicate possible targets for interventions to prevent suicide among youth.

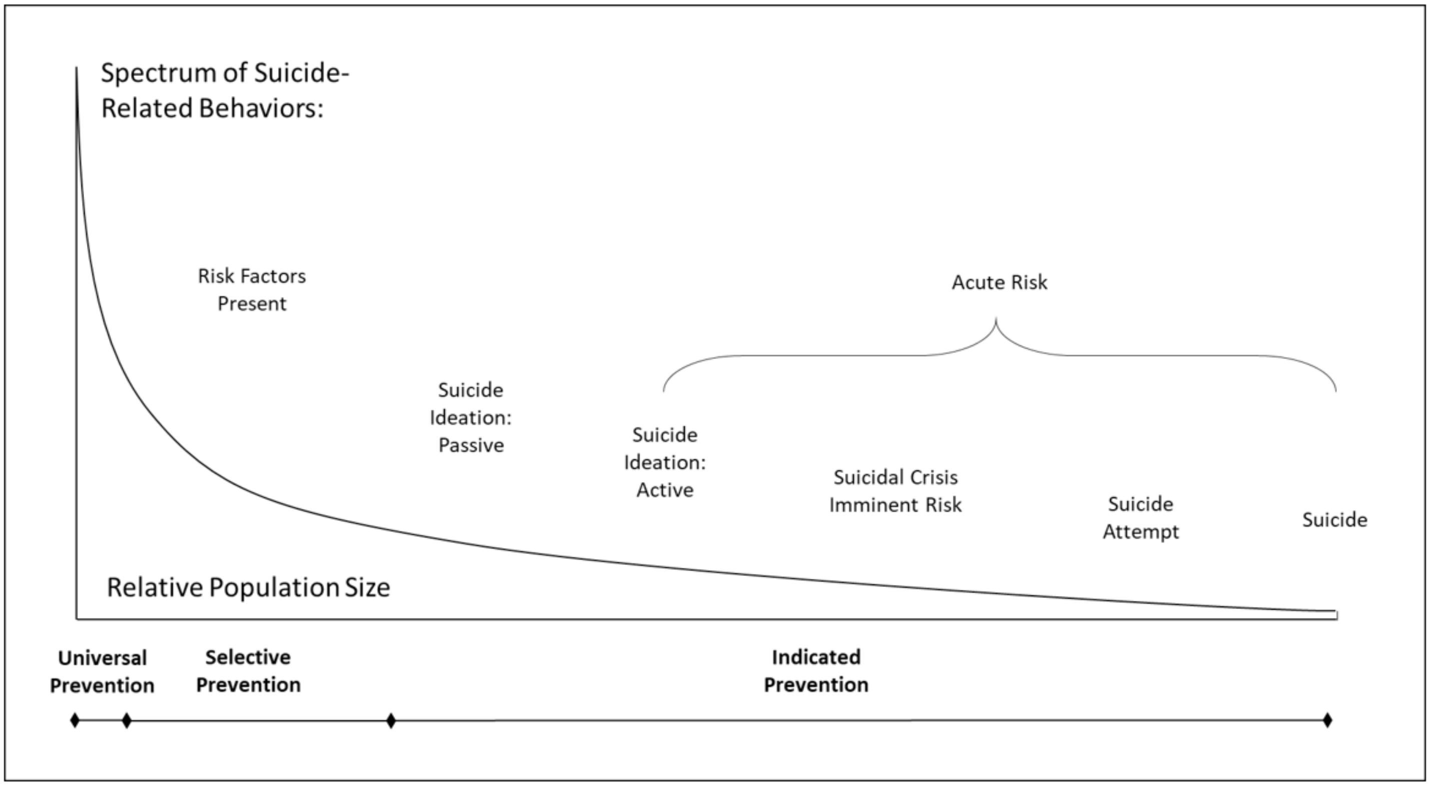
As described above, warning signs are proximally-situated factors that indicate *immediate* or *imminent* risk and the need for prompt risk assessment by a professional, as life-saving action may be necessary. Warning signs may be conceptualized as a subset of risk markers that are indicative of the possibility of acute escalation of suicide risk in the present or very near future (Freedenthal, 2018). As identified by Rudd (2014), warning signs may include frequent, intense suicidal thoughts, suicidal intent, preparations for suicide (such as gathering necessary materials, writing a will, or preparing a note), agitation, hopelessness, recklessness, feeling trapped, and having no reasons for living, among others. It is particularly important that service providers be vigilant for the presence of warning signs.

Suicide-Related Behaviors and Child Maltreatment

A substantial body of empirical evidence demonstrates associations between childhood abuse and maltreatment and suicide-related behaviors in adolescence and adulthood (Devries et al., 2014; Liu et al., 2017; Norman et al., 2012; Zatti et al., 2017). A meta-analysis of 124 studies found significantly increased odds of a suicide attempt among adults who were victims of childhood physical abuse, emotional abuse, and neglect (Norman et al., 2012). Other recent meta-analyses found similar results, with childhood sexual abuse, physical abuse, emotional abuse, and physical neglect each associated with suicide attempts up to 30 years later (Devries et al., 2014; Liu et al., 2017; Zatti et al., 2017).

Numerous individual studies concur with the findings of these meta-analyses, indicating that child abuse and maltreatment are associated with suicide-related behaviors across the lifespan: Sexual and physical abuse prior to age 16 years were significantly associated with suicide ideation and suicide attempts among adolescents, older adolescents, and young adults (Fergusson, Boden, & Horwood, 2008). Having a greater number of ACEs was significantly associated with younger first attempts as well as repeat attempts over a lifetime (Choi, DiNitto, Marti, & Segal, 2017). Data from a nationally-representative study of U.S. adults identified significant associations between childhood physical and sexual abuse and suicide ideation and

Figure 1. Universal, Selective, and Indicated Suicide Prevention



attempts in adult women (Afifi et al., 2008). The study found a similar pattern of results for adult men, with childhood physical and sexual abuse associated with suicide attempts (Afifi et al., 2008). Childhood experience of physical abuse, psychological abuse, and neglect have even been associated with new onset of suicide ideation and suicide attempts in adulthood, after controlling for sociodemographic characteristic and comorbid mental health disorders (Enns et al., 2006). This body of literature provides clear evidence that childhood abuse and maltreatment are associated with a sustained increased risk of suicide ideation and attempts across adolescence and into adulthood. Very few studies to date have examined the mediating mechanisms that may help to explain the relation between child abuse/maltreatment and future suicide risk. Some preliminary evidence suggests that maladaptive coping strategies (e.g., Kaplow et al., 2014) and/or severe interpersonal difficulties (Johnson et al., 2002) may increase the likelihood of suicide risk following trauma in general. Future studies that help to clarify these and other potential mechanisms are needed.

A Brief Review of Suicide Prevention

Given links between childhood abuse/maltreatment and suicide-related behaviors and associated psychological, societal, and economic costs, suicide prevention efforts for victims of abuse and maltreatment are an important public health issue. The complex nature of suicide risk screening and detection, the variable nature of suicide risk, and the fact that psychiatric and psychosocial treatments for suicidal youth are not universally effective, means that no single screening or treatment program is sufficient to reduce suicide risk across all at-risk populations. Optimal suicide prevention requires a multi-layered network of screening and preventive interventions that occur at several points in time and across a variety of settings so that all youth have multiple opportunities to be identified and referred for appropriate services. Understanding the complex landscape of suicide prevention can help service providers better understand the available resources and services, identify ways to contribute to suicide prevention, and more effectively advocate for children in need.

As depicted in Figure 1, prevention occurs in three general phases: universal, selective, and indicated, with each corresponding to a different level of risk (Munoz, Mrazek, & Haggerty, 1996). Universal prevention includes broad approaches delivered to an entire target population, regardless of individual level of risk. Examples of universal prevention include using seatbelts to prevent injury during traffic collisions and adding fluoride to drinking water to prevent tooth decay. Selective prevention includes interventions delivered to a subset of the general population at increased risk of some negative outcome, as determined by the presence of a predefined risk marker. For example, doctors may identify patients with high blood pressure (a predefined risk marker) and prescribe medication to reduce the likelihood of a heart attack. Finally, indicated prevention includes interventions that are directed toward individuals with detectable levels of a disorder in order to prevent progress of the disease or to reduce the duration of illness. For example, providing antiretroviral medication to individuals living with human immunodeficiency virus (HIV) can prevent progression from HIV to acquired immunodeficiency syndrome and reduce disease mortality.

As prevention shifts from the universal phase to the selective and indicated phases, the intensity of interventions typically increases. Universal prevention may involve brief advertisements or interventions delivered to very large groups, where individual attention is highly limited and the cost per person (in terms of financial cost, time spent, and resources required) is low. In contrast, indicated prevention is often one-to-one, with highly trained service providers or expensive procedures (e.g., hospitalization). Fortunately, as the intensity of prevention efforts increases, the size of the population in need of such intensive services typically decreases. Knowing what services exist at each level of prevention can aid in determining which services may be most appropriate for a given child – and avoid either under- or over-application of resources.

Universal Prevention

In terms of suicide prevention, universal approaches often include training gatekeepers or peer leaders to notice warning signs of suicide and increase participants' knowledge of appropriate action when encountering a suicidal individual (Isaac et al., 2009; Wyman et al., 2010). For example, the Question, Persuade, Refer (QPR) program teaches individuals to recognize warning signs for suicide and encourage treatment-seeking (Quinnett, 1995). QPR has been shown to increase knowledge of suicide warning signs among teachers, counselors, and hospital employees (Cross, Matthieu, Cerel, & Knox, 2007; Reis & Cornell, 2008). A similar program, ASK About Suicide to Save a Life, also provides training so that anyone can learn to recognize warning signs of suicide (Mental Health America of Texas, 2013). The Sources of Strength program (Wyman et al., 2010), seeks to increase awareness of suicide risk factors and encourage help-seeking in high schools through training peer leaders to recognize suicide risk. A similar program for use by the military is called ACE, Ask, Care, Escort. ACE is a friend/bystander support program, which increases active duty service members' awareness of the potential for suicidality in fellow service members and provides instruction to calm the upset person and escort them to a professional for care (United States Air Force, 2018). A substantial body of research supports the efficacy of these programs for increasing knowledge related to suicide risk factors and warning signs and increasing help-seeking (Isaac et al., 2009). However, evidence demonstrating whether these prevention-through-awareness programs result in significant reductions in suicide-related behaviors is less well documented (Isaac et al., 2009). Other universal prevention efforts include programs to increase awareness of suicide as a public health issue and efforts to support increased gun safety.

Selective Prevention

With regard to selective prevention, programs vary widely depending on the targeted risk marker. For example, gay, lesbian, and bisexual adolescents report highly elevated rates of suicide-related behaviors (Kann et al., 2016b). As a result, efforts have been made to support gay, lesbian, and bisexual youth, including introducing gay-straight alliances and safe spaces in schools or promoting supportive messaging for sexual and gender minority youth (e.g., the It Gets Better campaign; www.itgetsbetter.org). Interventions to address mental health, such as depression, anxiety, bereavement, and post-traumatic stress responses also act as selective prevention approaches (e.g., Lejuez, Hopko, & Hopko, 2001; Saltzman et al., 2017). Programs to help abused and maltreated youth, either by removing them from the abusive setting or helping them to cope with the mental health consequences of those experiences, would also constitute selective prevention. Though empirical studies of such interventions seldom consider suicide risk as a targeted outcome, given that they address known risk markers for suicide-related behaviors, these programs serve as selective prevention approaches.

To date, selective preventive interventions specifically designed to reduce suicide risk have received less empirical attention. Links to Enhancing Teens' Connectedness is a selective preventive intervention for bully victims, bully perpetrators, and socially isolated adolescents (Gipson, King, Opperman, & Ewell-Foster, 2014). Links to Enhancing Teens' Connectedness utilizes both adolescent-nominated mentors and trained community mentors to help adolescents build supportive relationships (Gipson et al., 2014). Another selective preventive intervention is the Learn, Explore, Assess Your Options, Do (LEAD) intervention, a web-based brief intervention for adolescents who perceive that they are a burden on others (Hill & Pettit, 2016).

Indicated Prevention

In the case of suicide prevention, indicated prevention involves programs designed to treat suicide ideation in order to prevent suicide attempts and deaths. Indicated outpatient therapy focuses on managing and reducing suicide risk. Dialectical Behavior Therapy is an outpatient therapy modality frequently used with chronically suicidal patients. Dialectical Behavior Therapy includes both individual and group therapy components, in-the-moment skills coaching for managing crises, and case management (Melhum et al., 2014; Miller, Rathus, & Linehan, 2017; Rathus & Miller, 2014). The Collaborative Assessment and Management of Suicidality is an outpatient therapy approach for assessing, monitoring, and managing suicide risk; research supports the efficacy of this approach for reducing suicide risk (Jobes, 2006, 2012). In addition to outpatient programs, many clinicians utilize safety planning as an additional prevention step. Safety planning involves developing a written plan for patients to manage their suicidal thoughts and urges via distraction, social support seeking, and maintaining a safe environment (Stanley & Brown, 2012).

Other indicated suicide prevention programs focus on the management of imminent suicide risk. These include crisis lines, such as the National Suicide Prevention Lifeline (www.suicidepreventionlifeline.org), The Trevor Project Lifeline (www.trevorproject.org), and the Crisis Text Line (crisistextline.org), as well as inpatient hospitalization, which provides a space for youth to receive psychiatric care and remain safe during a suicidal crisis. It should be noted, however, that these imminent risk responses are safety-oriented and time-limited and should not be used as standalone therapies. Crisis management and imminent risk hospitalizations should be followed by acute risk management approaches, such as the aforementioned outpatient therapy approaches, once the suicidal crisis has passed.

Summary

A variety of programs, ranging from brief universal programs to intensive outpatient treatment and inpatient hospitalizations, are available to help reduce the risk of suicide among youth (for a detailed review, see Calear et al., 2016). While there is need for further development of suicide prevention approaches, and some programs are not yet widely available, the science of suicide prevention is constantly evolving, with the goal of making suicide prevention available to everyone. Efforts are needed to expand those services supported by the empirical literature, and to evaluate those services that have not yet been studied empirically. For those working with potentially suicidal youth, awareness of existing services can aid in referring youth to appropriate interventions.

The Role of Abuse/Maltreatment Service Providers in Suicide Prevention

Those who provide services to youth who have dealt with child abuse and/or maltreatment play a role in suicide prevention. It is vital for those working with these youth to be aware of their increased vulnerability to suicide-related behaviors and to be knowledgeable about appropriate action steps, referrals for additional care, and emergency resources. Given the elevated risk of suicide-related behaviors among abused and maltreated children, any efforts providers can make to identify suicide risk and provide appropriate referrals have life-saving potential.

Recognize Risk

Since child abuse and maltreatment have been consistently associated with suicide risk, anyone working with abused and maltreated youth is, by default, working with an at-risk population. This makes the process of identifying youth with acute or imminent suicide risk both more critical and more challenging. While abuse and maltreatment may be the most prominent indicators of increased suicide risk in this population, their critical nature may overshadow the presence of co-occurring risk markers. Thus, it is important that service providers take the time to actively consider additional indicators of suicide risk and pay particular attention to youth with multiple sources of risk, as reviewed above. Critically, service providers should pay particular attention to the presence of warning signs as indicators that immediate action is needed.

To assist with identifying at-risk youth, service providers working with abused and/or maltreated youth may wish to acquire formal training in recognizing the warning signs of suicide. Several training programs exist to provide instruction in recognizing warning signs, asking about suicide, and encouraging appropriate help-seeking behavior. The QPR program provides brief training modules, both in person and online, to promote active recognition of suicide risk (Quinnett, 1995). QPR uses a three-step approach of recognizing and asking about suicide risk, encouraging others to seek professional assistance, and referral to appropriate resources. The American Association of Suicidology also provides accredited training programs for clinicians, physicians, and others for recognizing and responding to suicide risk (www.suicidology.org). The American Foundation for Suicide Prevention provides similar programs for early risk detection, designed for educators and others (www.afsp.org).

Screen for Suicide Risk

Service providers may also wish to include suicide risk screening as a regular part of working with abused and maltreated youth. Numerous suicide screening measures exist, some of which include formal training programs and are available at no cost. The Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011) is a brief but well-validated suicide risk screening and risk assessment tool that has been adapted for use in a multitude of settings (e.g., Hill, Hatkevich, Kazimi, & Sharp, 2017; Horwitz, Czyz, & King, 2015). In addition, the C-SSRS website provides risk assessment triage tools to help service providers determine the appropriate course of action depending upon the youth's answers to the C-SSRS screening items. Besides the C-SSRS, there are many other screening tools available, such as the Suicidal Ideation Questionnaire and Suicidal Ideation Questionnaire-JR (Reynolds, 1988), Suicide Risk Screen (Thompson & Eggert, 1999), and the Suicide Behavior Questionnaire – Revised (Osman et al., 2001). Each of these questionnaires includes a screen for and/or assessment of suicidal thoughts and behaviors. Additionally, the Patient Health Questionnaire-9 (Manea, Gilbody, & McMillan, 2015) and the Home, Education, Activities, Drug use and abuse, Sexual behavior, Suicidality and depression (HEADSS; Cohen, Mackenzie, & Yates, 1991) are commonly used screeners in primary care and other medical settings. Both include a brief suicide risk components and may be used as a first step, followed by a more in-depth assessment if suicide ideation is reported.

A persistent concern of both providers and laypersons is whether broaching the subject of suicidality and self-harm, specifically asking about it, could trigger a child or adolescent to become suicidal or act on ideation. A growing body of research shows that asking about suicide does not lead to negative consequences and may decrease distress among suicidal youth (Gould et al., 2005; Pena & Caine, 2006). Asking about suicide also helps destigmatize the topic and creates a safe space for the youth in the future if they begin struggling with suicidality. Consequently, providers can feel confident that they are not inducing suicidal thoughts through screening efforts.

Take Appropriate Action

Service providers who take steps to recognize warning signs or screen for suicide risk must also be prepared to take appropriate action steps when suicide risk is identified. In the event of mild to moderate suicide risk (as determined by a suicide risk screening tool), referral to a mental health professional for further evaluation and intervention is the most likely action step. To aid in making referrals, service providers should know what local resources are available, including the names and contact information for outpatient mental health services providers or agencies. As many outpatient psychology clinics have waitlists, it is helpful to be aware of any providers or agencies that are available to see families on short notice. It can also be helpful to know which providers accept Medicaid/CHIP insurance or provide free or low-cost services to low-income families. Service providers should also have emergency suicide prevention resources on hand, such as the number for the National Suicide Prevention Lifeline (phone: 1-800-273-TALK/8255; Substance Abuse and Mental Health Services Administration, 2017) and the Crisis Text Line (text: 741-741; Crisis Text Line, 2018), and provide this information to youth and families with any level of suicide risk. Even if youths may be unlikely to need crisis services, reviewing the resources available to them requires little effort and having these available likely does no harm. In addition to offering a list of local resources for youth mental health care, a provider may consider small actions they can take themselves that can have a big impact. For instance, the Safety Planning Intervention (Stanley & Brown, 2012), described above, can help youth to make better choices during a suicidal crisis.

For imminent risk (i.e., when there is substantial concern that the youth may act on suicidal thoughts or urges in the near future) or when youth perceive their suicidal urges as being uncontrollable, it may be necessary to contact emergency services. Emergency services for imminent suicide risk include hospital emergency department visits and inpatient psychiatric hospitalizations. While the need for emergency services should be relatively infrequent, anyone assessing suicide risk should be aware of where these services may be obtained in the event they are indicated. In the event of an emergency, professionals can also call upon security personnel or law enforcement to provide an escort to a local emergency department or psychiatric inpatient hospital. Additionally, strong evidence supports the importance of reducing access to lethal means of suicide, such as locking up or removing household medications and removal of firearms from the homes of those at risk for suicide (e.g., Barber & Miller, 2014; Miller & Hemenway, 2008). A discussion with youth and caregivers may be essential to removing youth access to lethal means and ensuring safety during a suicidal crisis.

Support Families in the Transition to Mental Health Care

After the initial interaction with the suicidal youth, research shows that follow-up care is effective and essential to youths' recovery and mental health (e.g., Luxton et al., 2014; Richardson, Mark, & McKeon, 2014). Most critically, youth experiencing suicidal thoughts need to be linked to local mental health services in a timely manner. While providing referral information is a first step, referral information alone may not be sufficient to ensure linkage to mental health care (Krulee & Hales, 1988). Periodic phone calls, text messages, letters or postcards to the youth letting them know you care and are available to provide support can help ensure that youth feel valued. Simple follow-up messages also provide an opportunity to continue to encourage contact with mental health services and to provide additional resources as needed. A little persistence can have an enormous impact.

Ensure a Trained and Engaged Workforce

While every additional service provider engaging in suicide prevention efforts can save lives, developing an engaged and unified workforce that emphasizes suicide prevention can provide support for service providers and help reduce individual provider burnout. When suicide prevention exists as an organizational goal, many share the challenge of supporting vulnerable youth. A unified workforce can also support its members in maintaining self-care strategies and work-life balance. For providers interested in developing organizational commitment to suicide prevention, it may be helpful to provide large-scale training in suicide risk assessment and prevention. "Train the trainer" programs make it possible to train groups of providers. For example, the QPR program (Quinnett, 1995) described above uses a "train the trainer" model, in which a representative of the organization can receive training to become an instructor in the QPR program. In this way, an organization can provide ongoing training to its personnel, while limiting training expenses.

Know Your Legal and Ethical Responsibility

Professional legal and ethical responsibilities vary between professions and across states. As a result, before engaging in suicide risk screening, providers may wish to review the legal and ethical requirements of their profession and the state in which they practice, to ensure that they take all appropriate steps in the event that they identify a suicidal youth. This is particularly important when working with abused and/or maltreated youth, since one of the most common actions when working with at-risk youth is to inform caregivers, who can be responsible for ensuring that youth stay safe and receive mental health care. In the case of abused and/or maltreated youth, complex legal situations concerning guardianship and parental rights may be common. Knowing exactly who to inform regarding a youth's suicide risk may not always be immediately clear, and there may be consequences for failing to report suicide risk. Furthermore, when substantial, immediate safety concerns exist, it may be necessary to suggest hospitalization. In our experience, if clearly and calmly explained, parents typically understand the need for, and consent to, hospitalization for the sake of safety. However, should parents refuse and the provider deem the child to be at imminent, acute risk for self-harm, involuntary hospitalization may be necessary. Service providers assessing suicide risk should be aware of available avenues for involuntary hospitalization in their jurisdiction. Finally, the adoption of "red flag" gun laws or "extreme risk protection orders" in some areas may provide another option for ensuring safety for a child. These laws allow a judge to order law enforcement to confiscate firearms in the event of severe risk of harm. As these laws are still emerging, their role in suicide prevention efforts is also emerging, though initial evidence seems to support modest impacts on suicide (Swanson et al., 2017). Taken together, careful review of reporting requirements and legal options to ensure patient safety specific to your discipline and jurisdiction is an important step. Those with access to legal consultation may wish to seek assistance in interpreting the applicable laws and statutes.

Know Where to Find Resources

National suicide prevention organizations provide a variety of resources, fact sheets, handouts, and training information for both service providers and community members. The American Foundation for Suicide Prevention (www.afsp.org), Suicide Prevention Resource Center (www.sprc.org), American Association for Suicidology (www.suicidology.org), and The Trevor Project (www.thetrevorproject.org) all offer suicide prevention resources for service providers. National suicide prevention organizations may also be a good place for to find supportive professionals. For example, the American Association for Suicidology has a publicly available listserv where providers can seek advice or referral information. For those interested in more information on suicide statistics, including data specific to a particular state or region, the Centers for Disease Control website (www.cdc.gov) houses both the Wide-ranging Online Data for Epidemiologic Research (WONDER) database and the Youth Risk Behavior Surveillance System data, which provide some of the most up-to-date statistics on suicide deaths as well as suicide attempts and ideation, respectively.

Conclusions

Abused and maltreated children are at elevated risk for suicide-related behaviors. Fortunately, a wide variety of preventive interventions exist to provide support and care for at-risk youth. Service providers working with these youth have a unique opportunity and responsibility to identify youth at risk for suicide and direct them to appropriate preventive interventions. By incorporating suicide prevention efforts into their daily practices, service providers working with abused and maltreated youth can save even more lives.

Table 1. Action Steps for Engaging in Suicide Prevention Efforts

The Role of Abuse/Maltreatment Service Providers in Suicide Prevention	
Recognize Risk	- Recognize the association between abuse/maltreatment and suicide risk. - Be mindful of additional risk markers. - Prioritize warning signs as indicators that immediate action may be needed. - Seek training in how to respond to suicide risk.
Screen for Suicide Risk	- Consider both formal (e.g., using C-SSRS or another screening tool) and informal screens (asking about suicidal thoughts conversationally). - Seek training in the use of formal screening tools. - Know that asking about suicide risk does NOT increase youth suicide risk.
Take Appropriate Action	- Know what to do when youths report suicide risk. - Facilitate access to quality care by having resources readily available and creating a warm hand off. - Be prepared to contact emergency services if necessary. - Consider a discussion of youth access to lethal means and how to reduce/limit access to such items for the protection of at-risk youth.
Support Families in the Transition to Mental Health Care	- Assist youth in linking to local mental health services in a timely manner. - Continually encourage contact with mental health services.
Ensure a Trained and Engaged Workforce	- Develop an engaged and unified workforce that emphasizes suicide prevention to support for service providers and help reduce individual provider burnout. - Ensure workforce members maintain self-care and work-life balance.
Know Your Legal and Ethical Responsibilities	- Review the legal and ethical requirements of your profession and the state in which you practice. - Know how, when, and to whom to report youth suicide risk. - Review any relevant laws in your jurisdiction and seek legal consultation if needed.
Know Where to Find Resources	- Identify sources of additional information or resources, so that you have access to support and can find answers to questions that may arise.

Table 2. Resource List

Resources	
Hotlines/Textlines	
National Suicide Prevention Lifeline	1-800-273- 8255 (TALK) 1-888-628-9454 (in Español)
Crisis Text Line	Text HOME to 741-741
Trevor Lifeline (for LGBTQ+ youth):	1-866-488-7386
Fact Sheets, Handouts, and Training Information	
American Association for Suicidology	www.suicidology.org
The American Foundation for Suicide Prevention	www.afsp.org
The Centers for Disease Control and Prevention	www.cdc.gov
Crisis Text Line	www.crisistextline.org
National Institute of Mental Health	https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml
National Suicide Prevention Lifeline	www.suicidepreventionlifeline.org
Suicide Prevention Resource Center	www.sprc.org
The Trevor Project	www.thetrevorproject.org

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Bonded to the Abuser: How and Why Children Form and Maintain Attachments With Abusive Caregivers

Key words: maltreatment, survivors, attachment

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It is common knowledge among those working with maltreated children that despite the abuse and/or neglect experienced at the hand of a parent, children generally want to maintain a relationship with the abuser. The experience of the first author when surveying boys in out-of-home care is illustrative. The survey included asking the boys for three wishes. It turned out that many of the boys did not have three wishes. With few exceptions, each boy had only one wish and most had the same wish: to go home and be reunited with the parent who had hurt them. The second author's decades of clinical practice with maltreated children has affirmed this phenomenon as well. Although some children—especially older teens—may express their disappointment and anger at a maltreating parent, the majority perceive their abusive parent as an attachment figure and desire to repair the relationship and reunite with the parent. This is the subject of this paper. In part one, we identify six sources of evidence to support and explain the phenomenon of children being bonded to an abusive caregiver. In part two, we present common themes in the writings of adult survivors of different forms of childhood maltreatment.

Part One: Six Sources of Evidence

Source of Evidence One: Clinical Observations

Throughout the clinical literature in the field of child maltreatment, many statements reflect the proposition that abused children are bonded to an abusive parent. An early example is the work of psychoanalyst Fairbairn (1952), who observed that children will assume "the burden of badness" to avoid recognizing parental flaws. He found that children would rather be a "sinner in a world ruled by god than a saint in a world ruled by the devil" (pp. 66-67), meaning that it was too threatening for children to accept that their parents were evil or out of control, and that it was preferable to see themselves as bad than to see their parents as bad. This statement also reflects the belief that children may prefer the experience of control from assuming blame for the maltreatment rather than the experience of not being able to control their maltreatment. Child abuse expert Briere (1992) wrote about the "abuse dilemma" that children face in trying to maintain a belief that both the self is good and the parent is good when being abused by a parent belies that tenet.

Like Fairbairn, Briere noted that children will readily assume that they are to blame for their parent's ill treatment of them. Likewise, trauma specialist Herman (1992) observed that children will go to great lengths to construct an explanation for being abused that absolves the parent of blame. Blizard and Bluhm

(1994) also noted that, "One of the greatest conundrums for therapists treating abuse survivors is the problem of understanding the attachment of the victim to the abuser" (p. 383). Similarly, M. Scott Peck (1983) wrote, "To come to terms with the evil in one's parents is perhaps the most difficult and painful psychological task a human being can be called on to face" (p. 130) and Alice Miller (1988) observed the psychological toll it takes when a child denies the harm caused by a parent. While much of the child maltreatment literature focuses on causes, consequences, and treatments for abused and neglected children, when the literature does note the felt experience of the child maltreatment victim, it is often observed to be reflected in a powerful bond with the abusive parent.

Source of Evidence Two: Primate Research

According to biographer Deborah Blum (1994), primate researcher Harry Harlow did not intend to study love and pain and the way they can comingle in intimate relationships. Yet his most well-known research is on this very point. Harlow's intention was to breed monkeys for his learning experiments; but he found that his desire to keep the monkeys germ-free by raising each baby alone in a cage resulted in damaged infants incapable not only of learning but of virtually all healthy social interactions. Absent any form of contact, these babies became "fanatically attached" to the cloth diapers lining their cages (Blum, 1994). They appeared to love these pieces of cloth as a baby loves its mother. From this observation, Harlow devised a program of research to identify the essential components of caregiving. The original study involved raising baby monkeys with two surrogate "mothers," one constructed from soft cloth and the other from wire, with a feeding bottle attached. Harlow observed the babies' interaction with these two mothers and found a strong preference for the cloth one. In fact, the baby monkeys only visited the wire mother for feedings, but otherwise spent their time clinging and cuddling exclusively with the cloth surrogate.

Harlow's research took a darker turn when he explored how bad a mother surrogate could be while still eliciting attachment behaviors from the baby. To test this, he devised several "monster mothers;" one blew cold air onto the baby, another poked the baby, and a third flung the baby to the side of the cage. Harlow measured how much time the babies raised with monster mothers spent clinging to their mother compared to babies raised with cloth surrogates, and found that the babies spent *more* time clinging to the monster mother (Rosenblum & Harlow, 1963). The aversive mothering induced *more* clutching and proximity seeking in the babies. The babies loved their mothers and sought comfort from them, despite the fact that it was the mother who inflicted pain on them.

Source of Evidence Three: Pain Studies

Two studies have examined the experience and expression of pain inflicted by mothers and shed light on whether child abuse is actually felt differently than other kinds of physical harm. The first studied the pairing of smell and pain in rat pups (Moriceau & Sullivan, 2006). In one group the odor-pain pair occurred in proximity to the mother, and in the other group the pain-odor paring occurred while the pups were away from the mother. The researchers found that only the group with the pairing away from the mother expressed fear of the odor, having learned the association between the odor and pain. Researchers concluded that the presence of the mother was a biochemical off switch for learning fear. They opined that nature makes it hard for the dependent and vulnerable rat pups to experience their mothers as aversive, because, "If a helpless newborn infant does not form an attachment to its caregiver, even to an abusive one, its chances of survival diminish" (Sullivan, Landers, Yeaman, & Wilson, 2000, p. 38). Later Sullivan and Lasley noted, "The fear, avoidance, and even memories associated with pain are extinguished—explaining why an abused child, even while trying to escape pain, will later seek contact with the abuser" (2010, p. 7).

In the second pain study, conducted by Drouineau et al. (2017), the sample was comprised of children seen in a hospital for serious injuries incurred either accidentally or through child abuse. Doctors, blind to the group status of the children, consistently rated the abused children lower on the pain scale than the accidentally injured children. If in fact they felt less pain, it may be because—as with the rat pups—the mother's presence reduced the intensity of the pain, in order to preserve the parent-child bond. Alternatively, it may be the case that they felt the same level of pain but showed it less in order to protect the parent, minimize the harm, or some other related reason.

Source of Evidence Four: Attachment Studies

In 1958 Harlow presciently commented that, “the mother or mother surrogate provides its young with a source of security, and this role or function is seen with special clarity when mother and child are in a strange situation” (p. 580). Two decades later, Ainsworth, Blehar, Waters, and Wall (1978) published the results of their research on individual differences in infant reactions to the paradigm they referred to as “The Strange Situation.” The purpose of the paradigm was to elicit the infant’s attachment reactions much the way Harlow’s studies were designed to, albeit without the pain and cruelty. In the Strange Situation, infants are induced to experience curiosity as well as low levels of fear. Ainsworth observed whether the infant used the mother as a secure base from which to explore the environment while the mother was present, noticed and reacted to the mother leaving, and experienced connection and comfort from the mother when she returned. Those infants who could were considered securely attached, while those who could not were classified as insecurely attached.

Of particular significance is a meta-analysis of ten studies of attachment in maltreated children (Cyr, Euser, Bakersman-Kranenburg, & van Ijzendoorn, 2010). The results revealed that even maltreated children have an attachment relationship with their parent, although for the majority of them the attachment was classified as insecure. What varied was the *quality* of the attachment, not whether there was an attachment.

Source of Evidence Five: Foster Youth Research

There are surprisingly few studies in which children in foster care are interviewed about their experience in the foster care system. Researchers were able to locate just 27 studies that involved interviewing youth in foster care about their thoughts and feelings. None were designed to examine the attachment of children in foster care to their birth families, but researchers examined each for any data on that point. Baker, Creegan, Quinones, and Rozelle (2016) independently coded each study for presence of three attachment-related themes: (1) missing and longing to be reunited with birth parents, (2) being afraid when placed into foster care, and (3) minimizing the abuse and/or assuming blame for it. Baker et al. found that of the 27 studies, 25 noted how the children felt about their birth parent and in all 25, the comments of the children focused on missing their parents and wanting to be reunited with them. Typical comments were, “Many young people took every opportunity to reiterate that they missed their families, would like more contact with family and friends and would like to return home eventually” (Timms & Thoburn, 2003, p. 19). Along the same lines, Bogolub (2008) concluded that, “No matter what their parents had done, all of the respondents missed and longed for their birth parents, and thought about them frequently” (p. 94). Likewise, Selwyn, Saunders, and Farmer (2010) noted that the desire to be reunited with their parents dominated the wish lists of the children interviewed.

In 18 of the 27 studies, there was some mention of how the children felt being removed from home, and in 83.3% of them, the children reporting feeling afraid. For example, Folman (1998) reported that, “The overwhelming majority of children reported feelings of fear, confusion, and an absence of coping strategies” (p. 16). Similarly, Mitchell and Kuczynski (2010) observed that, “Once notified that they would be moving to a new residence, children reported having concerns about whether the basic needs one would normally receive in a family environment would be provided once placed into care; that is, play, sleep, being fed, and companionship” (p. 441).

In 16 of the studies, children made comments about why they were in care. In all but one, the comments reflected self-blame and/or minimization of the harm. As an example, in one study a young boy named Morris, whose mother was in jail, was reported to blame himself for being in foster care and noted that he did not think he would see his mother again until he could fix his behavior (Whiting & Lee, 2003). Gil and Bogart (1982) reported many instances of self-blame, including a child who said he was in foster care because he was bad, and another who said that he was in care because he needed to solve a few family problems. In sum, an analysis of this set of studies produced ample support for the pervasive attachment of abused and neglected children to their caregivers in studies that were not even designed to study that phenomenon.

Source of Evidence Six: Memoirs

Memoirs written by survivors of childhood maltreatment represent the sixth source of evidence regarding children's attachment to their maltreating parent. Baker and Schneiderman read and analyzed 45 such memoirs (2015). Although the stories varied in many respects, the overwhelming theme that ran through them—regardless of the gender of the author, gender of the parent, age the abuse occurred, or type of abuse—was a profound attachment to the abuser and a desire for a repaired relationship with that caregiver. The authors of these memoirs revealed that as maltreated children they loved their abusive caregivers, no matter what.

Taken together, these six sources of evidence strongly support the tenet that children do form and maintain attachment relationships even with abusive caregivers. They cannot help but do so. They are hard-wired to form a preferential relationship with a caregiving adult who is likely to protect them from danger. Parental maltreatment affects the *quality* of the attachment, but not whether there is an attachment.

Part Two: Meaning of the Abuse

Next, we explore how children make meaning of the abusive experiences of their childhood. To do so, we synopsize the themes in the memoirs as reviewed by Baker and Schneiderman (2015).

Physical Abuse

While state definitions of physical abuse vary, they all involve caregiver behaviors that result in physical harm (or likelihood of harm) to a child. Without a doubt, the stories of adult survivors of childhood physical abuse all met this standard. They described being kicked and being beaten with hands, fists, belts, and other assorted objects. They described being whipped and burned. They described having scars, bruises, welts, and burns. There is no question that what each experienced would have met any state statute definition of physical abuse.

An overriding concern for these children was to understand why their parent was hurting them. They strived to make sense of the experience and to figure out how to avoid being hurt again. Many concluded that the problem lay with them, that they were naughty, bad, and deserved to be hit or beaten. Contributing to this belief were the statements made by the parents that linked the behavior of the child to the abuse. One abused girl remembered her mother saying, "You just love to make me hit you," reinforcing the idea that the child wanted and deserved to be hurt. Taking the blame for the abuse not only absolved the parent of guilt and responsibility but also met the child's need to maintain the image of the good parent and the illusion of control.

As noted above, the statements made to the children while being abused signaled that they were found by the parent to be so bad and wrong that they needed to be beaten as a corrective response. Thus, the abuse signaled to the children that they were deficient or damaged. While none relished being physically hurt or enjoyed being judged harshly, at the same time, the abuse was a relief in that it represented the parent's investment in the relationship and hence reassured them that the parent still cared and had not yet abandoned or given up on the child. In this sense the attention—even if negative—was better than no attention.

Many of the children experienced their parents as all powerful, all knowing, and god-like. In contrast, they experienced themselves as small, weak, and at the mercy of the parent. They felt exposed and vulnerable, as if their parent could see into their soul and know that they were bad. They did not feel safe anywhere, as if they were always being observed and judged. For this reason, some longed to be invisible, to be left alone without having to worry about what the parent was thinking or feeling. However, they rarely could let their guard down and were instead hypervigilant about the location, state of mind, and mood of the abusive parent. They learned to read the sound of the key in the door and the sound of footsteps in the hallways to know whether danger was around the corner.

As scary and painful as the abuse was, many of the children were made to be complicit in their own abuse. The parents commanded, "Get me the belt," "Pull down your pants," "Lean over," and, "You better not cry." No matter what was asked of them, the children complied. To them, they simply had no choice. To disobey would only increase the rejection and anger of the parent. Moreover, because they never knew what triggered the parent's anger and violence, they tried to be obedient as much as possible in order to avoid setting the parent off.

One striking element of the memoirs was that the physically abused children compared themselves to animals. They referred to themselves as a dirty cat, a submerged alligator, an unloved dog, a rat in a cage. This metaphor works on multiple levels, including connoting the degradation of unloved and uncared for animals, the innocence of animals, their helplessness and vulnerability, and their inability to protect themselves from a more cunning and powerful owner.

Many of the memoirs included background information on the childhood of the maltreating parent, especially whether and how the parent had been mistreated himself. It appeared that part of the recovery process was to see the abuser as a victim and not just a perpetrator. This seemed to create a feeling of connection with and empathy for the abuser. It helped the adult survivor make meaning of the abuse and allowed them to understand that it was not their fault as they developed an alternative explanation of why the parent abused them.

Sexual Abuse

There are three main types of sexual abuse, according to federal and state statutes: sexual activity between parent and child, sexual activity imposed on one person by the other with force and/or threat of harm, and sexual activity between an adult and a minor. The stories of sexual abuse presented in these memoirs involved at least two if not all three of these types.

Nonetheless, the memoirs written by adults who were sexually abused as children revealed how enthralled the children were of their molesters. They described these parents as charming, captivating, dynamic, and exciting, conferring on them a near celebrity status. At the same time, they reported being afraid and disgusted by that parent, especially during the sexual act, which transformed the parent into a more demanding, intense, and selfish version of themselves.

Like the physically abused children, the sexual abuse victims felt powerless both emotionally and physically. They felt overwhelmed by the physicality of the sexually abusive parent, and the strength of that parent's needs. They lacked the tools and the context to process what was happening to them. For the most part, they were treated as if they had no will or voice and they internalized that message and felt themselves to be lacking in agency, control, and power. They were treated as objects, and that is how they experienced themselves.

One way of coping with the confusion of the sexual abuse experience was for the children to psychologically split the abusive parent into a good parent and a bad parent, a daytime parent and a nighttime parent, a safe parent and a scary parent. Because the sexual abuse often occurred at night, the children could engage in a kind of shared delusion with the abuser that it didn't really happen, some other parent did those things, not the parent sitting at the breakfast table serving them pancakes. This allowed the child to preserve the good and loving parent, to relegate the abusive behavior to someone else.

Another coping strategy used by these children while being sexually abused was dissociation, by separating the mind from the body. When the abusive act became too intense and intimate and painful, the children allowed their minds to wander away to a safer place (or experienced this wandering in a more passive, non-volitional manner), a place where parents didn't do these things to their children. This was another way of protecting the abusive parent from being held accountable because the abuse was less real for the child.

Many of the sexual abuse victims felt themselves to be sullied, soiled, damaged, and dirty. They felt that they had been marked by the experience, as if they had a permanent stain or smell that separated them from other people, people who hadn't been touched or fondled or molested. They felt exposed, as if anyone could just look at them and know that they were dirty and damaged. They experienced themselves as ruined, not just in an immediate sense but also long-term, as if the stain of the abuse would be on them forever.

As improbable as it seems, many of the sexual abuse victims came to believe (partly because they were led to believe and encouraged to believe) that they had asked for the abuse, had invited it, and were, therefore, ultimately responsible for its occurrence. They felt guilty and ashamed and confused by this idea that they were complicit, as if they had seduced or enticed their parent to molest them.

Many of the memoirs of sexual abuse survivors mentioned that what they wanted (and felt they needed) as an adult was for the perpetrator to acknowledge what happened, to admit it, take responsibility for it, and ask for their forgiveness. It is clear that for most of them, forgiveness would have readily been forthcoming if only the parent had allowed the child to have a shared understanding with them that what had happened was not their fault. For most, however, this had not happened, and they were left feeling alone in their abuse experience and frustrated that the abusive parent could not or would not take responsibility for their actions.

Emotional Abuse

According to the American Professional Society on the Abuse of Children (APSAC), psychological maltreatment has six major subtypes that reflect either emotional abuse or emotional neglect (Hart, Brassard, Baker, & Chiel, 2017). With respect to emotional abuse, four of the subtypes are relevant: spurning, terrorizing, isolating, and exploiting/corrupting. In the memoirs of adult survivors, these types of emotional abuse were not only prevalent, they were pervasive. On a routine basis, these parents berated their children, humiliated them, called them denigrating and demeaning names, threatened to hurt and/or abandon them, said hateful things to them, and conveyed contempt and disgust at their mere presence.

In response to this barrage of hostile rejection, the children experienced three main reactions. The first was that they felt that they were not acceptable or accepted for who they were. The hostility and rejection of the parent conveyed to the children that there was something fundamentally flawed about them. The children experienced their parents as being outraged and disgusted at their very essence, their very being. The message conveyed to the children by the emotionally abusive parent was, "How dare you be who you are," and the children took this message to heart and internalized the belief that they were unlovable, unwanted, and unworthy.

The second response to the emotional abuse was that the children felt that they were not important. The message the parent conveyed was that they would do and say whatever they wanted regardless of the impact on their children. These parents revealed through their actions and words that they would pursue their pleasures regardless of how it hurt or inconvenienced others. Some of these parents engaged in substance abuse, some were mentally ill, others were preoccupied with their own emotional gratification. All were unwilling or unable to modify their behavior to attend to the needs of their children. Reasonably so, the children concluded that they were not important enough for the parent to set aside their own desires for their benefit.

The third response to emotional abuse was to feel unsafe. These parents failed to consider the impact of their behavior, words, and actions on their children. They did not filter their language, protect their children from exposure to adult behavior, nor consider how frightening and confusing their behavior might be. The children were left feeling overwhelmed, hurt, and confused, and sometimes terrified.

While the parents in these stories varied in many respects including the specific form of emotional abuse they perpetrated, what they shared was an inability and/or unwillingness to appreciate that their children were separate people with their own needs, experiences, and perceptions. The emotionally abusive parents exhibited what Shaw (2013) refers to as "traumatizing narcissism," in which the parent fails to grasp the separateness and integrity of the child as a separate individual. The parent relates to the child, if at all, as an extension of his or her own needs. The child's subjective reality is invalidated by the parent, especially the child's needs that are threatening, embarrassing, or inconvenient for the parent. As a result, the children of these parents experienced themselves as unlovable, unimportant, and unsafe.

Emotional Neglect

Whereas emotional abuse is reflected in acts of commission, emotional neglect is expressed through acts of omission, what the parent does not do. According to APSAC, denying emotional responsiveness to the child (essentially a synonym for emotional neglect) is one of the major forms of psychological maltreatment (Hart et al., 2017). While the specific acts of omission varied from memoir to memoir, the commonality was the parent's inability or unwillingness to pay attention to, be present for, and show love and affection to the child.

Each of the memoirs of emotional abuse was a story of a child's search for the love of the parent. This search was represented in a number of specific themes. The first theme was the strong emotional connection the children had to the scent of the mother. They spoke about how evocative the mother's perfume was for them, how breathing in her aroma helped them to feel close to the absent or emotionally unavailable parent. They were drawn to her scent in order to elicit a feeling of emotional connection that was not available otherwise.

The second theme was the preoccupation the children had with recapturing the unavailable parent's attention. Because many of the parents were able to focus their attention on the child periodically, the children were intermittently rewarded for their efforts. As learning research has established, intermittent reinforcement is extremely difficult to extinguish (Kendall, 1974), meaning that the children were caught in a web of persistent hopefulness that soon their parent would pay attention to them, shine their love upon them.

In many of the stories, the children told of being left behind or forgotten by the parent who was emotionally absent, preoccupied, and inwardly focused. The experience of being forgotten in a literal sense (i.e., waiting at school to be picked up) mirrored their emotional experience of being forgotten and acted as a foreshadowing of their greatest fear, which was that the beloved parent would disappear altogether.

The inconsistent attention from the parent resulted in the children longing for them as a low-level form of constant hunger and craving. They never felt satisfied because they never knew if the parent would disappear forever. Each moment of connection was bittersweet, as it held within it the potential for the end of the relationship. To them the parent was magical and enchanting when present, even more so perhaps because the parent came and went regardless of the needs or wishes of the child. The very unavailability of the parent made the parent that much more desirable.

These children would have done almost anything to ensure that their beloved parent would stay and be available to them. In some cases, the children assumed responsibility for the parent's emotional and physical well-being in a misguided attempt to ensure that the parent would pay attention and be available to them. They fed their parents, brought them medicine, cleaned the house, in an effort to protect and care for the fragile parent. In many cases the parents did not even notice the love and devotion showered on them by their children and, in response to the failure to notice, many of the children experienced themselves as not mattering, of being invisible. What they longed for more than anything was to look in their parent's eyes and see themselves reflected back as a child who is loved and seen. In the absence of that they felt not just invisible to the parent but also to themselves. They needed to be seen and validated by the parent in order to feel real to themselves.

Physical Neglect

Children who are physically neglected do not have their basic needs for food, shelter and clothing met, usually for reasons above and beyond poverty. In the memoirs, the parents were not simply unable to provide for the physical safety and well-being of their children, but were in some way making a choice to withhold the necessary nurturance and protections from them. How the parents managed and allocated family resources was what resulted in the neglect, over and above the scarcity of resources. In many of the stories written by adult survivors of childhood physical neglect, the parents suffered from alcoholism, drug addiction, hoarding, or some other mental illness that compromised the parent's ability to prioritize the child's need for food and shelter.

As a response to the chronic experience of hunger and physical discomfort the children had three basic reactions. The first was the experience of being an outsider. They spent an inordinate amount of time outside, usually because their parent pushed them outdoors with the expectation that they would stay away for hours at a time. They also felt like an outsider with respect to their peers and "normal" people who had homes, clean clothes, and enough food. The physically neglected children felt that they did not belong. They were banished from their homes, shunned by their peers for being weird or dirty, and were looked down upon by neighbors, shopkeepers, peers, and others.

Many also wrote about being highly attuned to the suffering of their parent. They appeared to be more empathic towards their parents than their parents were towards them. They saw that the mental illness or drug addiction that consumed their parent's time, energy, and money was a blight on the parent. The suffering and incapacity of the parent was visible for the child, which made it hard for them to sustain their anger at the parent.

At the same time, many of the stories contained an epiphanic moment when the child realized that the parent was in fact making choices that resulted in the suffering and deprivation of the child. There was a moment when the child realized that there would have been enough money for food and clothes and shelter if the parent hadn't spent it on alcohol, drugs, or other pursuits. The children witnessed their parent's ego or desires taking priority over the parent's need to protect and nurture them, and that was what hurt the most. That the suffering was preventable made it all the more painful.

In sum, regardless of the type of abuse inflicted on a child, the child's attachment to the abusive parent was not likely to be destroyed, erased, or made irrelevant. The attachment persisted, and appeared to be virtually indestructible. The evolutionary advantage of having a caretaking adult is so powerful that the attachment is preserved regardless of the quality of the parenting provided to the child. The common thread among the memoirs was the child's desire to be loved and approved of by the parent, no matter how cruel, unavailable, or irresponsible that parent was. Like Harlow's baby monkeys clinging to their monster mothers, abused children may be more attentive to and focused on their parent than other children, precisely because they have not had their needs met.

Clinical Implications

There are many practical implications of the information presented here, whether the abuse survivors are still children or are adults. Perhaps the most important one relates to the cognitive distortions that generally accompany maltreatment. There are several that were particularly observable in the memoirs, including that the abuse was deserved, that the child needed the parent's love and acceptance to feel good about himself, that the world was unsafe, that they had been ruined, and that people could not be trusted. These beliefs are common among maltreated children as byproducts of the abuse (Kolko & Swenson, 2002). Some of these beliefs were encouraged by the parents and some of the beliefs allowed the child to maintain the fantasy of the good and loving parent. In other words, the distortions worked for the child—up to a point.

The goal of therapy whether for the child or the adult survivor, therefore, would be to encourage them to describe their thoughts and feelings in order to correct dysfunctional and distorted thoughts and beliefs that might underlie ongoing emotional issues and dysfunctional interpersonal functioning. Maltreated children and adult survivors need help to change their self-perceptions and develop a sense of mastery and stop seeing themselves as defined by their victimhood. One possible tool in the therapeutic healing process is for abuse survivors to tell their stories as a way of taking ownership and gaining mastery and control over their maltreatment experience. Storytelling has a long history in the healing arts (Pennebaker, 1997) and practitioners have incorporated it into a whole generation of trauma-informed treatments (e.g., Kolko & Swenson, 2002). This process of storytelling is an essential component of many evidenced-based interventions for traumatized and abused children, commonly referred to as the trauma narrative or "processing the trauma," such as in Trauma-Focused CBT (Cohen, Mannarino, & Deblinger, 2012), Trauma and Grief Component Therapy (Saltzman, Layne, Pynoos, Olafson, Kaplow, & Boat, 2018), and Trauma Systems Therapy (Saxe, Ellis, & Kaplow, 2007). It was clear from the memoirs reviewed for this paper that telling the story was a rich and powerful part of the healing process for these adult survivors of childhood maltreatment.

With respect to treatment providers, the data strongly suggest that people working with maltreated children as well as adult survivors of childhood maltreatment need to be educated about the cause and the strength of the attachment abusive victims feel for their abusive caregivers. Training about the topics contained in this paper (the reasons why children bond with abusive parents, the abuse-specific experiences) should be mandatory for all mental health professionals. The training could help therapists be more empathic of the attachment dynamic in abusive relationships so that they can help abuse victims accept their own grief reactions in response to being separated from abusive caregivers.

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APSAC Research-to-Practice Brief: Early Exposure to Child Maltreatment and Academic Outcomes

Misti Jeffers, MA

Original study authors:
Joseph P. Ryan, Brian A. Jacob, Max Gross,
Brian E. Perron, Andrew Moore, Sharlyn Ferguson

Introduction

This study seeks to investigate the prevalence of early contact with child protection services (CPS) before the third grade and to understand whether early contact was associated with important academic outcomes (math and reading standardized test scores, grade retention, and special education status in third grade). This study is the first statewide analysis linking maltreatment to academic outcomes by merging data from the Michigan Department of Education (MDE), the Michigan Department of Health and Human Services (MDHHS), and the United States Census. This article expands previous understandings of relationships between CPS involvement and educational experiences by focusing on a broader definition of contact, estimating the number of children who have experienced at least one maltreatment investigation from birth to third grade, whether unsubstantiated or substantiated.

Research Questions

Rather than put forth hypotheses, the authors present two research questions: 1) What is the prevalence of formally investigated child maltreatment in the public school population by the time students reach third grade, and do prevalence rates vary by school district? 2) What is the association between early contact with CPS and critical academic outcomes?

Study Sample

This study included a diverse sample of over 700,000 children enrolled in Michigan's public schools who were born between 2000 and 2006 and had available data reported to MDE and MSHHS.

Findings

The authors found a high prevalence of contact with the child protection system for public school students before third grade (approximately 18%), ranging from 1% to as high as 59% across all school districts. Of all investigations, over one third were substantiated. Students receiving free lunch (an indicator of family poverty), students from poor neighborhoods, and Black students had disproportionately higher rates of CPS investigations.

Further, any involvement with CPS was negatively associated with all four measures of negative academic outcomes, even when controlling for other factors that may affect performance (i.e., race, gender, and poverty). Having substantiated investigations resulted in even larger negative outcomes than did unsubstantiated investigations.

Recommendations

The study findings are important for informing allied systems of care collaboration, particularly among child welfare and educational systems. The authors demonstrated the odds of experiencing CPS investigations is higher than the odds of experiencing other factors (e.g., asthma, child food allergies, child disabilities, and obesity) related to negative outcomes addressed within educational policies and support programs, highlighting the importance of allocating financial resources specifically to the population of maltreated youth. One option for addressing the needs of this population would be to better align information reported to CPS with information collected within schools to inform approaches similar to those used to support students with suspected disabilities (such as Individualized Education Programs). Yet, the authors emphasize the importance of considering privacy and confidentiality issues associated with this approach. Less controversial approaches would include a more general approach to trauma informed practices in schools.

Bottom Line

CPS involvement is not infrequent and may actually be the norm for students in some school districts, a finding that refutes the public's misconception that maltreatment is uncommon. Further, disparities exist for already vulnerable youth in our public education systems, including youth of color and poor youth, as well as by school district. Focusing on addressing the academic struggles of youth with maltreatment histories early in their educational trajectories is crucial to limiting the likelihood they will culminate in more complicated problems in the future.

Citation

Ryan, J.P., Jacob, B.A., Gross, M., Perron, B.E., Moore, A., & Ferguson, S. (2018). Early exposure to child maltreatment and academic outcomes. *Child Maltreatment 23*(4), 365-375.

About the Author

***Misti Jeffers** is currently a doctoral candidate in Social Policy at Brandeis University. She has conducted research related to child welfare, juvenile justice, and experiences of rural poverty. Misti earned her Bachelor of Science in Psychology and Human Services from East Tennessee State University, her Master's in Child Study and Human Development from Tufts University, and her Master's in Social Policy from Brandeis University.*

News of the Organization

Janet Rosenzweig, MS, PhD, MPA, Executive Director

A Major Milestone in Promoting Child Health and Well-Being

On November 5, 2018 the American Academy of Pediatrics (AAP) released an updated policy statement advising parents against the use of spanking as a disciplinary tool. They have concluded that spanking "increases aggression in young children in the long run and is ineffective in teaching a child responsibility and self-control," and urge parents to employ more supporting forms of discipline. APSAC also recognizes that physical punishment is a risk factor for physical abuse and is associated with psychological maltreatment.

APSAC commends the AAP for taking this position and urges the members of the many disciplines working with child maltreatment to implement this recommendation into your practices. National experts working with APSAC offer scientific evidence to support the harm caused by hitting children, as well as advice on alternatives to share with parents, in our full statement of support, found here.

APSAC also encourages you to consider helping establish No-Hit Zones in the children's hospitals and other organizations and institutions serving your community; you can register or find more information here.

APSAC fully supports this policy statement from the AAP and is optimistic about the benefits that will accrue to children and parents as more positive methods of discipline become the norm in the United States. Please help spread the word!

The 26th APSAC Colloquium Is Shaping Up to Be Another Great Educational Experience

Our colleagues submitted more than 200 abstracts for consideration, ensuring that APSAC's 26th Colloquium will continue our tradition of bringing high-quality learning opportunities to child maltreatment researchers and practitioners across experience levels and professions. Planned for June 19-23 in Salt Lake City, we're working hard right now assembling just the right combinations of key note addresses, plenary sessions, workshops, research briefs, poster sessions and round table discussions. For inspiration, check out our YouTube channel for a sample of the 2018 plenaries and micro-sessions!

Salt Lake City is a highly regarded family vacation destination, with a wide variety of fun and exciting things to do. Parks and recreation, historical sites, shopping, and a vibrant dining scene make this a great way to combine work and play this summer. Please click here to find out more about what Salt Lake City has to offer.

And bookmark this page to be sure not to miss our end-of-the-year Flash Sale on Colloquium registration, back by popular demand!

2019 Forensic Interview Training From APSAC

APSAC is pleased to share that we will offer our renowned five-day comprehensive forensic interview training August 26-30 in Seattle, Washington.

APSAC will offer advanced and refresher two-day institutes as well, in Salt Lake City June 18 and 19 as a pre-conference institute for our 26th Colloquium, and in December 2019 in New Orleans in cooperation with the Audrey Hepburn Child Advocacy Center. Complete information and registration information can be found here.

Financial support is available for available for law enforcement applicants; bookmark that webpage and watch for news of early bird pricing.

For more information, contact JCampbell@apsac.org

Join Us in San Diego

APSAC will be offering two preconference institutes at the celebrated Chadwick International Conference on Child and Family Maltreatment. National experts will offer the institute "***Hot Topics in Promoting Resilience in Children***," with sessions on promoting sexual health and safety (sex abuse prevention), understanding and identifying psychological maltreatment and supporting cultural norms to reduce a prevalent risk factor for child abuse, and corporal punishment.

"***Advanced Forensic Interviewing Techniques: Interviewing Victims of Commercial Sexual Exploitation and Using Evidence in Forensic Interviews***" will provide content that forensic interviewers should incorporate in interviews of minors suspected as trafficking and/or internet crimes victims. The focus will be on non-caregiver cases. The institute will compare and contrast commercial sexual exploitation interviews to intrafamilial cases, and discuss strategies to obtain case specific details. There will be a focus on advanced issues in presenting evidence in forensic interviews.

Learn more and register for these advanced training institutes here!

From the APSAC Amicus Committee: APSAC Opposes Federal Rule Change Regarding Immigrant Children

By Frank Vandervort, JD and Mary Kelly Persyn, J.D.

APSAC recently submitted comments opposing a rule change proposed by the Department of Homeland Security (DHS) and the Department of Health and Human Services Office of Refugee Resettlement (DHHS) that would permit the government to indefinitely detain children and their parents at the border as they await immigration proceedings. In Flores v. Reno, the federal government was sued over its policy and practices regarding the detention of unaccompanied children. In 1997, the government entered into a settlement agreement that limited the detention of minors to 20 days and put other constraints in place. The court retained jurisdiction, which enabled monitoring of facilities by court-appointed attorneys. Additionally, the settlement required state child welfare authorities to license the facilities in which children were detained.

The proposed rule would lift both requirements, allowing immigration officials to indefinitely detain children and eliminating the requirement that facilities meet state licensing requirements. By terminating the settlement, the proposed rule would also eliminate federal monitoring, which has yielded many successful motions to enforce the order in the face of abuses within the detention facilities. APSAC's comment opposing these changes can be found here.

Please Take Note!

Ready to Start a State Chapter?

APSAC state chapters are eligible for financial support from APSAC, and help provide a unified voice on behalf of all aspects of child maltreatment in your state. For information, please contact info@apsac.org.

Visit Our Database of Educational Programs

Click here to find an academic program from any discipline offering a focus on child maltreatment. To add your program to our database, complete this survey!

Remember APSAC for End-of-Year Giving

APSAC relies on the generosity of donors to help underwrite services, such as free Guidelines for Professional Practice and inexpensive memberships for students, young professionals, and front-line professionals. Please consider APSAC when the holiday season inspires your giving spirit! Donate here or consider a collaborative campaign using our fundraising platform. Please contact info@apsac.org for more information.

We Can Help With Conferences and Training

APSAC makes a great partner for a statewide organization planning a conference. Contact Jim Campbell if you'd like us to bring our national resources to your state or community. APSAC is now certified to offer CEUs in certain disciplines, further adding value to your event!

The American Professional Society on the Abuse of Children™

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Strengthening Practice Through Knowledge

Washington Update

John Sciamanna

HHS Releases Guidance & List on Family First Prevention Services

On Friday, December 1, the Children's Bureau released its first guidance and preliminary list of services for funding under the Family First Prevention Services Act (PL 115-123)—(FFA). The guidance at ACYF-CB-PI-18-09 gives an overview of some of the initial decisions made by Health and Human Services (HHS) in the interpretation and implementation of the Family First Act. A separate attachment includes an initial list of services and programs selected for the first review (and presumably) eligibility for funding under the services part of the new law. The initial list of a dozen programs includes:

- For Prevention Services and Programs Mental Health:
    - Parent-Child Interaction Therapy
    - Trauma Focused-Cognitive Behavioral Therapy
    - Multisystemic Therapy
    - Functional Family Therapy
- For Substance Abuse Prevention and Treatment:
    - Motivational Interviewing
    - Multisystemic Therapy
    - Families Facing the Future
    - Methadone Maintenance Therapy
- For In-Home Parent Skill-Based
    - Nurse-Family Partnership
    - Healthy Families America
    - Parents as Teachers
- In the separate category of Kinship Navigator Programs that can all be funded at the lower evidence level of "promising" evidence basis:
    - Children's Home Society of New Jersey Kinship Navigator Model
    - Children's Home Inc. Kinship Interdisciplinary Navigation Technologically-Advanced Model (KIN-Tech)

In selecting the initial list, the Bureau said that additional services and programs will be added for review on a rolling basis. They also said that they would give priority to services and programs recommended by the state and local government administrators. The first programs for review included these state and local preferences as well as programs that have been rated by the California Evidence-Based Clearinghouse; programs evaluated by Title IV-E Child Welfare Waiver Demonstrations; a recipient of a Family Connection Discretionary Grant; and recommendations solicited from agencies and partners within the Administration for Children and Families, Health Resources and Services Administration, the National Institutes of Health, the Centers for Disease Control and Prevention, the Office of the Assistant Secretary for Planning and Evaluation, and the Substance Abuse and Mental Health Services Administration.

The guidance provides some significant flexibility in that states can continue to provide services to an eligible child/family beyond the first 12-month service period on behalf of the same child for additional 12-month periods. In order to claim title IV-E for each additional 12-month period, the state must determine and document in the child's prevention plan that the otherwise eligible candidate for foster care or pregnant/parenting youth meets the requirements under the law.

Other significant interpretations of the law include allowing in-home services to be broadly defined so that they are not limited to services physically provided in the home. There is no further definition in trauma-informed approach beyond recognized principles and approach and trauma specific interventions. Significantly, prevention services may be provided for youth in care including up to age 21 if a state extends foster care to that optional older age, states may provide services by different geographic area (no state-wideness requirement), and they can provide different services in different areas.

Congressional Leadership in 2019

Shortly after the Thanksgiving break, the House of Representative moved closer to a final list of leaders for the 116th Congress. Minority Leader Nancy Pelosi (D-CA) came a step closer to securing the speakership when the new Congress starts on January 3, 2019. The Democratic caucus approved Pelosi, but technically the entire House selects the next Speaker. That requires at least 218 votes or a majority of those present and voting. Some Democrats have said they would not support her return during the campaign, but there is no specific opposition candidate. Some members could abstain, in which case she would not need 218 votes.

Before the break, the House Republicans selected Congressman Kevin McCarthy (R-CA) to become their new Minority Leader when the new Congress starts. Speaker Paul Ryan (R-WS) has retired from Congress.

In other developments, the House will have two women heading up the House Appropriations Committee, with Congresswoman Nita Lowey (D-NY) switching from ranking member to chairperson and Congresswoman Kay Granger (R-TX) winning out over some other committee Republicans to become ranking member.

Congressperson Karen Bass (D-CA) became chair of the Congressional Black Caucus (CBC). Rep. Bass is known to the child welfare community for her leadership on child welfare policy, and she co-chairs the Congressional Caucus on Foster Youth. Congressman Hakeem Jeffries (D-NY) was chosen for the head of the House Democratic Caucus, considered the number 5 spot in House leadership.

Beyond that the Senate remained largely the same, with Senators McConnell (R-KY) and Schumer (D-NY) staying in place. Significantly, Senator Grassley decided he will give up the Judiciary chairmanship in exchange for the Senate Finance Committee chairmanship. There will be some changes in Senate Committee assignment due to a slight uptick from the original 52 Republican senators at the start of the 115th Congress to this next Senate's 53 Republicans. There will also be some new senators and vacancies, including on the Senate Finance Committee, which will lose Senator Hatch (R-UT) due to retirement, and Senators Heller (R-NV), Nelson (D-FL), and McCaskill (R-MO) due to election losses.

Children's Bureau Promotes Primary Prevention

On November 16, the Children's Bureau issued ACYF-CB-IM-18-05, a memorandum on primary prevention, and "to strongly encourage all child welfare agencies and Children's Bureau (CB) grantees to work together with the courts and other appropriate public and private agencies and partners to plan, implement and maintain integrated primary prevention networks and approaches to strengthen families and prevent maltreatment and the unnecessary removal of children from their families."

The Information Memorandum (IM) emphasizes a theme that Commissioner Milner has repeated since coming into office, preventing child abuse and neglect before it happens and before the family is at risk of a foster care placement. In the past he has touted the Administration's 2019 budget proposal that would allow a waiver of Title IV-E foster care funds as a way to fund primary prevention. The IM states:

"Coordinated and robust primary prevention efforts are critically important to strengthen families, prevent the initial occurrence of and ongoing maltreatment, prevent unnecessary family disruption, reduce family and child trauma, interrupt intergenerational cycles of maltreatment, and build a well-functioning child welfare system…Children's Bureau's top priority is to reshape child welfare in the United States to focus on proactively strengthening families through primary prevention of child maltreatment. To accomplish this, CB believes strongly that primary prevention services must be located in communities where families live, where they are easily accessible, and culturally responsive. Those services should also focus on the overall health and well-being of both children and families and be designed to promote resiliency and parenting capacity."

The memo represents a resource in terms of prevention programs highlighted from across the country. The IM notes that common problems of limited or loss of income, inadequate housing, or civil legal issues, if left unattended, can escalate to crisis and lead to formal child welfare system involvement. Neglect was present at the time of removal for over 60 percent of children who entered foster care in 2016, and substance abuse was present in approximately one third of families, with the inability to cope by a parent(s) present for 14 percent of children that entered care. Those numbers are likely low since they are frequently based on a caseworker's first observation, and many families may have multiple challenges in which substance use is just one of many challenges.

The Bureau memo notes the need to address the protective factors in a family's life and how the erosion of such factors can push families into the child welfare or CPS systems.

"While some families may benefit from an evidence-based clinical intervention, many families… would benefit from a temporary boost, someone to listen and provide good counsel, or very basic concrete supports such as help paying rent or a security deposit for housing, child care, transportation, legal services, or brief periods of respite care to allow parents time to seek help and work through a challenging situation. These types of services and supports coupled with efforts to enhance parenting skills, promote healthy child development, build and maintain positive peer and relational support networks, and help families achieve financial self-sufficiency, before crises arise, are all critical primary prevention efforts that can help prevent bad things from happening in the lives of children and parents."

The memo encourages state and local child welfare agencies to work together with other key community partners and resources. They also highlight the need to coordinate and work with legal systems including judges. The IM provides eight examples of community-based efforts from Allegheny County, Pennsylvania to San Francisco, California and how these community-based efforts built up partnerships to provide an array of supports and services to families.

New HHS Research on Substance Use Treatment and Child Welfare

Last week the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in HHS released a new study on opioid treatment and child welfare. The report, Medication-Assisted Treatment for Opioid Use Disorder in the Child Welfare Context: Challenges and Opportunities, outlines some of the challenges in providing treatment to families involved with child welfare. Four takeaways include:

1. Limited availability of appropriate treatment. Quality treatment programs for parenting women are in short supply in many communities. In addition, limits on insurance coverage, including Medicaid coverage in some locations, often prevent sufficient treatment duration.
2. Misunderstanding of medication-assisted treatment (MAT). MAT is not always well understood by stakeholders, who may encourage tapering of MAT prematurely and do not insist that medications be accompanied by necessary psychosocial and recovery support services, undermining clients' opportunities for success. Divergent understanding and views of MAT also mean that parents with opioid use disorder receive mixed messages about appropriate treatment, which may undermine referral and treatment engagement efforts.
3. Limited interaction between child welfare agencies and MAT providers. The opioid crisis has prompted new entrants to the substance use disorder treatment community who are not familiar with child welfare agencies, are often unaccustomed to the needs of child welfare system clients, and may be resistant (even with appropriate client consent) to providing the feedback on parents' treatment progress needed for child welfare proceedings.
4. Need for alignment of systems and stakeholders with different perspectives and objectives. Child welfare outcomes related to safety, permanency, and well-being depend on multiple stakeholders who may have different perspectives on MAT and different objectives regarding client outcomes.

HHS Releases Latest Child Welfare Numbers 2017

On Thursday, November 8, HHS released the 25th Adoption And Foster Care Analysis and Reporting System (AFCARS) Report indicating that foster care placements increased for the sixth straight year, going from 436,551 in FY 2016 to 442,995 in FY 2017. The AFCARS reports are based on the number of children in the system as of the last day of the federal fiscal year, which is September 30, in this case September 30, 2017. They are a point in time, and for the entire year of 2017 there were 691,000 children who spent at least part of the year in care. The September 30 date allows a consistent comparison from year to year. Over the course of a year states will experience different numbers, with foster care placements and child abuse complaints generally increasing at the start of the school year in the fall, and foster care numbers decreasing during the year-end holidays as there are more reunifications—at least temporarily.

The increase to 442,000 represents a somewhat smaller increase from the previous half decade. From 2013 to 2017 the increases were 14,000, 13,000, 9,000 and 6,000 in this report. 34 states and Puerto Rico experienced an increase in foster care between 2016 and 2017, which also represents an improvement, with 39 states experiencing increases between 2015 and 2016.

At the same time the number of adoptions and children waiting to be adopted increased. The number of adoptions from foster care increased to 59,430, which represents the highest number since AFCARs tracked adoptions. There are also 123,000 children waiting to be adopted, which also represents an increase form 2016 when 116,000 children were waiting. That represents the biggest year to year increase in over half a decade.

Jerry Milner emphasized the positives in the numbers, saying:

"We are very happy that the rate of increase in the number of children in foster care is less than the prior year, and hope this is attributable to a greater focus on primary prevention of child maltreatment. Our goal is to keep families together and, when foster care placement is absolutely necessary, to reunify children back to safe and loving family conditions whenever possible. We can do this by addressing underlying behavioral and social issues through preventive and in-home services, so children do not have to enter into care and become separated from their families."

The number of children that entered foster care in FY 2017 decreased from 272,000 to 269,000 but the number that exited foster care also decreased from 248,000 to 247,000. (Entries and exits cannot be combined to come up with a final number since some children could enter or exit more than once in a fiscal year). According to HHS, slightly more than 96,700 children were removed from their home in FY 2017 because at least one parent had a drug abuse issue.

In terms of the overall foster care population, children five and younger represent 42 percent of the foster care population, and that has remained similar over the last two years. Entries into foster care are also similar, with 49 percent of children entering foster care at five or younger. That represents over 122,000 children with 50,000 of that total being infants under the age of one.

Under a relatively new AFCARS item, 41 percent of parents had a substance abuse problem as the reason associated for the child's removal (36 percent drugs, 5 percent alcohol). This was the 'primary reason," so it's likely that some of the other categories of reasons for removal such as "neglect" could also include alcohol or drugs as a contributing factor in removal.

The number of youth that were emancipated or "aged out" of foster care is under 20,000 at 19,945. That represents a decrease of 587 from 2016. This continues a trend of decreases from more than ten years ago when nearly 30,000 youth aged-out of foster care. There are now 13,316 youth ages 18, 19 and 20 in foster care, some of whom may have aged out of care in past years before states had the option to extend Title IV-E foster care to age 21.

Help for Social Workers on Loans

Congressman Danny Davis (D-IL) is promoting one-time funding that can assist social workers seeking education loan forgiveness. The temporary funding acts as a patch for some who qualify for loan forgiveness under a ten-year plan that covers some workers (including social workers working within child welfare) if they have paid on their loans over the past ten years. As explained by Congressman Davis's office: A recent funding bill allowed up to $500 million in loan forgiveness for the Temporary Expanded Public Service Loan Forgiveness program. The funds are to provide Public Service Loan Forgiveness for public servants who were denied Public Service Loan Forgiveness solely because they were in the wrong federal student loan payment plan. The funds go out on a first-come-first-served basis.

Here is an overview of the Temporary Expanded Public Service Loan Forgiveness from the website of the Department of Education.

Public servants must meet all requirements for Public Service Loan Forgiveness except that they made payments on an ineligible payment plan. To qualify, public servants must have:

- Submitted an application for Public Service Loan Forgiveness and had that application denied only because some or all of the payments were not made under a qualifying repayment plan;
- Had at least 10 years of full-time employment certified by a qualifying employer and approved by FedLoan Servicing, the federal loan servicer for the Public Service Loan Forgiveness Program;
- Made 120 qualifying payments under the new requirements for the Temporary Expanded Public Service Loan Forgiveness Program while working full-time for a qualifying employer or employers; and
- Be Direct Loan borrowers (borrowers with loans made under the Federal Family Education Loan Program are not eligible for the opportunity).

Davis's office indicates that public outreach is very important given the limited amount of funds available and given that that public servants must apply and be denied to qualify for this temporary opportunity. Many borrowers may not have formally applied for forgiveness if their servicers told them that they were in the incorrect payment plan and are ineligible. Congressional offices may be able to help borrowers submit their applications requesting expedited review by Federal Student Aid given the limited availability of these funds.

About the Author

__John Sciamanna__, Vice President of Public Policy for the Child Welfare League of America, began working for CWLA in 2001. In his role, he oversees federal legislative policy as it affects child welfare and children's programs. This includes federal legislative and administrative action as well as the annual federal budget.

Conference Calendar

January

January 26—27, 2019
Ray E. Helfer Society Annual Meeting
Pre-Conference Institutes: Abusive Head Trauma and Medical Evaluation of Child Physical Abuse
www.helfersociety.org
In Conjunction with Rady Chadwick Conference
http://www.sandiegoconference.org

January 27, 2019
APSAC's Pre-Conference
Advanced Training Institutes
San Diego, CA
877-402-7722
apsac@apsac.org
www.apsac.org
In Conjunction with the Rady Chadwick Conference
http://www.apsac.org

January 26, 2019—January 31, 2019
34th Annual San Diego International Conference on Child and Family Maltreatment
San Diego, CA
858-966-4972
http://www.sandiegoconference.org

March

March 18—21, 2019
35th International Symposium on Child Abuse
Huntsville, AL
256-533-KIDS(5437)
www.nationalcac.org

April

April 9—13, 2019
Child Welfare League of America
Meeting the Challenge of the Family First Prevention Services Act
Washington, D.C.
www.cwla.org

April 7—April 10, 2019
Ray E. Helfer Society Annual Meeting
Orlando, FL
www.helfersociety.org

May

May 31—June 4, 2019
National CASA Conference
Atlanta, GA
www.casaforchildren.org

May 29—June 1, 2019
56th AFCC Annual Conference
The Future of Family Justice: International Innovations
Toronto, Ontario, Canada
afcc@afccnet.org

June

June 5—7, 2019
The Field Center for Children's Policy, Practice and Research
One Child, Many Hands: Multidisciplinary Conference on Child Welfare
https://fieldcenteratpenn.org/one-child-many-hands/

June 18—22, 2019
26th APSAC Colloquium
Promoting Trauma-Informed Practice in All Disciplines
Salt Lake City, UT
877-402-7722
apsac@apsac.org
www.apsac.org

July

July 28—31, 2019
82nd NCJFCJ Annual Conference
Orlando, FL
775-507-4798
www.ncjfcj.org
kjones@ncjfcj.org

September

September 16—19, 2019
Prevent Child Abuse America Conference
Moving Upstream
Milwaukee, WI
www.preventchildabuse.org
bklika@preventchildabuse.org

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