

APSAC ADVISOR

A Publication from the American Professional Society on the Abuse of Children



Thank you for your interest in this publication from The American Professional Society on the Abuse of Children. APSAC is a non-profit professional society dedicated to translating research into best practices in child maltreatment prevention and all forms of legal and clinical intervention. We are funded almost completely by membership dues and revenue from publications and training. Please consider [making a contribution](#) or [joining APSAC](#) to enjoy all benefits we offer members!

ADVISOR



The American
Professional Society
on the Abuse of Children®

Strengthening Practice Through Knowledge

In partnership with



April 2019

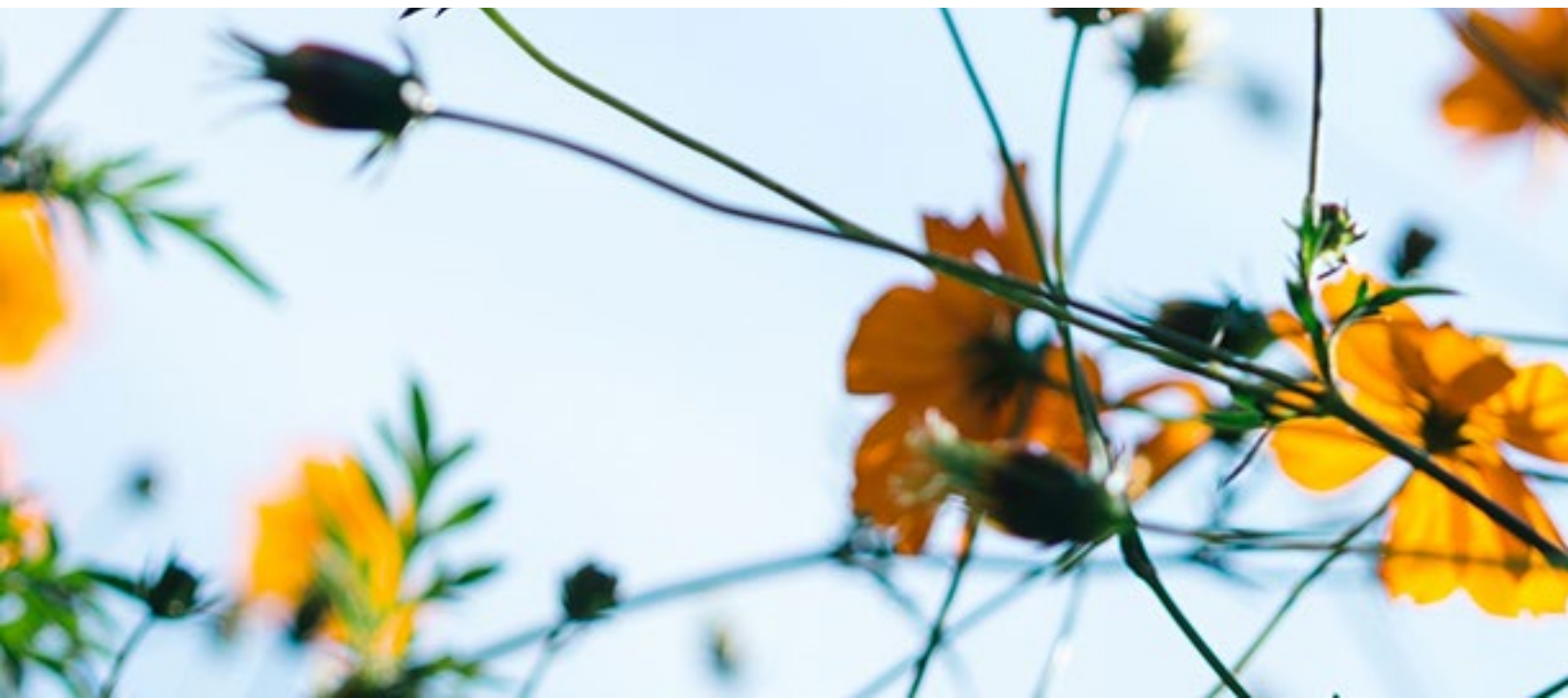
In This Issue

Mandatory Reporting,
Medical Research, and a
Special Section on Ending
Corporal Punishment





- page 4 **At Issue: Child Abuse Reporters and the Immunity Myth** | *Franne Sippel and Nancy Guardia*
The authors survey research studies that show a growing number of professionals who work with children fear retaliation. These studies also indicate that many mandated reporters have experienced serious negative consequences for their good faith actions to prevent, investigate, and treat child maltreatment cases. This article suggests that immunity for child abuse reporting is a false belief, based largely on the protections from liability contained in each state's law on mandatory reporting. However, these laws are not enforced by any state or federal government office. In recent years, legislation has been passed to increase the number of people legally obligated to report abuse, to increase training requirements for mandated reporters, and to increase the penalties for those who fail to report. Yet, these measures will do little to strengthen the mandatory reporting system as long as teachers, psychologists, social workers, and medical staff continue to experience dire consequences for working on the frontlines of child protection.
- page 12 **An Overview of Published Medical Research About Child Abuse and Neglect During 2006–2015** | *Vincent J. Palusci and Jessica Perfetto*
We evaluated the published medical literature concerning child abuse during 2006–2015 to better understand the strength of its evidence by using the following categories: (1) frequency of publication, (2) specialties of the journals publishing this research, (3) use of specific observational and interventional study designs and level of evidence, and (4) relationships with specific child maltreatment types. We located 366 articles listed in PubMed and other sources under the major subject headings of child abuse or shaken baby syndrome (after removal of nonmedical articles and duplicates) and found that the number of publications were increasing at a rate of 5% or more per year. Publication characteristics were similar to other medical research but differed from child abuse research overall in that the primary type of maltreatment studied was physical abuse, followed by sexual abuse, neglect, and multiple types. Case series or case reports predominated, followed by case-control, cross-sectional, ecological, longitudinal cohort, and clinical trial reports. The mean level of evidence was 3.59, which varied by child maltreatment type, and the greatest improvements in study design were in articles about neglect. Medical research in child abuse and neglect mirrored other medical specialties in its level of evidence, but improvements in study design and research support are needed for continued growth.
- page 24 **True Evidence-Based Practices Deserve Wide Acceptance** | *Bill Baccaglioni and Sylvia Rowlands*
Decades of clinical trials have provided compelling data that *evidence-based practices* (EBPs) are improving outcomes for children and their families. EBPs have been one of the most important developments in child welfare practice, but despite proven positive outcomes, they have continued to be met with resistance—resistance that must be overcome if the child welfare profession is to adopt true best practices. Government legislation such as The Family First Act encourages the implementation of EBPs, but the continued efficacy of EBPs and the effectiveness of that legislation will depend on how strictly evidence-based is defined.



ADVISOR Special Section: Ending Corporal Punishment

page **A National Initiative to End Corporal Punishment** | *Viola Vaughan-Eden, George W. Holden, and*
28 *Mel Schneiderman*

In response to APSAC's policy statement calling for the elimination of all forms of CP and physical discipline of children, a National Summit to End Corporal Punishment in the United States was convened October 12-13, 2017. The primary goal of the Summit was to develop a national strategy to end CP in the U.S. The Summit brought together 37 national experts and researchers in the areas of CP and violence to children, public health, and marketing and media as well as representatives from national organizations, government agencies, and foundations. This article discusses the purpose, goals, and outcomes of the Summit as well as the various activities (e.g., No Hit Zones) and accomplishments of the National Initiative in the following 18 months. Strategies to change social norms about CP and opportunities to collaborate are discussed.

page **No Hit Zones: A Simple Solution to Address the Most Prevalent Risk Factor in Child Abuse** | *Stacie*
37 *Schrieffer LeBlanc, Randell Alexander, Madison Mastrangelo, and Hannah Gilbert*

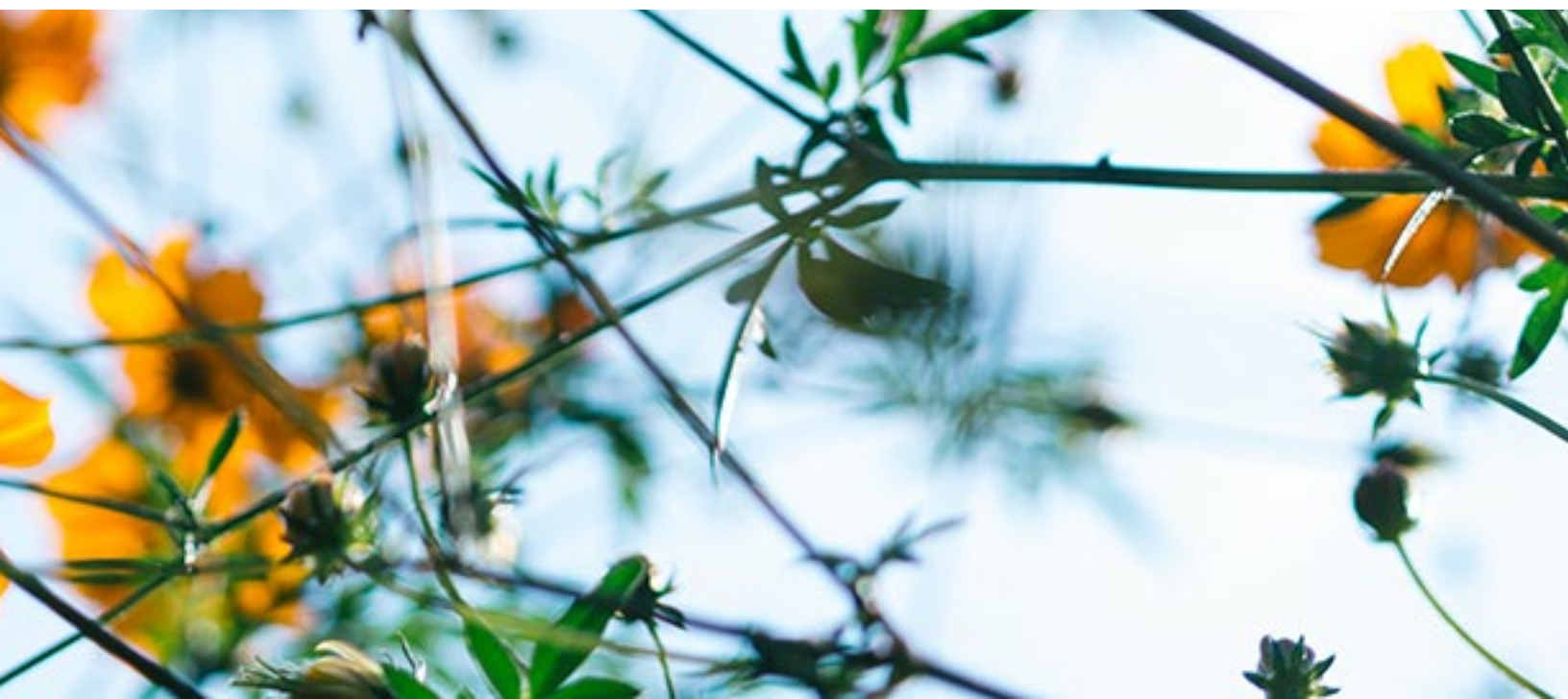
Reducing the most prevalent risk factor for child abuse in the United States—social norms around corporal punishment—is difficult but essential. Although the science is clear that corporal punishment is associated with numerous harms, professionals struggle communicating risk in the face of the overwhelming acceptance of spanking across cultures in the U.S. No Hit Zones (NHZs) offer a viable and simple solution to changing social norms, starting by banning hitting similar to the way no smoking areas were successfully established. This article details the need, purpose, evaluation, lessons, steps, and misconceptions of implementing NHZs. The journey to ending corporal punishment of children is admittedly difficult, and No Hit Zones offer one tested path.

page **Working with Molly: A Culturally Sensitive Approach to Parents Using Corporal Punishment**
52 **Because of Their Religious Beliefs** | *Victor I. Vieth*

Many parents hit their children as a means of discipline because they sincerely believe this practice is commanded by God. Child protection professionals must be mindful of this dynamic and employ a culturally sensitive approach when working with these parents. Using a hypothetical case, this article traces the roots of religious adherence to corporal punishment and finds that while this belief is predominate among theologically conservative Protestants, it is not universally accepted and has many nuances. Applying this knowledge, the reader is provided five theological arguments that are accepted by a number of conservative Protestants for moving away from the physical discipline of children.

Plus our regular features:

Research-to-Practice Brief, Washington Update, News of the Organization, and Conference Calendar



At Issue: Child Abuse Reporters and the Immunity Myth

Franne Sippel, EdD

Nancy Guardia, MSW

For decades legal experts and academics have reassured professionals required to report child abuse that they are protected from legal and financial harm when reporting suspected abuse or neglect. They have been told that as long as their reports are made in good faith, strong immunity laws will shield them from both criminal and civil liability.

“The good news is that in the United States, teachers are protected from litigation in situations where they report suspicions of child abuse, as long as they follow the requirements specific to their district and state. So breathe a sigh of relief, as chances are your worst fear will never come true. . . .” stated Dr. Matthew Lynch (2012).

But, such reassurances ring hollow for those who have performed their duty to protect vulnerable children and then experienced severe retaliation. Mandatory reporters who comply with the law subsequently have been fired, threatened, demoted, harassed, sued civilly, criminally charged, faced with professional board or ethics complaints, and had their identity released to the alleged perpetrator and made public.

Despite the myth that it is safe to “speak up for kids,” nothing prevents alleged perpetrators of abuse from bringing a civil lawsuit against a child abuse reporter. All they need is an attorney willing to take their case.

In the field of employment law, no government oversight or complaint process is available when an employer retaliates by firing or disciplining an employee for reporting child abuse. This is the legal equivalent of having federal and state laws governing unfair work practices with no state labor board to investigate and enforce these laws.

Thus, child abuse reporters’ only recourse is to sue their employer, a process that can have overwhelming financial and professional repercussions. Further, appellate courts frequently uphold an employer’s right to dismiss an employee “at will” and decline to extend “the public policy exception” for mandatory reporting (Paget, n.d.).

Employers’ rights have also superseded children’s safety in the infamous practice of “passing the trash,” which has been documented in investigations of pedophiles in the Catholic Church and in New England private schools. In numerous instances, adults who supported the child victims then experienced disciplinary actions by their employers, such as demotion and termination (Harris, 2017).

Carolyn Trost, in her 1998 article “Chilling Child Abuse Reporting: Rethinking the CAPTA Amendments,” expressed grave concern that the United States was undergoing a policy shift toward “legislation that favors parental interests over children’s interests.” Trost predicted the 1996 Amendments to CAPTA with their “higher immunity threshold and ambivalence toward

promoting (child abuse) reporting will ultimately increase litigation, and thus the cost of good faith child abuse reporting, and increase liability for erroneously reporting child abuse (p. 189).”

Trost (1998) discussed the fact that most reporting laws place the degree of suspicion required for reporting at a very low level to encourage reporting and protect as many children as possible. “Establishing a low level of suspicion necessarily assumes [that] enduring some erroneous reports is the price for detecting as much abuse as possible (p. 207).”

Trost (1998) also addressed the misconception that many child abuse reporters act with malice. Her research revealed a negligible number of court cases in which a credible claim of malice had been made. Furthermore, most states’ laws have severe penalties for mandated reporters who knowingly file a false report—including sanction or loss of one’s professional license.

Trost (1998) noted significant deterrents to reporting by mandated professionals existed before the 1996 Amendments, and that underreporting is widely recognized as a problem, hampering detection of abuse and efforts to protect children. She predicted that “increased litigation and decreased immunity will likely have a serious chilling effect on child abuse reporting (p. 214).”

Although malpractice lawsuits against psychologists have remained stable over the past two decades, licensure board complaints have increased dramatically. “Unfortunately, even a letter of reprimand, the lowest form of disciplinary action from a licensing board, can have serious consequences. It may result in the removal of the psychologist from a managed care panel or the loss of hospital privileges (Youngren, Vandecreek, Knapp, Harris, & Martin, 2013, p. 20).”

Board complaints against licensed professionals for their child protection work fall under administrative law. State licensing board members are political appointees. There is no federal or state government oversight of licensing board actions taken against child abuse reporters, and licensing boards are frequently a branch of a state’s Office of Consumer Affairs. Therefore, state government attorneys who prosecute licensing board

actions may consider their primary duty to be to the adult complainant, rather than the child victim.

Licensing board attorneys focus on whether licensing law and its regulations were violated; they do not focus on assessing whether or not the client actually suffered harm from a mandatory child abuse or neglect report. Since a licensing board action is an administrative, rather than a criminal, procedure, reporters (i.e., psychologists or social workers) are not granted the same due process rights and must hire their own legal representation. Child abuse reporters can also be denied coverage for board complaints by their employer’s professional liability insurance. In addition, standards for admissible evidence are less stringent, hearsay evidence is allowed, and the standard of proof is substantially lower (Youngren et al., 2013).

Fathers’ rights groups may go after professionals who work to protect children as well. Too often these groups find ways to intimidate licensure boards or file multiple complaints against good professionals. This is called “targeting,” and the authors report it has resulted in fewer mental health professionals willing to evaluate and protect abused children, especially during divorce proceedings (Kleinman & Pollack, 2017).

The misuse of confidentiality protections under the Health Insurance Portability and Accountability Act (HIPAA) may be a factor to consider when interpreting data regarding retaliation, since this is the basis for numerous board complaints filed by a caregiver *after* the mandated reporter filed a child abuse report against the caregiver. In one study, 9.7% of the complaints against the psychologists were for an alleged breach of confidentiality (Montgomery, Cupit, & Wimberley, 1999).

Kirkland and Kirkland’s (2001) study based on data collected from 34 states and provinces found an “astounding” number of licensing board complaints against psychologists performing child custody evaluations. The study noted a “low threshold for filing formal complaints” (p. 172). Complaints can easily be filed online, eliminating attorney fees. Most practitioners describe a board complaint as a “thoroughly harrowing experience even if the complaint is patently vengeful or frivolous” (p. 173). The study also

noted that although most disciplinary actions are not severe, the fact that a professional has been disciplined at all follows the practitioner for the remainder of one's career. Child custody decisions were rated among the most likely activities to cause both board complaints and malpractice suits.

In a study entitled "Complaints, Malpractice, and Risk Management: Professional Issues and Personal Experiences," 284 licensed psychologists were sampled (Montgomery et al., 1999). In the study, 71.5% reported that they knew a colleague who had a state licensure board complaint filed against them, 41% reported being threatened with a complaint, and 39% of those reported that the threat resulted in a complaint. The study also noted that 38.7% knew a colleague who had been sued for malpractice, and 6% had been sued themselves for malpractice. Out of the sample that had complaints filed against them (N=31), 9.7% were due to retaliation by the complainant.

Despite such studies demonstrating retaliation as a legitimate threat, child abuse reporters are routinely told they are absolutely safe making a report as long as the allegation of maltreatment is made in good faith. This widely believed myth of immunity says cases of retaliation are exceedingly rare and implies that the mandated reporter must have done something wrong to suffer serious negative consequences for simply helping a child. This belief appears to be based upon the mere existence of state immunity laws meant to protect mandatory reporters, rather than on a body of research supporting the actual efficacy of such laws.

For instance, Douglas Besharov (1994) stated unequivocally, "As long as persons who report are arguably acting in good faith, they face no liability for reporting, no matter how weak the evidence or reasons for doing so" (p. 145).

In his article "Disclosing Confidential Information," Stephen Behnke (2014) reviewed the California penal code: "No mandated reporter shall be civilly or criminally liable for any report required or authorized by this article, and this immunity shall apply even if the MR acquired the knowledge of reasonable suspicion of child abuse or neglect outside of his/her professional capacity or outside the scope of his/her employment" (p.

44). Behnke (2014) concluded that such a broad clause in the state's law offers "a high degree of protection to a psychologist who discloses confidential information pursuant to a child abuse reporting statute" (p. 44).

Yet, several recent Amicus briefs written in support of mandated reporters who were retaliated against after they reported child abuse—a doctor, a school administrator, a social worker, and a psychologist (*Jones v. Wang, Schott v. Wenk, Piro v. McKeever, and Kleinman v. New Jersey Board of Psychological Examiners*)—demonstrate that legal retaliation and board complaints are indeed serious issues facing child abuse reporters (for details, see Jones, Jones, & G. J. v. Wang, 2015, *Schott v. Wenk, 2015, Piro v. McKeever, Sapp, Barry, & Davidson Counseling Associates, 2016*).

In addition, the Child Abuse Prevention and Treatment Act's (CAPTA) (1978) *Report to Congress on Immunity From Prosecution for Professional Consultation in Suspected and Known Instances of Child Abuse and Neglect* (U.S. Department of Health and Human Services [USDHHS], 2013) determined "immunity from prosecution is a critically important issue facing professionals involved with responding to an investigating child abuse and neglect" (p. 3).

Included in the 2013 *Report to Congress* (USDHHS) were the results of a study of 544 mandatory reporters, mostly pediatricians, which found that 11% faced lawsuits (6% in state court and 5% in federal court) after filing an abuse report or providing professional consultation. This study measured only one type of retaliation, civil lawsuits, initiated by the alleged perpetrators against the mandatory reporter. The negative consequences from such litigation were reportedly "dire."

In the 2015 study "Factors That Influence Child Abuse Reporting: A Survey of Child-Serving Professionals," authors Walsh and Jones conducted an online survey of 556 child-serving professionals. Although their survey did not specifically address retaliation, survey participants were asked about the relevance of 12 factors that could possibly hinder decisions to report suspected abuse. Thirty-nine percent cited fear of making an inaccurate report, 35% cited unclear statutory laws, and 31% said fear of legal ramification for accusations that

proved false were factors that could negatively impact their decision to report suspected abuse.

Authors Rannah Gray and Jim Kitchens completed an unpublished national online survey in April 2017 to determine barriers to reporting child sexual abuse. Ms. Gray became interested in the subject when she learned during talks with groups, including mandatory reporters, that they were often discouraged by their supervisors and employers from reporting suspected child abuse (Kitchens & Gray, 2017).

The survey sample consisted of 600 adults. Among the notable findings, 49% said they worry about an accused abuser suing them for reporting, and 55% over age 65 cited this as a concern as well, indicating a significant deterrent for abuse reporting. A total of 59% feared the accused might retaliate against them (pose a safety threat), and 70% of ages 18–34 and 69% over age 65 specifically worried this retaliation might involve physical violence. Over all age groups, 36% worried about their reputation being harmed for reporting child sexual abuse, with 44% of the respondents in the 18–34 age range being the most concerned (Kitchens & Gray, 2017).

Other studies demonstrate that fear of litigation or having been previously sued decreases the likelihood of reporting child abuse (Flaherty et al., 2006; Gunn, Hickson, & Cooper, 2005; Lazenbatt & Freeman, 2006).

A 2011 study by Barlow sampled 1,223 nurse practitioners and nurse midwives. Survey participants were asked to list reasons why a healthcare provider might decide not to report suspected child abuse. One significant perceived barrier to reporting child abuse was a fear that reporting might harm the provider personally, professionally, or legally.

One co-author of this article, Franne Sippel, and her colleagues Karyl Meister, Ahmet Can, and Theresa Esser, are conducting a study, entitled “Mandatory Reporting and the Retaliation Factor,” in conjunction with Northern State University in Aberdeen, South Dakota (2018). Their study modifies and expands CAPTA’s 2013 *Report to Congress* to include a broader sample of mandatory reporters, measures multiple forms of retaliation, and explores how retaliation and

fear of retaliation may or may not impact child abuse reporting behaviors. To date, 566 mandatory reporters have responded and 23% say they have experienced some form of retaliation *after* reporting child abuse or neglect (Sippel et al., 2018).

Dr. Sippel has contacted a number of professional liability companies, including the Trust, HPSO, NASW Assurance Services, and PIAA, regarding claims against professionals filed by alleged perpetrators of child maltreatment. The information from their representatives and information available on their websites does not indicate that these companies consider retaliation as a separate risk management category. Consequently, their risk management training for mandatory reporters does not address the specific risks associated with reporting child maltreatment. Therefore, mandatory reporters are not being made aware of the possibility of retaliation or being advised on best practices to protect themselves from legal retribution.

For example, the Trust insurance company’s advertisement for risk management training states the following: “For the last ten years, there has been a major increase in the number of lawsuits, licensing board complaints, and ethics committee complaints against clinical psychologists (Harris, 2014).” Yet, the Trust does not note what percentages of these adverse actions are related to custody and child protection issues.

The professional liability company for social workers notes that a client or even a third party can sue a mandatory reporter without a legitimate reason. “Social work is a rewarding career that demands personal commitment. But helping others can put you at risk of being sued by someone dissatisfied with an outcome. You need professional liability coverage. Social workers need protection from frivolous lawsuits and from legal action due to negligent acts, errors, and omissions that can arise from their practices. These lawsuits may even arise years later, after the alleged event took place. Without insurance, you could spend precious time and resources defending yourself, regardless of whether there is any merit to the claim” (NASW Assurance Services, Inc., 2018).

Thus, professional liability companies promote the

necessity of liability insurance against malicious complaints and lawsuits while overlooking retaliation as a serious risk factor for the child abuse reporters who purchase this insurance.

Popular culture also promotes the belief that reporting suspected child abuse is an easy obligation with no personal liability for the reporter. Politicians routinely urge the public to stop the silence about child abuse by simply “speaking up” to protect children from harm.

Following Jerry Sandusky’s indictment for decades of child sexual abuse, which went unreported by Penn State’s top administrators, many states passed legislation to expand and strengthen mandatory reporting laws. The majority of these laws focused on increasing the pool of mandated reporters, increasing training requirements for child welfare professionals, and increasing civil and criminal penalties for professionals who fail to report.

Retaliation for child abuse reporting was addressed only by some statutes that forbid employers from discriminating against mandatory reporters. Unfortunately, none of these laws made any provisions for investigating instances of retaliation by employers or for enforcing penalties for an employer’s illegal actions.

Furthermore, the media often contribute to public misconceptions about mandatory reporting by confusing the role of professionals, who have a legal duty to report suspected child abuse, with the role of the states’ child protective services (CPS) workers, who investigate and act on these reports. Thus, relatively rare cases in which good parents lose custody may be attributed to overzealous child abuse reporting. In reality, the determination of whether or not child abuse occurred is made by child protection services (CPS)—not the child abuse reporter. The decision to remove a child from a parental home is made by a court of law—not the mandated reporter. Journalists may equate the debate about reporting parents who allow their children to play unattended with the far more consequential debate about reporting parents of infants born addicted to opiates (Goldberg, 2015).

Richard Wexler is one example of a journalist whose extremist family preservation argument has been widely

quoted in national newspapers such as the *New York Times*, the *Washington Post*, the *Los Angeles Times*, and *USA Today*. He has been interviewed on NPR, ABC, CBS, and NBC. (While Josh Powell was still being investigated for his wife’s murder, Wexler said the “least bad option” would be for the courts to allow Powell’s two young sons to remain in his custody—3 days later, the children were dead.). Wexler is the director of the one-man National Coalition for Child Protection Reform and claims to be an advocate for children despite a lack of training or credentials. Wexler has testified as a “child welfare expert” before the U.S. Senate and U.S. House of Representatives in opposition to laws to expand child abuse reporting.

In response to an op-ed piece by Dr. Sippel (2016) in the *Chronicle of Social Change*, Wexler (2017) alleged that mandatory reporters are arguing for less accountability in reporting.

[Child abuse reporters] already have protections from lawsuits that are so strong that they have to not only violate the law but [also] have good reason to know they’re doing it, or be acting maliciously, before a jury can even consider what they’ve done to an innocent family. The 2013 HHS report to Congress passes on recommendations from mandated reporters.... Surprise! They want even less accountability.... [T]he extremism of some seeking to avoid accountability knows no bounds. Pity the poor oppressed mandated reporter.” (p. 2)

In her response to Wexler, Nancy Guardia (2017), MSW and co-author of this article, countered by noting that no government entity prevents an alleged child abuser from suing a mandatory reporter. She also noted that no state ensures any enforcement of immunity protection contained in state laws. Guardia further argued that mandated reporters do not want child abuse reporting laws strengthened “to avoid accountability.” Rather, they are advocating for “enforced and expanded protections for those already serving as child abuse reporters (p. 2).”

It is neither logical nor ethical for our society to continue perpetuating the myth that the current laws on immunity from liability provide sufficient protection for child abuse reporters. *Instances of legal and other forms*

Child Abuse Reporters and the Immunity Myth

of retaliation are occurring, but they are rarely studied; furthermore, no private or government agency is measuring the extent of the problem. The chilling effect of retaliation on child abuse reporting already exists but is simply not addressed.

Ironically, the belief that mandatory reporters are without risk is actually placing them at increased risk. Too often mandatory reporters face a Hobson's choice, by which they can suffer dire professional and personal consequences for reporting, as well as for not reporting, the suspected or known abuse of a child. Child abuse reporters are not told the laws meant to protect them are unenforced and may help only after the damage has been done (i.e., after a lawsuit has been filed), or that immunity laws do not protect them from damaging professional ethics or board complaints. Denying that reporting child abuse can put mandatory reporters in serious jeopardy thus fails to prepare them for the unfortunate reality they may face.

In conclusion, child welfare legal experts and academics need to raise awareness that our present laws fail to provide adequate immunity for frontline child abuse reporters. CAPTA should be amended to make explicitly clear that those professionals mandated to report suspected child abuse or neglect are immune from the following: (1) criminal liability, (2) civil liability, and (3) complaints against their professional license. CAPTA should clarify that child abuse reporters are immune from liability under federal law.

Individual statutes must also be strengthened by clarifying the reporting process. We need to differentiate abuse and neglect reports made by a child's teacher, physician, therapist, and other legally mandated

reporters from those made by the general public. This would help CPS prioritize reports and acknowledge that child abuse reporters are assisting the government's interest in protecting children.

State whistleblower laws, and an ombudsman for mandated reporters, could monitor the enforcement of statutory protections from liability.

Finally, all state legislatures should amend their laws to incorporate the recommendations from CAPTA's 2013 *Report to Congress* (USDHHS), which concludes that

Virtually every aspect of investigations into child abuse or neglect cases calls for independent professional judgments and decision making that could be legally protected, as long as those actions are taken in good faith.... By providing these protections, professionals who work on those important cases could carry on their work ... with less fear of liability for providing assistance to vulnerable children. (p. 21)

About the Authors

Franne Sippel, EdD, a licensed psychologist, belongs to the National Association of Certified Mediators and the American Psychological Association. A practitioner for over 25 years, she serves as an expert on APSAC's Center for Child Policy, focusing on Maltreatment Reporting Laws. Corresponding contact: 605-397-7949, franne23@nvc.net.

Nancy Guardia, MSW, a clinical social worker and member of NASW, has provided therapy to individuals and families for over twenty years. She has done extensive research on the effective practices for reporting child abuse and neglect, and serves as an expert on APSAC's Maltreatment Reporting Laws Committee. Contact: 845-687-6481, nlguardia@gmail.com



At Issue: Child Abuse Reporters and the Immunity Myth

- Barlow, S. Lee. (2011). *Nurse practitioner barriers to reporting child maltreatment*. All Theses and Dissertations. Retrieved from <http://scholarsarchive.byu.edu/cgi/viewcontent.cgi?article=3671&context=etd>
- Behnke, S. (2014). Disclosing confidential information. *Monitor on Psychology*, 44-45. Retrieved from <http://www.apa.org/monitor/2014/04/disclosing-information.aspx>
- Besharov, D. J. (1994). Responding to child sexual abuse: The need for a balanced approach. *Sexual Abuse of Children*, 4(2), 135-155. Retrieved from <https://www.jstor.org/stable/1602528>
- Brief for The American Academy of Pediatrics, The American Professional Society on the Abuse of Children, The California Medical Association, and The Ray E. Helfer Society as Amici Curiae Supporting Respondents, Jones v. Wang 802 9th Cir. 990 (2015) (no. 12-55995). Retrieved from http://docs.wixstatic.com/ugd/eb6300_abbec56d906457e9e06f90f38beb9e5.pdf
- Brief for Ohio School Boards Association et al. as Amici Curiae Supporting Respondents, Schott v. Wenk, 136 U.S. 792 (2016) (no. 15-54). Retrieved from https://cdn-files.nsba.org/s3fs-public/reports/NSBA%20Brief-15-54_%20Schott_Wenk.pdf?ANlcP0F1amSXSdoOQI7nJX2XOuZpp9JX
- Brief for The National Association of Social Workers as Amici Curiae Supporting Respondents, Piro v. McKeever, 782 N.C. Ct. App. 367 (2016) (no. coa15-351). Retrieved from <https://www.socialworkers.org/assets/secured/documents/ldf/briefDocuments/Piro%20v%20%20McKeever.pdf>
- Child Abuse Prevention and Treatment Act of 1974, 42 USC §§5101–5106.
- Flaherty, E. G., Sege, R., Price, L. L., Christoffel, K. K., Norton, D. P., & O'Connor, K. (2006). Pediatrician characteristics associated with child abuse identification and reporting: Results from a national survey of pediatricians. *Child Maltreatment*, 11(4), 361-369.
- Goldberg, M. (2015, October). *Whose kid is big brother watching?* Retrieved from [https://drive.google.com/drive/folders/1S4uJKLRWmpjK0fwySL-fwf5I7upIxNf-\(64\)](https://drive.google.com/drive/folders/1S4uJKLRWmpjK0fwySL-fwf5I7upIxNf-(64))
- Guardia, N. (2017, February 27). Mandated reporters: Protection does not weaken accountability [Op ed]. *The Chronicle of Social Change*. Retrieved from <https://chronicleofsocialchange.org/opinion/response-claim-call-minimal-accountability-child-welfare/25077>
- Gunn, V. L., Hickson, G. B., & Cooper, W. O. (2005). Factors affecting pediatricians' reporting of suspected child maltreatment. *Ambulatory Pediatrics*, 5(2), 96-101.
- Harris, E. A. (2014). *(On demand) sequence II: Ethics risk management in specific high-risk areas* [Webinar]. Rockville, MD: The Trust. Retrieved from <http://thetrust.bizvision.com/product/ethics-and-risk-management%20sequences/ondemandsequenceiiethicsriskmanagementinspecifichighriskareas%2812224%29>
- Harris, E. A. (2017, April 23). Ousted over sexual misconduct claims, and on to the next teaching job. *The New York Times*. Retrieved from <https://www.nytimes.com/2017/04/23/nyregion/ousted-over-sexual-misconduct-claims-and-on-to-the-next-teaching-job.html>

- Kirkland, K., & Kirkland, K. L. (2001). Frequency of child custody evaluation complaints and related disciplinary action: A survey of the Association of State and Provincial Psychology Boards. *Professional Psychology: Research and Practice*, 32(2), 171-174.
- Kitchens, J. & Gray, R. (2017). *Barriers to reporting child sex abuse*. Unpublished manuscript.
- Kleinman, T., & Pollack, D. (2017). *Domestic abuse, child custody, and visitation*. New York, NY: Oxford University Press.
- Lazenbatt, A., & Freeman, R. (2006). Recognizing and reporting child physical abuse: A survey of primary health care professionals. *Journal of Advanced Nursing*, 56(3), 227-236. doi:10.1111/j.1365-2648.2006.04030.x
- Lynch, M. (2012). Ask Dr. Lynch: Can reporters of child abuse be sued? Education World, Inc. Message posted to <http://www.educationworld.com/a-curr/ask-dr-lynch/reporters-child-abuse-sued.shtml>
- Montgomery, L. M., Cupit, B. E., & Wimberley, T. K. (1999). Complaints, malpractice, and risk management: Professional issues and personal experiences. *Professional Psychology: Research and Practice*, 30(4), 402-410.
- NASW Assurance Services, Inc. (2018). *Professional liability (individuals)*. Retrieved from: <https://www.naswassurance.org/malpractice/professional-liability-individus/>
- Paget, M. H. (n.d.). Exceptions to the At-Will Employment Doctrine and its applicability to employment share holders. *MA Law Review*. Retrieved from www.academia.edu/12241563/massachusetts_law_review
- Sippel, F. (2016, December 28). Existing protections fall short for mandated child abuse reporters [Featured op-ed]. *The Chronicle of Social Change*. Retrieved from <https://chronicleofsocialchange.org/opinion/targeting-americas-mandated-reporters-why-existing-protections-fall-short/23662>
- Sippel, F., Can, A., Meister, K., & Esser, T. (2018). *Mandatory reporting and the retaliation factor*. Unpublished manuscript. Department of Counselor Education, Northern State University, Aberdeen, United States of America.
- Trost, C. (2017, September). *Chilling child abuse reporting: Rethinking the CAPTA Amendments*. Retrieved from [https://drive.google.com/drive/folders/1S4uJKLRWmpjK0fwySL-fwf5I7upIxNf-\(169\)](https://drive.google.com/drive/folders/1S4uJKLRWmpjK0fwySL-fwf5I7upIxNf-(169))
- U.S. Department of Health and Human Services (USDHHS), Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2013). *Report to Congress on immunity from prosecution for professional consultation in suspected and known instances of child abuse and neglect*. Washington, DC: Author. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/capta_immunity_rptcongress.pdf
- Walsh, W., & Jones, L. (2015, September). *Factors that influence child abuse reporting: A survey of child-serving professionals*. Retrieved from <http://unh.edu/ccrc/pdf/Final%20Reporting%20Bulletin%20Professional%20Perceptions.pdf>
- Wexler, R. (2017, January 19). Re: Just what we need in child welfare: Less accountability! [Web log message]. Retrieved from <https://chronicleofsocialchange.org/blogger-co-op/just-need-child-welfare-less-accountability/23927>
- Youngren, J., Vandecreek, L., Knapp, S., Harris, E., & Martin, J. N. (2013). *Assessing and managing risk in psychological practice: An individualized approach* (2nd ed.). Rockville, MD: The Trust.

An Overview of Published Medical Research About Child Abuse and Neglect During 2006-2015

Key words: Child abuse medical research; child abuse pediatrics; study design; level of evidence

*Vincent J. Palusci, MD, MS, FAAP**

Jessica Perfetto, MD

Introduction

The purpose of medical research has been described as “to rid men of diseases, to protect them from maladies with which they are threatened, and to relieve them of discomforts once they are established” (Cohn, 1938, p. 265). Given that approximately 1%–2% of all children are found annually to be victims of child abuse and neglect and 1 in 3 will be reported to child protective services (CPS) before age 18, it is apparent that *child maltreatment* (CM) is a “malady” affecting large numbers of children (United States Department Health Human Services [US DHHS], 2017; Kim, Wildeman, Jonson-Reid, & Drake, 2017). Medicine has played an important part in the determination, treatment, and prevention of the physical and emotional injuries caused by child abuse and neglect since they were widely recognized by the medical community (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962). The U.S. Institute of Medicine (IOM) and the National Research Council (NRC) have noted that a medical opinion is the only way to determine whether certain injuries to the head, bones, skin, anus, and genitals are the result of abuse or neglect (Petersen, Joseph, & Feit, 2014).

Published research on child abuse and neglect overall has addressed medical issues pertaining to epidemiology, clinical presentation, diagnosis, treatment, and prevention (Tran et al., 2018). Many research designs have been used, including

observational studies (e.g., case reports or other comparisons, with or without controls) that are analyzed prospectively or retrospectively without any intervention by the investigators) and experimental studies (in which the effects of an intervention are measured). Qualitative designs have been used to generate new knowledge or validate existing knowledge by using methods such as surveys or focus groups. As knowledge improves in medicine, there is generally more use of rigorous prospective, controlled, and randomized clinical trials and systematic meta-analyses, particularly for certain types of outcomes (Parfrey & Ravani, 2009). A validity hierarchy has been proposed with randomized controlled trials and meta-analyses offering the highest level of evidence, and the American Academy of Pediatrics (AAP) proposed four levels of aggregate evidence quality (A-D) for classifying evidence for the development of clinical guidelines (AAP, 2004; Sargeant, Kelton, & O’Connor, 2014). Systems have been developed to assess the level of evidence for particular injuries or issues (CORE INFO, 2017; Tanaka, Jamieson, Wathen, & MacMillan, 2010), and a system with five levels and multiple sublevels has been used internationally (Oxford Centre for Evidence-Based Medicine [OCEBM], 2009; OCEBM, 2011).

Although a number of reviews of child protection research has been published (Buckley, Corrigan, & Kerrins, 2010; Higgins, Adams, Bromfield, Richardson, Aldana, 2005; Taylor et al., 2015; Jones et al., 2017;

* Corresponding Author

Tanaka et al., 2010; Tran et al., 2018), the underlying methodologies and quality of medical research have not yet been specifically addressed. For example, the United Kingdom undertook an extensive review in 2015 to determine what research has been published and how it can be classified, in what disciplines, and using which designs and types of data. Of the 467 articles found published during 2010–2014, three quarters had first authors from the disciplines of psychology (28%), medicine (14%), social work (14%), and psychiatry (12%). In general, qualitative and nonexperimental studies predominated; however, only a small number of medical studies used a qualitative research design compared with over half of the studies from social work, law, sociology, social science, and nursing. Surveys were the next most utilized design, followed by nonexperimental evaluations and cohort studies. Very few academic papers reported the results of a randomized, controlled trial. In Canada, Tanaka et al. (2010) found 13 RCTs in a 50-year review of published interventions to reduce physical abuse and neglect recurrence. They concluded that there were too many methodological limitations in the studies to draw reliable conclusions as to the effectiveness of interventions. Levey et al. (2017) in the United States found only eight randomized controlled trials of interventions designed to prevent abuse among mothers identified as high risk. Of these, only three found statistically significant reductions in abuse by any measure, and only two found reductions in incidents reported to child protective services.

Even though medical research priorities continue to be identified, we feel it is important to evaluate the status of medical research in the field of child abuse and neglect to assist medical researchers in identifying trends and gaps in study design as well as in areas needing additional research (Lindberg et al., 2017). While *child abuse and neglect* is often characterized as “nonmedical” or “outside traditional medical research,” any such evaluation will take place in the context of medical research overall, in which there has been a perceived decline in the rigor of study design (Fletcher & Fletcher, 1979; McDermott et al., 1995). A review of 50 years of articles in the *Journal of Pediatrics*, for example, noted an increase in empirical articles, cohort surveys, and cross-sectional designs with smaller numbers of case reports and case-control

studies during 1932–1982 (Hayden & Saulsbury, 1982). Child abuse and neglect was not specifically categorized in this study, but may have been included under “behavioral pediatrics,” “general pediatrics,” or “other” categories. When repeated in 2009, there was an increase in pediatric analytic studies, some of which may have also been related to child abuse and neglect (Hellemes, Burka, & Hayden, 2009).

To better understand the strength of the evidence in medical research in child abuse and neglect, we reviewed this literature to assess the following: (1) the frequency of publication, (2) the specialties of the journals publishing this research, (3) the use of specific observational and interventional study designs and level of evidence, and (4) the existence of relationships between article characteristics and specific child maltreatment types.

Methods

Article Selection

To identify published medical research about child abuse and neglect, we searched the U.S. National Library of Medicine’s *PubMed* website (<https://www.ncbi.nlm.nih.gov/pubmed>) during March 2017. *PubMed* is a free resource developed and maintained by the National Center for Biotechnology Information (NCBI) at the National Institutes of Health (NIH), which comprises over 24 million citations for biomedical literature from MEDLINE, life science journals, and online books. The number of citations has risen annually from 634,318 in 2006 to more than 800,000 in 2015. Citations and abstracts in the fields of biomedicine and health that cover portions of the life sciences, behavioral sciences, chemical sciences, and bioengineering (with approximately 40%–45% coming from the U.S. *PubMed*) were searched for all citations during publication years 2006 through 2015 under the medical subject heading *child abuse*, which includes physical and sexual abuse and neglect. Not included in that subject heading was *shaken baby syndrome*, which was searched separately given its importance as a form of child abuse (Choudhary et al., 2018). The 10-year period 2006–2015 was chosen to allow sufficient time for complete indexing. We found 9,147 citations listed by the National Library of Medicine during this period under the major headings of *child abuse* or

shaken baby syndrome. Most publications identified by this broad search were not medical articles despite their citation in PubMed. By limiting the results to exclude letters, editorials, and nonmedical articles, that number was significantly reduced. Searches were also made for *clinical trial, cohort, case series, case report, cross-sectional, case control, and ecological articles* during the study period. To assure inclusion of reviews and consensus statements, additional searches were made using the terms *consensus, systematic review, meta-analysis, guidelines, and policy*. Additional searches were also made in the Cochrane (<http://www.cochrane.org/search/site/Child%20abuse?>) and CORE INFO (2017) databases (Higgins & Green, 2011). Animal studies, editorials, commentaries, correspondence, letters, and articles principally about mental health, child welfare, legal, or continuing medical education topics were excluded. When the articles were checked and compared with Cochrane and CORE INFO, and when duplicates and nonmedical studies were excluded, the remaining total was found to be 366.

Information collected and article characterization

Article title, journal name, publication date, and authors were recorded. Articles were characterized as *medical* if they studied the biology or pathophysiology of disease or injury, the prognosis or physical health outcomes, or both. Duplicates and articles dealing with primarily nonmedical issues were removed, and abstracts for the remaining articles were reviewed to ascertain a number of additional study characteristics. If these were not apparent from the abstract, actual articles were reviewed. Reports were classified by the level of evidence (LOE) based on study design. LOE was grouped into major levels based on OCEBM guidelines (OCEBM, 2011) in which level I evidence consisted of high-quality, randomized controlled trials that were adequately powered and the systematic reviews of such studies. Level II publications consisted of lesser-quality, randomized controlled trials; prospective cohort studies; and systematic reviews of those studies. Level III studies consisted of retrospective comparative studies and case-control studies and systematic reviews of those studies. Level IV studies were typically of the case-series variety or nonsystematic reviews of studies, and

level V articles were usually case reports, consensus, policy statements, or guidelines based on expert opinion. Qualitative studies were categorized as level III or IV depending on design. For reviews, including systematic reviews and meta-analyses, LOE was based on the quality of the underlying studies. Given that only small numbers of level II trials were found in our analysis, further categorization was not done. Journals were classified as general medicine, pediatrics, nonpediatric specialty, mental health, public health, child welfare, or legal/forensic. The primary type of maltreatment discussed was characterized as physical abuse, sexual abuse, neglect, or psychological maltreatment based on federal definitions (US DHHS, 2017). Medical child abuse and medical care neglect were coded with neglect due to small numbers, and articles with more than one type or nonspecific trauma were labelled as *multiple*.

Analysis

Frequencies of article and journal characteristics were stratified by year of publication and maltreatment type. Basic statistics were used for comparisons of the numbers and types of articles, and the level of evidence of their designs was stratified by year and the type of maltreatment. Statistical comparisons were done using chi square for categorical variables and Student t tests and ANOVA for continuous variables with posthoc comparisons across CM types as needed. Calculation of group modes, medians, means, 95% confidence intervals, and linear regression models were done using standard methods (SAS version 9.1, Cary, NC) with significance set at $p \leq 0.05$. This current study was deemed ineligible for review as human research by our institutional review committee.

Results

Among the 9,147 articles listed in PubMed during 2006–2015 under the major headings of *child abuse* or *shaken baby syndrome*, 494 remained after duplicates and nonmedical articles were removed. Of these, 138 were primarily related to mental health variables or outcomes, leaving 366 for analysis of primarily physical health studies, including historical and physical manifestations of injuries and disease. The number of articles per year ranged from 23 in 2007 to 58 in 2015 (Table 1). There was a trend for

An Overview of Published Medical Research...

Table 1. Study Designs and Child Maltreatment Types by Year Published.

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Total	32	23	36	39	44	45	24	29	36	58
CM Type										
Physical Abuse	18	10	20	19	17	18	9	13	11	23
Sexual Abuse	8	3	12	10	10	10	5	7	7	17
Neglect/MN/MCA	1	1	1		2	1		1	2	3
Multiple types/trauma	5	9	3	10	15	16	10	8	16	15
Study Design										
Case Control	2	0	1	2	5	3	1	2	1	0
Case Report/Series	17	12	19	18	13	16	6	7	4	15
Clinical Trial	2	4	1	1	4	2	1	4	3	3
Ecological	0	0	0	0	0	0	0	0	1	0
Longitudinal Cohort	0	0	2	0	0	0	0	0	0	2
Review	5	4	7	9	9	11	1	6	8	14
Cross-Sectional	6	3	6	9	13	13	15	10	19	24
Prospective, %	25%	26%	33%	28%	43%	22%	29%	21%	14%	16%

CM: Child Maltreatment; MCA: Medical Child Abuse; MN: Medical Neglect

Figure 1. Published Articles per Year, 2006–2015.

Frequency and Trendline of Published Articles in PubMed, 2006-2015

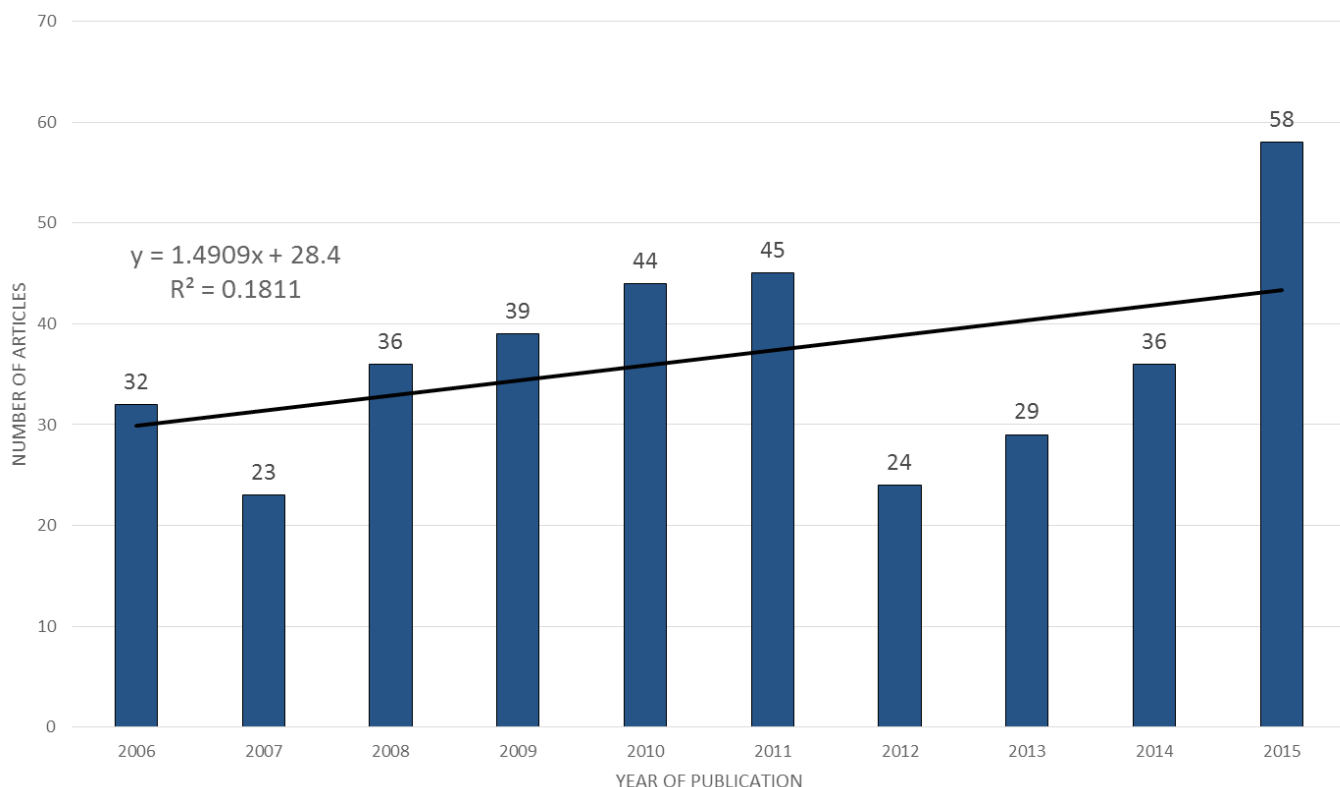


Table 2. Study Designs by Child Maltreatment Type.

	Physical Abuse	Sexual Abuse	Neglect/MN/MCA	Multiple Types/Trauma	Totals
Total	158	89	12	107	366
Study Design					
Case Control	5	3	2	7	17
Case Report/Series	80	29	3	15	127
Clinical Trial	3	10	2	10	25
Ecological	0	0	0	1	1
Longitudinal Cohort	0	2	0	2	4
Review	33	18	2	21	74
Cross-Sectional	37	27	3	51	118
Prospective, %	16%	31%	33%	32%	25%

MCA: Medical Child Abuse; MN: Medical Neglect

Table 3. Journal Fields by Child Maltreatment Type.

	Physical Abuse	Sexual Abuse	Neglect/MN/MCA	Multiple Types/Trauma	Totals
Total=	158	89	12	107	366
Journal Field					
Child Welfare	8	17	1	15	41
Forensic	31	9	1	5	46
Medicine	12	9	2	22	45
Mental Health	0	8	1	11	20
Pediatrics	38	26	5	26	95
Public Health	5	7	1	8	21
Other Specialty (subtotal):	64	13	1	20	98
Dentistry				1	1
Dermatology	1				1
Emergency Medicine	12	2		2	16
Endocrinology		1		2	3
Neurology	2	1		4	7
Nursing		4	1	6	11
Obstetrics & Gynecology		5		3	8
Ophthalmology	15			1	16
Orthopedics	8			1	9
Otolaryngology	4				4
Physical Medicine	1				1
Radiology	18				18
Surgery	3				3

MCA: Medical Child Abuse; MN: Medical Neglect

increases at the rate of 5% more per year (Figure 1). The primary type of maltreatment was physical abuse (158), followed by multiple types (107), sexual abuse (89), and neglect (12). There were no medical articles that primarily involved psychological maltreatment. Among designs, case series or case reports predominated (127), followed by cross sectional (118), clinical trials (25), case control (17), longitudinal cohort (4), and ecological designs (1). There were also 74 reviews or commentaries, 17 of which were systematic reviews of cases, 14 of observational studies, and 3 of trials. Most (75%) were retrospective studies, and there was a trend toward fewer prospective studies in later years. Using broad topic areas, most articles (205) were related to diagnosis, followed by professional issues/training (68), epidemiology (38), outcomes (35), and treatment (20).

When categorized by CM type, the majority of articles used case series for physical abuse, followed

by cohort and case control study designs (Table 2). Most articles came from journals in nonpediatric specialties (98), followed by pediatrics (95), forensic medicine (49), general medicine (48), child welfare (41), and public health (21) (Table 3). Most of the articles (98) published in nonpediatric specialty journals were related to physical abuse. For sexual abuse, case control and cohort studies predominated, closely followed by case reports and case series. Level III studies were the majority of designs used to study multiple CM types. Consensus statements, primarily from the American Academy of Pediatrics, addressed many CM types. Trials represented fewer than 10% of all studies in all categories, and there were no controlled clinical trials found in our sample.

The mode, median, and mean levels of evidence (LOE) for all the studies were 3, 4, and 3.59, respectively. LOE differed by CM type (Figure 2) with 3.86 for physical abuse; 3.47 for sexual abuse; 3.42 for neglect,

Figure 2. Published Articles, by Level of Evidence and Child Maltreatment Type, 2006–2015.

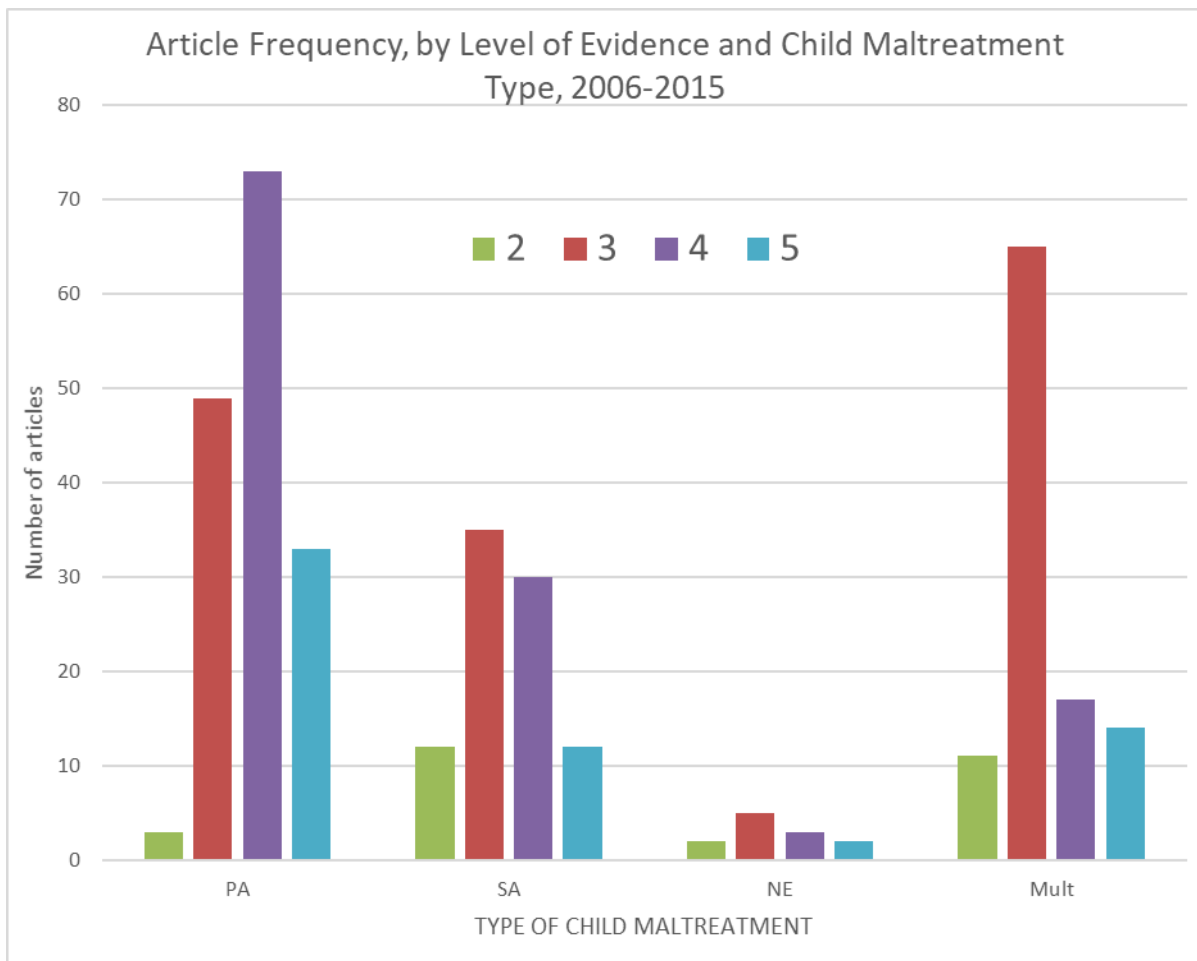
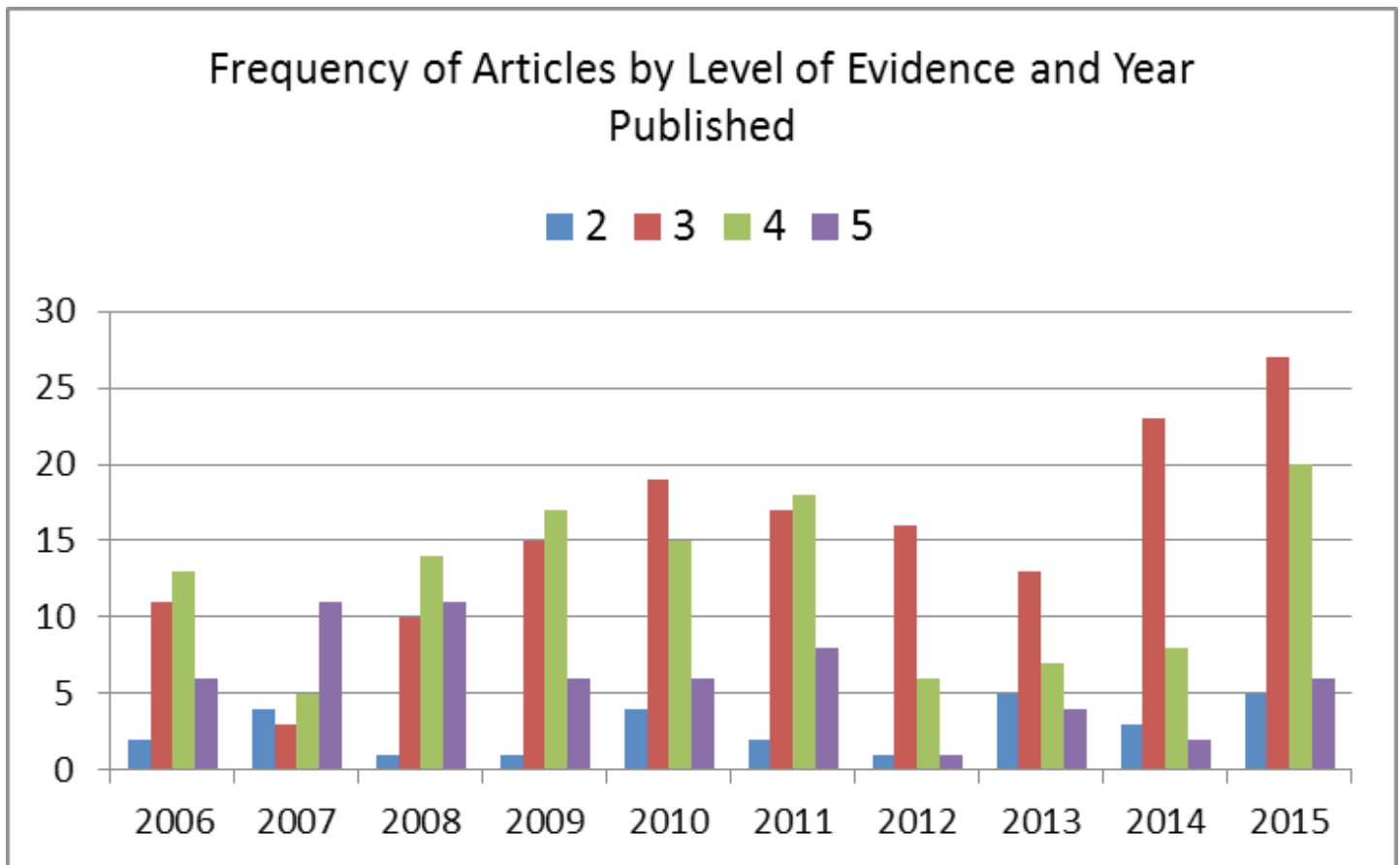


Table 4. Level of Evidence by Child Maltreatment Type.

	Physical Abuse	Sexual Abuse	Neglect/MN/MCA	Multiple Types	Totals
Total	158	89	12	107	366
Level of Evidence					
I	0	0	0	0	0
II	3	12	2	11	28
III	49	35	5	65	154
IV	73	30	3	17	123
V	33	12	2	14	61
Mode	4	3	3	3	3
Median	4	3	3	3	4
Mean	3.86	3.47	3.42	3.32	3.59
Trend Slope	-0.078	-0.006	-0.109	-0.056	-0.071
Trend r²	0.539	0.001	0.145	0.352	0.648

MCA: Medical Child Abuse; MN: Medical Neglect

Figure 3. Published Articles by Level of Evidence, by Year.



medical neglect, or medical child abuse; and 3.32 for multiple types, general trauma, or adverse childhood experiences (Table 4). Mean LOE for physical abuse articles differed significantly from sexual abuse and multiple-type articles ($p < 0.05$) but not neglect articles in post-hoc Tukey and Scheffe comparisons. The remaining pairwise comparisons were statistically not significant ($p > 0.05$). Over the ten-year period, a greater number of level II and III articles were published (Figure 3). For each of the CM types, the overall mean LOE improved (slope = -0.062 , $r^2 = 0.046$, $p < 0.0001$), with a negative slope indicating lower level of evidence numbers and thus higher quality of evidence. The greatest significant improvements were noted in studies of neglect (-0.109 , $p < 0.05$). Less but still significant improvement was seen in articles on physical abuse (-0.078 , $p < 0.05$) and multiple types (-0.056 , $p < 0.05$). Insignificant change was noted in articles about sexual abuse (-0.006 , $p > 0.05$).

Discussion

Among the 366 medical articles identified, the greatest number were related to medical diagnosis of child abuse and neglect. The overall level of evidence of 3.59 suggests that most studies or reviews of studies were of case reports and observational studies, such as case-control or cohort designs. No level I trials were identified, suggesting that the researchers did not modify treatments or outcomes using a controlled, randomized experimental design. A steady growth in the number of articles (5%) outpaced the growth of *PubMed* citations in general (2%–3%).

Scribano (2012) has noted that “as the Child Abuse Pediatrics field has ‘come of its own’ in these recent years, so has the science of the field...with new insights, emerging technology, and issues pertaining to child maltreatment (p. 153).” RCTs and meta-analysis have the potential to be the best source of evidence to inform decision making with underlying methods that have become much more sophisticated, but achieving this requires advances in the underlying science (Berlin & Golub, 2014). Additionally, there are limitations in the ethical usage of RCTs in the field of child abuse. Articles found in medical and surgical specialty journals usually pertained to specific organ systems where child maltreatment injuries occur

(e.g., Servaes et al., 2016). There were also articles in mental health and public health journals to a lesser degree. It is surprising that a recent review (Hellems et al., 2009) of articles in the *Journal of Pediatrics* did not specifically list child abuse and neglect as a topic area despite recognition of the problem in medicine (Kempe et al., 1962). With recognition of child abuse pediatrics by the American Board of Pediatrics for over ten years, the subspecialty is relatively new, and biomedical funding for child abuse medical research and training is limited (Block & Palusci, 2006; Krugman, 2016).

We noted several relationships between article characteristics and specific child maltreatment types. The level of evidence for physical abuse articles differed significantly from those regarding sexual abuse and multiple CM types. There was a dearth of published research about neglect that may reflect the relative paucity of physical injuries or conditions needing medical attention. The greatest number of published articles was for physical abuse, with the greatest proportion of these being case reports and uncontrolled studies. This may reflect that the science is less developed in this area than in sexual abuse, for example, which had a preponderance of more rigorous controlled and cohort studies. Studies of multiple types also included those looking at risk factors and biologic consequences for adverse childhood experiences, by far the greatest proportion of which were level III studies. Level II trials were found most often in this group and in sexual abuse articles. Trends over time showed the greatest improvements for neglect articles, which may reflect some degree of catch up in the level of science in this area.

While few similar studies were available for comparison, the LOE we found in child abuse medical research was not very different from that in other areas in medicine and contained a mix of different types of observational studies and a small number of trials. Small but growing numbers of articles in general medicine and pediatric journals have used clinical trials and more complex observational designs (Fletcher & Fletcher, 1979; Hayden & Saulsbury, 1982; McDermott et al., 1995; Hellems et al., 2009). Nyugen and Mahabir (2016) assigned similar level-of-evidence scores to examine the overall quality of plastic surgery

research and compared LOE grades in 2013 with those from 1983, 1993, and 2003. Their mean LOE was 3.42, and the comparison reported significant improvement in research quality over time, a decrease in the percentage of level IV and V studies, and increased higher quality level I and II studies. In a European review of the literature in otolaryngology (ENT), Rotter (2016) noted that the percentage of prospective trials in the ENT-specific literature was significantly higher than in other disciplines, including the fields of neurosurgery, ophthalmology, and orthopaedics, but most publications were classified as evidence level IV. Levels improved slightly with time, with 80% of the therapy studies classified as levels III–V and 75% of the diagnostic trials as evidence levels I and II. In a comparison of ENT with general pediatrics, a similar rate of RCTs was found in both disciplines (Shin, Rauch, Wasserman, Coblens, & Randolph, 2011).

It should be kept in mind that medical research in child abuse and neglect differs from other child abuse research overall. British studies (Taylor et al., 2015; Jones et al., 2017) noted that qualitative studies predominated in overall research in child abuse and neglect (followed by cross-sectional, nonexperimental, cohort studies, and RCTs) by a ratio of nonempirical to empirical studies of 3:1. Consequences of maltreatment in adulthood were commonly studied (21%), followed by system or practice responses (14%), attitudes and beliefs (11%), the nature of outcomes in childhood (11%), the etiology of child maltreatment (8%), and children's experiences (8%), and more research exists on sexual abuse than on physical abuse or neglect. An Australian review (Higgins et al., 2005) looked at the quality and types of studies for different issues within child abuse research (i.e., intervention programs, risk factors, etc.), and the research reviewed was largely qualitative. Quantitative research in their review was primarily nonexperimental and descriptive and tended to rely on categorical data with research objectives that tended to be exploratory rather than hypothesis-driven. There was also a heavy reliance on existing case records for data, and projects tended to be cross-sectional and retrospective. An Irish review, which discussed quality of research in terms of "external quality assurance" rather than levels of evidence, also found mostly qualitative research (Buckley et al., 2010).

Several limitations of our study may limit its usefulness and applicability. This study focused on physical health publications indexed in the medical literature and specifically excluded a number of nonmedical and mental health studies that are important for the field. We realize our search strategy was very selective and addressed only a narrow slice of the published literature with a topical review of identified papers. It is likely problematic to assess overall levels of evidence of research from different areas of child abuse and neglect because each of these areas needs differing study designs given the research questions posed and the state of knowledge in that area; studies of outcomes, for example, ideally need random assignment of the intervention. We also did not have the resources to perform a systematic review using the PRISMA guidelines (<http://www.prisma-statement.org/>). Our categorization of article information was limited, relying on published abstracts and not full articles unless the abstract was unclear or incomplete or may have resulted in more than one article reflecting results of a particular study; this approach resulted in a potential overcount. Our review also does not include more recent articles or those as yet uncategorized in *PubMed*, which could have resulted in an undercount. It also does not include a number of additional search engines, lists of references, or libraries. We also excluded articles that seemed to have a nonmedical or mental health focus, which may have resulted in our missing medical research. *PubMed* does contain a sizable number of citations from a variety of medical and child welfare journals, and more recent articles show promise with improved research design (Collier, Ramaiah, Glick, & Gottlieb, 2017; Levey et al., 2017). While our sampling is not and cannot realistically be considered exhaustive, our results likely represent a sizable sample of the medical research articles in the field over a decade and can be used to infer trends over time in the number of studies and level of evidence rather than considered a comprehensive review of all articles, topics, and journals.

Conclusions

Medical research in child abuse and neglect differs from overall research in child protection but mirrors other medical specialties in the level of evidence of its

published articles. There has been steady improvement in the number and level of evidence of articles that varies by the type of child maltreatment. Neglect and physical abuse research offers opportunities for development in the science of child abuse medical research, and biologic studies in adverse child experiences and CM outcomes show great potential. The Institute of Medicine (Petersen et al., 2014) has noted that more medical research is needed to further explore the processes and outcomes of the medical evaluation of child abuse and neglect, to support the development of more uniform approaches to practice, and to arrive at a medical consensus regarding thresholds for reporting neglect. Additional needs identified by the IOM include effective training of multidisciplinary researchers, a high-quality public health surveillance system, sustained funding for rigorous research endeavors, interdisciplinary research centers, and research attentive to diverse and underserved populations (Cohn, Salmon, & Stobo, 2002). Also needed are continued federal investment in longitudinal, nationally representative studies, and quality improvement in administrative data, including increased attention to establishing causality in developmental research and intervention studies (Diaz & Petersen, 2014; Krugman, 2016; Sege, 2016). Sege (2016) has noted that many of the answers to important questions about child abuse and neglect lie “well within the capacity of modern science (p. 234).”

We speculate that with additional research funding and publication outlets (e.g., a journal dedicated to child abuse pediatrics research), there can be advancement in the number and quality of published medical research articles to answer important biomedical and social questions about this devastating public health problem facing our children and families. Increased funding for child abuse pediatrics research and improvements in study design will be needed to further improve medical research in child abuse and neglect.

About the Authors

Vincent J. Palusci, MD, MS, FAAP, is Professor of Pediatrics at New York University School of Medicine. He chairs the Hassenfeld Children’s Hospital Child Protection Committee and is a general and child abuse pediatrician at NYU Langone Health and Bellevue Hospital in New York City. He is a former editor in chief of the *Advisor*, a past member of the APSAC Board of Directors, and is currently president of APSAC–New York, Inc. Contact: Corresponding author is Vincent.palusci@nyulangone.org, 212.562.6073.

Jessica Perfetto, MD, graduated from New York University School of Medicine in 2018. She is currently a first-year resident in the Pediatrics Residency Program at the Children’s Hospital of Philadelphia. Contact: perfetto@email.chop.edu.

Funding sources: This research did not receive any specific support from funding agencies in the public, commercial, or not-for-profit sectors.

References

An Overview of Published Medical Research About Child Abuse and Neglect During 2006-2015

- American Academy of Pediatrics (AAP), Steering Committee on Quality Improvement and Management. (2004). Classifying recommendations for clinical practice guidelines. *Pediatrics*, 114(3), 874–877.
- Berlin, J. A., & Golub, R. M. (2014). Meta-analysis as evidence: Building a better pyramid. *Journal of the American Medical Association*, 312(6), 603–605.
- Block, R. W., & Palusci, V. J. (2006). Child abuse pediatrics: A new pediatric subspecialty. *Journal of Pediatrics*, 148, 711–712.
- Buckley, B., Corrigan, C., & Kerrins, L. (2010). *CAAB research report no. 7: Report of an audit of child protection research in Ireland, 1990–2009*. Dublin: Trinity College School of Social Work and Social Policy and Children’s Research Centre. Retrieved from <http://www.tara.tcd.ie/bitstream/handle/2262/41271/Full-Report-Audit-of-Child-Protection.pdf;jsessionid=D3177C8F5937AD1567140A65E1479DB1?sequence=1>

- Choudhary, A. K., Servaes, S., Slovis, T. L., Palusci, V. J., Hedlund, G. L., Narang, S. K., ... Offiah, A. C. (2018). Consensus statement on abusive head trauma in infants and young children. *Pediatric Radiology*, 48(8), 1048–1065.
- Cohn, A. E. (1938, October). The meaning of medical research. *Bulletin of the New York Academy of Medicine*, 14(5), 265–291.
- Cohn, F., Salmon, M. E., & Stobo, J. D. (Eds.). (2002). *Confronting chronic neglect: The education and training of health professionals on family violence*. Washington, DC: Institute of Medicine, National Academy Press.
- Collier, Z. J., Ramaiah, V., Glick, J. C., & Gottlieb, L. J. (2017). A 6-year case-control study of the presentation and clinical sequelae for noninflicted, negligent, and inflicted pediatric burns. *Journal of Burn Care Research*, 38, e101–e124.
- CORE INFO: Cardiff Child Protection Systematic Reviews. (2017). Home page. Retrieved April 19, 2017, from <http://www.core-info.cardiff.ac.uk>
- Diaz, A., & Petersen, A. C. (2014). Institute of Medicine report: New directions in child abuse and neglect research. *JAMA Pediatrics*, 168(2), 101–102.
- Fletcher, R. N., & Fletcher, S. W. (1979). Clinical research in general medical journals. *New England Journal of Medicine*, 301, 180–183.
- Hayden, G. F., & Saulsbury, F. T. (1982). A review of the Journal of Pediatrics: The first 50 years. *Journal of Pediatrics*, 110, 5–11.
- Hellems, M. A., Burka, K. K., & Hayden, G. F. (2009). A review of the Journal of Pediatrics: The first 75 years. *Journal of Pediatrics*, 155, 16–20.
- Higgins, D. J., Adams, R. M., Bromfield, L. M., Richardson, N., & Aldana, M. S. (2005). *National audit of Australian child protection research, 1995–2004*. Melbourne: Australian Institute of Family Studies. Retrieved from <https://aifs.gov.au/cfca/sites/default/files/publication-documents/audit.pdf>
- Higgins, J. P. T., & Green, S. (Eds.). (2011, March). *Cochrane handbook for systematic reviews of interventions, Version 5.1.0*. The Cochrane Collaboration. Available from <https://training.cochrane.org/handbook>.
- Jones, C., Taylor, J., MacKay, K., Soliman, F., Clayton, E., Gadda, A. M., ... Jones, D. (2017). The landscape of U.K. child protection research [from] 2010 to 2014: A mapping review of substantive topics, maltreatment types, and research designs. *Child Abuse Review*, 26, 8–18.
- Kempe, C. H., Silverman, F. N., Steele, B. F., Droegemueller, W., & Silver, H. K. (1962). The battered-child syndrome. *Journal of the American Medical Association*, 181(1), 17–24.
- Kim, H., Wildeman, C., Jonson-Reid, M., & Drake, B. (2017). Lifetime prevalence of investigating child maltreatment among U.S. children. *American Journal of Public Health*, 107, 274–280.
- Krugman, R. D. (2016). Pediatric research and child maltreatment: Where have all the flowers gone? *Pediatric Research*, 79(1), 236–237.
- Levey, E. J., Gelaye, B., Bain, P., Rondon, M. B., Borba, C. P. C., Henderson, D. C., & Williams, M. A. (2017). A systematic review of randomized controlled trials of interventions designed to decrease child abuse in high-risk families. *Child Abuse & Neglect*, 65, 48–57.
- Lindberg, D. M., Wood, J. N., Campbell, K. A., Scribano, P. V., Laskey, A., Leventhal, J. M., ... Runyan, D. K. (2017). Research priorities for a multi-center child abuse pediatrics network—CAPNET. *Child Abuse & Neglect*, 65, 152–157.

- McDermott, M. M., Lefevre, F., Feinglass, J., Reifler, D., Dolan, N., Potts, S., & Senger, K. (1995). Changes in study design, gender issues, and other characteristics of clinical research published in three major medical journals for 1971–1991. *Journal of General Internal Medicine*, *10*, 13–18.
- Nguyen, A., & Mahabir, R. C. (2016). An update on the level of evidence for plastic surgery research published in Plastic and Reconstructive Surgery. *Plastic and Reconstructive Surgery—Global Open*, *4*, e798.
- Oxford Centre for Evidence-Based Medicine (OCEBM). (2009, March). Levels of evidence. Available from: <https://www.cebm.net/category/ebm-resources/loe/> Retrieved from <http://www.cebm.net/oxford-centre-evidencebased-medicine-levels-evidence-march-2009/>
- Oxford Centre for Evidence-Based Medicine, OCEBM Levels of Evidence Working Group. (2011). The Oxford 2011 levels of evidence table. Available from <https://www.cebm.net/category/ebm-resources/loe/> Retrieved from <http://www.cebm.net/wpcontent/uploads/2014/06/CEBM-Levels-of-Evidence-2.1.pdf>
- Parfrey, P., & Ravani, P. (2009). On framing the research question and choosing the appropriate research design., *Methods of molecular biology*, *473*, 1-17.
- Petersen, A. C., Joseph, J., & Feit, M. (Eds.). (2014). *New directions in child abuse and neglect research*. Washington, DC: Institute of Medicine and National Research Council (IOM), The National Academies Press.
- Rotter, N. (2016). Evidence and evidence gaps in therapies of nasal obstruction and rhinosinusitis. *GMS Current Topics in Otorhinolaryngology—Head and Neck Surgery*, *15*, 1–23.
- Sargeant, J. M., Kelton, D. F., & O'Connor, A. M. (2014). Study designs and systematic reviews of interventions: Building evidence across study designs. *Zoonoses and Public Health*, *61*(suppl. 1), 10–17.
- Scribano, P. V. (2012). Child maltreatment—An update on new science to a vexing pediatric problem. *Clinical Pediatric Emergency Medicine*, *13*(3), 153–154.
- Sege, R. D. (2016). Child abuse research 2015: It's time for breakthroughs. *Pediatric Research*, *79*(1), 234–235.
- Servaes, S., Stephen, D., Brown, S. D., Choudhary, A. K., Christian, C. W., Done, S. L. ... Slovis, T. L. (2016). The etiology and significance of fractures in infants and young children: A critical multidisciplinary review. *Pediatric Radiology*, *46*(5), 591–600.
- Shin, J. J., Rauch, S. D., Wasserman, J., Coblenz, O., & Randolph, G. W. (2011). Evidence-based medicine in otolaryngology, part 2: The current state of affairs. *Otolaryngology and Head & Neck Surgery*, *144*(3), 331–337.
- Tanaka, M., Jamieson, E., Wathen, N., & MacMillan, H. L. (2010). Methodological standards for randomized controlled trials of interventions for preventing recurrence of child physical abuse and neglect. *Child Abuse Review*, *19*, 21–38.
- Taylor, J., Mackay, K., Gadda, A., Soliman, F., Clayton, E., Jones, C., ... Anderson, A. (2015). *The landscape of child protection research in the U.K.: A U.K. mapping review*. Edinburgh: University of Edinburgh Child Protection Research Centre/NSPCC.
- Tran, B. X., Van Pham, T., Ha, G. H., Ngo, A. T., Nguyen, L. H., Vu, T. T. M., ... Ho, R. C. M. (2018). A bibliometric analysis of the global research trend in child maltreatment. *International Journal of Environmental Research and Public Health*, *15*, 1456. doi:10.3390/ijerph15071456
- U.S. Department of Health and Human Services (US DHHS), Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2017). Child maltreatment 2015. Available from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>

True Evidence-Based Practices Deserve Wide Acceptance

Bill Baccaglini
Sylvia Rowlands, PhD

Child welfare professionals strive every day to keep children safe, to keep families healthy and together, and to break multigenerational cycles of maltreatment. More than three million new cases of child abuse and neglect are reported every year in the United States and approximately 400,000 children are in foster care at any given time (U.S. Department of Health and Human Services [USDHHS], 2016). The financial cost to our society is enormous (Gelles & Perlman, 2012).

Caseworkers do their best, sometimes against overwhelming odds and with few effective engagement or intervention strategies. The community characteristics and population demographics may vary, but the common goals are always the safety and well-being of children and the preservation of families. We now have a moral imperative to recognize decades of hard data from multiple studies covering hundreds of thousands of clients and showing compelling evidence that a different approach can improve outcomes dramatically. Evidence-based practices (EBPs) indicate that child welfare interventions are now a science with protocols that have been proven effective through decades of clinical trials. Providers can now save more lives than ever before with the rigorous and diligent application of these strategies.

A century ago, doctors gave patients medications they developed themselves—sometimes with a good rationale based on their own personal knowledge

and experience. Some were effective, some were not, and some had very bad outcomes. Today, physicians do not prescribe, and the public would never accept, medications whose effectiveness had not been proven through multiple clinical trials.

But change, even when it represents proven improvements, is often met with resistance. When Joseph Lister began promoting the idea of sterile surgery and the use of antiseptics 150 years ago, many in the medical profession stubbornly refused to acknowledge the effectiveness of this new concept. They acted offended at the suggestion that the surgical techniques and approach to patient care they had used throughout their careers could be improved upon.

Today, the resistance to EBPs feels much the same as that faced by Dr. Lister. Some in our profession continue to express skepticism that EBPs can achieve improved results in their unique communities or question the cost or effort to implement a system that requires high levels of oversight, reporting, and accountability. Despite the voluminous data on outcomes for large numbers of families, demonstrating the efficacy of evidenced-based programs, they continue to resist.

EBPs have been in use since 1973 (Alexander, 1973). They require extensive training and adherence to well-defined and proven clinical protocols. They also require recording and measurement of clinician development and tracking of family progress on a granular level. Fidelity to the protocols, transparency, and peer reviews is key, so that others can monitor, guide, learn from,

improve on, and replicate success.

Well-established EBP clearinghouses have developed a clear definition for what constitutes *evidence-based*. Among the required characteristics of these programs is that they must be validated through multiple well-designed, rigorous scientific evaluations and produce data that show systematic and sustained improvement. It is important that the results, procedures, and protocols are transparent and that the program and its outcomes have been proven to be replicable.

So why the hesitation? Some believe that these practices will not translate to their unique populations or that social work practices cannot be broken down into metrics, measured, and replicated with rigid adherence. It is exhausting to hear a continual refrain from objectors: “My kids are different,” “my community is different,” “my situation is different,” “families are not all the same,” and “we are not robots.” This often comes without ever seeing data explaining why EBPs would be any less applicable to their families than they have been with over 300,000 others (Family Functional Therapy LLC, n.d.).

Some fear that the use of EBPs will interfere with the clinical relationship and render treatment ineffective. In fact, the opposite is true. EBPs actually facilitate the clinical relationship and enhance the role of the caseworker, whose client relationships must be at the center of any practice. No intervention can be effective without caring, creative, and dedicated caseworkers establishing and developing relationships with their clients.

Still others, regrettably, are bound by inertia. They have always done things a certain way. They have anecdotes describing the many lives saved and families strengthened over their careers. Some hear recommendations for change as negative criticism of their past practices. The idea that they could achieve better outcomes if they worked differently is uncomfortable. But no one who works in this profession expects a comfortable career. Caseworkers deal with the most challenging situations imaginable and, at the end of day, the outcomes for the children and families in our care fall under their responsibility. Improving our treatment of children and families in every way possible

to achieve better outcomes should be our paramount concern, and agencies have an obligation to provide caseworkers with the most effective tools for achieving that goal.

It is heartening to see the federal government, in the recently enacted Families First legislation, underscore the importance of EBPs by requiring their use. But the effectiveness of that legislation will ultimately depend on how the government defines *EBPs*—whether they require programs to be truly *evidence-based*, as defined by one of the established clearinghouses, or allow looser definitions that encompass a wide array of lesser-studied other programs.

The troubling debate over what constitutes evidence-based has picked up steam in recent years. Some organizations prefer to make changes to existing evidence-based programs and still call them evidence-based. Using small sample sizes, for example, may produce some evidence, but it does not make for the type of meaningful evidence-based program we need to go to scale with confidence. Likewise, client satisfaction surveys and staff surveys are not a substitute for rigorous testing with controlled clinical trials.

Some agencies argue that they should be able to treat EBPs simply as a guide and adapt them to account for community, cultural, or other population differences. In fact, innovation is needed, but only if it includes a rigorous clinical evaluation process, time frames, and complete and transparent reporting of results—so they can be reviewed by government agencies and peer organizations. Those are the kinds of requirements we should all adhere to and that the federal government has agreed to adopt in the rollout of The Family First Act (FFA).

FFA states that, for the first time ever, Title 4E funds will be used to keep children at home who would otherwise be placed in foster care (USDHHS, 2018). The federal government will financially encourage states to use Title 4E dollars toward the implementation of proven practices—those practices that have strong evidence of their positive impact—to prevent maltreatment. Along the same lines, the EBP constituency is hopeful that the NYC Administration for Children’s Services, in its 2020 rebidding of all contracts, will extend its investment in

certified EBPs by requiring their use in all preventive and foster care services.

Without requiring proof of effectiveness, the successful widespread implementation of EBPs will be undermined by programs that are EBPs in name only. Condoning the use of “EBP interventions” without rigorous proof of effectiveness would be like supporting a physician’s use of a home-grown drug therapy crafted in his own clinic and claiming it is a certified FDA-approved drug therapy. It does not bear consideration.

Anyone in our profession who honestly considers, with an open mind, the vast amount of data that now exists on EBPs cannot help but acknowledge them as proven strategies they should use within the clinical relationship to increase the probability of sustained positive outcomes for the children and families in their care.

Years of studies clearly show that EBPs are more efficient in engaging youth and families, from the beginning of treatment, though a range of complex and multifaceted situations, to achievement of goals (MST Services, n.d.). EBPs address the entire range of issues our families deal with, from abuse and neglect to domestic violence to mental health to substance abuse. They demonstrate conclusively the efficacy of these programs across different settings, with different races, genders, and socioeconomic status (MST Services, n.d.).

And there is an additional positive aspect of EBPs. Public funders and foundations alike increasingly want to see evidence of successful outcomes in programs they support. Although this is not the central reason to adopt EBPs—our mission is the central reason—for those of us who are always cognizant of the gap between funding and the services we provide, it is a tangential but important added benefit of these programs.

The compelling data are readily accessible, as are support and resources for implementations (MST Services, n.d.). EBPs are one of the most important developments in the practice of child welfare in decades. EBPs will help all of us more predictably achieve our primary objective: the safety and well-being of children and the preservation of their families.

About the Authors

Bill Baccaglioni, President and CEO of The New York Foundling, leads one of the oldest and largest child welfare organizations in the country. The Foundling has had a long history of advancing the science and practice of child welfare and, under Bill’s leadership, it has been a prominent advocate for innovative initiatives that have transformative impacts on the lives of children. Bill was one of the early proponents of the use of evidence-based practices (EBPs) and The Foundling today is not only utilizing EBPs to achieve better outcomes for its own families but has also become a global leader in this field. Through its participation in publicly available trials and studies and through the creation of the Implementation Support Center (ISC), The Foundling provides data and practical training to service providers and governmental entities in the United States and overseas. Bill has been a driving force in making education a centerpiece of The Foundling’s focus—based on the belief that, after ensuring health and safety, education can have the greatest impact on a child’s future. In addition, Bill has overseen the expansion of The Foundling’s Developmental Disabilities programming, which, through the addition of The Thrive Network, recently increased the number of individuals it serves to nearly 1000.

Sylvia Rowlands, PhD, Senior Vice President of Evidence-Based Community Programs at The New York Foundling, has led the organization’s use of evidence-based practices, and her pioneering work has made The Foundling a global leader in the field. She manages the world’s largest evidence-based practice portfolio with over 400 licensed professional staff and 200 paraprofessionals under her direction. Under Dr. Rowlands’ leadership, The Foundling created its Implementation Support Center (ISC) and has worked with numerous service providers and governmental entities in the U.S. and abroad to implement effective, evidence-based initiatives, including in Australia, England, Scotland, Canada, New Zealand, Russia, China, and Japan. She has a twenty-five-year background of social service and health care industry leadership, large system transformation expertise and executive management experience.

True Evidence-Based Practices Deserve Wide Acceptance

Alexander, J. A. (1973). *FFT research*. American Psychological Association. Retrieved from <https://www.ftllc.com/about-fft-training/fft-research.html>

Family Functional Therapy LLC (FFT LLC). (n.d.). *FFT research*. Retrieved from <https://www.ftllc.com/about-fft-training/fft-research.html>.

Gelles, R. J., & Perlman, S. (2012). *Estimated annual cost of child abuse and neglect*. Prevent Child Abuse America. Retrieved from http://preventchildabuse.org/wp-content/uploads/2016/02/PCA_COM2012-1.pdf

MST Services. (n.d.). *Proven results*. Retrieved from <http://www.mstservices.com/>

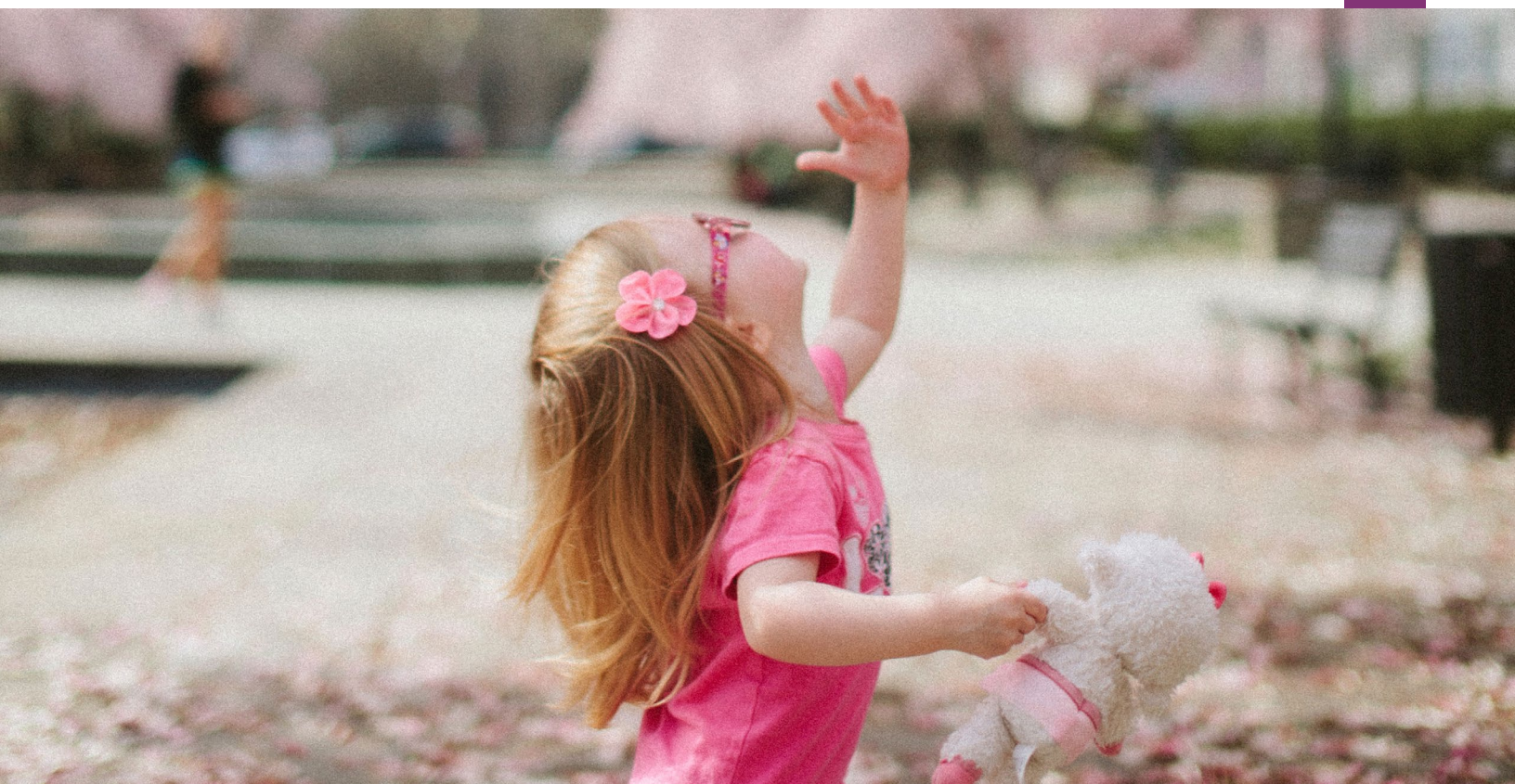
U.S. Department of Health and Human Services (USDHHS), Administration for Children and Families. (2018). *Family First Prevention Services Act of 2018*. Retrieved from <https://www.acf.hhs.gov/cb/news/family-first-prevention-services-act-of-2018>

U.S. Department of Health and Human Services (USDHHS), Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2016). *AFCARS report*. Retrieved from <https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport24.pdf>

Additional Resources

Annie E. Casey Foundation. (2018). Evidence-based practice. Retrieved from <https://www.aecf.org/work/evidence-based-practice/>

Blueprints for Healthy Youth Development. (2018). About us. Retrieved from <https://blueprintsprograms.org>



A National Initiative to End Corporal Punishment

Key words: corporal punishment, physical discipline, social norms, No Hit Zones (NHZ)

Viola Vaughan-Eden, PhD

George W. Holden, PhD

Mel Schneiderman, PhD

Spanking and slapping children, typically labeled *physical or corporal punishment* (CP), is alive and well in many schools and homes in the United States. Nineteen states allow children to be paddled in public schools and 48 states allow the discipline in private schools (Gershoff, Purtell, & Holas, 2015). A recent opinion poll, taken by ABC News in October 2018, found that 65% of the more than 1,000 randomly sampled, nationally representative adults approve of CP in the home. Half of the parents in the survey admitted to sometimes spanking their young children. But considerable regional differences were found, with the preference for spanking much higher in the south than other parts of the country. In contrast to home CP, 72% of the adults interviewed did not approve of school CP (Crandall, 2018). Furthermore, the General Social Survey (Child Trends, 2015) indicates the overall approval to parental use of CP has slowly decreased in the United States in the past few decades.

The decline is likely attributable to the increased attention regarding the consequences of adults hitting children. This awareness comes from a confluence of sources, including the ever-increasing number of empirical studies revealing the negative associations with CP (Gershoff & Grogan-Kaylor, 2016), stories in the press and social media (e.g., an interview with the football star, Adrian Peterson, who reports he continues to hit his child despite more than 4 years ago being suspended by the NFL and reprimanded by the court [CBS Sports, 2018], and periodic news that other

countries have legislatively banned CP based on human rights concerns (e.g., in October 2018, Nepal became the 54th nation).

Although the United States has lagged behind many other countries in recognizing the problem of CP (Sweden banned CP in 1979), the movement to end the practice in the U.S. is gaining steam. As we will describe, a reinvigorated effort is emerging due to the leadership of the American Professional Society on the Abuse of Children (APSAC) and the Vincent J. Fontana Center for Child Protection of the New York Foundling (The Foundling), along with researchers, social activists, and others committed to working to end this harmful disciplinary behavior. Many may be surprised to learn that efforts to end CP of children are not new in the United States (Holden, Wright, & Sendek, 2019). Therefore, we provide a brief summary of the movement of individuals, dating back to the colonial period, and more recently, of organizations that have spoken out against hitting children.

Brief History of Corporal Punishment in the U.S.

Harsh punishment was endemic in colonial schools and in many Puritan homes (Piele, 1978). However, it was not universal; many schools as well as families in the middle and southern colonies were unlikely to employ such disciplinary practices. Historians (e.g., Glenn, 1984) determined that from about 1820 until the onset of the Civil War (1820–1860), a campaign to end the use of “brute force” in schools had begun. The foremost

advocate of the movement was the educator Horace Mann, but he was joined by voices from other educators (e.g., Lyman Cobb), physicians (e.g., William Alcott), authors (e.g., Walt Whitman), and others.

The second wave of anti-CP activity emerged after the Civil War (from late 1870s to late 1920s). In fact, just 2 years after the war ended, New Jersey became the first state in the country to ban CP in its public schools. The horrendous child abuse and neglect case of Mary Ellen Wilson in 1874 added momentum to the second wave. Key individuals who argued against harsh punishment and taking a more child-centered orientation to education and childrearing included the following: the philosopher, psychologist, and educational reformer John Dewey; the social activist Jane Addams; and psychologists, such as Boris Sidis and John B. Watson. The second wave ended with the onset of the Great Depression, when the nation's attention turned to economic matters.

The third wave, roughly beginning in 1972 and continuing to the present, was initiated with the release of a report from the National Education Association's Task Force on Corporal Punishment. The report recommended the elimination of school CP. This wave differs from earlier efforts because it is supported by scientific evidence as well as a number of organizations. In the 1970s, researchers, most notably Murray Straus (1926-2016) and Irwin Hyman (1935-2005), began publishing articles about problems with parental CP and school CP, respectively.

Also, various organizations formed to promote an anti-CP message, including End Violence Against the Next Generation (founded by Adah Maurer), Parents and Teachers Against Violence in Education (Jordan Riak), End Physical Punishment of Children—USA (Philip Greven and Adrienne Haeuser), the Ohio Coalition for More Effective School Discipline (Nadine Block and Robert Fathman), and the Center for Effective Discipline (Nadine Block). Each of these organizations helped to educate the public and promote the use of nonviolent childrearing. However, the Ohio Coalition stood out as particularly successful because it succeeded in convincing the Ohio state government to ban CP in schools in 2009 (Block, 2013). Since that time, new social media-based organizations have been established

(e.g., U.S. Alliance to End the Hitting of Children [U.S. Alliance, endhitting.org], StopSpanking.org, and Parentingbeyondpunishment.com).

These volunteer organizations have operated independently and on “shoestring” budgets. Our current efforts are intended to address those shortcomings by creating a coalition of proponents, developing a national strategy, and establishing a concrete and measurable set of objectives with the initial goal of reducing CP and the secondary goal of ending CP in all schools and homes in the U.S.

The National Summit to End Corporal Punishment

Building upon recent developments in the field of violence to children as well as more than 50 years of research documenting the ineffectiveness and unintended negative consequences of CP, three organizations—APSAC, The Foundling, and the U.S. Alliance—joined forces to cosponsor the National Summit to End Corporal Punishment in the United States.

On October 12 and 13, 2017, with funding from The Foundling and held at their headquarters in New York City, the summit brought together 37 of the leading national experts and researchers in the field of child maltreatment and violence to children, including representatives from national professional organizations and social change agencies. Summit participants included representatives from the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Association, American Psychological Association, Gundersen National Child Protection Training Center, National Alliance of Children's Trust and Prevention, National Association of Pediatric Nurse Practitioners, and Prevent Child Abuse America.

The idea for the summit was inspired by the APSAC policy statement released in 2016 calling for the “*elimination of all forms of corporal punishment and physical discipline of children in all environments, including schools and at home* (APSAC, 2016).” APSAC committed itself to take direct action in informing professionals, parents, and the general public about the risks corporal punishment poses to children. The

summit sponsors were also aware of the successful international efforts to end corporal punishment. To date, 54 countries from around the world have passed legislation to prohibit corporal punishment in all settings and many more countries are considering prohibitions.

The decision was made by summit planners to focus efforts on changing parent attitudes and behavior rather than advocating for laws banning corporal punishment in the home. The consensus among the summit planners was that corporal punishment in the United States continues to be a controversial issue especially within certain faith-based communities and cultural groups. It was decided that attempts to pursue legal bans in homes would be counterproductive and unsuccessful at this time. However, because the practice of corporal punishment in schools is still legal in 19 states, summit planners agreed that one of the priorities would be advocating for the ban of corporal punishment in schools in the states where it is still legal.

Additionally, the decision was made to focus summit efforts on changing social norms as a determinate of corporal punishment behavior. The summit planners invited representatives from social change agencies to inform participants about social change strategies. Social change agencies attending the summit included the Family Room, Fenton Social Change Agency, The Montana Institute, and Rain Barrel Communications.

The planners agreed that invitations to participate in the summit would be sent to individuals and organizations that supported the goal of ending corporal punishment in the United States. Individuals and organizations invited to participate in the summit were determined on the basis of their contribution to field of violence to children or their potential to influence an end to corporal punishment. The broad strategy would be to plan the first coordinated national campaign aimed at ending corporal punishment in the United States.

In the fall of 2016, a steering committee was formed consisting of 17 prominent researchers and advocates in the field of child maltreatment. The steering committee's agenda was to help identify summit goals, select summit participants, design a 2-day summit program of tasks and activities, and to plan the logistical

supports needed to ensure a smooth running and effective summit. To work more efficiently, the steering committee formed a smaller executive committee consisting of five representatives from the three sponsoring organizations. The executive committee assumed primary responsibility for the planning of the summit and periodically reported back to the steering committee for feedback and final decision making.

The executive planning committee consisted of Mel Schneiderman, Senior Vice President of the Vincent J. Fontana Center for Child Protection of the New York Foundling and APSAC Board member; David Corwin, Child Forensic Psychiatrist and Clinical Professor at the University of Utah School of Medicine and APSAC President-Elect; George Holden, Chair of Psychology Department at Southern Methodist University and U.S. Alliance President; Stacie LeBlanc, Attorney and Executive Director of the New Orleans Children's Advocacy Center a program of the Audrey Hepburn CARE Center of Children's Hospital and APSAC Vice President, and Viola Vaughan-Eden, Associate Professor and PhD Program Director with The Ethelyn R. Strong School of Social Work at Norfolk State University and APSAC President Emerita.

The Summit Goals

The executive committee met on a biweekly basis and formulated goals that were presented to the steering committee for approval. The primary goal of the summit was to develop a multiyear, multidimensional national strategy to end corporal punishment in the United States. In addition, some specific goals included the following:

- Create the framework for a national public health/social media campaign to end corporal punishment.
- Conceptualize the creation of a coordinating body to train professionals, educate parents, and disseminate information about evidence-based parenting programs.
- Develop a systems approach for the prevention of corporal punishment incorporating, but not limited to, No Hit Zones (NHZ).

The Summit Format

The summit was designed to help participants consider

and think “outside the box” about how to achieve the strategic goal of ending CP in the United States. Presentations were brief and informative, and the majority of time was given for small and large group discussions.

On the morning of the first day, following introductions, six brief presentations set the stage to ensure all summit participants had sufficient information to engage fully in the first day’s discussion about how to create a strategic campaign to end corporal punishment. Joan Durrant spoke about the lessons learned from the international community’s efforts to ban CP. George Holden, who helped organize two prior conferences on corporal punishment, discussed the history of the movement to end CP in the United States. Elizabeth Gershoff, a prolific researcher in the area of corporal punishment, summarized the state of the science on CP. Robert Sege reported on the American Academy of Pediatrics’ upcoming policy statement recommending parents do not use physical punishment to discipline their children.

Jeffrey Linkenbach, Director of The Montana Institute, and Jennifer Hahn, Executive Vice President of Fenton, a social change agency, informed participants about best practices and campaign strategies. Linkenbach spoke about Kotter’s 8-Step Change Model and the four key elements of a successful strategic campaign—spirit, science, action, and returns. Jennifer Hahn outlined the ten essential components of a successful advocacy campaign.

In small and large group discussions, summit participants were asked to discuss what are the elements needed for a campaign to end corporal punishment, what is the spirit or emotional tone that might be most effective, what is a realistic timetable for our efforts, what are the roles needed and who will occupy those roles, and what are the metrics we would want to evaluate a successful effort.

On that afternoon, George Carey, founder and CEO of the Family Room, led summit participants in a discussion about the key hurdles to developing an effective strategy. He tasked participants to create a campaign strategy that speaks to the family’s heart not its head. Carey outlined four approaches to creating

such a campaign strategy. Small and large group discussions then focused on what matters most to parents on an emotional level in our target audience, what passion points are at the top of parents’ emotional spectrum, and how we can build a link between our goal to end CP and the core needs of parents.

Victor Vieth, founder of the Gundersen National Child Protection Training Center at Winona State University in Minnesota, spoke about the challenges from faith-based communities. Then, award-winning journalist, author, and child advocate Stacey Patton, Assistant Professor of Journalism at Morgan State University in Maryland, gave an impassioned talk about the challenges from African American communities. Stacie LeBlanc then discussed the challenges of changing the attitudes of parents holding an authoritarian childrearing dogma.

The final discussion of the day focused on the national strategy—what resources are needed and what action steps are necessary to create a national campaign to end CP. No Hit Zones were suggested as an important way to educate parents and professionals about the harms of hitting.

On the second day, Robert David Cohen, Co-Director of Rain Barrel Communications, led the discussion about public health/social media campaigns. The purpose of a public health/social media campaign is to shift attitudes about corporal punishment by raising awareness to its negative impact and offering positive alternative disciplinary practices. Small and large group discussions focused on whether the campaign and messaging should be specific to local and regional cultural and faith-based communities or be more general in scope. Questions were asked such as, “Who is the key audience for the campaign, i.e. professionals, general public, parents, or youth?” More important, the summit participants were requested to formulate possible campaign messages that were appropriate and relevant for key target audiences.

In the afternoon, David Finkelhor, Director of the Crimes Against Children Research Center, Codirector of the Family Research Laboratory, and Professor of Sociology at the University of New Hampshire, talked about the pros and cons of organizing and funding

a National Training and Resource Center to end CP. Finkelhor described existing national centers and the many challenges that establishing a national center would entail, including the funding needed to support and maintain such a center. Viola Vaughan-Eden led a discussion about the practicality of creating a national CP center in contrast to alternative models such as creating national alliances among different organizations.

The summit concluded by having participants commit to what they or their organization was willing to do to further the goal of ending CP in the United States. The most striking outcome of the 2-day summit was the enthusiastic commitment made by participants to continue to work toward the goal.

There was an agreement that efforts should continue under the direction of the summit's executive committee. The committee agreed to continue to meet on a regular basis to coordinate future efforts to build a national coalition aimed at ending the physical punishment of children in the United States. The consensus was that activities and tasks could be started right away without funding or a fully established national structure or organization to lead the effort. For example, the movement to increase No Hit Zones is already underway and the new national coalition can provide support and needed resources to expand No Hit Zones across the nation. Finally, The Foundling agreed to donate \$35,000 as seed money to hire a communications (social change) agency to develop a strategic social media campaign plan.

Post-Summit Implementation

In the 18 months since the 2017 Summit, a great deal has been accomplished. Immediately following the summit, a post-summit survey was conducted with participants. Respondents reported feeling optimism and gratitude for the opportunity to experience a shared commitment to ending violence against children. They also felt the summit brought the importance of this issue to the forefront and gave them a renewed motivation to increase their efforts. Open-ended and rank-ordered questions focused on five primary themes: (1) what strategies would have the greatest impact; (2) who should be the target audience; (3) what settings or organizations should energies focus; (4) what methods

are most important for maximum impact; and (5) what are the most effective ways to keep this movement active.

The respondents believed that educating parents, policymakers, and healthcare professionals on the negative risk factors associated with CP and alternatives to parenting would have the greatest impact. They identified parents (57.14%), mental health professionals (50.00%), and pediatricians (33.89%) as the most important audiences as well as professional organizations (53.85%) and hospitals (38.89%) as the best target of this initiative. Furthermore, they believed the most commonly supported strategies for maximum impact include developing a public health/media campaign (43.75%), organizational policy and educational efforts (e.g., No Hit Zones in hospitals; 28.57%), and professional organization statements (25.00%). To that end, they believed the most effective ways to keep the movement active were regular newsletter/updates to keep them aware of progress (50.00%), coalition building (46.67%), and identifying funding sources (41.67%).

Mindful of the survey responses, the executive committee used this information to outline next steps. The idea of naming the group going forward resulted in the change from Summit to Initiative (the National Initiative to End Corporal Punishment), knowing that in time and with the assistance of a marketing and public relations firm, a new name might be needed to improve social norms.

The decision was made to open the executive committee to other members with expertise not represented. Therefore, Darrell Armstrong, Pastor at Shiloh Baptist Church in New Jersey, and Robert Sege, Professor of Medicine and Pediatrics at Tufts University and member of the American Academy of Pediatrics Council on Child Abuse and Neglect, were invited to join. More recently, the committee asked Angela Diaz, Professor in the Department of Pediatrics and the Department of Environmental Medicine and Public Health with Icahn School of Medicine Mount Sinai, to become a member of the committee. All three individuals agreed. The executive committee met biweekly for the first year and now continues to meet monthly. In addition to serving on the committee, each member chairs or co-chairs at least one other committee.

Subcommittees and Goals

Based on the themes and strategic goals that emerged from the summit, seven committees evolved:

1. *Resource and Training Committee* is focused on identifying a repository of resources for parents, professionals, and key informants as well as developing and providing web-based training,
2. *Policy Committee* is focused on promoting and partnering with organizations and institutions, from local to national, to draft and adopt statements similar to AAP's, APSAC's, or others that discourage and promote the end of child CP,
3. *No Hit Zone (NHZ) Committee* is developing a toolkit for expansion and implementation of NHZ, identifying and tracking levels of NHZ implementation, registering and mapping existing and potential NHZ, conducting randomized controlled trial (RCT) evaluations of NHZ training videos, and developing an app for implementation of NHZ,
4. *Fundraising Committee* is promoting the membership drive (Ambassador for Children), identifying foundations and other sources of fundraising, and working with a media/public relations agency to develop a marketing plan,
5. *Communications Committee* will work closely with a media/public relations agency to develop the marketing plan, including messaging and branding,
6. *Faith-Based and Cultural Committee* will work to identify, address, and support the distinctive concerns and needs of communities of color, religion, and faith,
7. *Evaluation Committee* will identify appropriate methods to measure progress of the National Initiative and to identify outcomes variables.

To date the committees have been successful in accomplishing a number of initial goals. We list a few of them as follows:

- With the mission of bringing together national experts, researchers, advocates, organizations, and individuals to end corporal punishment, we have created an overarching strategic plan for the National Initiative. The primary task

is to change social norms about corporal punishment in the U.S. using a national strategy across the spectrum of prevention as a guide.

- A second meeting with a smaller group of the original participants and others was held in June 2018 at the APSAC Colloquium in New Orleans, where the strategic plan was reviewed and enhanced.
- A panel presentation was also conducted at the 2018 APSAC Colloquium to showcase the National Initiative and discuss the goals, purpose, and outcome of the 2017 Summit.
- In collaboration with the U.S. Alliance, software was bought and a membership drive implemented (Ambassador for Children). The membership drive's goal is to enlist 5,000 individuals to pay \$25 for lifetime membership in the campaign to end CP.
- APSAC-New York State Chapter, The Foundling, and the Child Abuse Medical Provider Program (CHAMP) has completed a two-part webinar series for health professionals. The state APSAC chapter is currently planning a drive to enlist 100 New York State organizations to endorse APSAC's policy statement on CP.
- Stacie LeBlanc and colleagues have created a No Hit Zone Toolkit and have expanded dissemination and training on its use across the country.
- A request for proposals (RFPs) was sent out to social change agencies to respond with a strategic plan to implement a public health campaign to end CP in the U.S.
- With funding from The Foundling, a media firm was hired to create a comprehensive communications plan for catalyzing the movement.
- Two foundations have been identified that have an interest in funding a campaign to end CP in the U.S.
- The Foundling is planning to hold national webinars on CP.

2019 Goals

In addition, each subcommittee identified goals for the

coming year:

1. Develop or identify annual national survey to determine parental attitudes regarding CP (Evaluation Committee),
2. Increase the number of No Hit Zones across the nation by 50% from 50 NHZ to 75 NHZ (No Hit Zone Committee),
3. Enlist 2,500 Ambassadors in 2019 (Fundraising Committee),
4. Launch an initiative to end CP in New York State. Enlist 100 New York State organizations to support AAP and APSAC policy statements regarding CP (APSAC-NY & Fontana Center),
5. Identify national organizations to support AAP and APSAC policy statements regarding CP. Enlist 50 national organizations (Policy Committee),
6. Develop a social media strategy to end CP. Identify funding needed to support the hiring of communication group to help launch a social media campaign (Communications & Fundraising Committees),
7. Utilize the U.S. Alliance's website to be the repository for resource materials for professionals and parents. Identify and vet appropriate materials and resources (Resource and Training Committee),
8. Develop webinars, workshops, and online training for professionals on current research and how to help end CP in the U.S. (Resource and Training Committee),
9. Develop workshops and interventions for parent groups to help change parent attitudes and behavior (Resource and Training Committee).

AAP Statement and Op-Eds in Response

A major triumph in the movement was accomplished by Sege and his colleagues at the American Academy of Pediatrics (AAP) when they released a new policy statement in November 2018, entitled *Effective Discipline to Raise Healthy Children*. AAP is a professional association of 67,000 pediatricians whose mission is “to attain optimal physical, mental, and social health and well-being for all infants, children,

adolescents and young adults (AAP, 2019).” This is their first updated guidance in 20 years advising parents on effective discipline. Based on the extensive research studies, AAP concluded that corporal punishment is not only harmful to child development but also places children at risk of more severe harm without evidence of improving behavior (Sege, Siegel, & the Council on Child Abuse and Neglect, Committee on Psychosocial Aspects of Family and Child Health, 2018).

In response to AAP's policy, a number of organizations issued statements of support, including APSAC, The Foundling, U.S. Alliance, and the National Partnership to End Interpersonal Violence. Of significance, the policy committee of the National Initiative organized and managed to get dozens of op-eds published in major news outlets across the country.

What You Can Do

As a member of APSAC or a professional committed to ending all forms of child maltreatment, or both, we expect that you are supportive of this movement. But, we hope you will do more than just nod your head in agreement. Following are a few of the concrete action steps you can take to promote the movement.

- Join the Ambassador for Children drive (www.endhitting.org). For only \$25.00 you can become a Lifetime Ambassador, although there are options for contributing more. Our initial membership goal for the Ambassador drive is 1,500 people. Besides adding your name to the membership list, the Ambassador drive will allow us to identify and then communicate with advocates in various parts of the country and in different professions. That information will be particularly helpful when we establish legislative efforts to end CP in the 19 states that still allow CP in public schools.
- Educate yourself about the problem of CP. There is no shortage of published research articles on the topic, and hundreds are published each year. Recent four-page research summaries can be found in Grogan-Kaylor, Ma, and Graham-Bermann (2018) as well as Durrant and Ensom (2017). More in-

depth reviews of the research can be found in Gershoff and Grogan-Kaylor (2016) and Gershoff et al. (2018).

- Talk to friends and neighbors; spread the word. For those involved in faith-based communities, speak to your spiritual leader, such as a minister, pastor, priest, imam, or monk (see the article by Victor Vieth, 2019, in this issue)
- One way to help inform the public and change opinion is to write an op-ed, letter to the editor, or blog. But you can also influence your social network through Instagram or Facebook postings, for example.
- If you happen to live in one of the 19 states that still allows school CP, write to your state legislators. Each year, a number of states introduce bills that restrict or try to ban school CP. Your voice can help.
- For those working in organizations, consider advocating for an anti-CP statement or policy, or a No Hit Zone (NHZ). See the article about NHZs by Stacie LeBlanc and colleagues (LeBlanc, Alexander, Mastrangelo, & Gilbert, 2019) in this issue.
- Members of APSAC state chapters can

organize an initiative to end CP in their state. Contact APSAC to find out how.

- Finally, help promote the anti-CP movement by donating your time. You can join one of the seven committees or become a leader in this effort. Contact any one of the authors of this article for more information.

About the Authors

Viola Vaughan-Eden, PhD, is Associate Professor and PhD Program Director with The Ethelyn R. Strong School of Social Work at Norfolk State University. She is President Emerita of APSAC, President of the National Partnership to End Interpersonal Violence, and a member of the Executive Committee of the National Initiative to End Corporal Punishment.

George W. Holden, PhD, is Professor and Chair of the Psychology Department at Southern Methodist University. He is also a founder and President of the U.S. Alliance to End the Hitting of Children, a member of the Executive Committee of the National Initiative to End Corporal Punishment, and a member of APSAC.

Mel Schneiderman, PhD, is Senior VP and Cofounder of the Vincent J. Fontana Center for Child Protection and former Senior VP of Mental Health Services at the New York Foundling. He serves on the Executive Committee of APSAC and is currently Chair of the Executive Committee of the National Initiative to End Corporal Punishment.



A National Initiative to End Corporal Punishment

- American Academy of Pediatrics (2019). *AAP facts*. Retrieved from <https://www.aap.org/en-us/about-the-aap/aap-facts/Pages/AAP-Facts.aspx>
- American Professional Society on the Abuse of Children (2016). *Position statement: Corporal punishment of children*. Retrieved from https://docs.wixstatic.com/ugd/631fe2_acb3fa42465645d1a7648e601aad7e83.pdf
- Block, N. A. (2013). *Breaking the paddle: Ending school corporal punishment*. Columbus, OH: Center for Effective Discipline.
- CBS Sports (2018). *Adrian Peterson admits to spanking his son with a belt four years after indictment, suspension*. Retrieved from <https://www.cbssports.com/nfl/news/adrian-peterson-admits-to-spanking-his-son-with-a-belt-four-years-after-indictment-suspension/>
- Crandall, J. (2018). *Poll: Most approve of spanking kids*. Retrieved from <https://abcnews.go.com/US/story?id=90406&page=1>
- Child Trends. (2015). *Attitudes toward spanking: Indicators on children and youth*. Retrieved from https://www.childtrends.org/wp-content/.../10/51_Attitudes_Toward_Spanking.pdf
- Durrant, J. E., & Ensom, R. (2017). Twenty-five years of physical punishment research: What have we learned? *Journal of Korean Academy of Child and Adolescent Psychiatry*, 28, 20-24. doi:10.5765/jkacap.2017.28.1.20
- Gershoff, E. T., Goodman, G. S., Perrin-Miller, C., Holden, G. W., Jackson, Y., & Kazdin, A. E. (2018). The strength of the causal evidence against physical punishment of children and its implications for parents, psychologists, and policymakers. *American Psychologist*, 73, 626-638. doi:10.1037/amp0000327
- Gershoff, E. T., Purtell, K. M., & Holas, I. (2015). *Corporal punishment in U.S. Public Schools: Legal precedents, current practices, and future policy*. New York: Springer.
- Gershoff, E. T., & Grogan-Kaylor, A. (2016). Spanking and child outcomes: Old controversies and new meta-analyses. *Journal of Family Psychology*, 30, 453-469. doi:10.1037/fam0000191
- Glenn, M. C. (1984). *Campaigns against corporal punishment: Prisoners, sailors, women, and children in Antebellum America*. Albany: SUNY—Albany.
- Grogan-Kaylor, A., Ma, J., & Graham-Bermann, S. A. (2018). The case against physical punishment. *Current Opinion in Psychology*, 19, 22-27. doi:10.1016/j.copsyc.2017.03.022
- Holden, G. W., Wright, K. L., & Sendek, D. D. (2019). History and progress of the movement to end corporal punishment in the United States. In B. J. Saunders, B. Naylor, & P. Leviner (Eds.), *Comparative social and legal developments in dealing with corporal punishment of children* (pp. 293-320). Amsterdam, The Netherlands: Brill.
- LeBlanc, S., Alexander, R., Mastrangelo, M., Gilbert, H. (2019, Spring). No Hit Zones: A simple solution to address the most prevalent risk factor for child abuse. *APSAC Advisor* 31(1), 37-51.
- Piele, P. K. (1978). Neither corporal punishment cruel nor due process due: The U.S. Supreme Court's decision in *Ingraham v. Wright*. *Journal of Law & Education*, 7, 1-19.
- Sege, R., Siegel, B., and the Council on Child Abuse and Neglect, Committee on Psychosocial Aspects of Family and Child Health. (2018, December). Healthy discipline to raise healthy children. *Pediatrics*, 142(6), e20183112. doi 10.1542/peds.2018-3112
- Vieth, V. (2019, Spring). Working with Molly: A culturally sensitive approach to parents using corporal punishment because of their religious beliefs. *APSAC Advisor* 31(1), 52-58.

No Hit Zones: A Simple Solution to Address the Most Prevalent Risk Factor in Child Abuse

Key words: No Hit Zone(s), Corporal Punishment, Spanking

Stacie Schrieffer LeBlanc, JD, MEd

Randell Alexander, MD, PhD

Madison Mastrangelo

Hannah Gilbert

Is your workplace a No Hit Zone? Are adults allowed to hit adults? Are adults allowed to hit children? Is there a policy that prohibits hitting? While many people instinctively respond that hitting is not allowed in their workplace, most institutions do not have policies, signage, or practices to support this assumption or to assist staff in effectively intervening and de-escalating when hitting is observed. Witnessing parents threatening and hitting children is common in child-serving organizations, such as hospitals (Font et al., 2016). Is smoking allowed? Is there signage and a policy? While it is now rare for people to light a cigarette in hospitals and child serving organizations, signage is still highly visible because it works.

Many mistakenly assume spanking cannot be restricted because it is legal. Yet, there are many legal behaviors that are restricted for the health and safety of all, from prohibiting certain attire to banning cell phone use and smoking. Smoking restrictions are attributed as one of the tools that decreased smoking. Similarly, with increased awareness of the harms associated with hitting children, No Hit Zones (NHZs) provide one tool to reduce the use of corporal punishment (CP) and to increase the use of alternative parenting strategies.

NHZs offer a simple solution to assist in the

difficult task of shifting long-standing social norms surrounding the use of CP as an acceptable form of child discipline. Although a large body of research establishes CP as a significant risk factor for physical abuse and a cause of unintended harm to children, it is legally tolerated and accepted across cultures in the United States. Surveys of approval of CP (defined as a good hard spanking) show only minor variations and fluctuations between cultures. The vast majority of American parents (over 66% of women and 76% of men) condone CP, and the decline in CP approval over time has been slow (Child Trends, 2018).

NHZs are areas that are publicly noticed as being out of bounds for spanking, slapping, CP, or any euphemism for hitting. The purpose of a NHZ is to create and reinforce an environment of comfort and safety for children, adults, families, and staff working at any given facility or organization. While much of the initial impetus for NHZs has been to protect children, the effort has expanded to include violence prevention for all ages. Figure 1 sums up the mantra by signs, teaching, and policy to affirmatively state what the organization intends on its premises.

Like no smoking zones, the concept of NHZs is not complex. The key elements of a NHZ are seen in Figure 2.

Beyond a tool to create public awareness of the harms of CP and discussion among families, NHZs are a mission statement by the organization against

No Hit Zones: A Simple Solution to Address...

Figure 1. Sample Signage Displaying NHZ Mantra



Figure 2. Available Toolkit Samples of NHZ Elements.

1. Policy: Create a Mission statement/Policy about becoming a NHZ	2. Signage: Publicly display posters, floor talkers, or other media to alert staff and the public about your NHZ. Include information about where they might go to learn more.	3. Training: Teach the entire staff about NHZs and if applicable, how to pre-empt or de-escalate situations they may see. This may mean creating a teaching module for large group.	4. Parent Resources: Refer to resources that can help with positive parenting and/or resources for adult improvement.	5. Resources For Children - distraction materials	6. Other Organizational Messaging: Have staff translate research by holding signs as art of Dear Parent's Campaign.
<p>NHZ Policy, Children's Mercy</p>  <p>NHZ Policy, Children's Hospital New Orleans</p> 	<p>Signage, Children's Hospital New Orleans</p>  <p>Badge Stickers, Children's Hospital New Orleans</p>  <p>Poster, Wolfson Children's Hospital</p>  <p>Signage, City of Madison Heights</p> 	<p>No Hit Zone Training Video</p>  <p>CHILDREN'S HOSPITAL IN NEW ORLEANS IS A NO HIT ZONE.</p> 	<p>Dane County District Attorney's Office</p>  <p>Children's Hospital New Orleans</p>  <p>Children's Hospital New Orleans</p>  <p>City of Stoughton</p> 	<p>Children's Hospital New Orleans</p>  <p>Children's Hospital New Orleans</p>  <p>Masonic Children's Hospital</p> 	<p>500 images of key informants translating research for screensavers</p>   

physical violence. As more organizations become NHZs, a change in social norms is expected. Years ago, smoking might have occurred in many settings, but now the norm is that smoking is restricted and largely undesired. NHZs have the potential to change the acceptance of hitting, spanking, and slapping, not only in designated areas but also throughout the community in all settings—including the home.

Purpose

Prevent Child Abuse

In 2007, a Child Maltreatment publication on prevention established that “Social norms regarding CP may be the most prevalent risk factor for child abuse in the United States” (Klevens & Whitaker, 2007, p. 371). In addition to risk of physical abuse being the most significant association with parental use of

spanking, as found in Gershoff and Grogan-Kaylor's 2016 meta-analysis, fear of CP is frequently listed as a reason that children delay disclosure or do not disclose sexual abuse, as reported by child abuse pediatricians and forensic interviewers. In one case, a 7-year-old was recorded saying, "I was afraid to tell my mama about my uncle touching me" because I'm "afraid [I] will get in trouble." When asked to tell more about getting in trouble, the child said, "I get a whoopin."

Support Professionals

While the majority of child abuse professionals from the American Professional Society on the Abuse of Children (APSAC) surveyed by Taylor and associates agree that CP is harmful, these professionals assume that others in their field do not concur as strongly, creating a silent majority (Taylor, Fleckman, & Lee, 2017). Similarly, a survey of U.S. pediatricians showed that while their personal opinions have changed, they too believe that their colleagues have more favorable views of CP (Taylor, Fleckman, Scholer, & Branco, 2018). These discrepancies cause "pluralistic ignorance," the mistaken belief that one is in the minority thereby silencing the informed (Taylor et al., 2018). These two surveys also showed a desire among professionals for training and assistance in communicating the harms of CP (Taylor et al., 2017; Taylor et al., 2018).

Recognizing the need for guidance and the influence pediatricians have on parents for anticipatory guidance, the American Academy of Pediatrics (AAP) issued a strong policy statement advising pediatricians to inform parents on the harms of CP and negative shaming discipline and to offer alternatives (Sege, Siegel, AAP Council on Child Abuse and Neglect, & AAP Committee on Psychosocial Aspects of Child and Family Health, 2018). Most medical providers do not receive education on role-playing these difficult communications or extensive education on parenting. NHZs in medical settings provide the simplest solution to accomplish the goals set forth in the AAP policy. After surveying parents and finding that over half had not received advice from their pediatrician on undesired child behavior, researchers recommended that the "first salient step" in reducing CP is to provide clear messaging (Irons, Flatin, Harrington, Vazifedan, & Harrington, 2018). NHZs provide that clarity.

Reduce Harm

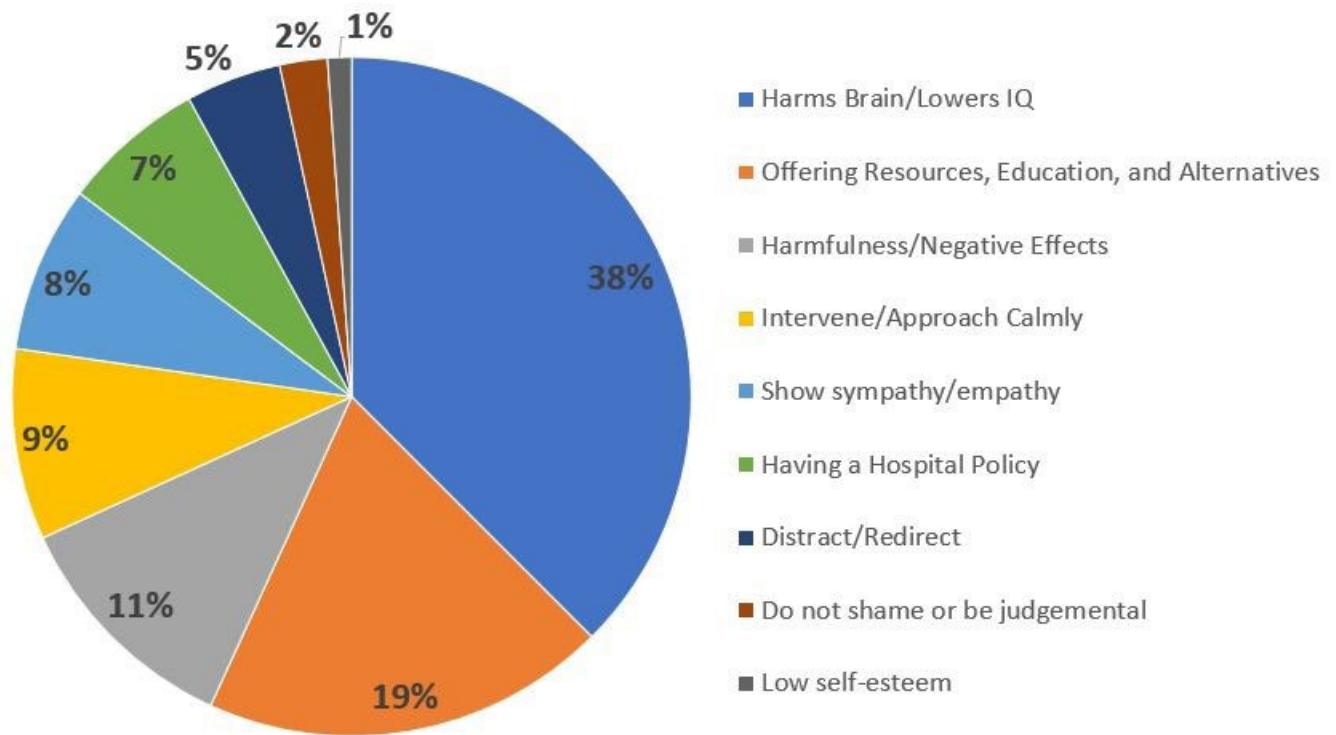
Multiple meta-analyses of CP have established significant correlations with a long list of negative health outcomes for children when they are exposed to CP. Beyond the strong association to physical abuse, spanking has been found to be correlated with mental health problems, antisocial behavior, child aggression, negative child-parent relationship, low self-esteem, child externalizing behavior, substance abuse, low self-control, and delinquent behavior (Gershoff & Grogan-Taylor, 2016).

Even after excluding confounding and demographic factors, significant correlations were found to high levels of childhood aggression by age 5 associated with mother's spanking children at age 3 (Taylor, Manganello, Lee, & Rice, 2010). Due to the strong association of childhood spanking with poor adult health outcomes, including increased odds of suicide attempts and moderate to heavy drinking, researchers concluded that spanking is empirically similar to physical and emotional abuse and that spanking should be considered an adverse childhood experience (ACE) (Afifi et al., 2017). Additionally, studies have found that no moderating factors, such as parental warmth, race, or culture, lessen the negative impact of spanking (Lee, Altschul, & Gershoff, 2013).

Protect Brains

Tomoda and colleagues compared brain scans of young adults who experienced childhood CP to a control group who experienced no CP or had minimal exposure. The study carefully excluded any indication of physical injury and instances in which parents used CP when angry. The study focused on what might be considered "ideal" CP, as was once recommended by the AAP, to only spank with an open hand to the buttocks or extremities and only when under emotional control. However, the brain scans of children who were hit by parents in emotional control (not striking out of anger) at least 12 times a year over a 3-year period where an object was used just once per year revealed a reduction in grey matter in 14.5% to 19.1% in three regions of the brain that are significantly correlated with performance IQ on the WAIS-2 (Tomoda et al., 2009). Similarly, Straus and Paschall (2009) found that spanking had a negative cascading effect on IQ over time. Spanking has

Figure 3. Qualitative Responses on Most Influential Messages in Response to “What Did You Learn Today That You Believe Would Most Influence Parents’ Attitude Toward Spanking?”



negative effects on the cognitive performance of the brain (Ferguson, 2013). These findings of changes to a child’s brain and the ability to learn may have the most potential to impact CP attitudes, and as such, they are frequently highlighted in NHZ training materials and handouts. Survey respondents from a NHZ training study from New Orleans frequently listed the impact on the brain as the most likely reason to change attitudes and behavior about CP and named lower self-esteem as the least likely, as illustrated in Figure 3.

Lessons From Global Progress in Reducing CP

In 1979, Sweden became the first country to ban CP of children entirely. Since then, more than a quarter of the world’s countries (54 countries through the end of 2018) have banned CP in the schools, public areas, and homes. In addition to pure humanitarian reasons, one of the stimuli behind the change has been ratification of the Convention on the Rights of a Child (CRC) (UNICEF, 1989). Respecting the rights of children to have a safe, nurturing, and stable childhood, countries have interpreted banning the hitting of children as

adhering to the CRC. Every country has ratified or adopted the CRC, except the United States.

In 1783, Poland became the first country to ban CP in public schools. In the U.S., currently 19 states still allow CP in schools. However, CP policies in schools are determined at the school district level. Hence, much of Georgia for example does not allow CP, and no school district in North Carolina does despite the state allowing it. Recently, Tennessee and Louisiana passed laws to ban paddling of school children with disabilities. While there have been reductions in the practice, hitting school children with boards is still occurring. In fact, the U.S. Department of Education (USDE) for civil rights reports that over 106,000 school children were beat in their schools during the 2013–2014 school year (USDE, 2013–2014). In the United States, an opportunity exists to decrease CP in schools at the federal, state, or local school district level. In the absence of legal changes at the state or federal level, a social norms strategy, such as No Hit Zones, might set the stage for eventual legal human rights change or make it socially obsolete.

The United States has banned the hitting of children

in some settings, such as detention facilities and Head Start programs, and many professional organizations have issued policy statements condemning the hitting of school children. Yet these professionals receive little advice and support in advising parents. NHZ resources can inform parents not only about the harms of hitting children but also of their parental rights to “opt out” of school CP. NHZ resources and materials can be a vehicle to empower parents who may unknowingly allow CP of their child at school and are uninformed of their rights.

Evaluation of NHZs

Gershoff and other leading CP researchers have evaluated NHZs in hospital settings and concluded that NHZs serve as a “feasible and potentially effective way to inform medical center staff and parent visitors about harms linked to spanking and to train staff in ways to intervene during incidents of hitting in order to promote a safe and healthy medical environment for patients, families, and staff” (Gershoff et al., 2018, p. 161). When NHZs are implemented in conjunction with staff training, significant changes in attitude regarding CP and confidence to intervene occur. Training staff to ensure that interventions are done without shame and blame is crucial to success. Training also has the added benefit of educating staff who may be unaware of the harms of hitting children and inspiring them to intervene effectively. Once staff members are armed with the information and tools, they are able to overcome the anxiety of approaching frustrated parents who may be threatening their child with CP (Gershoff et al., 2018). Evaluations showed that parents who read the NHZ materials were more likely to think spanking is harmful and that there are better alternatives than spanking. Staff attitudes continued to be less supportive of spanking 10 months after training (Gershoff et al., 2018).

An unexpected benefit of NHZs is to address and reduce the stress of staff and visitors who witness CP (Gershoff et al., 2018). Font and colleagues’ previous surveys of medical staff estimated that in medical settings, staff observed at least two incidents per day and that half of the physicians had witnessed at least one incident of hitting in the prior year (Font et al., 2016). Despite the high incidence of witnessing CP

in medical settings and feeling stressed, staff reported not intervening because they did not know what to do (Font et al., 2016). Font and colleagues also found that staff members who had a strategy on how to intervene were more likely to intervene. Other studies have also found that nurses (Hornor et al., 2015) and hospital staff, medical students, and residents (Burkhart, Knox, & Hunter, 2016; Scholer, Brokish, Mukherjee, & Gigante, 2008) were more likely to intervene when they had brief education on the harms of spanking.

While the implementation of NHZs is relatively recent and the evaluations limited at this point, the potential is promising, specifically when staff training, parent materials, and policy indications are included in the NHZ implementation.

How to Create a No Hit Zone

NHZs designed around the six strategies of the Spectrum of Prevention (SOP) model have the most likelihood to move beyond education to shifting cultural norms (Cohen & Swift, 1999). The SOP has proven successful in other injury and violence prevention efforts and lends itself well to the synergy needed to shift the high approval of a “good hard spanking.” Without much additional effort, NHZs can easily address all six levels of the SOP systematic action tool. The SOP model encourages prevention leaders to engage each level of the SOP by influencing policy, changing organizational practices, fostering coalitions, educating health and other providers, promoting community education, and improving individual skills and knowledge (Cohen & Swift, 1999). As such, the following discussion of No Hit Zones addresses implementing all levels.

Policy

An early step in the development of a NHZ is having a clear concept of what is to be accomplished, who will be involved, and what this means to staff. Depending on the organization, the policy may be a mission statement, declaration email, or signed policy that details how the organization intends to implement the program and publicize the policy. Policy will clarify expectations for staff training and staff responsibilities. Having the back-up of organizational policy has also been frequently noted by staff as making it easier to

approach parents and explain, “I am obligated to let you know that this a No Hit Zone.” Mandating training for all is ideal. In a children’s hospital, there may be a series of steps about how staff might anticipate and divert a situation, intervene if safe, or call for help if too risky. Resources about alternative parenting should be an integral part of the overall plan. In other locations, such as the Department of Motor Vehicles, a policy might not be structurally possible (government might not draft policies as such).

Organizational Practice

Highly visible public signage is key. Proudly displaying high-quality, permanent NHZ signage assures a consistent organizational message. Quality and permanent signage installed with hardware or hospital-grade adhesive is ideal. Clever organizational practices also have included magnets, elevator signs, floor talkers, banners, electronic signage, tote bags, pens, yard signs, and screen saver slide shows (Mastrangelo, 2018). The [Dear Parents Campaign](#), developed by the Audrey Hepburn CARE Center, provides black and white images of professionals across the country holding signs with simple translations of the latest research on the harms of CP and effective alternatives. Individuals can freely access, download, and disseminate the images and can participate in the campaign by uploading their own images. Displaying signage, using screensavers, and sharing on social media are easy organizational practices that are scalable.

Coalition Building

Sometimes, it is surprisingly easy to get a commitment. Simply asking an administrator might be enough. Personal relationships may be particularly helpful in generating enthusiasm for the project. The person in charge of an organization might be able to unilaterally implement policy. Other times, a champion may have to build a coalition that will help with momentum.

In large organizations, it may be necessary to start with key mid-level management such as social workers, child life specialists, nurse managers, or pastors. Even if they are not the initial champions, their acceptance is vital in that they may be the ones most tasked to carry out the project and to sustain it. Enlisting a coalition of such partners and then approaching higher management can be more successful than an individual approach. Having resources and the attached map (see Figures 4 and 5) of successfully implemented NHZs, as well as relating the experience that other places have not encountered perceived concerns, might help mollify those who are initially skeptical. The more support from the organization’s mid-level leadership, the more likely that top decision makers will be supportive. A powerful donor, a former organizational leader, or a key person from the outside who has influence can move the program forward at times when traditional approaches would not. NHZs also provide opportunities for marketing, press, branding, and regional leadership. These secondary gains may inspire some organizations.

Figure 4. Heat Map of NHZs.

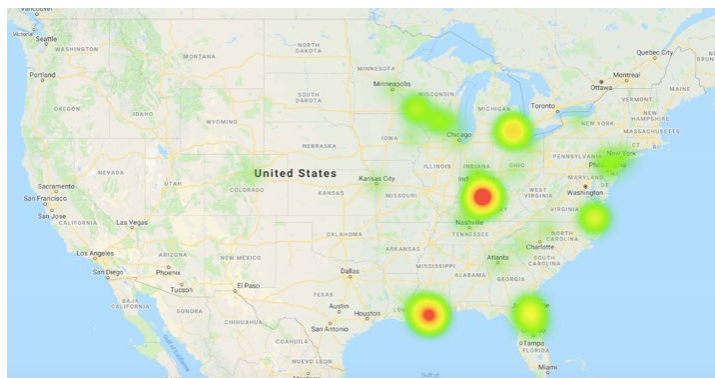
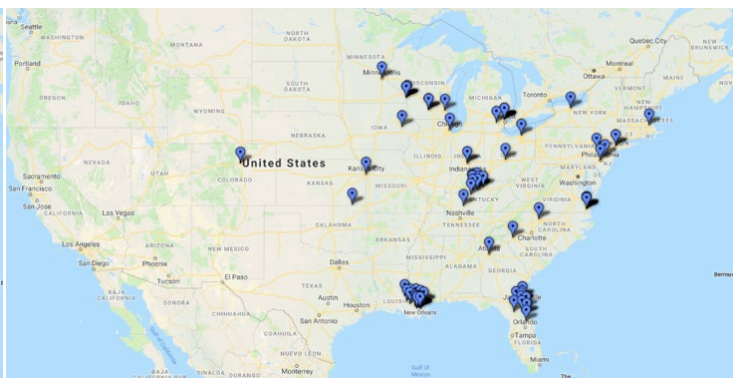


Figure 5. Locations of NHZs.



Training Key Informants

NHZs in hospitals, churches, mental health agencies, and schools provide an ideal tool for delivering messages from those most identified by parents as the key professional

sources they seek regarding information about child discipline.

As indicated by a study of an urban community sample, parents indicated that the following professionals in the order listed are the ones from whom they are most likely to seek advice regarding child discipline:

pediatricians, religious leaders, mental health professionals, and other professionals (Taylor, Moeller, Hamvas, & Rice, 2013).

Because these professionals may not

understand the potential impact their attitudes have on parents' discipline practices, key informants need to receive training and support. Short doses of No Hit Zone training can increase staff members' confidence and competence and empower them to intervene when they witness hitting. Samples of training materials, such as PowerPoints and videos that have been developed by NHZ champions, are readily available via a [toolkit](#) that has been compiled by the

National Initiative to End CP committee on No Hit Zones. Studies are underway at multiple sites to test materials and training videos. NHZ leaders are eager to share their expertise, and organizations [can register](#) their location or indicate the need for assistance (see

Figure 6).

Figure 6. Sample Registration Flyer.

NO HIT ZONE
PAINLESS PARENTING WORKS. HITTING HARMS.

Did you know... Spanking shrinks brains
Harvard Medical School found that kids who are spanked just once a month had **14-19% smaller brains** in the decision-making area.¹

Did you know... **1,574 studies** showed spanking is harmful²
Spanking is significantly correlated with.....

- Mental Health Problems**
10 studies showed children who are spanked exhibit mental health problems ^{2, 4, 5, 6, 7, 8, 9, 10, 11, 12}
- Anti-Social Behavior**
9 studies showed children who are spanked exhibit anti-social behavior ^{7, 13, 14, 15, 16, 17, 18, 19, 20}
- Child Aggression**
9 studies showed children who are spanked exhibit child aggression ^{5, 12, 13, 14, 15, 21, 22, 23, 24}
- Negative Parent-Child Relations**
5 studies showed children who are spanked exhibit negative parent-child relations ^{6, 25, 26, 27, 28}
- Low Self-Esteem**
3 studies showed children who are spanked exhibit low self-esteem ^{8, 29, 30}
- Child Externalizing Behavior**
13 studies showed children who are spanked exhibit externalizing behavior ^{14, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41}
- Substance Abuse**
4 studies showed children who are spanked exhibit substance abuse ^{42, 43, 44, 45}
- Low Self-Control & Delinquent Behavior**
11 studies showed children who are spanked exhibit low self-control & delinquent behavior ^{5, 11, 20, 43, 46, 47, 48, 49, 50, 51, 56}
- Physical Injury**
7 studies showed children who are spanked are victims of physical abuse ^{4, 52, 53, 54, 55, 56, 57}

Did you know... Spanking negatively affects IQ
University of New Hampshire found that American children who are spanked at ages 2-4 have **5 less IQ points** and ages 5-9 have **2.8 less IQ points** years later than non-spanked children.⁵⁸

Community Impact

Despite some extra effort, implementing a NHZ may be easier if more than one organization does so around the same time. This community effort bolsters the resolve of any one organization if it is not seen as doing this alone. For example, in Jacksonville, Florida, several organizations held a press conference announcing they would be NHZs. This diverse group included the following: Wolfson Children's Hospital, the

Medical Examiner's Office, Family Support Services (two counties), the First Coast Child Protection Team (eight counties), and a domestic violence shelter. By working together, the impact on the community was raised in the media and included efforts to enlist other organizations subsequently. Norfolk and New Orleans have similarly enlisted a diverse set of organizations, thereby propelling the awareness and adoption of additional NHZs in their communities. Conversely,

it becomes a selling point that an organization might not want to be seen as being left out—an argument that helped all the child advocacy centers in Florida agree to be NHZs. Because of the pioneering efforts of others, it is becoming increasingly easier to point out the experience of those helping to allay concerns about operational effectiveness and negative community reactions.

Improving Individual Skills and Knowledge

At their core, NHZs provide a unique opportunity to improve all individuals' knowledge about the harms of CP. NHZs create a challenge for parents to practice effective alternatives with the support of trained staff and an initiative for shifting parental attitudes and behaviors on the use of CP. While NHZs focus on settings frequented by families, the larger aim is to dissuade parents from using CP in all settings. To achieve this impact, NHZs provide a variety of ways to communicate the essential messages from highly visible signage, brochures, and electronic resources. NHZs fill gaps in knowledge of alternatives to CP and harms associated with CP, thereby supporting parents and providing a practical solution to a long-standing issue. In addition, NHZ training prepares staff with how to best communicate the three essential components of the program in order to improve individual knowledge.

Communicating the Three Essentials

Studies of countries that have significantly reduced the use of CP have demonstrated that the messaging to parents must include three components: (1) information on the detrimental effects of CP, (2) ineffectiveness of CP as a parenting strategy, and (3) information about effective alternatives (Porzig-Drummond, 2015). Too often key informants, for example pediatricians and parenting literature, highlight alternatives but avoid communicating the harms of hitting, delivering only half of the message. Without explaining the **harms** of hitting, parents will continue to use CP “as a last resort.” This incomplete messaging results in parents using CP when they are most frustrated, angry, and more likely to escalate

the force and severity of CP. Although it may seem preferential to communicate only positive parenting suggestions, the importance of communicating the harms of CP, even as a limited last resort, cannot be disregarded. CP has known risks, and parents have a right, even a responsibility, to at least know those risks. When an exposure is harmful and ineffective, those harms must be communicated clearly in addition to the alternatives. Similar to knowing about exposure to lead paint, asbestos, and second-hand smoke, education on the harms associated with CP is essential to changing long-standing behavior.

Harms

NHZs offer many opportunities to easily communicate and educate parents on the harms of hitting children via signage, resources, and verbal messaging once staff members are trained and confident. (See Figure 2 for sample policies, training materials, and signage.) NHZ materials are designed to communicate without shame and blame. One attached example prefaces all messaging with the following: “Dear Parents, Did you know...” spanking is associated with smaller brain size, childhood aggression, poor mental health outcomes, and a lower IQ? (See Figure 7.)

Pointing out the risk of physical abuse is typically not a persuasive parental deterrent because most parents firmly believe they “know the difference between abuse and spanking.” Parents do not want to injure their children and typically assert that they would never cross over the proverbial abuse line. The training needs to mention that the vast majority of parents who have physically abused their children also never thought they would until in the emotional act of discipline the violence escalates.

While no single message will resonate with all parents, the potential negative impact to brain development has been frequently listed as the most likely to impact parents by survey respondents. In fact, some of the harms of CP, such as fearing a parent and increased child aggression, have been noted by specific respondents as desirable. For example, when surveyed about CP, respondents stated that “it make[s] kids tough,” that they “don’t want to raise a pansy,” and that “kids today need to fear their parents to keep them safe.” Interestingly, the same respondents list harm to

Figure 7. Sample Resources For Parents.

WANT TO BECOME A NO HIT ZONE?

Register here:

<http://bit.ly/NHZRegistration>

Tool kit includes:

- sample policy
- signage
- effective parenting resources
- consulting



Benefits of being No Hit Zone:

- Create an environment of comfort and safety for parents, families, and staff
- Set a precedent within the community to reduce the harms of hitting children
- Help reduce the most prevalent risk factor for child maltreatment
- Promote effective parenting techniques

For more information, please contact the New Orleans Children's Advocacy Center at nocac@lcmchealth.org or (504)896-9237.



www.facebook.com/nocac



[@nocac_dearparents](https://www.instagram.com/nocac_dearparents)



brain as the most likely reason to consider alternatives. While these anecdotal and specific responses are not sufficient to frame communication marketing strategies, they demonstrate that not all messaging resonates the same way with parents and that some messaging can lead to an unintended impact. Hence, it is recommended that NHZ literature and resources include multiple different messages about the known potential risks.

Ineffectiveness

It is equally essential to communicate the ineffectiveness of CP in guiding desirable behavior. Sometimes, it may be as simple as pointing out that hitting a crying baby will cause only more crying. Or perhaps asking a parent, “Have you ever had to spank your child for the same misbehavior more than once?” For those who believe CP works, it is helpful to inquire about that effectiveness. A number of studies have found that spanking does not have the long-term impact desired by parents and that children often repeat the undesired behavior soon after being hit (Gershoff, 2013). One of the easiest ways to initiate this conversation is to ask parents to describe the child behavior that most frustrates them. Using this specific scenario, a provider can explain how causing pain will likely not teach different behavior or stop the undesired behavior, and then one can suggest simple, effective alternatives.

Alternatives

Framing positive parenting methods as effective parenting and consequences that teach will resonate better for parents who resist giving up punishment. Children need parental guidance and parents need easy access to a variety of effective alternatives for each developmental stage, child temperament, and past exposure to trauma. Most families have access to electronic devices, making websites and simple QR links a great tool for providing ample alternatives. NHZ staff training should emphasize communicating positive alternatives. When frustrated, parents may gravitate to negatively reinforcing types of discipline such as time-outs and restrictions, but NHZs are an opportunity to introduce parents to the abundance of well-tested positive parenting methods for guiding children.

Parents who were raised with CP may complain that if you take away the option of spanking, they have nothing left with which to manage their child. “Discipline” to some equals “spanking.” Understanding the parents’ language and parenting repertoire can be important when suggesting better ways. Parents may be completely unfamiliar within their own background about alternatives. Fortunately, a wide variety of resources can be recommended. [The Centers for Disease Control and Prevention \(CDC\)](#), [the American Academy of Pediatrics \(AAP\)](#), [U.S. Alliance to End the Hitting of Children](#), and others provide easy access to those with Internet access, and information can be printed out for parents.

Trainees in health care need modules about how to communicate behavior management as part of their educational programs. Research by Taylor and colleagues shows that parents most want to learn about this from their pediatrician (Taylor et al., 2013). Without training, however, understanding behavior management may be a weak link, but it is one the AAP recommends that all pediatricians address (Sege et al., 2018).

Dispelling Common No Hit Zone Misconceptions

Professionals often have questions about NHZs. In fact, misconceptions surround NHZs and can derail implementation by spreading misinformation about the initiative.

Misconception #1: Expensive

When interviewed as part of a Duke study, the majority of professionals at hospitals, District Attorney’s offices, and other institutions reported that they experienced competing demands on their resources and worried that they did not have the money or time to invest in a NHZ initiative (Mastrangelo, 2018). The experiences of regional NHZ leaders, including Norton Children’s Hospital and Champions For Children: Prevent Child Abuse Hampton Roads, demonstrate the low cost of NHZ implementation. A NHZ represents a flexible initiative that can start small with signage and policy and then become more comprehensive with staff training,

parenting resources, distraction kits, and other materials. NHZ leaders at Norton Children's Hospital stated that the implementation cost was "nominal" and that a \$1,844 budget purchased 4,000 brochures, 1,000 vinyl signs, and 12 posters (Frazier, Liu, & Dauk, 2014). The team designed the materials within the hospital, further reducing the cost. Other NHZ institutions solicited donations and raised money by selling merchandise, such as NHZ coffee mugs, to cover costs (Mastrangelo, 2018).

The time investment in NHZ implementation varies by institution and can be minimized by partnering with existing NHZ institutions. By sharing materials, NHZ champions reduce the upfront time investment (Mastrangelo, 2018). Institutions can utilize similar signage, educational resources, and promotional materials to reduce time and money needed to implement the NHZ.

Misconception #2: Difficult to implement

NHZ implementation starts with a no hitting policy, which represents the core of the initiative, and then involves signage and other materials to clearly communicate the policy to all. Training prepares employees to intervene if they witness hitting or threats of hitting and to discuss parenting alternatives with families.

Obtaining the endorsement of administrators, such as hospital officials, can delay implementation. When pitching a NHZ, champions can focus on the experiences of existing NHZs and connect the nonviolence policy to the organization's stated mission to gain administrator buy-in. For instance, a no hitting policy aligns with the missions of children's hospitals and other organizations that serve children and prioritize their health.

The implementation process can be further simplified with support from existing NHZ institutions. In interviews, individuals who received implementation assistance from an existing NHZ organization reported that the process was "simple" (Mastrangelo, 2018). For instance, Deb Sendek, the champion of the Gunderson implementation, has assisted and connected many champions. Children's Hospital New

Orleans also serves as a regional NHZ leader and has implemented NHZs in schools, shelters, 20 clinics, and in multiple other organizations. Champions who lend time, expertise, and materials to agencies greatly accelerate the growth and potential for norm change.

Misconception #3: Intrudes on parental rights

NHZs support children and families by creating a healthy environment and by promoting alternatives to CP. Some may argue that NHZs strip parents of their right to parent as they chose. However, organizations adopt a number of policies that restrict other rights, such as yelling or cell phone use. NHZs do not govern behavior outside of an institution's space, although they aim to shift social norms away from hitting in all circumstances. NHZs strive to communicate the harms associated with CP but do not penalize the behavior.

Although early adopters feared backlash after implementation, community resistance has not been frequent. Many institutions encounter little or no resistance about the policy from the larger community (Mastrangelo, 2018), and some receive none. For example, the Louisville Bats Slugger Field, home of the minor league baseball team, became a NHZ in 2012 and has not encountered any backlash from or dialogue with fans (Mastrangelo, 2018). Institutions can reduce potential resistance by clearly explaining the policy and quelling any concerns that there will be legal ramifications associated with spanking.

NHZ Targets: The Places We Go

An entity can be a NHZ with minimal effort, or it can be a community leader by working with others to advance the concept. To capture the operational levels by which established programs work, and to document the stage of development of others, a five-tier classification was piloted with eight centers to establish how well the scheme fit. Based on this, entities are classified as seen in Figure 8. This classification allows comparisons between similar entities and perhaps establishes explicit goals to build stronger efforts, if possible, for those at the lower levels.

Figure 8. The Five-Tier Classification of No Hit Zones.

Level	No Hit Zone Development
1 Concept	At least one person formulating plan on how the organization can implement the NHZ . Lead person has discussed creating a NHZ with other colleagues within their organization. Have attended a NHZ presentation and/or established communication with other NHZs.
2 Progress	More than one person working on the NHZ. Working on an implementation plan to develop materials and training. Gained support for implementation from organizational leadership. Communication with other NHZs (e.g. listserv and private Facebook group)
3 Basic	Training underway for personnel. On-going training plan. Signage and other declaration that the facility/organization is a NHZ.
4 Complete	Established training of all staff and training for new staff. Prominent signage and notification that the facility/organization is a NHZ. At least one person has NHZ as part of their job description. Community awareness that facility is a NHZ.
5 Regional	Established organized training of all staff and training for new staff. Prominent signage and notification that the facility/organization is a NHZ. At least one person has NHZ as part of their job description. Community awareness that facility/organization is a NHZ. Provides outreach education about NHZ. Enlists other organizations in the community/region to be a NHZ.

Hospitals

Hospitals have provided the initial impetus for NHZs—reflecting the health mission and need for nonviolence when tending to patients. Gradually, NHZs are expanding beyond children’s hospitals to include adult hospitals as well. Over 20 hospitals are in some stage of implementation, beginning with Rainbow Babies Children’s Hospital in 2005 and Norton Children’s Hospital—University of Louisville in 2012. Some of these hospitals have extended their reach within the community to enlist other

organizations, thereby becoming a Level-5 entity.

Schools

Schools are a logical place not only to ensure that children are not hit on the premise but also to serve as an informational platform for parents struggling with negative reports of behavior and grades. Recent research found a strong connection linking report cards that go home on Friday to increases in reports to CPS for physical abuse due to CP (Bright et al., 2018). NHZs in schools can be bolstered by having

pre-prepared letters that accompany report cards on the harms of hitting, the negative impact to the brain, the fact that CP does not improve grades, and the incredible list of effective alternatives to improve school performance. A New Orleans teacher reported feeling relieved when she was able to stop a parent swinging a belt by explaining the policy and was able to work with the parent on a plan.

Government Entities

Government entities can become NHZs despite state laws allowing CP. Stoughton, Wisconsin, became a NHZ for its city buildings and parks. Similarly, Madison Heights, Michigan, adopted NHZs for its buildings and parks. Prior to that, the Dane County Prosecutor's Office became a NHZ with considerable public awareness. The Alachua County Sheriff's Office (Florida) illustrates the diverse types of government organizations that can adopt this mission.

Churches

Churches provide the ideal setting to involve religious leaders who have been identified as the second professional key informant that African American parents look to for advice on child discipline (Taylor et al., 2013). In addition, church communities and leadership can address one of the common misconceptions that "spare the rod spoil the child" is written in the Bible. Religious scholars have clarified that in fact this phraseology does not appear in the Bible. Additionally, there are no references to any "rods" in the New Testament. The commonly misinterpreted Old Testament references to a "rod" were actually written in Hebrew, and the English translation can be better understood as a "staff," which was utilized by shepherds for guiding sheep by using the hook to bring the sheep closer and keeping the flock safe from predators—not for hitting the sheep. Likewise, NHZs provide a pulpit to keep families of the congregation safe.

Potential Spaces for NHZs

The list of potential other sites for NHZs is endless. Frequently suggested are supermarkets, retail stores, restaurants, airports, playgrounds, amusement parks, recreational facilities, apartments, and of course, ultimately homes.

Conclusion

The crux of NHZs is not to restrict parental rights or create a punitive ban but to build a platform for raising awareness of the harms of CP, the effective alternatives, and how to create a safe space for all children and visiting adults. No Hit Zones provide physical and psychological safe spaces for all served and an opportunity for parents to practice, model, and learn new skills for guiding children without risking the harms of CP.

About the Authors

Stacie LeBlanc, MEd, JD, directs the New Orleans Children's Advocacy Center and the Audrey Hepburn CARE Center at Children's Hospital New Orleans. She began her career as a child abuse prosecutor for ten years and founded the Family Violence Program. Stacie has trained over 51,000 professionals and serves as Vice-President of APSAC.

Randell Alexander, MD, PhD, is Professor of Pediatrics at the University of Florida, Chief of the Division of Child Protection and Forensic Pediatrics. He is Board Chair for the Academy on Violence and Abuse. He was on the board of APSAC, and is on the board of FLAPSAC.

Madison Mastrangelo graduates from Duke University in May 2019 with a Bachelor of Arts in Public Policy and Global Health, earning the honor of Highest Distinction in Public Policy based on her thesis on No Hit Zone implementation. Madison has accepted a position as a management consulting analyst for Accenture Federal Services.

Hannah Gilbert, a graduate of Tulane University, will obtain her master's degree in health care management in May 2019. She serves as Coordinator of Community Programming for the Audrey Hepburn CARE Center at Children's Hospital New Orleans. Hannah supervises over 54 interns in the tracking and development of No Hit Zones.

No Hit Zones: A Simple Solution to Address the Most Prevalent Risk Factor in Child Abuse

- Affi, T. O., Ford, D., Gershoff, E. T., Merrick, M., Grogan-Kaylor, A., Ports, K. A., ... Bennett, R. P. (2017). Spanking and adult mental health impairment: The case for the designation of spanking as an adverse childhood experience. *Child Abuse & Neglect, 71*, 24-31.
- Bright, M. A., Lynne, S. D., Masyn, K. E., Waldman, M. R., Graber, J., & Alexander, R. (2018). Association of Friday school report card release with Saturday incidence rates of agency-verified physical child abuse. *JAMA Pediatrics*. doi:10.1001/jamapediatrics.2018.4346
- Burkhart, K., Knox, M., & Hunter, K. (2016). Changing health care professionals' attitudes toward spanking. *Clinical Pediatrics, 55*(11), 1005-1011. doi:10.1177/00099228166673.
- Child Trends. (2018). *Attitudes toward spanking*. Retrieved from <https://www.childtrends.org/indicators/attitudes-toward-spanking>.
- Cohen, L., & Swift, S. (1999). The spectrum of prevention: Developing a comprehensive approach to injury prevention. *Journal of the International Society for Child and Adolescent Injury Prevention, 5*(3), 203-207.
- Ferguson, C. J. (2013). Spanking, corporal punishment, and negative long-term outcomes: A meta-analytic review of longitudinal studies. *Clinical Psychology Review, 33*(1), 196-208.
- Font, S. A., Gershoff, E. T., Taylor, C. A., Terreros, A., Nielsen-Parker, M., Spector, L., ... Olson-Dorff, D. (2016). Staff responses when parents hit children in a hospital setting. *Journal of Developmental and Behavioral Pediatrics, 37*(9), 730-736. doi:10.1097/DBP.0000000000000343.
- Frazier, E. R., Liu, G. C., & Dauk, K. L. (2014). Creating a safe place for pediatric care: a no hit zone. *Hospital Pediatrics, 4*(4), 247-250.
- Gershoff, E. T. (2013). Spanking and child development: We know enough now to stop hitting our children. *Child Development Perspectives, 7*(3), 133-137. doi:10.1111/cdep.12038
- Gershoff, E. T., Font, S. A., Taylor, C. A., Garza, A. B., Olson-Dorff, D., & Foster, R. H. (2018). A short-term evaluation of a hospital no hit zone policy to increase bystander intervention in cases of parent-to-child violence. *Children and Youth Services Review, 94*, 155-162. doi:10.1016/j.childyouth.2018.09.040
- Gershoff, E. T., & Grogan-Kaylor, A. (2016). Spanking and child outcomes: Old controversies and new meta-analyses. *Journal of Family Psychology, 30*(4), 453-469. doi:10.1037/fam0000191
- Honor, G., Bretl, D., Chapman, E., Chiocca, E., Donnell, C., Doughty, K., ... Quinones, S. G. (2015). Corporal punishment: Evaluation of an intervention by PNPs. *Journal of Pediatric Health Care, 29*(6), 526-535. doi:10.1016/j.pedhc.2015.04.016
- Irons, L. B., Flatin, H., Harrington, M. T., Vazifedan, T., & Harrington, J. W. (2018). Parental self-assessment of behavioral effectiveness in young children and views on corporal punishment in an academic pediatric practice. *Clinical Pediatrics, 57*(10), 1183-1190.
- Klevens, J., & Whitaker, D. J. (2007). Primary prevention of child physical abuse and neglect: Gaps and promising directions. *Child maltreatment, 12*(4), 364-377.

- Lee, S. J., Altschul, I., & Gershoff, E. T. (2013). Does warmth moderate longitudinal associations between maternal spanking and child aggression in early childhood? *Developmental Psychology, 49*(11), 2017-2028. doi:10.1037/a0031630
- Mastrangelo, M. (2018). *A policy analysis of No Hit Zones: What are barriers to No Hit Zone implementation?* Honors thesis, Duke University. Retrieved from <https://hdl.handle.net/10161/17826>.
- Porzig-Drummond, R. (2015). "Help, not punishment": Moving on from physical punishment of children. *Children Australia, 40*(1), 43-57. doi:10.1017/cha.2014.47
- Scholer, S. J., Brokish, P. A., Mukherjee, A. B., & Gigante, J. (2008). A violence-prevention program helps teach medical students and pediatric residents about childhood aggression. *Clinical Pediatrics, 47*(9), 891-900. doi:10.1177/0009922808319965.
- Sege, R. D., Siegel, B. S., AAP Council on Child Abuse and Neglect, & AAP Committee on Psychosocial Aspects of Child and Family Health. (2018). Effective discipline to raise healthy children. *Pediatrics, 142*(6), e20183112.
- Straus, M. A., & Paschall, M. J. (2009). Corporal punishment by mothers and development of children's cognitive ability: A longitudinal study of two nationally representative age cohorts. *Journal of Aggression Maltreatment & Trauma, 18*(5), 459-483. doi:10.1080/10926770903035168
- Taylor, C. A., Fleckman, J. M., & Lee, S. J. (2017). Attitudes, beliefs, and perceived norms about corporal punishment and related training needs among members of the "American Professional Society on the Abuse of Children." *Child Abuse & Neglect, 71*, 56-68. doi:10.1016/j.chiabu.2017.04.009
- Taylor, C. A., Fleckman, J. M., Scholer, S. J., & Branco, N. (2018). U.S. pediatricians' attitudes, beliefs, and perceived injunctive norms about spanking. *Journal of Developmental and Behavioral Pediatrics, 39*(7), 564-572. doi:10.1097/DBP.0000000000000592
- Taylor, C. A., Manganello, J. A., Lee, S. J., & Rice, J. C. (2010). Mothers' spanking of 3-year-old children and subsequent risk of children's aggressive behavior. *Pediatrics, 125*(5), e1057-e1065. doi: 10.1542/peds.2009-2678
- Taylor, C. A., Moeller, W., Hamvas, L., & Rice, J. C. (2013). Parents' professional sources of advice regarding child discipline and their use of corporal punishment. *Clinical Pediatrics, 52*(2), 147-155. doi: 10.1177/0009922812465944
- Tomoda, A., Suzuki, H., Rabi, K., Sheu, Y. S., Polcari, A., & Teicher, M. H. (2009). Reduced prefrontal cortical gray matter volume in young adults exposed to harsh corporal punishment. *NeuroImage, 47*(2), T66-71.
- UNICEF. (1989). Convention on the rights of the child. Retrieved from <https://www.ohchr.org/en/professionalinterest/pages/crc.aspx>
- U.S. Department of Education (USDE), Office for Civil Rights. (2013-2014). Civil rights data collection (CRDC). Retrieved from <http://ocrdata.ed.gov>

Working With Molly: A Culturally Sensitive Approach to Parents Using Corporal Punishment Because of Their Religious Beliefs

Victor I. Vieth, JD, MA

“As for parents, don’t provoke your children to anger, but raise them with discipline and instruction about the Lord” — Apostle Paul (Ephesians 6:4)

Introduction: Working With Molly

Molly was in tears when the doctor showed her the pictures of the bruises on her 4-year-old son’s buttocks and asked her what happened. “I didn’t know I was hitting him that hard. I was just trying to get him to mind. I don’t like spanking him, but my church says God requires it. I just want my son to grow up and be respectful of others. Mostly, I want to make sure my son goes to heaven.”

This hypothetical but realistic scenario of child physical abuse reflects a controversial and often overlooked dynamic in the struggle to end hitting children as a means of discipline. Many parents hit their children because they sincerely believe this type of discipline is commanded by God. Accordingly, if child protection professionals are to aid parents in moving away from corporal punishment, they must be mindful of this dynamic and employ a culturally sensitive approach. This will be challenging, in part, because some commentators suggest that attempts to dissuade clients from physical discipline rooted in religious beliefs “generally represent an unethical

violation of clients’ autonomy” (Hodge, 2004, p. 255). Respect for religion, though, must be balanced against the large and growing body of research documenting the risks of even mild corporal punishment (Gershoff & Grogran-Kaylor, 2016). To that end, this article provides a brief overview of religious beliefs pertaining to physical discipline and offers a research-rooted approach to working with parents such as Molly.

Determining Molly’s Religion

To understand Molly’s comments, we need to determine her theological framework. In the United States, approximately 95% of Americans identifying with a particular religion describe themselves as Christian (Newport, 2011, pp. 9–11; Newport, 2017; Pew, 2015)¹. It is not surprising, then, that Molly says her religious views are influenced by a Christian institution—namely, her church.

Within the Christian demographic, there are radically different views of corporal punishment. Although Catholic parents may employ corporal punishment, they rarely justify the practice by referencing their religious beliefs (Ellison & Sherkat, 1993). This may be because myriad Catholic commentaries discourage using the Bible as justification for physical discipline. For example, commentary in the *Catholic Study Bible*

¹ According to Pew’s Religious Landscape Study, 70.8% of Americans identify as Christian, 5.9% identify with a non-Christian faith, 1.8% are placed in a category of Other Faiths, and the remaining 22.8% are Unaffiliated or labeled by Pew as “nones” (Pew 2015). Gallup’s 2017 survey finds the following demographics in the United States: 48.5% of Americans are Protestant, 22.7% are Catholics, 1.8% are Mormon, 2.1% are Jewish, 0.8 are Muslim, 2.5% are other non-Christian religions, and 21.3 have no religious identity (Newport, 2017).

on Proverbs 23:13–14 states, “The sardonic humor means the exhortation is not to be taken literally, an argument for corporal punishment” (Senior, Collins, & Getty 2011, p. 867). In 2011, Archbishop Gregory Aymond noted, “I do not believe the teachings of the Catholic Church, as we interpret them today... can possibly condone corporal punishment” (Nolan, 2011). Accordingly, it is a relatively safe bet that Molly is not Catholic.

It is also a safe bet that Molly is not a member of a Protestant church that adopts a historical critical analysis of scripture. These churches, often described as progressive or “liberal,” interpret the Bible with “historical and literary sensitivity” as well as a greater emphasis on the “direction” in which the Bible is moving (Migliore, 2014, pp. 55–57). As a result, these churches tend to view the Bible not as the “last word” but the “living word” of God, which enables them to employ a “creative and critical process” to interpreting scripture (Migliore, 2014, p. 57). Churches adopting this approach tend to discourage corporal punishment because they are less rigid in reading biblical references to corporal punishment and are more receptive to contemporary research on the potential harm of even mild physical discipline. (Sege, 2018). Indeed, progressive denominations that have passed resolutions discouraging corporal punishment reference research and don’t specifically address biblical passages pertaining to physical discipline (Shapiro, 2012; United Methodist Church, 2012).

In the case of Molly, it can be safely assumed she is a member of a church that adopts a more conservative view of the Bible. Churches adopting this approach contend the Bible is “authoritative by virtue of its supernatural power and the direct identity of its words with the word of God” (Migliore, 2014, p. 49). This means that “every book, every chapter, every verse, every word was directly inspired by God” (Migliore, 2014, p. 49). Churches adopting this approach often fear a “slippery slope” of Biblical interpretation in which the dismissal of any passage of scripture may undermine critical teachings, such as the Christian belief of salvation through the death and resurrection of Christ (Vieth, 2014). Molly’s comments about fearing her child may not go to heaven if she abandons corporal punishment may reflect, at least in part, a

“slippery slope” concern that dismissing one passage may erode her trust in all of scripture.

Research Supporting the Necessity and Efficacy of Addressing Molly’s Theological Concerns

If we are correct in placing Molly in a Protestant community that views every passage of scripture as directly inspired by God, then passages that appear to encourage or require physical discipline will not be dismissed lightly. Indeed, decades of research has found little movement in the thinking of conservative Protestants about physical discipline irrespective of educational attainment (Hoffman, Ellison, & Bartkowski, 2017).

When working with a parent such as Molly, two studies suggest that simply providing education about the research on the risks of corporal punishment will have little impact (Perrin, Miller-Perrin, & Song, 2017; Miller-Perrin & Perrin, 2017). However, if a discussion of the risks of corporal punishment is combined with education on alternative views of Biblical passages pertaining to physical discipline, research suggests there is a realistic chance Molly will change her views about the practice (Perrin et al., 2017; Miller-Perrin & Perrin, 2017). However, any theological discussion must be cognizant of Molly’s cultural framework and thus employ a more conservative interpretation of scripture (Vieth, 2014).

To work within Molly’s belief system, it is necessary to explore what the Bible has to say about corporal punishment and to offer arguments that are sensitive to Molly’s understanding of these texts.

The Bible and Corporal Punishment: Understanding Molly’s Cultural Framework

The Bible consists of a minimum of 66 books penned over the course of 16 centuries (*Lutheran Study Bible*, 2009, pp. 26–29). Although written in a time period in which children received egregious corporal punishment, there are very few passages addressing the subject. For example, the New Testament contains no reference to the corporal punishment of children even though child discipline is discussed (e.g.,

Ephesians 6:4).

When people speak of biblical support for the idea of hitting children as a means of discipline, they are typically referring to a handful of verses in the book of Proverbs, which is a collection of wisdom verses that tradition attributes to King Solomon (Vieth, 2017). The Proverb most commonly cited as justification for physical discipline is as follows: “Those who spare the rod hate their children, but those who love them are diligent to discipline them” (Proverbs 13:24).

The Hebrew word translated *rod* appears 190 times in what Christians refer to as the Old Testament (Green, 2013, p. 1025). Among other things, a rod can refer to a stick, scepter, lance, or spear (Green, 2013, p. 1025). In Proverbs 13:24, the word translated *rod* appears with another Hebrew word *musar*, which “can mean the idea of physical or oral reproof and the idea of a body of knowledge to be mastered” (Green, 2013, p. 1025). Taken together, these words may be referring to physical punishment, verbal correction, or the sharing of knowledge (Green 2013, p. 1025). Given the broad language in this verse, even some conservative Protestant theologians find it problematic to use this verse as justification for corporal punishment (Andrae, 2014).

There are, however, several other proverbs referencing corporal punishment that make it clearer that a child is being physically struck. These verses include references to the beating of children (Proverbs 23:13–14). Accordingly, even theologians who oppose the corporal punishment of children concede “there is no question” these verses are referring to “a physical instrument and that these proverbs commend its active use as a disciplinary measure (Brown, 2008).

In working with Molly, then, it is probably impractical to suggest the Bible does not at least authorize the corporal punishment of children. A child protection professional making such an argument is probably employing a more liberal interpretation of scripture that is unlikely to resonate with Molly or the church leaders she may turn to for direction (Vieth, 2014).

Working With Molly: Theological Arguments That May Influence a Change in Practice

Prior to broaching the subject of religion with Molly, it

is critical for the professional to note two things. First, Molly likely loves her child and very much wants the best for him. Indeed, her comments reflect a concern not only for his temporal but also his eternal welfare. If this is true, there is a foundation to work with her on—the mutual concern for her child.

Second, Molly is likely skeptical of professionals who are insensitive to her religious views. Research indicates that evangelical Christians “often feel excluded, marginalized, and discriminated against by secular institutions and elites” (Hodge, 2004). If Molly feels this way, it is particularly important to articulate respect for her cultural belief and to assure her you are not attempting to change her religious views but to explore whether there is a basis within these views to use other forms of discipline that may be more effective in achieving her goals. Indeed, Molly’s comments that she doesn’t like spanking but her church requires it suggests she is open to finding an alternative to physical discipline that doesn’t run counter to her religious beliefs.

To that end, there are at least five arguments appearing in moderate to conservative theological journals or other publications that may resonate with Molly.

Scripture may authorize, but it does not require corporal punishment.

Given the broad nature of the word *rod* in Proverbs 13:24, some theologically conservative Protestant writers contend that although the Bible authorizes physical discipline, it does not command it (Schuetze, 2017, p. 295). The periodical *Christianity Today* (2012), which was founded by Billy Graham, has adopted this position.

In a similar vein, several conservative protestant Bible commentaries note that many of the proverbs are “figures of speech” referencing types of discipline at the time but are simply intending to convey the need to correct children as opposed to commanding a particular form of discipline (Barker 2011, p. 1049; Hoerber, 1986, p. 965). Although this trend is growing in conservative Protestantism (Merritt, 2014), the strand has always been present. For example, Martin Luther rarely used corporal punishment and expressed

grave concerns about its use (Vieth, 2017).

If Molly accepts these arguments, she may now have a theological basis for letting go the idea that she must employ corporal punishment in the discipline of her children.

There is as much scriptural support for the corporal punishment of adults as children.

Although some conservative Protestant leaders insist the Bible requires the corporal punishment of children (Mohler, 2004) and contend the Bible has a clear preference for physical discipline with a switch as opposed to a hand (Hindson, 2013, p. 942)², they are noticeably silent about the numerous proverbs pertaining to the corporal punishment of adults (e.g., Proverbs 18:6, 19:25, 19:29; 26:3, 10:13). Although early Catholic and Protestant writings required the corporal punishment of wayward adults (Janz, 2008, p. 258; Rule of St. Benedict, pp. 24, 50, 53, 94), the modern church recognizes these verses as conveying an underlying wisdom that misdeeds bring consequences—whippings at the time of Solomon and jails and fines in our current era.

It is unlikely that Molly or her church believes that she or other adults should receive corporal punishment for their transgressions, but it is also something she may have given little thought to. Reminding Molly that the church does not interpret Proverbs about hitting adults as therefore requiring corporal punishment may make the move away from the physical discipline of children more comfortable.

Scripture emphasizes non-corporal forms of discipline.

As a collection of wisdom verses, Proverbs contains a number of sayings that are seemingly incompatible (e.g., Proverbs 26:4–5). In the case of physical discipline, the verses referencing corporal punishment must be balanced against verses that note corporal punishment is not needed or is ineffective (Proverbs 17:10) as well as the many verses about instructing children with words, examples, and other non-corporal forms of guidance and discipline (Brown,

2008). According to one Protestant seminary professor, the overall lesson of Proverbs is that “wisdom in all her authority and majesty...spares the rod, and in so doing relativizes its use, much in tension” with the Proverbs referencing physical discipline (Brown, 2008).

As noted earlier, there is no reference to the physical discipline of children in the New Testament. Indeed, references to child discipline in the New Testament discourage parents from provoking their children to anger—a message that was counter-cultural to the harsh corporal punishment in place at the time (Joersz, 2013, p. 161).

The modern concept of “spanking” is not found anywhere in the Bible.

Protestant proponents of “spanking” recommend striking the buttocks one or two times but never hard enough to leave marks. Hitting the child should also be preceded by an explanation and followed with a comforting prayer. This is a modern invention that has no direct biblical support (Merritt, 2014). Instead, references to corporal punishment in the Bible speak of blows to the back that result in bruises or stripes—conduct that would be considered criminal in most jurisdictions today (Merritt, 2014).

As a writer for *Religion News Services* noted,

The spanking restrictions Christians promote as Biblical would sound bizarre to those from the ancient Jewish cultures from which these passages arise. “Biblical spanking,” if one reads and applies these passages literally, is much more severe than the modern Western behaviors. (Merritt, 2014)

In working with Molly, this may be a critical lesson. Because she is concerned about abandoning a biblical concept, it may be helpful for her to realize that even conservative Protestants advocating for spanking have abandoned a literal interpretation of these verses.

Non-corporal forms of discipline are operating closer to the heart of the text.

² The King James Study Bible, Second Edition (Hindson, 2011) includes the following commentary on Proverbs 13:24: “Love and discipline go together. The rod does not necessarily mean a spanking but simply whatever physical discipline is reasonable for the offense. The rod refers to a branch or switch. It is a small object that stings, but does not inflict serious bodily harm. The use of the rod for spankings is clearly taught in scripture in preference to spanking with one’s hand” (p. 942).

Once we realize that even advocates for spanking do not encourage the type of corporal punishment referenced in the Bible, it becomes easier to ask what, exactly, is the purpose or meaning of these passages? As noted earlier, the writer of Proverbs was conveying bits of wisdom and did so by referencing practices in play at the time. Each generation is called upon to apply these verses to its era (Troftgruben, 2018).

As one example, Proverbs 31:6–7 tells us to give wine or strong drink to ease the pain of those in anguish. According to some Bible commentaries, this is a reference to the use of alcohol as a medication (Engelbrecht, 2009, p. 1046n). Applying this standard today, we wouldn't be obligated to give someone in great pain wine, we would instead use morphine or another modern drug.

In his book *Corporal Punishment in the Bible*, Tyndale Seminary Professor William Webb (2011) noted that the underlying purpose of the corporal punishment verses is “avoiding folly and embracing divine wisdom” (p. 91). Because decades of research informs us that non-corporal forms of discipline are more effective in achieving the goal advanced in Proverbs, Webb (2011) points to the “delightful irony” that parents using non-corporal forms of discipline “have in fact become more (not less) biblical in their child-rearing practices” (p. 91).

Conclusion: The Need for Faith Partnerships

With the growing body of research documenting the ineffectiveness of corporal punishment and its association with many cases of child physical abuse, a number of Christian writers, both liberal and conservative, have urged the church to re-evaluate

ancient texts often used to justify physical discipline. Early research suggests a deeper, culturally sensitive analysis of these texts can be helpful in moving many conservative Protestants away from physical discipline.

Unfortunately, many multidisciplinary teams (MDTs) lack a professional qualified to work with parents worried that abandoning physical discipline will be frowned upon by God. For this reason, a number of child abuse experts have urged MDTs to develop working relationships with faith leaders or even to consider adding a chaplain to an MDT to assist in securing appropriate spiritual care services when appropriate (Tishelman & Fontes, 2017; Vieth, Everson, Vaughan-Eden, & Tiapula, 2013). At least one child advocacy center (CAC) has done just that (GSA Biz Wire, 2017).

There is every reason to believe that a culturally sensitive approach to the issue of corporal punishment will aid religious parents in maintaining traditional beliefs and practices even as they let go of the physical discipline of children.

About the Author

Victor Vieth, JD, MA, is Director of Education and Research for the Zero Abuse Project and currently serves as President of the Academy on Violence and Abuse. He is Founder of the National Child Protection Training Center and previously served as Executive Director of the National Center for the Prosecution of Child Abuse. He has been instrumental in implementing 22 state and international forensic interview training programs and dozens of undergraduate and graduate programs on child maltreatment. He is the recipient of numerous awards, including the Pro Humanitate Award for Child Advocacy from the North American Child Resource Center for Child Welfare and the Heritage Service Award from the National Partnership to End Interpersonal Violence. He holds degrees from Winona State University, Hamline University School of Law, and Wartburg Theological Seminary.

Working With Molly: A Culturally Sensitive Approach to Parents Using Corporal Punishment Because of Their Religious Beliefs

- Andrae, E. R. (2014). Spare the rod, spoil the child? Spare me! *Lutheran Forum*, 12, 12–16.
- Barker, K. L. (Ed.). (2011). *NIV study Bible*. Grand Rapids, MI: Zondervan.
- Brown, W. P. (2008). To discipline without destruction: The multifaceted profile of the child in Proverbs. In Bunge, M. J. (Gen Ed.), *The child in the Bible* (pp. 63–81). Grand Rapids, MI: Eerdmans.
- Christianity Today*. (2012, January 16). Thou shall not abuse: Reconsidering spanking [Editorial]. Retrieved from <https://www.ChistianityToday.com/ct/2012/January/editorial-spanking-abuse.html>
- Ellison, C. G., & Sherkat, D. E. (1993). Conservative Protestantism and support for corporal punishment. *American Sociological Review*, 58(1), 131–144.
- Engelbrecht, E. A. (Gen. Ed.). (2009). *The Lutheran study Bible*. St. Louis: Concordia.
- Gershoff, E. T., & Grogran-Kaylor, A. (2016). Spanking and child outcomes: Old controversies and new meta-analysis. *Journal of Family Psychology*, 30, 453–469.
- Green, J. B. (Ed.). (2013). *The CEB study Bible*. Nashville, TN: Common English Bible.
- GSA Biz Wire. (2017, January 17). *Julie Valentine Center becomes first child advocacy center in the U.S. to add chaplain to its staff*. Retrieved from <http://gsabizwire.com/julie-valentine-center-becomes-the-first-child-advocacy-center-in-the-us-to-add-chaplain-to-its-staff/>
- Hindson, E. (Gen. Ed.). (2013). *The King James study Bible, second edition*. Lynchburg, VA: Thomas Nelson.
- Hodge, D. R. (2004). Developing cultural competency with evangelical Christians. *Families in Society: The Journal of Contemporary Social Services*, 85, 251–260.
- Hoerber, R. G. (Gen Ed.). (1986). *Concordia self-study Bible*. St. Louis: Concordia.
- Hoffman, J. P., Ellison, C. G., & Bartkowski, J. P. (2017). Conservative Protestantism and attitudes toward corporal punishment. *Social Science Research*, 63, 81–94.
- Janz, D. R. (Ed.). (2008). *A Reformation reader: Primary texts with introduction*. Minneapolis: Fortress Press.
- Joersz, J. C. (2013). *Reformation heritage Bible commentary: Galatians, Ephesians, and Philippians*. St. Louis: Concordia.
- Lutheran study Bible*. (2009). Minneapolis: Augsburg Fortress.
- Merritt, J. (2014, October 3). 5 myths of “biblical spanking.” Taking the text literally would land you in jail. *Religion News Services*. Retrieved from <https://religionnews.com/2014/10/03/5-myths-biblical-spanking-taking-text-literally-land-jail>
- Migliore, D. M. (2014). *Faith seeking understanding: An introduction to Christian theology, third edition*. Grand Rapids, MI: Eerdmans.
- Miller-Perrin, C., & Perrin, R. (2017). Changing attitudes about spanking among conservative Christians using interventions that focus on empirical research evidence and progressive biblical interpretations. *Child Abuse & Neglect*, 71, 69–79.
- Mohler, A. (2004, June 22). *Should spanking be banned? Authority under assault*. Retrieved from <https://albertmohler.com/2004/06/22/should-spanking-be-banned-parental-authority-under-assault/>
- Newport, F. (2011). *God is alive and well: The future of religion in America*. New York: Gallup Press.

References, cont.

- Newport, F. (2017). *Update on religion in America*. New York: Gallup Press. Retrieved from <https://news.gallup.com/poll/224642/2017-update-americans-religion.aspx>
- Nolan, B. (2011, February 27). *Corporal punishment at St. Aug is morally troubling, New Orleans Archbishop says*. Times-Picayune. Retrieved from <https://www.nola.com/education/2011/02/corporal-punishment-at-st-aug/html>
- Pew Research Center. (2015). *Religious landscape study*. Retrieved from <http://www.pewforum.org/religious-landscape-study/>
- Perrin, R., Miller-Perrin, C., & Song, J. (2017). Changing attitudes about spanking using alternative biblical interpretations. *International Journal of Behavioral Development*, 41, 514–522.
- Rule of St. Benedict*. (1981). Trans., Leonard Doyle (1948). Collegeville, MN: Liturgical Press.
- Schuetze, J. D. (2017). *Doctor of souls: The art of pastoral theology*. Milwaukee, WI: Northwestern Publishing House.
- Sege, R. D., Siegel, B. S., & Council on Child Abuse and Neglect, Committee on Psychosocial Aspects of Child and Family Health. (2018, December). Effective discipline to raise healthy children [Policy statement]. *American Academy of Pediatrics*, 142(6), e20183112.
- Senior, D., Collins, J. J., & Getty, M. A. (Eds.). (2016). *The Catholic study Bible, third edition*. Oxford, UK: Oxford University Press.
- Shapiro, J. (2012). PCUSA passes resolution against spanking children. *Christian Post*. Retrieved from: <https://www.christianpost.com/news/pcusa-passes-resolution-against-spanking-children-77776/>
- United Methodist Church. (2012). *Book of resolutions: Discipline children without corporal punishment*. Retrieved from <http://www.umc.org/what-we-believe/discipline-children-without-corporal-punishment>
- Tishelman, A. C., & Fontes, L. A. (2017). Religion in child sexual abuse forensic interviews. *Child Abuse & Neglect*, 63, 120–130.
- Troftgruben, T. (2018). Toxic theology: A pastoral response to Bible passages often used to justify the abuse of children or prevent them from seeking care. *Currents in Theology and Mission*, 45, 56–60.
- Vieth, V. I. (2014). From sticks to flowers: Guidelines for child protection professionals working with parents using scripture to justify corporal punishment. *William Mitchell Law Review*, 40(3), 907–942.
- Vieth, V. (2017). Augustine, Luther, and Solomon: Providing pastoral guidance to parents on the corporal punishment of children. *Currents in Theology and Mission*, 44, 25–33.
- Vieth, V. I., Everson, M. D., Vaughan-Eden, V., & Tiapula, S. (2013). Chaplains for children: Twelve potential roles for a theologian on the MDT. *Centerpiece*, 3(6), 1–5.
- Webb, W. J. (2011). *Corporal punishment in the Bible: A redemptive-movement hermeneutic for troubling texts*. Downers Grove, IL: InterVarsity.

Impact of Emergency Shelter Utilization and Kinship Involvement on Children's Behavioral Outcomes

Jennifer R. Clark, PsyD
Kendra Alkire

Original study authors:

Lauren A. Hindt, Grace Jhe Bai,

Brynn M. Huguenel, Anne K. Fuller, Scott C. Leon

Introduction

Children involved in the child welfare system may be placed in emergency shelter care while awaiting a more permanent placement such as a foster home or group home. The temporary nature of emergency shelter care equates to placement insecurity. This insecurity, along with the separation from community supports and kinship connections, places these children at notable risk for emotional and behavioral difficulties. The Child Welfare League of America and numerous legal cases have highlighted inappropriate emergency shelter care practices (e.g., overcrowding, abuse, stays greater than 6 months, unsanitary conditions). Yet, there is minimal research exploring the impact of these placements on children's long-term well-being.

Research has found that kinship involvement can mitigate the potential negative impact of social isolation associated with placement in congregate care settings (e.g., group homes or residential treatment centers). Further, in non-foster care samples, kinship involvement can protect against the development of externalizing behaviors and internalizing symptoms. However, no research has investigated the impact of kinship involvement on the well-being of children in emergency shelter care.

Research Questions

The current longitudinal study sought to examine the impact of an initial placement in an emergency shelter on children's long-term emotional (internalizing) and behavioral (externalizing) outcomes. In addition, the researchers sought to explore if kinship involvement moderated the effect of shelter placement on these outcomes. For the purposes of this study, kinship involvement included contact with kin and fictive kin.

Study Sample

The study included 282 children (55.3% male and 43.7% female) between the ages of 6 and 13 (average age 9.9 years) who entered the care of the Department of Child and Family Services in Cook and Will counties in Illinois between October 2011 and June 2014. To be included in the sample, the children had to be in foster care a minimum of 6 months, thereby allowing for three assessment points. The sample consisted of 60.5% African American, 17.4% Multi-Racial, 14.6% Latino, and 7.5% Caucasian or Asian American children.

Findings

Overall, the researchers found that shelter placement was not associated with long-term internalizing or externalizing outcomes.

The study found that children who experienced emergency shelter care (39.6% of the sample) had less kinship involvement and more externalizing behaviors than those who did not experience emergency shelter care. This is consistent with the expectation that children with family support and fewer behavioral difficulties are less likely to be placed in shelter care. The number of days spent in a shelter was not associated with negative outcomes, suggesting that the placement itself, and not the amount of time there, is most relevant.

Emergency shelter care placement was also found to be a risk factor for behavioral maladjustment in the short term; however, greater kinship involvement was found to buffer this effect. For children who had less kinship involvement, shelter placement was associated with more internalizing difficulties.

Recommendations

Efforts should be made to promote kinship involvement (including fictive kin networks) with children who are placed in emergency shelter care. Shelter agencies can learn from congregate care agencies about ways to improve involvement of a child's kinship network. In addition, caseworkers can make greater efforts to connect with family of children in these situations.

Bottom Line

Kinship involvement with children who experience shelter care placements may protect against negative outcomes.

Citation:

Hindt, L. A., Bai, G. J., Huguenel, B. M., Fuller, A. K., & Leon, S. C. (2019). Impact of emergency shelter utilization and kinship involvement on children's behavioral outcomes. *Child Maltreatment, 24*(1), 76–85. doi.org/10.1177/1077559518797198

About the Authors

Jennifer Clark, PsyD, is Associate Professor at Pacific University School of Graduate Psychology in the PsyD program. Her areas of clinical and research interest include parenting, child welfare, trauma, attachment, child abuse and neglect, preventative interventions and programing, and the interface of psychologists with the legal system.

Kendra Alkire is a graduate student at Pacific University School of Graduate Psychology in the PsyD program. Her areas of clinical and research interest include pediatric psychology, neurodevelopmental disorders, pediatric medical traumatic stress, and community-based research.



News of the Organization

Janet Rosenzweig, MS, PhD, MPA, Executive Director

The 26th APSAC Colloquium is shaping up to be another great educational experience!

Our 26th Colloquium will continue the tradition of bringing high-quality learning opportunities to child maltreatment researchers, educators, and practitioners across experience levels and professions. Planned for June 19–23 in Salt Lake City, Utah, the event anticipates more than 150 keynote addresses, plenary sessions, workshops, resketch briefs, poster sessions, and roundtable discussions. Eight pre-conference institutes round out this extraordinary educational opportunity. For inspiration, [check out our YouTube channel](#) for a sample of the 2018 plenaries and micro-sessions!

When the state of Utah was selected to participate in the Center for Disease Control’s [Essentials for Childhood](#) Initiative, we found yet another opportunity for collaboration. Together, we designed both a pre-conference institute and a workshop track in the Colloquium, highlighting elements of the [Essentials for Childhood Framework](#).

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 [click here](#) to learn about a special off-site social event!

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 2-day institutes as well, in Salt Lake City June 18 and 19 as a pre-conference institute for our 26th Colloquium, and December 18 and 19, 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. For more information, contact JCampbell@apsac.org.

From the APSAC Center for Child Policy

The National Foundation to End Child Abuse and Neglect ([EndCAN](#)) announced the winners of its “disruption” paper competition, which asked professionals in the child maltreatment field to share their most disruptive ideas on how to end child abuse and neglect in our lifetime. The APSAC Center for Child Policy is proud to announce that a paper authored by policy committee members Vincent Palusci, MD, Debangshu Roygardner, PhD, and Kelli Hughes, JD, was selected for honorable mention in the prevention category. The paper was one of six selected from a pool of over 50 entries covering the topics of prevention, clinical practice, and research. It will be published this fall in a special issue of the new journal entitled *The International Journal of Child Maltreatment*.

The APSAC Center for Child Policy Abusive Head Trauma Committee has completed one of the two papers that the committee committed to produce. This policy paper, on legal issues related to abusive head trauma, is available on the [Center for Child Policy website](#).

The Policy Center is forming a new expert committee on psychological maltreatment who's initial work be focus on identifying public policy issues around child maltreatment.

Interested in learning more about the APSAC Center for Child Policy? Contact Kelli Hughes: KelliHughes@centerforchildpolicy.org

MBP Task Force To Become Ongoing Committee

The APSAC Munchausen by Proxy (MBP) task force met at the San Diego International Conference on Child Maltreatment and asked APSAC for guidance on formalizing the structure to facilitate ongoing work. The initial projects, [APSAC Practice Guidelines on MBP](#) and the special issue of the APSAC Advisor devoted to MBP, are now being used by professionals in various fields—criminal prosecutors, guardians ad litem, child protective services, members of law enforcement, dependency and civil courts, and concerned lay public—who suspect this type of child abuse. The task force intends to be a continuing asset to APSAC, its members, and the child welfare field.

Get to Know MemberLeap

Last year, APSAC launched a new membership platform designed to simplify business transactions and create more opportunities for members to connect with one another online. With the new platform, you can easily

- [View and register](#) for all of APSAC's upcoming events,
- [Participate in discussion boards](#) regarding important issues in child maltreatment,
- [Search for expert members](#) around the world using our member directory,
- [Explore the publications](#) available for download or purchase in our online store,
- [Utilize APSAC's private, members-only social network](#) to connect online,
- And more!

[Log in](#) to start exploring!

Find Research to Practice Briefs [Here](#)

For APSAC to achieve our goal of strengthening practice through knowledge, we must ensure that up-to-date, high-quality research results are reaching the practitioners who need them most. To accomplish this, APSAC is assembling cadres of individuals working in psychology, social work, medicine, child welfare, and law to write two- to three-page translational summaries of articles from *Child Maltreatment*. These briefs are designed to provide clear policy and practice implications of the research useful to people working in different disciplines.

Briefs may appear in the *APSAC Advisor*, in the *APSAC Alert*, on the APSAC website, other places as needed. If you are interested in writing these translational pieces, [contact Bri Stormer](#).

Please Take Note!

Think of APSAC during Child Abuse Prevention Month!

We are pleased to offer new resources to help promote child abuse prevention month in your community on our website. We have a [sample proclamation](#) that you can modify and share with local officials as part of a request to declare it child prevention month in your community. You can also find [statistics on the cost of child abuse](#) in each state, and [advice on preparing an op-ed or letter to the editor!](#)

Many of our APSAC members are raising funds for their organizations in April, providing even more evidence your dedication to this work. In recognition that APSAC will not be conducting a major fund-raising effort. If you can consider supporting subsidized APSAC memberships for students and front-line professionals, new and improved Guidelines for Practice and the other services we offer members, please, [donate here](#) or consider fund raising for APSAC or launching a collaborative campaign using our [fundraising platform](#). Please contact info@apsac.org for more information. THANK YOU!

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!](#)

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[™]

In partnership with



Strengthening Practice Through Knowledge



Washington Update

The National Child Abuse Coalition

With the Child Abuse Prevention and Treatment Act (CAPTA) up for reauthorization, The [National Child Abuse Coalition](#) is hard at work curating the best thinking by advocates, practitioners, and researchers to create materials to inform legislative decision makers. All regular authors of the Washington Update for the APSAC Advisor are members of the coalition (as is APSAC), and the Coalition agreed that for this edition of the Advisor, we direct readers to the report: “[Taking CAPTA to the Next Level: Recommendations for Transformational Systems Change to Prevent Child Abuse and Neglect](#).”

A summary follows:

The National Child Abuse Coalition supports a public health approach to child abuse and neglect, as part of a reformed and updated Child Abuse Prevention and Treatment Act (CAPTA) that reflects the entire continuum of supports to families, starting with primary prevention strategies at the heart of Title II and extending into the identification and treatment of abuse and neglect in Title I. We envision an overhaul of CAPTA that supports a system aimed at empowering families and communities so they can provide a healthy, safe home for their children, so that foster care is a system of last resort.

As noted by the Associate Commissioner of the Children’s Bureau at HHS, Jerry Milner: “Tweaking what we have in place won’t solve the problems... we need to change the focus of child welfare to primary prevention of maltreatment and unnecessary removal of children from their families. We can only break the cycle of family disruption and maltreatment by addressing the root causes of those situations.”¹ The

reauthorization of CAPTA provides Congress a prime opportunity to do just that.

The National Child Abuse Coalition, a collection of over twenty-five national organizations committed to the prevention and treatment of child abuse and neglect, respectfully offers recommendations to Congress for CAPTA reauthorization to help states support strong and healthy communities, reduce child maltreatment, and more effectively respond in cases of abuse and neglect.

Policy recommendations are guided by the following principles:

- Healthy families are the key to child abuse and neglect prevention and resilient children;
- Prevention should be community-based;
- Child and family safety are not just the child welfare system’s responsibility;
- Prevention and treatment efforts must help families heal from trauma;
- Research and data are central to a public health approach;
- Significant additional resources are necessary for CAPTA to be effective.

Policy Recommendations

1. Substantially increase funding for both titles in CAPTA
2. Strengthen Title II to build robust state and local systems that enhance coordination, quality, availability, and access to core services that strengthen families, improve child well-being, and prevent child abuse and neglect
3. Take steps to strengthen CAPTA by

¹ “Trump’s Top Child Welfare Official Speaks” The Chronicle of Social Change, November 6, 2017.

restructuring the “use of funds” in Section 106 to further emphasize a primary prevention approach and help states and communities build a more cohesive system to child abuse and neglect prevention and treatment

4. Encourage state reform by streamlining and updating the Title I state plan to improve transparency and accountability in long-required state practices and state systems
5. Build the evidence base and help states and communities implement evidence-based prevention systems

6. Reduce child fatalities and near fatalities from child abuse and neglect by implementing some key recommendations from the Commission to End Child Abuse and Neglect Fatalities
7. Take steps to reduce the incidence of sexual abuse within institutional contexts
8. Spur local innovation in the field through new competitive grants focused on supporting families and prevention of child abuse and neglect.



Conference Calendar

Regular Features

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 29-June 1, 2019

Association of Family and Conciliation Courts 56th
Annual Conference
Toronto, Canada
<https://www.afccnet.org/Conferences-Training/AF-CC-Conferences>

May 29—June 1, 2019

56th AFCC Annual Conference
The Future of Family Justice: International Innovations
Toronto, Ontario, Canada
afcc@afccnet.org

May 31—June 4, 2019

National CASA Conference
Atlanta, GA
www.casaforchildren.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
kjones@ncjfcj.org | www.ncjfcj.org

August

August 12-15, 2019

Crimes Against Children Conference
Dallas, TX
<http://www.cacconference.org/>

August 26-30, 2019

APSAC Forensic Interview Clinic
Seattle, WA
www.apsac.org/forensic-interview-clinics
apsac@apsac.org

September

September 4-8, 2019

International Summit on Violence, Abuse & Trauma
Across the Lifespan
Unifying Voices Against Violence & Abuse
San Diego, CA
www.ivatcenters.org/san-diego-summit

September 16—19, 2019

Prevent Child Abuse America Conference
Moving Upstream
Milwaukee, WI
bklika@preventchildabuse.org | preventchildabuse.org

December

December 11-12, 2019

APSAC Forensic Interview Clinic
New Orleans, LA
www.apsac.org/forensic-interview-clinics
apsac@apsac.org

January

January 25-21, 2020

25th Annual San Diego International Conference on
Child and Family Maltreatment
San Diego, CA
www.sandiegoconference.org

APSAC Officers and Board of Directors

President

David L. Corwin, MD

Professor and Director of Forensic Services
University of Utah, Pediatrics
Sandy, UT

Immediate Past President

Tricia Gardner, JD

Associate Professor
Center on Child Abuse & Neglect
Oklahoma City, OK

Vice President

Stacie LeBlanc, JD, MEd

Executive Director
Children's Hospital-CARE Center
New Orleans, LA

General Counsel and Secretary

Bill S. Forcade, JD

Attorney at Law
Chicago, IL

Treasurer

Roslyn Murov, MD

Senior Vice President, Mental Health Services
The New York Foundling
New York, NY

Member at Large Elected to Executive Committee

Kathleen C. Faller, PhD

Professor Emerita
University of Michigan School of Social Work
Ann Arbor, MI

Director

Ryan Brown, MD, FAAP

Clinical Associate Professor
University of Oklahoma College of Medicine
Medical Director, Child Protection Committee
The Children's Hospital at OU Medical Center
Oklahoma City, OK

Director

Carmen Jirau-Rivera, MSW, LSW

Chief Program Officer
The New York Foundling
New York, NY

Director

Bart Klika, PhD, MSW

Chief Research and Strategy Officer
Prevent Child Abuse America
Chicago, IL

Director

Jemour Maddux, PsyD, ABPP

Managing Director
Lamb and Maddux, LLC
New York, NY

Director

Bethany Mohr, MD

Clinical Associate Professor
Medical Director, Child Protection Team
Division of Hospital Medicine
Department of Pediatrics and Communicable Diseases
Michigan Medicine
University of Michigan
Ann Arbor, MI

Director

Mel Schneiderman, PhD

Senior Vice President, Mental Health Service
The New York Foundling
New York, NY

Director

Susan Hardie, RN, PhD

Private Practice; President CAPSAC
Calabasas, CA

Director

Ron Laney

Office of Juvenile Justice and Delinquency Prevention
U.S. Department of Justice (Retired)
Dale City, VA

Director

Mary L. Pulido, PhD

Executive Director
The New York Society for The Prevention of
Cruelty to Children
New York, NY

Director

Itohan Omoregie, JD

Special Counsel
The New York Foundling
New York, NY

Director

Victor Vieth, JD

Director of Education and Research
Zero Abuse Project
Lewiston, MN

President Emeritus

Ronald C. Hughes, PhD

Director, Institute for Human Services and
North American Resource Center for Child Welfare
Columbus, OH

President Emeritus

Viola Vaughan-Eden, PhD, MJ, LCSW

Associate Professor & PhD Program Director
Norfolk State University
Norfolk, VA

Executive Director

Janet F. Rosenzweig, PhD, MPA

APSAC Advisor Staff

ADVISOR Co-Editors in Chief

Angelo P. Giardino, MD, PhD
Department of Pediatrics
University of Utah
Salt Lake City, UT

Christopher S. Greeley, MD, MS, FAAP
Texas Children's Hospital
Baylor College of Medicine
Houston, TX

ADVISOR Consulting Editors

Child Protective Services

Maria Scannapieco, PhD
University of Texas at Arlington
School of Social Work
Center for Child Welfare
Arlington, TX

Cultural Issues

Lisa Fontes, PhD
University Without Walls
University of Massachusetts
Amherst, MA

Law

Frank Vandervort, JD
University of Michigan Law School
Ann Arbor Michigan

Medicine

Randell Alexander, MD, PhD
University of Florida Health Sciences System
Division of Child Protection and Forensic Pediatrics
Jacksonville, FL

Prevention

Bart Klika, PhD, MSW
Prevent Child Abuse America
Chicago, IL

Research

David Finkelhor, PhD
University of New Hampshire
Family Research Laboratory
Durham, NH

Social Work

Colleen Friend, PhD, LCSW
Child Abuse and Family Violence Institute
California State University
Los Angeles, CA

Washington Update

Ruth Friedman, PhD
The National Child Abuse Coalition
Washington, DC

ADVISOR Publishing Team

Mark Meyer
Department of Pediatrics
Baylor College of Medicine
Houston, TX

Bri Stormer, MSW
The American Professional Society on the Abuse of
Children
Chicago, IL

Opinions expressed in the APSAC Advisor do not reflect APSAC's official position unless otherwise stated.

Membership in APSAC in no way constitutes an endorsement by APSAC of any member's level of expertise or scope of professional competence.

© APSAC 2019

