ADVISOR

The American Professional Society on the Abuse of Children™
Strengthening Practice Through Knowledge
apsac.org @The_APSAC

In partnership with THE NEW YORK FOUNDLING
nyfoundling.org @TheNYFoundling

March 2021

Issues Affecting Children and Maltreatment Professionals

Intersection between child and animal maltreatment, forensic interviewing, and neurodevelopment consequences of trauma

The American Professional Society on the Abuse of Children™
Strengthening Practice Through Knowledge
apsac.org @The_APSAC

In partnership with THE NEW YORK FOUNDLING
nyfoundling.org
@TheNYFoundling

The American Professional Society on the Abuse of Children in Partnership with the New York Foundling

About APSAC

Since being established in 1986, APSAC has served the field of child maltreatment as an interdisciplinary professional society. APSAC's Mission "is to improve society's response to the abuse and neglect of its children." APSAC's Vision is a world where all children and their families have access to the highest level of professional commitment and services to prevent and address child maltreatment. APSAC pursues its mission through expert training and educational activities, policy leadership, the production and dissemination of public education materials, collaboration, and consultation that emphasize theoretically sound research and evidence-based principles. APSAC's members are attorneys, social workers, law enforcement personnel, forensic interviewers, educators, researchers, and medical and behavioral health clinicians, and professionals from allied disciplines.

About the New York Foundling

The New York Foundling trusts in the power and potential of people and deliberately invests in proven practices. From bold beginnings in 1869, this New York-based nonprofit has supported hundreds of thousands of its neighbors on their own paths to stability, strength, and independence.

The New York Foundling's internationally-recognized set of social services are both proven and practical. The Foundling helps children and families navigate through and beyond foster care, helps families struggling with conflict and poverty grow strong, helps individuals with developmental disabilities live their best lives, and helps children and families access quality health and mental health services—core to building lifelong resilience and wellbeing.

Register for the APSAC & Foundling Online Course

Child maltreatment work is by nature multidisciplinary; we all share the same goal of ensuring health, safety and justice for children and families. APSAC and the New York Foundling have developed a comprehensive, multidisciplinary online course for professionals to help expand their perspective and knowledge base to support effective practice in any child welfare setting. Learn from leading experts in child maltreatment and enhance your understanding of the multiple systems, professionals, and interventions that comprise our field!

Psychology CEs available. Group pricing available upon request.

Learn More **Register for the Online Course**

To see an up-to-date list of all training opportunities, please **visit the APSAC website.**

The American Professional Society on the Abuse of Children™

ADVISOR

Vol. 33 | No. 1

Editorial: New Beginnings

Lisa Schelbe, PhD, MSW

Most can agree that 2020 was filled with crises, chaos, and heartache. The pandemic, increased awareness around racial inequality, and political tension are the top three situations that stand out to me. While a new year brings promises of new beginnings, these problems were not resolved at midnight on January 1st. There are reasons to be optimistic about what 2021 holds for us. For example, there is a vaccine, as well as signs (albeit often small) about commitment and progress in addressing racial inequity that will bring together all people of the United States who have been deeply divided. However, as we all know, we're not yet there.

Many APSAC members are at the frontline of addressing the crises in the United States and meeting the needs of children, families, and communities in this stressful time. Across the multiple disciplines that we represent, APSAC members are making a difference. Active in our communities, we are serving the most vulnerable who have been disproportionally impacted by the pandemic and racial inequity. We are thinking about the big questions and finding innovative solutions as we work together.

Why do I mention the new year and the major issues happening in the United States when the *APSAC Advisor*, a journal for interdisciplinary professionals in child abuse and neglect, seeks to inform readers of the latest development in practice and policy in the field of child maltreatment? I do so because context matters. It influences our work in a multitude of ways and frames our understanding of the world. With all that is going on in our country, the work in child maltreatment is even more important. Now, more than ever we need to connect with one another and share ideas and knowledge about what work, for whom, and in which circumstances.

I mention the new year because although I am not one to typically make New Year's resolutions, this year, I found myself happily bidding 2020 goodbye and eagerly awaiting a new year and new beginnings. One of my new beginnings—several months in the making—is that this is the first issue that I have overseen since assuming the role of Editor of the *Advisor*. To be clear, this issue is due to the work of many. Dr. Carlo Panlilio, who serves as Associate Editor of the *Advisor*, and Ms. Bri Stormer, who is the Director of Publications and Member Services, were involved in each and every step. APSAC staff, the Publication Committee, and Board of Directors members were helpful during the transition of the editorial team and continue to be a source of information and ideas. I want to recognize the contributions of the reviewers who provided thoughtful feedback to the authors and the authors who make this publication possible.

Dr. Carlo Panlilio and I are thrilled to have the opportunity to assume the leadership of editing the *Advisor*. We are committed to maintain the high quality of articles that inform practice related to child maltreatment prevention and intervention. Our goal is

to make current knowledge accessible those who need it. We are committed to empirical, practice-focused articles that are written in an accessible way that have the potential to influence practice and policy, and we are also going to (1) prioritize the inclusion of high-quality review articles that highlight the most current research on topics, (2) include information about how to interpret and apply research findings, and (3) develop a policy section that shares innovative ideas and opportunities for advocacy.

One thing that readers can expect is an increased emphasis on racial equity within the *Advisor*. This is consistent with the APSAC Board of Directors' position statement on eliminating systemic racism and implicit bias in the child maltreatment field and the formation of the APSAC Commission for Racial Justice in Child Maltreatment. Each *Advisor* issue will have an article that focuses explicitly on racial equity. Authors will be encouraged to consider racial equity within their manuscripts.

The editorial team plans to solicit new authors from diverse perspectives. Those new to the child maltreatment field as well as veterans are encouraged to submit manuscripts. We will work with authors with limited experience in publishing. As we seek to demystify the process, Dr. Panlilio and I are going to share tips about how to write for the *Advisor*. We encourage professionals in all disciplines to consider writing about their successes and insights.

I am looking forward to the new year and all that the *Advisor* will bring to you—this year and beyond. Please feel free to reach out to me with any questions or comments about the *Advisor* at Lschelbe@fsu.edu. Associate Editor Dr. Carlo Panlilio is also available at ccp15@psu.edu. All submissions should be sent to Ms. Bri Stormer, Director of Publications and Member Services, at info@apsac.org.

About the Editor-in-Chief

***Lisa Schelbe, PhD**, **MSW**, is Associate Professor at Florida State University College of Social Work and a Faculty Affiliate at the Florida Institute for Child Welfare. She serves as a Co-Editor-in-Chief of the* Child and Adolescent Social Work Journal. *Her research focuses on young people transitioning out of foster care and services to assist with their transition out of care. She is a qualitative methodologist with experience working on interdisciplinary teams. She has published over 30 referred journal articles and co-authored a book titled* Intergenerational Transmission of Child Maltreatment *(Springer, 2017). Dr. Schelbe received her doctorate in social work from University of Pittsburgh, where she was a Doris Duke Fellow for the Promotion of Child Well-being.*

Editorial

A Look into the Mirror: Reflecting on Systemic Racism and Implicit Bias

Carlo Panlilio, PhD

Although the year has started anew, our country continues to be haunted by the sins of our past as senseless violence and social injustices continue to be inflicted upon Black, Indigenous People, and People of Color (BIPOC). Events in the last few years, such as the Fort Laramie Treaty violation against the Standing Rock Sioux Tribe because of the Dakota Access Pipeline, the separation and detention of refugee children at our borders, the killing of George Floyd and Breonna Taylor, or the inequities exposed by the global pandemic, are deeply rooted in generations of racism and implicit bias that plague our great nation. Although it is an ugly truth that most of us would rather not contend with, we need to look into the mirror once again and reflect upon how we contribute to, and actively dismantle, this insidious cancer. Admittedly, this appears to be a tall order at first blush. After all, what can I, a singular individual, do to combat racism and social injustice?

The answer, though seemingly complex, begins by reaching out to you, our APSAC community, who are already making a difference and are heavily invested in the well-being of the most vulnerable children, families, and communities that you serve. As a community of professionals dedicated to the prevention of child maltreatment, we can all work together to engage in an ongoing critical examination of systemic racism and implicit bias that is prevalent in our own field. It is through such reflection that we are able to identify the dissonance between our commitment to ensure the safety and well-being of children and families and the use of research, policies, and practices that implicitly (and sometimes explicitly) sustain the trauma of racism and bias.

For example, the most recent publication by the Administration of Children and Families (U.S. Department of Health & Human Services, 2020) highlighted the disproportionality that continues in the child welfare system, where African American children made up 20.6% of substantiated victims despite comprising only 13.7% of the total U.S. population. In addition, American Indian or Alaska Native children had the highest rate of victimization (15.2 per 1,000 children), followed by African American children (14.0 per 1,000 children). Care should be taken when we interpret such findings, particularly since these disproportionate numbers have been brought up time and again over the last few decades. That is, causality of such rates should not be attributed solely to race or ethnicity, avoiding victim blaming. Rather, we should look at the Gestalt of why such disproportionate numbers exist in our field, paying close attention to the systems that have contributed to these widening disproportionalities and disparities. These interconnected systems include, but are not limited to, the areas of child welfare, education, juvenile justice, and mental health, just to name a few.

It is at this point that I have to look in the mirror, reflect, and acknowledge the role of the system I work with (i.e., education) and how the problems of racism and social injustice persist. In looking at the same publication by the U.S. Department of Health & Human Services (2020), education personnel made up the largest proportion of child protective services (CPS) referrals at 20.5%. This means that for a majority of school-aged children, entrance into the child welfare system begins, or continues, with schools due to its compulsory nature and the increased surveillance on children's well-being due to mandated reporting laws. When looking at school disciplinary practices, Black students and students with disabilities are often suspended or expelled at higher rates than other students (Lipscomb et al., 2017). Oftentimes, such severe or harsh disciplinary practices begin as early as preschool, given the increased likelihood that African American boys are perceived as more problematic (Gilliam et al., 2016). There is also evidence of the bidirectional effect between maltreatment and disabilities (Corr & Santos, 2017), which has been found to increase the risk for special education referrals (Stone, 2007). Unfortunately, such inequities result in long-term consequences as the achievement gap widens further across academic levels (U.S. Department of Education, Office for Civil Rights, 2014).

When the risk factors for BIPOC children are taken together, one can see that their intersection increases the potential for referral to CPS at a much higher rate than for others. Although I cannot offer a quick solution to address such a wicked or ill-structured problem, acknowledging the tangled web of factors that promote systemic racism and implicit bias must be called out. Professionally and personally, this means that I need to be aware of, and explicitly understand, the confluence of systemic factors that provide the context in which children develop and learn.

As a researcher, I must therefore strive to employ theories or frameworks that move away from deficit perspectives toward those that actively seek to explain how multiple ecological systems interact dynamically to explain different trajectories of development and learning. I also strive to employ research methods and statistics that allow the empirical testing of such complexities instead of "controlling for" these important contexts that influence development and learning. Just as it is difficult to understand evolutionary biology without understanding the environment in which species develop, it is difficult to understand developmental trajectories without considering the policies and practices that directly and indirectly influence the fair distribution of resources to help families and children gain a head start and succeed. Such endeavors are sometimes challenging because interdisciplinary perspectives need to be incorporated even though alternative frameworks and methods that differ from the status quo elicit discomfort.

As an educator, whether teaching courses in learning, development, maltreatment and advocacy, or statistics (yes, even statistics!), I find ways in which to engage both undergraduate and graduate students in critically examining what we have often taken for granted as unquestionable truth in foundational theories and methods. That is, we unpack the context in which theories were developed and empirical data were interpreted, understand how we can weave in contextual factors that influence well-being outcomes, and learn how systemic racism and bias may have influenced each step of the scientific process that affects policy and practice. Given the inequities we see in the education system, I believe that engaging in such critical discourse is necessary for the future educators enrolled in my classes.

Giving a voice to those who have none and speaking out when injustices are committed are no small tasks that continue to be a challenge, but one I hope to continue to reflect upon, learn from, and grow. However, this is a journey that I cannot and should not take alone. Many of you are in a similar

journey, and I invite each of you in our APSAC community to connect with one another. Efforts to promote anti-racism and increase social justice across systems and individuals continue in the form of trainings, policy changes, practice changes, and many others. Given such efforts, therefore, the dialogue and reflection should remain open among all of us in the APSAC community.

As Associate Editor, I, along with our Editor in Chief, Dr. Lisa Schelbe, hope to make this open dialogue and reflection a regular part of our *APSAC Advisor* issues. We will dedicate a section that allows people to share their own reflections and journey in acknowledging where such systemic problems of racism continue and offer ideas on how we as a community can help one another dismantle such problems. We therefore welcome your voice in these efforts and invite each of you, as members of our APSAC community, to connect with one another.

About the Associate Editor

***Carlo Panlilio, PhD**, is Assistant Professor in the Department of Educational Psychology, Counseling, and Special Education, and a faculty member with the Child Maltreatment Solutions Network at the Pennsylvania State University. He received his PhD in Human Development from the University of Maryland, College Park, with a specialization in Developmental Science and a Certificate in Education Measurement, Statistics, and Evaluation. He was a former Doris Duke Fellow for the Promotion of Child Well-being. His program of research focuses on the dynamic interplay between maltreatment, context, and development and how these processes influence individual differences in learning across the lifespan. His research is guided by an interdisciplinary approach to examine the multisystemic influences of early adversity on self-regulatory processes that explain variability in the academic outcomes of children with a history of maltreatment. He has published several journal articles and chapters and was editor of* Trauma-Informed Schools: Integrating Child Maltreatment Prevention, Detection, and Intervention. *Dr. Panlilio previously worked as a licensed clinical marriage and family therapist in private practice, community agencies, treatment foster care, and a residential treatment facility for adolescents.*

References

A Look into the Mirror: Reflecting on Systemic Racism and Implicit Bias

Corr, C., & Santos, R. M. (2017). Abuse and young children with disabilities: A review of the literature. *Journal of Early Intervention, 39*(1), 3–17. https://doi.org.10.1177/1053815116677823

Gilliam, W. S., Maupin, A. N., Reyes, C. R., Accavitti, M., Shic, F., Fontaine, J. J., Holloway, C., & Stevenson, H. (2016). *Do early educators' implicit biases regarding sex and race relate to behavior expectations and recommendations of preschool expulsions and suspensions?* http://ziglercenter.yale.edu/publications/Preschool Implicit Bias Policy Brief_final_9_26_276766_5379.pdf

Lipscomb, S., Haimson, J., Liu, A. Y., Burghardt, J., Johnson, D. R., & Thurlow, M. L. (2017). Preparing for life after high school: The characteristics and experiences of youth in special education. Findings from the National Longitudinal Transition Study 2012. Volume 1: Comparisons with other youth: Full report (NCEE 2017-4016). U.S. Department of Education, Institute of Education Sciences, National Center for Education Evaluation and Regional Assistance.

Stone, S. (2007). Child maltreatment, out-of-home placement, and academic vulnerability: A fifteen-year review of evidence and future directions. *Children and Youth Services Review, 29*(2), 139–161. https://doi.org.10.1016/j.childyouth.2006.05.001

U.S. Department of Education, Office for Civil Rights. (2014). Data snapshot: *Early childhood education (suspension policies in early childhood settings*). Author.

U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2020). *Child Maltreatment 2018.* https://www.acf.hhs.gov/cb/research-data-technology /statistics-research/child-maltreatment.

Child and Animal Maltreatment: Intersections, Challenges and Opportunities When Intervening with Maltreating Families

Mary Elizabeth Rauktis, PhD
Elizabeth Moser, MSW

Keywords: animal abuse, child abuse, child maltreatment, at-risk families, pets

A young orange, male tabby cat jumped onto my lap during my home visit. He gave small head-bumps into my hand as I petted him, the vibrations of his purrs reverberating through the small kitchen. Surprised, the client noted, "He likes you."

"The feeling is mutual," I replied. Continuing to pet the cat, I asked, "Does he have a name?"

Making eye contact, she responded, "The kids call him Tiger. I want to get him fixed and get a flea collar for him." We talked about where she could find low-cost options for neutering, and I asked a few questions about fleas: Did the children complain of any bites? Had she seen fleas on the children?

Talking about Tiger was not idle chit chat. This discussion encouraged the client to talk about the challenges that she was facing, which had led to the call to child welfare about marked developmental delays in her children and to my home visit. From our conversation about Tiger, I obtained several useful pieces of information. The cat had been named, signifying an attachment to the cat by her children. The client was concerned for the animal's health and the health of her children. There was an absence of the smell of ammonia, which told me the cat had a litter box somewhere in the house. Although unaltered and a little thin, the cat seemed to be healthy and friendly, suggesting that he was being fed and not being abused. The client seemed to have an awareness of her children's emotional attachment to the cat. As the animal was young, and I had not been in this home before, I did not know if this was a home with a revolving number of young animals, which can be a warning sign for a dysfunctional home (DeViney et al., 1983; Loar & Colman, 2004). When discussing Tiger, this was something that I could ask about—the presence of other or previous pets. Although still guarded with me, she let our conversation about Tiger open a small window of conversation.

"What do pets have to do with investigating child abuse?" asked my puzzled student when I inquired about the animals in the families that he was working with in his role as a caseworker supervisor. This is a common response from students and child welfare professionals when I talk to them about the importance of asking about pets in the home. The division between child and animal welfare is recent. We do not need to go very far back in history to see a time when child and animal welfare protection intersected. In the nineteenth century, the founding members of many societies for the prevention of cruelty to animals were involved in the abolition of slavery, education, and housing reforms as well as the protection of children (Hoy-Gerlach et al., 2019). Societies for the protection of animals predated those

concerned with children, and these societies were the precursors to child welfare organizations in Australia, America, and Great Britain, impacting the creation of child protection laws (Lebow & Cherney, 2015; Ryan, 2014). It is only in the last century that the oversight and protection of animals and of children have become separate systems.

As a child welfare professional, you have probably worked with families who have pets in the home. Based upon the 2018 General Social Survey, approximately 63.8% of households with children report having at least one companion animal in the home (Applebaum et al., 2020). Moreover, pet ownership did not differ by family income (Applebaum et al., 2020). Living with an animal confers emotional and physical benefits for the adults, such as less depression (Peacock et al., 2012), improved immune functioning (Charnetski et al., 2004), adherence to medical regimes (Herrald et al., 2002), less social isolation (Irvine, 2013), and greater social capital (Wood et al., 2005). For children, pets are a source of emotional support and are associated with social competence, self-esteem, and prosocial behavior (Covert et al., 1985; Van Houtte & Jarvis, 1995). The presence of therapy animals was also found to reduce fear and anxiety for children in highly stressful situations (Vincent et al., 2020).

Returning to the question posed by the student, "What do pets have to do with child abuse?" we know that animal abuse and neglect do not occur in a vacuum but as a part of a pattern of dangerous behavior that jeopardizes both animals and humans (Ascione et al., 2007; McDonald et al., 2015). Lawmakers are recognizing this connection. The National Council of Juvenile and Family Court Judges (NCJFCJ) passed a resolution stating that animal cruelty is a crime of violence and that judges are in a leadership position to adjudicate cases in a manner that effectively promotes the safety and wellbeing of people and their pets (NCJFCJ, 2019).

A legislative approach to the problem of co-occurrence of human and animal maltreatment led to the introduction of a bill in the House of Representatives that would amend the Child Abuse Prevention and Treatment Act (CAPTA) to include data on animal abuse within the National Child Abuse and Neglect Data System (NCANDS). In their request to the Health and Human Services Appropriation Committee, the sponsors wrote the following:

> In light of the acknowledged close relationship between child maltreatment and animal abuse, and the exposure to animal abuse considered an Adverse Childhood Event (ACE), the committee encourages HHS to explore the feasibility of including a category of animal abuse to caregiver characteristics and environmental factors that may place the child at risk for maltreatment. (National Link Coalition, 2020)

Additionally, New York has several bills in committee that would permit mandated reporters of suspected child abuse to report suspected animal cruelty if the act were committed by a person also suspected of child abuse and maltreatment. They have also amended the definition of child endangerment to include animal cruelty in the presence of a child and to strengthen penalties for existing animal cruelty charges when committed in the presence of a child (National Link Coalition, 2020). On January 6th, 2020, the Ohio Governor signed a bill into law requiring that social service professionals and animal welfare professionals and humane officers cross-report child abuse and animal abuse (Sara P. Carruthers News, 2020).

Now that child protection laws are recognizing this intersection, how should child welfare respond? We believe that expanding the lens of the child welfare practice model to include animals is not only congruent with the history of the profession but also complements the work in three ways: (1) helping to identify maltreatment and violence in the home, (2) engaging and building a collaborative relationship with children and adults, and (3) identifying helpful community resources and interventions to create and support protective factors and reduce risk for both species.

Provide Information in Assessing Safety of the Children and Animals and Future Risk

The relationship between humans and animals in the

home can mirror the health and safety of the people in the family (Hoffer et al., 2018). Although families struggling with violence are as likely to have animals in the home as other families, one key difference is the age of the animals (Loar & Colman, 2004). Homes with older, healthy animals suggest that the adults have been able to care for the animals over time and there is a commitment to their welfare. However, a home with two or more young animals could be a sign of a family dysfunction. Loar (2014) writes that "turnover of puppies and kittens is a warning signal suggesting a family where ties are transient and attachments fleeting" (p. 138). Seeing animals in the home who are ill, malnourished, and in need of veterinary care is a risk indicator of human abuse or neglect (Arkow, 2020).

If the adults cannot manage the needs of an animal, it calls into question their protective capacities for children. Some exotic pets, poisonous reptiles, and cock-fighting paraphernalia are also risk indicators, especially for young children with unsupervised access, and should be included in evaluations of the living environment. Moreover, if a child is engaging in abusing or torturing animals, this may be an indicator that the child has experienced abuse or has serious mental health issues that increase the likelihood of violence occurring in the home (Arkow, 2020; Pinillos, 2018).

Therefore, safety and risk assessments should include several questions about animals in the home; the number, age, and type; and the observation of health and hygiene of the pets (Loar, 2014). When looking at protective factors, assessments should include the parental responses to the pet(s) in the home and how bonded the child is to these pet(s). Pets can provide a source of solace and comfort to children in a violent home, and a relationship with a pet is a protective emotional factor that should be noted in an assessment. In addition, pets should be included in psychosocial assessments, assets mapping and ecomaps, and family team conferencing as members of the family (Hodgson & Darling, 2011).

Talking About Pets Can Help in Getting a "Foot in the Door" and Assist in Building a Collaborative Relationship With Parents and Children

It can be difficult to engage with clients due to anger and fear arising from a visit from child protective services. Getting a "foot in the door" rapport is critical to being able to assess safety and risk. As my "chit chat" about Tiger illustrated, by focusing our initial conversation on the cat, I was able to identify, and later verify, some important information about the functioning of the family, as well as the condition of the home. By offering some resources for Tiger, I quickly demonstrated that I was listening and willing to help the mother, even though trust would take time to be established. This opened a small window of opportunity to begin our work. Unfortunately, pets also can be used to threaten or coerce children into not disclosing when abuse and domestic violence occurring in the home. Observing children with their pet and engaging them in a conversation about the safety of the pet may elicit an unguarded and candid response more quickly than directly asking about their own abuse, neglect, or violence (Boat, 2010).

Reporting and Working Across Disciplines and Sharing Resources to Make Pets, Families, and Communities Safer and Stronger

This is a common scenario: child welfare is called in to find temporary placement for children whose parents overdosed and were hospitalized. Naturally, the primary concern of child welfare is the traumatized children, but the often children express concern about what might happen to the family pets. The pets cannot go with the children into temporary shelter. Similarly, those who work in victim advocacy know the difficult choice women make when they leave a violent relationship without their family pets. For hotline advocates and caseworkers, trying to find a place for the family pets during a crisis may be lowest on the list of priorities. As a result, the family pets can be sent to a shelter, become homeless, or be given to unscrupulous persons.

The good news is that animal welfare advocates are recognizing that they must widen their mission to address the root causes of why animals end up homeless or in shelters (Arrington & Markarian, 2018). A critical piece of this work is creating cross-system collaborations. One example is the Linkage Project in Maine, which enables alliances between individuals and groups involved in animal welfare, child protection, elder services, domestic violence prevention, and law enforcement (Linkage Project, n.d.). Animal Friends, a shelter-focused agency, has a social worker embedded in the community outreach team. Additionally, they provide pet food to over 30 food pantries and have worked informally with social service agencies to help clients access pet resources (Animal Friends, n.d.).

The first step in building coalitions and sharing resources is by cross-training child and older adult caseworkers to identify and report animal abuse and neglect and animal welfare workers to recognize and report human maltreatment. Additional training highlighting the impact of the human-animal bond will also be needed to create a shared understanding of the interconnectedness of human and animal systems. Gathering stakeholders from animal and human welfare organizations can be a first step in building interdisciplinary teams to coordinate resources to improve outcomes for families and their pets. Another method of building future interdisciplinary relationships and teams is to create field placements for MSW students at humane societies. Even if they do not go on to work in an animal-focused area (e.g., veterinary social work), they will have a deeper appreciation of the importance of animals in family life (Hoy-Gerlach et al., 2019). Finally, collaboration could even take the form of animal welfare professionals operating within human service agencies who can coordinate pet resources for families involved in human services systems.

Limitations

The COVID-19 pandemic has stretched the capacities of both animal and human protection systems, and the suggestions in this paper are reasonable but difficult to implement during a time of great need and limited resources. However, working in a pandemic has shown us how effective video communication can be in engaging individuals and systems not typically able to come to in-person meetings or sessions. It is during such periods that we find creative ways of collaborating across systems and realize that systems rules are more malleable during times of crisis. At a time when animals and humans are experiencing the social and economic consequences of COVID, we have a window of opportunity to highlight the shared vulnerabilities and the effectiveness of addressing the needs collaboratively.

An unfortunate commonality for both child and animal welfare is that both areas have workers with high caseloads or care demands, and both struggle with high turnover of staff. Therefore, any cross-training will need to ongoing, coached by champions from both human and animal organizations, and embedded into practice. This is not a "one and done" training but a standard curriculum that is part of the on-boarding training for both professions and that is reinforced in supervision and in data collection and monitoring.

Conclusion

Tiger remained with his family as different providers worked together to address the problems that had led to the referral to child welfare and to treat the developmental delays of the children. Tiger's health care needs were also met; he was neutered and received his vaccinations and flea collar. Most youth and families that we work with are likely to have at least one pet, and that pet can play a significant role in that family. You do not have to be an "animal person" to appreciate how working with both the "human" and "nonhuman" aspects in child welfare can create a healthier, safer, and more humane community.

About the Authors

***Mary Elizabeth Rauktis, PhD**, teaches at the University of Pittsburgh School of Social Work. Contact: Mar104@pitt.edu or maryrauktis@gmail.com*

***Elizabeth Moser, MSW**, a graduate of the University of Pittsburgh School of Social Work, has spent her career working at the intersection of people and their pets. She coordinates pet support programming and a food bank at Animal Friends. Contact: emoser@thinkingoutsidethecage.org*

References

Child and Animal Maltreatment: Intersections, Challenges and Opportunities When Intervening with Maltreating Families.

Animal Friends. (n.d.). https://thinkingoutsidethecage.org

Applebaum, J., Peek, C., & Zsembik, B. (2020, Mar 6). Examining U.S. pet ownership using the General Social Survey. *The Social Science Journal*. [online]. https://doi.org/10.1080/03623319.2020.1728507

Arkow, P. (2020). Human-animal relationships and social work: Opportunities beyond the veterinary environment. *Child and Adolescent Social Work Journal*. [online first]. https://doi.org/10.1007/s10560-020-00697-x

Arrington, A., & Markarian, M. (2018). Serving pets in poverty: A new frontier for the animal welfare movement. *Sustainable Development Law & Policy, 18*(1). https://digitalcommons.wcl.american.edu/sdlp/vol18/iss1/11/

Ascione, F. R., Weber, C. V., Thompson, T. M., Health, J., Maruyama, M., & Hayashi, K. (2007). Battered pets and domestic violence: Animal abuse reported by women experiencing intimate violence and by nonabused women. *Violence Against Women, 13*(4), 354–373. https://doi.org/10.1177/1077801207299201

Boat, B. W. (2010). Understanding the role of animals in the family: Insights and strategies for clinicians. In A. H. Fine (Ed.), *Handbook on animal-assisted therapy: Foundations and guidelines for animal-assisted interventions* (3rd ed., pp. 265–282). Academic Press.

Charnetski, C. J., Riggers, S., & Brennan, F. (2004). Effect of petting a dog on immune system function. *Psychological Reports, 95*, 1087–1091. https://doi.org/10.2466/pr.0.95.3f

Covert, A., Whiren, A., Keith, J., & Nelson, C. (1985). Pets, early adolescents, and families. *Marriage & Family Review, 8*(3-4), 95–108. https://doi-org.pitt.idm.oclc.org/10.1300/J002v08n03_08

DeViney, E., Dickert, J., & Lockwood, R. (1983). The care of pets within child abusing families. *International Journal for the Study of Animal Problems, 4*(4), 321–329. https://www.wellbeingintlstudiesrepository.org/acwp_awap

Herrald, M., Tomaka, J., & Medina, A. Y. (2002). Pet ownership predicts adherence to cardiovascular rehabilitation. *Journal of Applied Social Psychology, 32*(6), 1107–1327.

Hodgson, K., & Darling, M. (2011). Pets in the family: Practical approaches. *Journal of the American Animal Hospital Association, 47*, 299–305.

Hoffer, T., Hargreaves-Cormany, H., Muirhead, Y., & Meloy, J. R. (2018). Violence in Animal Cruelty Offenders. *Springer Briefs in Psychology*. [eBook]. https://doi.org/10.1007/978-3-319-91038-3

Hoy-Gerlach, J., Delgado, M., Sloane, H., & Arkow, P. (2019). Rediscovering connections between animal welfare and human welfare: Creating social work internships at a human society. *Journal of Social Work, 19*(2), 216–232. [preprint].

Irvine, L. (2013). Animals as lifechangers and lifesavers: Pets in the redemption narratives of homeless people. *Journal of Contemporary Ethnography, 42*, 3–30. https://doi.org/ 10.1177/0891241612456550

Lebow, E., & Cherney, D. J. (2015). The role of animal welfare legislation in shaping child protection in the United States. *International Journal of Education and Social Science, 2*, 35–45.

Linkage Project. (n.d.). https://www.linkageproject.org/about-us/

References, cont.

Loar, L. (2014). "How is Fido?": What the family's companion animal can tell you about risk assessment and effective interventions—if only you would ask! In T. Ryan (Ed.), *Animals in social work: Why and how they matter* (pp. 13135–13150). Animal Ethics Series. Palgrave-Macmillan.

Loar, L., & Colman, L. (2004). *Teaching empathy: Animal-assisted therapy programs for children and families exposed to violence*. Latham Foundation.

McDonald, S. E., Collins, E. A., Nicotera, N., Hageman, T. O., Ascione, F. R., Williams, J. H., & Graham-Bermann, S. A. (2015). Children's experiences of companion animal maltreatment in households characterized by intimate partner violence. *Child Abuse & Neglect, 50*, 116–127. https://doi.org/10.1016/j.chiabu.2015.10.005

National Link Coalition. (2020, August). Congressional Group Seeks to Include Link in NCANDS Reporting. *The Link-Letter, 13*(8). http://nationallinkcoalition.org/resources/link-letter-archives

National Council of Juvenile and Family Court Judges. (2019). *The NCJFCJ releases resolution regarding animal cruelty and its link to violence*. https://www.ncjfcj.org/news/the-ncjfcj-releases-resolution-regarding-animal-cruelty-and-its-link-to-violence/

Peacock, J., Chur-Hansen, A., & Winefield, H. (2012). Mental health implications of human attachment to companion animals. *Journal of Clinical Psychology, 68*(3), 292–303. https://doi.org/10.1002/jclp.20866

Pinillos, R. G. (2018).The connections between animal and human abuse and neglect: In R. G. Pinillos (Ed.), *One Welfare: A framework to improve animal welfare and human well-being* (pp. 16-22). CABI.

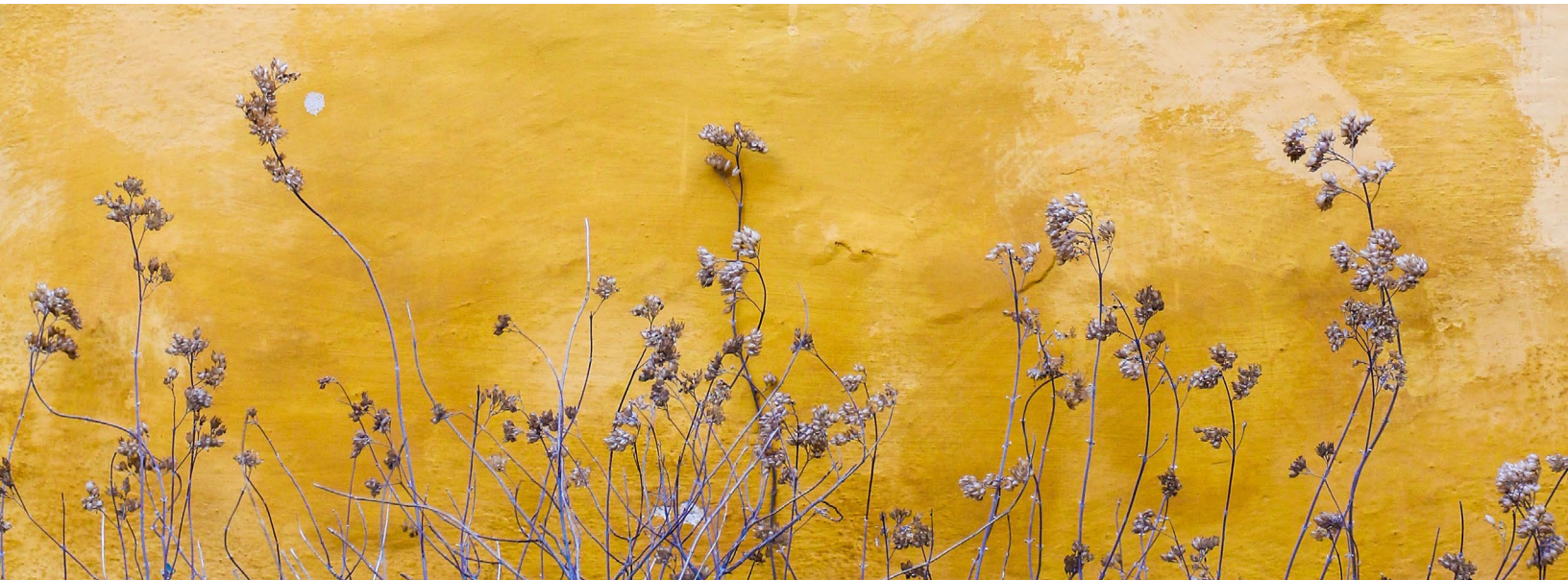
Ryan, T. (2014). The moral priority of vulnerability and dependency: Why social work should respect both humans and animals. In T. Ryan (Ed.), *Animals and social work: How and why they matter* (pp. 80–101). Animal Ethics Series. Palgrave-MacMillan.

Sara P. Carruthers News. (2020, June 11). Ohio House passes bill creating animal abuse reporting requirements. https://ohiohouse.gov/members/sara-p-carruthers/news/ohio-house-passes-bill-creating-animal-abuse-reporting-requirements-103150

Van Houtte, B., & Jarvis, P. A. (1995). The role of pets in preadolescent psychosocial development. *Journal of Applied Developmental Psychology, 16*(3) 463–479. https://doi.org/10.1016/0193-3973(95)90030-6

Vincent, A., Heima, M., & Farkas, K. (2020). Therapy dog support in pediatric dentristy: A social welfare intervention for reducing anticipatory anxiety and situational fear in children. *Journal of Child and Adolescent Social Work, 37*(6), 615–642.

Wood, L., Giles-Corti, B., & Bulsara, M. (2005). The pet connection: Pets as a conduit for social capital. *Social Science & Medicine, 61*, 1159–1173.



Under the Influence: Fetal Alcohol Spectrum Disorders and the Biology of Trauma

John Stirling, MD
Karen Zilberstein, MSW, LICSW

Keywords: Fetal alcohol, fetal alcohol spectrum disorder, fetal alcohol syndrome, neurodevelopmental disorder/prenatal alcohol exposure, trauma, neurodevelopment, post-traumatic stress, adverse childhood experiences, trauma therapy

The past two decades have seen revolutionary advances in understanding the neurodevelopmental consequences of childhood trauma (Nemeroff, 2016; Teicher & Samson, 2016). As awareness has spread, trauma-informed practices have been urged on medical practitioners (Oral et al., 2016) and child welfare agencies (Hanson & Lang, 2016). Evidence-based, trauma-specific therapies have been widely promoted and adopted (Blaustein & Kinniburgh, 2010; Cohen et al., 2016; Lanktree & Briere, 2013).

Childhood maltreatment often co-occurs with parental substance abuse and prenatal alcohol exposure, which are also known to affect children's neurodevelopment (Coggins et al., 2007; Walsh et al., 2003). Understanding of the global effects of prenatal alcohol exposure lags behind that of toxic stress, and little research has explored the relationship between the two. However, there are considerable and often confusing similarities between the clinical manifestations of toxic stress and prenatal alcohol exposure, and their interactions can be significant. This paper evaluates the similarities, differences, and interactions between the two conditions and the concomitant implications for diagnosis and intervention.

Trauma and Neurodevelopment

Traumatic experience, especially when chronic or repeated, alters neurophysiology. Changes are actuated primarily through the release of stress hormones at various sensitive periods in a child's development (Shonkoff et al., 2012; Teicher & Samson, 2016). Faced with an acute threat, the brain's neuroendocrine stress response system (hypopthalamic-pituitary-adrenal axis, or HPAA) prioritizes safety by temporarily activating brain areas and physiologic systems that help the organism react to danger. When the threat passes and the environment returns to normal, these previously useful adaptations need to be reversed. Such plasticity, or resilience, is one of the hallmarks of a healthy brain.

Chronic or repeated ("toxic") stress puts a strain on this system, especially when adult caregivers do not provide soothing interactions that help regulate the child's psychophysiological state. The brain's adaptation to chronic or repeated stress can produce hypervigilance, constant hyperarousal, and hyperreactivity. The chronically aroused brain, prioritizing quick and decisive responses, devotes less attention to developing cognitive functions and controls (Marusak et al., 2015). Input from sensory systems may be muted, presumably to decrease distraction and distress (Shimada et al. 2015; Teicher & Samson, 2016). Such learned stress responses, however, often prove maladaptive in classrooms or

other normative environments. While it is tempting to think about these changes as evidence of damage, it may be more useful to recognize them as protective adaptations (Elbers et al., 2017; Teicher & Samson, 2016).

Numerous studies examine how the experience of childhood maltreatment and resultant toxic stress appear to impact the growth and structure of the growing brain (Hart & Rubia, 2012; Marusak et al., 2015; Kavanuagh et al., 2017; Paquola et al., 2016; Teicher & Samson, 2016). When alterations in brain structure arise, they consistently appear to reduce the size, connectivity, and functioning of a few prime areas (see Table 1): the prefrontal cortex, anterior cortex, hippocampus, amygdala, corpus callosum, and cerebellum. These regions control executive functions, working memory, attention, inhibition, and the processing of emotions.

Findings from clinical studies of neurocognitive functioning map closely with data gathered through brain imaging of trauma victims (Hart & Rubia, 2012; Herringa et al., 2013; Paquola et al., 2016; Teicher & Samson, 2016) (see Table 2). Identified difficulties include lowered IQ and deficits in attention, language, abstract reasoning, visual-spatial skills, and inhibition. Memory can be diminished, as can the ability to regulate emotion and attention. Robust findings suggest that childhood trauma interferes with the development of executive functions (Ford, 2009; Gabowitz et al., 2008; McCrory et al., 2010). Hyperaroused, inattentive, and impulsive children tend to miscue social and other situations, contributing to relational difficulties. Reduced connectivity between neurons has been linked with anxiety, depression, and low IQ (Teicher & Samson, 2016).

Trauma is clinically associated with difficulties with mood and behavior (see Table 2) (Ford, 2009; Gabowitz et al., 2008; Goslin et al, 2013). In young children, trauma adaptations may manifest as symptoms of regression and anxiety. As children age and cognitive and behavioral demands increase, anxiety, depression, aggression, withdrawal, dissociation, learning problems, hyperactivity, social difficulties, and somatic complaints become prominent. High incidences of ADHD, PTSD, and bipolar disorder occur in adulthood (Felitti et al., 1998; Ford, 2009; Sugaya et al., 2012).

Fetal Alcohol and Neurodevelopment

Only in recent decades have the toxic effects of prenatal alcohol exposure (PAE) been studied with scientific rigor. Fetal alcohol syndrome (FAS), a combination of distinctive phenotypical traits including growth inhibition and neurodevelopmental impairments, was first described by Jones and Smith (1973). Children with FAS exhibit characteristic facial dysmorphologies, growth deficits, and congenital anomalies involving other organ systems. Cognitive, emotional, and behavioral impairments are common (Mattson et al., 2019).

It has subsequently been recognized that individuals exposed *in utero* to alcohol, even those who do not display the distinctive facial features and poor growth seen with FAS, tend to suffer similar, persisting neurodevelopmental impairments (Murawski et al., 2015; Mattson et al., 2001). When neurodevelopmental deficits are the only manifestation of toxic exposure, which is the case in an estimated nine out of 10 children with FASD, the disorder is harder to recognize (Bakhireva et al., 2018; Green et al., 2009; Mattson et al., 2019; May et al., 2009).

Though the broad term FASD is still commonly used in the literature to refer to all disorders related to PAE, FASDs with neurodevelopmental features appear in the most recent *Diagnostic and Statistical Manual, 5th Edition*, or DSM–5 (APA, 2013) under the more specific sobriquet "Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure (ND-PAE)." The new diagnosis focuses on the importance of alcohol-associated neurologic impairments. Diagnosis of ND-PAE requires demonstration of neurocognitive, self-regulatory, and executive function deficits in a child with known exposure to alcohol in utero. Though including children with FAS, diagnosis of ND-PAE does not depend on demonstrating any phenotypic criteria.

Ethyl alcohol is a neurotoxin, which can affect neuroreceptors and neurohormonal modulation at

Table 1. Comparison of Brain Anomalies.

	Trauma	FASD/PAE
Affected brain regions	• Reduced size or thickness of o Prefrontal cortex (PFC) o Anterior cortex (ACC) o Hippocampus o Amygdala o Corpus callosum (CC) o Cerebellum • Alterations in sensory systems: o Visual cortex o Occipital pole o Auditory cortex o Insula • Fiber tracts linking different areas of the brain show reduced integrity • Different cortical organization: Reduced centrality of left CC and temporal pole, and increased centrality of right precuneus and right anterior insula	• Reduced size or thickness of o Overall brain o Prefrontal cortex o Amygdala o Basal ganglia/Caudate nucleus o Left temporal mode of hippocampus o Corpus callosum o Cerebellum o Grey matter • Volume asymmetries in hippocampus greater than in controls • Abnormalities in corpus callosum, including thinning, displacement, and sometimes absence • Reduced myelination of sensory and motor pathways, and prefrontal cortex • Atypical activity and disorganization of network connectivity
Associated neurocognitive difficulties	• Executive functioning (PFC, ACC, cerebellum) • Memory (hippocampus, PFC) • Regulation of emotions (amygdala, PFC, ACC, cortical network organization, cerebellum) • Regulation of attention (PFC, ACC, CC) • Impulsivity (PFC) • Lack of inhibition (PFC) • Difficulty with learning, problem-solving and complex tasks (CC) • Difficulty accurately detecting emotions and social cues (amygdala, CC, ACC, visual cortex, occipital pole) • Language deficits (fiber tracks) • IQ deficits (fiber tracks, CC) • Visual memory and spatial deficits (fiber tracks, visual cortex, occipital lobe, cerebellum) • Self-awareness (anterior insula)	• Executive functioning (basal ganglia, PFC, CC, cerebellum) • Memory (basal ganglia, CC, hippocampus) • Regulation of emotions (amygdala, PFC, basal ganglia, cerebellum) • Regulation of attention (PFC, CC) • Impulsivity (PFC) • Lack of inhibition (basal ganglia, PFC) • Difficulty with learning, problem-solving, and complex tasks (CC, cerebellum) • Difficulty understanding emotions and social cues (CC) • Language deficits (CC, temporal lobe) • Lowered IQ (myelination, PFC, grey matter) • Motor difficulties (cerebellum, motor pathways, parietal lobe)

Table 2. Comparison of Symptoms and Common Comorbidities.

	Trauma	FASD/PAE
Cognition	• Language deficits • Lowered IQ and learning difficulties • Memory difficulties • Difficulties with attention • Understanding social interactions • Rigid problem-solving styles • Difficulties with abstract reasoning	• Speech and language delays • Intellectual and learning disabilities • Memory difficulties • Difficulties with attention • Theory of Mind difficulties • Difficulty with reasoning, problem solving, and understanding consequences of actions • Problems following directions leads to rule breaking
Self-regulation/ Behavior	• ADHD symptoms • Reactive to stress • Difficulty controlling impulses • Difficulty regulating emotions and behavior • Aggression associated with physical abuse • Dissociation	• ADHD in approximately 50%–90% of children • Reactive to stress • Difficulty controlling impulses • Difficulty regulating emotions and behavior • Rigidity and resistance to change • Behavioral problems and rule-breaking
Emotion	• Comorbid mood and anxiety disorders • Emotional overarousal • Guilt or shame	• Comorbid mood and anxiety disorders • May not share emotions easily • Difficulty recognizing others' emotions
Social	• Miscue social interactions • Difficulty managing social relationships	• Difficulty with social cuing • Difficulty with reciprocal social relationships • May not show affection • Lacks understanding of others' thoughts and feelings
Sensory/ Physical	• Hypersensitive to stimuli or decreased body awareness • Somatic complaints • Physical health problems: heart, respiratory, digestive, arthritis, diabetes	• Sensory sensitivities • Sensory integration difficulties • Facial dysmorphology • Growth deficits • Vision or hearing problems • Heart, kidney, or bone problems • Poor coordination/motor difficulties

every stage of the brain's development (Boschen & Klintsova, 2017, Fidalgo et al., 2017). Brain imaging conducted on individuals with ND-PAE illuminates widespread alterations to neural anatomy (see Table 1). Researchers studying both animal and human subjects conclude that fetal alcohol exposure decreases the brain's overall size, with alterations in the basal ganglia, caudate nucleus, prefrontal cortex, temporal and parietal lobes, and cerebellum (Henry et al., 2007; Mattson et al., 2019; Wilhoit et al., 2017). Functionally, widespread atypical activity and disorganization of network connectivity have been noted (Hoyme et al., 2016; Mattson et al., 2019). Reduction in grey matter and stunted myelination of sensory and motor pathways also occur (Hoyme et al., 2016). Abnormalities have been observed in the corpus callosum, including decrease in size and alterations in shape and volume (Mattson et al., 2001; Wilhoit et al., 2017). In the human hippocampus, volume asymmetries exceed those in control children (Mattson et al., 2001).

Corresponding behavioral and performance deficits are observed clinically (compare Tables 1 and 2). As might be expected from the DSM-5 criteria, deficits have been described in cognitive function (memory, intellect, reasoning, information processing), self-regulation (sensory integration, regulating behavior, inhibiting responses), and executive function (following directions, social skills, learning, attention) as well as in speech and language, vision and hearing problems, and motor function (Chasnoff et al., 2015; Hoyme et al., 2016; Mattson et al., 2019; Wilhoit et al., 2017). Approximately 70%–90% of children with FASD exhibit problems with attention, hyperactivity, and impulse control (Green et al., 2009; Greenbaum et al., 2009; Mattson et al., 2001; Wilhoit et al., 2017). It has been suggested that the damage done to the prefrontal cortex underlies ADHD seen after alcohol exposure (Louth et al., 2016).

Children with ND-PAE may miss social cues and struggle to show affection to caretakers (Wilhoit, et al., 2017), behavior which can lead to the misdiagnosis of an autistic spectrum disorder (ASD; Mukherjee et al., 2011; Stevens et al., 2013). As social learning requires both the pattern recognition skills of the right cerebral hemisphere and the analytic talent of the left, it may be hypothesized that children with inadequate development of the corpus callosum would find social learning challenging.

Because of their many challenges, children with ND-PAE are at risk for secondary pathology. Acquired psychiatric problems include depression and anxiety (Mattson, et al., 2001; Wilhoit et al., 2017). Impulsivity, difficulty following directions, and diminished understanding of consequences can lead to rule-breaking and trouble with the law (Mattson et al., 2001). Limited adaptive living skills may make achieving independence difficult.

Combined Effects of FASD and Trauma

Only a few studies try to probe the symptoms of children with PAE who have also experienced trauma and neglect, and their results must be interpreted cautiously (see Price et al., 2017, for a review). The most extensive study by Henry et al. (2007) compared 274 children aged 6–16 years old, 97% of whom had suffered severe trauma and 40% who had also been diagnosed with FASD and found that the combined group scored statistically lower on intelligence, attention, memory, receptive, and expressive language. Parents and teachers also rated the trauma/FASD group as showing more oppositional, social, impulsive, and inattentive symptoms than the trauma alone group. Coggins et al. (2007) studied 573 children aged 6–12 diagnosed with FASD and found that a high percentage had experienced abuse and neglect. They evaluated children's social communication abilities and concluded that the combination of FASD and maltreatment conspire to robustly compromise children's abilities. Koponen et al. (2009) studied 38 children in foster care with a mean age of 10 who had been exposed in utero to alcohol and found that traumatic experiences aggravated social, emotional, and neurocognitive problems. Mukherjee et al., in 2019, compared data on 99 subjects and concluded that prenatal alcohol exposure inflicted more neurodevelopmental damage than neglect. The authors cautioned against misattributing children's symptoms to neglect and poor parenting quality when the primary damage may arise instead from prenatal alcohol exposure.

The limited research conducted thus far suggests that PAE and trauma, when combined, lead to worse symptoms than would be expected in either condition alone. A child whose stress response system and executive functioning abilities are diminished possesses fewer tools with which to organize and regulate behavioral responses to stress. Resilience is compromised by both conditions.

Challenges in Applying Research Findings

Although researchers have attempted to delineate the independent and combined effects of both prenatal toxins and postnatal trauma, results of the many studies and meta-analyses must be viewed cautiously. Studies are often troubled by small sample sizes, differences in populations, lack of consistent measures, and other problems.

Controlling for confounding variables, though of crucial importance, proves especially difficult. One of the greatest challenges researchers face is separating the effects of pre-existing neurodevelopmental difficulties from those of subsequent maltreatment. Parental alcohol abuse is both a diagnostic necessity for ND-PAE and a major association with child maltreatment (Walsh et al., 2003). Yet when Kavanaugh et al. (2018) reviewed studies investigating neurocognitive impairments in maltreated youth, only three out of 24 published reports specifically mention excluding individuals with FASD, leaving open the possibility that a proportion of subjects in the studies of childhood trauma suffered from undetected ND-PAE, potentially confounding results. Conversely, traumatic postnatal experiences can be a significant confounding factor in studies purporting to demonstrate effects of early alcohol exposure.

Fortunately, animal models provide independent evidence for the neurobiological effects of both prenatal alcohol and of analogues to childhood maltreatment. Rodents exposed to alcohol in a controlled environment predictably develop altered neural architecture, endocrine dysfunction, and behavioral changes analogous to those seen in humans with ND-PAE (Mattson et al., 2019; Fish et al., 2018; Hellemans, et al., 2008). Laboratory animals, known not to have been exposed to alcohol in utero, also show alterations in response systems and brain regions affecting learning and executive functioning when subjected to early stress (Flandreau & Toth, 2018, Teicher et al., 2006), producing behaviors analogous to PTSD. Animal studies help give confidence that, despite the much greater difficulties in drawing valid conclusions from human studies, fetal alcohol exposure does target many of the same structures affected by traumatic stress, potentially impairing resilience.

Diagnostic Issues

Given their similar target organs and presentations, the effects of trauma can be difficult to separate from those associated with ND-PAE. As always, awareness is the first step, as differential diagnosis is only as good as the variety of conditions considered. Before attributing a given dysfunction to the exclusive effects of trauma, it is important to consider the role played by coexisting neurodevelopmental disorders, especially ND-PAE. In seeking to understand the effects of childhood trauma, assessors should find out as much as possible about the child's baseline level of function before the trauma and view behaviors in this context.

Both alterations in brain structure wrought by trauma and those seen after PAE affect parts of the brain that regulate stress, but underlying mechanisms differ. Alcohol affects the developing fetus as a teratogen, damaging structures and neural networks. Alcohol's effects appear to be more widespread and severe than trauma's (Henry et al., 2007; Price et al., 2017; Mukherjee et al., 2019). Trauma's alterations typically begin *after* birth, as the brain reorganizes itself to contend with environmental circumstances. The brain's innate ability to learn and change in response to new experiences and stimuli remains intact (Belsky & Pluess, 2009; Hart, 2011). In fact, some evidence suggests that children who are most susceptible to brain changes as a result of adversity may also be more amenable to the reparative effects of positive experience (Belsky & Pluess, 2009). Therapeutic interventions depend on such ongoing plasticity.

Evidence suggests that the damage inflicted by alcohol is more permanent and less responsive to treatment than are the changes wrought by early trauma

(Murawski et al., 2015; Young et al., 2016). When the brain's ability to learn and change is organically impaired, response to standard therapies is affected. Effective interventions cannot be implemented without considering the independent and combined consequences of trauma and ND-PAE.

Evidence-based recommendations for assessment of trauma's effects cast a wide net, but often not wide enough to catch the interplay with alcohol-related neurodevelopmental disorders. Time and attention are given to determining symptoms common to trauma along cognitive, relational, affective, behavioral, and somatic domains. They include examining inaccurate and maladaptive thinking, social difficulties, anxiety, depression, anger, and self-regulation (as well as their severe manifestations in suicidality, substance abuse, or psychosis), dissociation, flashbacks, traumatic triggers, and avoidance (Cohen et al., 2016; Ford, 2009; Wherry, 2014). In the few instances that published recommendations urge assessment of executive functioning and neurocognitive skills, impairments are generally viewed as sequelae of maltreatment. Gabowitz et al. (2008), in describing the neurocognitive assessment of a 10-year-old boy with a history of severe emotional and physical neglect, who presents with dissociation and impairments in executive functioning, organizing information, integrating details, inhibition, and inflexibility, conclude that

> If a trauma framework were not applied to this case, it is likely that Zachary would be labeled with a diagnosis that captured his specific behavioral manifestations (e.g., Attention Deficit Disorder, Oppositional Defiant Disorder), and treatment would be targeted to his isolated symptoms (aggression/impulsivity, difficulty concentrating, not following directions), without attention to their etiologies or functions…. Zachary's early traumatic experiences have resulted in neuropsychological deficits in his executive functioning. (p. 172)

As cogent as these comments are, it is perhaps ironic that the authors do not describe attempts to screen for prenatal alcohol exposure, which is also well known to impair executive function.

One of the difficult diagnostic questions concerns whether and to what degree observed symptoms precede or result from trauma. Trauma on its own certainly contributes to neurocognitive difficulties. At the same time, neurodevelopmental impairments such as ND-PAE are seen both to intensify the risk of maltreatment and to heighten sensitivity to stress, increasing incidence and severity of PTSD (Finzi-Dottan et al., 2006). Conversely, high IQ, executive functioning, and verbal ability tend to boost resilience, decreasing behavior problems after traumatic experiences (Goslin et al., 2013; Horn et al., 2018). Given this bidirectional interaction, it can be difficult to recognize whether a given symptom arises from trauma-related maladaptation, preexisting neurocognitive difficulties, or a combination of both. Signs of neurodevelopmental difficulties, including those associated with alcohol exposure, may be mistaken for trauma or the existence of trauma overlooked in children with significant neurocognitive impairments.

Research on, and recognition of, FASDs is still evolving, and many professionals have difficulty with diagnosis and treatment. Studies indicate that missed and misdiagnoses are common (Chasnoff et al., 2015; May et al., 2018; Woolgar & Baldock, 2015) and that families perceive lack of support from their medical providers (Coons et al., 2018; Domeij et al., 2018; Helgesson et al., 2018). This lack is all the more surprising as FASDs are common: It is estimated that from 3% to 10% of the general United States population may qualify for the diagnosis. In the child welfare population, the incidence rises to 17%, reflecting the interaction between ND-PAE and trauma (May et al., 2018; Young et al., 2016; Zarnegar et al., 2016). Among the population presenting for mental health treatment, percentages of FASDs are likely to be greater. Given both the frequent absence of distinctive physical characteristics and the difficulties obtaining a reliable history of maternal alcohol consumption, as well as the frequent co-occurrence of alcohol exposure with subsequent abuse and neglect, it is likely that even these high numbers are underestimations. The condition likely remains undetected in many children.

Diagnosis is further complicated by the fact that ND-PAE is a heterogeneous disorder. Damage and symptomatology vary widely, depending on timing, duration, and severity of exposure as well as genetic vulnerabilities. The DSM triad of neurocognitive impairment, poor self-regulation, and lack of executive function may also manifest differently through the lifespan and result in other medical and psychiatric diagnoses. In a meta-analysis of behavioral symptoms in children with FASD diagnoses, Popova et al. (2016) identified 428 additional diagnoses describing medical, mental, neurocognitive, and behavioral disorders. The most prevalent neurocognitive and behavioral conditions included impulsivity (90.7% pooled prevalence), receptive language disorder (81.8%), and expressive language disorder (76.2%).

What is not clear from Popova's meta-analysis is how many subjects in the pooled studies also experienced in utero exposure to other toxic substances, or whether the children experienced subsequent childhood adversity and to what degree. Nicotine, opiates, cocaine, and methamphetamines have been associated with decreased fetal growth and later with children's impulsivity, attention, learning, and executive functioning difficulties (Behnke et al., 2013). Concomitant use of drugs and alcohol, which occurs in many instances, complicates attribution of a specific problem to one toxin or another. Also unclear is whether subsequent exposure to trauma might have affected the range or severity of symptoms noted in the studies.

Confidently diagnosing FASDs is complicated as there are at present no laboratory tests that could objectively confirm alcohol exposure in utero, and parents fearing stigma and guilt may not provide an accurate history of alcohol intake (Murawski et al., 2015). Especially for children in the child welfare system, prenatal histories may not be known (Bakhireva et al., 2018; Murawski, et al., 2015). As a result, as Young et al. (2016) note,

> When children with ADHD and associated FASD are separated from their birth mothers and moved through the care system, they are often inaccurately identified as having insecure or disorganized attachment disorders, instead of being accurately identified as having developmental, emotional, and behavioral difficulties attributed to PAE. (p. 9)

Interpretation of symptoms can be biased by clinicians' familiarity with some disorders (notably attachment and PTSD) and not others (Coons et al., 2018; Domeij et al., 2018; Woolgar & Baldock, 2015; Young et al., 2016). The combined and cascading effects of FASD with maltreatment make it particularly hard to recognize FASD as an underlying impairment and identify it as a factor in treatment (Zarnegar et al., 2016).

Assessment involves piecing together the diagnosis through evaluation of symptoms and signs, taking a careful history of prenatal exposures, and ruling out other disorders that might cause similar symptoms.

Treatment

A healthy brain that has adapted to a stressful environment can be expected to be more resilient than one whose coping mechanisms have been compromised by prenatal toxins. The extent to which traumatized children with comorbid FASD possess the neurocognitive capacity to partake in trauma treatment remains under-researched. As neurocognitive difficulties influence how well children understand, retain, and apply interventions, trauma-informed treatments need to consider children's neurocognitive abilities and the types of interventions in which they can best engage. In their study of foster children with FASD, Koponen et al. (2009) found that children whose diagnoses of FASD had been missed exhibited more behavior problems than diagnosed children, perhaps because their symptoms were misunderstood and appropriate interventions not offered.

The current clinical emphasis on trauma has led some clinicians to recommend that, when potential comorbidities exist, trauma should be treated first (Griffin et al., 2011). However, impaired resilience associated with an FASD can mean slower progress and more challenges in therapy, and increased stress and frustration for caregivers whose expectations do not take the child's limitations into account (Koponen et al., 2009; Paintner et al., 2012). When two conditions are so closely related, it would be a mistake to treat either preferentially.

Behavioral medications prescribed in FASDs or trauma tend to target presenting symptoms, demonstrating significant, if quite variable, success in controlling ADHD, anxiety, and depression. Specific evidence for medications' clinical efficacy in the presence of ND-PAE remains rudimentary. While one literature review found that stimulants worked to decrease symptoms in 88% of studied FASD patients (Paintner et al., 2012), another systematic review found little evidence to support the use of psychotropic medications in FASDs (Mela et al., 2018). Indeed, increased behavioral disturbances have been reported after medication (Murawski et al., 2015; Young et al., 2016). Neurobiological differences seen after prenatal exposure to alcohol may make those individuals respond differently to symptom-directed medication.

As individuals with FASDs tend to break rules and can find themselves in legal trouble (Mattson et al., 2001), child welfare and legal professionals would benefit from increased knowledge of ND-PAE. When youth's underlying disabilities go unrecognized, they are expected to understand and perform better than they are able. They may be given punitive or impractical sentences and service plans that set them up for failure. Institutions and professionals serving maltreated youngsters should become informed about the types of supportive and ameliorative interventions FASD youth require.

Conclusions

Because prenatal alcohol exposure alters the same parts of the brain as trauma, its presence is often obscured and overshadowed by a history of adversity. Yet overlooking its effects on a child's presentation and symptoms would be a mistake. Alcohol damages tissues and brain structures more widely and permanently than does trauma, affecting how a child learns, grows, and reacts to stress (Mattson et al., 2019; Murawski et al., 2015; Wihoit et al., 2017). As alcohol diminishes structures in the brain that confer resilience, children with FASDs who are subsequently exposed to traumatic experiences will be less prepared to deal with them and suffer greater and longer-lasting consequences.

Since children subject to maltreatment show high degrees of comorbid FASDs (Coggins et al., 2007; Koponen et al., 2009), professionals who specialize in trauma treatment and evaluation should become aware of FASDs and routinely screen for them in children presenting with neurocognitive deficits. By recognizing and assessing for alcohol exposure, professionals will gain useful information to guide and improve clinical, legal, and child welfare services.

Much remains unknown about the combined effects of FASD and trauma, as well as the types of interventions best suited to support and treat individuals with dual exposure. Longitudinal research is needed that can track many aspects of neurodevelopment over time, beginning in the prenatal period. Studies should include controls as well as children affected singly and doubly by FASDs and trauma. Research is also needed to determine how maltreated children with FASDs respond to current interventions in clinical, legal, and child welfare arenas, and what further interventions are needed to improve their functioning.

About the Authors

***John Stirling, MD**, is a pediatrician who has served as a medical consultant in child abuse and foster care for Santa Clara County in San Jose, California, Stanford Children's Hospital and Rady Children's Hospital in San Diego. He is a regional champion for the American Academy of Pediatrics' Regional Education and Awareness Liaison Network on Fetal Alcohol Spectrum Disorders. Contact: jstirlings@aol.com*

***Karen Zilberstein, MSW, LICSW**, is Clinical Director for A Home Within and specializes in the treatment of youth who have experienced trauma and foster care. An author and speaker, she has recently published a narrative nonfiction book Parenting Under Pressure: Struggling to Raise Children in an Unequal America, which won two Indie book awards.*

References

Under the Influence: Fetal Alcohol Spectrum Disorders and the Biology of Trauma

American Psychiatric Association (APA). (2013). *Diagnostic and statistical manual of mental disorders, fifth edition* (DSM–5). Author.

Bakhireva, L., Garrison, L., Shrestha, S., Sharkis, J., Miranda, R., & Rogers, K. (2018). Challenges of diagnosing fetal alcohol spectrum disorders in foster and adopted children. *Alcohol, 67*, 37–43.

Behnke, M., Smith, V., Committee on Substance Abuse, & Committee on Fetus and Newborn. (2013). Prenatal substance abuse: Short- and long-term effects on the exposed fetus. *Pediatrics, 131*(3), e1009–e1024. https://doi.org/10.1542/peds.2012-3931

Belsky, J., & Pluess, M. (2009). The nature (and nurture?) of plasticity in early human development. *Perspectives on Psychological Science, 4*(4), 345–351.

Blaustein, M., & Kinniburgh, K. (2010). *Treating traumatic stress in children and adolescents: How to foster resilience through attachment, self-regulation, and competency*. Guilford Press.

Boschen K., & Klintsova, A. (2017, November). Neurotrophins in the brain: Interaction with alcohol exposure during development. *Vitamins and Hormones, 104*, 197–242. https://doi.org/10.1016/bs.vh.2016.10.008

Chasnoff, I., Wells, A. & King, L. (2015). Misdiagnosis and missed diagnoses in foster and adopted children with prenatal alcohol exposure. *Pediatrics, 135*(2), 264–270.

Coggins, T., Timler, G., & Olswang, L. (2007). A state of double jeopardy: Impact of prenatal alcohol exposure and adverse environments on the social communicative abilities of school-age children with fetal alcohol spectrum disorder. *Language, Speech, and Hearing Services in Schools, 38*, 117–127.

Cohen, J., Mannarino, A., & Deblinger, E. (2016). *Treating trauma and traumatic grief in children and adolescents, second edition*. Guilford Publications.

Coons, K., Watson, S., Yantzi, N., & Schinke, R. (2018). Adaptation in families raising children with fetal alcohol spectrum disorder. Part II: What would help. *Journal of Intellectual and Developmental Disability, 43*(2), 137–151.

Domeij, H., Fahlstrom, G., Berilsson, G., Hultcrantz, M., Munthe-Kaas, H., Gordh, C., & Helgesson, G. (2018). Experiences of living with fetal alcohol spectrum disorders: A systematic review and synthesis of qualitative data. *Developmental Medicine & Child Neurology, 60*(8), 741–753.

Elbers J., Rovnaghi, C., Golianu B., & Anand K. (2017). Clinical profile associated with adverse childhood experiences: The advent of nervous system dysregulation. *Children, 4*(11), 98.

Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., Koss, M., & Marks, J. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study. *American Journal of Preventive Medicine, 14*, 245–258.

Fidalgo, S., Skipper, C., Takyi, A., McIver, A., Tsiligkaridis, T., Quadir, A., & Gard, P. (2017). Low-dose chronic prenatal alcohol exposure abolishes the pro-cognitive effects of angiotensin IV. *Behavioural Brain Research, 30*(329), 140–147.

Finzi-Dottan, R., Dekel, R., Lavi, T., & Su'ali, T. (2006). Posttraumatic stress reactions among children with learning disabilities exposed to terror attacks. *Comprehensive Psychiatry, 47*, 144–151.

Fish, E., Weiczorek, L., Rumple, A., Suttie, M., Moy, S., Hammond, P., & Parnell, S. (2018). The enduring impact of neurulation stage alcohol exposure: A combined behavioral and structural neuroimaging study in adult male and female C57BL/6J mice. *Behavioural Brain Research, 338*, 173–184.

Flandreau, E., & Toth, M. (2018). Animal models of PTSD: A critical review. *Current Topics in Behavioral Neuroscience, 38*, 48–68.

Ford, J. (2009). Neurobiological and developmental research: Clinical implications. In C. Courtis & J. Ford (Eds.), *Treating complex traumatic stress disorders: An evidence-based guide* (pp. 31–58). Guilford Press.

Gabowitz, D., Zucker, M., & Cook, A. (2008). Neuropsychological assessment in clinical evaluation in children and adolescents with complex trauma. *Journal of Child & Adolescent Trauma, 1*(2), 163–178.

Goslin, M., Stover, C., Berkowitz, S., & Marans, S. (2013). Identifying youth at risk for difficulties following a traumatic event: Pre-event factors are associated with acute symptomatology. *Journal of Traumatic Stress, 26*, 475–482.

Green, C., Mihic, A., Nikkel, S., Stade, B., Rasmussen, C., Munoz, D., & Reynolds, J. (2009). Executive function deficits in children with fetal alcohol spectrum disorders (FASD) measured using the Cambridge Neuropsychological Tests Automated Battery (CANTAB). *The Journal of Child Psychology and Pyschiatry, 50*(6), 688–697.

Greenbaum, R., Stevens, S., Nash, K., Koren, G., & Rovet, J. (2009). Social cognitive and emotion processing abilities of children with fetal alcohol spectrum disorders: A comparison with attention deficit hyperactivity disorder. *Alcoholism: Clinical and Experimental Research, 33*(10), 1656–1670.

Griffin, G., McLelland, J., Holzberg, M., Stolbach, B., Maj, N., & Kisiel, C. (2011). Addressing the impact of trauma before diagnosing mental illness in child welfare. *Child Welfare, 90*(6), 69–89

Hanson, R., & Lang, J. (2016). A critical look at trauma-informed care among agencies and systems serving maltreated youth and their families. *Child Maltreatment, 21*(2), 95–100.

Hart, S. (2011). *The impact of attachment: Developmental neuroaffective psychology*. W. W. Norton & Co.

Hart, H., & Rubia, K. (2012). Neuroimaging of child abuse: A critical review. *Frontiers in Human Neuroscience, 6*(52), 1–24.

Hellemans, K., Verma, P., Yoon, W., & Weinberg, J. (2008). Prenatal alcohol exposure increases vulnerability to stress and anxiety-like disorders in adulthood. *Annals of New York Science, 1144*, 154–175.

Helgesson, G., Bertilsson, G., Domeij, H., Fahlström, G., Heintz, E., Hjern, A., Gordh, C., Nordin, V., Rangmar, J., Rydell, A., Wahlsten, V., & Hulcrantz, M. (2018). Ethical aspects of diagnosis and interventions for children with fetal alcohol spectrum disorder (FASD) and their families. *BMC Medical Ethics, 19*(1), 1–7.

Henry, J., Sloane, M., & Black-Pond, C. (2007). Neurobiology and neurodevelopmental impact of childhood traumatic stress and prenatal alcohol exposure. *Language, Speech, and Hearing Services in Schools, 38*, 99–108.

Herringa, R., Birn, R., Ruttle, P., Burghy, C., Stodola, D., Davidson, R., & Essex, M. (2013). Childhood maltreatment is associated with altered fear circuitry and increased internalizing symptoms by late adolescence. *Proceedings of the National Academy of Science, 110*(47), 19119–19124.

Horn, S., Roos, L., Beauchamp, K., Flannery, J., & Fisher, P. (2018). Polyvictimization and externalizing symptoms in foster care children: The moderating role of executive function. *Journal of Trauma and Dissociation, 19*(3), 307–324.

Hoyme, H., Kalberg, W., Elliott, J., Blankenship, J., Buckley, D., Marais, A., Manning, M., Robinson, L., Adam, M., Abdul-Rahman, O., Jewett, T., Coles, C., Chambers, C., Jones, K., Adnams, C., Shah, P., Riley, E. Charness, M., Warren, K., & May, P. (2016). Updated clinical guidelines for diagnosing fetal alcohol spectrum disorders. *Pediatrics, 138*(2), e20154256. https://doi.org/10.1542/peds.2015-4256

Jones, K., & Smith, D. (1973). Recognition of the fetal alcohol syndrome in early infancy. *Lancet, 302*(7836), 999–1001.

Kavanaugh, B., Dupont-Frehette, B., Jerskey, B., & Holler, K. (2017). Neurocognitive deficits in children and adolescents following maltreatment: Neurodevelopmental consequences and neuropsychological implications of traumatic stress. *Applied Neuropsychology: Child, 6*(1), 64–78.

Koponen, A., Kalland, M., & Autti-Rämö, I. (2009). Caregiving environment and socio-emotional development of foster-placed FASD-children. *Children and Youth Services Review, 31*, 1049–1056.

References, cont.

Louth, E., Nignell, W., Taylor, C., & Bailey, C. (2016). Developmental ethanol exposure leads to long-term deficits in attention and its underlying prefrontal circuitry. *eNeuro, 3*, ENEURO.0267-16.2016.

Lanktree, C., & Briere, J. (2013). Integrative treatment of complex trauma (ITCT) for children and adolescents. In J. D. Ford and C. A. Courtois (Eds.), *Treating complex traumatic stress disorders with children and adolescents: An evidence-based guide* (pp. 143–161). Guilford Press.

Marusak, H., Etkin, A., & Thomason, M. (2015, April). Disrupted insula-based neural circuit organization and conflict interference in trauma-exposed youth. *NeuroImage: Clinical, 8*, 516–525. https://doi.org.10.1016/j.nicl.2015.04.007

Mattson, S., Bernes, G., & Doyle, L. (2019). Fetal alcohol spectrum disorders: A review of the neurobehavioral deficits associated with prenatal alcohol exposure. *Alcoholism: Clinical and Experimental Research, 43*(6), 1046–1062.

Mattson, S., Schoenfeld, A., & Riley, E. (2001). Teratogenic effects of alcohol on brain and behavior. *Alcohol Research & Health, 25*(3), 185–191.

May, P., Chambers, C., Kalberg, W., Zellner, J., Feldman, H., Buckley, D., Kopald, D., Hasken, J., Xu, R., Honerkamp-Smith, G. Taras, H., Manning, M., Robinson, L. Adam, M., Abdul-Rahman, O., Vaux, K., Jewett, T., Elliot, A., Kable J…& Hoyme. E. (2018). Prevalence of fetal alcohol spectrum disorders in 4 US communities. *Journal of American Medical Association, 319*(5), 474–482.

May, P., Gossage, J., Kalberg, W., Robinson, L., Buckley, D., Manning, M., & Hoyme, E. (2009). Prevalence and epidemiologic characteristics of FASD from various research methods with an emphasis on recent in-school studies. *Developmental Disabilities Research Reviews, 15*(3), 176–192.

McCrory, E., DeBrito, S., & Viding, E. (2010). Research review: The neurobiology and genetics of maltreatment and adversity. *Journal of Child Psychology and Psychiatry, 51*(10), 1079–1095.

Mela, M., Okpalauwaekwe, O., Anderson, T., Eng, J., Nomani, S., Ahmed, A., & Barr, A. (2018).The utility of psychotropic drugs on patients with fetal alcohol spectrum disorder (FASD): A systematic review. *Psychiatry and Clinical Psychopharmacology, 28*(4), 436–445.

Mukherjee, R., Cook, P., Norgate, S., & Price, A. (2019). Neurodevelopmental outcomes in individuals with fetal alcohol spectrum disorder (FASD) with and without exposure to neglect: Clinical cohort data from a national FASD diagnostic clinic. *Alcohol, 76*, 23–28.

Mukherjee, R., Layton, M., Yacoub, E., & Turk, J. (2011). Autism and autistic traits in people exposed to heavy prenatal alcohol: Data from a clinical series of 21 individuals and nested case control study. *Advances in Mental Health and Intellectual Disabilities, 5*(1), 2–49.

Murawski, N., Moore, E., Thomas, J., & Riley, E. (2015). Advances in diagnosis and treatment of fetal alcohol spectrum disorders: From animal models to human studies. *Alcohol Research: Current Reviews, 37*(1), 97–108.

Nemeroff, C. (2016). Paradise lost: The neurobiological and clinical consequences of child abuse and neglect. *Neuron Review, 89*, 892–909.

Oral, R., Ramirez, M., Xoohey, C., Nakada, S. Walz, A., Kuntz, A., Benoit, J., & Peek-Asa, C. (2016). Adverse childhood experiences and trauma informed care: The future of health care. *Pediatric Research, 79*, 227–233.

Paintner, A., Williams, A.., & Burd, L. (2012). Fetal alcohol spectrum disorders—Implications for child neurology. Part 2: Diagnosis and management. *Journal of Child Neurology, 27*(3), 355–362.

Paquola, C., Bennetta, M., & Lagopoulosa, J. (2016). Understanding heterogeneity in grey matter research of adults with childhood maltreatment: A meta-analysis and review. *Neuroscience and Biobehavioral Reviews, 69*(1), 299–312.

Popova, S., Lange, S., Shield, K., Mihic, A., Chudley, A., Mukherjee, R., Bekmuradov, D., & Rehm, J. (2016). Comorbidity of fetal alcohol spectrum disorder: A systematic review and meta-analysis. *Lancet, 387*, 978–987.

Price, A., Cook, P., Norgate, S., & Mukherjee, R. (2017). Prenatal alcohol exposure and traumatic childhood experiences: A systematic review. *Neuroscience & Biobehavioral Reviews, 80*, 89–98.

Shimada, K., Takiguchi, S., Mizushima, S., Fujisawa, T., Saito, D., Kosaka, H., Okazawa, H., & Tomoda, A. (2015). Reduced visual cortex grey matter volume in children and adolescents with reactive attachment disorder. *NeuroImage: Clinical, 9*, 13–19.

Shonkoff, J., Garner, A., & the Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care, Section on Developmental and Behavioral Pediatrics. (2012). *Pediatrics, 129*(1), e232–e246.

Stevens, S., Nash, K., Koren, G., & Rovet, J. (2013). Autism characteristics in children with fetal alcohol spectrum disorders. *Child Neuropsychology, 19*(6), 579–587.

Sugaya, L., Hasin, D., Olfson, M., Lin, K., Grant, B., & Bianco, C. (2012). Child physical abuse and adult mental health: A national study. *Journal of Traumatic Stress, 25*(4), 384–392.

Teicher, M., & Samson, J. (2016). Annual research review: Enduring neurobiological effects of childhood abuse and neglect. *The Journal of Child Psychology & Psychiatry, 57*(3), 241–266.

Teicher, M., Tomoda, A., & Andersen, S. (2006). Neurobiological consequences of early stress and childhood maltreatment: Are results from human and animal studies comparable? *Annals of the New York Academy of Sciences, 1071*, 313–323.

Walsh, C., MacMillan, H., & Jamieson, E. (2003). The relationship between parental substance abuse and child maltreatment: Findings from the Ontario Health Supplement. *Child Abuse & Neglect, 27*, 1409–1425.

Wherry, J. (2014). The role of assessment in evidence-based treatment with trauma-exposed children. In B. Allen & M. Kronenberg (Eds.), *Treating traumatized children: A casebook of evidence-based therapies* (pp. 26–46). Guilford Press.

Wilhoit, L., Scott, D., & Simecka, B. (2017). Fetal alcohol spectrum disorders: Characteristics, complications, and treatment. *Community Mental Health Journal, 53*, 711–718.

Woolgar, M., & Baldock, E. (2015). Attachment disorders versus more common problems in looked after and adopted children: Comparing community and expert assessments. *Child and Adolescent Mental Health, 20*(1), 34–40.

Young, S., Absoud, M., Blackburn, C., Branney, P., Colley, B., Farrag, E., Fleisher, S., Gregory, G., Gudjonsson, G., Kim, K., O'Malley, K., Plant, M., Rodriguez, A., Ozer, S., Takon, I., Woodhouse, E., & Mukherjee, R. (2016). Guidelines for identification and treatment of individuals with attention deficit/hyperactivity disorder and associated fetal alcohol spectrum disorders based upon expert consensus. *BMC Psychiatry, 16*(324).

Zarnegar, A., Hambrick, E., Perry, B., Azen, A., & Peterson, C. (2106). Clinical improvements in adopted children with fetal alcohol spectrum disorders through neurodevelopmentally informed clinical intervention: A pilot study. *Clinical Child Psychology and Psychiatry 21*(4), 551–567.

Increasing True Reports Without Increasing False Reports: Best Practice Interviewing Methods and Open-Ended Wh- Questions

Thomas D. Lyon, JD, PhD
Hayden M. Henderson, PhD

The special issue of the *APSAC Advisor* on forensic interviewing (2020) reveals a remarkable degree of consensus regarding best practice. Although the terminology used to describe interviewing techniques varies, there is general agreement regarding the utility of narrative practice rapport building, initiating the allegation phase of the interview with a "tell me why" question about the reasons for the interview, and eliciting details as much as possible with "invitations," which are very broad, open-ended requests for recall. The agreement regarding best practice is particularly remarkable because of the wide diversity of authors, including the interviewing pioneers Kathleen Faller (Faller, 2020) and Mark Everson (Everson et al., 2020), representatives of the CornerHouse protocol (Stauffer, 2020) and ChildFirst training programs (Farrell & Vieth, 2020), and the proponents of the National Institute of Child Health and Development (NICHD) protocol (Stewart & LaRooy, 2020). The consensus has been built through the efforts of APSAC (2012) and the Office of Justice Juvenile Delinquency Prevention (OJJDP) (Newlin et al., 2015) to establish best practice guidance, and several experts who contributed to those efforts are also represented in the special issue (Kenniston, 2020; Steele, 2020; Toth, 2020). We were personally heartened to note that the Ten-Step Interview (Lyon, 2014), a modification of the NICHD protocol, also played a role in shaping the emerging consensus (Kenniston, 2020; Stewart & LaRooy, 2020; Toth, 2020).

In this paper, we will discuss how the logic underlying this consensus can be extended to recommendations for asking children open-ended wh- questions. One of the major challenges for forensic interviewers is how best to elicit specific types of important information often missing after interviewers have asked invitations, that is, after interviewers have elicited a narrative through "what happened?" questions and requested elaboration through "tell me more about [content]" questions. Here, the consensus is less clear. For example, Stewart and LaRooy (2020) discussed the use of wh- questions about children's subjective reactions to abuse, such as "how did you feel?" They noted that although the NICHD protocol does not include direct questions about feelings, the Utah modification of the NICHD protocol recommends them. Similarly, the APSAC guidelines (2012) also recommend asking children's feelings questions.

At first glance, the move from invitations to wh- questions implicates the tradeoff identified by Everson and Rodriquez (2020) between false positives and false negatives. False positives include false details, whereas false negatives occur when one concludes falsely that something didn't occur. At their worst, false positives mean false allegations of abuse, and at their worst, false negatives mean false denials. One of the goals

of invitations is to minimize suggestibility and thus reduce false positives, whereas more specific questions often increase the likelihood of error (Lamb et al., 2018). However, invitations may overlook certain details, including the child's feelings during abuse, whereas more specific questions can capture those details (Lyon et al., 2012; Stolzenberg et al., in press). Given these considerations, one might characterize the choice between invitations and wh- questions as a choice between minimizing false positives and minimizing false negatives.

However, Everson and Rodriguez (2020) were careful to note that considering both false positives and false negatives "*often* requires a tradeoff" (p. 92; italics added). The best argument for invitations is that they increase true information without increasing false information: They elicit longer, richer, and more convincing reports from children (Brown et al., 2013; Lamb et al., 2018). This helps to explain why implementation of the NICHD protocol increased the successful prosecution of child sexual abuse (Pipe et al., 2013). Indeed, most of the methods that have achieved consensus in the field as best practice have done so because they avoid a stark tradeoff between false positives and false negatives.

At the same time, it is the case that invitations often fail to elicit some types of details. With respect to specific details, we will argue that one can identify productive open-ended wh- questions that also increase true details with little risk of increasing false details. Asking children who have disclosed abuse "how did you feel?" is one such question. Moreover, future progress in protocol development can identify additional wh- questions that increase true information without sacrificing accuracy.

At the same time, we will show that there is an important line between open-ended wh- questions, on the one hand, and closed-ended wh- questions and recognition questions on the other hand. Closed-ended wh- questions are wh- questions that lead to high rates of guessing, as we'll discuss below. Recognition questions include yes/no questions (i.e., questions that can be answered yes or no), and forced-choice questions (i.e., questions that provide a choice among options with an "or"). Some protocols support the use of the "how did you feel?" question, but they add that if the child has difficulty responding, the interviewer should consider asking a question such as "did it hurt, or tickle, or something else?" (Stauffer, 2020). Hence, they support asking a forced-choice question about feelings, albeit with the "something else" option.

Moving from open-ended wh- questions to recognition questions raises more serious concerns about the risks of increasing false positives to increase true positives. Furthermore, cognizant of Everson and Rodriguez' (2020) concern that interviewers not focus exclusively on false positives, we will emphasize how recognition questions don't solve the problem of high rates of false negatives. Indeed, they create false negatives that are particularly damaging to children's credibility, because they entail explicit denial of details that a reluctant child might later choose to report.

In what follows, we discuss how narrative practice, introducing the allegation with a "tell me why" question, and maximizing the use of invitations avoid stark tradeoffs between false positives and false negatives. Noting that "tell me why" questions are not invitations but equivalent to wh- questions, we'll introduce the concept of open-ended wh- questions and contrast their advantages with the dangers of closed-ended wh- and recognition questions. Illustrating the tradeoffs, we'll discuss research on clothing placement and subjective reactions to abuse. We'll then suggest future areas for identifying productive open-ended wh- questions and discuss what interviewers can do when they feel recognition questions are necessary. Our hope is to help create a consensus around the use of open-ended wh- questions.

Narrative Practice

Narrative practice, also known as episodic memory training, has been shown to increase the productivity of abuse reports (Sternberg et al., 1997) and to increase the accuracy of information produced in lab studies (Roberts et al., 2004). There are other likely benefits as well: it helps to build rapport, enables the interviewer to assess the child's comfort and developmental level, and allows the interviewer to become accustomed to the child's speech. Evidence of ill effects emerge only

if narrative practice goes on too long; therefore, it is recommended that interviewers take about five to seven minutes (Hershkowitz, 2009).

An underappreciated benefit of narrative practice is that children's reluctance to participate provides a strong hint that the child is reluctant to disclose, which counsels postponement of direct questions about the allegation since they are likely to lead to a denial (Hershkowitz et al., 2006). This doesn't mean that narrative practice actually increases the likelihood of a disclosure and decreases false denials; indeed, experimental evidence suggests that it doesn't do so (Lyon et al., 2014). But it means that as we move into an era in which multiple interviews are understood as warranted (and often necessary; Blasbalg et al., in press), it provides a means to identify children who are going to deny true abuse if we push them too hard.

Introducing the Allegation With a "Why" Question

Protocols and guides nearly universally recommend that interviewers ask children a question such as "tell me why you came to talk to me today" when turning to the allegation. Of course, the question will only be effective if children know why they are being interviewed, and this is largely dependent on whether the child has previously disclosed abuse. However, since sexual abuse is usually discovered because of a disclosure, this will be true in a large percentage of sexual abuse cases (Lyon et al., in press), and the question has been found to be highly effective (Lamb et al., 2018). If the child discloses abuse, it is also generally agreed that interviewers should elicit as much information as possible with invitations such as "tell me everything that happened" "what happened next?" and "tell me more about [content mentioned by child]" questions. Individual episodes are elicited by asking the child to report "everything that happened" the "last time," the "first time," and other times the child can recall.

This approach reduces false allegations because of the non-suggestive nature of the questions. The interviewer is not suggesting content to the child and therefore cannot be accused of tainting the child's report. But just as important is the way in which the approach reduces the likelihood of false denials. If a child fails to disclose abuse when asked a "tell me why" question, the child is not denying that abuse occurred. If the child is reluctant or forgetful (or if the child really doesn't know why they are being interviewed), they will provide a "don't know" response. If the child doesn't disclose in response to the "tell me why" question, the interviewer asks additional questions, introducing content gradually to allow the child who has something to report to do so without excessive prompting.

When a child discloses, moving to invitations to elicit a complete narrative ensures that a false story isn't embellished by suggestive questioning. This also ensures that a true story won't be undermined by suggested content. Furthermore, continuing to ask invitations to elicit specific episodes of abuse when the abuse was repeated reduces the likelihood that the child's report will confuse different episodes, which would undermine the child's credibility.

Wh- Questions Versus Invitations

It is important to note that the question "tell me why you came to talk to me," is not an invitation but a kind of wh- question. Asking a wh- question as a "tell me" prompt does not turn it into an invitation (Henderson et al., 2020). It is nevertheless unobjectionable because, although it assumes the child has a reason to talk to the interviewer, it does not suggest what that reason is. Moreover, as with other wh- questions (what, how, who, when, and where), it queries recall rather than recognition memory. The child must generate the to-be-remembered information, rather than affirm or deny (yes/no question) or choose (forced-choice) information suggested by the interviewer.

To understand how to think about wh- questions, it is helpful to think more about invitations. We train our students to identify two types of invitations. The first type includes the word *happened*. This includes questions about "what happened," including "tell me everything that happened," and "what happened next?" and, after the child mentions a place, "what happened in the [place]?" or if the child mentions an event, "what happened when [the event]?" Note that the interviewers assume that *something* happened, but

beyond that, they provide no content other than what the child has provided. The second type asks the child to "tell me more" about a detail the child has provided. Note that the interviewers assume that the child has *something* more to offer, but beyond that, they suggest no content.

Technically, "what happened next?" is presumptive, because it presumes that something happened next, and asking "tell me more" assumes that the child has more to tell. However, if nothing more happened, or the child has nothing more to tell, the child is fully capable of answering "nothing." By the same token, many wh- questions presume information, but they present little danger of suggestion. "What did *he* do?" and "what did *you* do?" are wh- questions that presume people did things, but they are easily answered with "nothing." They are less preferred to invitations not because they are suggestive, but because they are more specific and thus may overlook a detail. That is, something may have happened even if someone didn't *do* anything. For that reason, they are not optimal questions for initiating a narrative, but they are excellent questions for obtaining more specific information.

Invitations are preferred to wh- questions because they are less specific, giving the child free reign to report anything that they remember. As we noted above, they lead to longer and more productive responses. They often lead to recall of idiosyncratic content that is unlikely to be the product of coaching or suggestion. However, precisely because they are less specific, they are less likely to lead to particular types of information, and this is where wh- questions may be useful supplements.

In our interviews, we initially focus on obtaining a chronological narrative and thus rely on "what happened next" questions. If a child provides three details that appear to be chronological when first asked to "tell everything" (either about a narrative practice topic or the abuse allegation), we subsequently ask "what happened next" questions until the child has completed their narrative. If the child provides fewer than three details, or details that appear jumbled, we help initiate their narrative by following up with "what's the first thing that happened?" and then continue with "what happened next" questions. Our follow-up questions will vary depending on whether the child's initial narrative clearly relates a single episode, multiple episodes, or a script report.

As we build on the child's initial narrative, in addition to asking "tell me more" questions to follow up, we also ask wh- questions about specific components of the child's story, which we discuss below. And this is where the protocols and guides appear to differ. In our view, one can move to many wh- questions after invitations without increasing the likelihood of false details or reducing the likelihood of true details. In turn, one can follow up answers to wh- questions with invitations. On the other hand, we are especially careful to avoid yes/no, forced-choice, and some types of wh- questions when eliciting abuse reports.

Problems With Recognition Questions (Yes/No and Forced-Choice)

As noted above, wh- questions elicit recall memory because children must generate the to-be-remembered information. Recognition questions, which include yes/no and forced-choice questions, present the to-be-remembered information in the question. Recognition questions have both advantages and disadvantages. It is easier to recognize information than to recall information. Therefore, one can facilitate memory by asking recognition questions. But it is also easier to answer recognition questions when one *doesn't* know the answer, and therein lies the problem.

"Response availability" is the ease with which a question can be answered. Recognition questions have high response availability. At a very young age, children learn how to answer yes/no questions: with yeses and no's, nods and shakes of the head (Horgan, 1978). Similarly, very young children are able to answer forced-choice questions by choosing one of the options (Sumner et al., 2019). Because it is so easy to answer recognition questions, children guess more often and say "don't know" less often (Waterman et al., 2000). Guesses will lead to inaccurate information and inconsistencies, because a child's guess on one occasion might not match their guess on another.

In addition to guesses, children will exhibit response biases to recognition questions. If questions are incomprehensible, 2-year-olds and young 3-year-olds tend to answer "yes," but by age 4, children usually answer "no" (Fritzley & Lee, 2003). If questions ask about something plausible, young children are more likely to answer "yes" (Rocha et al., 2013). If questions ask about undesirable acts, young children tend to answer "no" (Talwar & Crossman, 2012).

Even among children who don't exhibit response biases, recognition questions tend to elicit unelaborated answers (Lyon et al., 2019). That is, if a question can be answered yes or no, children will simply answer "yes" or "no." If a question can be answered simply by choosing an option, children will only choose an option. An extreme example of this is when children are asked "do you know" questions that contain an embedded wh- question, such as "do you know where it happened?" An immature response is an unelaborated "yes," without an answer to the embedded "where" question (Evans et al., 2017). Because the question can be answered yes, young children will simply answer yes.

Response biases and unelaborated responses lead to a litany of problems with recognition questions (Lyon, 2014; Lyon et al., 2019). Because children's responses are so brief, the interviewer does virtually all the talking. This means that the interviewer's perspective prevails, and unusual details are likely to be overlooked. Unusual details are helpful in distinguishing between reports that are more likely to be true and reports that are more likely to be the product of coaching or suggestion. Furthermore, if the interviewer is asking recognition questions and the child is giving unelaborated answers, then almost all of the words are generated by the interviewer, meaning that the chances of miscommunication due to difficult terminology or grammar are maximized. And since the child can easily provide an answer, they are unlikely to indicate when they don't understand.

In sum, recognition questions involve a trade-off. On the one hand, it is easier to recognize than to recall, and so recognition questions will facilitate children's ability to remember details. On the other hand, it is easier to give a false answer to recognition questions than to recall questions, and therefore recognition questions increase the likelihood of false answers. Furthermore, because recognition questions lead to unelaborated answers, they lead to other problems, including overlooking unusual details and obscuring misunderstandings.

At first glance, opposition to recognition questions might be falling into the trap described by Everson & Rodriguez (2020). Rather than avoiding false positives at all costs, they argue that interviewers should value sensitivity (identifying true allegations) as much as they value specificity (avoiding false allegations). In support of recognition questions, one can point to how they facilitate memory. Specifically, one can cite research in the laboratory demonstrating that children are more likely to disclose transgressions when asked recognition questions than when asked recall questions (Lyon et al., 2014).

However, this argument overlooks the ways in which recognition questions undermine true allegations. Imagine a case in which a child has been abused but is asked a series of recognition questions. First, if asked yes/no screening questions about abuse, it is easy for the child to simply answer "no." The child is now on record as denying abuse, and any subsequent disclosure will appear less convincing as a result of this inconsistency. Because of response biases and guesses, the child is likely to provide inaccurate and inconsistent information. Because of unelaborated responses, the child is unlikely to provide unusual details and unlikely to let the interviewer know when the questions are confusing. Recognition questions might increase the likelihood of eliciting a true allegation, but they also decrease the likelihood of eliciting a convincing allegation.

The Advantages of Wh- Questions

Wh- questions avoid many of the problems with recognition questions. When children don't know the answer to a question, they are less likely to guess and more likely to acknowledge that they don't know when asked a wh- question (Waterman et al., 2000). They are also more likely to inform the interviewer when they don't understand a wh- question, and if they answer

regardless, their misunderstanding is more likely to be apparent. This is because an uncomprehending response to a recognition question will look sensible: the child will have simply said "yes" or "no" or chosen an option.

As the reader is already aware, wh- questions are a bit tricky to categorize. The most open-ended wh- questions are invitations (e.g., "what happened?"), and some other wh- questions are quite open-ended (e.g., "what did you do?"), but they are not quite invitations. The most productive wh- questions appear to be those that ask about actions (Ahern et al., 2018), which is fortunate both because children are likely to better remember actions (than descriptions; Peterson et al., 1999) and because the most important details in abuse cases tend to concern the actions of familiar people in familiar places. Although protocols and practice guides talk about maximizing the use of invitations, few would complain about wh- questions asking about actions.

The real difficulty arises with those wh- questions that are more like recognition questions. As we noted, recognition questions elicit lots of guessing because it is so easy to respond to them. Some wh- questions ask about concepts for which children have a limited number of easily retrievable (but often wrong) responses. Without knowing much about what individual words mean, young children learn that some words refer to number, color, and time (Sandhofer & Smith, 1999; Shatz et al., 2010; Wynn, 1992). Thus, they are able to guess when asked questions such as how many, what color, or how long. That is, they understand, for example, that "how many?" calls for a number, and they have learned some number words and therefore can provide a number in response to a number question. Moreover, they can do so in the same way that they answer recognition questions: with only a word or two. For this reason, these types of wh- questions are appropriately called "closed-ended" and should be treated much how we treat recognition questions.

Clothing Placement

The challenge for interviewers is therefore how to obtain specific information without asking recognition or closed-ended wh- questions. We have studied these issues in several specific areas and have advice to give in each. First, in sexual abuse cases, the intrusiveness of the touching is often an issue. If the touching is more intrusive, then one can be more confident that the touching was abusive, rather than accidental, affectionate, or playful. Traditionally, interviewers would ask questions such as "did he touch you over the clothes or under the clothes?" or "were your clothes on or off?" Of course, these are forced-choice questions, and we know, based on both research about forced-choice questions generally and research on young children's responses to clothing specifically, that children will simply choose one of the options. They will do so regardless of whether they know the answer or not, and even worse, when they know that both answers are wrong. That is, clothes are often neither totally on nor totally off, but intermediate, and yet if one asks "were your clothes on or off?" young children are inclined to choose one or the other (Wylie et al., in press; Stolzenberg et al., 2017a). For example, imagine that the child's clothes were pulled down to her knees. Both "on" and "off" are misleading responses.

We have shown that a simple wh- question, "where were your clothes?" is more likely to elicit an intermediate response than yes/no questions or forced-choice questions, both in the lab (Wylie et al., in press; Stolzenberg et al., 2017a) and in the courts (Stolzenberg & Lyon, 2017). This illustrates the advantages of many wh- questions. If the interviewer has done a good job of eliciting a narrative, and asked "what happened next" and "tell me more about [detail]" questions, they might elicit a spontaneous description of the clothes being removed or displaced. But if the child doesn't spontaneously mention whether something happened to their clothes, the "where" question is a useful supplement and avoids the difficulties with recognition questions.

Some practitioners have argued that the risks of forced-choice questions are reduced by asking an open-choice or something-else question: "were your clothes on or off or something else?" Unfortunately, these questions were advocated (and appear to have been widely adopted) without a research base. Had practitioners sought the advice of researchers, they would have been warned that children's tendency to guess in response to forced-choice questions might lead them to simply choose one of the options when given an open-choice question, including simply

answering "something else." More speculatively, researchers would worry that children would choose "on" or "off" regardless of the "something else" option, because their tendency to guess would lead them to choose the option that seemed closest to the right answer. The fact that the questions appeared effective in the field would be treated with caution, because without knowing what actually occurred, one could not determine whether children's answers were accurate.

There is now research support for these worries: Studying 3- to 6-year-old children, we have found in two studies that when clothing is neither on nor off, open-choice questions are less likely than wh-questions to elicit intermediate responses, and they are quite likely to elicit unelaborated choices, including unelaborated "on" and "off" responses (Wylie et al., in press; Stolzenberg et al., 2017a). Unfortunately, there is only one other study on open-choice questions, and it is also critical of their use (London et al., 2017). Further research is needed to determine what to make of the children who respond "something else." Can they elaborate on their response? Wouldn't one need to follow-up their response with a "where" question, and if so, isn't it therefore better to simply start with the "where" question?

Even the "where" question leaves room for improvement. Children are more likely to describe intermediate placement with "where" questions, but nowhere near 100% (also known as "ceiling") performance. Furthermore, in our latest study, 3- to 6-year-olds appeared to sometimes respond "on" to "where" questions about intermediate placement because of their reticence; they were providing elliptical versions of "on the legs" or "on the arms" (Wylie et al., in press). We have also identified problems in the field. In our forensic interviews, we find that children are sometimes confused by the question, probably because we failed to specify that we wanted to know where the clothes were when the touching occurred. We suspect that "what happened to your/his clothes" may be an even better question, and this is worthy of future work.

Children's Emotional and Physical Reactions to Abuse

Another important topic is how to elicit information about children's subjective reactions to abuse. Children tend to exhibit little affect when disclosing and describing abuse, which can undermine their credibility (Castelli & Goodman, 2014). On the one hand, they often fail to spontaneously describe their emotional and physical reactions to abuse if predominantly asked "what happened" questions (Katz et al., 2016). On the other hand, we have shown that they are quite articulate if asked "how did you feel" questions (Lyon et al., 2012; Stolzenberg et al., in press), and that they can elaborate if brief responses to feelings questions (e.g., "sad") are followed up with questions like, "You said 'sad.' Tell me more about that" (Stolzenberg et al., in press). As noted above, Utah has added wh- feelings questions to its protocol (Stewart & La Rooy, 2020), and the questions are recommended by others as well (APSAC, 2012).

When children fail to respond to "how did it feel" questions, some groups recommend following up with an open-choice question, such as "did it hurt, or tickle, or something else?" (Stauffer, 2020). This raises the same issues with open-choice questions with respect to clothing placement. Of course, if a child answers "something else" and then elaborates, there is less reason to worry. But if the child chooses one of the words and either cannot elaborate on their response or is not asked to do so, then one has to seriously consider whether the child's response was a guess. Furthermore, the child's subsequent use of the chosen word may now appear to be the product of suggestion.

By moving to the open-choice question, we are crossing a line from recall to recognition, from asking the child to generate a response to allowing the child to merely choose a response. On the one hand, we may be capturing true feelings that children are too inarticulate or reluctant to express, but on the other hand, we might be adding false details to the child's report. These tradeoffs come closer to implicating the balance between sensitivity and specificity that Everson and Rodriquez (2020) describe, and reasonable minds may disagree about where the line should be drawn. But no matter one's values, we would emphasize how children's true reports may *appear* tainted, and in some cases actually be tainted by their acceptance of terms offered by interviewers. In other words, even if one focuses one's efforts on

maximizing the ability to detect abuse when it occurs, there are drawbacks in moving to open-choice questions when wh- questions fail to elicit information. We believe that continued field and experimental work can uncover interviewing methods that do not force difficult tradeoffs.

The Future for Wh- Questions

A general theme of much of our ongoing work is the potential for wh- questions to elicit information that invitations often overlook and recognition questions misstate. Many promising wh- questions appear suppositional and are therefore avoided by interviewers, but presuppose information that is easily rejected by children. For example, in our forensic interviews, we routinely ask children who have narrated abuse, but failed to report conversations, what the perpetrator and the child said during the abuse. Importantly, the question does not suggest any specific content. One can still object that the question presupposes that *something* was said, but children have no difficulty in responding "nothing." The questions often elicit useful information evincing seduction, threats, sexual intent, and inducements to secrecy.

We suspect that some screening questions may also be phrased as wh- questions rather than recognition questions, which can help to reduce the likelihood that children will simply answer yes/no screening questions about maltreatment (such as "do people get in trouble in your house?"; Farrell & Vieth, 2020) with a curt "no" response. For example, the question "what does your [caretaker] do when they get mad at you?" presupposes, but only the unexceptional fact that the caretaker has gotten angry at the child. Similarly, "what does your [caretaker 1] do when they get mad at [caretaker 2]?" seems similarly innocent. Following up with "what is the worst thing that they have done?" enables the interviewer to determine if the behavior is sufficiently serious to elicit concern. These questions are worthy of further study.

There are situations in which interviewers feel compelled to ask yes/no questions, and Lamb and his colleagues (2018) recommend "pairing," in which one follows up "yes" responses to yes/no questions with invitations (such as "tell me about that"). There is surprisingly little research examining the efficacy of this approach. We examined pairing in a broken toy study in which the interviewer asked a series of yes/no questions about specific toys being broken (Stolzenberg et al., 2017b) and found that false yes responses were distinguishable from true yes responses because false yes responders were unable to elaborate when asked to say more. This suggests that the risks of false positives with yes/no questions is reduced by pairing. However, a large percentage of children (who had broken toys) simply said "no" to the yes/no questions, highlighting the way in which yes/no questions elicit false negatives. (Stolzenberg et al., 2017b). Future field studies should examine interviewers' adherence to recommendations for pairing, children's ability to elaborate on their "yes" responses, and whether children's "no" responses might be attributable to reluctance, based on subsequent disclosures.

We are hesitant to endorse the suggestion that interviewers follow up "no" responses with "tell me more" questions (Kenniston, 2020), because this may risk children feeling excessively pressured to produce content. It is reminiscent of Poole and Lindsay's (2001) study in which parents read children stories suggesting details about a visit to a science lab. When they asked yes/no questions about whether children experienced events, and asked for further details even when receiving "no" responses, they found that "children frequently denied a non-experienced event but then described it after prompting, basing their narratives on the recent suggestions from their parents" (Poole & Lindsay, Supplemental Report, 2001, p. 3).

Conclusion

Practitioners and researchers of all stripes can endorse interviewing techniques that increase productivity at the same time that they reduce error. The beauty of techniques such as narrative practice, the "tell me why" allegation questions, and invitations is that they maximize children's ability to disclose in their own words with only minimal prompting from the interviewer. It is likely that future improvements in interviewing will further enhance children's abilities to recall their experiences freely. At the same time, some details are resistant to "what happened next?" and "tell me more." Open-ended wh- questions provide a means by which interviewers can take careful steps toward being more specific without being suggestive. Moving

toward recognition often seems necessary, but it risks increasing error. The major challenge for the field is to identify questions that maintain our commitment to protect children without doing harm.

About the Authors

***Thomas D. Lyon, JD, PhD**, is the Judge Edward J. and Ruey L. Guirado Chair in Law and Psychology at the University of Southern California Gould School of Law. His work has focused on maximizing children's productivity as witnesses while minimizing error. He is the Past-President of the American Psychological Association's Section on Child Maltreatment and a former member of the Board of Directors of the American Professional Society on the Abuse of Children. His work has been supported by the National Institutes of Health, the National Science Foundation, and the U.S. Department of Justice. Correspondence Contact: University of Southern California Gould School of Law, 699 Exposition Blvd, Los Angeles, CA, 90089. Contact: tlyon@law.usc.edu*

***Hayden M. Henderson, PhD**, works as a postdoctoral research associate with Professor Thomas Lyon at the University of Southern California Gould School of Law. Her research similarly focuses on improving the treatment of children in legal contexts in attempts to increase productivity and credibility while decreasing error and reluctance. She completed her dissertation at the University of Cambridge under Professor Michael Lamb, where she examined special measures intended to improve the cross-examinations of child sexual abuse victims in criminal trials.*

References

Increasing True Reports Without Increasing False Reports: Best Practice Interviewing Methods and Open-Ended Wh- Questions

American Professional Society on the Abuse of Children (APSAC). (2020). Special issue on forensic interviewing. *APSAC Advisor, 32*(2). https://www.apsac.org/guidelines.

American Professional Society on the Abuse of Children (APSAC) Taskforce. (2012). *Practice guidelines: Forensic interviewing in cases of suspected child abuse*. Author. https://www.apsac.org/guidelines.

Ahern, E. C., Andrews, S. J., Stolzenberg, S. N., & Lyon, T. D. (2018). The productivity of wh-prompts in child forensic interviews. *Journal of Interpersonal Violence, 33*(13), 2007–2015. https://doi.org/10.1177/0886260515621084

Blasbalg, U., Hershkowitz, I., Lamb, M. E., & Karni-Visel, Y. (in press). Adherence to the revised NICHD protocol recommendations for conducting repeated supportive interviews is associated with the likelihood that children will allege abuse. *Psychology, Public Policy, & Law*. https://doi.org/10.1037/law0000295

Brown, D. A., Lamb, M. E., Lewis, C., Pipe, M., Orbach, Y., & Wolfman, M. (2013). The NICHD investigative interview protocol: An analogue study. *Journal of Experimental Psychology: Applied, 19*(4), 367–382. http://dx.doi.org/10.1037/a0035143

Castelli, P., & Goodman, G. S. (2014). Children's perceived emotional behavior at disclosure and prosecutors' evaluations. *Child Abuse & Neglect, 38*(9), 1521–1532. https://doi.org/10.1016/j.chiabu.2014.02.010.

Evans, A. D., Stolzenberg, S. N., & Lyon, T. D. (2017). Pragmatic failure and referential ambiguity when attorneys ask child witnesses "do you know/remember" questions. *Psychology, Public Policy, & Law, 23*(2), 191–199. https://doi.org/10.1037/law0000116

Everson, M., & Rodriguez, S. (2020). Why forensic balance should be recognized as a foundational best practice standard: A commentary on the state of child forensic interviewing. *APSAC Advisor, 32*(2), 92–99.

Everson, M., Snider, S., Rodriguez, S., & Ragsdale, C. (2020). Why RADAR? Why now? An overview of RADAR child interview models. *APSAC Advisor, 32*(2), 36–47.

Faller, K. (2020). Forensic interview protocols: An update on the major forensic science interview structures. *APSAC Advisor, 32*(2), 4–8.

Farrell, R., & Vieth, V. (2020). ChildFirst Forensic Interview Training Program. *APSAC Advisor*, 32(2), 56–63.

Fritzley V. H., & Lee K. (2003). Do young children always say yes to yes-no questions? A metadevelopmental study of the affirmation bias. *Child Development, 74*(5), 1297–1313. https://doi.org/10.1111/1467-8624.00608

Hershkowitz, I. (2009). Socioemotional factors in child sexual abuse investigations. *Child Maltreatment, 14*(2), 172–181. https://doi.org/10.1177/1077559508326224

Henderson, H. M., Russo, N., & Lyon, T. D. (2020). Forensic interviewers' difficulty with invitations: Faux invitations and negative recasting. *Child Maltreatment, 25*(3), 363–372. https://doi.org/10.1177/1077559519895593

Hershkowitz, I., Orbach, Y., Lamb, M. E., Sternberg, K. J., & Horowitz, D. (2006). Dynamics of forensic interviews with suspected abuse victims who do not disclose abuse. *Child Abuse & Neglect, 30*(7), 753–769. https://doi.org/10.1016/j.chiabu.2005.10.016

Horgan, D. (1978). How to answer questions when you've got nothing to say. *Journal of Child Language, 5*(1), 159–165. https://doi.org/10.1017/S0305000900002014

Katz, C., Paddon, M. J., & Barnetz, Z. (2016). Emotional language used by victims of alleged sexual abuse during forensic investigation. *Journal of Child Sexual Abuse, 25*(3), 243–261. https://doi.org/10.1080/10538712.2016.1137666

Kenniston, J. (2020). The evolution of the Childhood Trust Child Forensic Interview Training. *APSAC Advisor, 32*(2), 48–55.

Lamb, M. E., Brown, D. A., Hershkowitz, I., Orbach, Y., & Esplin, P. W. (2018). *Tell me what happened* (2nd edition). Wiley.

London, K., Hall, A. K., & Lytle, N. E. (2017). Does it help, hurt, or something else? The effect of a something else response alternative on children's performance on forced-choice questions. *Psychology, Public Policy, & Law, 23*(3), 281–289. http://dx.doi.org/10.103 7/law0000129

Lyon, T. D. (2014). Interviewing children. *Annual Review of Law & Social Science, 10*, 73–89. https://doi.org/10.1146/annurev-lawsocsci-110413-030913

Lyon, T. D., McWilliams, K., & Williams, S. (2019). Child witnesses. In N. Brewer & A. B. Douglass (Eds.), *Psychological science and the law* (pp. 157–181). Guilford.

Lyon, T. D., Scurich, N., Choi, K., Handmaker, S., & Blank, R. (2012). "How did you feel?": Increasing child sexual abuse witnesses' production of evaluative information. *Law and Human Behavior, 36*(5), 448–457. http://dx.doi.org/10.1037/h0093986

Lyon, T. D., Wandrey, L., Ahern, E., Licht, R., Sim, M. P., & Quas, J. A. (2014). Eliciting maltreated and nonmaltreated children's transgression disclosures: Narrative practice rapport building and a putative confession. *Child Development, 85*(4), 1756–1769. http://doi.org/10.1111/cdev.12223

Lyon, T. D., Williams, S., &Stolzenberg, S. N. (in press). Understanding expert testimony on child sexual abuse denial after New Jersey v. J.L.G.: Ground truth, disclosure suspicion bias, and disclosure substantiation bias. *Behavioral Sciences & the Law*. https://doi.org/10.1002/bsl.2490

Newlin, C., Steele, L. C., Chamberlin, A., Anderson, J., Kenniston, J., Russell, A., & Vaughan-Eden, V. (2015). *Child forensic interviewing: Best practices*. U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention (OJJDP).

Peterson, C., Dowden, C., & Tobin, J. (1999). Interviewing preschoolers: Comparisons of yes/no and wh-questions. *Law & Human Behavior, 23*(5), 539–555. https://doi.org/10.1023/A:1022396112719

Pipe, M. E., Orbach, Y., Lamb, M. E., Abbott, C. B., & Stewart, H. (2013). Do case outcomes change when investigative interviewing practices change? *Psychology, Public Policy, and Law, 19*(2), 179–190. https://doi.org/10.1037/a0030312

References, cont.

Poole, D. A., & Lindsay, D. S. (2001). Children's eyewitness reports after exposure to misinformation from parents. *Journal of Experimental Psychology: Applied, 7*(1), 27–50. https://doi.org/10.1037/1076-898X.7.1.27

Rocha, E. M., Marche, T. A., & Briere, J. L. (2013). The effect of forced-choice questions on children's suggestibility: A comparison of multiple-choice and yes/no questions. *Canadian Journal of Behavioral Science, 45*(1), 1–11. https://doi.org/10.1037/a0028507

Roberts, K. P., Lamb, M. E., & Sternberg, K. J. (2004). The effects of rapport-building style on children's reports of a staged event. *Applied Cognitive Psychology, 18*(2), 189–202. https://doi.org/10.1002/acp.957

Sandhofer, C. M., & Smith, L. B. (1999). Learning color words involves learning a system of mappings. *Developmental Psychology, 35*(3), 668–679. https://doi.org/10.1037/0012-1649.35.3.668

Shatz, M., Tare, M., Nguyen, S. P., & Young, T. (2010). Acquiring non-object terms: The case for time words. *Journal of Cognition and Development, 11*(1), 16–36. https://doi.org/10.1080/15248370903453568

Stauffer, J. (2020). A look inside the CornerHouse Forensic Interview Protocol. *APSAC Advisor, 32*(2), 19–29.

Steele, L. C. (2020). Interviewing preschool children. *APSAC Advisor, 32*(2), 64–71.

Sternberg, K. J., Lamb, M. E., Hershkowitz, I., Yudilevitch, L., Orbach, Y., Esplin, P. W., & Hovay, M. (1997). Effects of introductory style on children's abilities to describe experiences of sexual abuse. *Child Abuse & Neglect, 21*(11), 1133–1146. https://doi.org/10.1016/S0145-2134(97) 00071-9

Stewart, H., & La Rooy, D. (2020). NICHD: Where we've been and where we are now. *APSAC Advisor, 32*(2), 30–35.

Stolzenberg, S. N., & Lyon, T. D. (2017). "Where were your clothes?" Eliciting descriptions of clothing placement from children alleging sexual abuse in criminal trials and forensic interviews. *Legal and Criminological Psychology, 22*(2), 197-–212. https://doi.org/10.1111/lcrp.12094

Stolzenberg, S. N., McWilliams, K., & Lyon, T. D. (2017a). Spatial language, question type, and young children's ability to describe clothing: Legal and developmental implications. *Law and Human Behavior, 41*(4), 398–409. https://doi.org/10.1037/lhb0000237

Stolzenberg, S. N, McWilliams, K., & Lyon, T. D. (2017b). The effects of the hypothetical putative confession and negatively-valenced yes/no questions on maltreated and non-maltreated children's disclosure of a minor transgression. *Child Maltreatment, 22*(2), 167–173. https://doi.org/10.1177/1077559516673734

Stolzenberg, S. N., Williams, S., McWilliams, K., Liang, C., & Lyon, T. D. (in press). The utility of direct questions in eliciting subjective content from children disclosing sexual abuse. *Child Abuse & Neglect.* https://doi.org/10.1016/j.chiabu.2019.02.014

Sumner, E., DeAngelis, E., Hyatt, M., Goodman, N., & Kidd, C. (2019). Cake or broccoli? Recency biases children's verbal responses. *PLoS ONE, 14*(6), p. e0217207. https://doi.org/10.1371/journal.pone.0217207

Talwar, V., & Crossman, A. M. (2012). Children's lies and their detection: Implications for child witness testimony. *Developmental Review, 32*(4), 337–359. https://doi.org/10.1016/j.dr.2012.06.004

Toth, P. (2020). APSAC's approach to child forensic interviews: Learning to listen. *APSAC Advisor, 32*(2), 9–18.

Waterman, A. H., Blades, M., & Spencer, C. P. (2000). Do children try to answer nonsensical questions? British *Journal of Developmental Psychology, 18*(2), 211–225. https://doi.org/10.1348/026151000165652

Wylie, B., Stolzenberg, S. N., McWiliams, K., Evans, A. D., & Lyon, T. D. (in press). Young children's ability to describe intermediate clothing placement. *Child Maltreatment*. https://doi.org/10.1177/1077559520930825

Wynn, K. (1992). Children's acquisition of the number words and the counting system. *Cognitive Psychology, 24*(2), 220–251. https://doi.org/10.1016/0010-0285(92)90008-P

Do Ethical Standards Apply to Forensic Interviewers?

Mark D. Everson, PhD

Prevailing practice in cases of alleged sexual abuse is to conduct a single forensic interview of the child before coming to a decision about the likelihood of abuse. This was Kathleen Faller's observation in her 2007 comprehensive review of forensic interviewing and a similar observation would likely be accurate today (Faller, 2007; 2015). Nevertheless, there continues to be substantial debate in our field about whether a single-session interview format should be considered best practice (Everson & Rodriguez, 2020).

In a recent *APSAC Advisor* article, Scott Rodriguez and I argue that a single-session interview conducted by an adult stranger openly disregards what is known about the disclosure process (Everson & Rodriguez, 2020). The disclosure process, especially in cases of child sexual abuse, is often "painful, incremental, and protracted" (Faller, 2020, p. 133). An hour interview may not provide sufficient time to develop rapport with children mistrustful from their abuse or to identify and overcome even common barriers to telling. We also questioned the validity of various rationales used to defend the single-session interview as best practice, including the claim that more than one session, even by the same interviewer, is inherently traumatizing to many child victims.

The present commentary extends the debate on the use of single-session interviews in two ways. First, it makes a critical distinction between two single-session interview formats: the single-session-*only* format and the single-session-*optional* format. In the single-session-only format, the interviewer is limited by multidisciplinary team (MDT) agreement, center policy or judicial constraints, to one interview session regardless of child and case characteristics. In the single-session-optional format (i.e., variable-session format), the interviewer has the flexibility, based on the child's best interests, to conduct one session or more than one session as needed.

Second, this commentary extends the debate by challenging the single-session-only format (but not the single-session-optional format) on ethical grounds. We will argue that the strict single-session-only format breaches ethical standards and should not be considered accepted practice. The ethical analysis that follows is organized around these five questions:

1. Do ethical standards apply to forensic interviewers?
2. If so, what specific ethical standards are most relevant?
3. Does the single-session-only interview format meet ethical standards?
4. If not, how does the use of a single-session-only format adversely affect abuse victims?
5. What interview format do the major forensic interview training models promote?

We will address each question before discussing implications for forensic interview practice.

Response to Question 1: Ethical standards do apply to forensic interviewers.

The *APSAC Code of Ethics* (1997) outlines major ethical principles and standards of conduct for professionals in the field of child maltreatment. The *APSAC Practice Guidelines: Investigative Interviewing in Cases of Suspected Abuse* (APSAC Taskforce, 2012) specifically recognizes the *Code of Ethics* as a primary standard for defining acceptable practice in forensic interviewing. Toth (2020) also emphasizes the importance of the *APSAC Code of Ethics* in setting standards of conduct for forensic interviewers.

While the *APSAC Code of Ethics* technically applies only to APSAC members, the APSAC ethics code can serve at least three crucial functions for all child maltreatment professionals, regardless of APSAC membership. First, the ethics code offers guidance in defining appropriate standards of professional conduct. Second, the ethics code provides support for professionals attempting to maintain high ethical standards in their professional practice. Third, the ethics code provides standards of conduct for appraising professional practice for either instructional or corrective purposes.

Response to Question 2: Good ethics require prioritizing the child's best interests throughout the interview process.

The *APSAC Code of Ethics* requires that forensic interviewers conduct interviews "… in a manner consistent with the best interests of the child" (APSAC, 1997, p. 1). The forensic interviewer is expected to hold the "best interests" principle above all other competing considerations. Prioritizing the child's best interests typically requires individual accommodations to interview practice based on child and case characteristics. It is important to note that the *Code of Ethics* leaves no room for misunderstanding. The best interests of the child (i.e., the child in front of us) supersedes the principle of the greater good (i.e., more children can be served with our limited resources if we are willing to make a few compromises). The child's welfare rules.

Response to Question 3: Single-session-only interviews fail to meet "the best interests" standard of conduct.

The "best interests" ethical standard requires that the interviewer individualize the interview to accommodate child and case characteristics that might inhibit disclosure or adversely affect the completeness or accuracy of the child's account. Such accommodations often require one or more follow-up sessions, typically by the same interviewer to build upon initial rapport. Sometimes additional sessions are also needed to clarify inconsistencies in the child's account or explore case complexities.

A comprehensive list of factors that should trigger consideration of follow-up sessions is offered. The list represents a compilation of child and case criteria from a number of published sources as well as from the author's 35-year career in forensic assessment. (The published sources include Carnes et al., 2001; Faller, 2007; Hershkowitz et al., 2006; Newlin et al., 2015; Paine & Hansen, 2002.) One or more follow-up sessions may be warranted, and in the best interests of the child, if *any* of the following criteria are met:

- Young chronological or developmental age
- Language or cultural issues that impede communication
- Significant symptoms of psychological trauma (e.g., dissociation)
- Major rapport, attention, or separation problems
- Significant anxiety, fear, or distress observed in interview or reported by caregivers
- Significant barriers to disclosure reported or suspected (e.g., perpetrator is a close family member).
- Concerns about external influences on child (e.g., coaching, threats, perpetrator with access)
- Non-disclosure despite credible prior disclosure or other substantive evidence of abuse
- Child's account vague, incomplete, inconsistent, or contradictory
- Significant discrepancies in child's current

account vs. prior account or other substantive evidence
- Complex case history (e.g., poly-victimization, counter-accusations in a custody dispute)
- Additional perpetrator(s) or multiple events likely.

Note that these 12 criteria represent child and case characteristics that reduce the likelihood that the maltreatment concern can be resolved in a single interview session. Attempting to do so risks substantial error and is therefore contrary to the child's welfare. Several of these problematic child and case characteristics can be identified or anticipated prior to the initial session. Others become evident only during the session itself. It is thus not possible to predict ahead of time which child will need multiple sessions. Ideally, every interviewer should have the training and scheduling flexibility to conduct follow-up sessions as needed.

It is useful to expand our typology of interview formats to include four distinctive types of interviews: single-session-only formats, variable-session formats (i.e., single-session-optional formats), multiple-session formats, and extended session formats. A single-session-only interview is defined as one in which the interviewer has no option or intention to conduct a follow-up interview or to refer the child for extended interviewing. A variable-session interview is one in which the interviewer has the option, as needed, to conduct one or more follow-up sessions or to refer the child for extended interviewing. A multiple-session interview is one in which the interviewer plans to conduct more than one interview session regardless of the outcome of the initial session. An extended session interview, defined as four or more interview sessions, is typically reserved for cases in which the initial interview session(s) failed to resolve the abuse concerns.

By this categorization, the single-session-only interview breaches the best interest standard because the decision to conduct only one session is made irrespective of the child's needs or best interests. In contrast, single-session interviews within the context of the variable-session interview format are ethical, as long the decision to forgo additional sessions was based on "best interests" considerations. Regardless of their prior status as best practice, therefore, single-session-only interview formats are inherently unethical and should no longer be considered accepted practice.

Response to Question 4: Single-session-only interviews significantly increase the risk that true cases of abuse will be missed or mistakenly unsubstantiated.

The child's account is often the central evidence in the decision whether to substantiate the abuse allegation. In the last section, we discussed the observation that a single interview session may shortchange the MDT in the critical information needed for case determinations. In this section, we will examine research suggesting that the single-session-only format results in a high rate of false denials of abuse among abuse victims. Such denials typically mean true cases go unsubstantiated and children are left to fend for themselves against their abusers.

Two publications are directly relevant. In the first, Lyon (2007) reviewed 16 studies of children age 3 or above who were identified as CSA victims from medical diagnoses of gonorrhea. Among 437 children across the 16 studies, only 185 or 42% disclosed sexual contact in the initial forensic interview. The false denial rate in one-session interviews was therefore 58%. This error rate fell substantially when additional interview sessions were conducted, presumably at least in part due to better rapport (Lyon, 2007).

Hershkowitz et al. (2014) compared the disclosure rates in the standard National Institute of Child Health and Human Development (NICHD) interview and the Revised-NICHD protocol in single-session formats. The sample included 426 Israeli children, ages 4–13, for whom there was substantial independent corroborative evidence of either physical or sexual abuse. The standard NICHD protocol was used in interviewing 165 of the children and 261 were interviewed using the revised protocol. As expected, the revised protocol, which included more emphasis on rapport building than did the standard protocol, elicited a significantly higher disclosure rate (59.3% vs. 50.3%). However, the most noteworthy findings are the false denial rates of 40.7% and 49.7%, respectively, for the revised and standard NICHD protocols.

The high rates of false denials in the Lyon and Hershkowitz et al. studies are alarming. The two studies are consistent in suggesting that among true cases of sexual and physical abuse, up to 50% of the child victims may need more than one forensic interview session to disclose. This is especially likely to be true when there is no prior disclosure. False denials in such cases typically result in non-substantiation, with the risk of unfortunate outcomes for children including further abuse.

In brief, bad ethics = bad practice = bad outcomes for abuse victims.

Response to Question 5: The major interview training models generally endorse the variable-session format over the single-session-only format.

The recent *APSAC Advisor* (2020) contained articles describing seven prominent forensic interview training models, some but not all affiliated with a specific protocol such as Revised-NICHD and ChildFirst. The specific training models included the following: the APSAC Forensic Interview Training Model (Toth, 2020); the ChildFirst Forensic Interview Model (Farrell & Vieth, 2020); the Childhood Trust Forensic Interview Model (Kenniston, 2020); the CornerHouse Forensic Interview Protocol (Stauffer, 2020); the National Children's Advocacy Center (NCAC) Preschool Interview Training Model (Cordesco Steele, 2020); the Revised-NICHD Forensic Interview Protocol (Stewart & LaRooy, 2020); and the RADAR (Recognizing Abuse Disclosures and Responding) Child Interview Models (Everson et al., 2020). The authors also responded to an email survey requesting additional information on instructional topics for this commentary.

Table 1 provides a summary of instructional topics taught by the seven training models related to the use of follow-up sessions. Two findings are especially pertinent. First, all seven training models teach in their basic five-day interview class that at least some children need more than one interview. They all agree therefore in principle that a strict single-session-only format is no longer accepted practice. Second, our field has begun the transition from the single-session-only format to a more flexible variable-session format, but progress is slow. Several training models do not provide instruction during basic training on how to transition to or conduct follow-up sessions. Instead, they defer to a later advanced class for such instruction. Three training models do offer at least minimal instruction on follow-up interviews. This instruction varies from brief guidelines about stretching the single-session model across additional sessions (NCAC, Linda Cordisco Steele, personal communication, November 18, 2020) to almost a full half-day spent on selection criteria, transition strategies, outlines of different follow-up sessions, and role play practices (RADAR, Everson et al., 2020).

To summarize, the training models in Table 1 rightly recognize that all interviewers should be informed that a significant subset of children need more than one interview session to get at the truth in an allegation of abuse. However, most training models defer significant instruction on follow-up interviews to advanced courses at a later date and at additional cost. Thus, most forensic interview trainees graduate from basic training ill-prepared and ill-equipped to conduct ethical forensic interviews when child or case characteristics require more than one session. Unfortunately, most trainees will be immediately deployed to conduct frontline interviews.

Final Thoughts on Ethical Practice Among Forensic Interviewers

Whether one views the task before us as a challenge well within reach or as an objective that is unrealistic and unattainable, we have little choice but to proceed. We as a field must replace the one-session-only interview with a variable-session or multiple-session interview for all children and provide the time and resources for basic interviewer training on conducting multiple sessions.

The obstacles in replacing interview formats include funding for additional interview personnel, demands for the use of limited facilities and equipment, availability of MDT members to observe more than one session, and logistical constraints, including the travel demands on caregivers. Prosecutor resistance

Table 1. Instructional Topics on Follow-up Sessions in Basic and Advanced Interview.

Instructional Topics	APSAC	ChildFirst	Childhood Trust	Corner House	NCAC	NICHD	RADAR
Follow-up session sometimes needed	B NA	B A	B A	B A	B A	B A	B A
Criteria for follow-up sessions provided	B NA	B A	B A	B A	~~B~~ ~~A~~	B A	B A
How to transition to follow-up	~~B~~ NA	~~B~~ A	~~B~~ A	~~B~~ A	B A	~~B~~ A	B A
How to conduct follow-up session	B NA	~~B~~ A	~~B~~ A	~~B~~ A	B A	~~B~~ A	B A

B = Basic, 5-day interview class **A** = Advanced interview class NA = No advanced class ~~**A**~~ **or** ~~**B**~~ = No instruction at that level

to more than one interview session is also an issue in some jurisdictions. Many child advocacy centers and child abuse programs have already made the shift away from strict one-session formats so there is likely much we can learn from them. Some interview approaches that have been found effective include the use of hourly, contract interviewers to supplement staff interviewers, the scheduling of initial interviews in the morning with follow-up sessions, if needed, scheduled later in the day, and the use of virtual technology to allow remote viewing of live interviews by MDT members.

Limited training options are another obstacle to good ethical practice. The five-day, basic training schedule is already full before adding a single additional word about follow-up sessions. We may have to rethink what is required in the basic training curriculum. We must also establish cost-effective approaches for providing "advanced" training on the variable-session format to current interviewers who have only conducted single-session interviews.

Perhaps the greatest uncertainty going forward involves the question of leadership. Who is going to lead this reformation in forensic interview practice? Specifically, is this going to be a top-down or bottom-up effort? The leadership of our field has long been aware of the serious limitations inherent in the single-session-only format (e.g., Elliot & Briere, 1994). However, our leadership (including protocol developers and training directors) has generally chosen to proceed slowly in addressing the problem. If our current leadership does not fully commit to the needed reforms, frontline interviewers may have to step up to take the lead. Ultimately, forensic interviewers may have to choose between aggressively advocating for comprehensive training and more child-centered forensic practice, or continuing to violate professional ethics to the detriment of a significant subset of the children they serve.

About the Author

***Mark D. Everson, PhD**, is Professor in the Department of Psychiatry, University of North Carolina at Chapel Hill. He has been involved in research, clinical work, teaching, and training in child sexual abuse, child forensic interviewing, and forensic assessment since the early-1980s. He has authored over 50 peer review articles and publications. Dr. Everson has been a member of the American Professional Society on the Abuse of Children since the late 1980s and has served on the APSAC Board of Directors (1991–1993) and the APSAC National Advisory Board (1994–1998). He also served as associate editor of the* APSAC Advisor *(1989–1993) and was awarded the APSAC Career Research Award in 2003. Since 2009, he has served as the lead developer and senior author of the RADAR Child Forensic Interview Models. Contact: meverson001@gmail.com*

References

Do Ethical Standards Apply to Forensic Interviewers?

American Professional Society on the Abuse of Children (APSAC). (1997). *APSAC Code of Ethics*. https://www.apsac.org/apsacpublications

American Professional Society on the Abuse of Children (APSAC). (2020). Special issue on forensic interviewing. *APSAC Advisor, 32*(2). https://www.apsac.org/

American Professional Society on the Abuse of Children (APSAC) Task Force. (2012). *APSAC Practice Guidelines: Investigative interviewing in cases of suspected abuse*. Author. https://www.apsac.org/guidelines

Carnes, C., Nelson-Gardell, D., Wilson, C., & Orgassa, U. (2001). Extended forensic evaluations when sexual abuse is suspected: Multisite study. *Child Maltreatment, 6*(3), 230–242. https://doi.org/10.1177/1077559501006003004

Cordisco Steele, L. (2020). Interviewing preschool children. *APSAC Advisor, 32*(2), 64–71. https://www.apsac.org/

Elliot, D., & Briere, J. (1994). Forensic sexual abuse evaluation of older children: Disclosures and symptomatology. *Behavioral Science and the Law, 12*, 261–277. https://doi.org/10.1002/bsl.2370120306

Everson, M. D., & Rodriguez, S. M. (2020). Why forensic balance should be recognized as a foundational best practice standard. *APSAC Advisor, 32*(2), 92–99. https://www.apsac.org/

Everson, M. D., Snider, S., Rodriguez, S. M., & Ragsdale, C. T. (2020). Why RADAR, why now? An overview of RADAR child interview models. *APSAC Advisor, 32*(2), 36–47. https://www.apsac.org/

Faller, K. C. (2007). *Interviewing children about sexual abuse: Controversies and best practice*. Oxford. https://doi.org/10.1093/acprof:oso/9780195311778.001.0001

Faller, K. C. (2015). Forty years of forensic interviewing of children suspected of sexual abuse: Historical benchmarks. *Social Sciences, 4*, 34–65. https://doi.org/10.3390/socsci4010034

Faller, K. C. (2020). The cutting edge of forensic interviewing. *Journal of Child Sexual Abuse, 29*(2), 129–137. https:/doi.org/10.1080/10538712.2020.1718819

Farrell, R., & Vieth, V. (2020). ChildFirst forensic interview training program. *APSAC Advisor, 32*(2), 56–63. https://www.apsac.org/

Hershkowitz, I., Orbach, Y., Lamb, M., Sternberg, K., Pipe, M., & Horowitz, D. (2006). Dynamics of forensic interviews with suspected abuse victims who do not disclose. *Child Abuse & Neglect, 30*(7), 753–770. https://doi.org/10.1016/j.chiabu.2005.10.016

Hershkowitz, I., Lamb, M., & Katz, C. (2014). Allegation rates in forensic child abuse investigations: Comparing the Revised and Standard NICHD Protocols. *Psychology, Public Policy, and Law, 2*, 336–344. https://doi.org/10.1037/a0037391

Kenniston, J. (2020). The evolution of the Childhood Trust forensic interview training. *APSAC Advisor, 32*(2), 48–55. https://www.apsac.org/

Lyon, T. D. (2007). False denials: Overcoming methodological biases in abuse disclosure research. In M. E. Pipe, M. Lamb, Y. Orbach, & A. Cederborg (Eds.), *Disclosing abuse: Delays, retractions, and incomplete accounts* (pp. 41–62). Erlbaum.

Newlin, C., Cordisco Steele, L., Chamberlin, A., Anderson, J., Kenniston, J., Russell, A., Stewart, H., & Vaughn-Eden, V. (2015, September). *Child forensic interviewing: Best practices*. OJJDP Juvenile Justice Bulletin, 1–17.

Paine, M. L., & Hansen, D. (2002). Factors influencing children to self-disclose sexual abuse. *Clinical Psychology Review, 22*, 271–295. https://doi.org/10.1016/S0272-7358(01)00091-5

Stauffer, J. (2020). A look inside the CornerHouse forensic interview protocol. *APSAC Advisor, 32*(2), 19–29. https://www.apsac.org/

Stewart, H., & La Rooy, D. (2020). NICHD: Where we've been and where we are now. *APSAC Advisor, 32*(2), 30–35. https://www.apsac.org/

Toth, P. (2020). APSAC's approach to child forensic interviews: Learning to listen. *APSAC Advisor, 32*(2), 9–18. https://www.apsac.org/

If Odysseus Were a Child Welfare Department Director

Daniel Pollack, MSSA (MSW), JD
Francesca LeRúe, MSW, MPA

In FFY 2018, child welfare agencies received an estimated 4.3 million referrals alleging abuse and neglect, representing approximately 7.8 million children (U.S. Department of Health and Human Services, 2020, ix). While unfortunate that such agencies even need to exist, the statistics compellingly stress the importance of having a courageous leader and expert to fill the child welfare director job. The duties vary depending on the organization. Typically, child welfare directors plan, organize, manage, evaluate, and direct the agency's staff. They ensure policies and procedures meet legal requirements and provide direction on budgetary, contractual, personnel, and organizational development matters. One of the most critical duties is maintaining close relations with the community to assess program needs and service delivery effectiveness. It is not a job that many people want. Indeed, in 2007, Congress was told that the average tenure of a child welfare director in the United States was between 18 months and two years (Rawlings, 2019).

Some child welfare systems are county-administered and others state-run. Either way, politics play a significant role in the life of a child welfare director. When a new child welfare director comes on board, a period of cordiality and enthusiasm generally prevails. This honeymoon period can pass quickly, and, to some extent, that is best. Most child welfare directors report to a high-level executive from whom they get their "marching orders." From day one, child welfare directors need to find out what internal and external stakeholders' agendas are and begin synthesizing information gathered. The new director needs to

- Learn what skills the management team and line staff have.
- Figure out what is working well and what needs immediate attention.
- Rapidly put a plan of action in place and begin to execute it. There is always great urgency in child welfare; children do not have the luxury of time, and every minute counts.

Many of us recall learning about the Greek mythological hero Odysseus sailing home from the Trojan War. His challenge was having to navigate through the Strait of Messina. On one side was the six-headed monster Scylla; on the other side was Charybdis, a whirlpool that sucked in ships that sailed too near her. Today's child welfare director faces a similar situation. Many child welfare systems are hobbled because they were never meant to serve as many children as they do. Also, there simply are not enough resources (Chibnall et al., 2003). In some instances, the media fuels negative attitudes toward the child welfare system, especially when there is a child fatality. Workers suffer from burnout, often resulting in high turnover. On top of these challenges, some perennially malcontented employees, and some internal or external partners, many of whom have no

expertise in child welfare or have ever worked in child welfare, are pushing their own agendas. Politics in child welfare have led to swift reactive actions to "fix" a myriad of problems. The child welfare director is continuously dealing with this between-a-rock-and-a-hard-place situation.

Working With Employees

Ask newly minted college graduates with a social work, psychology, counseling, or sociology degree what kind of a job they would like. Whatever their answer, it would not include being part of a large bureaucratic organization, feeling hindered by laws, policies, and procedures. Child welfare workers are first responders but receive little recognition or benefits for putting their lives on the line. Another reality that affects workers is that directors and managers have a responsibility to ensure that their agency meets various federal, state, and local mandates. This can interfere with spending time with the families and children on their caseload in front-line workers' eyes. There are also large workloads, secondary trauma, and compassion fatigue, which lead child welfare workers to experience burnout at elevated rates—estimated at 20%–40%—compared with the general population (Casey Family Programs, 2017).

The director needs to invest a lot of his or her time with the agency's staff. Simultaneously, the director needs to communicate a clear vision and develop a safe learning organization where coaching and mentoring allow workers to become their best. Never to be underestimated is the principle that the director needs to carefully balance advocating for the department staff while not compromising the children's interests and families the department is serving.

Dealing With Politics

In many workplaces, specific topics of conversation are strictly off-limits. Among the most prominent are religion and politics. Politics are not off-limits in a department of child welfare – certainly not in the director's office. But politics are a frequent guest that can derail efforts to address an already complex and crippled system. Long before the past two presidential elections and their intense ideological differences, child welfare directors knew they had to be adept at dealing with their job's political aspects. Lessons to master include the following:

- Paying as much attention to the personality of a speaker as to the content of their speech.
- Forthrightly educating and sharing information and ideas while being aware that—yes—the walls have ears.
- Being genuinely open to all points of view and being willing to try new approaches.
- Always communicating the "why" behind major decisions.
- Knowing that not every question requires an immediate answer. It is all right to make some decisions swiftly while legitimately putting others on the back burner.
- Always being aware of the chief executive's (county executive, mayor, governor) interests and positions.
- Regularly revisiting goals and marching orders with the boss. Course corrections should be done jointly and should be documented.
- Maintaining integrity. Siding with children and families to keep them safe, well, and thriving is always the right thing to do.

Conclusion

Child abuse and neglect are serious national public health problems. Unsurprisingly, the child welfare system dealing with these problems is often reactive rather than proactive. Changes to fix the system, including hiring a new child welfare director, are frequently incident-driven and are apt to set back advances. Most people who work in child welfare departments are selfless, kind, empathetic, patient, and persevering team players. Unfortunately, a few can make the life of a child welfare director quite challenging from a legal and liability perspective. The stakes are extremely high, and dilettante interference is unhelpful.

Child welfare directors need to actively work on preventing child maltreatment and ensuring that system-involved families and children receive timely quality services when needed. There is a lot to balance. Today, with school buildings shuttered, some homes have become a petri dish for child maltreatment. Child

welfare experts, community representatives, and those that are directly affected by child protection agencies need to drive improvements to our child welfare systems.

Homer's *Odyssey* describes Odysseus's ten-year return journey back to his home on the island of Ithaca. Looking forward over the next ten years, professional child welfare directors face a similar daunting task. The rest of us need to be available to support, assist and embrace the changes needed to improve the child welfare system.

About the Authors

***Daniel Pollack, MSSA (MSW), JD**, is a professor at the School of Social Work, Yeshiva University, New York City, and a frequent expert witness in child welfare lawsuits. Contact: dpollack@yu.edu; 212-960-0836.*

***Francesca LeRúe, MSW, MPA**, has 31 years of child welfare experience. She is a former child welfare director and a strategic consultant, trainer, and expert witness. Contact: leruestrategicconsulting@gmail.com.*

References

If Odysseus were a Child Welfare Department Director

Casey Family Programs. (2017, December 29). *How does turnover affect outcomes and what can be done to address retention?* Author. https://www.casey.org/turnover-costs-and-retention-strategies/

Chibnall, S, Dutch, N., Jones-Harden, B., Brown, A., Gourdine, R., & United States, Children's Bureau (2003). *Children of color in the child welfare system: Perspectives from the child welfare community.* https://www.childwelfare.gov/pubs/otherpubs/children/implications/

U.S. Department of Health and Human Services (USDHHS), Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau. (2020). *Child Maltreatment 2018.* https://www.acf.hhs.gov/sites/default/files/cb/cm2018.pdf

Rawlings, T. (2019, August 15). Leading child welfare systems past the worst tragedies. *The Imprint*. https://imprintnews.org/opinion/leading-child-welfare-systems-past-the-worst-tragedies/36979

Next Steps for ACEs: An Interdisciplinary Approach to Understanding, Treating, and Preventing Childhood Adversity

A Book Review of *Adverse Childhood Experiences: Using Evidence to Advance Research, Practice, Policy, and Prevention*

Catherine A. Murphy, MPPA

Citation: Asmundson, G. J. G., & Afifi, T. O. (Eds.). (2020). Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention. Elsevier, Academic Press.

Keywords: adverse childhood experiences (ACEs), childhood adversity, ACEs instrument, ACEs screening, ACEs score, prevention program interventions, prevention strategies, trauma-informed care (TIC)

Adverse childhood experiences (ACEs) have become ubiquitous within a variety of disciplines, including the public health, social work, medicine, law, and criminal justice fields. The pivotal 1998 Centers for Disease Control and Prevention (CDC) and Kaiser Permanente ACEs study (CDC-Kaiser ACEs study) highlighted the prevalence of childhood adversity and the lifelong, intergenerational effects of early exposure to toxic stress. Since then, literature on ACEs has developed significantly, yet two decades later, the field is in need of robust, cohesive strategies to reduce or prevent ACEs. The editors, Drs. Asmundson and Afifi (2020), and contributors of this book seek to close this gap by providing historical information on ACEs and childhood trauma, overviewing the current research related to ACEs impact and outcomes, discussing recent controversies and developments of ACEs instruments, and guiding next steps for policy, prevention, and continued research. Central to this book, as noted by the authors, is its relevance to diverse audiences with the shared mission to understand, treat, and prevent ACEs. Sections I and II examine ACEs through a historical context and highlight current efforts in the field. As mentioned, the CDC-Kaiser ACEs study found that child adversity is common and associated with physical, psychological, and social problems in adulthood (Dube, 2020). The adverse experiences examined in this initial study include physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, violence against a mother, parental divorce, household member with substance use/abuse issues, household member with mental illness, and incarcerated household member (Dube, 2020; Dube et al., 2003; Felitti et al., 1998, as cited in Afifi, 2020). Research indicates that childhood exposure to one or more ACEs increases the risk of physical health (e.g., cardiovascular conditions or chronic metabolic disorders) (Vig et al., 2020), mental health (e.g., depression, substance abuse) (Sheffler et al., 2020), and behavioral issues (e.g., poor coping strategies) (Ports et al., 2020; Sheffler et al., 2020; Vig et al., 2020). Moreover, children who experience ACEs are more prone to participating in risky behaviors and violence, including sexual violence, perpetration,

[1] *Toxic stress is defined as "the excessive or prolonged activation of the physiologic stress response systems in the absence of the buffering protection afforded by stable, responsive relationships" (Garner & Shonkoff, 2012).*

or victimization (Taillieu et al., 2020; Wekerle et al., 2020). The pervasiveness of ACEs and their impact on various aspects of an individual's life initiated a public health response to address this problem.

In Section III, the contributors McLennan, McTavish, and MacMillan (2020) tackle the issue of universal ACEs screenings. The ACEs instrument, developed initially for the CDC-Kaiser ACEs study, is a questionnaire, based upon other established risk-assessment surveys, that evaluates the 10 childhood adversities noted above. The results of the instrument produce a 10-point score (i.e., ACEs score) where the cumulative score range indicates varying degrees of negative health outcomes. Currently, there are numerous variations of the instrument used as screening tools for identifying childhood adversity risk factors. Universal ACEs screen advocates maintain that identifying these risk factors will raise awareness of the prevalence of childhood adversity. However, the authors note that the knowledge gained from the screens does not, in itself, improve health outcomes. Additionally, the collective objective of population-level screens (i.e., ACEs awareness vs. reducing/preventing ACEs) remains unclear, and there is limited empirical evidence assessing these instruments (McLennan et al., 2020). Therefore, the authors recommend that universal ACEs screenings should not be implemented at this time. Rather, researchers, practitioners, policymakers, and other stakeholders should focus on understanding and establishing evidence-based intervention and prevention efforts pertaining to ACEs.

As noted, the number of different tool adaptations raises methodological concerns regarding the ACEs instrument. The contributors Holden, Gower, and Chmielewski (2020) examined eight versions and found that there is limited evidence regarding reliability and validity of the instrument. Accordingly, the authors recommend improvements to the ACEs instrument by increased empirical research on psychometric data, revising the tool to capture the severity, frequency, chronicity, and distress of a participant's adverse experiences and performing a large study evaluating the utility of all the ACEs instruments (Holden et al., 2020). The goal would be to create a new evidence-based, psychometrically sound instrument to better assess childhood adversity.

Section IV discusses ACEs on a global scale as well as examines prevention programming, the importance of resilience studies, and implementation of trauma-informed care to evaluate childhood adversity. ACEs are a significant global public health concern, yet research and program implementation has occurred primarily in the United States and Canada. Although continued evaluation of ACEs programs and data collection efforts are important in these countries, it is also critical to collect quality data from various cultures, contexts, and countries (Massetti et al., 2020). This global insight can aid in targeted prevention initiatives and multi-sector collaboration to advance ACEs prevention policies worldwide.

As the ACEs field continues to expand, several frameworks and models help provide theoretical context for understanding childhood adversity. Prevention programs and policies are rooted in the prevention framework, characterized by primary (i.e., universal), secondary (i.e., targeted/at-risk), and tertiary (i.e., indicated/"after the fact") strategies. Programmatic efforts in the field are defined by the varied stages of prevention. Recently, public health officials have incorporated the World Health Organization's Social Determinants of Health framework to understand the structural, economic, and environmental factors that may influence a person's access to healthcare and susceptibility to adversity. Furthermore, the ecobiodevelopmental framework is a new approach to understanding and evaluating effective child adversity prevention. This framework is a modification of the social-ecological framework and "further builds on neuroscience, biology, genomics, and social sciences to provide a new perspective on the interaction between experience, environment, and genetic predisposition" (Brennan et al., 2020, p. 254). The ACEs field is also advancing its understanding of the neurodevelopmental impact of childhood adversity. The contributors Sheridan and McLaughlin (2020) present the dimensional model of adversity and psychopathology (DMAP).

[2] Social determinants of health are defined as "the circumstances in which people grow, live, work and age, and the systems put in place to deal with illness" (World Health Organization, 2013, as cited in Brennan, Stavas, & Scribano, 2020, p. 236).

The DMAP takes an alternative, multidimensional approach to understanding how a wide range of adverse experiences, including environmental factors, threat, and deprivation, influence developmental (i.e., cognitive, emotional, and neurobiological) processes (Sheridan & McLaughlin, 2020). In practice, these models are reflected in prevention programs. For example, home visiting prevention programs (e.g., Healthy Families America) target a particular adversity (i.e., child maltreatment) using a multifaceted approach (i.e., building the parent-child relationship). In other words, interventions tactics are not a "one size fits all" solution and require support at the individual, relational, communal, and societal levels.

In addition to the advancement of ACEs theoretical frameworks, there has also been progress in understanding the role of resilience and trauma-informed care (TIC) in the treatment and prevention of childhood adversity. Resilience is the developmental process in which children positively adapt to adversity and are able to function effectively and sometimes thrive in the world (Oshri et al., 2020). The distinction between resilience promotive factors (i.e., positive adaptation) and protective factors (i.e., reducing ACEs burden through interaction and heightening positive adaptation) is imperative to advancing this body of research (Oshri et al., 2020). Moreover, promoting resilience via prevention-based interventions may further benefit youth affected by adverse experiences. Yet, continued cross-disciplinary research is needed to understand the importance of resilience.

Furthermore, the practice of trauma-informed care is a promising method to address the long-term and severe effects of ACEs. TIC applies a holistic approach to recognizing how trauma impacts society at different levels. Importantly, one's environment and culture influence how they perceive and process traumatic events. Therefore, the interdisciplinary practice of TIC prioritizes these contexts into the development, delivery, and evaluation of services (Piotrowski, 2020). TIC provides a systematic approach to understanding the complexity of trauma and resilience, while providing cost-effective programming to minimize poor health and developmental outcomes throughout the life course (Piotrowski, 2020).

The public health approach to ACEs, thus far, has been successful in defining the problem, raising public awareness regarding the seriousness of the issue, and understanding the severe consequences of early exposure to adversity. However, work remains to advance the best clinical practices, programs, research, and policy to prevent childhood adversity. Comprehensive ACEs prevention strategies must prioritize an interdisciplinary, evidence-based, and data-driven approach to inform definitions, screenings, programmatic interventions, and public policies (Afifi & Asmundson, 2020). This book provides audiences with a thorough guide for reducing and preventing childhood adversity, supporting children and families, and breaking the intergenerational cycle of ACEs.

The knowledge gained from the CDC-Kaiser ACEs Study is profound and provides a baseline for understanding the consequences of childhood adversity. Yet, as this body of research continues to grow, the field needs to be cognizant of and focus on the impact of structural, economic, and environmental conditions that may intensify the effects of the 10 original ACEs and other adversities. The editors and contributors of this text opine that future research should look to expand the definitions of ACEs to include items such as economic hardships, generation trauma (e.g., dislocation or forced migration), exposure to community violence, and peer victimization, among others (Afifi & Asmundson, 2020; Afifi et al., 2017; Cronholm et al., 2015; Finkelhor et al., 2013, as cited in Ports et al., 2020). Moreover, current ACEs instruments use a 1-to-1 ratio, cumulative scoring method, wherein each of the 10 constructs holds the same weight despite the disproportionate frequency, severity, chronicity, and overall impact one adversity may have over another (Afifi & Asmundson, 2020; Merrick et al., 2020; Ports et al., 2020). Furthermore, historically disadvantaged groups (e.g., women, racial/ethnic minorities, or the LGBTQ+ community) may also suffer a higher prevalence of certain types of adversity or victimization (Wekerle et al., 2020). Expanding the ACEs definitions, incorporating the varying degrees of adversity, and bolstering insight of the effects of adversity on diverse populations may increase the complexity to the current understanding and

implementation of the ACEs tool. However, the benefit of integrating these items into a robust assessment is that it would increase accuracy of capturing childhood adversities and their effects on health outcomes among diverse populations (Holden et al., 2020). This understanding can help improve targeted, inclusive, and interdisciplinary prevention efforts at the individual and relational levels as well as provide evidence for broader public health initiatives (i.e., strategies and public policies) on the community and societal level to treat and prevent ACEs.

About the Author

***Catherine Murphy, MPPA**, is Research and Data Specialist at Prevent Child Abuse America. In this role she supports data and research initiatives across the organization. She has participated in research exploring child maltreatment prevention, child maltreatment and court outcomes, and state data collection policies.*

References

Next Steps for ACEs: An Interdisciplinary Approach to Understanding, Treating, and Preventing Childhood Adversity

A Book Review of *Adverse Childhood Experiences: Using Evidence to Advance Research, Practice, Policy, and Prevention*

Afifi, T. O. (2020). Considering for expanding the definition of ACEs. In G. J. G. Asmundson & T. O. Afifi (Eds.), *Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention* (pp. 35–42). Elsevier, Academic Press.

Afifi, T. O., & Asmundson, G. J. G. (2020). Current knowledge and future directions for the ACEs field. In G. J. G. Asmundson & T. O. Afifi (Eds.), *Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention* (pp. 349–355). Elsevier, Academic Press.

Afifi, T., Ford, D., Gershoff, L., Merrick, M. T., Grogan-Kaylor, A., Ports, K. A., MacMillan, H. L., Holden, G. W., Taylor, C. A., Lee, S. J., & 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.

Asmundson, G. J. G., & Afifi, T. O. (Eds.). (2020). *Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention*. Elsevier, Academic Press.

Brennan, B., Stavas, N., & Scribano, P. (2020). Effective prevention in ACEs. In G. J. G. Asmundson & T. O. Afifi (Eds.), *Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention* (pp. 233–264). Elsevier, Academic Press.

Cronholm, P. F., Forke, C. M., Wade, R., Bair-Merrit, M. H., Davis, M., Harkins-Schwarz, M., Pachter, L. M., & Fein, J. A. (2015). *Adverse childhood experiences: Expanding the concept of adversity. American Journal of Preventive Medicine*, *49*(3), 354–361.

Dube, S. R. (2020). Twenty years and counting: The past, present, and future of ACEs research. In G. J. G. Asmundson & T. O. Afifi (Eds.), *Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention* (pp. 3–14). Elsevier, Academic Press.

Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., & Anda, R. F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The adverse childhood experiences study. *Pediatrics, 111*, 564–572. https://doi.org/10.1542/peds.111.3.564

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of child abuse and household dysfunction to many of the leading causes of death in adults. The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*, 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

Finkelhor, D., Shattuck, A., Turner, H., & Hamby, S. (2013). Improving the adverse childhood experiences study scale. *JAMA Pediatrics, 167*(1), 70–75.

Garner, A. S., & Shonkoff, J. P. (2012). Early childhood adversity, toxic stress, and the role of the pediatrician: Translating developmental science into lifelong health. American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health; Committee on Early Childhood, Adoption, and Dependent Care; Section on Developmental and Behavioral Pediatrics. *Pediatrics, 129*(1), e224-e231. https://doi.org/10.1542/peds.2011-2662

Holden, G. W., Gower, T., & Chmielewski, M. (2020). Methodological considerations in ACEs research. In G. J. G. Asmundson & T. O. Afifi (Eds.), *Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention* (pp. 161–181). Elsevier, Academic Press.

Massetti, G. M., Hughes, K., Bellis, M. A., & Mercy, J. (2020). Global perspective on ACEs. In G. J. G. Asmundson & T. O. Afifi (Eds.), *Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention* (pp. 209–231). Elsevier, Academic Press.

McLennan, J. D., McTavish, J. R., & MacMillan, H. L. (2020). Routine screening of ACEs: Should we or shouldn't we? In G. J. G. Asmundson & T. O. Afifi (Eds.), *Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention* (pp. 145–157). Elsevier, Academic Press.

Merrick, M. T., Ports, K. A., Guinn, A. S., & Ford, D. C. (2020). Safe, stable, nurturing environments for children. In G. J. G. Asmundson & T. O. Afifi (Eds.), *Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention* (pp. 329–356). Elsevier, Academic Press.

Oshri, A., Duprey, E. K., Liu, S., & Gonzalez, A. (2020). ACEs and resilience: Methodological and conceptual issues. In G. J. G. Asmundson & T. O. Afifi (Eds.), *Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention* (pp. 287–303). Elsevier, Academic Press.

Piotrowski, C. (2020). ACEs and trauma-informed care. In G. J. G. Asmundson & T. O. Afifi (Eds.), *Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention* (pp. 307–328). Elsevier, Academic Press.

Ports, K. A., Ford, D. C., Merrick, M. T., & Guinn, A. S. (2020). ACEs: Definitions, measurement, and prevalence. In G. J. G. Asmundson & T. O. Afifi (Eds.), *Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention* (pp. 17–31). Elsevier, Academic Press.

Sheffler, J. L., Stanley, I., & Sachs-Ericsson, N. (2020). ACEs and mental health outcomes. In G. J. G. Asmundson & T. O. Afifi (Eds.), *Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention* (pp. 47–69). Elsevier, Academic Press.

Sheridan, M. A., & McLaughlin, K. A. (2020). Neurodevelopmental mechanisms linking ACEs with psychopathology. In G. J. G. Asmundson & T. O. Afifi (Eds.), *Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention* (pp. 265–285). Elsevier, Academic Press.

Taillieu, T. L., Graces Davila, I., & Struck, S. (2020). ACEs and violence in adulthood. In G. J. G. Asmundson. & T. O. Afifi (Eds.), *Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention* (pp. 119–140). Elsevier, Academic Press.

Vig, K. D., Paluszek, M. M., & Asmundson, G. J. G. (2020). ACEs and physical health outcomes. In G. J. G. Asmundson & T. O. Afifi (Eds.), *Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention* (pp. 71–90). Elsevier, Academic Press.

Wekerle, C., Hébert, M., Daigneault, I., Fortin-Langelier, E., & Smith, S. (2020). ACEs, sexual violence, and sexual health. In G. J. G. Asmundson & T. O. Afifi (Eds.), *Adverse childhood experiences: Using evidence to advance research, practice, policy, and prevention* (pp. 91–118). Elsevier, Academic Press.

News of the Organization

Janet Rosenzweig, MS, PhD, MPA, Executive Director

APSAC Is Working for You!

When COVID-19 dramatically changed the way almost everyone conducted business last year, APSAC changed with the times and in doing so increased our reach by more than ten-fold over prior years. APSAC educational programs were experienced more than 9,000 times. APSAC educational videos on YouTube had more than 8,000 views. APSAC forensic interviewing clinics were redesigned for the virtual environment and ran at capacity. While so many aspects of life seemed to just stop, the need to keep children safe remained a priority. APSAC, our members, and colleagues have risen to the challenge and will continue to redouble our efforts in 2021. Stay in touch with APSAC at www.apsac.org and see how APSAC expanded education and training offerings can benefit you, your practice, and your community.

Meet the APSAC Commission for Racial Justice in Child Maltreatment

This Commission for Racial Justice in Child Maltreatment was formed by APSAC in response to the heinous evidence of systemic racism and implicit bias evidenced in 2020. APSAC released a statement pledging "an enduring effort to develop, monitor, and regularly update an APSAC Action Plan to Eliminate Systemic Racism and Implicit Bias in the Child Maltreatment Field." To date, APSAC has developed a certificate program in Eliminating Systemic Racism and Implicit Bias in the Child Maltreatment Field with lectures delivered by vetted experts in the field and has launched the APSAC Reading Club for Racial Justice led by a diverse group of professionals, exploring topics such as racism in psychotherapy, recognizing micro-aggressions in child maltreatment work, and addressing white supremacy culture.

APSAC will host a Learning Collaborative focusing on "Dismantling Privilege II: An Examination of Racism in U.S. Youth-Serving Systems." The 8-week independent training course with weekly group discussion will cover the experiences of African American youth from slavery to the present day. Future plans include developing curriculum for professionals working with or in the child maltreatment field to increase knowledge regarding systemic racism and to promote remedial behavioral change and organizational assessment and credentialing.

For more information or to join any of these efforts, please contact APSAC.

Now Virtual! The APSAC 28th Colloquium, July 11–15, 2021

The 2021 Colloquium theme is "Promoting Racial Diversity, Equity, and Inclusion Across Disciplines and Organizations Addressing Child Maltreatment." Schedule and registration info are coming soon! Watch the APSAC website for more information.

APSAC Welcomes New Members to the Board of Directors

APSAC is pleased to welcome new members to the Board of Directors:

Darrell Armstrong, MDiv, EdS-MFT, DD, is civic leader, a grassroots community organizer and a child welfare/family strengthening advocate who is committed to eradicating the individuals and generational effects of ACEs (Adverse Childhood Experiences). His policy training at Stanford University (BA in public policy), theological training at Princeton Theological Seminary (MDiv), and

therapeutic/ clinical training at The College of New Jersey (EdS in marriage & family therapy) have uniquely prepared him to be a respected voice in the national and international child welfare/family strengthening communities.

Ernestine C. Briggs-King, PhD, is Director of Research at the Center for Child and Family Health (CCFH), Director of the Data and Evaluation Program at the UCLA–Duke University National Center for Child Traumatic Stress, and Associate Professor in the Department of Psychiatry and Behavioral Science at Duke University School of Medicine. Her clinical and research interests include minority mental health, resiliency, reducing disparities, chronic adversity, child maltreatment and traumatic stress. She is currently on the board of directors of the National Children's Alliance and was a past president.

Leslie Schmerler, MA, received her Bachelor of Science in Education with a major in special education from the University of Georgia. She completed her Master's in the intellectual disabilities and autism program with an emphasis in severe and multiple disabilities at Teachers College, Columbia University, completing a research assistantship in the field of child abuse and disabilities. Leslie is Director for the Vincent J. Fontana Center of The New York Foundling. She serves on the board of directors for the American Professional Society on the Abuse of Children- New York.

Coming Soon! The 2021 APSAC/New York Foundling Webinar Series

A repeat of the format of highly popular series first offered in 2020, 2021 events include John Briere and Cheryl Lanktree on February 25 discussing the latest developments in trauma treatment involving tele-therapy due to the pandemic; Viola Vaughan-Eden on April 13 discussing talking to parents about corporal punishment; Judith Cohen on May 25 discussing whether the trauma narrative is necessary for successful treatment outcomes focusing on trauma-focused cognitive behavioral therapy (TF-CBT) for children with traumatic stress symptoms; Victor Vieth on July 20 presenting on investigating and prosecuting cases of child neglect and/or sexual abuse and more! Learn more and register here.

APSAC Can Support Your Conferences and Training

APSAC makes a great partner for a statewide organization planning a conference. Contact Dr. 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. We now also offer back-end support including online registration and credit card processing.

APSAC Is a Great Partner for Grant and Contract Opportunities!

States often issue Requests for Proposals (RFPs) to add training, research, or evaluation activities to their child welfare, child health, or related services. APSAC has joined state chapters in successfully responding to state-issued RFPs. If APSAC's experience, access to national experts, and other resources can add value to your response to an RFP, please contact Dr. Janet Rosenzweig.

APSAC Is Working to Make Research Findings More Accessible!

We are proud of the high-impact factor of our journal, Child Maltreatment, but know that not everyone has the time or inclination to read entire research articles. This problem is not specific to APSAC; national reports suggest a 20-year gap between generating clinical knowledge through research and use of that knowledge across the mental health and healthcare fields. To help meet our goal of strengthening practice through knowledge, APSAC is now publishing Research to Practice Briefs to translate research findings published in CM into plain language, with an emphasis on implications for practice and policy. All briefs contain an introduction to the issue, a summary of the research questions, a summary of the findings, and the implications for policy and practice.

To join our team of brief writers, or explore bringing this project to a graduate class, contact Bri Stormer, MSW.

APSAC Welcomes Our Newest Members!

August 1 - December 31, 2020

Sara Abed
Kelly Adams
Angela Adams
Steven Adelman
Elisa Adolphsen
Labrena Aiken-Furtick
Lynn Aladeen
Aiszellyn Alvarez
Courtney Anderson
Jennifer Andrews
Shani Armstrong
Annette Arroyo
Adrienne Atzemis
Denise Aubuchon
Daniel Avina
Viviana Azar
Selena Baca
Megan Banet
Britney Barker
Emily Barnes
Dawn Barras
Catherine Bass
Iris Baughman
Julianne Baumann
Ruth Beaglehole
Christi Bell
Angelina Bell
Alicia Benedetto
Christine Bennett
Morgan Benson
Brooke Bentley
Virginia Berlinerblau
Yamilette Berrios
Hannah Billett
Melissa Birdsell
Joshua Bissell
Robin Blair
Jamie Lynn Blum
Amber Bond
Victoria Bones
Rachel Booker
Brenda Borders
Wendy Bowen
Mary Boyce
Crystal Bradshaw
Christy Bradshaw Schmidt
Patricia Brady
Deidra Breaux
Larry Breitenstein
Lorrie Brennan
Mary Bunyard
Amber Burmeister
Connie Cahue
Pamela Carey
Yazmin Carriles
Maricarmen Carrillo Justiniano
Katharine Carson
Kennedy Carvalho
Grace Casanova
Dara Chanin
Dena Chappell
Suzanne Chester
Deborah Chosewood
Treice Christmas
Michelle Chudow
Lesli Clark
Elizabeth Clark
Natalie Clavon-Carter
Kelli Clune
Kathryn Coker
Felicia Coleman
Jaqueline Collard
Charlene Collibee
Lindsey Collins
Tonya Collins
Lisa Collins
Jeffrey Combs
David Cooperson
Patty Cornwell
Jamny Coronado
Anne Costello
Kristin Coyne
PSP Trooper Tyler Craig
Barbara Craig
Ania Craig
Donna Crow
Edith Croxen
Angela Cruz
Maggie Cullinan
Caitie Dahl
Laura Davie
Mayra Esther Davila Rivera
Rachel Davis
George Davis
Mary Beth Dawson
Sarah Dean
Jennifer Deazvedo
Kelly Deckard
Leslie Deen
Alli Deering
Susana Diaz
Alexandra Dischinger
Stephanie Dodge
Lisa Donnelly
Tambra Donohue
Paula Doty
Keith Driscoll
Shelby Duarte
Krystal Duran
Joan Durrant
Matthew D'Urso
Daji Dvalishvili
Nancy Dye
Heidi Eckroth
Leonard Edwards
Emma Edwards
Sara Eleoff
Laartatnetta Elepano
Samantha Engelstad
Mehnaaz Essop
Amy C Evans
Molly Evans
Dora Falls
Kristyn Farris
Amy Feath
Megan Feely
Rebecca Fernau
Amanda Ferraro
Kristina Filomena
Hadley Finley
Flor Fleischer
Lori Fluegel
Ashleigh Fuller
Cassell Galligan-Davis
Maria Gandarilla Ocampo
Kristi Gates
Tara Gauthier
Danielle Gauthier
Elizabeth Gentile
Jamie Gfell
Sydney Gilbert
Maria Gjonaj
Trisha Glenn
Cansas Goller
Lorena Gomez
Armando Gonzalez
Anthony Gonzalez
Karyzz Gonzalez Cavasos
Breana Gordon
Alyssa Graye
Alyse Green
Yehuda Green
Latoya Greene
Gregory Grier
Andi Grosvald Hamilton
Rebecca Grounsell
Robin Grove
Rosy Guerra
Kelli Guise
Megan Hackl
Victoria Halcomb
Daelauren Harris
Lisa Harvath
Talesa Heger
Giselle Henriquez
Nicola Herting
Hugues Herve
Melanee Hester
Abigail Hill
Jennifer Hillgoth
Shelley Hitzel
Kim Hokanson
Jacqueline Holloway
LaDonna Holmes
Kina Holmes Cypress
Melanie Hopkins
Dakeda Horton
Cotina Houston
Emily Houston
Stephenie Howard

Rhonda Hudson
Mackenzie Hughes
Haylie Humble
Roberta Humphries
Stephanie Hundt
Jennifer Hutchinson
Pamela Ingram
Kristen Iniguez
Ginger Isenberg
Olga Jablonka
Yo Jackson
Kasey Jackson
Stacy Jackson
Katherine Jaeger
Aedan Jager
Ramona Jaime
Katie Jalazo
Kay Jankowski
Veronica Jensen
Lee Johnson
Julia Johnson
Jennifer Jones
Lindsey Jordan
Cory Kalvig
Nicole Keefer
Gwynetth Kelly
Mary Kelly
Peg Kennedy
David Kennedy
Tara Keough
Barbara Kern-Pieh
Harris Kirk
Deborah Kleypas
Steve Knauts
Angela Knieriem
Sarah Kramer
Beth Kutzera
LCWTA LA Child Welfare Training Academy
Marina Landviger
Lisa Larrabee
Coty Laudermilk
Greg Lauren
Betty Lavoie
Mayra León
Joyce Lee
Dawn Leemon
April Leming
Gertrud Lenzer
Gladys Levario
Marva Lewis
Brandi Liles
Kathleen Liner
Tenesha Littleton
Elisabeth Liu
Robin Livingston
Anthony Luczak
Beatriz Lynch
Matthew Lynch
Tara Lzicar
Carolynn Macallister
Carmen Madriñán

Camia Magee
Angie Marsh
Joy Martin
Benjamin Martinez
Mina Martinez
Kara Marts
Jennifer Masters
Vera Matter
Kristen McBeth
Kathy McCarrell
Michael McCarthy
Gloria McClary
Shyeeta Mcfarlane
Maureen McGettigan
Deanna McGettigan
Kathleen McGimpsey
McKenzie McIntosh
Julie McKellar
Kathleen McNamara
Jeissie Mederos
Val Meyers
Patricia Milizio
Susan Miller
Cassy Miller
Stacy Miller-Brathwaite
Sidney Minor
Jamal Mitchell
Lisa Mizell
Ted Moe
Kyla Molina
Crispin Montelione
Ruth Mori
Katy Morris
Kimberly Morton
Patricia Mosher
Laura Mueser
Leisa Mukai
Kelly Myers
Pat Neal
Dee Nesby
Chris Newlin
Taylor Newman
Rachel Niemiec
Boyenah Nimley
Taelor Nisbeth
John Oliveira
Stephanie Olsem
Kathy Olson
Michele Oncken
Beverly Orth-Georghegan
Maria A Ortiz Rivera
Elizabeth Osowiecki
Lindsey Palmer
Jennifer Parker
Kristen Paul
Janice Pelletier
Debbie Perry
Daniel Swerdlow-Freed Ph.D.
Camille Phillips
Peggy Pisano
Sandra Price
Lauren Pride

Joanne Prinzhorn
Amy Pumo
Kristine Putz
Brooklyn Rager
Rebecca Ratcliff
Sarah Ellen Ratliff
Frances Respicio
Landon Rice
Krystal Rich
Elizabeth Rischard
Lauren Rockwell
Rebecca Rodriguez-Pou
Myrelis Román-Colón
Elisa Romano
Eric Roseman
Anne Rosenberg
Sydney Rossiter
Gracie Rosson
Chenita Rountree
Victoria Rutigliano
Peter Samuelson
Ashley Sanders
Alison Sands
Jennifer Savage
Ondria Sawyer
Annalisa Scheele
Jennifer Schooler
Sarah Schultz
Sarah Scozzafava
Robert Sege
Sitara Shaikh
Monica Shambaugh
Rinku Shanker
Denese Shervington
John Sheveland
Kate Shipley
Kristie Sickel
Dayna Siegel
Magdalena Sigur
Julia Silva
Jo Simonsen
Peter Simonsson
Susan Sims Smith
Gurmeet Singh
Shawn Singleton
Katherine Siroky
Sharon Skrabacz
Kelly Slover
Caroline Smith
Hayley Smith
Kelly Smith
Leah Smith
Heather Smith
Valerie Smith
Paige Smith
Dan Sneider-Cotter
Nena Sopher
Madeline Sparks
Tracey Stearns
Karen Steed
Benjamin Steinberg
Winn Stephens

New Members

Allyson Stewart
Elizabeth Stilwell
Sharon Strange
Andy Stuart
Molly Sullivan
Alessandra Suuberg
Atiquah Syed
Sharon Syzmanski
Melanie Takinen
Abner Taub
Lynn Teribery
Sarah Thomas
Thomas Thompson
Sheba Thone
Michelle Tremblay
Carnigee Truesdale
Natalia Tsokos
Grace Tucker
Kathryn Turman

Sheila Turner
Kellie Ulbricht
Sarah Urdiales
Carla Valdivia
Andrea Venegas
Monica Vidro Madigan
Sue Villa
William Viser
Rebecca Voss
Candise Walker
LaTasha Walker
Steffanie Walstra
Heather Warden
Stacey Wasserman
Robin Watts
Bryan Weber
Priscilla Westberg
Tara Whitman
Staci Whitney

Mary Widmann
Becca Wilbershide
Nicole Wilbon
Tyra Wiley
Kathy Wilkerson
Barbara Williams
JoAnne Williams-Carryl
Monique Willoughby
Courtney Wills
Catey Wohlford
Miriam Wolf
Shannon Wood
Yanfeng Xu
Katherine Yoder
Claudia Zambrana
Brooke Zamora

Washington Update

Ruth Friedman, PhD

Congress to Pass American Rescue Bill

Congress is expected to pass a large COVID-19 response package very soon that is based on the Biden American Rescue Plan. Final details are still being negotiated, but in addition to funding related to COVID-19 management, it is likely to include many temporary supports for families, including paid leave (for COVID-related reasons), eviction moratorium, stimulus checks for individuals and families, expanded child tax credit with advance monthly payments, funding for child care, WIC, SNAP, school meals, school reopenings, housing subsidies, and community health centers. The bill in the House of Representatives also includes $150 million for home visiting through the Maternal Infant and Early Childhood Home Visiting (MIECHV) program and $350 million for the Child Abuse Prevention and Treatment Act (CAPTA), with $100 million directed to state child welfare agencies and $250 million for Community-Based Child Abuse Prevention Grants. The Senate bill is expected to include a similar provision, but details of that bill have not yet been released. Final passage is expected before March 15, when pandemic-related unemployment assistance provisions would otherwise expire.

Key Child Welfare Provisions in the Consolidated Appropriations Act of 2021

The COVID relief package Congress, finalized December 27, 2020, included funding and flexibilities for child welfare-related programs. It includes $400 million for the Chafee Foster Care Program for Successful Transition to Adulthood, extends eligibility to age 27 through September 2021, and allows more of the funding to be directed toward housing assistance. It also prohibits states from requiring a child to leave foster care solely due to their age through the public health emergency period. It also increases the federal portion of the Title IV-E prevention program, making it less costly to states to make these services available, and it provided $85 million for Title IV-B Part 2 child welfare program, additional flexibilities for kinship navigator programs, and $10 million through the Court Improvement Program for activities related to the COVID-19 public health emergency. The Children's Defense Fund has released a detailed summary.

Key Political Appointments at HHS Expected Soon

A date has not yet been set for Senate confirmation of President Biden's nominee for Secretary of Health and Human Services, Attorney General Xavier Becerra. But the first slate of HHS appointees have been named. Appointments to lead the Administration for Children and Families; the Administration of Children, Youth, and Families; and the Children's Bureau are expected as soon as the week of February 22. All three of these positions will be involved in directing the Administration's child welfare policy.

Trump-Era Rule Allowing Discrimination in Federally-Funded Child Welfare Programs Temporarily Paused

In January, the Trump Administration finalized a rule that allowed discrimination in federally funded HHS programs, including child welfare programs, against youth on the basis of sexual orientation and gender

identity and against foster and adoptive parents on the basis of sex, sexual orientation, general identity, and religion. This January rule overturned an Obama-era rule that prohibited discrimination on the basis of sex, religion, gender identity, and sexual orientation from programs receiving federal funds from the Department of Health and Human Services (HHS). On February 10, the Biden Administration agreed to a court order halting implementation of the Trump rule. The Biden Administration is reviewing the rule and is widely expected to return to regulations that prohibit discrimination.

CAPTA Reauthorization

The prospects for CAPTA reauthorization in this Congress look good. In January, the lead Democrat (Rep. Bobby Scott) and lead Republican (Rep. Virginia Foxx) on the House committee with jurisdiction over the law reintroduced *The Stronger Child Abuse Prevention and Treatment Act* legislation, which reauthorizes CAPTA and includes many reforms advocated for by the National Child Abuse Coalition. This same bill passed the House during the 116th Congress, but progress stalled in the Senate. The Senate Health, Education, Labor, and Pensions Committee, which has jurisdiction over CAPTA, has new leadership due to the retirement of prior-Chairman Lamar Alexander (R-TN) and the November 2020 election. Senator Murray (D-WA) will now serve as Chair of the HELP Committee and Senator Richard Burr (R-NC) will serve as the Ranking Member. The Committee is expected to proceed with CAPTA reauthorization this spring.

More Programs Rated by Prevention Services Clearinghouse

The HHS Title IV-E Prevention Services Clearinghouse continues to slowly add newly rated programs to the clearinghouse. The Clearinghouse was established by the U.S. Department of HHS and developed in accordance with the Family First Prevention Services Act (FFPSA) of 2018 to systematically review research on programs and services intended to provide enhanced support to children and families and prevent foster care placements. The Clearinghouse is administered by Abt Associates and rates programs and services as promising, supported, and well-supported practices. Services and programs must be rated appropriately to be eligible for federal funding under Title IV-E. The list of programs set for upcoming review by the Clearinghouse can be found on its website.

About the Author

Ruth Friedman, PhD, *is Executive Director of the National Child Abuse Coalition. She is an independent child and family policy consultant and national expert on early education, child welfare, and juvenile justice. She spent 12 years working for Democratic staff of the U.S. House Committee on Education and the Workforce, helping spearhead early learning, child safety, and anti-poverty initiatives. Dr. Friedman has a doctorate in clinical psychology and a master's degree in public policy. Prior to working for Congress, she was a researcher and therapist, focusing on resiliency in children and families.*

From Child Welfare to Jail: Mediating Effects of Juvenile Justice Placement and Other System Involvement

Bri Stormer, MSW

Original study authors: Sarah Goodkind, Jeffrey Shook, Karen Kolivoski, Ryan Pohlig, Allison Little, and Kevin Kim

Introduction

Previous studies have identified a relationship between involvement in the child welfare system and later involvement in the justice system. There is, however, a gap in the research on how different experiences in the child welfare system, receipt of services, and juvenile justice system involvement relate to later jail involvement. The purpose of this study is to explore the relationship between child welfare experiences, other system experiences, and later jail system involvement.

Research Questions and Hypotheses

The researchers posed the following questions: (1) How are child welfare system experiences related to jail involvement? (2) How are mental health and substance abuse treatment related to jail involvement among child welfare-involved youth? (3) Does juvenile justice placement mediate these relationships?

They hypothesized that out of home placement (OOHP) in the child welfare system, placement instability, running away, and congregate care placement were positively associated with jail involvement and that the relationships would be mediated by juvenile justice placement. They also hypothesized that youth who received mental health and substance abuse services would be more likely to have future jail involvement and that those relationships would be mediated by juvenile justice system involvement. Lastly, they hypothesized a stronger association between child welfare system involvement and jail involvement for Black youth.

Study Sample and Variables

The authors used a birth cohort sample of all children born between 1985 and 1994 in Allegheny County, Pennsylvania, who received in-home child welfare services and/or out-of-home care for any period of time. Since the birth cohort was 94% Black or White, only these two racial groups are included in the analysis. The authors further limited their analysis to children whose families were involved in the child welfare system prior to the juvenile justice system. This led to a full sample of 37,079 children from 19,782 families. They also created an OOHP subsample, which included 8,317 children from 4,872 families. The authors provide separate analysis for White and Black youth for both the full sample and placement subsample.

The authors defined the dependent variable of jail involvement as a dichotomous measure for whether a youth spent time in a county jail (yes/no). They also looked at the child's sex (m/f), age, age when child welfare case was closed (before age 10, between 10–14, 14+), juvenile justice detention (yes/no), receipt of mental health service prior to juvenile justice detention (or, if no detention, receipt of mental health services at any time) (yes/no), receipt of drug and alcohol services prior to juvenile justice detention (or, if no detention, receipt of drug and alcohol services at

any time) (yes/no), placement in congregate care (yes/no), length of time spent in OOHP, total number of OOHPs, and whether the child ever ran away from a child welfare placement (yes/no).

Findings

Among White youth in the full sample (n=18,218), the researchers found that (1) males had higher odds than females of both juvenile justice placement and jail involvement, (2) juvenile justice placement was positively associated with jail involvement, (3) prior receipt of drug and alcohol services was associated with higher odds of jail involvement and was not mediated by juvenile justice placement, and (4) the relationship between mental health services and jail involvement was mediated by juvenile justice placement.

Among Black youth in the full sample (n=18,218), the researchers found that (1) males had higher odds than females of both juvenile justice placement and jail involvement, (2) age was negatively associated with juvenile justice placement and positively associated with jail involvement, (3) receipt of drug and alcohol services decreased likelihood of juvenile justice placement but increased odds of jail involvement, and (4) receipt of mental health services, having a case open after age 14, and being in OOHP were all associated with jail involvement and mediated by juvenile justice placement.

Among White youth in the OOHP subsample (n=2,755), the researchers found that (1) males had higher odds of juvenile justice placement, and sex mediated the relationship between juvenile justice placement and jail involvement, and (2) having a case open after age 14 was associated with higher odds of juvenile justice placement, and juvenile justice placement mediated the relationship between cases open after 14 and jail involvement.

Among Black youth in the OOHP subsample (n=5,562), the researchers found that (1) males had higher odds of juvenile justice placement, and sex mediated the relationship between juvenile justice placement and jail involvement, and (2) having a case open after age 14, receipt of drug and alcohol services, amount of time in OOHP, and number of OOHPs were all associated with jail involvement and all mediated by juvenile justice placement. Notably, however, drug and alcohol services and more time in OOHP decreased odds of juvenile justice placement, while cases being open after 14 and number of placements increased odds of juvenile justice placement.

Interpreting the Findings in the Context of Systemic Racism and Recommendations

Because the authors use a birth cohort, even the descriptive statistics of this study speak to the issues of disproportionality and systemic racism in the child welfare system. While the White and Black full samples are about the same size (between 18,000 and 19,000), the OOHP subsample of Black youth is more than double that of White youth. Within that placement sample, Black youth had higher rates of congregate care, longer lengths of time in OOHP, more OOHPs, lower rates of drug and alcohol and mental health services, and higher rates of juvenile justice and jail involvement. While rates of juvenile justice placement and jail involvement were higher for both groups in the OOHP subsample, drug and alcohol services and fewer OOHPs reduced juvenile justice placement for Black youth. As professionals in the child welfare system seek to improve the outcomes in the child welfare system for all youth, it is imperative to understand that the experiences therein are not universal and may differ extensively across racial lines. Working to improve the service offerings and placement stability for Black youth specifically may reduce juvenile justice and jail involvement, which, in turn, could improve outcomes across the lifespan.

It is also important to note that by using juvenile justice detention, rather than arrest, as the indicator of juvenile justice involvement, the authors saw relatively small percentages of juvenile justice system involvement in the full sample (9% overall), which doubled in the OOHP subsample (18% overall). This both counters the narrative that justice system involvement is an inevitability for child welfare-involved youth and suggests that targeted child welfare services that work to prevent the need for OOHP could have a positive impact on justice system

involvement overall. When OOHP cannot be avoided, targeting services toward children in OOHP and seeking to reduce placement instability, especially for Black youth and youth over the age of 14, may reduce justice system involvement.

This study found juvenile justice placement increased the likelihood for jail involvement for all individuals in the sample. The authors suggest better cross-system collaboration, communication, and formalized training toward the goal of updating policies and practices to reduce the number of justice-involved youth overall. More research is needed on new models, such as restorative justice programs and coordinated child welfare/juvenile justice system models, to determine if they help reduce the overall level of justice-involved youth.

Lastly, we must acknowledge the over-surveillance and differential treatment of Black vs. White people in the justice system. While all the above strategies are important pieces of reducing justice system involvement for child welfare-involved youth, this work will continue until we are able to build more equitable juvenile and criminal justice systems for all.

Bottom Line

Juvenile justice system involvement increases the likelihood of jail involvement for child welfare-involved youth. Experiences in the child welfare system impact the likelihood of both juvenile justice placement and jail involvement and differ for White and Black youth. Child welfare and juvenile justice professionals must work collaboratively toward the goal of reducing juvenile justice system involvement and improving efficacy of services for child welfare-involved youth, thereby reducing later criminal justice involvement.

Citation

Goodkind, S., Shook, J., Kolivoski, K., Pohlig, R., Little, A., & Kim, K. (2020). From child welfare to jail: Mediating effects of juvenile justice placement and other system involvement. *Child Maltratement, 25*(4), 410–421.

About the Author

***Bri Stormer, MSW**, is Director of Publications and Member Services for APSAC. Bri earned her Bachelor of Arts in Psychology and Theatre from Case Western Reserve University and her Master's in Social Work with a concentration in Community Organizing, Planning, and Administration from University of Southern California.*

The American Professional Society on the Abuse of Children™
Strengthening Practice Through Knowledge
apsac.org @The_APSAC

In partnership with THE NEW YORK FOUNDLING
nyfoundling.org
@TheNYFoundling

2021 APSAC Board of Directors

President
Stacie LeBlanc, JD, MEd
CEO, The UP Institute
New Orleans, LA

Immediate Past President
David L. Corwin, MD
Professor and Director of Forensic Services
University of Utah, Pediatrics
Sandy, UT

Vice President
Mel Schneiderman, PhD
Senior Vice President
Vincent J. Fontana Center for Child Protection
The New York Foundling
New York, NY

Secretary
Susan Hardie, RN, PhD
Private Practice
Calabasas, CA

Treasurer
Jemour Maddux, PsyD, ABPP
Managing Director
Lamb and Maddux, LLC
Hackensack, NJ

Member at Large Elected to the Executive Committee
Bart Klika, MSW, PhD
Chief Research and Strategy Officer
Prevent Child Abuse America
Chicago, IL

Director
Randell Alexander, MD, PhD
University of Florida – Jacksonville
Department of Pediatrics
Professor and Chief
Division of Child Protection and Forensic Pediatrics
Jacksonville, FL

Director
Darrell Armstrong, MDiv, Eds., MFT, DD
Pastor
Shiloh Baptist Church
Ewing, NJ

Director
Ernestine Briggs-King, PhD
Center for Child & Family Health
Durham, NC

Director
Bethany Mohr, MD, FAAP
Clinical Associate Professor
Medical Director, Child Protection Team
Michigan Medicine Department of Pediatrics
University of Michigan
Ann Arbor, MI

Director
Roslyn Murov, MD
Senior Vice President, Mental Health Services
The New York Foundling
New York, NY

Director
Ron Laney
Officer 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
Leslie Schmerler, MA
Director
Vincent J. Fontana Center for Child Protection,
New York, NY

Director
Victor Vieth, JD, MA
Director of Education & Research
Zero Abuse Project
St. Paul, MN

President Emeritus
Ronald C. Hughes, PhD, MScSA
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
Newport News, VA

APSAC ADVISOR Staff

ADVISOR Editor-in-Chief

Lisa Schelbe, PhD, MSW
Florida State University
College of Social Work
Tallahassee, FL

ADVISOR Associate Editor

Carlomagno C. Panlilio, PhD
Department of Educational Psychology, Counseling, and Special Education
Child Maltreatment Solutions Network
The Pennsylvania State University
State College, PA

ADVISOR Consulting Editors

Law
Frank Vandevort, JD
University of Michigan Law School
Ann Arbor, MI

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

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

ADVISOR Publishing Team

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

APSAC Staff

Janet Rosenzweig, PhD, MPA
Executive Director

Jane Campbell, MEd
Administrator, Training and Education

Jim Campbell, PhD
Training Director

Ilana Feldman, BS
Manager, Educational Programs and Administration

Hannah Gilbert, MSHCM
Marketing and Media Assistant

Betsy Poulos
Clerical Assistant for Member Services

Bri Stormer, MSW
Director, Publications and Member Services

Kenneth Watson, BS
Office Assistant

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.

The American Professional Society on the Abuse of Children™

Strengthening Practice Through Knowledge

apsac.org @The_APSAC

In partnership with

THE NEW YORK FOUNDLING

nyfoundling.org

@TheNYFoundling