Randall Alexander

Celebrating 35 Years of Improving Society's Response to Abuse and Neglect of Children: An Interview with Randall Alexander, MD

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Randall Alexander, MD, began his practice as a child abuse pediatrician under the mentorship of Ray E. Helfer, MD, in the mid 1970s. Child abuse pediatrics is a subspecialty of medical practice in which physicians are trained to diagnose and treat infants, children, and teens who are victims of suspected child abuse and neglect. Although, collectively, these physicians have practiced for over three decades, this subspeciality was not officially recognized by the Accreditation Council for Graduate Medical Education (ACGME) until 2006. Likewise, the first qualifying exam did not occur until 2009 (Pediatric News, 2009). Certified child abuse pediatric providers are experts in conducting child physical and sexual abuse exams as their training is more specialized than other medical professionals; this often enables them to catch indicators of abuse and trauma earlier than noncertified providers. In addition to providing medical care, child abuse pediatricians primarily focus on the diagnostic side of care, commonly working alongside law enforcement, judicial experts, and child welfare workers in multidisciplinary teams.

When Dr. Alexander began his career, child abuse prevention was not yet mainstream in public health circles; thus, this was a small, tightknit group of practitioners able to develop and implement strategies that were less encumbered by bureaucratic restrictions than those of today. One of Dr. Alexander's earliest contributions to the field was creating a child abuse prevention program and a child abuse clinic during his tenure at Butterworth Hospital in Grand Rapids, Michigan. He went on to become an expert in the fields of shaken baby syndrome and Munchausen syndrome by proxy. Currently, he is Professor of Pediatrics at the University of Florida College of Medicine—Jacksonville and is also Chief of their Division of Child Protection and Forensic Pediatrics in the Department of Pediatrics.

Dr. Alexander previously served as Statewide Medical Director of Florida's Child Protection Teams from 2004 to 2015. In 2013, he received the American Professional Society on the Abuse of Children's William Friedrich Memorial Award, and in 2017, he received the Ray E. Helfer Teaching Award for Significant Contributions as a Teacher of Child Abuse Pediatrics. In 2018, he was awarded the Lifetime Achievement Award presented by Gundersen National Child Protection Training Center at the Violence Intervention and Prevention (VIP) Summit. As a longtime member of the American Professional Society on the Abuse of Children (APSAC). Dr. Alexander has served on various national committees, executive committees, and boards. He currently serves as the co-chair of APSAC's Guidelines Committee.

Early Career

From the beginning of his career, Dr. Alexander cultivated a person-centered, holistic view of development, focusing on the relationship between psychology and human development. While working toward his PhD in experimental psychology, he shifted gears and entered medical school at Wayne

State University, although he did ultimately finish his PhD at the University of Michigan during his fourth year of residency. At this time, he also became chief resident and a fellow in community pediatrics under the tutelage of Dr. Helfer, a pioneer in the field of child abuse prevention. As a fellow in community pediatrics, Dr. Alexander credits Dr. Helfer with bringing greater awareness to the broader, long-term effects abuse has on child development, proclaiming, "When we talk about the history of the field, Ray Helfer is one of the most important [child abuse professionals] others should know about."

Dr. Helfer was a pediatrician trained under C. Henry Kempe, MD, a Nobel Prize nominee noted for his contributions in the recognition and identification of child abuse and neglect in the medical community. Dr. Helfer developed clinical guidelines for the detection and treatment of child abuse, and ultimately, he dedicated his career to reducing abuse and neglect through prevention strategies. Dr. Alexander recalls a pivotal experience and conversation with Dr. Helfer following a particularly disturbing child examination in which Dr. Helfer was troubled by not only the medical aspects of the case but also the news that the abuser would not receive clinical treatment in prison with a rehabilitative approach not yet offered during this time. He strongly felt any intervention had to be *proactive*, providing individuals with the tools necessary to enable them to choose an alternate action other than abusing a child. Up until his death in 1992, Dr. Helfer spent his career researching and raising awareness of child abuse and the need for prevention services. The time during which Dr. Alexander spent with Dr. Helfer influenced him so much so that, to date, Dr. Alexander is the only fellow who has stayed within the child abuse pediatric field.

Initial APSAC Involvement

Dr. Alexander says child abuse programming and legislation often come about via advocacy initiatives. Dr. Helfer's passion for building alliances and increasing child abuse prevention outreach and education have had a notable influence on Dr. Alexander's advocacy efforts. This all took a pivotal turn when he first became involved with APSAC shortly after its initial inception in 1986. As a new member during his early days with APSAC, he was at a meeting to discuss their upcoming agenda. During an informal conversation, he mentioned to his colleagues his concern that APSAC was predominantly known for its work on child sexual abuse (CSA) and not recognized for its work in other areas of child abuse and neglect. He believed this misguided perception was limiting APSAC's reach and expressed his belief that the members needed to improve their messaging to include more than CSA. During that meeting, there was a call for ideas, and his colleagues, who agreed and supported his idea, nudged Dr. Alexander to share his thoughts on the topic with leadership. At their encouragement, he addressed the group expressing his concerns and rationale for change. His idea sparked a new committee, which in turn led to a seat on APSAC's Board of Directors.

APSAC Accomplishment Highlights

Reflecting on this time in his career, Dr. Alexander says he feels "lucky" he was on the ground floor with multiple child abuse organizations that were defining how child abuse and neglect would be identified and treated. One such project led to a publication in 2002 in which APSAC published extensive guidelines on the assessment, diagnosis, and treatment of Munchausen syndrome by proxy. Updated in 2019, this has become the most widely referenced document on the disorder in the medical and legal communities. Dr. Alexander credits the work of the Munchausen syndrome by proxy task force as one of the most notable contributions APSAC has made to the field.

Another successful advocacy effort coordinated by APSAC President and Chair of the National No Hit Zone (NHZ) Committee, Stacie Schrieffer Le Blanc, was in partnership with the archdiocese of New Orleans to designate all their Catholic Schools as

NHZs. The NHZ is a campaign approach similar to the No Smoking campaigns of the 1980s. The NHZ aims to reduce the use of corporal punishment in public spaces using targeted signage. By providing this signage to organizations and public facilities, an environment of safety and comfort for families and staff is created and reinforced. Early evaluation of NHZ efforts show promising outcomes related to increased knowledge of the harms of spanking by parents. There is also evidence of staff feeling more knowledgeable and comfortable to intervene or report when they see these forms of corporal punishment occurring (Gershoff et al., 2018).

Dr. Alexander and colleagues (Schrieffer et al., 2019) continue to promote the implementation of NHZ. At the state level, Dr. Alexander achieved success with the NHZ initiatives and converted all Florida child advocacy centers (CACs) to official NHZs. Yet, he believes there is more to be done. He is inspired by these partnerships to help extend the reach of this valuable prevention program into the broader society, so that discussion and prevention of physical punishment does not remain a private family issue. As he says, change comes in waves, and he is optimistic this partnership has the potential to laun a larger tide.

Future APSAC Initiatives and Advocacy Opportunities

When asked about his APSAC future goals wish list, Dr. Alexander paused and smiled, stating, "The good news is, history is on our side," referring to the increased awareness of child abuse and how we have "more watchful eyes" to identify abuse or neglect when it happens. He continued, "Our job is to try to [make change] in our lifetime, or to catalyze it so that it doesn't take 200 years to do something. We can do it in 100 years… We want to shape it and accelerate it." What should APSAC focus on for the future? Dr. Alexander described three primary areas at the top of his wish list: education, advocacy/outreach, and prevention.

In terms of education, Dr. Alexander would like APSAC to disseminate the knowledge, guidelines, and technical documents its members have created. In addition, he would like to see the creation of a set of working documents to accompany the more specialized, technical medical guidelines. These technical documents were written with a medical and judicial lens. He believes APSAC could expand its reach by including accompanying documents more suitable for the child welfare workforce, social service professionals, educators, and the public. He would also like to shift the way we think about child abuse by placing it under the umbrella of child health. Learning from history, APSAC and upcoming leaders in the field should continue the work laid out by Bob Block, MD, MPH, Past President of the American Academy of Pediatrics and stanch supporter of the Child Abuse Prevention and Treatment Act (CAPTA) to create a campaign that switches the narrative from mental health to brain health and child health. Because mental health is highly stigmatized and often thought of as a deficiency, framing the trauma of abuse as brain health aligns it with the medical model and treats the brain as another organ in our bodies. By educating the public on what happens to a child's brain when they experience abuse or neglect, the negative outcomes of child abuse and neglect can be openly discussed and destigmatized.

Although Dr. Alexander believes APSAC does an excellent job guiding the day-to-day issues in the field, he would like to see the organization apply more efforts helping to guide the big picture challenges child welfare professionals face, such as designing a nationwide model of care that has a clear structure and a systematic method of diagnoses and treatment of child abuse and neglect. Having seen the benefits of legislative involvement, he would like APSAC and future leaders to focus more on the legislative-policy arena. He believes that, nationally, APSAC could help move the child abuse and neglect agenda forward by creating special committees that lobby Congress to pass vital legislation, such as the reauthorization of CAPTA. At the state level, local

APSAC units should develop committees to draft, lobby, and help pass local child abuse legislation.

Overall, Dr. Alexander's highest priority advocacy goal is a nationwide focus on the prevention of child abuse and neglect. He believes APSAC should embrace a proactive stance against child abuse. More specifically, he said, "We want to reduce the number of kids going into foster care; [however,] that is not prevention. That's program management. Prevention [means] no child abuse." He feels the best way to accomplish this is through primary prevention efforts. He believes we need to stop child abuse before it happens *and* have a stable system in place to respond when it does. One potential avenue would be for APSAC to partner with other organizations such as Prevent Child Abuse America and Stop It Now! to begin a prevention movement.

Dr. Alexander believes that although not primary prevention-specific, another focus for the future should be the use of comprehensive child protection systems. He views systemic change as necessary to improve the field and the quality of services provided to vulnerable children and their families. He supports the use of the Child Protection Teams (CPTs) that Florida currently utilizes to further understand and prevent child abuse and neglect. Indeed, he moved from Georgia to Florida to become Medical Director for Florida's CPTs. CPTs are found only in Florida and are unique in that they are medically directed, multidisciplinary programs that coordinate child abuse and neglect investigations with local sheriff's offices, the judicial system, and departments of children and family services (DCF). These teams (22 spread throughout the state), employ over 100 medical providers, physicians, and nurse practitioners who have specialized certifications in child abuse pediatrics and perform the medical and sexual abuse examinations of all children identified within the system. In addition, CPT medical personnel read over 200,000 child abuse reports annually via a centralized, statewide hub where CPT medical professionals have access to all records of cases seen by CPTs, as well as any previous CPT involvement. Dr. Alexander views this access as a major benefit in providing collaborative care because it enables the CPT medical providers to walk into examination rooms armed with information. In his opinion, this access is critical because it enables the CPTs to look at the reports through a medical lens and use their expertise on child abuse identification and treatment to determine whether the child needs to be seen by the team's medical personnel. He believes this is possible because all CPTs operate independently from law enforcement and DCF.

Dr. Alexander believes Florida's child welfare model is exemplary because it is legislatively mandated and funded (i.e., the Florida Department of Health receives 25 million dollars annually to support CPTs). Each CPT team has dedicated and specialized medical providers who provide continuous quality control measures and are accountable for giving vulnerable children the care they deserve during a traumatic time. In many ways, Dr. Alexander's pride in, and desire for, other states to adopt Florida's CPT model is his own form of advocacy within the child welfare system. He firmly believes all children seen within the system deserve the most precise and specialized care possible. If not, "when you go to court…[caseworkers will not have] good answers as to what it is they're dealing with and mistakes can get made." This includes mistakes made with allegations and diagnosis. He believes it is vital for practitioners to be accurate and thorough, otherwise innocent people end up in jail or children fall through the cracks in the system; both deserve better from a system set up to protect.

Messages for Future Leaders

A specific piece of advice Dr. Alexander has for researchers and practitioners is for them to become proficient in the history of child abuse and neglect work. For example, many people know Henry Kempe's name, but fewer know Ray Helfer, and

in many ways, Dr. Helfer is just as prominent in the rise of the public health awareness of child physical abuse (i.e., shaken baby syndrome). Although Dr. Alexander does not expect his name to be commonplace, the work he has done with Munchausen syndrome by proxy has contributed to the syndrome becoming mainstream. Nevertheless, few would be able to point to this contribution. In other words, he believes that to know where one is going, one needs to know where they came from, and this cannot be done without understanding the history of the work done to get the field where it is today.

Dr. Alexander also believes in the widespread use of data and more professionals becoming committed to eradicating child abuse and neglect; there is much promise for future interventions, specifically primary preventions. However, he does not believe change will occur as quickly without a clear knowledge of the history of child abuse and neglect. Dr. Alexander's bottom line is as follows: "Appreciate the history [so you're not] likely to repeat something that's already been tried unsuccessfully."

Dr. Alexander challenged us to be the change makers. professing, "The thing that holds you back is more *you* than [the] system stuff." He says it isn't the bureaucratic systems [becoming an obstacle] but ourselves getting in our own way. He also advocates for just going out there and doing what is most important to you—after learning your history, of course. Ever optimistic, he said we must figure out what we want to do and make it happen. More specifically, Dr. Alexander suggested, "Do what you want to do, [that is] with APSAC. If you want to have a committee on something, tell [one of] the board members. Just ask and tell them you're going to chair it and go with it…. [T]here aren't people organized against you." From experience he has found there is less opposition if you commit to tackling the work. It is only by putting yourself out there that change occurs.

Individual Reflections: Stacey L. Shipe, Postdoctoral Fellow

I thoroughly enjoyed our conversation with Dr. Alexander. Although I am familiar with the child abuse pediatric subspeciality, it was enlightening to understand the history of the profession and how it complements day-to-day child welfare practice. I was also impressed with Dr. Alexander's excitement and commitment to the Child Protection Team approach that exists in Florida. I do believe having a multidisciplinary approach to CPS cases is essential for more precise assessments, diagnoses, and recommendations specific to physical, sexual abuse, and severe neglect cases.

I appreciated Dr. Alexander's suggestions for the future that would lead to more prevention. As a junior scholar currently focused on the prevention of child maltreatment, I believe that to stop child abuse and neglect from occurring, the subject needs to be regularly discussed and presented to the public in ways that are similar to the "Stop Smoking" campaigns. Given that child maltreatment stopped being a "family issue" and became a "public health" issue only within the last 40 years, it is not surprising that primary prevention work is only beginning to gain momentum; however, I believe that with the foundation that Dr. Alexander and his colleagues have laid, this social investment will continue to grow.

Another area I appreciated in our conversation was Dr. Alexander's suggestion that work gets done because someone wants to do it. In other words, I hear that self-motivation and dedication to a cause get the ball rolling. In the field of child maltreatment, multiple areas still need attention, and Dr. Alexander's words are to "just go do it." In some ways, it is this simple and requires many of the skills that social workers—my profession—are trained in, such as organizing and leadership. For example, I have a vested interest in the well-being

of single fathers and their children, yet they are an overlooked and stereotyped population within child welfare. Therefore, it is upon me to gather the necessary information about these families, present at conferences, and write empirical articles (and editorials) so the needs of these families are met with skilled child welfare staff. It is equally upon me to collaborate with other parties so that information is disseminated to multiple groups. Dr. Alexander has participated in these exact movements, which is why one obscure diagnosis such as Munchausen by proxy is now familiar in more than just clinical spaces.

Overall, Dr. Alexander is an excellent example of "walking the walk and talking the talk." He is passionate about his work, believes in his role as a mentor, networks with the necessary legislators to get policy passed that benefits families in need, and truly has taken the field of child maltreatment to another level. Although he humbly believes his success was because of timing, which may have some truth, I personally think it's because of his belief that creating change is everybody's job. You just have to want to do it.

Lasting Impression: Carmella Miller, LCSW, Doctoral Candidate

Walking away from our meeting with Dr. Alexander, I felt invigorated and optimistic. I don't know if it was his passion for his work, or the challenge he gave us to find an area we are interested in and pursue it, or both, but I ended our interview with a sense of hope and determination. My initial thought was how refreshing it was to hear him talk about the positive side of the child welfare workforce. I truly believe Dr. Alexander has such optimism because he genuinely believes his job is to provide the children he sees with knowledgeable and compassionate care. He sees himself as part of the healing process.

I was pleasantly surprised to hear Dr. Alexander speak about the importance of a holistic approach to treatment saying that we, as a field, can't make strides forward if we are *just* treating the child or responding to the abuse. As a clinical social worker who firmly believes in the person-in-environment model of care, I agree, of course, and his words made my heart happy. Treating the child involves examining the environment, providing services to caregivers, and true coordination of services among support team members. In addition, Dr. Alexander doesn't want us to lose track of the humanity of it all or see the work as something to be checked off on our job task list. The responsibility of child abuse prevention, diagnosis, and treatment is not monochromatic but has shades of grey that represent the unique intricacies involved in each case. If we ignore those intricacies in favor of rote procedures, we will undoubtedly miss opportunities to truly make a difference.

I am thankful for Dr. Alexander's generosity of time and wisdom. Truth be told, our interview was close to two hours, and it could have been longer. In fact, it was more of a conversation than an interview; at the end it felt like we had known each other for years. One thing is for sure, learning about his wealth of experience, accomplishments, and his future visions for APSAC members confirmed the importance of building connections and furthering their work in this important field.

At the end of our time together, Dr. Alexander relayed a story about Albert Einstein, who spoke about identifying *your number 13*. As he told it, Einstein would ask his colleagues and students to think of the last 12 things they had completed and then identify one thing they could add to that list to improve upon it. He challenged them to find one way to make their work better, more effective, or more efficient. That one thing was what Einstein called your number 13. In telling this story, Dr. Alexander said he does the same with his fellows and challenges them to find their number 13. After a brief pause, he asked Stacey and me to find our number 13s. We both had to stop and really think about it. I am not sure why, but that question hit me

like a jolt. Since then, I have made it a habit at the end of the day to ask myself, *What is your number 13?* Reflecting on our interview and this article, I've decided that mine is to help connect you, the readers, with the genuine spirit Dr. Alexander brings to his work and the field of child welfare. So, in honor of Dr. Alexander, I challenge you to find your own number 13.

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