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# APSAC ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

SPECIAL ISSUE

## HOLDING THERAPY: PART 1

**Guest Editor: William N. Friedrich**


**Introduction to Holding Therapy: Part 1**
*William N. Friedrich, PhD, ABPP*

The "attachment therapy" promulgated by the Attachment Center of Evergreen, Colorado, and its devotees is **not** derived from the attachment theory developed by John Bowlby and Mary Ainsworth. In fact, this approach is counter to attachment theory along a number of critical dimensions, including the view that the problem is inherent in the child. **2**

**Description, History, and Critique of Corrective Attachment Therapy**
*Matthew L. Speltz, PhD*

The author explains the roots of holding therapies and describes a treatment center (The Center) with a coercive protocol similar to the Evergreen Attachment Center model, in which the therapist replaces the parent and seeks to provide a "corrective emotional experience." An incisive critique follows including theoretical linkages, potential physical and psychological risks, and alternative treatments. **4**

**Reactive Attachment Disorder: What Do We Really Know About This Diagnosis?**
*Rochelle F. Hanson, PhD*

Despite the proliferation in the use of the RAD diagnosis and an increased focus on attachment problems in general, there is considerable disagreement about what RAD actually is and, perhaps more importantly, how to treat the problems purportedly displayed by children with this diagnosis. The focus of this article is to (1) provide an overview of the RAD diagnosis and problems associated with its use, (2) discuss concerns related to current treatment approaches, and (3) present some guidelines for possible interventions for children displaying attachment-related difficulties. **10**


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# Introduction to the Special Issue: Part 1

William N. Friedrich, PhD, ABPP
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If there is one take-home message from this special issue on such an important topic, it is the following: The "attachment therapy" promulgated by the Attachment Center of Evergreen, Colorado, and its devotees is **not** derived from the attachment theory developed by John Bowlby and Mary Ainsworth. In fact, this approach is counter to attachment theory along a number of critical dimensions.

For example, the intervention suggests that the problem is inherent in the child, a highly individual notion that is in direct contrast to attachment as a relational process. This dissonance is true whether or not the therapy being described is labeled as the traditional rage reduction approach, or its variations (i.e., holding therapy, attachment therapy, or humanistic attachment therapy).

Matthew Speltz's contribution to this special issue places these attachment therapies squarely within a sociological tradition. This tradition has served as the underpinnings of such "therapies" as the Reunification Church of the Rev. Moon and the ill-fated and now disregarded Synanon program from the late 1960s, which was designed to "break down" adult addicts.

Beverly James was an early critic of rage reduction therapy and its various permutations, and, in her seminal text, she elaborated on this sociological phenomenon (James, 1994). She suggested that mental health practitioners have long held to a hydraulic view of emotional problems. My summary of her perspective is that emotional problems are akin to fluids or pressures that build up and, after a certain point, they become bad things being held inside. The uninformed therapy that results from this viewpoint would be to "get the bad things out." Some of you may remember "primal scream" therapy from 25 years ago (Janov, 1970). This therapy, which still has its followers, is directly related to the hydraulic view.

James views these naïve theories advocating the "discharge of emotions" as an enormous obstacle to thinking accurately about therapy. As you will read in Speltz's description of the process, attachment therapy holds to this emotional discharge view of mental health.

Professionals who work with maltreated children know how challenging many of these children can be, whether in their birth homes, foster homes, or adoptive placements. I personally have found them among the most difficult children with whom I have ever attempted therapy. The increase in orphanage-reared Eastern European children now living in the United States and Canada has also created challenges for therapists. It is difficult to sit in an office with a warm-hearted, well-meaning couple who adopted a child with a lifelong history of neglect, hear their pleas for help, and not wish that behavior change could be more rapid. These factors, in combination with the highly publicized death of a 10-year-old girl while undergoing holding therapy in Colorado (King, 2000), prompted this special issue.

A stunning lack of precision and science abounds in the field of child mental health. The diagnostic labels of reactive attachment disorder and childhood onset bipolar disorder seem to be used indiscriminately and frequently. Attention deficit-hyperactivity disorder (ADHD) is increasingly viewed solely as a brain phenomenon. This is despite the research literature indicating that when ADHD presents in combination with oppositional defiant disorder or conduct disorder in the young child, it frequently means the child has been maltreated or traumatized or both (Ford, Racusin, et al., 2000).

This same lack of empiricism extends to psychotherapy with children. Despite the empirical support for relational approaches, such as parent-child interaction therapy (Hembree-Kigin & McNeil, 1995), or directive approaches, such as cognitive behavioral therapy in the treatment of maltreatment-related symptoms (Deblinger & Heflin, 1996; Deblinger, Lippman, & Steer, 1996), the majority of therapy with children continues to be nondirective and supportive (Friedrich, Jaworski, & Berliner, 1994). I believe that as members of a field, we should strive to practice at the most empirically supported level possible. The absence of empirical support for attachment therapy is another argument against its utilization.

We are privileged to have two outstanding contributors to Part 1 of this special issue. Dr. Rochelle Hanson presents a critique of the RAD diagnosis, the diagnostic category that therapists and service providers often use to validate the child's basic untreatability. Dr. Matthew L. Speltz's paper began as a document designed to educate a judge in Washington State about attachment therapy. As such, it provides an excellent overview of the history of this approach as well as the interventions involved. These authors also present separate critiques of the approach.

In Part 2 of this topic, to be printed in the following issue of the *Advisor*, we include the perspectives of two noted attachment theory experts, L. Allan Sroufe and Martha F. Erickson. Dr. Sroufe is an internationally recognized authority on attachment and one of the investigators of the ongoing, longitudinal Mother-Child project at the University of Minnesota, where one of his collaborators has been Dr. Erickson (example, Sroufe, et al., 1999). The two of them were gracious enough to respond to questions germane to the topic of holding therapy. In addition, I present several alternate perspectives about the assessment and treatment of severely disturbed and maltreated children that supplement some of the therapeutic interventions suggested by Hanson and Speltz. Rounding out the second issue on this topic are papers by Lucy Berliner of the Harborview Sexual Assault Center and Rosie Oreskovitch of the Department of Human Services in Washington State.

I believe that we have brought together some excellent perspectives in these two special issues of the *Advisor*. Clearly, this topic is important to those who work with maltreated children.

*This special issue could not have been compiled without the additional input from Lucy Berliner, MSW, and Erna Olafson, PhD. I also acknowledge the influence of Beverly James, MSW, whose work in the field added to the momentum for this issue.*

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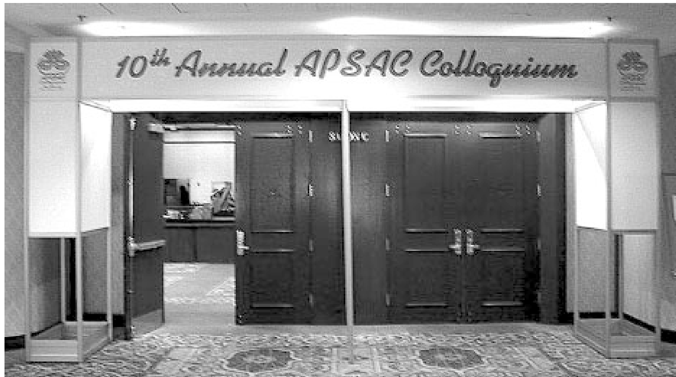


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## About the Contributors

**William N. Friedrich, PhD, ABPP**, is a professor and consultant in the Department of Psychiatry and Psychology of the Mayo Medical School and the Mayo Clinic. He has developed an integrated model to guide the treatment of maltreated children. One component of this model is parent-child attachment, and a number of attachment-related interventions are suggested in his book, *Psychotherapy with Sexually Abused Boys*, which was published by Sage Publications in 1995.

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**Matthew A. Speltz, PhD**, is a professor of psychiatry and behavioral sciences in the University of Washington Medical School in Seattle, Washington. He has served as the clinical director of the Child and Adolescent Psychiatry Outpatient Program at Children's Hospital and Regional Medical Center since 1988. He is also the director of the Clinic for Children with Attachment Problems, located at Children's Hospital within the outpatient program. This program provides evaluation services to foster/adopted children and their caregivers; the majority of these children have histories of significant maltreatment and unsuccessfully treated psychiatric disorders. Dr. Speltz has been the principal investigator for three longitudinal research projects funded by the National Institutes of Health; two of these have focused on the development of attachment in young children, including the study of boys with early-onset conduct disorder.

### Greetings from the new Editor-in-Chief:

As the new editor, I invite letters to the editor and brief commentaries from readers about this and other special issues and articles published in the *ADVISOR.* Letters and commentaries can be sent to my address, which is listed in the "Call for Papers" page of this issue.

I'm very pleased to be taking on the editorship and grateful to Terry Hendrix and Ann West for their help, Lucy Berliner for suggesting this special issue, and Bill Friedrich for putting it together.

— Erna Olafson

# Description, History, and Critique of Corrective Attachment Therapy

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## Procedural Distinctions

Prescribed physical contact between parents and children, and between therapists and children, is not uncommon in mental health treatments. Parents are often asked to initiate affectionate physical contact with their problem children (sometimes contingent on the child's positive behavior). It is also sometimes necessary for a parent or mental health specialist to escort a child physically to a time-out situation as part of a planned behavior program.

A parent or clinician may be asked to physically restrain violent or self-injurious children for safety reasons, releasing them when they regain control. However, the holding therapies included in "corrective" attachment therapy do not address safety needs. They differ in that a therapist or parent *initiates* the holding process for the purpose of *provoking* strong, negative emotions in the child (e.g., fear, anger), and the child's release is typically contingent upon his or her compliance with the therapist's clinical agenda.

## History

Today's holding therapies trace their roots to the controversial techniques developed by Robert Zaslow in the 1970s for autistic individuals. Zaslow believed that inducing rage by holding autistic individuals—often against their will— would lead to a breakdown in the person's defense mechanisms, making the individual more receptive to and cooperative with others (Zaslow & Menta, 1975). These ideas have been dispelled by research on the genetic/biologic causes of autism. Unlike Zaslow's techniques, interventions based on behavioral principles have proven effective with autistic children.

A decade later, Martha Welsh (1984, 1989) described a technique for children with attachment problems called holding time. Mothers were instructed to take hold of their defiant child at these times, holding them tightly to the point of inducing anger. Mothers were told to expect that the child may spit, scream, swear, attempt to get free, bite, and try to cause alarm by saying that he is in pain, cannot breathe, will vomit, is going to die, or needs to urinate. In this approach, parents were encouraged to accept these behaviors calmly and silently. Welsh described a subsequent stage (marked by the child's weeping and wailing) in which parents were encouraged to resist the temptation to feel sorry for the child or to feel guilty about what they are doing. Mothers were told that if they could successfully resist these temptations, the child would enter an acceptance stage in which the child would fight less and become relaxed and tired. The mother was then instructed to loosen her hold on the child, at which point a bonding process was believed to begin, in which the child would find comfort from the mother in this relaxed state. To my knowledge, no evidence for the efficacy of this method has ever been provided.

Foster Cline (1991) and associates at the Attachment Center at Evergreen, Inc. (Evergreen, Colorado) began to promote the use of the same or similar holding techniques with adopted, maltreated children who were said to have an attachment disorder (not to be confused with DSM-IV's reactive attachment disorder). For several reasons, maltreated children and their adoptive parents were ideal recipients for this innovative but risky intervention. That is, maltreated children are difficult to change and adoptive parents (mostly from middle-socioeconomic backgrounds) tend to have high expectations for good child deportment. In addition, many adoptive parents are desperate for any intervention that promises rapid change (within days instead of months or years), and a relatively high percentage of adoptive parents have the resources to pay privately for mental health services not traditionally covered by traditional payor mechanisms. Most important, the Evergreen model offered a conceptualization that placed the cause of child mental health problems squarely on the child rather than on the quality of the family environment.

## Description

(The following is a description of attachment therapy used by a treatment center in the Pacific Northwest, referred to as The Center. Quotations are taken from this center's published material.)

The Center's protocol appears to be a replication of the Evergreen Attachment Center model and is very similar to the Welsh methods described above, except that a therapist replaces the parent, at least in the initial stages of therapy. As stated in The Center's therapeutic protocol (from which the quotations below are taken unless otherwise noted), the therapist seeks to provide a "corrective emotional experience" in a 10-day intensive therapy program. Like Welsh (1984, 1989), The Center induces rage by physically restraining the child and forcing eye contact with the therapist (the child must lie across the laps of two therapists, looking up at one of them).

In a workshop handout prepared by two therapists at The Center, the following sequence of events is described: (1) therapist "forces control" by holding (which produces child "rage"); (2) rage leads to child "capitulation" to the therapist, as indicated by the child breaking down emotionally ("sobbing"); (3) the therapist takes advantage of the child's capitulation by showing nurturance and warmth; (4) nurturance at this juncture is believed to produce greater "trust" in the child; and (4) this new trust allows the child to accept "control" by the therapist and eventually the parent.

According to The Center's treatment protocol, if the child "shuts down" (i.e., refuses to comply), he or she may be threatened with detainment for the day at the clinic or forced placement in a temporary foster home; this is explained to the child as a consequence of not choosing to be a "family boy or girl." If the child is actually placed in foster care, the child is then required to "earn the way back to therapy" and a chance to resume living with the adoptive family.

Children who comply with the holding procedure go on to "practice a new way of being with Mom and Dad" (including adoptive parents' use of "in arms holding") and a procedure in which the child is required to forgive and say good-bye to his or her birth mother. This is a staged scenario or psychodrama in which the therapist plays the role of the child's birth mother for about 10 minutes. Children are expected to tell their birth mother "what they've always wanted to say" and then to say good-bye. At this point the adoptive mother is prompted to enter the room to provide "comfort and closeness." If the child does not seem ready to say good-bye to the birth mother, the therapist can facilitate the process by

getting the child to remember or acknowledge certain negative characteristics about the birth mother. For example, this might include the therapist reminding the child about the birth mother's history of drug use and prostitution.

Other techniques that are used during the 10-day intensive therapy include a confession procedure, in which children are asked to write down all the "negative, mean things" they have done (called the "clean slate list") and to make "amends" by doing something nice for a family member as a consequence for a previous mean behavior. As a follow-up measure at home, adoptive parents are encouraged to use "natural consequences" for undesired child behaviors. For example, in one case first seen at The Center and then seen subsequently in the Attachment Clinic at Seattle Children's Hospital, parents described to me a procedure in which they were encouraged to make their preschool child use a toothbrush to clean the grout on the family's back patio. This was deemed appropriate punishment for misbehavior involving spilling something in the house.

In my reviews of the literature on various attachment holding therapies, I have found limited variation in the degree of coercion employed. For example, Hughes (1997) prepares the child for holding beforehand (with discussion and demonstration), and he states that he would discontinue the holding if the child showed "terror" or "strong fear." Although not explicitly stated, it does not appear that Hughes (1997) uses punishment contingencies (such as not returning home when the child is noncompliant), as is done in The Center's procedure. Hughes also states that he would respect an adolescent's refusal to be held, as this would require other adults to help restrain the adolescent (presumably, however, younger children are not given this option).

## Relation of Attachment Therapy to Other Coercive Methods for Behavior Change

Intensive attachment therapy bears remarkable similarity to other programs that use coercive persuasion to change human behavior—the comparison is helpful, I believe, in understanding the theoretical context and potential risks and benefits of intensive attachment therapy.

Sociologists have studied thought reform programs that rely on intense interpersonal and psychological methods to "destabilize" an individual's sense of self in order to promote compliance with an ideology or organization (Borgatta & Borgatta, 2000). The targets of such procedures are typically adults who participate voluntarily in the process, at least initially. Well-known examples include the recruitment strategies employed by some religious organizations and social movements (e.g., a notable historical example is the Rev. Moon's Unification Church), fringe rehabilitation programs (e.g., Synanon, a now obsolete and ineffective drug rehabilitation program), some police and military interrogation methods, and quasi-therapeutic programs such as those popular in the human potential movement of the 1970s and 1980s.

According to Borgatta and Borgatta, all of these programs share the following three components: (1) a staged and intense interpersonal experience in which the individual's psychological defenses are taken away and the individual is flooded with powerful emotions; (2) an opportunity for the targeted individual to escape further destabilization procedures by (a) accepting the proffered ideology, (b) rejecting previously held beliefs, or (c) confessing previous undesired acts; (3) a final stage in which there is organized social approval for the individual's compliance with the goals of the program and rejection of competing ideas.

With respect to the efficacy of these procedures, Borgatta and Borgatta report that in most applications there have been only transient alterations in behavior that were limited to the environment in which the coercive persuasion was applied. Borgatta and Borgatta note that such programs have produced high rates of what are termed "psychological injuries" to participants including anxiety/panic, manic episodes, and psychiatric disturbances.

In my opinion, intensive attachment therapy contains elements of all three of the stages described above: (1) the child is subjected to an intense interpersonal experience that is explicitly designed to induce powerful emotions (e.g. rage and sobbing); (2) while in this vulnerable state, the child is given the opportunity to terminate the procedure by complying with the wishes of the therapist and adoptive parent, and/or by choosing his adoptive parents over memories of birth parents; and (3) the child's verbalized acceptance of the adoptive family and rejection of the birth family are strongly reinforced by the therapists and adoptive parents. However, unlike the adults who typically volunteer to participate in these procedures (who, with the exception of prisoners, are free to leave), the child recipients of intensive attachment therapy are given no choice in the matter and may be threatened with expulsion from their family if they do not comply. For them, the consequences of noncompliance with this version of thought reform are potentially life changing, (e.g., the adoption being reversed, placement in residential treatment facilities).

## Critique

### 1)Diagnostic Formulations

There is currently no reliable diagnosis of attachment problems with proven validity including the DSM-IV reactive attachment disorder (RAD). One of the country's leading researchers of RAD, Charles Zeanah, MD, of Tulane University School of Medicine, has recently reported that evidence can be found in support of only some RAD criteria. He also notes the significant "discrepancy between popular accounts of RAD and more formal definitions in the scientific literature" (Zeanah, 2000, p. 230). It is anticipated that the next version of DSM will contain a substantially revised version of RAD.

In my experience with therapists in the Pacific Northwest, this diagnosis tends to be made whenever maltreatment is known or suspected in the history of a child referred for psychiatric problems, although this event is only one of several criteria required for diagnosis. Consequently, there is likely to be significant over diagnosis of RAD. The implication of this is that many children believed to have unique and highly specialized needs because of their RAD diagnosis may in fact have other, better-understood diagnoses that suggest different and potentially more effective treatment plans. It is important to understand that adoptive parents tend to support a diagnosis of RAD because it implies that the child's problems are due almost exclusively to the birth parents, and that resulting psychopathology is "within the child," rather than a broader reflection of the child's adoptive family and other interpersonal relationships. However, almost all research in developmental psychopathology indicates that children's disruptive behavior problems result from complex interactions between genetic factors and past and current environmental (e.g., family, interpersonal) factors.

As noted, Foster Cline (1979) is an important figure in the attachment therapy movement. He has described an attachment disorder that is based solely on child characteristics (e.g., antisocial behavior, disordered eating, counterfeit emotionality, toileting problems) and differs considerably from the DSM-IV version. To my knowledge, this diagnosis has not been empirically validated, but its clinical "face validity" is reasonably strong (i.e., it seems to capture many of the characteristics commonly seen in maltreated children, for example, mood regulation problems, obsessive tendencies, compulsive behaviors, hoarding, counterfeit emotionality, toileting problems). This may explain why many adoptive parents are attracted to the promise of intensive attachment therapies; they make the understandable assumption that a therapist who can so accurately *describe* (diagnose) their child should be able to effectively *treat* the child as well.

**2) Theoretical Linkage**

Although recent writings by therapists at the Evergreen Attachment Center and elsewhere (e.g., *Handbook of Attachment Interventions*, edited by Terry Levy, PhD, 2000) have increasingly emphasized the link between their methods and the considerable scientific literature on human attachment, there is very little connection between the two. Rather, as suggested above, the theoretical origins of holding therapies can be traced more directly to the work of Zaslow and Menta (1975), Welsh (1984, 1989), and the thought reform methods employed by trainers in the human potential movement. In my opinion, the recent integration of holding therapies with mainstream scientific work largely represents a post hoc effort to legitimize highly controversial methods that would otherwise remain on the fringe of mental health treatment.

The writings of intensive attachment therapists are inconsistent with mainstream attachment theory and research in ways too numerous and technical to detail here (e.g., intensive attachment therapists often talk about the "unattached child," a theoretical unlikely possibility from the perspective of John Bowlby and others, and one that is inconsistent with research on the attachment behaviors of institutionalized, severely maltreated orphans). Furthermore, interventions that have been legitimately based on the scientific study of attachment and related theories and hypotheses (e.g., Erickson, et al., 1992; Van den Boom, 1994; Speltz, 1990) contain goals and procedures that are diametrically opposed to those utilized by intensive attachment therapists. The goals of the former are to *enhance* the sensitivity of the caregiver, to provide the child with *more* control rather than less, to *reduce* caregivers' expectations for rapid change (and encourage *acceptance* of the child's basic temperament and personality), to *unlink* contingencies between the child's behavior and his or her perceived permanency within the family, and to *emphasize* reinforcement and positive exchanges of affection (when the child wants it) rather than punitive consequences that tend to erode the quality of family relationships.

**3) Potential Risks**

**a. Psychological risks**

Because of the traumatic nature of the abusive encounters, many children who have been physically or sexually abused experience extreme anxiety or panic when forced into close contact with others. For this reason, forced or intimate physical contact with unfamiliar caregivers can further traumatize the child as well as maintain or exacerbate anxiety-spectrum symptoms.

In our clinical work, we have found that some adoptive families are simply too intrusive with newly adopted children. For example, some parents may expect their child to quickly engage in discussions of their emotional and psychological status or to respond favorably to physical affection within weeks or months of adoption. In one case with which I'm familiar, the parents wanted their adoptive child to change her last name to theirs within a few months of the adoption; they interpreted her resistance to this idea as an attachment problem. In such cases, we would advise parental patience and a desensitization approach, in which intimacy on various levels is approached slowly in a step-wise fashion with the child given maximum control.

I would also anticipate harmful psychological effects of procedures that make "nurturing" (love) contingent upon the child's submission to authority. In my opinion, this recapitulates the interactions that many abused children have experienced earlier in their lives (e.g., sexually abused children may be given extraordinary nurturance for submitting to demands for sexual favors).

Similarly, the procedure of responding to child noncompliance with threats of expulsion from the adoptive family (in many cases, a family with whom the child has lived for many years) can significantly exacerbate a child's fear of abandonment. (I know of no other legalized situation in which individuals can be removed immediately from their family if they do not comply with a procedure from which they seek escape.) This procedure also reinforces the notion that the child is acceptable to the adoptive family only if the child, in essence, becomes a different person. In our clinical work, we have found that antisocial maltreated children tend to improve (i.e., stop testing their caregivers' commitment with increasing levels of disruptive behavior) when they consistently hear the message that they are permanent members of the family, *regardless of how they behave* (replicating the circumstances naturally experienced by most children in their biological families).

The procedure of requiring children to say good-bye to their birth parents and facilitating the process by emphasizing the birth parents' negative characteristics is potentially harmful to the child's self-perception (i.e., derogation of one's birth parent requires implicit derogation of one's self, at least in part). This practice is inconsistent with theory and clinical experience suggesting that many adopted children retain positive fantasies about their biological parents that are helpful to their development, especially during the adolescent years (when many nonadoptive adolescents fantasize about life with a better parent).

The challenge for adoptive parents is to develop the ego strength or resilience to encourage the adopted child's *acceptance* of birth parents, to see the *good* in birth parents, and perhaps eventually (as an adult) to come to understand the difficult circumstances that may have forced the birth parents to give up the child. If the adoptive parent criticizes birth parents, the adopted child experiences loyalty conflicts that can lead to the child feeling misunderstood and criticized. For the younger child, it may be better to hold a somewhat idealized or romanticized version of the birth parent than one that is harshly objective.

Finally, there is a striking manipulative quality to the behavior of the therapists and adoptive parents in this staged psychological intervention that has the potential to reduce the child's already fragile security and trust in the behavior of adults. Children are not likely

to trust an adult who only minutes before deliberately provoked intense anger and fear. Although many children may portend acceptance of the procedure in order to end it as soon as possible, in my opinion most will leave with an enduring suspicion of therapists and caregivers (e.g., a 12-year-old girl referred to our clinic, who had previously been subjected to attachment therapy, reported a deep mistrust of adults as a result of her previous experience).

**b. Physical risks**

The probability of physical harm to the child is increased by the physical confrontation that defines the holding method. Children have been known to hit, bite, scratch, and do anything they can to release themselves from a therapist's grip. Holding therapists tend to regard the child's complaints of discomfort as manipulative strategies, and these protests are therefore typically ignored. This perspective may have been the precipitant of death for 10-year-old Candace Newmaker by an Evergreen, Colorado, psychotherapist during an extreme version of holding therapy, called "rebirthing" (the child's complaints of being unable to breathe while wrapped in a rug were apparently ignored). To my knowledge, therapists at The Center do not use such extreme measures, and the probability of serious injury or death is relatively low in my opinion; however, the risk of mild to moderate injuries cannot be discounted in a therapy situation that requires physical restraint of children who may panic when forcibly held against their will.

It is also important to understand the tremendous emotional stress that is placed upon the *therapist* during the holding encounter. Imagine the difficulty of trying to restrain a 10-year-old who is hitting, biting, swearing, and yelling "I hate you" repeatedly. Few clinicians can regulate their emotions and remain objective throughout such an encounter, and we have no information about the type of training, preparation, or oversight that would allow a therapist to manage such a risky and volatile procedure.

## 4)Potential Benefits

In my opinion, there are no potential benefits to the child as a result of participation in intensive attachment therapy. There may be a dramatic, but very short-term change in child behavior that is desired by the therapists and/or adoptive parents as a result of the child's overt submission (e.g., increased compliance to parental directives). However, as suggested by the results of research on thought reform programs, such changes are likely to be transient and shown primarily in the presence of the adoptive family, with very limited generalization to school, peer group, and other settings.

Unfortunately, there has been no empirical study of holding therapy using scientifically rigorous methods. Almost all that is known about the effects of this therapy are testimonials and other anecdotal information. Most of it is found on Internet sites promoting the use of this approach or a related product (e.g., see the 40 plus consumer reviews of Welsh's *Holding Time* on Amazon.com).

In my review of the literature in preparation for this article, I located a single journal publication, conducted as part of a student's dissertation project (Myeroff, Mertlich, & Gross, 1999). A quasi-experimental design was used to examine the pre- and posttreatment effects of holding therapy conducted at the Attachment Center at Evergreen. Data analyses showed a significant decrease in adoptive parent reports of specific aggressive behaviors as measured by the Child Behavior Checklist (Achenbach, 1991). However, there was no effective control group, no randomized assignment of children to treatment conditions, and no subjective measures of child status and well-being. Ascertainment methods were questionable. These methodological limitations are so significant that it becomes impossible to interpret the data from this single study.

**a. Risk versus scientific evidence**

The Center for Evidence-Based Medicine at Oxford University has developed standards for evaluating the risks and benefits of new treatments and determining whether such treatments meet criteria for acceptable scientific scrutiny. In this system, five levels of scientific evidence are described as follows, from most to least rigorous: 1) randomized clinical trial, 2) prospective cohort study, 3) case-control study, 4) case-series studies, and 5) expert opinion. Treatments that involve relatively higher levels of risk (e.g., endanger the safety of patients or carry high probability of iatrogenic effects) are required to meet higher levels of scientific evidence. Similarly, the American Psychological Association has established criteria for what it terms "empirically supported treatment" (Chambless & Holton, 1998).

In my opinion, (a) intensive attachment therapy carries a high risk of psychological injury to the child that requires the highest levels of evidence in support of its benefits (#1 or #2 above), and (b) the current support for this treatment (primarily personal testimony) does not meet criteria for any of the five levels listed above or any of the criteria listed by Chambless and Holton (1998). Until a randomized clinical trial of a well-specified coercive attachment or holding therapy is conducted and replicated, it is both unethical and dangerous to involve a child in this form of treatment. Other researchers and clinicians also believe this treatment is unethical and dangerous and have stated so in published papers or books (e.g., Hanson & Spratt, 2000; Hoyle, 1995; Miller, 1997).

## 5) Alternative Treatments

It is important to understand the limitations of current technology in psychology, psychiatry, and education because adults' expectations for children's behavior change often far exceed what is currently possible. For example, there is no known technology that can change a child's basic temperament or personality or one that can completely eliminate or reverse the effects of maltreatment in early life. There *are* effective technologies for stabilizing, managing, and containing children's antisocial and violent behavior, reducing family conflict, improving children's social skills and their ability to regulate emotion, improving school adjustment and achievement and peer relationships, and reducing anxiety and fear in children who have been traumatized by early experiences.

There are many alternatives to intensive attachment therapy for adoptive children with histories of maltreatment that have been empirically supported in studies with nonadoptive high-risk and/or severely disordered children (see Greenberg, Domitrovich, & Bumbarger, 2001, for examples). Empirically supported treatments for aggressive/disruptive behavior, anxiety, sleep disorders, and toileting problems (commonly found in foster/adopt populations) are described in a recent book (*Treatments That Work With Children: Empirically Supported Strategies for Managing Childhood Problems*) by Christophersen and Mortweet (2001), published by the American Psychological Association.

## DESCRIPTION Cont'd

These treatments include parent and family interventions, cognitive-behavior therapy for children's emotion regulation and social skills, and specialized behavior programs for home and school. Maltreated children with behavior problems typically need a combination of such services as well as intensive in-home, parental support. To my knowledge, none of these strategies has been specifically studied in samples of adopted children with severe behavior problems. However, in my opinion, these treatments are likely to be effective when applied by therapists with specific expertise and experience in child maltreatment and issues germane to foster and/or adoptive parents.

I would agree with holding therapists that traditional "supportive counseling" (or "talk therapy") for the individual child is rarely effective, especially when used as a solitary intervention. When individual treatment is the sole intervention, the child's problems once again are not viewed from an attachment-perspective, but rather are seen to reside solely in the child.

It is important to note that the effective treatment of maltreated children does not necessarily require a focus on attachment processes, although therapist knowledge of attachment theory and related interventions is in my opinion likely to enhance the probability of a positive outcome. Most children and adolescents are incapable of resolving (or "working through") their "abandonment, grief, and loss," either by talking about it or through brief, staged interventions like holding therapy. In my clinical experience, these issues are more productively addressed (if needed) when maltreated individuals reach late adolescence or early adulthood. Perspective can emerge with age, and it is as a young adult that the issues of maltreatment and subsequent loss of family can eventually be resolved. Most children and adolescents are overwhelmed and confused by discussions of their early experiences of maltreatment. It is more appropriate to focus on stabilization of the child's behavior, coping skills, attainment of critical developmental milestones, and the quality of the adoptive parent-child/adolescent relationship.

**Most children and adolescents are overwhelmed and confused by discussions of their early experiences of maltreatment. It is more appropriate to focus on stabilization of the child's behavior, coping skills, attainment of critical developmental milestones, and the quality of the adoptive parent-child/adolescent relationship.**

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# CALL FOR PAPERS for *APSAC ADVISOR*

**Purpose:** The *APSAC ADVISOR*, a quarterly publication of the American Professional Society on the Abuse of Children, serves as a forum for succinct, practice-oriented articles and features that keep interdisciplinary professionals informed of current developments in the field of child maltreatment. *ADVISOR* readers are the more than 2,500 social workers, physicians, attorneys, psychologists, law enforcement officers, researchers, judges, educators, administrators, psychiatrists, nurses, counselors, and other professionals who are members and supporters of APSAC.

**Appropriate material:** *ADVISOR* editors are seeking practical, easily accessed articles on a broad range of topics that focus on particular aspects of practice, detail a common problem or current issue faced by practitioners, or review available research from a practice perspective.

**Inappropriate material:** Articles should be well documented and of interest to a national, multidisciplinary audience. The *ADVISOR* is not an appropriate outlet for poetry or fiction, anecdotal material, or original research-based articles heavy on statistics but lacking clear application to practice.

**Length:** *ADVISOR* articles range from four to twelve double-spaced manuscript pages set in a 12-point typeface.

**Previous publication:** The *ADVISOR* prefers original material but does publish excerpts from previously published articles on topics of unusual or critical interest.

**Peer review:** All articles submitted to the *ADVISOR*, whether solicited or unsolicited, undergo peer review by the appropriate Associate Editor. If he or she thinks pursuing publication is appropriate, the Associate Editor may send copies of the article to one or two additional reviewers or return the article with comments to guide a revision.

**Submission:** All articles should be typed and double-spaced in 12-point type on 8.5 x1 1 inches white paper, and submitted with an accompanying disk in Microsoft Word plus a brief cover letter indicating that the article is offered for publication in the *APSAC ADVISOR.* The *ADVISOR* uses the manuscript format set forth in the latest edition of the style manual of the American Psychological Association.

**Please send unsolicited manuscripts to:**
**Erna Olafson, PhD**
**Editor-in-Chief, *APSAC Advisor***
**Dept. of Psychiatry ML0539**
**University of Cincinnati Medical School**
**Cincinnati, OH 45267**

**NOTE:** An abbreviated style sheet for *ADVISOR* authors is being prepared by graphic designer/typesetter Julie King and developmental editor Ann West to assist in ease of manuscript preparation.

# Reactive Attachment Disorder: What Do We Really Know About This Diagnosis?

Rochelle F. Hanson, PhD
Medical University of South Carolina

Over the past several years, increased attention has been paid to children who are alleged to have difficulties bonding and attaching to others. More specifically, there has been a surge in the use of reactive attachment disorder (RAD) as a diagnosis to describe a wide range of problem behaviors and disturbed interactions between infants or children and their caregivers.

Despite this proliferation in the use of the RAD diagnosis and an increased focus on attachment problems in general, there is considerable disagreement about what RAD actually is and, perhaps more importantly, how to treat the problems purportedly displayed by children with this diagnosis. The focus of this article is to (1) provide an overview of the RAD diagnosis and problems associated with its use, (2) discuss concerns related to current treatment approaches, and (3) present some guidelines for possible interventions for children displaying attachment-related difficulties. (For a more thorough discussion of these topics, please refer to Hanson and Spratt, 2000.)

## DSM-IV Diagnostic Criteria

To begin, it is important to highlight the criteria specified in the *American Psychiatric Association, Diagnostic and Statistical Manual*, fourth edition (DSM-IV) (1994), for a diagnosis of RAD. According to the DSM-IV, reactive attachment disorder (RAD) refers to "markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years" (p. 116). Children may be classified as having the Inhibited Type, which is described as a "persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions," or a Disinhibited Type, characterized by "the failure/inability to discriminate in their social interactions (e.g., excessive familiarity with relative strangers or lack of selectivity in choice of attachment figures)" (p. 116).

In addition to demonstrating the inhibited or disinhibited type of behaviors, the DSM-IV specifies that there must be evidence of pathogenic care, which refers to "persistent disregard" of the child's basic physical or emotional needs, or frequent disruptions in caregiving "that prevent formation of stable attachments (e.g., frequent changes in foster care)" (p. 118). By definition, children who have experienced abuse or neglect meet the pathogenic care requirement, which may explain the high rates of the RAD diagnosis among maltreated children. Another important issue regarding the DSM-IV RAD diagnosis is that the foregoing description is all that is specified. No additional information is provided, yet children with a host of severe behavioral and emotional problems are being diagnosed with RAD.

Another definitional issue with the RAD diagnosis is that attachment-related problems are not confined to the child's primary caregiver. As stated by the DSM-IV, the child's attachment difficulties are evidenced across multiple settings and with multiple caregivers (Richters & Volkmar, 1996). Despite this specific criteria, children whose relationship difficulties are solely confined to interactions with their primary caregiver, but not evidenced with others (e.g., teachers, therapists), are still receiving the RAD diagnosis (Zeanah, 2000).

## Problems With the RAD Diagnosis

A significant problem with the RAD diagnosis is its apparent misuse and overuse. Children exhibiting behaviors that extend beyond DSM-IV criteria are being given the RAD diagnosis. For example, Reber (1996) provides a table that lists common symptoms of RAD obtained from the files of the Family Attachment Center in Salt Lake City, Utah. The list includes problems or symptoms across multiple domains (social, emotional, behavioral, and developmental) and ranges from DSM-IV criteria for RAD (e.g., superficial interactions with others, indiscriminate affection towards strangers, and lack of affection towards parents) to nonspecific behavior problems including destructive behaviors; developmental lags; refusal to make eye contact; cruelty to animals and siblings; lack of cause and effect thinking; preoccupation with fire, blood, and gore; poor peer relationships; stealing; lying; lack of a conscience; persistent nonsense questions or incessant chatter; poor impulse control; abnormal speech patterns; fighting for control over everything; and hoarding of or gorging on food.

Clearly, this laundry list of symptoms and problem behaviors extends far beyond the criteria provided by the DSM-IV and might more appropriately indicate other types of disorders, such as conduct disorder, attention deficit-hyperactivity disorder, or other disruptive behavior problems that may not specifically stem from dysfunctional attachment. Thus, careful adherence to diagnostic criteria is important before labeling a child with a highly controversial and potentially stigmatizing diagnosis.

A second problem with the RAD diagnosis is that it falls under the umbrella of a much broader array of attachment-related problems. Difficulties in attachment may or may not meet DSM-IV criteria for RAD, and this important distinction is not typically made by the diagnosing clinician. A related problem with the use of both the RAD diagnosis and attachment problems in general centers on issues related to co-morbidity. Simply stated, children with attachment problems typically display other behavioral and emotional problems that may not be diagnosed. Examples include posttraumatic stress disorder (PTSD), attention deficit-hyperactivity disorder (ADHD), conduct disorder, anxiety disorders, or impulsive disorder. The reason why this issue becomes particularly important is that these other diagnoses, which may more accurately reflect the problems of the child, have evidence-based treatment interventions available for use. In contrast, there are *no* empirically validated treatments for RAD. The unfortunate outcome is that when practitioners focus on the RAD diagnosis, rather than on potentially more applicable diagnoses, they may ignore empirically validated interventions that could have a significant impact on the child's behavior.

A third problem is that the DSM-IV specifies that evidence of attachment-related problems and pathogenic care must be evident prior to age 5. However, for many children, historical information on their infancy and early childhood is not available. Thus, in theory, the RAD diagnosis should *not* be applied to any child for whom this early historical information is unknown. In practice, however, children are diagnosed with RAD, despite the absence of this critical information. An assumption is made about their early years, without available data.

A fourth concern with the RAD diagnosis is that there are no standerized measures, apart from the strange situation measure used only with infants and toddlers. In addition, subsequent studies indicated that attachment style was related to a host of other factors including confusion, fear, ambivalence, aggression, and hypervigilance in interactions with others. However, strange situation procedures are time-intensive, require extensive training, and are unlikely to be utilized by the average practitioner. The outcome of this is that practitioners may rely on unvalidated, poorly developed measures to assess for attachment problems or use no type of objective measurement at all.

Perhaps the biggest concern related to RAD and attachment problems, overall, is the complete absence of any evidence-based treatment interventions. Despite this (or perhaps as a consequence of this), many practitioners are relying on highly controversial and potentially harmful treatment interventions for children identified as suffering from attachment problems.

### Coercive Treatment Techniques

Beverly James (1994) provided an excellent overview of some of the coercive treatment techniques being utilized with attachment-disordered children. These treatment interventions have variously been referred to as holding therapy, attachment therapy, and rage reduction therapy. The basic components of the treatment procedures include the following: (1) prolonged restraint (other than for protection); (2) prolonged noxious stimulation; and (3) interference with body functions. During these procedures, a child is held immobile by one and up to several adults. While the child is restrained, a clinician makes deliberate attempts to provoke the child by yelling repeatedly and applying other noxious stimuli (i.e., poking ribs, continuously tapping chest or feet, tickling, pulling toes, moving child's head from side to side, covering child's eyes, pinching child's nose). Eventually, the child becomes physically and emotionally aroused and may scream or cry. At this point, the child is typically soothed, rocked, and told that he or she has done a "good job." These procedures may be conducted over several hours and may be repeated daily.

The alleged premise of such techniques is that the child's repressed rage interferes with the ability to form attachment. Prolonged restraint, noxious stimulation, and interference with bodily functions release the rage and convey to the child that adults can and will control him. When a child "surrenders," he or she is given to the caregiver(s) and the child will now "attach."

### Critique of Coercive Techniques

In addition to the potential for physical harm and even death, as in several known cases in this country, parents may be told that this type of intervention is the only way to keep their child from institutionalization or a career as a serial killer and that alternative conventional treatments will not work for their child. Professionals who express concerns about attachment therapy may be dismissed as misinformed or as having "unresolved issues of their own." It is critical to keep in mind that many children who get these treatments are extremely vulnerable. Because of the criteria regarding evidence of pathogenic care, many children given the RAD or attachment disorder diagnoses and thus subjected to these treatments have severe abuse/neglect histories and multiple out-of-home placements. This vulnerable population is at high risk of long-term difficulties even before being subjected to highly controversial and potentially traumatizing interventions (James, 1994).

Proponents of attachment therapy argue that it has been mischaracterized. They prefer to describe attachment therapy as confrontational and intense but also nurturing and sensitive. Proponents have presented anecdotal statements from parents who attest that attachment therapy worked where all else failed. However, anecdotes aside, the fact remains that there is simply no empirical evidence at present to support the assertion that attachment therapy is more effective, or even as effective, when compared with accepted and conventional approaches.

Indeed, the entire underlying rationale for the intervention is faulty. There are simply no data to postulate that children with attachment problems exhibit signs of repressed rage or that intentionally provoking a child's anger will result in ready attachment with a caregiver. As stated above, one of the most difficult aspects of attachment problems in general, and the RAD diagnosis in particular, is the absence of evidence-based interventions to address these difficulties. This makes it particularly difficult to make specific recommendations regarding appropriate, effective interventions. The important take-home point is that *any* intervention having even the potential to cause harm should not, under any circumstances, be utilized. In addition, it is incredibly rare that a child displaying attachment difficulties is not also displaying other behavioral or emotional problems.

A more careful focus on these behavioral and emotional problems appears to be the better way to address these children's difficulties, particularly because evidence-based interventions are available for other related behavior and emotional problems (e.g., treatments for ADHD, CD, PTSD) and a reliance on such interventions, whose goal is to reduce behavior and emotional problems, should have the added effect of improving caregiver-child relationships.

## Guidelines for Working With Children With RAD

Thus, despite the absence of RAD-specific evidence-based interventions, there are guidelines to follow when working with children who appear to have difficulties with attachment. Three important components comprise this discussion: First, careful assessment is critical. Second, specific preconditions should be in place before attempting any specific intervention. Third, when possible, evidence-based interventions that target observed behavioral and emotional difficulties should be utilized. In the absence of strong, empirical data, treatment interventions should be selected that have no potential for harm, that have a clear, cogent rationale, and that would be generally accepted among most clinicians working with children. Each of these points is discussed below:

### Careful Assessment Is Critical

It is important for assessment to determine whether the child meets criteria for other DSM-IV diagnoses that may lend themselves to the use of evidence-based interventions. Assessment should be multimodal and multirespondent. In other words, whenever possible, it is important to collect information from multiple sources, such as the child's caregiver(s), teachers, previous therapists, physicians, and the child directly. Assessment should also include standardized self-report measures (depending on the age of the child) as well as direct observation of child-caregiver interactions. It cannot be emphasized enough that if attachment problems are being reported, it is critical that assessment includes observations of the child, the child's caregivers, and other adults in the home, school, and clinic settings. There is also no substitute for a thorough clini-

cal interview. This can include both structured as well as unstructured components but should assess developmental history, medical history, family medical and psychiatric history, school functioning, and treatment history.

**Preconditions to Treatment**

Before any intervention can begin, certain preconditions need to be in place (Swenson & Hanson, 1998). Although many of these are intuitive, they can often be overlooked or assumed as already present. First, it is crucial that the child be in a safe environment. If a child has been abused and still has contact with the perpetrator, treatment will be completely ineffective. The child has to feel that he or she is safe from harm, and this includes the potential for future harm.

The second component includes the importance of providing a consistent, predictable environment in which the child feels some sense of control both within the home and in the therapeutic environment. As much as possible, stability and predictability can be enhanced by arranging set appointment days, times, and settings and by establishing a routine for the course of the therapy session. To further enhance a feeling of control, the therapist can offer the child some reasonable choices, for example, selection of a specific medium to work with (e.g., use of crayons versus markers) or some variation during the therapy session (e.g., meeting caregiver first, then child, or visa versa). It will also be up to the practitioner to set clear rules, consequences, and appropriate boundaries. Again, all of these components will increase feelings of safety, trust, and control, which will ultimately facilitate the therapeutic process.

The third, perhaps obvious, component is crisis stabilization. If a child is suicidal or homicidal, for example, any attempts to focus on trauma or family issues will be pointless until the crisis is resolved. However, it is important to avoid the trap of focusing exclusively on the weekly "crisis" at the expense of the specific goals of treatment. Finally, and perhaps most importantly, when addressing attachment-related issues, the inclusion of a supportive caregiver cannot be overstated. Caregivers can benefit from instruction in behavior management and positive parenting practices as well as from education regarding their child's trauma history, symptoms, and risk reduction strategies.

**Interventions**

Interventions should include individual therapy with the child; individual therapy with caregivers; dyadic therapy with child and caregivers; family therapy; and home-based services. Because the majority of children referred for attachment issues also display significant behavior problems, several evidence-based interventions can be utilized, such as parent-child interaction therapy (Hembree-Kigin & McNeil, 1995). Involvement of the caregiver is critical because if the child is experiencing problems in attachment, it makes intuitive sense to include the caregiver in all phases of treatment. The caregiver can benefit from a focus on behavior management skills training, and when behavior problems improve, a more positive child-caregiver relationship can develop.

Traumatic events possibly experienced by the child should also be addressed. That is, the RAD diagnosis requires evidence of pathogenic care. Many children who have histories of physical abuse, sexual abuse, and/or domestic violence may receive a RAD diagnosis, but trauma-related symptoms are often left untreated. Thus, clinicians need to note any symptoms of fear, anxiety, and other trauma-related problems. Further, interventions in the area of child maltreatment have empirical support and should be utilized. These include psychoeducation, affective processing, instruction on the use of adaptive coping and anxiety management skills, and gradual exposure (e.g., Cohen & Mannarino, 1996; Deblinger & Heflin, 1996; Deblinger, Steer, & Lippman, 1999; Deblinger, McLeer, & Henry, 1990; Stauffer & Deblinger, 1996). Deblinger and colleagues have demonstrated that outcome is improved when a supportive caregiver is included in the treatment process (e.g., Deblinger & Heflin, 1996; Deblinger, et al., 1999; Deblinger, et al., 1990; Stauffer & Deblinger, 1996).

In sum, this article has addressed a number of specific concerns regarding the diagnosis of RAD and the use of controversial treatments. With respect to diagnosis, it appears that the RAD diagnosis may be overused, particularly among children with a trauma history. A thorough assessment by a professional can examine potential attachment difficulties as well as recognize more prevalent diagnoses, such as anxiety. Second, there is no empirical evidence for any treatment intervention for attachment disorders at the present time. A reliance on controversial, unproven treatments can have a severely detrimental, even fatal, effect on children. However, if practitioners assess and target specific behavior and emotional problems, it may be possible to rely on proven, well-established treatment interventions. If, as the DSM-IV diagnosis specifies, these problems begin at a very early age, it is important to recognize that progress will be slow, especially in older children. There simply is no overnight "fix." To the extent that practitioners and caregivers recognize this fact, they will avoid novel treatments promising a quick cure.

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Note: References inadvertently omitted from this article will be included in the forthcoming Special Issue, Part 2.

## ERNA OLAFSON APPOINTED EDITOR-IN-CHIEF OF *APSAC ADVISOR*

The Executive Committee of APSAC recently voted unanimously to appoint Erna Olafson, PhD, PsyD, Editor-in-Chief of the *APSAC ADVISOR*. Beginning with this issue of the quarterly newsletter, she will serve for one year with the hope that her schedule will allow her term to be extended for a second year.

Dr. Olafson is Director of the Program on Child Abuse Forensic and Treatment Training and Associate Professor of Clinical Psychiatry and Pediatrics at the Childhood Trust, Cincinnati Children's Hospital and the University of Cincinnati School of Medicine. She directs the Childhood Trust's trainings in child forensic interviewing and has written training curricula for Pennsylvania and Illinois. She is Training Director of CHMCC's Child Abuse Trauma Treatment Replication Center, one of ten regional centers for the National Child Traumatic Stress Network funded by the U.S. Department of Health and Human Services, SAMHSA. Dr. Olafson is on the Advisory Board for the American Prosecutor's Research Institute's "Half a Nation Finding Words" project and is also Treasurer of the Ohio Professional Society on the Abuse of Children.

Terry Hendrix, Chair of the APSAC Publications Committee and a retired publisher, endorsed her appointment. He is enthusiastic about the future quality and appeal of the ADVISOR under Dr. Olafson's guidance.

## GETTING EVERYONE ON "THE SAME PAGE"

Remember the good old days when you weren't quite sure if your APSAC membership renewal was due? Even when you received a renewal form, it often went into a pile on your desk to deal with later. Then, maybe you forgot you actually had received it and, before you knew it, your membership had "slipped through the cracks." Well, guess what? Those days are gone.

In January 2002, APSAC changed operations to a calendar fiscal year (January–December). To be fiscally consistent, we also instituted an annual membership renewal system. This means that all renewals will be due at the same time each year—in January.

Making the January renewal changeover has not been without challenges. Because membership renewals in the previous system might come due any day of the year, we had to individualize renewals by prorating the amount required for 2002. This is why all of you were charged varying amounts for your 2002 renewal.

Now, the changeover is near completion. We are gearing up to send out renewals for 2003, and we're starting early. Current members will receive a renewal notice for 2003 during the first 2 weeks of October 2002. The amount requested will cover all dues for Year 2003. One exception applies to members who paid for 2-year memberships and are already covered through 2003. They will receive a renewal notice in October 2003.

Changes in the membership renewal process will get all members on the same cycle and decrease the amount of paperwork generated. Many of you have told us that keeping up with renewal forms that come at varying times is distracting and that many months can go by before you realize that you have not received the latest *Child Maltreatment* journal or the *ADVISOR*. We hope that the January renewal process will be more efficient for all. Even with strong efforts toward efficiency and communication, renewal notices may still get lost or never reach a member. If you have not received a renewal notice, please call Membership at 843-744-6901 or send a message via e-mail to gethsemani@comcast.net.

## *CHILD MALTREATMENT* IS GOING ELECTRONIC

Starting in January 2003, Sage Publications will provide the APSAC-sponsored journal *Child Maltreatment* electronically to all APSAC members. To date, issues have been available on-line only to libraries. Members will be notified of the publication of the journal via e-mail and can then access *CM* directly on-line. Please make sure that Membership has your current e-mail address.

If you also wish to receive hard copies of *CM*, APSAC members may order these on the 2003 renewal form for a charge of $15.00 total per year (4 issues). This fee will cover Sage's costs for printing and mailing the journal. When you receive your 2003 membership form, please pay particular attention to the e-mail address that we have on file for you and make any necessary corrections.

For the foreseeable future, expect to receive the *ADVISOR* and other materials in printed form in the mail. If you have any questions, feel free to contact Membership Manager Toby Smith at 843-744-6901 or send her a message at gethsemani@comcast.net.

## JUNIOR BRIGADE DRAFTED FOR OPERATION RENEWAL 2003

The APSAC Junior Brigade will be called into service this summer to help stuff 2003 renewal envelopes. The APSAC Junior Brigade is a group of children ages 8 to 13 that comes to the Gethsemani Community Center in an inner-city neighborhood in North Charleston. This Center is also the site of the APSAC membership office.

Over the course of the last 2 years, the children have expressed an interest in volunteering to help with APSAC tasks and have helped send out your renewals and other mail. In return, we have recognized their efforts publicly via the President's Honor Roll and provided pizza (not funded by APSAC). So, when you received your mail from the membership office, you might have noted dirty fingerprints left by a child just coming in from playing outside. Or, you might have noticed reddish fingerprints. These were from pizza sauce. Although we make every effort to send clean documents, we make even greater efforts to include children in the mission of APSAC.

When you receive your 2003 renewal, look for a little note from a special helper inside your renewal envelope. Thanks to each and every one of you for your continued support throughout the year.

**Who thought stuffing envelopes could be this much fun?**

## 10th ANNUAL APSAC COLLOQUIUM RATED MAJOR SUCCESS

Over 800 child abuse professionals attended the 10th Annual APSAC Colloquium. The conference was held in New Orleans, Louisiana, on May 29 to June 1, 2002. The attendees represented a variety of professions including those in medicine, law, social work, mental health, administration, advocacy, and law enforcement. Over the course of the 4-day conference, attendees had the opportunity to participate in workshops provided by over 175 experts in the field.

Wednesday May 29 was an all-day advanced training focusing on cultural issues. Approximately 150 people attended this unique event that started with a panel titled "The Criminalization of Family Violence and Its Effects on Communities of Color." This was followed by three sets of 1-hour workshops focusing on a variety of topics, such as working with Native American, Muslim, and Vietnamese families.

A panel of experts including Brian Holmgren, JD, Sandra Alexander, MEd, Marilyn Sandberg, David Cory, MSW, and Jon Conte, PhD, set the tone for the sessions on Thursday with an opening keynote titled "Through the Looking Glass: Reflections of Child Abuse in the Media." During the conference, there were nine sets of 1- to 6-hour workshops. Fifteen workshops were offered during each time slot for a total of 135 sessions. The topics of track choices included advocacy, interdisciplinary issues, law and law enforcement, research, mental health, medicine and nursing, prevention, cultural diversity, and child protective services. A special track featured information from the Office of Juvenile Justice and Delinquency Prevention (OJJDP).

The opening reception and silent auction gave us an opportunity for fun and networking. Doria Plakotos, the reigning Miss Crescent City, welcomed everyone to New Orleans and provided vocal entertainment with the help of New Orleans style music from a local band. Meanwhile, there was intense bidding on some exceptional items donated to the auction, ranging from trainings by several nationally recognized speakers to breakfast for two at Brennan's in the heart of the French Quarter. A special note of thanks to Bente Hess and her co-workers at the Southwest Mississippi Child Advocacy Center for organizing and conducting the silent auction. This event was a success due to their hard work, and we look forward to their assistance again next year.

## 10th Annual Membership Luncheon and Awards Presentation Again a Highlight of the Colloquium

Jon Conte, president of APSAC, served as the Master of Ceremonies for the Annual Membership Luncheon and Awards Ceremony. This annual meeting for APSAC members recognizes and celebrates the hard work and dedication of outstanding professionals in the field of child abuse and neglect. The following recipients were recognized during the awards ceremony.

**Outstanding Professional Award**

Judith Cohen, MD
MCP-Hahnemann School of Medicine & Psychiatry

This award recognizes outstanding contributions to the field of child maltreatment and to the advancement of APSAC's goals.

**Outstanding Service Award**

Diane DePanfilis, PhD
University of Maryland

This award recognizes substantial contributions to APSAC through leadership and service to the Society.

**Outstanding Advancement of Cultural Competency in Child Maltreatment, Prevention, and Intervention**

Veronica Abney, MSW
Private Practice, Santa Monica, CA

This new award honors outstanding contributions to the advancement of cultural competency in child maltreatment prevention and intervention.

**Outstanding Doctoral Dissertation**

Joaquin Borrego, Jr., PhD, *Texas Tech University*
Lilly Jacobson, PhD, *Wayne State University*

This award recognizes the doctoral dissertation completed within the last calendar year that made the most outstanding contribution to research on child maltreatment.

**Research Career Achievement Award**

David Kolko, PhD
University of Pittsburgh

This award recognizes repeated, significant, and outstanding contributions to research on child maltreatment over the recipient's career.

**Overall, the 10th Annual APSAC Colloquium was a huge success. We are now working to match the same quality of training at the 11th Annual Colloquium scheduled for July 23-26, 2003, in Orlando, Florida.**

**Outstanding Media Coverage Award**

Ruth Teichroeb, *Seattle Post Intelligencer*
Mary Ann Rotoni, *Dateline NBC*

This award recognizes a reporter or team of reporters in print or electronic media whose coverage of child maltreatment issues in the previous calendar year shows exceptional knowledge, insight, and sensitivity.

**Outstanding *Child Maltreatment* Article of 2001 Award**

William Friedrich, Jennifer Fisher, Carrie Dittner, Robert Action, Lucy Berliner, Judy Butler, Linda Damon, W. Hobart Davies, Alison Gray, and John Wright

This award recognizes the most outstanding article published in APSAC's journal.

**2nd Annual Past-President's State Chapter Challenge**

Alabama State Chapter, Texas State Chapter, Washington State Chapter

To honor state participation at our annual colloquium, the Past-Presidents of APSAC have created a monetary award from their generous donations to recognize state chapters for the following accomplishments: state with the highest percentage of people attending compared with the number of members in the state chapter (AL–31 attendees); the state with the largest overall attendance (TX–76 attendees); and the state whose participants came from the furthest distance (WA).

**2001 President's Honor Roll**

Wendy Deaton, Janetta Michaels, Anthony Joyner, Julie Robbins, Crystal Green, Shamekia Ferrell, Denzel Williams, Kevin Taylor, Glenn Singleton, Jazmine Windley, Dyshell Williams, Brittney Smith, Lauren Smith, Union Heights Community Council–Charleston, SC

This award acknowledges APSAC members and supporters whose exceptional support and contributions have gone far beyond the call of duty.

## NEW AWARD PLANNED FOR 2003

APSAC will present the first annual Outstanding Practitioner Award at the 2003 Colloquium in Orlando, Florida, to acknowledge a member involved in frontline efforts to improve services to abused and neglected children. Be thinking of colleagues to nominate for this new award. For additional information about the nominating process, please contact Tricia Williams at 405-271-8202.

## PUBLICATIONS / ORDER FULFILLMENT MOVES FROM CALIFORNIA TO OKLAHOMA

On July 22, APSAC's publications operation was moved from Westlake Village, California, to Oklahoma City, Oklahoma. APSAC's newest staff member, John Madden, is now Publications Manager. John, a recent graduate of the University of Oklahoma, joined APSAC in January to provide administrative help for the professional education department. He will be fulfilling all publication orders, processing requests to reprint APSAC's published material, and providing support to the Editor-in-Chief of the *APSAC ADVISOR.* Should you need any information concerning publications, please call John at 405-271-8202.

# JOURNAL HIGHLIGHTS

## By Ernestine C. Briggs, PhD

*Journal Highlights informs readers of current research on various aspects of child maltreatment. APSAC members are invited to contribute by sending a copy of current articles (preferably published within the past 6 months) along with a two- or three-sentence review to Ernestine C. Briggs, PhD, Duke University Medical Center, Trauma Evaluation, Research and Treatment Program, Center for Child and Family Health–North Carolina, 3518 Westgate Drive, Suite 100, Durham, NC 27707 (Fax: 919-419-9353).*

## SEXUAL ABUSE

### Relationship between CSA severity and borderline personality disorder symptoms

This article examined the severity of sexual abuse reported by 290 borderline personality disorder (BPD) inpatients and the relationship among factors, such as the severity of childhood sexual abuse (CSA), other forms of childhood abuse, and childhood neglect and severity of BPD symptoms and psychosocial impairment. Regression analyses showed that CSA severity was significantly related to symptom severity in core sectors of BPD psychopathology and overall severity of BPD and psychosocial impairment. Severity of childhood neglect was significantly related to 5 of the 10 factors studied including the overall severity of BPD, and the severity of other forms of childhood abuse was significantly related to 2 of these factors. Results suggest that 1) the majority of sexually abused BPD inpatients may have been severely abused, and 2) that severity of CSA, other forms of childhood abuse, and childhood neglect may all play a role in the BPD severity and psychosocial impairment.

Zanarini, M. C., Yong, L., Frankenburg, F. R., Hennen, J., Reich, D. B., Marino, M. F., & Vujanovic, A. A. (2002). Severity of reported childhood sexual abuse and its relationship to severity of borderline psychopathology and psychosocial impairment among borderline inpatients. *Journal of Nervous & Mental Disease, 190*(6), 381-387.

### Development of dissociation in maltreated preschool-aged children

This study compared evidence of dissociation in 45 maltreated children (assessed for sexual abuse, physical abuse, and neglect) with dissociation in 33 nonmaltreated children. Rather than depend on adult observer reports of behavior, the study sought to gain an understanding of dissociation from the child's own point of view. It used a measure of dissociation evidenced in children's narrative story-stem completions. Maltreated children, especially physically abused children and sexually abused children, demonstrated more dissociation than did nonmaltreated children. During the preschool period, maltreated and nonmaltreated children followed different trajectories. Thereafter, dissociation increased for maltreated children but did not do so for nonmaltreated children. Results were discussed in terms of cascading effects of maltreatment throughout development and of the importance of developmentally sensitive interventions.

Macfie, J., Cicchetti, D., & Toth, S. L. (2001). The development of dissociation in maltreated preschool-aged children. *Development & Psychopathology, 13*(2), 233-254.

### Impact of child sexual and physical abuse on Native American women's well-being

This article examined the impact of perceived child abuse history on 160 adult, Native American women's emotional well-being (i.e., depressive mood and anger) and AIDS risk. Child physical-emotional abuse was found to have greater impact on depressive mood and anger and AIDS risk than child sexual abuse. This finding was independent of current stress in women's lives. Women who were physically-emotionally abused as children had 5.14 times greater odds of having a sexually transmitted disease in their lifetimes than did women who experienced only marginal or no physical-emotional abuse. Moreover, consistent with the communal culture of Native Americans, social support was found to contribute more to resilience than was sense of mastery.

Hobfoll, S. E., Bansal, A., Schurg, R., Young, S., Pierce, C. A., Hobfoll, I., & Johnson, R. (2002). The impact of perceived child physical and sexual abuse history on Native American women's psychological well-being and AIDS risk. *Journal of Consulting & Clinical Psychology, 70*(1), 252-257.

## PHYSICAL ABUSE

### Support and positive school experience may moderate link between CPA and purging

This study examined resiliency in 18,592 adolescent females (aged 12-18 yrs) who reported being physically abused. Factors examined included physical abuse, purging, age, ethnicity, family structure, parental education, sexual abuse, religiosity, family support, parent-adolescent communication, other adult support, and school climate. Results show that both physical abuse and sexual abuse were associated with purging 2 or more times per week. Physically abused adolescents were less likely to purge 2 or more times per week if they received high levels of family support and had positive experiences in school. Physically abused adolescents were more likely to engage in purging if they had also been sexually abused.

Perkins, D. F., Luster, T., & Jank, W. (2002). Protective factors, physical abuse, and purging from community-wide surveys of female adolescents. *Journal of Adolescent Research, 17*(4), 377-400.

## Association between sibling abuse and subsequent experiences of dating violence

This contribution examined the association between abuse by siblings and subsequent experiences of dating violence, comparing this with the relationship between parental abuse and dating violence in 120 college students. For males, dating violence was associated with abuse by older and younger siblings. For females, dating violence was associated with abuse by older siblings but not by younger siblings. Dating violence among males was more strongly associated with sibling abuse than with parental abuse. For females, dating violence was more strongly associated with abuse by parents. Examination of the type of violence revealed that emotional and physical aggression received from parents and siblings was associated with expressed emotional dating violence among males and with expressed physical dating violence among females. The findings support the hypothesis that abuse by siblings, like abuse by parents, may contribute to a cycle of violence in the lives of persons victimized by sibling abuse.

Simonelli, C. J., Mullis, T., Elliott, A. N., & Pierce, T. W. (2002). Abuse by siblings and subsequent experiences of violence within the dating relationship. *Journal of Interpersonal Violence, 17*(2), 103-121.

## PCIT applied to the treatment of child physical abuse: A case example

This article described the clinical application of parent-child interaction therapy (PCIT), detailing its essential clinical components and presenting a case example illustrating the application of PCIT to the treatment of child physical abuse. Recommendations for common implementation difficulties were presented through the case example.

Herschell, A. D., Calzada, E. J., Eyberg, S. M., & McNeil, C. B. (2002). Clinical issues in parent-child interaction therapy. *Cognitive & Behavioral Practice, 9*(1), 16-27.

## Culturally competent strategies for reducing violence in Latino families

This article examined common areas of misunderstanding between professionals and low-income Latino families concerning issues of physical abuse. It argued that low-income immigrant children deserve the same protection from harsh physical punishment as all other children. Suggestions gave culturally competent ways for counselors to work with Latino families to eliminate all forms of violence toward children, including corporal punishment.

Fontes, L. A. (2002). Child discipline and physical abuse in immigrant Latino families: Reducing violence and misunderstandings. *Journal of Counseling & Development, 80*(1), 31-40.

# OTHER ISSUES IN CHILD MALTREATMENT

## Additive impact of multiple types of abuse and suicidal behavior

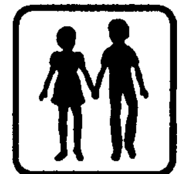
This study examined the association between exposures to multiple forms of childhood abuse (emotional, physical, and sexual) and adult suicidal behavior in a sample of 360 low-income, African American women (aged 18-65 yrs). Logistic regression analyses revealed that, compared with women who did not report any experiences of childhood abuse, women who experienced one, two, or three forms of abuse were 1.83, 2.29, or 7.75 times more likely to attempt suicide, respectively. Furthermore, compared with women who reported one or two types of abuse, women who reported all three types of abuse were more likely to attempt suicide.

Anderson, P. L., Tiro, J. A., Price, A. W., Bender, M. A., & Kaslow, N. J. (2002). Additive impact of childhood emotional, physical, and sexual abuse on suicide attempts among low-income African American women. *Suicide & Life-Threatening Behavior, 32*(2), 131-138.

## History of child abuse linked with increased neuroendocrine stress reactivity in women

This study evaluated the relative role of early adverse experience versus stress experiences in adulthood in the prediction of neuroendocrine stress reactivity in women. A total of 49 women underwent a battery of interviews, completed rating scales on stress experiences and psychopathology, and were subsequently exposed to a standardized laboratory stressor. Outcome measures were plasma adrenocorticotropin (ACTH) and cortisol responses to the stress test. Peak ACTH responses to psychosocial stress were predicted by a history of child abuse, the number of separate abuse events, the number of adult traumas, and the severity of depression. Similar predictors were identified for peak cortisol responses. Although abused women reported more severe negative life events in adulthood than controls, life events did not affect neuroendocrine reactivity. The interaction of child abuse and adult trauma was the most powerful predictor of ACTH responsiveness. Findings suggest that a history of child abuse is related to increased neuroendocrine stress reactivity, which is further enhanced when additional trauma is experienced in adulthood.

Heim, C., Newport, D. J., Wagner, D., Wilcox, M. M., Miller, A. H., & Nemeroff, C. B. (2002). The role of early adverse experience and adulthood stress in the prediction of neuroendocrine stress reactivity in women: A multiple regression analysis. *Depression & Anxiety, 15*(3), 117-25.



## Differential symptom pattern in children with PTSD and concurrent depression

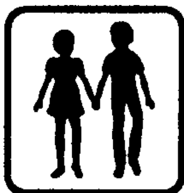
The present study attempted to examine specific differences in the posttraumatic stress disorder (PTSD) symptomatology among abused children with and without concurrent major depressive disorder (MDD). Analyses revealed that nine items reflecting depressive symptomatology, primarily vegetative symptoms, differentiated the diagnostic groups (PTSD-only, MDD-only, and the combined group). Analyses also revealed that three posttrauma symptoms—psychological amnesia, flashbacks/reenactments, and sleep difficulties—discriminated between the groups. The PTSD-only group reported more episodes of psychological amnesia while the PTSD and MDD group experienced more flashbacks. For the sample of abused children examined, these results illuminate differences with respect to PTSD-symptom presentation for those children with PTSD who have a concurrent depressive disorder compared with their non-depressed counterparts.

Runyon, M. K., Faust, J., & Orvaschel, H. (2002). Differential symptom pattern of posttraumatic stress disorder (PTSD) in maltreated children with and without concurrent depression. *Child Abuse & Neglect, 26*(1), 39-53.

## Risks of subsequent CPS maltreatment allegations

This study sought to (1) assess the relationship between identified prenatal substance use and the risk of subsequent maltreatment allegations among families involved with child protective services; and (2) compare the types of safety threats encountered by children whose parents had substance-exposed infant (SEI) allegations with the types of safety threats faced by children whose parents had other types of allegations. Cox regression models were conducted to assess the relative risk of subsequent allegations associated with parents whose child welfare case opened following an SEI allegation (the SEI group) compared with parents whose case opened following other types of allegations. The likelihood of subsequent allegations is greater among parents in the SEI group. However, the increased risk stems almost entirely from subsequent SEI-related allegations. Parents in the SEI group are not more likely to incur other types of allegations, such as physical abuse or lack of supervision.

Smith, B. D., & Test, M. F. (2002). The risk of subsequent maltreatment allegations in families with substance-exposed infants. *Child Abuse & Neglect, 26*(1), 97-114.



## Liability issues in child abuse reporting laws

This article reviewed the liability provisions found in child abuse and neglect reporting statutes and summarized relevant court findings. According to the author, courts seem motivated by 2 key considerations, namely, that statutes should be interpreted broadly and that states' interests in such reporting are compelling. These opinions offer practical guidance as well as information relevant to the debate on how these reporting statutes should be reformed.

Small, M. A., Lyons, P. M., & Guy, L. S. (2002). Liability issues in child abuse and neglect reporting statutes. *Professional Psychology—Research & Practice, 33*(1), 13-18.

## SAVE THESE DATES!!!!

**APSAC's 11th Annual National Colloquium**
**July 23 - July 26, 2003**
**Hyatt Orlando Hotel, Orlando, Florida**

Join your colleagues and bring your family to exciting Orlando for the most energizing professional training of your career!

A tropical setting on 56 landscaped acres located just 1.5 miles from Walt Disney World, the Hyatt Orlando will provide a unique training opportunity for professionals while allowing the family to come along or join you after the colloquium for fun and relaxation. The Hyatt is also just a short drive from Sea World, Universal Studios, Busch Gardens, and Kennedy Space Center.

APSAC would also like to thank Board Member Terry Hendrix for his volunteer role as Publications Manager for the past 2 years. Without the donation of his valuable time (and space in his house and garage!), many orders would have gone unfilled.

THANK YOU TERRY!!!!

# WASHINGTON UPDATE
# By Thomas Birch, JD

## CONGRESS BEGINS WORK ON 2003 SPENDING BILLS

Congress began drafting appropriations bills for 2003 just prior to the August recess. On July 18, the Senate Appropriations Committee approved FY2003 funding for the Department of Health and Human Services (HHS), which includes money for the Departments of Labor and Education as well. In this $433 billion bill, appropriations were set for child welfare, such as child abuse and neglect prevention and treatment services.

If passed, the bill will provide substantial increases for education funding—$4.2 billion more than this year and triple the President's proposed budget. It also provides $3.7 billion in increases for the National Institutes of Health (NIH), which completes a 5-year effort to double funding for the biomedical research agency. However, the bill proposes leaving most child welfare programs with funding for 2003 at the same level as 2002.

The Senate would leave the Child Abuse Prevention and Treatment Act (CAPTA) basic state grant program level funded at $22,013 million. Likewise, CAPTA's community-based family resource and support grants would receive the same amount next year as in 2002—$33,417 million. In 2003, only CAPTA's discretionary grants for research and demonstrations would increase—by $201,000 to $26,351 million.

Funding for the Title XX Social Services Block Grant, which the states use in large part to pay for child welfare services, is level-funded in the Senate's bill at $1.7 billion.

The Senate money bill proposes significant increases for other programs aimed at supporting families and promoting healthy child development. Head Start would increase by $333 million to $6.8 billion. The extra funding will support the enrollment of an additional 20,000 children, bringing Head Start enrollment to more than 935,000.

The bill also adds $130 million requested by the President for the Promoting Safe and Stable Families program, bringing the total appropriation from $375 million to $505 million. The funds go to states to support child abuse and neglect prevention services, intensive services to families in crisis, and postadoption services.

The Senate appropriations measure is expected to go to the floor for a vote in September after the August recess. The House Subcommittee on Labor, HHS, and Education Appropriations plans to approve its draft version of the 2003 spending bill on September 8. Once the Senate passes the bill, reconciling the Senate-approved funding levels with the companion House measure may be difficult. The House Appropriations Committee is working from a discretionary spending total that is $9 billion smaller than the Senate's.

## HOUSE VOTES 411-5 TO PASS CAPTA BILL

The Senate's legislative agenda on children's issues has been largely preoccupied this year with child care and renewing the Temporary Assistance for Needy Families (TANF) program. Meanwhile, the House moved to reauthorize the Child Abuse Prevention and Treatment Act (CAPTA), voting 411-5 on April 23 to pass H.R.3839, which continues CAPTA through 2007.

Rep. Peter Hoekstra (R-MI), the bill's chief sponsor, said that the bill "emphasizes the prevention of child abuse and neglect before it occurs." It also "promotes partnerships between child protective services and community organizations, including education and health systems, to ensure that services and linkages are more effectively provided," mirroring provisions proposed by the National Child Abuse Coalition.

Hoekstra referenced the legislative provisions he personally put forth that point to "a growing concern over parents being falsely accused of child abuse and neglect and the aggressiveness of social workers in their child abuse investigations. The bill increases public education opportunities to strengthen the public's understanding of the child protection system and appropriate reporting of suspected incidents of child maltreatment" (Congressional Record, 2002, April 23, p. H1509).

The legislation authorizes CAPTA's programs through 2007, suggesting only modest increases in authorized funding—from the current $100 million for Title I discretionary grants and state grants to $120 million, and from the current $66 million for Title II community-based prevention grants to $80 million annually.

Speaking on the House floor during debate on the bill, Rep. George Miller (D-CA), ranking Democrat on the House Education Committee, called attention to the paucity of resources available to protect children and prevent abuse.

> The Federal approach to addressing child abuse and neglect does not go far enough to help States prevent child abuse from happening and providing treatment services for children and families once it has occurred. Only 12 percent of the Federal monies for child abuse and neglect go toward prevention and treatment.
>
> This bill we are reauthorizing today is extremely important because it is the only Federal program specifically aimed at the prevention and treatment of child abuse; and yet this program is only appropriated half of the money of its authorized level. (Congressional Record, 2002, April 23, p. H1509)

Many provisions proposed by the National Child Abuse Coalition have been incorporated into the bill including several on the theme of improving linkages between CPS and health care services, more attention on using basic state grants for improving the CPS infrastructure, and highlighting prevention in Title II community-based grants.

Other amendments added during the committee's drafting process include the following: 1) amendment by Hoekstra requiring state procedures for a caseworker to advise an individual, at the initial time of contact, of allegations made in the child maltreatment complaint against that individual; 2) amendment by Rep. Susan Davis (D-CA) expressing the sense of Congress that agencies serving children and families with CAPTA funding should provide materials and services in an appropriate language other than English; and 3) amendment offered by Rep. Jim Greenwood (R-PA) requiring state procedures to require that health care providers involved in the delivery of infants born with fetal alcohol syndrome or drug addiction be referred to CPS—not to constitute a report of child maltreatment or to result in drug prosecution for the mother, but to provide for the development of a plan of services for infant and mother.

The no votes on H.R.3839 were cast by Reps. Jeff Flake (R-AZ), Ron Paul (R-TX), Dana Rohrabacher (R-CA), Bob Schaffer (R-CO), and Thomas Tancredo (R-CO), each of whom voted in

opposition to procedural objections about bringing a spending authorization bill to the floor without any possibility of amendment. (The CAPTA measure was brought to the House floor under suspension of the rules, which prohibits any amendments and requires a two-thirds majority vote to pass.)

The Senate is expected to turn its attention to drafting its version of the CAPTA reauthorization legislation early in the fall.

## SUPREME COURT RULING DELAYS ONLINE PROTECTION LAW

The U.S. Supreme Court, in a limited decision, has upheld the 1998 Child Online Protection Act (COPA), a federal law aimed at preventing children from gaining access to pornography. In an opinion written by Justice Clarence Thomas, the court ruled that the law's application of "community standards," to define material on the Internet that is "harmful to minors," does not necessarily violate the First Amendment's free speech guarantees.

However, the Supreme Court sent the case back to the U.S. Court of Appeals for the 3rd Circuit, forbidding the enforcement of COPA until the lower court has examined questions of whether the government could have found a less restrictive means of protecting children other than the community standards approach.

Congress has reworked legislation over the past several years to overcome constitutional objections to legislative attempts at restricting children's access to the Internet to protect them from exposure to pornography. The Supreme Court's decision in this case of Ashcroft v. ACLU marks the first time that the court has said that community standards could be applied to the World Wide Web. The lower court had ruled the law unconstitutional because it would give the most conservative communities control (via the Internet) over sexual content anywhere.

The only dissent in the 8-1 decision came from Justice John Paul Stevens, who sided with the appeals court's decision.

## SUPREME COURT TO REVIEW MEGAN'S LAW

The U.S. Supreme Court plans to review the constitutionality of two state laws that require publication on the Internet of personal identifying information about convicted sex offenders. Megan's Law, as the sex-offender registration statutes are known, has been enacted in all 50 states and the District of Columbia.

One case accepted for review by the high court is *Connecticut Department of Public Safety v. Doe*, in which two Connecticut residents claim that they are not a danger to the community and would be denied due process of law if their names were posted without a hearing to determine if they were dangerous. Twenty other states and D.C. have laws similar to the Connecticut statute.

The Second District U.S. Court of Appeals in New York upheld the ruling of a federal district judge, which shut down Connecticut's online sex offender registry, saying that it unfairly branded individuals as dangerous offenders whether or not they actually are.

The second case, *Otte v. Doe*, which came to the Supreme Court from Alaska in February, would review a lower court's ruling that the Internet posting represents an unconstitutional form of extra punishment for offenders who had committed their crimes before Alaska passed its version of Megan's Law in 1994. The Alaska statute is similar to that of 11 other states.

The Supreme Court has said it will hear arguments in the two cases in the fall 2002, with the rulings to come by July 2003.

## SENATE PANEL VOTES WELFARE EXTENSION, FLOOR VOTE UNCERTAIN

The Senate Finance Committee on June 26 approved legislation to reauthorize the Temporary Assistance to Needy Families (TANF) program, leaving unresolved issues over the adequate amount of spending on child care. Although increased funding for child care subsidies enjoys the support of many Senate Democrats and some Republicans, disagreement arises over how to finance additional child care support.

The committee passed the TANF renewal bill sponsored by Sen. Max Baucus (D-MT), Finance Committee chair, by a 13-8 vote, with Sen. Tom Daschle (D-SD) voting against the bill to register protest over the measure's child care subsidy. The committee-passed bill increases child care funding by $5.5 billion over 5 years, compared with a $1 billion increase in the House bill. Sen. Jeff Bingaman (D-NM) offered and then withdrew an amendment to increase the child care money to $7 billion. Bingaman may propose the increase again when the legislation goes to the Senate floor.

A schedule for that vote is uncertain. Daschle may choose to bring the bill to the floor in September or let the reauthorization go with a 1-year extension, continuing the child care funding issue into this fall's congressional elections.

The Senate legislation differs from the bill passed by the House on issues besides child care spending. The Senate bill would require welfare recipients to devote fewer hours each week to work-related activities–30 versus 40 hours in the House bill. And the Senate, but not the House, would make legal immigrants eligible for assistance, a group written out of the welfare program in the 1996 reform package.

## CDF CONGRESSIONAL SCORECARD: VOTES FOR CHILDREN

The Children's Defense Fund Action Council has compiled its 2001 Nonpartisan Congressional Scorecard, which documents how U.S. Senators and Representatives cast votes affecting the lives of America's children.

Based on 10 crucial votes for children, the scorecard identifies 10 Senators and 48 House Members who had scores of 100 percent; 8 Senators and 95 House Members failed children and scored below 10 percent. The report also reveals a wide disparity in the ratings among state congressional delegations based on their Members' votes and includes a chart detailing how each state delegation ranked.

(The 2001 Nonpartisan Congressional Scorecard is available online at http://www.cdfactioncouncil.org/2001scorecard.htm.)

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# CONFERENCE CALENDAR

## 2002 CONFERENCES

**September 15-18, 2002**
**4th National Conference on Shaken Baby Syndrome, Salt Lake City, UT.**
Call 801-627-3399 or visit Website www.dontshake.org

**September 26-29, 2002**
**The 25th National Children's Law Conference of the National Association of Counsel for Children, Orlando, FL.**
Call 303-864-5320 or 1-888-828-NACC, Fax 303-864-5351, or E-mail advocate@NACCchildlaw.org

**October 21-22, 2002**
**6th Annual New England Conference on Child Sexual Abuse, Burlington, VT.**
Call 802-476-8825, E-mail Dogriver@vermont.com , or visit Website at www.newenglandcoference.net

**September 24-28, 2002**
**7th International Conference on Family Violence, San Diego, CA.**
Call 858-623-2777 x427, Fax 858-646-0761, E-mail fvsai@alliant.edu, or visit Website at www.fvsai.org

**October 2-5, 2002**
**21st Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, Montreal, Quebec, Canada.**
Call 503-643-1023, Fax 503-643-5084, E-mail connie@atsa.com

**November 6-8, 2002**
**18th Western Regional Symposium on Child Abuse & Sexual Assault, Eugene, OR.**
Call 541-747-1235, Fax 541-747-4722, or E-mail susiej@scar-jaspermtn.com

**September 26-28, 2002**
**2002 National Conference on Health Care and Domestic Violence, Atlanta, GA.**
Visit Website at www.endabuse.org/health

**October 7-10, 2002**
**18th Annual Midwest Conference on Child Sexual Abuse, Middleton (Madison), WI.**
Call 1-800-442-7107, Fax 1-800-741-7416, or visit Website at www.dcs.wisc.edu/pda/hhi/midwest

**November 7-10, 2002**
**18th Annual Meeting of the International Society for Traumatic Stress Studies, Baltimore, MD.**
Call 847-480-9028 or visit Website at www.istss.org

**November 13-16, 2002**
**54th Annual Meeting of the American Society of Criminology, Chicago, IL.**
Call 614-292-9207, Fax 614-292-6767, or E-mail asc41@infinet.com

## 2003 CONFERENCES

**February 3-7, 2003**
**17th Annual San Diego Conference on Responding to Child Maltreatment, San Diego, CA.**
Fax 858-966-8018 or E-mail dmartin@chsd.org

**April 17-18, 2003**
**2nd Annual Conference hosted by Prevent Child Abuse Nebraska, Lincoln, NE.**
Call 402-476-7226 or visit Website at www.pcanebraska.org

**October 8-11, 2003**
**22nd Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, St. Louis, MO.**
Call 503-643-1023, Fax 503-643-5084, or E-mail connie@atsa.com

**March 11-14, 2003**
**19th National Symposium on Child Sexual Abuse, Huntsville, AL.**
Call 256-534-1328, ext.203, Fax 256-534-6883, E-mail symposium@ncac-hsv.org , or visit www.ncac-hsv.org

**May 11-14, 2003**
**Child & Youth Health Congress**
E-mail congress@venuewest.com or visit Website at www.venuewest.com/childhealth2003

**November 19-22, 2003**
**55th Annual Meeting of the American Society of Criminology, Denver, CO.**
Call 614-292-9207, Fax 614-292-6767, or E-mail asc41@infinet.com

**March 31-April 5, 2003**
**14th National Conference on Child Abuse & Neglect, St. Louis, MO.**
Call 703-528-0435, Fax 528-7957, or E-mail 14Conf@pal-tech.com

**July 23-26, 2003**
**11th Annual APSAC Colloquium, Orlando, FL.**
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