THE THREE R'S (RECOGNIZING, REPORTING, AND RESPONDING PLUS ETHICS) IN CHILD ABUSE AND TRAUMA

TASP

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Learning Objectives

- Review issues related to reporting
- Establish the important link between early trauma and poor behavioral and medical health outcomes via the ACEs study;
- Consider the finer distinctions between traumatic events and those that are negative, stressful, or unpleasant;
- Examine the utility of a "trauma lens" when considering both child and adult behavior as it relates to existing models of development, diagnosis, assessment, and treatment;
- Compare and contrast innovative versus evidence-based treatments
- Contemplate the controversies
- Consider ethical issues

ACE Study
Vincent J. Felitti, MD
R.F. Anda, M.D., et al.
http://www.acestudy.org/

Felitti, V. J.MD, Anda, R. F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Mary P. Koss, M. P., Marks, J.S. (1998). Relationship of Childhood Abuse and Household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14* (4), 245-258.

The Adverse Childhood Experiences (ACE) Study

- Examines the health and social effects of ACEs
- throughout the lifespan among 17,421 members
- of the Kaiser Health Plan in San Diego County

Adverse Childhood Experiences Are Common

- Household Dysfunction
  - Substance abuse 27%
  - Parental sep/divorce 23%
  - Mental illness 17%
  - Battered mother 13%
  - Criminal behavior 6%
- Abuse:
  - Emotional 11%
  - Physical 28%
  - Sexual 21%
- Neglect:
  - Emotional 15%
  - Physical 10%

Adverse Childhood Experiences Score Trauma "Dose

Number of individual types of adverse childhood experiences were summed…

ACE score	Prevalence
0	33%
1	26%
2	16%
3	10%
4 or more	16%

Adverse Childhood Experiences as a National Health and Economic Issue

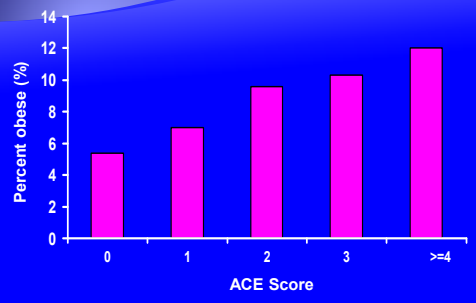
ACEs have a strong influence on:

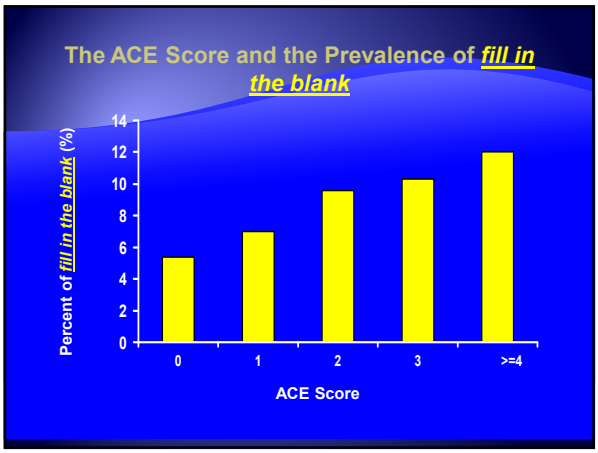
- -adolescent health
- -reproductive health
- -smoking
- -alcohol abuse
- -illicit drug abuse
- -sexual behavior
- -mental health
- -risk of revictimization
- -stability of relationships, homelessness
- -performance in the workforce

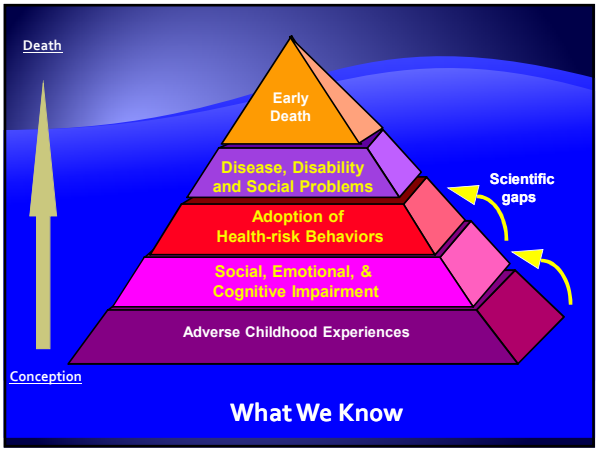
ACEs increase the risk of

- Heart disease
- Chronic lung disease
- Liver disease
- Suicide
- Injuries
- HIV and STDs
- and other risks for the leading causes of death

The ACE Score and the Prevalence of Severe Obesity







National Child Traumatic Stress Network

www.nctsnet.org

NCTSN The National Child Traumatic Stress Network

Stress, adverse events, and trauma—what's the difference?

- Stress—Can be positive or negative and depends on the context—e.g., giving this talk elicits stress which serves to motivate me to prepare
- Adverse experiences—can include trauma responses, but also include less than traumatic responses, including:
  - Separation
  - Homelessness
  - Family members attempting self-harm
  - Mental illness in the family
  - Witnessing violence
- Trauma—an experience or threat which activates the fight or flight response

Uncertainty & chronicity

Using the trauma lens

- Does not conflict with
  - A family-centered approach
  - A strength-based approach
  - A behavioral approach
- But without a trauma-informed approach, children may be misdiagnosed and receive inappropriate treatment and languish in a system where they are over-medicated as a form of behavioral control

Using the trauma lens

- In Lubbock, the Children's Home of Lubbock began about four years ago making the transition to a trauma-informed system
- Done without:
  - Grant funding
  - My consultation initially
- Reductions
  - Medications
  - Hospitalizations

Trauma informed
vs.
Evidence-based trauma treatment

Focus: Child sexual abuse

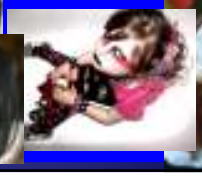
- Often painful or threatening
- Often unpredictable
- Multiple, negative effects are well documented
- Chronic events tend to result in worse outcomes for the aggregate (though not always for the individual)

Recognition

With the Realization That

- Diverse family backgrounds among abused children--even those abused by someone outside the family





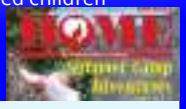

With the Realization That

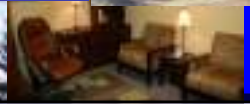
- Diverse abuse or trauma backgrounds




With the Realization That

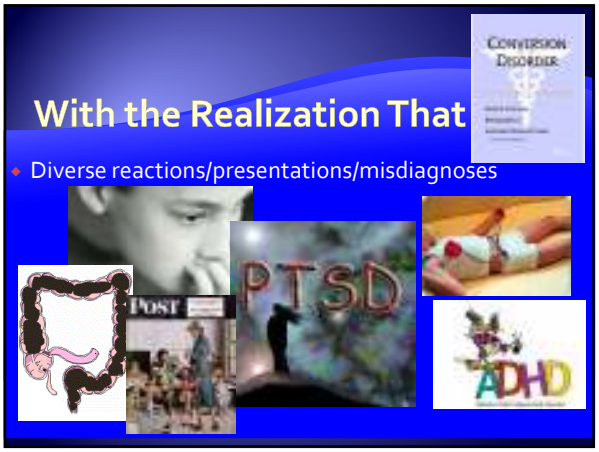
- Diverse settings where sexually abused children are potentially identified



With the Realization That

- Diverse reactions/presentations/misdiagnoses



Scope of the Problem

Women

1 in 4 women have been sexually abused in some form by age 18

Men

1 in 6 men have been sexually abused in some form by age 18

(Finklehor, 1990)

Cases

- 14-year-old presenting to asthma clinic
- 14-year-old "conversion disorder"

California Evidence-Based Clearinghouse for Child Welfare

http://www.cachildwelfareclearinghouse.org/assmt-intro

California Evidence-Based Clearinghouse for Child Welfare

http://www.cachildwelfareclearinghouse.org/search/maltreatment-type

National Registry of Evidence-based Programs and Practices

http://nrepp.samhsa.gov/

Evidence-Based Resources for OJJDP

http://ojjdp.ncjrs.gov/funding/evidencebasedresearch.html

Evidence-based treatment

- Control group
- Random assignment
- Can it be replicated; can someone be trained

Evidence-based assessment

- Is it based on anything more than clinical judgment? (e.g., an interview, a mental status exam)
- Is it reliable? (Do you get the same answer if asked twice? Are answers to similar questions reliably answered? Do two trained people obtain the same conclusion/rating?)
- Is it valid? (Does it measure what it purports to measure?)

Problem

- **Identification** or "diagnosis" of sexual abuse in children is the initial step
- Sexually abused children rarely are screened to assess for trauma-related symptoms
- Even more rarely do they receive appropriate care

TRAINING & ACCESS TO SERVICES

Presumptions

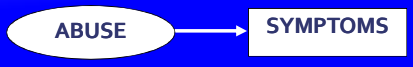
- **Child sexual abuse is under-reported by children (in contrast to retrospective studies)**
- **Child abuse allegations are not offered spontaneously or even easily at a first interview**

(Finkelhor et al., 1990; Elliott, 1993; Gomes-Schwartz, 1990; Bruxte, 1994; Sorensen & Snow, 1991)

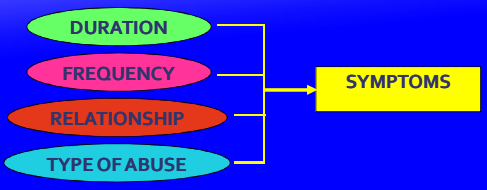
- **"Clinical" populations are over-represented by children who have been abused**
- **Child abuse may result in any number of diagnostic presentations, though no diagnostic presentation is pathognomonic for abuse**
- **Our views of trauma, symptoms, and etiological factors are entirely too simplistic**

The Conceptual Model

A History of Conceptualization

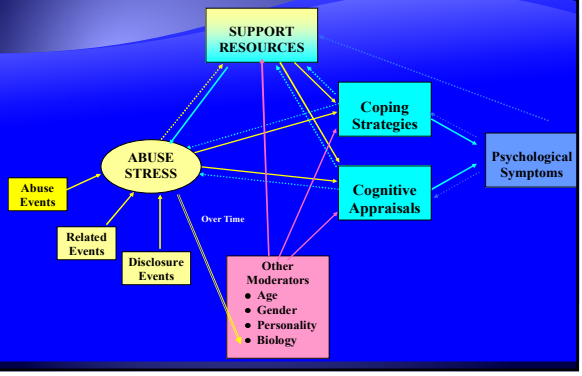


A History of Conceptualization

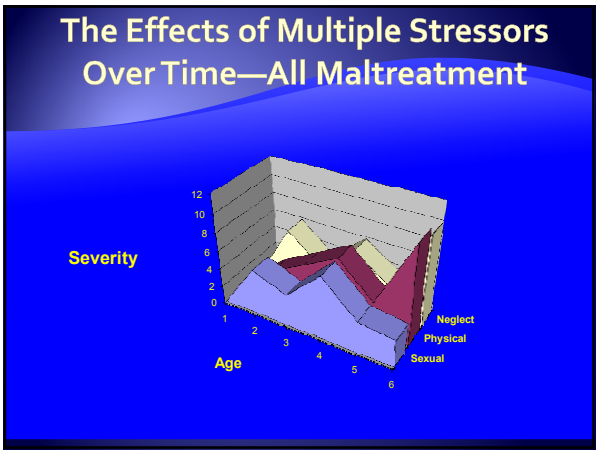


- Knowing these facts accounts for a relatively small percentage of the variance in outcome and symptomatology.

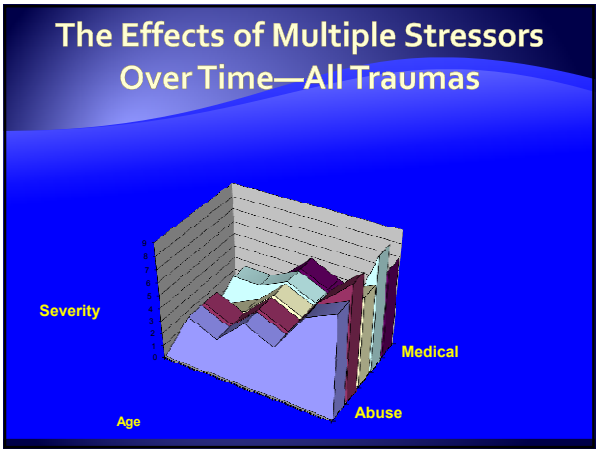
Spaccarelli (1994)



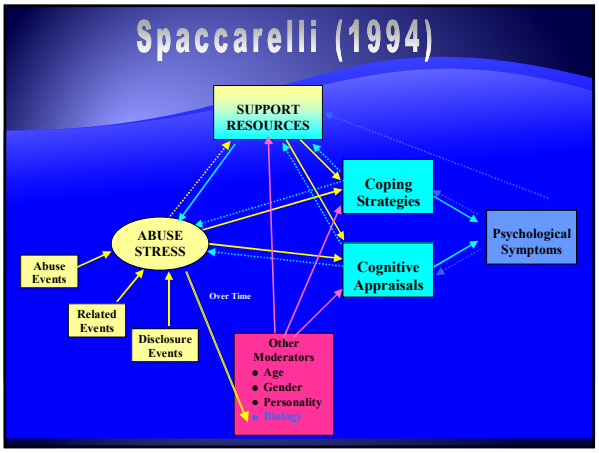
The Effects of Multiple Stressors Over Time—All Maltreatment



The Effects of Multiple Stressors Over Time—All Traumas

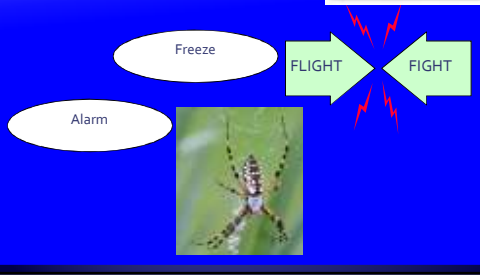


Spaccarelli (1994)



BIOLOGY of Trauma

Biology



Alarm Reaction(PTSD)

- Increase in sympathetic nervous system
  - ↑Heart rate
  - ↑Blood Pressure
  - ↑Respiration
  - ↑Released of stored sugar
  - ↑Muscle Tone
  - ↑Hypervigilance
  - ↑Tuning out non-critical information

Stress Response (Dissociation)

- Decreased blood pressure
- Decreased heart rate
- Endogenous opiods

COMMON SIGNS AND SYMPTOMS

Recognition

Signs and Symptoms

- **Physical/Medical Indicators**
  - **Enuresis**
  - **Encopresis**
  - **Abdominal pain**
  - **Sexually transmitted diseases**
  - **Recurring urinary tract infections**
  - **Recurrent vaginal infections**
  - **Pregnancy**
  - **Conversion disorder or somatic complaints**

Signs and Symptoms

- Behavioral Indications
  - Self-destructive/Suicidal behavior (82%)
  - Sleep/Bedtime difficulties
  - Sexual acting out—especially in preschool and adolescent children
  - Firesetting
  - Running away
  - Concentration
  - Eating disorders among adolescents
  - Substance abuse
  - Anger

Signs and Symptoms

- Physical/Medical Indicators
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Signs and Symptoms

- Behavioral Indications
  - Self-destructive/Suicidal behavior (34%)
  - Sleep/Bedtime difficulties
  - Sexual acting out—especially in preschool and adolescent children
  - Firesetting
  - Running away
  - Concentration
  - Eating disorders among adolescents
  - Substance abuse
  - Anger

Typical Reactions

Trauma

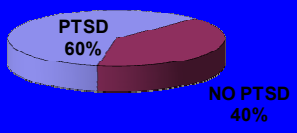
Sexualized response

Behavioral problems and negative affectivity

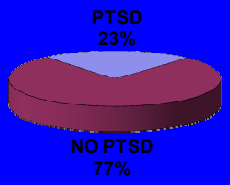
PTSD Criteria

Arousal (2)	*Re-Experiencing (1)*	*Avoidant (3)*
Sleep	Recollections	Thoughts/Feelings
Irritability	Dreams	Activities
Concentration	Seems to Recur	Memories
Hypervigilance	Symbols	Interests
Startle		Others
Physiologic		Affect
		Future

PTSD in Sexually Abused Youngsters



PTSD in Physically Abused Youngsters



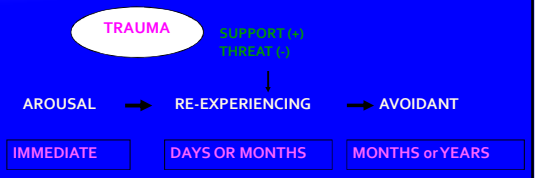
DSM-IV Criteria for PTSD by DICA Parent Report* & Reaction Index by Child **

Category	Percent	
Arousal	89%*	50%**
Re-experiencing	84%*	67%**
Avoidance	53%*	25%**
Full Diagnosis	47%*	22.5%**

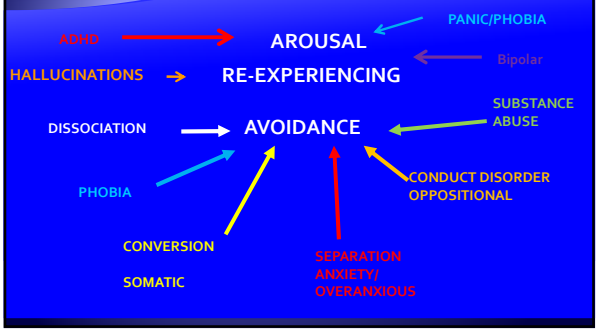
*Pollio (2002): 57 sexually abused children using DICA-R

**Aaron, Zaglul, & Emery (1999) 40 w/ acute physical injury using RI

PTSD Over Time



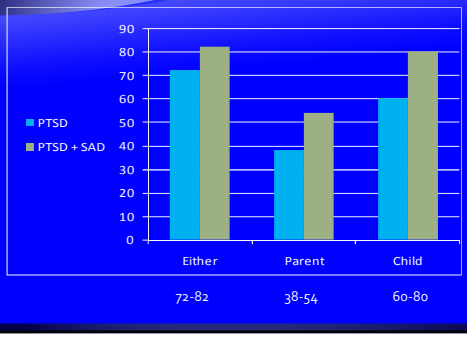
Misdiagnosis and Comorbidity: A PTSD Formulation for Children



Misdiagnosis and Medicating Symptoms which Obfuscate the Substantive Issues

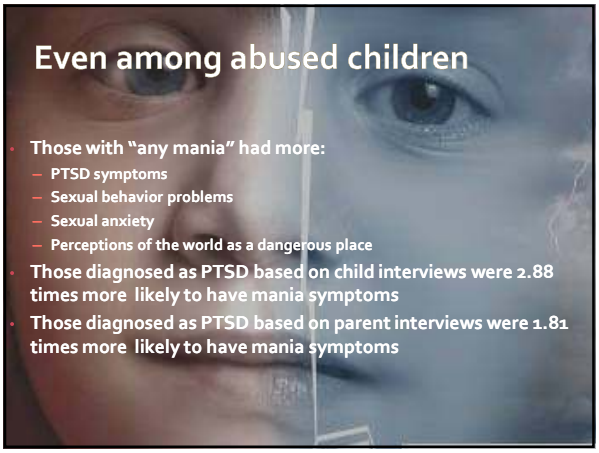
- Inattention
- Sexual acting out
- Hallucinatory-like re-experiencing
- Anxiety in response to symbolic reminders
- Emotional dysregulation
- ADHD
- Manic phase of Bipolar
- Psychosis or schizophrenia
- Panic disorder
- Impulse control disorder or borderline personality disorder

When SAD Counts as One (1) Symptom of Avoidance




Any Mania
We found in 1994, based on parent or child interviews (DICA-R)
50 of 79 (or 63.3%) met criteria for any mania

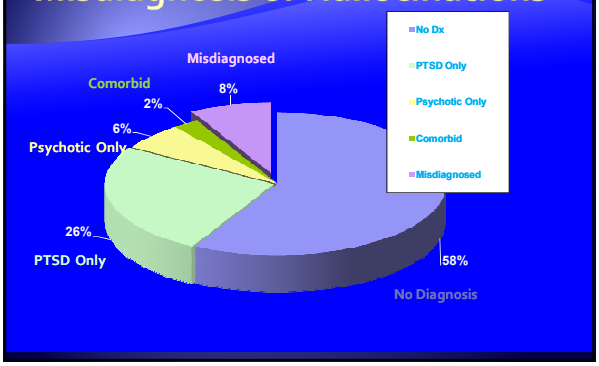

Possible Misdiagnosis of Mania/Bipolar
63.3% is outrageously high
Has there ever been a time in your life when you had a lot more energy than usual and you felt really good or excited and were able to do a lot more things than usual?
Has there ever been a time in your life when you felt very happy, in a really great mood and everything seemed to be going well for you?
Has there ever been a time in your life when you felt REALLY angry or crabby for several days or more?
Has there ever been a time in your life when you slept a lot less than usual but DIDN'T FEEL TIRED?
Has there ever been a time when you found yourself talking a lot more or a lot faster than usual?


Even among abused children
Those with "any mania" had more:
PTSD symptoms
Sexual behavior problems
Sexual anxiety
Perceptions of the world as a dangerous place
Those diagnosed as PTSD based on child interviews were 2.88 times more likely to have mania symptoms
Those diagnosed as PTSD based on parent interviews were 1.81 times more likely to have mania symptoms

Implications

- With a 40 fold increase in the diagnosis of "Bipolar Disorder" in the last decade, a more careful study of the prevalence of mania should take place
- Developmentally sensitive criteria normed for children are essential
- This is especially true for abused children where a variety of behaviors may be a "rough index" of distress

Misdiagnosis of Hallucinations



Suicide (Outpatient CAC)

- 34% of children experienced thoughts of suicide
  - 45% when both child and parent report were available
- Parent-Child Agreement
  - 12% agreed that present
  - 54% agreed that NOT present
  - 33% did not agree though present by one report
- Age
  - 14% (ages 3-5),
  - 81% (ages 6-12), and
  - 32% (ages 13-17).

Assessment

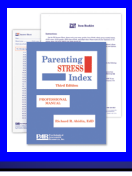
- Evaluations vs. Testing ("Psychological")

Assessment or Clinical Intake

Screening

Instruments for Use with Parents

- Child Abuse Potential Inventory—Joel Milner (***physical*** abuse only)
  - "Predictive validity
- Parenting Stress Index



"Simple PTSD" vs. Complex Trauma

- PTSD plus
  - Affect dysregulation
  - Identity issues
  - Suicidality
  - Negative relationships
  - Anxiety, depression, anger
  - Dissociation
  - Tension reduction (cutting, bulimia, sex)
  - Substance abuse

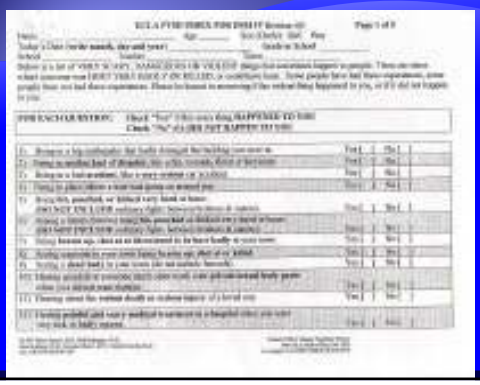
Typical Reactions

Trauma

Sexualized response

Behavioral problems and negative affectivity

Assessing Trauma Exposure

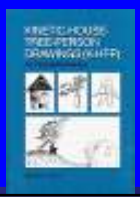


Structured Clinical Interviews

- Diagnostic Interview for Children and Adolescents—IV (DICA-IV)
- Diagnostic Interview Scales for Children (DISC)
- Structured Clinical Interview for DSM (SCID)

Projectives

- Rorschach
- Thematic Apperception Test (TAT)
- Drawings



Other Self-Report Scales

- Child Depression Inventory
-
- Conners
- Adolescent Anger Rating Scale

Intelligence

- **Wechsler Intelligence Scale for Children -IV**

Other

- Millon Adolescent Personality Inventory

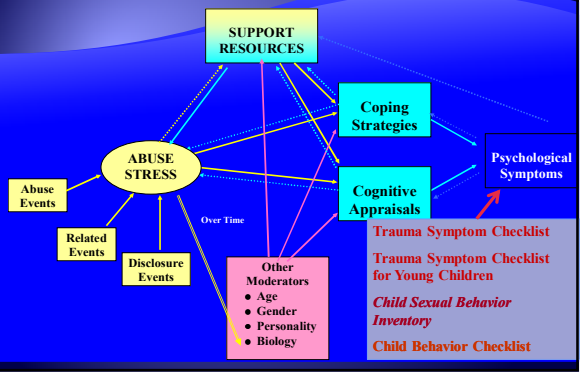
Sexual Abuse Assessment: Psychological Testing

- There is no "psychological profile" for abuse victims
- Testing may serve to inform therapist about:
  - Coping
  - Current symptoms or discomfort
  - Resources
  - Problems ahead
- Testing may serve as a baseline

Sexual Abuse Assessment: Psychological Testing

- Testing should be "depathologized"
- Testing should target typical sexual abuse effects
- Testing should take an approach that is:
  - Multitarget: General & abuse-specific
  - Multimethod: Self-report, parent, projective
  - Multisource: Self, parent, teacher

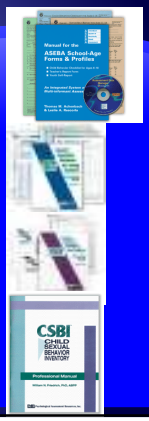
Spaccarelli (1994)



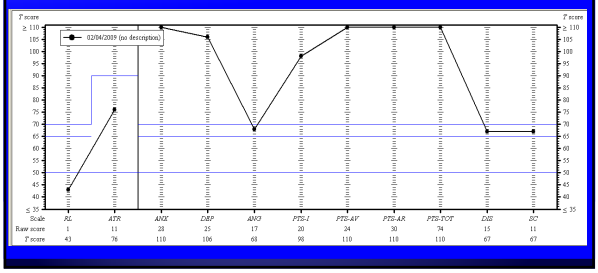
"Evidence-Based Assessment"

Clinical Assessment

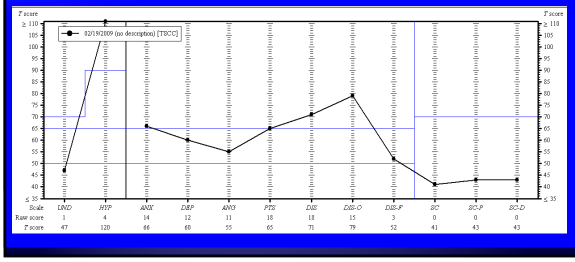
- Broad band ratings (e.g., CBCL, BASC)
- Trauma Symptom Checklist for Young Children (TSCYC; PAR; Briere)
- Trauma Symptom Checklist for Children (TSCC; PAR; Briere)
- Child Sexual Behavior Inventory (CSBI; PAR; Friedrich)



TSCYC (9-year-old female ;SA)



TSCC (9 year old female; SA)



Trauma Symptom Checklist for Children

Trauma Symptom Checklist for Young Children

Child Behavior Checklist

Child Sexual Behavior Inventory

Reporting

Reporting Child Abuse

- http://www.naccchildlaw.org/childrenlaw/documents/MandatoryReporting_000.pdf
- Mandated Reporters (48 states)
  - Social workers
  - School personnel
  - Health care workers
  - Mental health professionals
  - Childcare providers
  - Medical examiners or coroners
  - Law enforcement officers

Other Mandated Reporters

- Commercial film or photograph processors (in 11 States and 2 territories),
- Substance abuse counselors (in 13 States), and
- Domestic violence workers (6 States)
- Members of the clergy (25 States)
- Approximately 18 States and Puerto Rico require all citizens to report suspected abuse or neglect, regardless of profession. (e.g., Kentucky)

"Permissive Reporters"

- In all States, territories, and the District of Columbia, any person is *permitted to report. These voluntary reporters of* abuse are often referred to as "permissive reporters."

Standards for Reporting

- When the reporter, in his or her official capacity, *suspects or has reasons to believe that* a child has been abused or neglected.
- Another standard frequently used is when the reporter has knowledge of, or observes a child being subjected to, conditions that would reasonably result in harm to the child.
- Permissive reporters follow the same standards when electing to make a report.

Phone Numbers

- All States' Numbers
  - http://www.childwelfare.gov/pubs/reslist/rl_dsp.cfm?rs_id=5&rate_chno=11-11172
- Call Childhelp USA, National Child Abuse Hotline (1-800-4-A-CHILD).
- Texas
  - **Texas** Toll-Free: (800) 252-5400
  - www.txabusehotline.org

Reporting Child Abuse

- When must a mandatory child abuse reporter file a report?
  - Professionals often feel obligated to report, even if they do not believe abuse occurred
    - For example, abuse reported by other individuals
  - 49 states and District of Columbia do not require to report if the reporter does not believe there has been abuse
  - Report by the law and not out of confusion

Privileged Communication

- Recognized
  - Attorney client
  - The clergy-penitent privilege is also widely recognized, although that privilege is usually limited to confessional communications and, in some States, is denied altogether.
- Unrecognized
  - The physician-patient and husband-wife privileges are most commonly denied by States.

Forensic vs. Clinical Interviews

- Forensic interviews are for evidentiary purposes
  - Various schools of thought with regard to the nature of the interview and the qualifications of the interviewer
  - The science of interviewing is developing
  - At about age 4, interviews of children are valid
  - Level of training required: Extensive (the skills of a good clinical interviewer do not generalize to good forensic interviewing)

116 Confirmed Cases of Child Sexual Abuse (3 to 17 years)

80% Confession or Legal Plea
14% Criminal Conviction
6% Strong Medical Evidence

Sorenson and Snow (1991)

Type of Initial Disclosure

26% Intentional
74% Unintentional

- Older Children were more likely to intentionally disclose

Initial Response

11% Clear, Detailed Disclosure
17% Tentative Disclosure
72% Denial

Sorenson and Snow (1991)

Eventual Response

96% Clear, Detailed Disclosure
22% Recantation
93% Reaffirmed Disclosure

Forensic vs. Clinical Interviews

- Clinical Interviews
  - Essential question: For treatment what and how would you ask about rape in a young adult?
  - A clinical interview does not have to stand the scrutiny of court
  - When you determine reasonable suspicion of CSA, refer to a child advocacy center

Use of Conjoint Interviews

- Major concerns:
  - Worsen trauma for child
  - Unwarranted inferences may be made based off of parent-child interaction
- No persuasive empirical evidence for their use

Responding to a Subpoena

- *Duces tecum:* You must come with the record—you need not produce it
- Your attorney (ouch!) may need to file a motion to quash the subpoena
- *In camera review:* Allows a judge to determine if there is anything relevant

Juvenile Sexual Offenders

- Assessment
  - Clinical
    - Multi-source behavioral history
      - Review of victim interviews, police records
    - Interview of JSO and family
    - Detailed sexual history after establishing the limits of confidentiality
    - Psychological testing to assess specific target areas
      - Jesness Inventory (conduct disordered)
      - Multiphasic Sex Inventory for Adolescents
    - Plethysmograph MAY be appropriate in older adolescents suspected of deviant arousal patterns (and used ethically and according to standardized norms)
  - Recidivism/Reoffense
    - No actuarial system for adolescents

Juvenile Sexual Offenders

- Treatment
  - No studies with random assignment to treatment vs. non-treatment, so cannot establish if treatment is effective
  - Does appear to be some impact though on recidivism rates
    - 5%-15% with an average of about 7%
      - But 50% reoffend in a non-sexual way (some other crime)
  - Often the approach is to apply adult models to juveniles—no support

Adult Sex Offenders

- Sexual assaults in general, and of children specifically, usually go unreported
  - When reported, 10% lead to arrests, and 8% lead to convictions
  - So, what we know is based on the 8%

Adult Sex Offenders

- Characteristics
  - 80-83% are males; 17-20% are females
  - There is no child molester profile
    - There is no test that identifies molesters
  - Psychopathy predicts recidivism (callous, exploitive, lacking guilt, lying, violent)
  - 30% abuse substances prior to abusive behavior
  - Groth (1979): Fixated and regressed

Adult Sex Offenders

- Treatment
  - Cognitive behavioral + relapse prevention (triggers, warning signs, and plans to re-offend)
  - Acknowledgement + assessment
  - Address: Victim empathy, distorted thinking patterns, social skills, deviant arousal patterns, sex education
  - Surgical (physical castration) and pharmacological intervention (chemical castration) occasionally used with a subset
- Outcomes
  - Recent studies (since 1985) suggest that recidivism rates are reduced by treatment
    - 3-39% for treated offenders
    - 12.5%- 57% for untreated

Other Ethical Issues

- Confidentiality
- Record keeping
- Release of records

Responding

Treatment Considerations

- Likelihood of multiple trauma history sexual abuse
- Importance of addressing externalizing problems e.g., sexual acting out
- Question of involvement of non-offending (but unsupportive) parent
- Foster parent apprehensions/biases/worries regarding sexual abuse history or possibility of inappropriate sexual behavior
- Addressing the urgent vs. the important

Evidence-Based Treatments

Trauma-Focused Cognitive Behavioral Therapy

Esther Deblinger
Tony Mannarino &
Judith Cohen

Core Components

- **PSYCHOEDUCATION:** Providing **education** to **children and their caregivers** about the **impact** of trauma on children and common childhood reactions to trauma
- **STRESS MANAGEMENT:** Developing personalized **stress management skills for children and parents**
- **AFFECTIVE EXPRESSION & MODULATION:** Helping children and parents **identify and cope** with a range of **emotions**
- **COGNITIVE COPING:** Teaching children and parents how to **recognize the connections between thoughts, feelings and behaviors**

Core Components

- **CREATING THE TRAUMA NARRATIVE:** Encouraging children to **share their traumatic experiences** either verbally, in the form of a written narrative, or in some other developmentally appropriate manner.
- **COGNITIVE PROCESSING:** **Modifying** children's and parents' **inaccurate or unhelpful** trauma-related **thoughts**, and
- **BEHAVIOR MANAGEMENT TRAINING**: Helping parents develop skills for optimizing their children's emotional and behavioral adjustment
- **PARENT CHILD SESSIONS:** Helping children and parents **talk with each other about the traumatic experiences**

Exposure of Children to Violence

- 20-50% of American children are victims of violence
  - Within their families
  - At school
  - In their communities

Cognitive Behavioral Intervention for Trauma in Schools

http://cbitsprogram.org/

CBITS

- Intended for
  - use with GROUPS of children
  - ages 11-15
  - experiencing significant traumatic experiences
  - are suffering from PTSD or depression

CBITS is NOT

- Recommended for use by teachers

CBITS is

•For use by social workers, psychologists, school counselors

Screening of students is recommended

- UCLA PTSD Index
  - Child
  - Adolescent
  - Parent

Child Sessions

- Child Group PLUS Individual Sessions
  - Group #1: Introduction, confidentiality, & orientation
  - Group #2: Psychoeducation
- Individual Sessions—Relaxation training
  - Group #3: Thoughts & feelings
  - Group #4: Combating negative thoughts
  - Group #5: Avoidance & coping (fear hierarchy + alternative coping strategies)
  - Group #6 & 7: Gradual exposure
  - Group #8 & 9: Social problem-solving
  - Group #10: Relapse prevention

Parent Sessions

- Session #1: Psychoeducation
- Session #2: How we teach children to change their thoughts and actions

Actual Mismanaged* Case

- Adderal 20 mg po q am
- Depakote 500 mg po q hs
- Seroquel 200 mg po bid
- DDAVP 0.4 mg po at hs
- Ducosate sodium 100 mg po bid
- Berocca plus 1 tab po q am
- Zoloft 50 mg po q am
- Imipramine 25 mg po hs
- Clindamycin solution to face bid
- Trazadone 100 mg hs
- Ortho Novum 777 1 tab q am
- Tenex 2 mg po bid
- Dexedrine 10 mg po q 4 pm
- Zyprexa 15 mg po hs
- Topiramate 200 mg q am
- Inderall La 80 mg po q am
- Detrol 4 mg po bid
- Bromocryptine 2.5 mg od

Problems with classes?

Motivation!

Teaching v. Coaching

Behavioral Parent Training

- **Parents**
  - Parenting Programs
    - Carolyn Webster-Stratton's Incredible Years program (http://www.incredibleyears.com/)
    - Matt Sanders' PPP (http://www.pfsc.uq.edu.au/02_ppp/ppp.html)
  - PCIT—Coaching parent with Child

Parent Child Interaction Therapy

http://www.pcit.org/

PCIT

- Seek to restructure interaction patterns between the parent and child
- The therapist intervenes based on direct observations
- Parent errors are corrected immediately (COACHING)

Child-Directed Interaction

DO

- Praise
- Reflect
- Imitate
- Describe
- Enthusiasm

DON'T

- Give Commands
- Ask Questions
- Criticize

Possibly Innovative versus Risky Treatments

- Eye Movement Desensitization and Reprocessing (EMDR)
- Rebirthing Therapy
- Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)
- Interpretive Play Therapy
- Thought Field Therapy
- Past-life regression therapy
- Neuro-Linguistic Programming
- Music
- Movement
- Yoga (breathing)
- Drumming
- Therapeutic massage
- Neurosequential Model of Therapeutics

Possibly Innovative versus Risky Treatments

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Dismantling Studies

Questionable Therapies for Abuse

No data or poor outcomes

- Equine-assisted therapy
- Many forms of play therapy
- Nondirective therapies (e.g., psychoanalysis, client-centered therapy)

Detrimental

- Rebirthing therapy (10-year-old Candace Newmaker)
- Attachment therapy
- Holding therapy
- Over medication

National Child Traumatic Stress Network

www.nctsnet.org

NCTSN The National Child Traumatic Stress Network

Training Models

- In order to develop skills, the following will ***not*** work:
  - Lectures
  - Conferences
  - Plenary talks

Training Models

- Assumptions made by the public, agencies, foundations, and elected officials
  - Health care and allied health care trainees receive training in school to deliver effective assessment and treatment services
  - The reality
    - Medical school curriculum
    - Applied psychology curriculum
    - Nursing
    - LPC
    - Social work
  - Result: A haphazard patchwork of experiences—often without exposure to evidence-based approaches

Training Models

- Need: An integrated curriculum across disciplines with specific skills (not facts) demonstrated, repeated, and rehearsed in training settings with supervision and consultation available as skills are taught over time (e.g., 9-12 months)
- Current alternative: Learning collaboratives
- Imperative: Graduate and professional training

Other Controversies

- Prevention of:
  - **Sexual abuse***
  - **Physical abuse**
  - **Neglect**

*Chaffin, M. (2005). Response to letters. *Child Abuse & Neglect, 29*, 241-249.

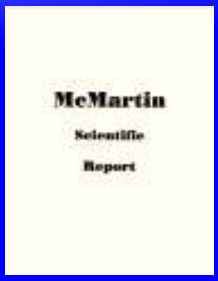
Free Online Training—TF-CBT

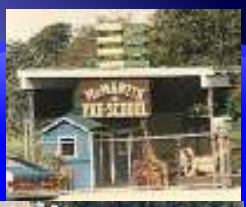
http://tfcbt.musc.edu/

Free Online Training—TF-CBT with Childhood Traumatic Grief

http://ctg.musc.edu/

McMartin Case





Disclosure (Sorensen & Snow, 1991)

- 116 cases of CSA – substantiated by compelling evidence
- Most disclosures were accidental (74%)
- For those that did disclose
  - 22% recanted
  - Of the 22%, 92% reaffirmed

Other Studies on Recantation (4-33%)

- CPS Cases
  - Bradley and Wood (1996) 4%
  - Crewdson (1998) 12%
  - Faller (1998) 33%
  - Jones and McGraw (1987) 8%
- Treatment Cases
  - Gonzalez et al. (1993) 27%

Delays in reporting do not nullify the validity of the allegation

- Smith et al. (2000) found that about half of rape victims raped at a mean age of 10, did not tell within the first year
- A majority of girls did not disclose to a trained interviewer even when there was unequivocal evidence (STD) (Lawson & Chaffin, 1992)

Studies involving strictly problematic cases

Author (Year)	Sample Size	% of false allegations
Green (1986)	11	36% *fabricated*
Benedek & Schetky (1985)	18	55% *unable to document*
Jones & Seig (1988)	20	20% were *fictitious*

Unsubstantiated & Intentionally False

- Third National Incidence Study (NIS-3; King et al., 2003)
  - 60% of cases were unsubstantiated
  - .02% of SA cases in five states were intentionally false
- Canadian Incidence Study—1998 (CIS-98; Trocmé et al., 2001)
  - 33% of cases were unsubstantiated
  - 4% of all abuse cases were intentionally false

Other Studies of Child Protective Cases

Author(Year)	Location	Sample Size	% of intentionally false allegations
Oates et al. (2000)	Australia	551 of SA	2.5%
Trocmé et al. (1994)	Ontario	2,447 child abuse & neglect	2.5%
Jones & McGraw (1987)	U.S.	576 of SA	6%
Anthony & Watkins (1991)	U.K.	350 of SA	8.5%

Court Cases

Author(Year)	Location	Sample Size	% of intentionally false allegations
Thoennes & Tjaden (1990)	U.S.	court cases	2% alleged SA .3% were intentionally false

Noncustodial parent was more likely to make a false allegation than the custodial parent.

Medical Findings

Author(year)	Dubowitz (1992)	Adams (1994)	Kellogg (1998)	Pugno (1999)	Berenson (2000)	Heger et al. (2002)
Number	99	236	157	1,058	192	2,384
Vaginal Normal /nonspecific	62%	77%	85%	64.7%	97.5%	96.3%
Suspicious /Suggestive	10%	9%	12%			
Definitive	28%	14%	3%			
Anal Normal /nonspecific	65%	93%	100%			96.3%
Suspicious /Suggestive	35%	7%	0%			