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

http://www.acestudy.org/

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...

<table>
<thead>
<tr>
<th>ACE score</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>33%</td>
</tr>
<tr>
<td>1</td>
<td>26%</td>
</tr>
<tr>
<td>2</td>
<td>16%</td>
</tr>
<tr>
<td>3</td>
<td>10%</td>
</tr>
<tr>
<td>4 or more</td>
<td>16%</td>
</tr>
</tbody>
</table>
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
The ACE Score and the Prevalence of \textit{fill in the blank}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{ace_score_graph.png}
\caption{Graph showing the relationship between ACE score and percentage of fill in the blank.}
\end{figure}

---

What We Know

Death

- Adverse Childhood Experiences
- Death
- Disease, Disability
- and Social Problems

Adoption of Health-risk Behaviors

Social, Emotional, & Cognitive Impairment

Early Death

- Conception

---

National Child Traumatic Stress Network

www.nctsn.org

---
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

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
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)
With the Realization That

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

- Diverse abuse or trauma backgrounds

- Diverse settings where sexually abused children are potentially identified
Diverse reactions/presentations/misdiagnoses

With the Realization That

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

(Finkelhor, 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-intensive

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 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?)
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
- "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**

-Sexual Abuse-
Knowing these facts accounts for a relatively small percentage of the variance in outcome and symptomatology.
**BIOLOGY of Trauma**

**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 opioids

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

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

Trauma

Sexualized response

Behavioral problems and negative affectivity

PTSD Criteria

Arousal (3)
- Sleep
- Irritability
- Concentration
- Hypervigilance
- Startle
- Physiologic

Re-experiencing (1)
- Recollections
- Dreams
- Seems to Recur
- Symbols

Aversion (2)
- Thoughts/Feelings
- Activities
- Memories
- Interests
- Others
- Affect
- Future

PTSD in Sexually Abused Youngsters

60% PTSD

40% NO PTSD
PTSD in Physically Abused Youngsters

- PTSD: 23%
- NO PTSD: 77%

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>Arousal</td>
<td>85%*</td>
</tr>
<tr>
<td>Re-experiencing</td>
<td>84%*</td>
</tr>
<tr>
<td>Avoidance</td>
<td>53%*</td>
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<tr>
<td>Full Diagnosis</td>
<td>47%*</td>
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</tbody>
</table>

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

PTSD Over Time

- Trauma
- Support/Care
- Arousal
- Re-experiencing
- Avoidant
- Immediate
- Days or Months
- Months or Years
Misdiagnosis and Comorbidity: A PTSD Formulation for Children

- AROUSAL
- RE-EXPERIENCING
- AVOIDANCE
- PANIC/PHOBIA
- SUBSTANCE AROUSE
- CONDUCT DISORDER
- OPPOSITIONAL
- HALLUCINATIONS
- DISSOCIATION
- PHOBIA
- CONVERSION
- SOMATIC
- SEPARATION ANXIETY DISSOCIATION

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

- PTSD
- PTSD + SAD

<table>
<thead>
<tr>
<th></th>
<th>PTSD</th>
<th>PTSD + SAD</th>
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<tbody>
<tr>
<td>Child</td>
<td>72-82</td>
<td>78-94</td>
</tr>
<tr>
<td>Parent</td>
<td>38-54</td>
<td>60-80</td>
</tr>
<tr>
<td>Either</td>
<td>0-10</td>
<td>10-20</td>
</tr>
<tr>
<td>70-80</td>
<td>20-30</td>
<td>30-40</td>
</tr>
</tbody>
</table>
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?

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

Even among abused children
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:
  - 72% agreed that present.
  - 54% agreed that NOT present.
  - 23% did not agree though present by one report.
- Age:
  - 24% (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)

SUPPORT RESOURCES

ABUSE STRESS

Coping Strategies

Psychological Symptoms

Cognitive Appraisals

Gender

Age

Personality

Biology

Abuse Events

Related Events

Disclosure Events

Over Time

“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)
Mandated Reporters (48 states)
- Social workers
- School personnel
- Health care workers
- Mental health professionals
- Childcare providers
- Medical examiners or coroners
- Law enforcement officers

http://www.naccchildlaw.org/childrenlaw/documents/MandatoryReporting_000.pdf
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
- Call Childhelp USA, National Child Abuse Hotline (1-800-4-A-CHILD).
- Texas
  - Texas Toll-Free: (800) 252-5400
  - [www.txabusehotline.org](http://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 disorder)
    - 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%
    - 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

- Adderall 20 mg po q am
- Depakote 500 mg po q hs
- Seroquel 200 mg po bid
- DDAVP 0.4 mg po at hs
- Berocca plus 1 tab po q am
- Zohlib 2 mg po q am
- Imipramine 25 mg po hs
- Clindamycin solution to face bid
- Tenex 2 mg po hs
- Ortho Novum 777 1 tab q am
- Trazadone 100 mg po bid
- Desomorphine 20 mg po q 4 pm
- Zyprexa 15 mg po hs
- Topiramate 200 mg po q am
- Inderal 4.2 mg po q am
- Detrol 4.5 mg po bid
- Bromocriptine 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/](http://www.incredibleyears.com/))
  - 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

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

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


Free Online Training—TF-CBT

http://tfcbt.musc.edu/
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

<table>
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<tr>
<th>Author (Year)</th>
<th>Sample Size</th>
<th>% of false allegations</th>
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<tbody>
<tr>
<td>Green (1986)</td>
<td>21</td>
<td>36% fabricated</td>
</tr>
<tr>
<td>Benedek &amp; Schetky (1986)</td>
<td>18</td>
<td>55% unable to document</td>
</tr>
<tr>
<td>Jones &amp; Seig (1988)</td>
<td>20</td>
<td>20% were fictitious</td>
</tr>
</tbody>
</table>
Unsubstantiated & Intentionally False

- Third National Incidence Study (NIS-3; King et al., 2003)
  - 60% of cases were unsubstantiated
  - 0.02% 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

<table>
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<th>Author(Year)</th>
<th>Location</th>
<th>Sample Size</th>
<th>% of intentionally false allegations</th>
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<tbody>
<tr>
<td>Oates et al. (2000)</td>
<td>Australia</td>
<td>551 of SA</td>
<td>2.5%</td>
</tr>
<tr>
<td>Trocmé et al. (1994)</td>
<td>Ontario</td>
<td>2,447 child abuse &amp; neglect</td>
<td>2.5%</td>
</tr>
<tr>
<td>Anthony &amp; Watkins (1991)</td>
<td>U.K.</td>
<td>350 of SA</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

Court Cases

<table>
<thead>
<tr>
<th>Author(Year)</th>
<th>Location</th>
<th>Sample Size</th>
<th>% of intentionally false allegations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoennes &amp; Tjaden (1990)</td>
<td>U.S. court cases</td>
<td>3% of SA</td>
<td>3% were intentionally false</td>
</tr>
</tbody>
</table>

Noncustodial parent was more likely to make a false allegation than the custodial parent.
<table>
<thead>
<tr>
<th>Medical Findings</th>
<th>Author/year</th>
<th>Number</th>
<th>Normal/nonspecific</th>
<th>Suspicious/Suggestive</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dubowitz (1992)</td>
<td>99</td>
<td>62%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>Adams (1994)</td>
<td>236</td>
<td>77%</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td>Kellogg (1998)</td>
<td>1,658</td>
<td>85%</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>Pugno (1999)</td>
<td>192</td>
<td>64.7%</td>
<td>37.5%</td>
</tr>
<tr>
<td></td>
<td>Berenson (2000)</td>
<td>2,384</td>
<td>96.3%</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>Heger et al. (2002)</td>
<td>2,384</td>
<td>62%</td>
<td>9%</td>
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</tr>
</tbody>
</table>