Children's Services
PRACTICE NOTES
For North Carolina's Child Welfare Workers
From the NC Division of Social Services and the Family and Children's Resource Program

Volume 20, Number 2
April 2015

This publication for child welfare professionals is produced by the North Carolina Division of Social Services and the Family and Children's Resource Program, part of the Jordan Institute for Families within the School of Social Work at the University of North Carolina at Chapel Hill.

In summarizing research, we try to give you new ideas for refining your practice. However, this publication is not intended to replace child welfare training, regular supervision, or peer consultation—only to enhance them.

Let us hear from you!
To comment about something that appears in *Practice Notes*, please contact:

John McMahon
Jordan Institute for Families
School of Social Work
UNC–Chapel Hill
Chapel Hill, NC 27599-3550
jdmcmaho@unc.edu

Newsletter Staff
Mellicent Blythe
Sarah Marsh
John McMahon

Visit Our Website
www.practicenotes.org

Child Sex Abuse Interviews in North Carolina

In August 2014 the NC Division of Social Services asked North Carolina's county DSS child welfare professionals what they'd like to learn more about through publications and webinars. Child sexual abuse interviews was among their top choices.

It's no surprise. Though they are less common than other CPS assessments, child sexual abuse interviews are complex and important enough to be a major concern for child welfare professionals and their agencies.

In response to their interest, this issue of *Practice Notes* gives child welfare professionals an overview of the child sexual abuse interview, shares insights and suggestions from experts, and offers links to training and other resources. Our goal is to help you be ready whenever the need to do a child sexual abuse interview arises. ◆

Child Sex Abuse Interview Protocols: An Overview

When someone reports a child has been sexually abused, North Carolina state law (NCGS § 7B-302) requires child protective services (CPS) to have immediate face-to-face contact with the alleged victim and all other children living in the home. During this meeting, CPS assessors begin trying to determine two things: whether sexual abuse occurred and, if so, whether it might happen again. (*Prosecution of the offender, if it occurs, is the responsibility of law enforcement.*)

CPS assessments of child sexual abuse can be difficult. Typically, this crime occurs in secret and involves only the child and the offender. Medical evidence is rare, occurring in only 5% of cases. Physical evidence (e.g., pictures, text messages, video, body fluids) is present in only 10-30% of cases. The offender is unlikely to tell (Staller, 2010).

Although CPS also talks with the protective/non-offending parent and collaterals (e.g., teachers, day care providers, neighbors, etc.), in most instances the child is the best source of information.

This means that when we interview *cont. page 2*

Sexual Abuse in the U.S.

Incidence of sexual abuse has ***greatly decreased***. Substantiated sexual abuse cases dropped 44% between 1992 and 2006. This is a "real decline," as opposed to changes in reporting or data collection (Finklehor & Jones, 2004; Sedlak, et al., 2010). This decline is due in part to growing awareness that everyone is responsible to report abuse, and to prevention programs.

In 2013, 60,956 U.S. children were found to be victims of sexual abuse. This represents 9% of confirmed child maltreatment cases that year (USDHHS, 2015). Note: This is most likely an undercount, since most child sexual abuse never comes to the attention of state agencies.

Traits of Victims

- Girls are most at risk. From 9-32% of women and 5-10% of men say they were victims of sexual abuse and/or assault during childhood (Sedlak, et al., 2010; Douglas & Finklehor, 2005).
- All ages are at risk, but teens appear to be at highest risk (Douglas & Finklehor, 2005).
- Minority children are more at risk than white children (Douglas & Finklehor, 2005; Sedlak, et al., 2010).
- All income levels are affected, but the poorest families may be most at risk (Sedlak, et al., 2010).
- Family dysfunction is a risk factor. Sex abuse is associated with family problems such as parental alcoholism, parental rejection, and marital conflict (Douglas & Finklehor, 2005).

Overview

continued from the previous page

children about possible sexual abuse, it is critically important that we do it right.

Child Sexual Abuse Interviews

Interviews assessing for child sexual abuse (CSA) differ from interviews conducted in supportive counseling, mental health treatment, or other clinical settings. Child sexual abuse interviews are fact-finding efforts with three goals:

1. Minimizing the trauma of the interview.
2. Maximizing the amount and accuracy of information obtained.
3. Maintaining the integrity of the CPS assessment—in other words, gathering information without trying to "prove" a particular hypothesis (Azzopardi, 2013)

When it comes to achieving these goals the most important factor is ***interviewer skill***. This is especially true when it comes to information quality; how interviewers behave during an interview affects the amount and accuracy of information produced (Saywitz, 2014; Lamb, 2008).

Based on a substantial body of research evidence, there is broad agreement about the techniques most likely to yield accurate, credible information. Unfortunately, studies also show that many workers do not use these techniques in the field, even when they know what "best practice" is.

For example, most interviewers know they should use open-ended questions, yet typically only 2% of the questions they ask are open-ended. Most often, they ask specific questions such as, "Did he touch you?" even though research indicates answers to direct questions are far more likely to be wrong (Lamb, 2008; Aprile, et al., 2009).

Evidence-Based Protocols

To promote the use of effective, proven techniques, experts developed structured child sexual abuse interviewing protocols and tested them with over 30,000 children in the U.S., Australia, Israel, and the United Kingdom (Lamb, 2008; Saywitz, 2014; Pipe, 2007). Today there are five recognized CSA interviewing protocols:

- NICHD (developed by the National Institute of Child Health and Human Development)*
- The Step-Wise Interview
- Developmental Narrative Elaboration
- Cognitive Interview
- Child First (*formerly "Finding Words"*)

There are slight differences among these protocols, but all are remarkably similar. Each consists of five steps: (1) introduction/rapport building; (2) instructions; (3) free narrative practice; (4) free narrative; (5) closure. These protocols are so similar because the research is clear which techniques are most likely to yield the best information.

**RADAR (Recognizing Abuse Disclosure types and Responding), taught in the NC DSS-sponsored class "Child Forensic Interviewing," is an adaptation of the NICHD protocol.*

Benefits of Protocols

Evidence-based protocols make interviews easier for children and increase the amount and quality of information gathered.

Using a protocol:

Improves interviewer performance. Protocols reduce problems such as interviewer miscommunications and misleading questions. Workers using protocols ask three times more open-ended questions and cut in half the number of suggestive questions they ask (Lamb, 2008; Pipe, 2007).

Makes the interview easier for the child. Protocols enhance the child's participation, elicit more memory from the child, and take into account what children are able to do at certain ages. Protocols are especially beneficial for interviewing children from both low income families and minority ethnic groups (Lamb, 2008; Pipe, 2007).

Using a free narrative protocol increases information without decreasing accuracy (Saywitz, 2014; Azzopardi, 2013). This is especially true for events from long ago, even for children with learning disabilities or low IQ (Lamb, 2008; Pipe, 2007).

Facilitates case decisions. With a protocol, the child provides more details and more leads that investigators can corroborate (e.g., names of others present; locations; existence of videotape, phone messages, photos, etc.). This makes it easier to evaluate the child's statements.

May increase prosecution of offenders. When a protocol is used cases are more likely to be submitted to the district attorney, more likely to lead to charges or arrests, and more likely to go through the criminal justice system (Lamb, 2008; Pipe, 2007).

Use of Protocols in NC Today

Several countries have made the use of child sexual abuse protocols mandatory (Lamb, 2008; Pipe, 2007). While North Carolina has not, it does endorse a modified version of the NICHD protocol, which it makes available through the course *Child Forensic Interviewing*. This course, which has been offered 62 times since 2004, has been attended by a total of 886 people from 80 county DSS agencies, including 839 direct client contact workers (e.g., CPS assessors), 31 supervisors, and 2 agency directors. Many others have also attended *Introduction to Child Sexual Abuse*. (*Intro to CSA* has recently been replaced by *Responding to Child Sexual Abuse*—for more on this change, see p. 3).

Of course, attendance figures can't tell us to what extent CSA interviewing protocols are being used consistently and with fidelity, either by individuals or by whole agencies. At present this data does not exist.

Given what the research says about the benefits, formally including CSA interview protocols in agency policy and taking steps to support their ongoing use—with fidelity—are worthwhile investments. ◆

CSA Interviews: Learning Resources

CPS Assessments

The Course: This 4-day, classroom-based course teaches participants how to use a family-centered approach when conducting family assessments and investigative assessments. It also lays a strong basis both for practice and for what is taught in *Responding to Child Sexual Abuse* and *Child Forensic Interviewing*.

Audience: Mandatory in the first year for county DSS employees responsible for completing CPS assessments.

Offered: Twelve times a year.

Responding to Child Sexual Abuse

The Course: A crucial foundation for assessing sexual abuse allegations in a way that supports the child and family. Provides an overview of protocols for legally defensible interviewing and the latest best practice guidelines, including interviewing perpetrators and non-offending parents.

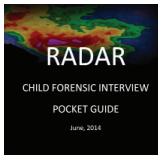
This course is divided into two 3-day sessions (6 days total) featuring lectures, videos, small group work, and many opportunities for skills practice and transfer of learning activities.

Audience: County DSS social workers and supervisors with at least a year of experience with CPS investigative assessments.

CPS professionals are encouraged to take this course even if they have taken *Intro to Child Sexual Abuse*. The new course includes current research, new interviewing protocols, and more skills practice—it's quite different from the old *Intro* course.

Offered: Seven times a year.

Child Forensic Interviewing



The Course: Those attending this 4-day course will learn to conduct legally-defensible, developmentally sensitive interviews of alleged child and adolescent victims of child maltreatment. The course teaches an adaptation of the National Institute of Child Health and Development (NICHD) child forensic interview protocol. Through lecture, video demonstrations, and small group exercises participants learn an effective interviewing approach that will help them avoid the errors of both undercalling and overcalling abuse.

Audience: County DSS social workers and supervisors involved in CPS investigative assessments. Supervisors of participating CPS workers are *strongly* encouraged to attend.

Offered: Five times a year.

Fostering and Adopting the Child Who Has Been Sexually Abused

The Course: This 4-day course prepares certified MAPP leaders to deliver a training that teaches foster and adoptive families to work with children who have been sexually abused. Topics covered include: understanding child sexual abuse, handling the double trauma of sexual abuse and placement, responding to disclosures, managing behaviors, and collaboration with mental health, legal, and social service providers.

Audience: Certified MAPP leaders from county DSS agencies and therapeutic/private agencies; includes foster parent and adoptive parent MAPP leaders.

Offered: Four times a year.

Training: Safeguard Your Investment

Training can have a huge positive impact on child and family outcomes. Too often, however, training's potential isn't fully realized. Sometimes this is because training is seen as a one-time event. But research increasingly shows that the "train and pray" approach doesn't work.

Agencies serious about applying best practices in child sexual abuse cases will want to safeguard their investment in training by ensuring that when they return to work after training their staff get ample opportunity to have their interviews observed (with feedback) and are coached in the application of new skills.

For a transfer of learning tool supervisors can use to help workers practice and apply what they learn in class, go to: http://bit.ly/1BSK745

Trauma-Informed Behavior Management

The Course: Although it does not focus specifically on sexual abuse, child welfare professionals working with birth families, foster and adoptive parents, and relative caregivers will find this 2-day course extremely helpful. Through lecture and skills practice, it equips child welfare workers to support families and teach them a specific process for analyzing, understanding, and responding effectively to challenging child behaviors caused by trauma.

Audience: County DSS child welfare social workers and supervisors.

Offered: Four times a year.

To learn more or to register for these courses, go to www.ncswLearn.org

National Interviewing Skills Classes

Child First North Carolina. This five-day forensic interviewing course teaches you to defend forensic interviews when testifying in court. Offered 2-3 times a year by Cumberland County DSS in conjunction with its community partners. www.ncchildfirst.org

Nat'l Children's Advocacy Center in Huntsville, Alabama offers two week-long courses: *Forensic Interviewing* and *Advanced Forensic Interviewing of Children*. www.nationalcac.org

APSAC Child Forensic Interview Clinic held in various locations around the country is a five-day course taught by leading experts. www.apsac.org

CSA Interviews in North Carolina: By the Numbers

Figures and data in this article are from Duncan, 2015

What do administrative data tell us about child sexual abuse interviews and sex abuse victims in NC?

CPS assessments

In December 2014, North Carolina county DSS agencies employed 1,023 CPS assessors (NC DSS, 2015). When child maltreatment reports are accepted, these individuals conduct an assessment with the child and family.

The number of children involved in CPS assessments each month has been gradually increasing. Between January 2000 and April 2014, about 11,800 children were assessed each month.

Sexual abuse interviews

Hundreds of the CPS assessments conducted each month concern sexual abuse. Figure 1 shows the number of NC children assessed and substantiated for sexual abuse each month between 2006 and 2014. Most of these assessments likely involved a child sexual abuse interview.

Substantiated victims

In North Carolina only a minority of CPS assessments for allegations of sexual abuse result in substantiation of sexual abuse. A variety of factors may contribute to this. Some reports simply are unfounded, though when this happens there is usually no malicious intent. Other times, sexual abuse has occurred but CPS substantiates for something else (e.g., neglect/lack of supervision). In some cases CPS can't identify the perpetrator.

In other instances children are not believed, though research suggests fictitious allegations of sexual abuse from children are quite uncommon, comprising 3% or less of all sexual abuse reports (sources cited in Faller, 2007).

Each month from 2006-2014, between 59 and 147 NC children were found to be victims of sex abuse. Most were between the ages of 6 and 12, followed by youth ages 13-18. Relatively few victims were under age 6.

To see the numbers of children assessed and substantiated for child sexual abuse in specific NC counties, see Figures 4 and 5 on the next page.

Unexpected disclosures

Sometimes an agency gets involved with a family for one reason only to discover sexual abuse has also occurred. As Figure 3 shows, for an average of 5-10% of the children substantiated as sex abuse victims each month, the initial report did not allege sex abuse. Some children disclose sexual abuse only after months or years in foster care, when they finally feel safe.

Figure 1

Number of NC Children Assessed and Substantiated for Sexual Abuse, by Month

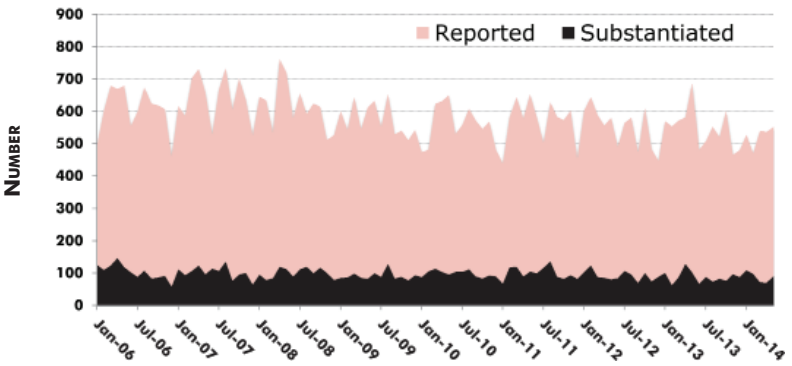


Figure 2

Number and Gender of NC Children Substantiated for Sexual Abuse, by Month

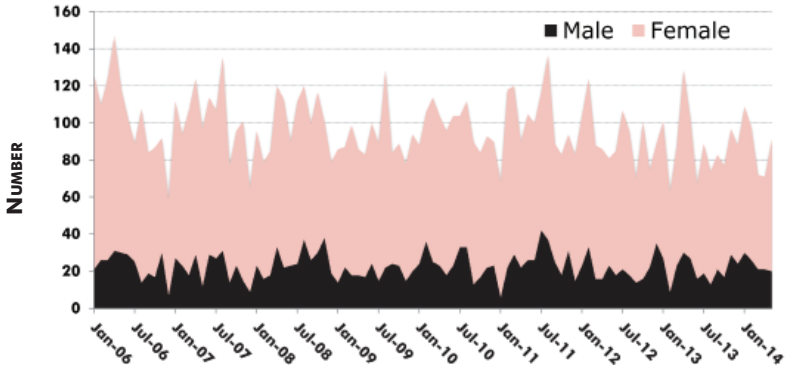
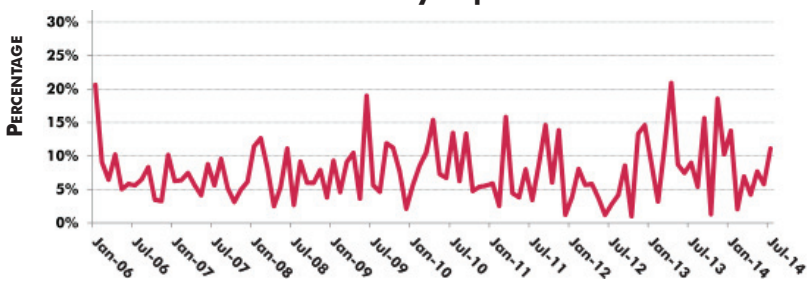


Figure 3

NC Children Found to be Victims of Sexual Abuse Who Were Not Initially Reported to be Victims



Practice Tip

Data can be valuable in court. Consider keeping track of your own cases. Track the number of sex abuse cases you investigate and the number you do and do not substantiate. In court, if an attorney suggests that you find sexual abuse "in every case you investigate," you can use data to demonstrate that neither you nor your agency "always" substantiate sexual abuse (Flick, et al., 2014).

Caution and limitations

Administrative data are an imperfect tool for estimating the number of sex abuse victims. Most victims likely go uncounted. Reasons can include: they were abused by someone other than a caretaker, they did not disclose the abuse, their disclosure for some reason did not result in substantiation, or the sexual abuse was not tracked due to a coding error. Many victims do not disclose until adulthood.

Numbers

continued from the previous page

Figure 4 **Children Assessed for Sexual Abuse by NC County, Jan.-Dec. 2013**

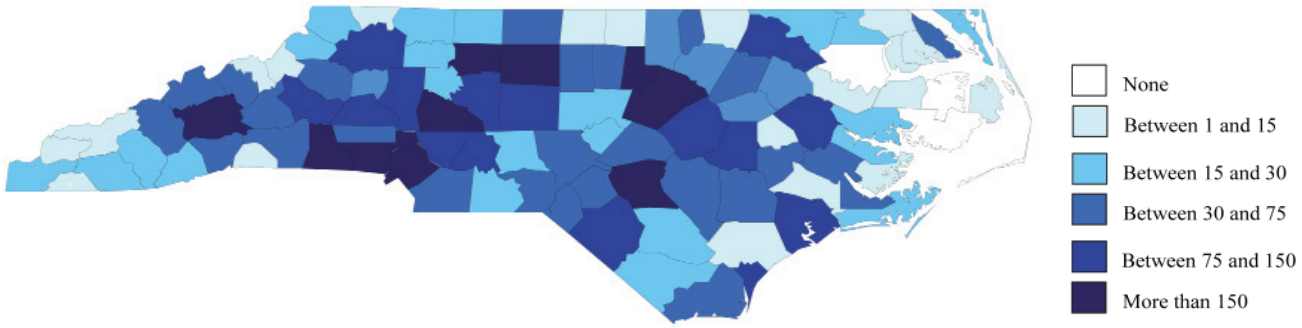
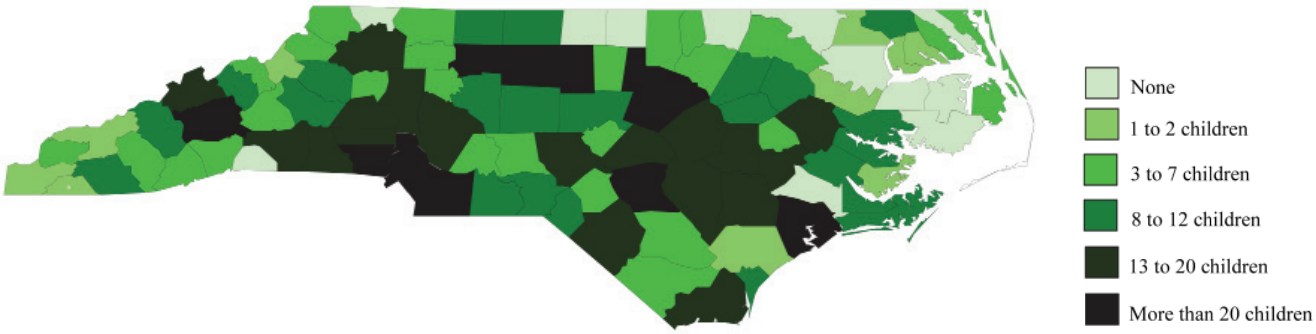


Figure 5 **Children Substantiated for Sexual Abuse by NC County, Jan.-Dec. 2013**



How to Be Family-Centered While Responding to "Tough" Cases

Cooperation, which increases the chances that the issues that brought the family to the agency's attention will be resolved successfully, is possible even when coercion is required (Turnell & Edwards, 1999). The following family-centered suggestions may help you inspire family cooperation, even when assessing reports of child sexual abuse or other forms of maltreatment.

Take time to engage families. Your relationship with the family is at the heart of your investigation and everything that follows. Invest the time needed to build a rapport with the family and you will probably obtain more and better information, and you and others from your agency will have a solid foundation for working with the family. Here your ability to listen empathically is key—when you listen respectfully, with an open mind, and withholding judgment, families feel heard and understood, defensiveness becomes unnecessary, and solutions can be sought (BIABH, 2002). Underlying principles: *Everyone needs to be heard* and *Everyone desires respect*.

Look for family strengths. Point out positives to the family when you learn about them. Use strengths-based language in your documentation. Underlying principle: *Everyone has strengths*.

Help families with transitions. Be clear, informative, and supportive as you explain things to the family, and whenever it is time to move to the next step in the process. Underlying principle: *Families are our partners*.

Give families empowering choices. Research tells us that when clients feel they have been given a say and presented with options, they respond favorably (Turnell & Edwards, 1999). Underlying principle: *Partners share power*.

Pay attention to the words you use. Present information in as non-threatening a way as possible. Practice using nonadversarial, nonauthoritarian language before you interact with families. For example, you may wish to come up with alternatives to phrases such as, "I'm not at liberty to say." Underlying principle: *Judgments can wait*.

Provide families with constructive alternatives. If alcohol is contributing to a safety risk, it is not enough to tell a parent to stop drinking. "Change and safety in child protection is about the presence of something new, not just the absence of risk" (Turnell & Edwards, 1999). Underlying principle: *Families are our partners*.

Exercise your authority only when necessary. Invoking your authority is easier and requires less skill than being family-centered. Avoid, to the extent possible, actions that minimize/undermine parents' power. Instead, look for opportunities to put the family in a position of authority—for example, by asking for permission, when appropriate. People are more disclosing, open, and cooperative if they don't feel threatened and judged. Underlying principles: *Families are our partners,* and *Partners share power*.

Child Forensic Interviewing: A 30-Year Perspective

By Mark D. Everson, PhD, University of North Carolina at Chapel Hill

"You're a good therapist. Just wing it."

I was about to do my very first "forensic" interview in 1983 and this was my faculty supervisor's advice. I don't remember who was more terrified that day, the five-year-old who was to be interviewed or me, the UNC "expert."

This was the beginning of my 30+ year career devoted to improving the way children are interviewed in cases of suspected child sexual abuse (CSA). The field of child forensic interviewing has evolved substantially since its infancy in the early 1980's. Overwhelmingly, the changes have been significant improvements. However, there have been a few retreats from effective interview practice mixed in among the many advances.

This article offers one child abuse professional's appraisal of the field of child forensic interviewing during the last three decades.

Key Advances

My observations are listed in no particular order. Each represents a major step forward and away from the "wing it" approach to CSA interviews.

1. Paradigm shift from "clinical" to "forensic"

Our understanding of the impact of CSA and the nature of the disclosure process has changed markedly.

In the 1980's, accepted interview practice was shaped by three beliefs commonly held at the time:

(1) Sexual abuse and the disclosure process itself are both highly traumatizing for most victims;

(2) Most child victims are reluctant to disclose and require substantial psychological support and encouragement to do so; and

(3) Suggestive interview approaches, including the use of dolls and puppets, are often necessary to aid children in the disclosure process.

During much of the 1980's, the "disclosure interview," as the interview with the alleged child victim was frequently called, was widely viewed as a clinical interview, ideally to be conducted by a trained clinician. The interviewer was given significant leeway to push the envelope of appropriate questioning to ensure no CSA victim was missed and left unprotected.

Child forensic interviewing has evolved substantially since its infancy in the early 1980's.

By the early to mid-1990's, the underlying assumptions as well as the methodology of the clinical interview paradigm were widely discredited. A number of factors contributed to this change in perspective, including new research on children's memory and suggestibility and several high profile cases in which "overly suggestive" interview techniques were believed to have resulted in criminal charges and convictions of innocent adults.

The forensic interview paradigm, with its emphasis on implementation of research-based practice, replaced all things clinical. The playroom stocked with toys and dolls was replaced by the bare interview room equipped with a marker and a pad of paper.

2. Development of structured interview protocols

Dissatisfaction with the inefficiency and errors of freelance interviews resulted in the development of structured and semi-structured interview protocols. Barbara Boat and I published a semi-structured protocol for using anatomical dolls in child interviews in 1986. The CornerHouse RATAC protocol was developed in the late 1980's. Early versions of structured protocols offered scaffolding for the interviewer to construct the interview around, guided by what the protocol developers considered to be best practice interview principles.

In the mid-1990's, Michael Lamb and colleagues introduced the highly innovative NICHD Investigative Interview protocol. With NICHD, the interview is largely scripted, providing many of the words for the interviewer to say in order to reduce interviewer error. Second, the protocol was the first to bring together all the elements of narrative interview technology in a single interview format.

The NICHD interview protocol has been widely researched and dominates the field today. While the original protocol comes across as formal and not child friendly, it has been widely adapted and softened. The RADAR forensic interview protocol, which is taught in the NC DSS-sponsored course *Child Forensic Interviewing*, is one such adaptation. RADAR offers scripting for the novice interviewer and scaffolding for more experienced interviewers.

3. Use of narrative interview technology

For decades researchers have been telling interviewers that the most open, least suggestive form of questions are narrative requests such as "Tell me about X."

During the 1980's, many of us tried the use of narrative requests, producing the following scenario:

Interviewer: Tell me about school today.

Child: We played.

The interviewer then follows up with a series of more direct questions.

In those days, narrative requests elicited, at most, a brief sentence; to elicit the substance of what occurred more directed questioning was required. As a result, people quickly gave up on narrative questioning.

Lamb and his colleagues demonstrated in their NICHD protocol that narrative interview strategies do work if the child is properly trained and encouraged to reply in narra-

A 30-Year Perspective

continued from the previous page

tive form. In brief, narrative interview technology includes building rapport through building narratives, formal narrative practice, and specialized narrative questioning concerning the target event.

When this approach is used, many children as young as 4 or 5 years old can provide rich, detailed narratives about the substantive events under investigation. These narratives often yield an abundance of leads that can be used to corroborate or refute the child's statement.

4. Specialization of the child forensic interviewer role

As the forensic interview has become more structured and research-based, the position of interviewer has required more specialized training. Best practice standards have been delineated and expectations for periodic video reviews have become established. This has led to increased specialization of the role of forensic interviewer. "Child forensic interviewer" is now a job title as well as a viable career choice. The professionalization and specialization of the role has substantially enhanced the quality of interviews.

5. Commitment to forensic balance in the investigative process

Sensitivity and specificity are two indices of diagnostic accuracy. Applied to our field, sensitivity is a measure of the success of CSA investigators in correctly identifying true cases of abuse while minimizing the number of true cases that are missed or not substantiated. Specificity defines accuracy as the rate of success in correctly identifying false cases and avoiding false positive errors.

The 1980's was a "Sensitivity Era": an overemphasis on making sure no victim was overlooked increased the risk that children who had not experienced abuse were nonetheless identified as victims (i.e., false positive errors). The early to mid-1990's marked the beginning of a "Specificity Era" in which preventing false positive errors became the priority at the risk of increased false negative errors.

To oversimplify slightly, the motto of the Sensitivity Era was "Tell me your secret so I can help." This was replaced in the Specificity Era with the motto "Convince me, if you claim you have been abused."

A few regrettable retreats are mixed in with the many improvements we've seen.

In the last decade or so, our field has begun to acknowledge that false positive and false negative errors both have devastating impacts on those affected. Both types of errors should be avoided without trading off one for the other. We have entered a new era of "forensic balance" where sensitivity and specificity receive equal emphasis.

Regrettable Retreats

As described above, the early to mid-1990's represent a critical dividing point in the field of child forensic interviewing. The field pivoted from a clinical perspective with an emphasis on minimizing false negative errors to a research-based perspective with an emphasis on preventing false positive errors. This shift meant that clinical insights which shaped interview practice in the 1980's were often dismissed as irrelevant or unproven. This section highlights what I believe are two unfortunate retreats from widely accepted interview practice in the 1980's.

1. Flexibility in the use of multiple interviews

Disclosure is a process. "Just ask, they'll tell" is not an effective interview strategy for most CSA victims. Many child and adolescent victims require time to develop rapport and the courage to provide a full disclosure to the stranger interviewing them. These truths were better appreciated in the 1980's, when interviewers had greater flexibility in scheduling follow-up interviews to better meet the needs of reluctant victims. This flexibility has been replaced in many child abuse programs and agencies with a rigid, one-interview model that fails to serve many child victims.

2. Recognition of the need to address barriers to disclosure

Current structured interview protocols work best for children who have made a deliberate, prior disclosure of the abuse. The interviews are less effective with children who are not in an active disclosure phase. Structured interviews are least effective with child victims who have significant psychological barriers or fears related to disclosure. Forensic interviewers seldom have the time within one interview to effectively address the existence of barriers to disclosure. Unfortunately, this means that today many of the most vulnerable children are therefore least well served.

Implications for Child Welfare Practice

The specialization of the child forensic interviewer role, complete with the requirement of substantial entry-level training, the use of a structured interview protocol, and expectation of periodic video review, has led to the increasing marginalization of child welfare personnel in the CSA interview process. Career interviewers in child advocacy centers and specialized medical clinics have taken over the heavy lifting—aided by the fact that they have access to video equipment. The strength of the child welfare approach in developing rapport and establishing relationships with child clients has been essentially neutralized by the dominance of the one-interview model.

As best practice standards evolve to reflect an emphasis on forensic balance rather than specificity, we can expect a reappraisal of several aspects of current practice. At the top of the list for reappraisal is our field's misplaced confidence in the single child forensic interview. ◆

Dr. Everson is a professor and the director of the Program on Childhood Trauma and Maltreatment at UNC-CH.

Providing a Trauma-Informed Response to Child Sexual Abuse

We know children who experience sexual abuse can be further traumatized by CPS assessments and law enforcement investigations. We also know that without appropriate treatment, survivors of child sexual abuse are at increased life-long risk for a broad array of physical and mental health problems, as well as future victimization (Hilaski, et al., 2008; O'Brien & Scher, 2013; Sachs-Erisson, et al., 2009; all cited in Flick, et al., 2014).

What can child welfare workers and agency leaders do to ensure their involvement minimizes trauma and promotes healing?

1. Practice self-care. We can't take care of others unless we care for ourselves. Workers and agencies must find ways to integrate self-care into their normal routines. Hearing horrific details of child sexual abuse, feeling the pressure of added legal scrutiny, managing uncertainty and ambiguity, and experiencing intense reactions towards the alleged offender and other family members—all this can cause workers to dread and distance themselves emotionally from these cases (van Dernoot Lipsky, 2009). Yet child sexual abuse victims need an authentic connection with an engaged and caring worker who will advocate for and support them. Professionals themselves need support and protection from the damaging effects of secondary traumatic stress. For more on this, visit http://bit.ly/1COZSUn.

2. Reduce the trauma of the investigative process. The following steps reduce the negative impact on a child while the interdisciplinary process unfolds (Aprile, et al., 2009; Saywitz & Comparo, 2014; Staller & Faller, 2010; all cited in Flick, et al., 2014):

- Reduce the number of ***interviewers***. Have the same person interview the child when more information is needed, rather than requiring the child to tell their story over and over to different people. This rapport building may also increase the child's feeling of safety, making disclosure in a later interview possible even if the child does not initially disclose.
- Reduce the number of ***interviews***. Use video recording, one-way mirrors, and other methods to minimize the number of times the child needs to be questioned. Children's Advocacy Centers (CACs) use many of these approaches, as well as skilled interviewers who can make the experience less stressful and more empowering for the victim. Ask parents, school teachers, and counselors not to interview or interrogate the child.
- Select the interview location carefully. Use a place that is private, comfortable, and familiar to the child.
- On the rare occasion that a very young child refuses to be seen without a caregiver present, allow a support person to be with the child. Tell this person they can come into the room initially, but must sit behind the child, must not respond to anything the child says or does, and must not be involved in the interview. If the child looks to them for an answer, they are to say, "I can't help you answer. It's okay to tell Miss Carol." Once the child is comfortable, the adult should find an excuse to leave. "Have the adult give the child instructions: Tell the truth because we want to understand what you remember."
- Get the child's agreement for the medical exam. Children who have been sexually violated need as much control as possible over their bodies. If the child resists the exam, don't force the child to cooperate. Giving an age-appropriate explanation of what to expect during the exam, the reasons for the exam, and rescheduling it can help the child feel psychologically safe enough to cooperate. If it is a medical emergency and the exam must be done immediately, the doctor could make the child feel safer through the use of sedation.
- Explain everything—at the child's developmental level—and offer choices. Children may be able to give their agreement to many things that happen in an investigative assessment, such as where and when to meet, where they might like to sit, or what supports or people would be helpful. If the child and family are safe and mental health issues are stable, older youth may be part of discussions about whether to arrest an alleged offender. Offering choices helps you join with the child and increases their sense of control over what happens to them.
- Do not use polygraphs or voice analyzers with children or teens. Such methods give the message that they are not believed, and their efficacy has not been established for children.
- Have the law enforcement officer testify at the probable cause hearing, not the child.

There's a lot we can do to ensure our involvement minimizes trauma and promotes children's healing.

3. Let children talk. Sometimes workers feel anything related to the abuse is a forbidden topic if there is an ongoing investigation, says Jeanne Preisler, Coordinator of Project Broadcast, North Carolina's federally-funded initiative to build a trauma-informed child welfare system. "You're not conducting an interview and you don't want to probe, but the child may mention things or want to tell you how they're feeling. They may spontaneously disclose things that they haven't said to others." Children may also express feelings of guilt and responsibility, not only for the abuse but also for the upheaval that followed their disclosure. Families that have experienced sexual abuse often have cultures of secrecy and shame, and children are frequently given the message that they are to blame for what has happened (Sgroi, 1982).

As a child welfare professional, you may provide a safe place for the child to express their true feelings, and you can send the child the message that she is not to blame for what has happened. It is possible to listen empathically and reduce children's sense of shame without compromising the investigation.

continued next page

 continued from the previous page

4. Attend to psychological and physical safety. In child sexual abuse cases our attention is understandably focused on physical safety: making sure the alleged abuser has no unsupervised contact or access to the child. Yet it's important to remember that to heal, children have to feel safe.

Various factors can contribute to children continuing to worry even after being removed from an abusive situation, including "valid fears about their own safety or the safety of loved ones, difficulty trusting adults to protect them, hyperawareness of potential threats, and problems controlling their reactions to perceived threats" (NCTSN, 2013). Further complicating the situation, children may face "people, situations, places, or things that remind them of traumatic events," causing them to "experience intense and disturbing feelings tied to the original trauma. These 'trauma reminders' can lead to behaviors that seem out of place, but were appropriate—and perhaps even helpful—at the time of the original traumatic event" (NCTSN, 2013).

Talk with children about people, places, and situations that make them feel worried, and those that make them feel safe. Some children more easily share their ideas about a "safe home" by creating a drawing in which they draw or list inside the house things that make them feel safe, and draw or list worrisome things outside the house.

Since children may not even be aware their reactions are related to trauma, you can also educate caregivers to look for patterns of difficult or confusing behavior that may be related to trauma reminders. Caregivers need education to help them interpret children's problematic behaviors as trauma reactions, rather than labeling the child as "bad" or "manipulative."

5. Advocate for and support effective treatment. The good news for children who experience sexual abuse is that there are effective, evidence-based treatments available. One effective model becoming increasingly available in our state is Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT). To find therapists certified in TF-CBT, visit the NC Child Treatment Program's provider map: www.childtreatmentprogram.org/NCCounties/Index.rails

What about when TF-CBT is not available, or not appropriate for a particular child? DSS agencies are important voices to advocate for increasing the availability and funding for TF-CBT and other trauma-informed treatments. Your Managed Care Organization (MCO), System of Care agencies, and current providers are all important partners in bringing effective, high quality treatment to your community.

Once children access treatment, as a child welfare professional you are a consultant for the therapist, just as they are a consultant for you in understanding what is happening for the child and how best to help. Social workers can:

- Ensure the therapist has the information needed for a comprehensive assessment and treatment plan;
- Promote the use of a trauma- and evidence-informed approach; and
- Monitor whether the child is making measurable progress over time.

See the box below for questions to ask therapists, and the following interview on the next page for tips on collaboratively supporting children's treatment and healing. ◆

Trauma-Focused Questions for Mental Health Providers

1. Do you provide trauma-specific or trauma-informed therapy? If yes, how do you determine if the child needs a trauma-specific therapy?
Providers should describe an assessment process that involves obtaining a detailed social history, including all forms of trauma, as well as the use of a standardized, trauma-specific measure.

2. How familiar are you with the evidence-based treatment models designed and tested for treatment of child trauma-related symptoms?
Providers should mention one of the specific interventions listed on this site: http://www.NCTSN.org.

3. Describe a typical course of therapy for traumatized children and their families.
Approaches described should incorporate some or all of the following:

Building a strong therapeutic relationship. Trauma treatment requires the skillful development of a clinical relationship with the child and caregivers.

Psycho-education about normal responses to trauma. Most trauma-informed therapy includes a component that helps the child and caregivers understand normal reactions to trauma.

Parent support, conjoint therapy, or parent training. Caregivers are typically powerful mediators of the child's treatment and recovery. Involving caregivers is a vital element of trauma treatment.

Emotional expression and regulation skills. Helping the child to identify and express powerful emotions related to the trauma and to regulate or control their emotions and behavior is an important element of trauma-informed therapy.

Anxiety management and relaxation. It is often necessary to teach the child (and sometimes the caregiver) skills and tools for mastering the overwhelming emotions associated with trauma and its reminders.

Cognitive processing or reframing. Many children form destructive misunderstandings in the aftermath of the trauma. Therapy often helps correct these misattributions.

Construction of a coherent trauma narrative. Trauma treatment often includes building the child's capacity to talk about what happened in ways that do not produce overwhelming emotions and that make sense of the experience. This sometimes involves gradual exposure to traumatic reminders while using newly acquired anxiety management skills.

Personal safety training and other empowerment activities. Trauma treatment often teaches children strategies that give them a sense of control over events and risks.

Resiliency and closure. Treatment often ends on a positive, empowering note, giving the child a sense of satisfaction and closure as well as increased competency and hope for the future.

Adapted from National Child Traumatic Stress Network, 2013

Partnering with Mental Health Clinicians in Sex Abuse Cases

A Conversation with Ashley Fiore

Ashley Fiore, MSW, LCSW, is the director of trauma-informed practice for Barium Springs, clinical faculty/consultant for the NC Child Treatment Program, and a clinical consultant for Partnering for Excellence.

What can DSS social workers do to advocate for evidence-based, trauma-informed treatment?

We really need to insist on this. Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) clinicians in the NC Child Treatment Program are achieving a 90% success rate in reducing children's trauma symptoms to subclinical levels. That beats the national average! If we knew there was a treatment for a serious physical ailment where 80% or more of the children who got that treatment got much better much faster than children who got treatment as usual, we wouldn't accept that it wasn't available.

Sometimes we hear people say, "But my child likes his current therapist." But if your child had a physician she really liked but only 60% of kids seen by that physician were likely to get better, wouldn't you change doctors? And, the research shows clients actually like their TF-CBT clinicians just as much as their other clinicians.

My dream is that DSS workers would realize how integral they are to linking children to effective services. They are "brokers of service," to use a term from Project BEST in South Carolina. Project BEST talks about brokers identifying whether a family needs mental health services; selecting evidence-informed treatment and skilled providers; monitoring the client's progress and treatment; and taking action if outcomes aren't being met. Of course, to do this you need a working understanding of the model to make sure it's appropriate and that progress is on target.

Part of the challenge is empowering DSS social workers to question mental health providers about the treatment they're providing, and to make sure they are familiar with how clinicians are measuring client outcomes.

What are elements of trauma-informed work for DSS?

Start with safety. Determine what the child and caregiver need for physical and emotional safety. It's also important to include a focus on helping the child develop coping skills to manage symptoms associated with trauma, as well as helping the caregiver understand what's driving the child's behavior and how they can help reduce and manage the child's symptoms.

The National Child Traumatic Stress Network (NCTSN) has developed "12 Core Concepts for Understanding Traumatic Stress Response in Children and Families" (available here: http://bit.ly/1w5oYBs). These are essential building-blocks that underpin whatever model you're using.

Another good resource is by the American Academy of Child and Adolescent Psychiatry. They have parameters for many different types of treatment and specific mental health disorders (available here: http://bit.ly/1vlhQ3l). Social workers should ask clinicians if they are familiar with these parameters, and how their work fits within AACAP's best practice recommendations.

Another critical part of treatment is actually at the very beginning: making sure there is an appropriate assessment. This should include standardized assessment measures, information from at least three sources (child, caregiver, and teacher), a developmentally-appropriate clinical interview from a bio-psycho-social perspective, and consideration of the impact of trauma. Agencies can choose to refer to clinicians for assessments based on whether they see evidence of these things in talking with the clinician or in the clinician's final written assessment.

"My dream is that DSS workers would realize how integral they are to linking children to effective services."

Once a child is receiving appropriate treatment, how can social workers support the therapeutic goals?

1. Coordinate with mental health providers. If a parent has a DSS meeting that conflicts with a therapy appointment, they have to prioritize the DSS meeting. Let's work together to make sure parents are doing what they need to do, not missing one appointment for another or feeling overwhelmed by multiple requirements.

2. Recognize that parents must be actively involved, and that the work is very, very hard for them. As a clinician I'm more of a consultant to the parent; the parent is doing the heavy lifting. I tell families, "The child has just 60 or 90 minutes a week with me. The rest of the time ***you*** will be their coach, helping them practice skills and create new, positive associations." It is helpful to actually write into the case plan "parent and child will ***successfully*** complete all of the components of treatment." It's sometimes important to have that leverage to complete the treatment successfully, with parents remaining engaged.

3. Call and check with the provider. Ask where we are in the model. Ask what we're seeing. A good clinician is spending time doing case management for children involved in the child welfare system, and should be accessible to you.

4. Be cautious about asking for visitation or custody recommendations. That's not the therapist's role. I understand completely why it happens. Sometimes the judge wants to know what the therapist thinks. But giving a recommendation impacts the therapist's ability to create a relationship with the caregiver and to serve as a coach and cheerleader for the parent. Therapists can't be in a dual role of also deciding the outcome

continued from the previous page

of the family's case. Clinicians can describe what a child needs to thrive and optimize their progress, based on the research on trauma, and on what they're seeing. But the therapist's focus needs to be on symptom reduction.

How can DSS social workers most effectively communicate with clinicians regarding the child's DSS and clinical plans?

We need to know each other's roles and limitations. A lot of animosity is due to misunderstanding. We need to appreciate that different viewpoints give us a broader perspective and allow us to be more helpful as a group than we could be individually. We all need to pick up the phone more often.

For their part, DSS workers should be sure they know what the therapeutic goals are for the child, how the therapist is measuring progress, and whether the child is making progress.

How can social workers promote psychological as well as physical safety for children who have been sexually abused?

Make a careful assessment and plan for visitation. A child should not be around the person who sexually abused them until both have received effective treatment and are clear about who is responsible for the abuse.

Even after this, we still need to think very carefully about who is supervising visits. How do we vet those people? What support and training do they have? Can they recognize certain looks or subtle threats an offender might give? Are we putting a parent who is a previous victim in the position of having to keep the child safe? If I'm a child and I've seen my mother unable to keep herself safe, how can I be sure she will keep me safe?

It's important to create rules for visits with a family member who can't admit wrongdoing, who minimizes the offender's responsibility, or who simply doesn't believe it happened. For example, a grandma may not believe her son did anything. Rules might include the following:

- Focus on the present: no talking about the future until things are known;
- Talk to parents about looks and other threatening gestures that will cause the visit to be ended early;
- Teach parents how to express their feelings and validate their children's feelings without making promises.

At the same time, I think mental health providers have been slow to accept the fact that most families ultimately reunify. It's far better this happens in a therapeutic way that's planned and out in the open. I see this as final phase of treatment, after you've resolved the trauma symptoms. This requires the person treating child and the person treating the adult or sexually aggressive youth to collaborate closely. Too often clinicians stay in silos, which may unwittingly model avoidance. This is an essential phase that we need to consider after trauma symptoms have resolved. ◆

Working with Non-Offending Parents

Social workers sometimes describe personal challenges in working with the protective/non-offending parent in child sexual abuse cases. Often workers feel that the parent "must have known." What's your perspective on understanding and engaging the non-offending parent?

Ashley Fiore: Start from a point of compassion and making positive attributions about that non-offending parent's behavior. For the child, sexual abuse has often been a chronic stress that they've been dealing with for a long time. To some extent, disclosure can be a relief. If it's handled well, the abuse stops and the child gets help.

But for the parent, the child's disclosure is an acute trauma. They have suddenly learned that their child has been hurt by someone they trusted. It's their husband, or one of their other children, or a relative or friend. This has significant implications for your future. Not only is the child groomed for sexual abuse, but the non-offending parent has been groomed, too. We really need to recognize how insidious sexual abuse is.

We also need to be aware of the overlap between domestic violence and sexual abuse. Domestic violence victims face additional obstacles—they're typically financially dependent, isolated, and fearful.

What's helped me has been to align myself with the non-offending parent's confusion, denial, and disbelief. I view this as a grief process, and there is self-protection in "not knowing." Another thing that's helped me is that, in my experience, the parents who are the angriest are the ones who are feeling the most guilty. I'm not saying we give people a pass. We put in place supervision for the child while the caregiver works through those feelings. But the absolute worst thing we can do is to shut them out and shut them down because they're not behaving protectively from the get-go. That pushes them directly into the offender's arms, and to what is much easier to believe.

Jan Hindman developed a very helpful concept about three types of non-offending parents. Type 1 are those who immediately believe and intervene effectively. Type 2 are those who should have known about the abuse or intervened ineffectively. This group needs education. Type 3 are those who knew about the abuse and its consequences but did not intervene. They are culpable.

But here's the thing. You can't stay a Type 2. A lot of parents we see as Type 3 are really Type 2. We need to give them everything they need to be a Type 1. It's not helpful to push them and shame them. It's more helpful to say, "Tell me what it's like to have your husband be accused of this. What is that like for you? What would it mean if this happened?" We can help move people to become a Type 1 supportive parent if we don't give up on them based on their initial response.

References for this Issue *(Children's Services Practice Notes, v. 20, n. 2 • www.practicenotes.org)*

Aprile, A., Ranzato, C., Rizzotto, M. & Facchini, P. (2009). *Child sexual abuse: Pitfalls in the substantiation process*. NY: Nova Science Pubs, Inc.

Azzopardi, C. & Kirkland-Burke, M. (2013). *Forensic interviewing with children: Best practices, challenges and controversies*. Presented at SickKids conference "Current Issues in Child Maltreatment: Multidisciplinary Perspectives" November 27-28, 2013, Toronto, Ontario.

Bringing It All Back Home Study Center. (2002). *Partners in change* [curriculum]. Boone, NC: Author.

Douglas, E. M. & Finklehor, D. (2005, May). *Children sexual abuse fact sheet*. Retrieved March 1, 2006. Durham, NH: Crimes Against Children research Center. http://www.unh.edu/ccrc/factsheet/pdf/CSA-FS20.pdf

Duncan, D. F. (2015). Sex abuse and child welfare in North Carolina. Presented January 7, 2015 at the Injury-Free NC Academy, UNC Injury Prevention Center conference "Creating Communities That Are Free of Sexual Abuse and Sexual Violence." Chapel Hill, NC.

Everson, M. D. & Boat, B. W. (1989). False allegations of sexual abuse by children and adolescents. Journal of the American Academy of Child and Adolescent Psychiatry, 28(2), 230-235

Faller, KC. (2007). *Interviewing children about sexual abuse: Controversies and best practice*. NY: Oxford Press.

Finkelhor, D. & Jones, L. M. (2004). *Explanations for the decline in child sexual abuse cases*. Juvenile Justice Bulletin [NCJ199298], pp. 1-12. Order #CV44.

Finkelhor, D. (1994). Current information on the scope and nature of child sexual abuse. The Future of Children, 4(2), 31-48.

Fisher, R. P. & Geiselman, R. E. (August 1992). *Memory-enhancing techniques for investigative interviewing: The cognitive interview*. Charles C. Thomas Publishers.

Flick, J., Jacobs-Deese, T., Little, R. & Williams, A. (2014). *Responding to child sexual abuse* [curriculum]. Chapel Hill: Jordan Institute for Families, UNC-Chapel Hill School of Social Work.

Hilarski, C., Wodarski, J. & Feit, M. (eds.) (2008). *Handbook of social work in child and adolescent sexual abuse*. NY: Haworth Press.

Jones, D. P. H. & McGraw, J. M. (1987). Reliable and fictitious accounts of sexual abuse to children. Journal of Interpersonal Violence, 2, 27-45.

Lamb, M. E., Hershkowitz, I., Orbach, Y. & Espin, P. W. (2008). *Tell me what happened: Structured investigative interviews of child victims and witnesses*. West Sussex, England, John Wiley and Sons, Ltd.

Lovett, B.B. (2004). Child sexual abuse disclosure: Maternal response and other variables impacting the victim. *Child and Adolescent Social Work Journal, 21*(4), 355-371.

National Child Traumatic Stress Network. (2013, January). *Child welfare trauma training toolkit (2nd ed.): Trainer's guide*. http://learn.nctsn.org/mod/page/view.php?id=1813

NC Division of Social Services. (2015). NC Division of Social Services data book. Raleigh, NC: Author.

O'Brien, B. S., & Sher, L. (2013). Child sexual abuse and the pathophysiology of suicide in adolescents and adults. *International Journal of Adolescent Medicine and Health, 25,* 201-205.

Pipe, M. E., Lamb, M., Orbach, Y. & Cederborg, A. (eds). (2007). *Child sexual abuse: Disclosure, delay and denial*. Mahwah, NJ: Lawrence Erlbaum Associates Pubs.

Sachs-Erissson, N., Cromer, K., Hernandez, A. & Kendall-Tackett, K.A. (2009). A review of childhood abuse, health, and pain-related problems: The role of psychiatric disorders and current life stress. *Journal of Trauma & Dissociation, 10*, 170–188.

Saywitz, K. & Comparo, L. B. (2014). *Evidence-based child forensic interviewing*. NY: Oxford Press.

Saywitz, K. J., Goodman, G. S., Nicholas, E. & Moan, S. F. (1991). Children's memories of a physical examination involving genital touch: Implications for reports of child sexual abuse. Journal of Consulting and Clinical Psychology, 59(5), 682-691. http://dx.doi.org/10.1037/0022-006X.59.5.682

Sedlak, A. J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A. & Li, S. (2010). *Fourth national incidence study of child abuse and neglect (NIS–4): Report to congress, executive summary*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

Sgroi, S.M. (1982). *Handbook of clinical intervention in child sexual abuse*. Lexington, MA: Lexington Books.

Staller, K. & Faller, K. C. (2010). *Seeking justice in child sexual abuse: Shifting burdens and sharing responsibilities*. NY: Columbia Press.

Turnell, A. & Edwards, S. (1999). *Signs of safety: A solution and safety oriented approach to child protection*. New York: W. W. Norton & Co.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2015). *Child maltreatment 2013*. Available from http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment

Van Dernoot Lipsky, L. (2009). *Trauma stewardship: An everyday guide to caring for self while caring for others*. San Francisco: Berrett-Koehler Publishers.