

A close-up photograph of a young child's face, partially hidden in the shadows of a dark, floral-patterned blanket. The child is holding a small, pink flashlight up to their eye, illuminating their face and the surrounding darkness. The scene conveys a sense of mystery and discovery.

The 2018 Research to Practice Brief Compendium



The American
Professional Society
on the Abuse of Children™

Strengthening Practice Through Knowledge

In partnership with





page [Introduction to the Compendium](#) | *Bri Stormer*
6

Student Briefs

page [Annual Cost of U.S. Hospital Visits for Pediatric Abusive Head Trauma](#) | *Jane I. Smith*
7
Original study authors: Cora Peterson, Likang Xu, Curtis Florence, and Sharyn E. Parks

page [A Pilot Study of Trauma-Focused Cognitive-Behavior Therapy Delivered via Telehealth Technology](#) | *Kymber Stanley*
9
Original study authors: Regan W. Stewart, Rosaura E. Orengo-Aguayo, Judith A. Cohen, Anthony P. Mannarino, and Michael A. de Arellano

page [Building Capacity for Trauma-informed Care in the Child Welfare System: Initial Results of a Statewide Implementation](#) | *Keith Geiselman*
11
Original study authors: Jason M. Lang, Kimberly Campbell, Paul Shanley, Cindy Crusto, and Christian Connell

page [Depressive Symptom Trajectories Among Sexually Abused Youth: Examining the Effects of Parental Perpetration and Age of Abuse Onset](#) | *Hanna Boussi*
13
Original study authors: Matthew W. Carlson and Assaf Oshri

page [Disentangling the Cycle: Potential Mediators and Moderators in the Intergenerational Transmission of Parent-Child Aggression](#) | *Sunghyun Hong*
15
Original study authors: Christina M. Rodriguez, Paul J. Silvia, Samantha Gonzalez, and Maria-Ernestina Christl

page [Intergenerational Effects of Childhood Trauma: Evaluating Pathways Among Maternal ACEs, Perinatal Depressive Symptoms, and Infant Outcomes](#) | *Jessica M. Ladd*
17
Original study authors: Christina G. McDonnell and Kristin Valentino

Research to Practice Brief Team

Bri Stormer, MSW
Research to Practice Brief Editor

Todd Herronkohl, PhD
Student Research to Practice Brief Liaison

Bart Klika, PhD, MSW
Chair, APSAC Publications Committee

Professional Briefs

page 19 [Early Exposure to Child Maltreatment and Academic Outcomes](#) | *Misti Jeffers*
Original study authours: Joseph P. Ryan, Brian A. Jacob, Max Gross, Brian E. Perron, Andrew Moore, and Sharlyn Ferguson

page 21 [Effectiveness of a Trauma-Informed Care Initiative in a State Child Welfare System: A Randomized Study](#) | *Areesah Abdus-Shakur*
Original study authours: M. Kay Jankowski, Karen E. Schifferdecker, Rebecca L. Butcher, Lynn Foster-Johnson, and Erin R. Barnett

page 23 [Intergenerational Transmission of Trauma: Maternal Trauma-Related Cognitions and Toddler Symptoms](#) | *Karen Zilberstein*
Original study authors: Rebecca L. Babcock Fenerci and Anne P. DePrince

page 25 [The Prevention of Child Maltreatment Through the Nurse Family Partnership Program: Mediating Effects in a Long-Term Follow-Up Study](#) | *Pamela Miller*
Original study authors: John Eckenrode, Mary I. Campa, Pamela A. Morris, Charles R. Henderson, Kerry E. Bolger, Harriet Kitzman, and David L. Olds

page 27 [What is Neglect? State Legal Definitions in the United States](#) | *Bri Stormer*
Original study authors: Rebecca Rebbe

APSAC Staff

Janet Rosenzweig, PhD, MPA
Executive Director

Jane Campbell, MEd
Administrator, Training and Education

Jim Campbell, PhD
Training Director

Ilana Feldman, BS
Executive Assistant

Hannah Gilbert, MSHCM
Marketing and Media Assistant

Betsy Poulos
Clerical Assistant for Member Services

Bri Stormer, MSW
Manager – Publications and Special Projects



2019 APSAC Board of Directors

President

David L. Corwin, MD

Professor and Director of Forensic Services
University of Utah, Pediatrics
Sandy, UT

Immediate Past President

Tricia Gardner, JD

Associate Professor/Section Administrator
Developmental and Behavioral Pediatrics
University of Oklahoma Health Sciences Center
Oklahoma City, OK

President Elect

Stacie LeBlanc, JD, MEd

CEO, The UP Institute
New Orleans, LA

General Counsel and Secretary

Bill S. Forcade, JD

Attorney at Law
Chicago, IL

Treasurer

Jemour Maddux, PsyD, ABPP

Managing Director
Lamb and Maddux, LLC
Hackensack, NJ

Member at Large Elected to the Executive Committee

Bart Klika, MSW, PhD

Chief Research and Strategy Officer
Prevent Child Abuse America
Chicago, IL

Director

Ryan Brown, MD, FAAP

Clinical Associate Professor
University of Oklahoma College of Medicine
Medical Director, Child Protection Committee
The Children's Hospital at OU Medical Center
Oklahoma City, OK

Director

Carmen Jirau-Rivera, LMSW

Chief Program Officer
The New York Foundling
New York, NY

Director

Bethany Mohr, MD, FAAP

Clinical Associate Professor
Medical Director, Child Protection Team
Michigan Medicine Department of Pediatrics
University of Michigan
Ann Arbor, MI

Director

Roslyn Murov, MD

Senior Vice President, Mental Health Services
The New York Foundling
New York, NY

Director

Mel Schneiderman, PhD

Senior Vice President
Vincent J. Fontana Center for Child Protection
The New York Foundling
New York, NY

Director

Victor Vieth, JD, MA

Director of Education & Research
Zero Abuse Project
St. Paul, MN

Director

Susan Hardie, RN, PhD

Private Practice; President CAPSAC
Calabasas, CA

Director

Ron Laney

Office of Juvenile Justice and Delinquency Prevention
U.S. Department of Justice (Retired)
Dale City, VA

Director

Mary L. Pulido, PhD

Executive Director
The New York Society for The Prevention of
Cruelty to Children
New York, NY

Director

Itohan Omorogie, JD

Special Counsel
The New York Foundling
New York, NY

President Emeritus

Ronald C. Hughes, PhD, MScSA

Director
Institute for Human Services and
North American Resource Center for Child Welfare
Columbus, OH

President Emeritus

Viola Vaughan-Eden, PhD, MJ, LCSW

Associate Professor & PhD Program Director
Norfolk State University
Newport News, VA



What is APSAC?

The American Professional Society on the Abuse of Children, now in partnership with The New York Foundling, was founded in 1986 and is a nonprofit, national organization focused on meeting the needs of professionals engaged in all aspects of services for maltreated children and their families. Especially important to APSAC is the dissemination of state-of-the-art practice in all professional disciplines related to child abuse and neglect. Our members are attorneys, physicians, nurses, investigators, social workers, forensic interviewers, clinicians, law enforcement professionals, educators and researchers, and others all working together to meet our mission.

The mission of APSAC is to improve society's response to the abuse and neglect of its children by promoting effective interdisciplinary approaches to identification, intervention, treatment, and prevention of child maltreatment.

APSAC is strongly committed to:

- Preventing child maltreatment;
- Eliminating the recurrence of child maltreatment;
- Promoting research and guidelines to inform professional practice;
- Connecting professionals from the many disciplines to promote the best response to child maltreatment;
- Ensuring that America's public policy concerning child maltreatment is well-informed and constructive, and;
- Educating the public about child abuse and neglect.

Connect with APSAC

@The_APSAC

[Facebook.com/The APSAC](https://www.facebook.com/The.APSAC)

[Linkedin.com/company/APSAC](https://www.linkedin.com/company/APSAC)

Email: info@apsac.org

APSAC

1706 East Broad St.
Columbus, OH 43203

(Phone) 614-827-1321
(Toll Free) 877-402-7722
(FAX) 614-251-6005

Introduction to the Compendium

Bri Stormer, MSW

In the summer of 2017, the APSAC Board of Directions, APSAC Publications Committee, and *Child Maltreatment (CM)* Editorial Board identified a problem: APSAC's frontline practitioner members did not consider receiving *CM* an important benefit of APSAC membership, as they had difficulty applying the findings reported in the journal to their practice. This problem is not unique to APSAC. In the mental health and health care sectors, there is a reported 20-year gap between identification through research of important clinical knowledge, and the application of that knowledge into direct practice (Brekke, Ell, & Palinkas, 2007). While there are many reasons for this gap, one reason was abundantly clear to APSAC and *CM* leadership: to achieve the goal of "strengthening practice through knowledge," APSAC must do more to ensure the best science is being effectively communicated into practice settings.

These stakeholders suggested APSAC create Research to Practice Briefs on articles from *CM*. The goal of these briefs is to translate the research findings into plain language, with an emphasis on implications for practice and policy. APSAC staff created a structure (usually introduction, hypothesis/research questions, subjects, findings, recommendations, bottom line) and a sample brief. APSAC began soliciting its networks for brief authors and received over 40 volunteers across disciplines and experience levels. In 2018, APSAC began assigning these authors to produce briefs from *CM* articles. APSAC released these briefs in its newsletters, shared them via social media, and added them to the APSAC website, where they are publicly available to members and non-members alike.

In summer 2018, Dr. Todd Herrenkohl reached out to APSAC about bringing the Research to Practice Brief to one of his MSW classrooms at the University of Michigan. The Publications Committee approved the

project and worked with Dr. Herrenkohl to develop a sample assignment. Students prepared briefs from *CM* articles in the classroom and were given the opportunity to submit them to APSAC for professional publication. Six students submitted to APSAC; APSAC staff offered feedback and suggested revisions and students' briefs were published on the APSAC website.

APSAC believes that high-quality research translation has the potential to help bridge the gap between research and practice. As a multidisciplinary professional organization, APSAC is in a unique position to solicit authors well-versed in research and reach practitioners across disciplines and experience levels. By involving students, APSAC hopes to help build a new generation of child maltreatment professionals skilled in research translation and less siloed in their fields of either research or practice.

This compendium includes all briefs produced in 2018, both by professional and student authors. The Table of Contents identifies students who participated in the classroom assignment. To view all currently published briefs, you can visit <https://www.apsac.org/researchtopractice>.

We hope you enjoy this compendium of briefs! Please feel free to share the full compendium or individual briefs with your students and colleagues. If you are interested in bringing briefs to your classroom as an assignment, or if you are interested in serving as an expert reviewer for student briefs, please contact Bri Stormer, APSAC Manager of Publications and Special Projects, at bstormer@apsac.org.

Reference

Brekke, J.S., Ell, K., & Palinkas, L.A. (2007). Translational science at the National Institute of Mental Health: Can social work take its rightful place? *Research on Social Work Practice* 17(1), 123–133. doi: 10.1177/1049731506293693

Annual Cost of U.S. Hospital Visits for Pediatric Abusive Head Trauma

Jane I. Smith, MPH Candidate, BS

Original study authors: Cora Peterson, Likang Xu, Curtis Florence, and Sharyn E. Parks

Introduction

This study aims to investigate the financial impact of pediatric abusive head trauma (AHT), also known as shaken baby syndrome. Experts have long known that pediatric AHT is a serious public health issue; however, there has not been a comprehensive way to document it. With the advent of an administrative code-based definition of AHT, created by the Centers for Disease Control (CDC), experts can measure the health and financial consequences of AHT more systematically and accurately nationwide. Previous studies have examined the prevalence of AHT mortality and hospital admissions and visits with this code, but no previous study has looked at the costs of hospital services, neither inpatient nor emergency, for diagnosing and treating AHT cases that fit the code. By examining the financial implications, researchers can better understand AHT from another crucial perspective, and thus experts can allocate public health prevention efforts for child maltreatment appropriately.

This study aims to document the annual frequency of hospital emergency and inpatient visits and provider costs for the diagnosis and treatment of AHT. The study also assesses relationships between AHT patients and associated hospital medical costs nationwide in the United States using this code.

Research Questions

In the United States, what is/are 1) the frequency of hospital visits (emergency and inpatient admissions)

for patients with AHT annually? 2) the cost from the provider perspective of hospital visits for patients with AHT? 3) characteristics of AHT patients that result in higher than average per-visit costs?

Subjects

The researchers used publicly available data from U.S. hospital emergency department visits to identify AHT diagnoses among children 0-4 years old between the years 2006-2011. These data included frequency of visits, patient characteristics, and medical costs. Using the CDC code, AHT was classified as a skull or intracranial injury caused by intentional blunt impact or aggressive shaking.

Findings

From 2006 to 2011, among children 0-4 years of age, the number of annual emergency department visits for AHT ranged from 1,009-1,223 visits per year, and the number of annual inpatient admissions for AHT ranged from 1,790-2,688 admissions per year. Over the study period, providers diagnosed AHT in a total of 6,827 emergency department visits and 12,533 inpatient admissions nationwide.

During the study period (2006-2011), average estimated medical costs for an AHT-related emergency department visit and inpatient admission were \$2,612 and \$31,901, respectively. Additionally, the estimated total cost of all AHT emergency department visits and inpatient admissions for AHT ranged between \$58.9 million and \$98.5 million annually, with an estimated annual average of emergency department visits and inpatient admissions combined equaling \$69.6 million.

Characteristics associated with higher per-visit emergency department costs in AHT patients included (1) the patient being less than 1 year old, (2) having an existing chronic condition like epilepsy, (3) developmental delays, (4) congenital abnormalities, (5) having public insurance, and (6) going to a hospital equipped for trauma cases or a teaching hospital in an urban area. Characteristics of AHT patients associated with higher per-visit inpatient admissions included (1) the patient being male, (2) having an existing chronic condition, and (3) coming from a household with a higher income.

Recommendation

Results underscore the need for greater AHT prevention efforts. Practitioners should give consideration to universal prevention and awareness efforts, including home visiting and parent education. Providers should prioritize prevention efforts for families of children with existing conditions, such as premature birth, developmental delays, congenital abnormalities, or colic.

Bottom Line

AHT is an extremely serious form of child maltreatment that results in poor health outcomes for children and high healthcare costs. Nationwide AHT prevention efforts could minimize these negative health outcomes and reduce high healthcare costs by millions of dollars. Cost analysis could be an effective avenue to advocate for AHT prevention efforts and resource allocation.

Citation

Peterson, C., Xu, L., Florence, C., & Parks, S. E. (2015). Annual cost of U.S. hospital visits for pediatric abusive head trauma. *Child Maltreatment*, 20(3), 162–169. doi:10.1177/1077559515583549

About the Author

Jane Smith, MPH Candidate, BS, is a master's student at the University of Michigan School of Public Health in the Department of Health Behavior and Health Education and is pursuing a graduate certificate in Injury Sciences. Prior to her matriculation into the master's program, she received her Bachelor of Science in Biopsychology, Cognition, and Neuroscience from the University of Michigan.



A Pilot Study of Trauma-Focused Cognitive-Behavioral Therapy Delivered via Telehealth Technology

Kymber Stanley, MSW Candidate, BSW

Original study authors: Regan W. Stewart, Rosaura E. Orengo-Aguayo, Judith A. Cohen, Anthony P. Mannarino, and Michael A. de Arellano

Introduction

This study seeks to reduce barriers for youth in need of mental health services via Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) delivered through telehealth technology, via videoconferencing software. These barriers include: (1) lack of transportation and means to travel (e.g., gas/parking money) to mental health facilities, (2) lack of insurance, (3) employment barriers (e.g., scheduled work hours, leave restrictions), and (4) limited availability of culturally and linguistically competent services for Spanish-speaking children and families. While telehealth has great potential to reduce these barriers, experts have conducted little research on the effectiveness of TF-CBT delivered to youth via telehealth technology. This study examines the effectiveness of telehealth technology in delivering TF-CBT to children and adolescents with PTSD or adjustment disorder.

Research Questions

Researchers explore two guiding questions: (1) Does telehealth technology improve access to TF-CBT for trauma-exposed youth from economically disadvantaged backgrounds? (2) Does TF-CBT delivered by telehealth technology to these youth appear to lessen PTSD, depression, and anxiety symptoms?

The researchers focus on five outcomes of interest: (1) strategies for providing TF-CBT via telehealth, (2) technical performance of the telehealth equipment, (3)

safety issues, (4) number of sessions attended and rates of treatment completion, and (5) clinical outcomes related to self-reported and parent-reported symptoms of PTSD, depression, and anxiety.

Subjects

Participants included 15 youth, age 7-16, referred for treatment at a trauma treatment center. Fourteen were female, 46.7% Hispanic, 40% African American, and 13.3% Caucasian. Ten participants lived in underserved urban locations, and five lived in rural locations. All youth met criteria for either PTSD (12) or adjustment disorder (3). Five youth had an index trauma of sexual abuse, one had an index trauma of physical abuse, three experienced the traumatic loss of a loved one, two witnessed the armed robbery of a family member, one witnessed the physical abuse of a sibling, and three experienced multiple traumas. Researchers excluded youth from the study if they presented with current suicidal ideation or exhibited serious externalizing behaviors and were a danger to themselves or the telehealth equipment. Barriers to treatment services included lack of transportation, language preference of the child and/or caregiver, caregiver work schedule, and rural location.

Treatment utilized both school and home settings. Researchers established basic guidelines for videoconferencing sessions: select a space with minimal distractions and privacy, silence or turn off cell phones, and avoid using the computer for other activities. For home sessions, researchers emphasized to parents the importance of respecting the child's privacy by providing a space where they would not

be overheard. Participants completed sessions held at school using a provided laptop, and practitioners instructed school staff on how to use the equipment. Practitioners addressed technology issues before the initiation of treatment, and these issues were minimal throughout. Practitioners established safety plans with schools and parents before treatment began, but these were not necessary over the course of this study. Practitioners lessened barriers to technology access by giving participants laptops or network accessible iPads to use for the duration of the treatment. Practitioners predownloaded appropriate software, which reduced technological issues. The HIPPA compliant Vidyo videoconferencing software proved beneficial for screen sharing from provider to patient. Providers expressed satisfaction with the telehealth model, and the parents who completed satisfaction surveys (47%) were 100% satisfied with telehealth.

Findings

Researchers found that TF-CBT delivered via telehealth technology was successful at reducing barriers to treatment. All participants completed between 12 and 19 45-90 minute sessions. All youth completed treatment (0% dropout). All youth had a caregiver who actively participated in treatment. Both youth and their caregivers reported a decrease in youth PTSD symptoms. At the completion of treatment, all youth no longer met criteria for either PTSD or adjustment disorder as measured by the UCLA PTSD Reaction Index, which assesses trauma exposure and post-traumatic stress symptoms among children and adolescents.

Recommendation

The study's findings suggest that providers working with youth impacted by trauma should consider offering TF-CBT through telehealth technologies as a means of reducing barriers and promoting treatment engagement and completion.

The school setting proved conducive in this study for increasing access to treatment. More youth may be able to receive treatment if schools offered an environment where telehealth services were more easily accessible to their students. Increased funding is needed to provide technology for treatment use as well as making quality providers accessible and

affordable for underserved communities. Encouraging partnerships between providers and schools to offer mental health services via telehealth ensures the use of appropriate technology, addresses safety concerns, and maintains privacy.

Future research considerations include increasing male participants, using a larger sample size, using a comparison group and randomization, including participants without a caregiver involvement in treatment, and focusing on either home setting or school setting in order to increase the validity of findings.

Bottom Line

This research suggests that TF-CBT delivered by telehealth technologies can be just as effective as in-person treatment.

Trauma-focused cognitive-behavioral therapy delivered via telehealth technologies proves successful in reducing youth barriers to accessibility while lessening PTSD symptoms and promoting the completion of treatment.

Citation

Stewart, R. W., Orengo-Aguayo, R. E., Cohen, J. A., Mannarino, A. P., & Arellano, M. A. (2017). A pilot study of trauma-focused cognitive-behavioral therapy delivered via telehealth technology. *Child Maltreatment*, 22(4), 324–333.

About the Author

Kymber Stanley, BSW, is currently a Master of Social Work candidate with a concentration in Interpersonal Practice and Mental Health at the University of Michigan. She is also a psychotherapy intern at The Women's Center of Southeastern Michigan. Kymber earned her Bachelor of Arts in Psychology and Bachelor of Social Work from Spring Arbor University.

Building Capacity for Trauma-Informed Care in the Child Welfare System: Initial Results of a Statewide Implementation

Keith Geiselman, MSJ, MDiv, LLMSW

Original study authors: Jason M. Lang, Kimberly Campbell, Paul Shanley, Cindy Crusto, and Christian Connell

Introduction

The study examines the effectiveness of a change strategy to create a statewide trauma-informed child welfare system (CWS). Trauma-informed treatment is especially important in the CWS because of the high prevalence of trauma in children in state and tribal CWSs, and because exposure to childhood trauma is a major public health concern. Because there is no consensus about what constitutes a trauma-informed system, the Administration for Children and Families (ACF), a division of the U.S. Department of Health and Human Services, funded the development and evaluation of trauma-informed CWSs to improve child well-being.

The article describes one model used to create a trauma-informed CWS—including workforce development; trauma screening; policy change; and improved client access to evidence-based, trauma-focused treatments—during a three-year implementation and evaluation in the state of Connecticut.

Research Questions

The primary question is whether the CWS can become a trauma-informed system. The study measures this using the Trauma System Readiness Tool (TSRT), which utilizes 90 items to measure 12 domains of trauma informed care. These domains include: 1) trauma training and education; 2) staff trauma knowledge and practice; 3) individual trauma knowledge and practice; 4) trauma supervision and

support; 5) staff supports child relationships; 6) birth family trauma support; 7) resource family trauma support; 8) staff addresses child psychological safety; 9) agency trauma assessment; 10) access to trauma informed services; 11) local agency collaboration, general; 12) local agency collaboration, trauma. The study evaluates changes in system readiness and capacity to deliver trauma-informed care using a stratified random sample of staff prior to and two years following implementation.

Findings

Components of the change model were: the creation of multi-disciplinary teams, identification of “trauma champions” to be early adopter liaisons, implementation of screening and assessment procedures, and education on evidence-based practices (EBPs) for trauma-focused interventions. The study found that training must be ongoing (that is, it is hard to sustain change when practitioners see change as “one more thing,” and supervisors provide them with no relief from other responsibilities). Researchers also found that support for worker wellness and secondary trauma needs further attention.

Mean scores on the TSRT increased significantly across nearly all domains from Year 1 to Year 3. Among the components studied, researchers observed the greatest improvements for trauma supervision and supports, access to trauma-informed services, and trauma-related supports for birth and resource families. The study saw moderate gains across all other scales, with the exception of general collaboration with local mental health agency staff. Improvements in

trauma training and education, birth family support, resource family support, and child relationship support were greatest among staff working directly with clients and less so for managers and supervisors, who had less direct contact.

The authors noted that lighter than national average caseloads and higher salaries in CT led to long-term staff stability (average tenure was 13.5 years vs. a national turnover of CWS staff of 23-60% annually). The effect of staff stability on implementation of a trauma-informed CWS needs further study.

Recommendation

The study makes five recommendations for implementing systemic organizational change:

1. Assess and commit sufficient financial and staffing resources for a five-year plan that includes, training, IT infrastructure for reporting, evaluation team, and workflow modeling.
2. Ensure that leadership at the highest level is fully committed long-term to the change.
3. Evaluate organizational readiness and initial capacity, with sufficient time to plan implementation.
4. Identify and encourage formal and informal “champions” at all levels of the organization.
5. State and federal policy changes and funding opportunities supporting trauma-informed care can accelerate the change.

It is also important to create a feedback process to strengthen the connection between organizational

parts to a shared vision. Leadership needs to frequently share successes to help the teams focus on the bigger reasons for making the change—that is, better client outcomes through the processing of trauma.

Bottom Line

Trauma-informed CWSs are necessary to better serve youth, who frequently have a trauma history that negatively impacts their physical and mental health throughout their lives. This study suggests that creating a trauma-informed CWS is possible. The model implemented in the Connecticut CWS provides a roadmap to making the necessary changes system-wide. State and national policy changes to accelerate the adoption of trauma-informed CWSs should be identified and implemented, keeping in mind the holistic nature of a trauma-informed CWS and ensuring organizational readiness for this level of change.

Citation

Lang, J. M., Campbell, K., Shanley, P., Crusto, C. A., and Connell, C. M. (2016). Building capacity for trauma-informed care in the child welfare system: Initial results of a statewide implementation. *Child Maltreatment*, 21(2), 113-124.

About the Author

Keith Geiselman, MSJ, MDiv, LLMSW, is a 2018 graduate of the University of Michigan School of Social Work. He interned at Washtenaw County (Michigan) Community Mental Health and is minister and therapist in group practice.

Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2013). Violence, crime, and abuse exposure, in a national sample of children and youth: An update. *Journal of the American Medical Association: Pediatrics*, 167, 614-621.

Kilpatrick, D. G., Ruggiero, K. J., Acierno, R., Saunders, B. E., Resnick, H. S., & Best, C. L. (2003). Violence and risk of PTSD, major depression, substance abuse/dependence and co-morbidity: Results from the National Survey of adolescents. *Journal of Consulting and Clinical Psychology*, 71, 692-700.

Depressive Symptom Trajectories Among Sexually Abused Youth: Examining the Effects of Parental Perpetration and Age of Abuse Onset

Hanna Boussi, MSW Candidate, BSW

Original study authors: Matthew W. Carlson and Assaf Oshri

Introduction

This study seeks to understand trajectories of depressive symptoms for sexually abused children under three scenarios: (1) when the perpetrator is a parent, (2) when the perpetrator is not a parent, and (3) based on the age of abuse onset. Data are from the National Survey of Child and Adolescent Well-Being I (NSCAW-I) and include: (1) baseline data collected 2-6 months after practitioners classified the investigations as closed, (2) 18 months after, (3) 36 months after practitioners closed the case, and (4) 72 months post-baseline.

Research Questions

The researchers hypothesize that children who experienced childhood sexual abuse (CSA) would experience more depressive symptoms when the perpetrator was a parental figure, defined in the article as a biological mother/father or a stepmother/stepfather. Parental figures did not include grandparents, uncles/aunts, or boyfriends/girlfriends of parents, even if they were living in the home and acting as a parental figure. They also investigate whether victimized youth (children 12 and younger) were at greater risk for heightened symptomatology than victimized adolescents. The study uses the relationship between the child and perpetrator as well as the age of abuse onset as moderators when exploring if CSA was associated with higher depressive symptoms in victimized youth. Critically, the authors do not hypothesize if age of abuse onset played a

pivotal role in the depressive symptom levels of victimized youth.

Subjects

Participants were 444 sexually victimized children who researchers identified from Child Protective Service reports, which they collected from the National Survey of Child and Adolescent Well-Being I (NSCAW-I). The researchers interviewed a sample of sexually victimized children, their caregivers, and caseworkers. Researchers conducted the interviews in three forms: face-to-face, computer-assisted personal interviews, and audio computer-assisted self-interview programs to minimize reporting biases.

Findings

CSA was associated with higher depressive symptoms moderated by the child's age at abuse onset and relationship type between child and perpetrator. The study followed three growth trajectories: falling, rising, and flat to further analyze how histories of CSA predict depressive symptoms during adolescence. Victims of CSA whose perpetrator was a parent were associated with rising and falling trajectories indicating the presence of higher depressive symptoms than those affiliated with the flat trajectory. Additionally, children who were sexually abused at a younger age followed the falling trajectory, whereas children sexually abused at a later age followed the rising trajectory. Notably, the data suggested that gender played a crucial role in classifying the effects of CSA on depressive symptomatology, with females having an increased risk for a falling trajectory in comparison to males.

Breaking down the sample across the three trajectories, the study found that individuals in all four waves exhibited lower depressive symptoms while remaining in the flat trajectory. Additionally, it is critical to mention that a majority of the sample experienced consistently low depressive symptoms, which could be a strong indicator of high levels of resiliency among sexually victimized youth. The results of the study were consistent with the hypotheses that the authors presented.

Recommendation

Clinicians should work closely with sexually victimized youth to identify the best course of treatment for coping with the trauma associated with abuse. Since there is a link between child sexual assault and the development of depressive symptomatology, practitioners can closely evaluate if these links are reason to screen repeatedly for depression or related disorders, particularly when factoring in age of abuse onset and parental perpetration. Additionally, policy makers might consider allocating funding for follow-up screenings and assessments of victims of sexual abuse. This is pertinent since CSA victims on the rising trajectory may not require services during the initial screening; however, they may develop symptoms later on.

Bottom Line

Depressive symptom trajectories vary based on age of abuse onset and parental perpetration. Youth who experience child sexual abuse at a later age experience an increase of depressive symptoms over time when the perpetrator of violence is a parental figure. Conversely, youth who experience an earlier onset of abuse experience a decrease in depressive symptoms over time. Ultimately, consistently low depressive symptoms among the sampled victimized youth may be an indicator of resiliency.

Citation

Carlson, M.W., & Oshri, A. (2018). Depressive symptom trajectories among sexually abused youth: Examining the effects of parental perpetration and age of abuse onset. *Child Maltreatment*, 23(4), 387–398.

About the Author

Hanna Boussi, MSW Candidate, BSW, is a student at the University of Michigan pursuing her Master of Social Work with a specialization of Interpersonal Practice in Health. Hanna received her Bachelor of Social Work from Oakland University in 2018. Hanna is currently an intern at Workit Health, an opioid addiction treatment center that provides Medication Assisted Treatment (MAT). Her main areas of interest include oncology, substance abuse, mental health, and the impacts that they have on an individual's overall well-being. Hanna is a member of the National Association of Social Work.

Disentangling the Cycle: Potential Mediators and Moderators in the Intergenerational Transmission of Parent-Child Aggression

Sunghyun Hong, MSW Candidate, BS

Original study authors: Christina M. Rodriguez, Paul J. Silvia, Samantha Gonzalez, and Maria-Ernestina Christl

Introduction

There is significant evidence of an intergenerational transmission of trauma, meaning that parents who were victims of child maltreatment are more likely to use violence in disciplining their children. Nonetheless, parents can break this cycle of violence by learning alternative disciplining methods that are more appropriate. This longitudinal study examines mediators that link parents' history of childhood abuse and their elevated parent-child aggression (PCA) risk as measured by parenting attitudes and behaviors and usage of physical and psychological aggression toward children. The study also assesses moderators related to buffering parents' history of childhood abuse on their own PCA risk. The study collects data on PCA risk across three time points: the last trimester of the pregnancy, when the child is 6 months old, and when the child is 18 months old. The study assesses mediators and moderators of mothers and fathers separately. The study treats a history of harsh and/or abusive parenting as a time-invariant variable and only assesses this variable prenatally.

Research Questions/Hypotheses

The research examines the following mediators: parents' mental health, substance use, intimate partner violence, attitudes surrounding approval of PCA, negative child attribution and compliance, and knowledge of nonphysical discipline alternatives. In addition, the researchers explore four moderators:

coping skills, couple satisfaction, emotion regulation, and social support satisfaction. The study measures the effect of mediators and moderators on mothers and fathers separately.

Subjects

Due to the nature of the longitudinal study, the number of participants varied at each time point. Overall, the study included 180 mothers and 141 fathers in data analysis. If a mother changed partners, researchers only included the father from time one in the analysis. On average, mothers were 26 years old and fathers were 29 years old. Racial/ethnic identities of mothers and fathers followed: 51%, 54% Caucasian; 47%, 45% African American; 2.5%, 0.7% Asian American or Native American; 3%, 4% Hispanic/Latino; and 6%, 5% biracial. One third of mothers and one fourth of fathers had an education level of high school or lower and had a household income under \$40,000. Seventy-four percent of mothers were living with the father of the child.

Findings

The results suggested that there are not consistent mediators and moderators over time. Researchers found significant findings only prenatally.

Prenatally, both parents' history of physical and psychological aggression was significantly associated with PCA risk. Both parents' lack of knowledge of nonphysical discipline alternatives and greater PCA approval attitudes mediated PCA risk. Personal

vulnerabilities, such as mental health, substance use problems, and intimate partner violence further significantly mediated PCA risk among mothers. In both parents, high couple satisfaction significantly buffered PCA risk. In addition, mothers' problem-focused coping strategy and fathers' emotion regulation and social satisfaction significantly moderated PCA risk.

Post-childbirth, both parents' histories of physical and psychological aggression were significantly linked to PCA risk at 18 months. However, the study found no significant mediators for buffering PCA risks. The researchers also did not observe strong moderators during postpartum, although high couple satisfaction marginally moderated PCA risk for both parents.

Recommendation

The study notes a challenge in developing an intervention for parents during and after pregnancy, due to the complexity and inconsistency in risk and protective factors linked with their elevated PCA risk. This research study finds significant mediators and moderators only during the prenatal period. The researchers encourage future study to further explore mediators and moderators that are significant during the postpartum period. In addition, future study should reassess the personal history of childhood abuse at each time point.

Couple satisfaction significantly moderates PCA risk in both parents before childbirth. Couples therapy for increasing couple satisfaction may help to lessen the intergenerational transmission of violence. The service may also increase access to other resources that can assist in preparation for future parenthood.

This study also suggests that mothers and fathers

may need different types of support. The prospective intervention may provide prenatal psychoeducation to mitigate PCA risk. Some topics may include reducing PCA approval attitudes, increasing knowledge of nonphysical discipline alternatives, and diversifying coping skills specific to mothers and fathers.

Bottom Line

Overall, the study supports the existing evidence on the intergenerational transmission of PCA. Parents' histories of child abuse predict their PCA risk. The mediators and moderators of PCA may vary based on the developmental stage of the child; the impact of mediators and moderators assessed in this study are especially salient prenatally. In addition, there may be differences between mothers and fathers in how mediators and moderators influence parents' childhood abuse experiences and on their PCA risk.

Citation

Rodriguez, C. M., Silvia, P. J., Gonzalez, S., & Christl, M. E. (2018). Disentangling the cycle: Potential mediators and moderators in the intergenerational transmission of parent-child aggression. *Child Maltreatment* 23(3), 254–268. doi: 1077559518767571

About the Author

Sunghyun Hong, MSW Candidate, BS, is a student at the University of Michigan. She will be starting her joint PhD in Social Work and Developmental Psychology at the University of Michigan in fall 2019. She also received her BS with Honors in Biopsychology at the University of Michigan. Post undergrad, she engaged in developing a culturally competent, evidence-based intervention in underserved communities of color in Chicago. Concurrently, she volunteered as a mentor for adolescents affected by gang violence. The past experiences cultivated her desire to utilize research as advocacy for social justice.

Intergenerational Effects of Childhood Trauma: Evaluating Pathways Among Maternal ACEs, Perinatal Depressive Symptoms, and Infant Outcomes

Jessica M. Ladd, MSW Candidate, BSW

Original study authors: Christina G. McDonnell and Kristin Valentino

Introduction

This study seeks to determine whether maternal adverse childhood experiences (ACEs) influence prenatal and postnatal depression, as well as the physical and socioemotional outcomes of their children. The Adverse Childhood Experiences questionnaire is a ten-question yes or no answer test that relates to childhood trauma. It contains five questions that discuss personal issues (emotional and physical neglect and physical, verbal, and sexual abuse) and five that relate to other family members (an alcoholic parent; mother as a victim of domestic violence; family member diagnosed with mental illness; disappearance of parent through death, abandonment, or divorce; and a family member in jail). Answering yes to a question scores it as a one, while answering no to a question scores it as a zero. The end result of the ten questions is an ACE score. Previous literature has stated that ACEs have been associated with negative mental and physical health throughout the life course, and that there are associations between negative birth outcomes and maternal ACE scores.

Hypotheses

The research is guided by three hypotheses: (1) Maternal ACEs will predict higher levels of prenatal and postnatal depressive symptoms and less improvement towards a non-depressive state in the perinatal period. The association between

depressive symptoms and ACE scores will be stronger for participants who had experiences of childhood maltreatment over those with household dysfunction; (2) Maternal exposure to ACEs will predict poorer reproductive outcomes (weight at birth, premature delivery). They predict that this association will be mediated by the age of the mother at the time of her first pregnancy; (3) Maternal ACEs will predict poorer socioemotional outcomes of the infant, which will be mediated by the mother's age at first pregnancy and the infant's birth weight.

Subjects

Participants were 398 pregnant woman 15-46 years of age at an initial prenatal assessment. Over half of the pregnant women were Caucasian, half were unemployed, and just under half were never married. Researchers recruited participants from Women, Infants, and Children (WIC) offices in a Midwestern city. Researchers assessed the subjects twice: prenatally and at a 6-month postnatal follow-up.

Findings

There were three major findings from this study. First, there were positive associations between both childhood maltreatment and household dysfunction with prenatal depressive symptoms. Only childhood maltreatment was positively correlated with maternal postnatal depressive symptoms at the 6-month mark.

Second, childhood household dysfunction of the

mothers was significantly negatively correlated with maternal age at first pregnancy. Birth weight was positively correlated with maternal age at first pregnancy and negatively correlated with infant socioemotional symptoms, creating an indirect relationship between maternal child household dysfunction and infant maladaptive socioemotional symptoms.

Third, childhood maltreatment of the mother was associated with high levels of maladaptive socioemotional symptoms in children at 6 months. Findings support those of other studies, which show that maternal childhood maltreatment and household dysfunction increase the risk of depressive symptoms and poor functioning in young children. The age of the mother at the time of her first pregnancy was also associated with a history of childhood trauma as well as adverse reproductive outcomes. Researchers must consider other known risk factors for adverse birth outcomes, such as African American race. This helps to conclude the transitive relationship of maternal trauma in childhood to negative health outcomes for their children.

Recommendation

Future research on risk and resilience can help experts to understand the relationship between childhood trauma and its effects later in life as well as birth outcomes of children whose mothers have a high ACE score. With further research, providers can plan interventions, creating positive outcomes such as less stress and lower depression scores. Providers should consider maternal ACEs during prenatal and postnatal care for both mother and child. They can do this by administering the ACE questionnaire during prenatal appointments. With this information, providers can educate mothers on previous outcomes so that they can be aware of their predisposition to them. Since depression scores are related to ACEs, it is important to monitor this.

Psychoeducation is also crucial for pregnant women and young mothers with significant ACEs. Education can enhance outcomes of more positive mental health as well as better pregnancy outcomes (e.g., stress from ACEs impacting low birth weight). If providers educate mothers about the risk factors, mothers

can, along with their healthcare providers, work on preventing negative outcomes.

Bottom Line

Pregnant mothers' ACE scores and histories of childhood maltreatment make them more vulnerable to higher levels and more persistent and severe depressive symptoms after birth. This maltreatment is also associated with maladaptive socioemotional symptoms in their children. Factors such as race, age at first pregnancy, and childhood household dysfunction can have a negative impact on infant birth weight and infant socioemotional symptoms. This can affect children in all stages of life. If researchers and clinicians together can support pregnant women who have high ACE scores pre- and post-birth, this could interrupt the transmission of effects of intergenerational trauma through evidence-based practices.

Citation

McDonnell, C. G., & Valentino, K. (2016). Intergenerational effects of childhood trauma: Evaluating pathways among maternal ACEs, perinatal depressive symptoms, and infant outcomes. *Child Maltreatment*, 21(4), 317–326.

About the Author

Jessica Ladd BSW, is currently an MSW candidate, concentrating in Interpersonal Practice with a Mental Health focus, at the University of Michigan and will graduate in July of 2019. Jessica received her BSW from Saint Mary's College in 2018. Her experience includes working as an advocate and counselor for survivors of domestic violence and sexual assault at multiple organizations. This is her area of interest as well as working with women and children.

Early Exposure to Child Maltreatment and Academic Outcomes

Misti Jeffers, MA

Original study authors: Joseph P. Ryan, Brian A. Jacob, Max Gross, Brian E. Perron, Andrew Moore, and Sharlyn Ferguson

Introduction

This study seeks to investigate the prevalence of early contact with child protection services (CPS) before the third grade and understand whether early contact is associated with important academic outcomes (math and reading standardized test scores, grade retention, and special education status in third grade). This study is the first statewide analysis linking maltreatment to academic outcomes by merging data from the Michigan Department of Education (MDE), the Michigan Department of Health and Human Services (MDHHS), and the United States Census. This article expands previous understandings of relationships between CPS involvement and educational experiences by focusing on a broader definition of contact, estimating the number of children who have experienced at least one maltreatment investigation from birth to third grade, whether unsubstantiated or substantiated.

Research Questions

Rather than put forth hypotheses, the authors present two research questions: 1) What is the prevalence of formally investigated child maltreatment in the public school population by the time students reach third grade, and do prevalence rates vary by school district? 2) What is the association between early contact with CPS and critical academic outcomes?

Study Sample:

This study included a diverse sample of over 700,000

children enrolled in Michigan's public schools who were born between 2000 and 2006 and had available data reported to MDE and MSHHS.

Findings

The authors found a high prevalence of contact with CPS for public school students before third grade (approximately 18%), ranging from 1% to as high as 59% across all school districts. Of all investigations, over one third were substantiated. Students receiving free lunch (an indicator of family poverty), students from poor neighborhoods, and Black students had disproportionately higher rates of CPS investigations. Further, any involvement with CPS was negatively associated with all four measures of negative academic outcomes, even when controlling for other factors that may affect performance (i.e., race, gender, and poverty). Having substantiated investigations resulted in even larger negative outcomes than did unsubstantiated investigations.

Recommendations

The study findings are important for informing allied systems of care collaboration, particularly among child welfare and educational systems. The authors demonstrate the odds of experiencing CPS investigations are higher than other factors (e.g., asthma, child food allergies, child disabilities, and obesity) related to negative outcomes addressed within educational policies and support programs, highlighting the importance of allocating financial resources specifically to the population of maltreated youth. One option for addressing the needs of this

population would be to better align information reported to CPS with information collected within schools to inform approaches similar to those used to support students with suspected disabilities (such as Individualized Education Programs). Yet the authors emphasize the importance of considering privacy and confidentiality issues associated with this approach. Less controversial approaches would include a more general approach to trauma-informed practices in schools.

Bottom Line

CPS involvement is not infrequent and may actually be the norm for students in some school districts, a finding that refutes the public's misconception that maltreatment is uncommon. Further, disparities exist for already vulnerable youth in our public education systems, including youth of color and poor youth, as well as by school district. Focusing on addressing the academic struggles of youth with maltreatment histories early in their educational trajectories is crucial to limiting the likelihood they will culminate in more complicated problems in the future.

Citation

Ryan, J.P., Jacob, B.A., Gross, M., Perron, B.E., Moore, A., & Ferguson, S. (2018). Early exposure to child maltreatment and academic outcomes. *Child Maltreatment* 23(4), 365–375.

About the Author

Misti Jeffers, MA, is currently a doctoral candidate in Social Policy at Brandeis University. She has conducted research related to child welfare, juvenile justice, and experiences of rural poverty. Misti earned her Bachelor of Science in Psychology and Human Services from East Tennessee State University, her Master's in Child Study and Human Development from Tufts University, and her Master's in Social Policy from Brandeis University.



Effectiveness of a Trauma-Informed Care Initiative in a State Child Welfare System: A Randomized Study

Areesah Abdus-Shakur, LMSW

Original study authors: M. Kay Jankowski, Karen E. Schifferdecker, Rebecca L. Butcher, Lynn Foster-Johnson, and Erin R. Barnett

Background

In the past 20 years, trauma-informed care (TIC) initiatives have gained increased interest in the social service arena. Interest in trauma by child welfare agencies is fitting; children entering the child welfare system have often experienced trauma such as abuse, neglect, and witnessing domestic violence. The child welfare system itself can also be traumatic, such as when child welfare agencies must remove children from their homes and place them in foster care, and when children experience placement disruptions. Children involved in the child welfare system have significantly higher rates of trauma than children in the general population.

TIC initiatives have gained interest, but TIC's definition, measurement, impact, and cost effectiveness are still unclear. The purpose of this study is to rigorously examine, using a randomized, matched-pairs, crossover design, whether a 5-year, multi-pronged, statewide TIC initiative in a child welfare agency changes trauma-informed attitudes, skills and behaviors, and perceptions of system performance related to trauma among child welfare staff. Researchers studied the New Hampshire Division for Children, Youth and Families (DCYF), which includes both the child protective and juvenile justice systems.

Intervention

Researchers randomly assigned 10 district offices of DCYF to either Cohort 1 (early intervention group)

or Cohort 2 (late intervention group). Researchers collected data three times: Time 1 was prior to any intervention, Time 2 was post-intervention for Cohort 2, and Time 3 was post-intervention for Cohort 3.

Interventions included (1) monthly training focused on principles of TIC and their application to child welfare and juvenile justice, along with training in using the Mental Health Screening Tool; (2) installation and implementation of a new web-based Mental Health Screening Tool; (3) weekly consultative support to each district office for 3 months after training to provide guidance for staff members implementing the TIC practices in their work; (4) identifying and providing advanced training to three staff members (trauma specialists) responsible for maintaining application of TIC practices; and (5) subcommittee work to review and implement system-level processes and policies on TIC (i.e., establish formal policies to integrate the new screening, case planning, and progress monitoring).

Measures

Researchers based measures on self-reports of involved staff. The study measured six TIC domains:

1. Trauma screenings (frequency and proficiency)
2. Case planning (frequency)
3. Referrals for trauma-informed treatment and involving families in meeting behavioral needs of the child (frequency)
4. Progress monitoring (i.e., frequency of rescreening, updating case plans,

communication with mental health providers for child's progress)

5. Collaboration between DCYF staff and mental health providers (i.e., information sharing, attitudes toward a shared vision)
6. System-level TIC practices (attitudes about the state child welfare system carrying out several TIC practices)

Findings

At Time 1, 51.3% of eligible staff responded to the survey; after researchers eliminated certain responses for not meeting the criteria of working with children and families or for missing data, they included 145 staff: 77 in Cohort 1 and 68 in Cohort 2.

Researchers used linear mixed modeling to examine the effect of the intervention on the six outcome variables. There were significant findings in three areas: initial case planning and communication, trauma screenings, and perceptions of DCYF's TIC system performance.

Across all three domains, Cohort 1 saw little change across all three time points. For Cohort 2, ratings dropped from Time 1 to Time 2, and then increased significantly at Time 3. Researchers hypothesized that the TIC intervention may have buffered Cohort 1 from the effects of an increasing number of stressors on the child welfare system, from Time 1 to Time 2. For Cohort 2, the intervention improved attitudes and behaviors for trauma screening, case planning, and TIC system performance at Time 3. While Cohort 2 was receiving the intervention, the child welfare system was burdened with even more stressors. Researchers hypothesized that staff in Cohort 2 District Offices were particularly receptive to a TIC approach, and that they received additional support provided via the project given the continued opioid crisis and more children entering the child welfare system.

The mixed findings were consistent with the mixed findings of prior studies. With few significant results, the authors question if such a comprehensive TIC intervention is cost effective. The authors acknowledge that the ongoing systemic challenges in child welfare, such as budget reductions, increased need for services

partly due to the opioid crisis, and chronic workforce shortages, are a factor in any TIC initiative being effective in child welfare services. Further research is warranted, perhaps to identify whether certain domains of TIC are more effective than others and can achieve measurable, objective child and family outcomes.

Bottom Line

While these results are mixed, showing effects in three of the six measured domains (case planning, trauma screening, and perceptions of TIC), the authors maintain support for adopting a "trauma lens" in the child welfare and juvenile justice systems. They also acknowledge that the effects will likely be limited if these systems continue to face challenges such as underfunding, increased need for service, and issues with workforce shortages and turnover. Until a larger effort is made to address the core issues facing child welfare, the authors suggest TIC interventions must take into consideration the challenges child welfare inevitably faces.

Citation

Jankowski, M.K., Schifferdecker, K.E., Butcher, R.L., Foster-Johnson, L., & Barnett, E.R. (2018). Effectiveness of a trauma-informed care initiative in a state child welfare system: A randomized study. *Child Maltreatment*, 24(1), 86–97. doi:10.1177/1077559518796336

About the Author

Areesah Abdus-Shakur, LMSW, has been a social worker for 25 years in a variety of community based services. She is currently working with Quality Assurance for Behavioral Health Services within county government. She resides in Pennsylvania.

Intergenerational Transmission of Trauma: Maternal Trauma-Related Cognitions and Toddler Symptoms

Karen Zilberstein, LICSW

Original study authors: Rebecca L. Babcock Fenerci and Anne P. DePrince

Introduction

This study seeks to show how mothers with histories of maltreatment and certain trauma-related cognitions transmit traumatic reactions to their young children, and whether this results in negative child outcomes. It considers cognitive pathways, such as posttrauma appraisals (i.e. shame, self-blame, anger, fear, betrayal, and/or alienation around a trauma memory) and disorganized memory (memories of maltreatment that are non-sequential or lacking), as possible methods of transmission. Both *posttrauma appraisals* that mothers express through thoughts, feelings, or behavior, and *disorganized memory*, which cause distressing thoughts and emotions, can lead to mothers' distorted understandings of their children and disrupt healthy attachment. Top-line finding: If a mother believes her child, rather than prior trauma, caused her distress, a dysfunctional parent-child relationship could result, as well as mood and/or behavior problems in the child.

Hypotheses:

Researchers hypothesize that higher levels of maternal posttrauma appraisals and disorganized memory will be associated with maternal trauma symptoms, more child internalizing and externalizing symptoms, and dysfunction in the mother-child relationship. They also hypothesize that dysfunctional mother-child relationships will affect child symptoms.

Subjects:

Participants in this study included 113 mothers of 2-5-year-olds who lived in a metropolitan area in the Rocky Mountain West and who had experienced child abuse or neglect. Most of the mothers were married and over two thirds were white, with African-American mothers making up the second largest grouping. Over two-thirds identified as middle class or higher, and three-quarters had at least some college education.

Findings

Researchers found strong associations between mothers' traumatic symptoms and their children's mood and behavior problems. Maternal trauma-related cognitions, however, correlated only with child internalizing symptoms, not externalizing ones. Maternal posttrauma appraisals and disorganized memory predicted higher levels of dysfunction in the mother-child relationship than did the mothers' trauma symptoms. However, dysfunctional mother-child relationships did not appear to directly affect child symptoms.

As the current study relied on maternal self-report and is cross-sectional in design, causal relationships could not be inferred. Other factors not studied could also have affected the findings.

Recommendation

The study's findings suggest that clinicians working

with trauma survivors and their children may find that targeting parental cognitions could enhance the mother-child relationship and decrease child mood symptoms.

Future research that employs multi-method, multi-reporter, longitudinal approaches and/or randomized control trials would help clarify the causal mechanisms through which parental cognitions lead to child problems and the interventions most likely to alleviate them.

Bottom Line

This research suggests that trauma can pass from parent to child through alterations in maternal thought processes and traumatic memories. Treatment to improve mother-child relationships or child mood symptoms should include a focus on how mothers recall and think about their own maltreatment experiences.

Citation

Babcock Fenerci, R.L. & DePrince, A. (2018). Intergenerational transmission of trauma: Maternal trauma-related cognitions and toddler symptoms. *Child Maltreatment* 23(2), 126–136.

About the Authors

Karen Zilberstein, LICSW, is Clinical Director for A Home Within, a national nonprofit that provides pro bono psychotherapy for individuals who have experienced foster care. She has authored numerous journal articles and a book, Parenting under pressure: Struggling to raise children in an unequal America, that will be released in 2019.



The Prevention of Child Maltreatment Through the Nurse Family Partnership Program: Mediating Effects in a Long-Term Follow-Up Study

Pamela Miller, JD, MSW, LISW-S

Original study authors: John Eckenrode, Mary I. Campa, Pamela A. Morris, Charles R. Henderson, Kerry E. Bolger, Harriet Kitzman, and David L. Olds

Introduction

This study seeks to understand the specific mechanism by which nurse home visitation programs reduce child maltreatment over the long term.

The article introduces the Nurse Family Partnership (NFP), an evidence-based model where nurses make home visits to low-income first-time mothers and their children. These nurses focus on interventions in three primary areas of family functioning: (1) health-related behaviors during pregnancy and early childhood, (2) care parents provide to their children, and (3) maternal life-course development including helping moms with family planning, progressing in their education, and getting employment. A previous evaluation of the NFP program (conducted from 1978-1980) found that program participants saw reduced rates of child maltreatment during the first two years of the child's life, and most significantly, a follow-up study conducted when the children were 15 years old found that the reduced rates of child maltreatment were sustained and became stronger over time. These findings applied to the 80% of participating families who had low to moderate levels of domestic violence. The 20% of families who had high levels of domestic violence did not fare as well.

This article seeks to identify the actual mechanism(s)

by which NFP reduced child maltreatment over the long term as described in the landmark 15-year follow-up of the Elmira study. Once identified, other home visiting programs hoping for similar reductions in child maltreatment rates can use this information to enhance and target these processes within their own programs.

Hypotheses

The article hypothesizes that NFP altering significant aspects of the mother's life course, such as family planning and economic self-sufficiency, through education and employment cause the program's long-term effect in reducing child maltreatment.

Subjects

Participants were pregnant women in Elmira, New York recruited from a free county health clinic and the offices of private obstetricians, who were giving birth to their first child, could begin the program prior to their 25th week of pregnancy, and had at least one of the following characteristics: (1) under age 19, (2) unmarried, (3) low socioeconomic status. Also, any first-time mother enrolled in NFP who asked to participate in the study was allowed to participate.

Findings

A reexamination of the data from the Elmira study found that over the first 15 years of the target child's life, participant mothers with low or moderate levels of

domestic violence had 4.52 times fewer substantiated maltreatment reports compared to mothers from the control group. Also, data taken at the time the child was age 15 indicated that mothers who received NFP home visits spent fewer months on public assistance and had fewer subsequent children compared to the control group. Most importantly, data analysis showed these two outcomes were significant predictors of child maltreatment. Data analysis indicated that having fewer children and staying off public assistance accounted for about one half of the total effect of the NFP program on reducing child maltreatment.

Recommendation

Home visiting programs should target and enhance their focus on helping mothers alter their life course through family planning (using birth control to have fewer children) and education and employment (staying off public assistance). These particular interventions account for half of the reduction in child maltreatment achieved by NFP in the Elmira study. Other NFP interventions, such as focusing on health-related behaviors and parental care, combined, account for the other half of the reduction in child maltreatment. This difference in impact is important; this study shows that a focus on life-course development issues has the greatest impact.

Bottom Line

Home visiting programs will increase the likelihood of preventing child maltreatment by focusing on helping mothers have fewer children and stay off public assistance through education and employment. Large family size and poverty increase the risk of child maltreatment, while smaller family size and higher income reduce that risk.

Citation

Eckenrode, J., Campa, M.I., Morris, P.A., Henderson, C.R., Bolger, K.E., Kitzman, H., & Olds, D.L. (2017). The prevention of child maltreatment through the Nurse Family Partnership Program: Mediating effects in a long term follow-up study. *Child Maltreatment* 22(2), 92–99.

About the Author

Pamela Miller, JD, MSW, LISW-S, is a clinical social worker and attorney. She is a psychotherapist for young children in foster care and founder of the Children's Justice Project. She currently serves on the board of the National Association of Social Workers Ohio, on the amicus committee for APSAC, and on the Mandatory Reporting Committee for Center for Child Policy. She also serves on the Children and Families Council for the city of Cincinnati.



What is Neglect? State Legal Definitions in the United States

Bri Stormer, MSW

Original study authors: Rebecca Rebbe

Introduction

This study seeks to better understand state legal definitions of neglect by comparing them both to one another and to the definitions specified the Fourth National Incidence Survey (NIS-4). The author examines each legal definition for nine types of physical neglect (medical care delay or failure, inadequate nutrition, inadequate supervision, abandonment/refusal of custody, inadequate shelter, inadequate clothing, illegal transfer of custody, other refusal of custody, inadequate personal hygiene), two types of educational neglect (failure to register/enroll, permitted chronic truancy), ten types of emotional neglect (exposure to maladaptive environments, refusal to seek care for emotional problem, refusal to provide care for emotional problem, knowingly permitting substance abuse, domestic violence, inadequate nurturance/affection, knowingly permitting maladaptive behavior, overprotectiveness, inadequate structure, inappropriate advanced expectations), three types of exclusions (general religious exemption, specific religious exemption, and involuntary neglect), and four categories from literature (threat of harm enough, child-focused definition, substance exposed infant, exposure to drug activity). The study uses content analysis and notes the presence or absence of each dimension for each type of abuse.

Research Questions

Rather than declaring a hypothesis for this study, the author puts forth two research questions: 1) What aspects of the NIS-4 definitions of neglect will appear

in the state legal definitions of neglect? 2) Can states be grouped by what is and is not included in their definitions of neglect?

Findings

After coding the contents of each state's definition, the author sorted states into one of three clusters based on the number of the dimensions for each type of neglect contained in the statute and the similarity of those aspects with other states. Analysis resulted in three clusters.

The Minimalist Cluster contained 15 states and had an average of 5.4 definitional aspects. The most common definitional aspects for these states were lack of supervision, lack of medical care, and abandonment. 80% of these states required actual harm to have been done before the maltreatment met the legal threshold for neglect. 80% of these states included a general religious exemption, while only 13% offered an involuntary neglect exemption.

The Cornerstones Cluster contained 31 states, all of which included lack of medical care and inadequate food and shelter in their definitions of neglect. Other commonly shared definitional aspects included inadequate clothing, inadequate supervision, and abandonment. 87% of states in this cluster determined threat of harm to be sufficient to meet the legal threshold for neglect. 61% of these states contained a religious exemption, and 52% contained an exemption for involuntary neglect.

Five states belonged to what the author calls the Expanded Definitions Cluster. These states had legal

definitions most likely to be child focused (60%) and to indicate threat of harm as sufficient to be deemed neglect (80%). This cluster showed the highest level of certain emotional neglect definitional aspects, with 80% of these states including failure to seek treatment for an emotional problem in their definitions of neglect and 40% including knowingly permitting substance abuse. This cluster also had the highest percentage of states including exposure to drug activity in their definitions of neglect at 60%.

Recommendation

The author notes that these definitions provide a window into the level of discretion state-level officials have when intervening in potential maltreatment cases. For example, a state that requires actual harm to meet the threshold for neglect may miss an opportunity for preventative services when threat of harm is detected. Furthermore, states lacking the involuntary neglect exemption will prevent child protection workers from considering the full family, community, and social environment when making a determination about a given family. States in the Cornerstones Cluster offer more discretion but lack the child-focused definitional aspect that allows child protection workers to focus on the effects on the child rather than the behavior of the parent when identifying neglect, an approach that has gained popularity among neglect researchers.

The author also notes that the way states define neglect may determine the financial resources available for treatment. As such, expanding legal definitions of neglect may also expand the number and diversity of resources child protection workers can offer families to treat and prevent neglect.

Bottom Line

Many states use legal definitions of neglect that lack the full range of physical, educational, and emotional definitional aspects studied in the NIS-4. Some states' definitions lag far behind best practices for understanding and treating neglect, such as setting the threshold for neglect at threat of harm or including an exemption for involuntary neglect.

The author notes the importance of legal definitions of neglect that align with the needs of children and

families, as legislation generally determines funding priorities. For example, the passage of the Families First Prevention Services Act passed in early 2018 will likely increase states' focus on the impact of substance abuse, given the new provision enabling states to use IV-E funds for substance abuse treatment to prevent children from entering foster care. Professionals wishing to reduce neglect in their states should assess how an amendment to their current definition of neglect could bring funds to the programs and services families need most.

In addition to contributing to the body of research on how states define neglect, this article can serve as a practical resource to state leaders interested in comparing their state's definition of neglect with both the NIS-4 and other states, potentially offering a blueprint for amending or expanding their state's definition to better align with current neglect research. Updating a state's definition of neglect may offer new resources and pathways to improve practice around the treatment, intervention, and prevention of neglect.

Citation

Rebbe, R. (2018). What is neglect? State legal definitions in the United States. *Child Maltreatment* 23(3), 305–315.

About the Author

Bri Stormer, MSW, is Manager of Publications and Special Projects for APSAC, where she staffs APSAC's publications, state chapters, and student and young professional division (YAPSAC). Bri earned her Bachelor of Arts in Psychology and Theatre from Case Western Reserve University and her Master's in Social Work with a concentration in Community Organizing, Planning, and Administration from University of Southern California.



Become an APSAC Member Today!

How does an APSAC membership benefit you?

Stay Informed

APSAC's publications, practice guidelines, and resource materials deliver the information and research most relevant to your work so you're prepared to take on any situation.

Continue Your Professional Development

Advance your career by taking advantage of APSAC's many educational opportunities; members receive discounts to all events.

Make Connections

Connect with thousands of your peers online and in-person. Participate in a committee or become active in your APSAC state chapter.

How can your APSAC membership make a difference at both the national and local level?

All APSAC members have access to our national advocacy resources. When you join APSAC, you automatically become a member of your state's chapter. Visit www.apsac.org to learn more about state chapters.

Annual Events Include:

- Advanced Training Institutes
- Forensic Interview Clinics
- Annual Colloquia

New for 2019:

- An 8 module, on-line course featuring dozens of national experts
- A webinar series co-sponsored with the New York Foundling

...and more!

Additional events are held throughout the year. Visit APSAC's website for a complete list of events. Subscribe to our newsletter to stay up-to-date on upcoming events. To get information on APSAC events happening locally, reach out to your APSAC state chapter.

APSAC Publications Include:

- APSAC Advisor
- APSAC Alert
- Child Maltreatment Journal
- Practice Guidelines
- Position Papers
- Research to Practice Briefs
- Topical Monographs

New: Access up to 30 years of back issues of all APSAC publications, searchable by topics or authors in our new, online library. Learn more at apsac.org.

Join today at www.apsac.org!