

## Conducting Child Abuse and Neglect Evaluations

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**I**N 2010, U.S. state and local child protective service workers received an estimated 3.3 million reports of child maltreatment (abuse and neglect), at a rate of 43.8 per 1,000. Child Protective Service officials estimated that 695,000 children (9.2 per 1,000) were victims of maltreatment. The total lifetime economic burden resulting from new cases of fatal and nonfatal child maltreatment in the United States is about \$124 billion (U.S. Department of Health and Human Services, Administration for Children and Families, 2011). In 2008 dollars, the average lifetime cost for each surviving victim of child maltreatment was \$210,012, compared to a lifetime cost for stroke of \$159,846 and between \$181,000 and \$253,000 for type 2 diabetes. Child maltreatment is a serious and prevalent public health problem (Russo, 2008; Wang & Holton, 2007).

In order to conduct an evaluation of children and parents in cases of alleged child maltreatment, one needs an in-depth understanding of the etiology and impact of child maltreatment. Early research highlighted linkages between hypothesized predictive factors and maltreatment outcomes. Main effect linear models of predictive risk factors quickly fell away in the research community in favor of complex, multilevel (culture, community, family), multidirectional, multifactorial, and interactive etiological models (Alink, Cicchetti, Kim, & Rogosch, 2012; Cicchetti, 2004). Static and dynamic causal agents are hypothesized to explain the occurrence of child maltreatment. Some causes are relatively ingrained over the course of history (e.g., societal attitudes toward family privacy and autonomy, individual and collective notions of responsibility for the well-being of children, prevailing societal notions of what constitutes child maltreatment and when it is appropriate to intervene); some are situational (impoverishment, geographic access to services, neighborhood quality); some are sociocultural (family structure, acceptance and expectations of youthful parenting, definitions and tolerance of violence); and

some are individual attributes of parents and children (parental personality style, expressions of social dominance, physiological consequences of repeated exposure to stress). Increasingly, researchers are examining biological and genetic aspects of child maltreatment perpetration and victim traumatic responses (Alia-Klein et al., 2009; Alink et al., 2012; Simon et al., 2012). Definitional issues remain a challenge, particularly because maltreatment types often are defined by legal codes or social service systems and because researchers have not reached consensus on some of the nuances of definitions (see Condie, 2003; Marshall, 2012, for examples). There is, however, growing consensus over research definitions and subtypes (Cicchetti, 2004; Runyan et al., 2005).

Researchers studying risk factors, protective factors, and intervention methods have concluded that it is difficult to isolate one form of maltreatment from another in order to adequately classify or study factors that might be specific to one form of child maltreatment (i.e., physical abuse, sexual abuse, emotional/psychological abuse, neglect). Because different forms of child maltreatment tend to co-occur, pure scientific analysis of contributing factors is difficult (Cicchetti, 2004; Marshall, 2012). As a result, researchers have instead focused on maltreatment typology overlap and comorbidity, the degree and nature of maltreatment, and child protection policy analysis (Brandon, 2001; Marshall, 2012). A second problem affecting the integrity of scientific research is the degree to which social or legal definitions of child abuse meaningfully correspond to real behavior. Classification entries in state records of child maltreatment typically are recorded after negotiation and consultation with families, representatives of the justice system, and representatives of child protective systems (Bae, Solomon, Gelles, & White, 2010; Putnam-Hornstein, Webster, Needed, & Magruder, 2011). With the exception of large-scale funded projects, research samples typically are drawn from small convenience samples. Thus, there are a variety of challenges to research on the etiology and impact of child maltreatment. They are briefly mentioned here to alert evaluators to the inherent limitations in the state of the science. Researchers studying child maltreatment acknowledge the methodological difficulties; unfortunately, the difficulties are not easily overcome (MacMillan, 2005).

Theories of child maltreatment (see Belsky, 1993; Condie, 2003) include these models:

- Psychological (e.g., personality variables, emotional variables, characteristics of perpetrators)
- Sociological (societal and contextual conditions giving rise to child maltreatment)
- Criminological (social class variables, rational choice theory, self-interest motives, communal relationships, strain theory)
- Interactional (dyadic parent-child goodness of fit, communal relations)
- Genetic (epigenetics, gene/environment interactions and correlations)

No model has emerged that fully explains child maltreatment or less severe forms of problematic parenting (Belsky, 1993; Runyan et al., 2005; Simon et al., 2012). Child maltreatment, in any of its forms, is multiply influenced by a variety of determinants that coalesce through transactional processes at various levels of analysis (life course, immediate-situational, stressors-support, potentiating-protective, historical-evolutionary) in the broad context of parent–child or other caregiver–child relationships (MacMillan, 2005). No single pathognomonic factor or unique set of conditions is reliably predictive of child maltreatment. There do seem to be commonly recurring protective factors, most notably in the social domain of functioning, but those factors do not reliably protect children from maltreatment in all cases (Afifi & MacMillan, 2011; Belsky, 1993; Corse, Schmid, & Trickett, 1990; Li, Godinet, & Arnsberger, 2011). When potentiating microsocial and macrosocial factors outweigh supports and compensatory strategies, the probability of child maltreatment increases (Belsky, 1993; Cicchetti, 2004; Howes, Cicchetti, Toth, & Rogosch, 2000; Runyan et al., 2005). There are many pathways to child maltreatment.

Similarly, there is no single or uniform solution to the problem of child maltreatment. Interventions range from preventive to clinical, self-help to formal intervention, individual to macrosocial, and psychological to legal. Policies within child protective service systems range from emphasis on termination of parental rights to emphasis on family preservation strategies, and sometimes those goals take place concurrently. The targets of intervention might include a specific parent, a set of parents with common struggles, a specific child or set of children from the same family, children from similar maltreatment environments, or the neighborhood and social conditions contributing to child maltreatment risk.

## RISK OF CHILD MALTREATMENT

Risk factors are factors that increase the odds that child maltreatment will occur. Because child maltreatment has a major economic and social impact, early detection is of great importance. Researchers have developed taxometric structures for predicting child maltreatment. Risk variables and mediators of risk tend to fall under the categories of developmental and psychological factors, social and community variables, and contextual variables.

### DEVELOPMENTAL AND PSYCHOLOGICAL FACTORS

Evaluators benefit from a comprehensive understanding of factors contributing to and mediating risk of child maltreatment. Although developmental and psychological risk factors contribute to and mediate risk of child maltreatment, determining the potency of risk factors or combinations of risk factors is by no means straightforward. Child maltreatment has been associated with a host of developmental

and psychological variables that include examples such as parents' own histories of maltreatment, mental health and personality variables, and substance use. Developmental and psychological protective factors associated with diminished maltreatment risk include access to parental partners (whether formal or informal), social support, neighborhood cohesiveness, and access to child care (Belsky & Jaffee, 2006).

*Parental Factors.* Researchers studying parental factors that raise the risk of child maltreatment have focused on childhood histories of abusive and neglectful parents, personality variables, social-emotional variables, and psychological resources. For example, intergenerational researchers have focused on harsh parenting and warm-supportive parenting (Belsky, Conger, & Capaldi, 2009). Traditionally, researchers focused on maltreatment by mothers, but there is a trend toward including fathers in research on child maltreatment (Dixon, Hamilton-Giachritsis, Browne, & Ostapuk, 2007; Herring, 2009). Introducing fathers into research endeavors presents a different set of challenges compared to the study of mothers who maltreat their children. Research questions include whether there are gender differences in patterns of child maltreatment, patterns of unreliability in the presence and involvement of fathers and stepfathers, transient stepparenting, child maltreatment in the context of cohabiting/dating situations, and different patterns in the forms and severity of child maltreatment that potentially are based on gender. The salience, type, and patterns within and across the foregoing factors may be different for male and female caregivers. The relative lack of information about gender similarities or differences in child maltreatment risk is in need of remedy.

In the early decades of research examining parental risk factors, researchers hypothesized that parents who maltreated their children had their own histories of child maltreatment (Dubowitz, Hampton, Bithoney, & Newberger, 1987; E. Herrenkohl, Herrenkohl, & Toedtler, 1983). Many investigators failed to take the developmental status of the children into account, and thus an infant child might have been classified along with older adolescents as nonmaltreated even though the parents of that child had many more years of parenting ahead of them (Belsky, 1993). Few well-designed prospective studies have provided findings indicating a robust linkage between reported histories of child maltreatment and perpetration of child maltreatment (Egeland, Jacobvitz, & Papatola, 1987; Ertem, Leventhal, & Dobbs, 2000). However, the few prospective studies that have been conducted provide modest support for the hypothesis (Capaldi, Pears, Patterson, & Owen, 2003; Conger, Neppl, Kim, & Scaramella, 2003). Based on combined retrospective and prospective studies, overall support for the intergenerational transmission hypothesis has ranged from weak to modest (Belsky, 1993; Dixon & Hamilton-Giachritsis, 2009; Ertem et al., 2000; Hardt & Rutter, 2004). Most members of the scientific community abandoned the intergenerational transmission hypothesis as a primary causal factor, viewing it as too unidimensional and recognizing that it held up in only a minority of retrospective convenience sample studies

(Babiker & Herbert, 1998; Widom, 1989). Researchers consider it one of many facets of enduring child maltreatment, and the link is not viewed as inevitable (Capaldi et al., 2003; Conger et al., 2003; Dixon & Hamilton-Giachritsis, 2009; Ertem et al., 2000; Hardt & Rutter, 2004).

In prospective studies, researchers estimated the rate of intergenerational transmission to be 30% plus or minus 5% (range 7%–70%; Belsky & Jaffee, 2006; Capaldi et al., 2003; Conger et al., 2003). High-quality work is lacking that highlights conditions under which maltreatment is not transmitted across generations (Belsky et al., 2009). A history of child maltreatment is insufficient, in and of itself, to explain intergenerational transmission (Capaldi et al., 2003; Chen, Liu, & Kaplan, 2008; De Bellis, 2012). Thus, although intergenerational transmission of child maltreatment is a risk factor of interest, it has no greater salience or significance than other risk factors, and it is best understood in the context of a broad range of risk and protective factors.

Researchers instead began to ask what determines whether a victim of maltreatment grows up to become a perpetrator of child maltreatment. Learning theory mediators include modeling, direct reinforcement, coercion training (learning and incorporating methods abusers use to control victims and gain victim compliance), and inconsistency training (randomness in dispensing rewards and punishment that ultimately leads to escalation of negative behaviors not because they are desired but because the response to them is predictable and provides a false sense of control over the situation; Wahler & Dumas, 1986). Other theorists added elements of parental philosophies of discipline and harshness of personality. Thus, social learning theorists would hypothesize that maltreating parents believe in the legitimacy of strict and physical discipline (Simon, Whitbeck, Conger, & Wu, 1991), and childhood victimization leads to aggressive behavior, emotional dysregulation, and limited empathy that promotes predictable personalities and parenting styles in adulthood (Brent & Corwyn, 2002; Feshbach, 1989; Howes et al., 2000; Trickett & Kuczynski, 1986).

Attachment theorists hypothesized that perpetrators of child maltreatment developed an internal working model in childhood that incorporated maltreatment into parenting (Bowlby, 1988; Main, Kaplan, & Cassidy, 1985). Parents who did not experience parental responsiveness in childhood, but who instead experienced rejection or ambivalence, are less open to the signals and needs of their children. They have difficulty taking a child's perspective, and they feel threatened by their children's anxiety (Baer & Martinez, 2006; Cyr, Bakermans-Kranenburg, & van Ijzendoorn, 2010; Main et al., 1985). They are likely to take an adversarial perspective when responding to their children or to believe they must establish control and impose their wishes or needs. Neglecting parents are less likely to believe their relationships with their children can meet their needs, are less likely to believe they can elicit satisfactory responses from their children, and are more likely to report feelings of emptiness and depression (van Ijzendoorn, 1995).

In studies of parents victimized in childhood by maltreatment who successfully refrained from child maltreatment, attachment theorists found that parents who

recalled early maltreatment experiences and integrated them into a revised working model of parent–child relationships more successfully broke the cycle of neglect, whereas parents who ignored their negative experiences were more likely to engage in neglect (Dixon & Hamilton-Giachritsis, 2009; Main & Goldwyn, 1984). Attachment theory provides models of lawful discontinuity of child maltreatment (Belsky & Pensky, 1988). Parents maltreated in childhood who did not maltreat their own children had more extensive social support, had developed a nonabusive close relationship with one parent while growing up, were involved with an emotionally supportive spouse or dating partner, and/or were more openly angry and thus more willing to provide detailed accounts of their negative childhood experiences compared to those who engaged in maltreatment (Caliso & Milner, 1992; Egeland et al., 1987). Thus, the prediction that parents can modify their internal representation of interpersonal parent–child relationship expectations holds up in studies of perpetration and desistance of maltreatment. Researchers continue to examine whether the prediction holds up for men as well as women and attempt to better understand the processes or influences that result in desistance of maltreatment. Personal resolve not to repeat the maltreatment contributes to desistance, but it is less clear under what circumstances such resolve is sufficient (Egeland et al., 1987). There is initial support for the idea that it helps to seek out emotionally corrective close relationships (with nonabusive partners, close friends, therapists) and both formal and informal educational experiences. The question remains as to how individuals built sufficient trust in others to seek out those relationships and educational experiences (Collishaw et al., 2007; Quinton, Rutter, & Liddle, 1984).

Researchers have studied the impact of mental illness on parenting. Personality theorists initially focused on serious mental illness or distinct psychological patterns to explain persistence of child maltreatment. For example, early researchers focused on specific forms of mental illness, specifically parents with psychosis and specific personality disorders, but this approach was abandoned due to lack of support (Belsky, 1993). Research later emerged that focused on specific personality variables, psychological attributes, and symptoms correlated with maltreatment (Kim, Cicchetti, Rogosch, & Manly, 2009). There remains general agreement that few maltreating parents are overtly psychotic or otherwise mentally disturbed to a clinically significant degree. Epidemiological studies show only a modest relationship between mental health problems and parenting problems in large-scale population studies. Studies specific to care and protection samples of parents have yielded more robust data relevant to actual or probable mental health problems in parents who severely maltreat their children (De Bellis, 2012; Kohl, Jonson-Reid, & Drake, 2011). Although it is useful to examine diagnostic status as a possible variable of relevance, no characteristic patterns of symptoms are associated with child maltreatment (De Bellis, 2012; Kohl, Jonson-Reid, & Drake, 2011; Wolfe, 1985). The literature gives only nominal support to any pattern of symptoms of mental illness or personality attributes associated with child maltreatment. There is a

hypothesized modest link between lower intelligence and child maltreatment, but more research is needed to understand, in the context of prospective studies, the level and nature of risk (Valentine, 1990). Researchers have noted trends associating maltreatment with lowered impulse control, lowered self-esteem, impaired capacity for empathy, and impaired ego resiliency (Alink et al., 2012; Cicchetti & Rogosch, 2012; Feshbach, 1989; Kim et al., 2009). Studies have shown inconsistent results in associations between these factors and child maltreatment (Howes et al., 2000). Similarly, studies of associations between maltreatment and depression and/or anxiety have yielded inconsistent results (Banyard, Williams, & Siegel, 2003; Gelfand & Teti, 1990; Goodman & Tully, 2008). Although studies have found interesting associations between variants in genes and resilience in maltreated children (Cicchetti & Rogosch, 2012), behavioral genetics thus far does not hold promise in identifying heritable dimensions of personality related to child maltreatment or the obverse condition of friendly, considerate, responsive parenting (Plomin, Nitz, & Rowe, 1990). Regardless of whether the focus is psychoticism, social-emotional variables, or personality variables, differences in samples, measures, and definitions of child maltreatment systematically affect the results obtained. Research is similarly limited by the use of models measuring only a few of these variables or factors at a time. Researchers have only recently begun to turn to more sophisticated prediction models, using structural and hierarchical equation modeling. Variables that are nonsignificant in isolation can be better understood in the context of multivariate research designs. If child maltreatment is indeed multiply determined and embedded in transactional processes involving parents, children, family systems, and communities, it is best to turn to methodology that seeks contributing rather than determinative agents (T. Herrenkohl & Herrenkohl, 2007). Linkages are more easily identified in designs that allow analysis of predictor variables, interactions, and time-dependent linear equations.

One construct that does seem to hold promise is that of negative reactivity, but its robustness is dependent on attributional variables with potential to exacerbate the reactivity. Researchers focusing on internal psychological resources have examined the influences of negative reactivity and attributional style in parents (Belsky, 1993). Because most episodes of maltreatment take place during routine parent-child interactions, it has been hypothesized that parents who engage in maltreatment may be particularly reactive to aversive events or interactions (Bauer & Twentyman, 1985). Negative reactivity has been observed in studies of parental reactions to tape recordings of crying children and to both stressful and nonstressful parent-child interactions (Watson & Clark, 1992; Youngblade & Belsky, 1989). It is hypothesized that personality traits and emotional processes such as negative reactivity reflect different levels (trait and state) of influence, with neither factor sufficient by itself to turn an interaction into one involving maltreatment (Belsky, 1993). Similarly, attributions of diminished personal control, externality, and instability add another level of analysis to the influences (Bugental, Blue, & Lewis, 1990; Pidgeon & Sanders, 2009). Difficult child behavior is regarded as threatening and unmanageable,

and the parent experiences negative emotional arousal. There appears to be an interactional influence between attributional style and affective orientation. Mothers who attribute negative intent to individuals in ambiguous circumstances are likely to initiate coercive/aggressive interactions with and react negatively toward their children, compared to mothers who do not attribute negative intent (MacKinnon-Lewis, Lamb, Arbuckle, Baradoran, & Veiling, 1992). Researchers have begun to examine the combined effects of affective tendencies, cognitive biases, attributional style, negative reactivity, and specific personality traits in the context of child maltreatment research. Attributional style has a small effect in some studies, but it does not hold up for all forms of maltreatment (Gibbs, 2002). Large-scale studies are needed to better understand the combined effects of multiple levels of influences.

*Child Factors.* Epidemiological researchers have highlighted age and developmental level as important variables in understanding child maltreatment. Child maltreatment that comes to the attention of authorities is not evenly distributed across the developmental spectrum. Reported cases of child maltreatment decline with age in the United States (Centers for Disease Control and Prevention [CDC], 2012). Younger children are more likely to be the recipients of physical force because they spend more time with and are more dependent on their parents. Child maltreatment peaks for children between ages 3 and 8. Within this age range, children remain vulnerable, and they become publicly visible in child care agencies and schools (Belsky, 1993). Rates begin to drop after age 8, but preadolescents and adolescents remain vulnerable to child maltreatment (CDC, 2012). Results on the link between physical illness/physical disability and child maltreatment are mixed. There is an inconsistent association between physical health status or disability and child maltreatment (Jaudes & Mackey-Bilaver, 2008). Similarly, the problematic behaviors of children are inconsistently related to risk of child maltreatment, and the cause-and-effect relationship between maltreatment and child behaviors is difficult to isolate (Schulz-Heik et al., 2010). Prospective longitudinal designs that enroll children in infancy support the hypothesis that child behavior variables are a product rather than a determinant of child maltreatment (Schulz-Heik et al., 2010).

*Contextual Factors.* Development occurs in the context of both macrosocial influences (social systems, culture, mass media, political systems, and other broad social systems and structures) and microsocial influences (individual social agency, neighborhood and community variables, face-to-face social interaction variables, and other variables relevant to smaller social influences). These variables influence development. Examples of the larger context include societal trends that contribute to social isolation, historical trends in conceptions of parenting and childhood, and caregiving resources. Researchers examining macrosocial variables have questioned whether there are enduring societal attitudes within which maltreatment

is tolerated and may even flourish. Variables of interest include societal attitudes toward physical/domestic violence and sexual abuse, corporal punishment, and the status and rights of children (Belsky, 1993). Macrosocial analyses of child maltreatment center on societal willingness to tolerate high levels of violence. Examples include tolerance of physical punishment and sometimes infamous efforts by authorities to ignore and even cover up victim complaints of child maltreatment (Brackenridge, Bishopp, Moussalli, & Tapp, 2008; Terry, Schuth, & Smith, 2011). Historical views of children as property and tolerance of school-based corporal punishment are examples of macrosocial influences that may contribute to rates of maltreatment of children (Condie, 2003). Misconceptions concerning the appropriate care of children indirectly influence maltreatment. Evidence that the care of children is not prioritized is reflected in relatively low pay for child care providers, teachers, and other staff members responsible for educating and caring for children in American society. Thus, although the link between macrosocial variables and child maltreatment is not immediate or proximate, it is likely that sociocultural attitudes and practices, conceptions of the rights of children, and socioeconomic variables contribute to rates of child maltreatment.

Another macrosocial phenomenon of interest is competition for resources. The interests of parents and children are not always shared, harmonious, or noncompetitive (Herring, 2009). Children can pose a conflict of interest, parents and children may not share goals and interests related to food and reproductive interests, and those conflicts can lead to child maltreatment (Belsky, 1993). Nurturing responses compete with parental investments and continued reproductive interests, particularly when conditions accentuate the biological conflict of interest between parent and child (Burgess & Draper, 1989). Conditions likely to exacerbate the conflict of interest would include economic or societal instability, unpredictability, and limited resources. Consistent with this point of view is the replicated finding that impoverishment is related to child maltreatment (Brooks-Gunn & Duncan, 1997; Coulton, Korbin, & Su, 1999; Korbin, Coulton, Chard, Platt-Houston, & Su, 1998). The influence of impoverishment on child maltreatment provides support for the contextual features hypothesized to exacerbate child maltreatment. Similarly, limited parental education, unplanned pregnancy, larger family size, job loss, underemployment, and unemployment contribute to resource instability and inadequacy that, from an evolutionary perspective, might be tied to child maltreatment (Zuravin & Greif, 1989).

Social factors influence the age at which individuals become parents. Researchers have examined whether the age at which parents first give birth has relevance to risk of child maltreatment. Risk of child maltreatment is elevated in younger parents, particularly young teenagers. Sociobiological theory predicts that older parents are likely to refrain from child maltreatment due to advancing age and lessened childbearing prospects. Researchers have illustrated an inverse relationship between maternal age and child maltreatment (Whipple & Webster-Stratton, 1991), but the

effect is due primarily to elevated risk among young teenage parents and lessened risk among women reaching the termination of childbearing years (Malkin & Lamb, 1994). Evolutionary theory dovetails with developmental theory in emphasizing egocentricity in young adulthood and generativity in older adulthood. Similarly, the personality and emotional attributes contributing to maltreatment (low empathy) may contribute to reproductive capacity under adverse environmental conditions (Belsky, 1993). Whether reproductive fitness is a primary variable contributing to maltreatment in settings of limited economic resources remains an empirical question in evolutionary biological theory.

Researchers interested in microsocial variables have made progress in distinguishing physically abusive and neglectful parenting features. In particular, early studies of social interaction variables illustrated that neglectful mothers of infants were relatively unresponsive to their infants, and they had lower rates of social interaction and prosocial behavior directed toward older children (Crittenden, 1985). Physically abusive parents engaged in fewer forms of positive behaviors and engaged in controlling, interfering behavior toward their children (Howes et al., 2000; Whipple & Webster-Stratton, 1991). More recent studies have supported those findings (Appleyard, Berlin, Rosanbalm, & Dodge, 2011). Physically abusive parents are more likely than comparison parents to use physical punishment, physical control strategies, and punitive methods (threats and disapproval), and they are less likely to engage in reasoning or to show flexibility in their approaches to discipline (Appleyard et al., 2011; Trickett & Kuczynski, 1986; Whipple & Webster-Stratton, 1991). Thus, maltreatment arises in the immediate context of parent-child interaction or discipline when a parent predisposed to negative reactivity, irritability, or hostility becomes increasingly emotionally aroused, attempts to exert physical influence and control over the child, and loses control. Further learning and attachment influences, shaped by childhood victimization by maltreatment, shapes and exacerbates the behaviors (Belsky, 1993).

Societal trends toward increased isolation is a phenomenon of interest. Social support has positive influences on psychological functioning, and its absence has been linked to child maltreatment (Appleyard, Yang, & Runyan, 2010). Maltreating parents tend to have fewer friendships, to have less contact with immediate and extended family members, and to feel lonely and a sense of social isolation (Corse et al., 1990; Coulton et al., 1999). They are less likely to take advantage of available resources (Appleyard et al., 2011). Researchers have also investigated social and family conflict and competition for resources. Neighborhood quality variables also contribute to maltreatment. In a study of Chicago neighborhood quality in socioeconomically similar neighborhoods that varied in rates of maltreatment, parents coming from high-maltreatment neighborhoods had difficulty thinking of anything good to say about their neighborhoods, were unsatisfied with the quality of physical spaces housing community programs, and viewed the neighborhoods as socially disorganized and lacking in social coherence. By contrast, people from low-maltreatment neighborhoods described their neighborhoods as poor but decent,

had access to more services, and described neighborhood leaders as strong and appreciated (Garbarino & Sherman, 1980; Melton, 1992).

#### SUMMARY

The foregoing analysis illustrates the main point that child maltreatment is multiply determined by factors operating at multiple levels of analysis that include evolutionary, developmental, situational/contextual, individual, microsocial, macrosocial, and demographic. Maltreatment is the final common outcome of multiple pathways. In any individual child protective service investigation of child maltreatment, it is possible to identify multiple etiological correlates. A different set of correlates, with or without overlapping variables, might not appear in the next investigation. Unique clusters may recur across cases but not in a reliably predictable manner. The multidetermined nature of child maltreatment must be considered by both researchers and clinicians in order for them to better understand and empirically substantiate the transactional processes presumed to contribute to child maltreatment (Belsky, 1993; Condie, 2003). Researchers analyzing risk factors imperfectly distinguish between different forms of maltreatment, because of the frequent comorbidity of different forms of maltreatment and the lack of distinctiveness of any individual or cluster of predictors for any one form of maltreatment (Condie, 2003). A point of emphasis for future research will be to highlight features that distinguish levels of severity and chronicity of child maltreatment. Two physically abusive or neglectful parents might not be equally abusive or neglectful. Descriptive research is needed to better understand what factors contribute to severity and chronicity of child maltreatment and what factors contribute to lessened or diminishing severity and desistance of maltreatment.

Not all abusive or neglectful parents are the same kind of person, and researchers have begun examining the utility of classification schemes. Researchers are beginning to describe typologies of maltreating parents that include combinations of variables at different levels of analysis. The multidetermined nature of child maltreatment may make this undertaking difficult, at least from the perspective of intervention planning. It is a challenge to design interventions that address the needs of a diverse group of parents with diverse contributing influences related to child maltreatment, particularly in the setting of a relatively high rate of child poverty (Korbin et al., 1998). Not every young parent, impoverished parent, single parent, or parent with children having closely spaced births mistreats his or her children. Thus, interventions must address more than impoverishment, fertility, and social support. Program developers have begun to address parental developmental histories, negative emotionality, emotional reactivity, and insecure expectations, but with mixed results (Kohl et al., 2011). Interventions must target multiple factors simultaneously, creating incentives for adolescents to remain in school, reducing school truancy and academic underachievement, addressing neighborhood quality, and increasing school-based case management (Belsky, 1993).

## EVALUATION METHODOLOGY

Methodology for evaluations depends on the nature of the referral question. The use of consistent methodology and the use of multimodal assessment procedures enhance the reliability and validity of evaluation results. In child maltreatment cases, flexibility in methodology across referral questions is needed to accommodate the degrees of breadth and depth necessary to answer a given referral question or set of questions. Care and protection evaluation methodologies and reports range from brief consultations to comprehensive descriptions of multiple family members and their interrelationships (Condie, 2003). Although there is no single methodology for care and protection evaluations, the prototypical example includes:

- Obtaining informed consent
- Interviewing one or more parents or caregivers
- Observing the parents or caregivers with the child (when indicated)
- Interviewing the children
- Gathering collateral information and relevant records
- Seeking releases for access to privileged and/or confidential records
- Administration of psychological measures or tools when indicated

Examples of measures include measures of general mental health or adaptive functioning, measures related to specific symptoms or behaviors, or measures that address risk factors and hypothesized correlates of elevated risk of child maltreatment. Specific potentiating factors are included to enhance the predictive validity of risk assessment beyond that of amorphous broad constructs of mental illness, mental deficiency, or organic impairment. When translating information from research to clinical practice, however, one must consider potential compromises to validity and reliability when the relative weight of any risk factor is unknown as it applies to clinical populations. When those factors are included in a risk assessment, there must be a clear link between any factor or combination of factors and child maltreatment. A person can be mentally ill, and a person can engage in child maltreatment. The co-occurrence of those two elements in a single case might or might not be the result of a direct or indirect causal link. Thus, it is important to examine how mental illness manifests itself (e.g., the impact on the individual's interpretive process, attributional style, etc.) and any possible link to elevated risk of child maltreatment.

### EVALUATING CAREGIVERS

Using a systematic approach, the caregiver portion of the evaluation satisfies informed consent procedures, introduces the referral questions and evaluation content, and reviews the anticipated scope of the evaluation. The referral question(s) frame the evaluation methodology. Multimodal assessment is conducted to enhance the reliability and validity of the evaluation results. Good methodology allows for

flexibility to accommodate different degrees of breadth or comprehensiveness of referral questions, caregiver variables, and caregiver–child interaction variables.

*Informed Consent and Notification of the Limits of Confidentiality.* The first step of any evaluation is to obtain informed consent in keeping with prevailing regulations and practice standards. The individual being interviewed must be informed of the limits of confidentiality prior to being interviewed (American Psychological Association [APA], 2013; APA Committee on Professional Practice and Standards, 2011 [the Specialty Guidelines are reprinted as the appendix to this volume with permission of the APA]). If the individual does not comprehend the notification, steps should be taken to determine whether the evaluation ought to proceed. Examples include contacting the referring attorney or notifying the court in the case of a court-ordered evaluation. The explanation should include:

- A clear explanation of the referral question
- The individuals who are a party to the evaluation
- Who will view the report
- The lack of confidentiality
- Who “owns” the report
- Provisions (or lack thereof due to judicial restrictions in some jurisdictions) for release of the report to individuals who are not a party to the legal proceedings
- The difference between medical records and forensic records as defined in state or federal statutes and regulations relevant to both psychological record keeping and care and protection proceedings (Condie, 2003)

When a report describes multiple parties to the case, the evaluator should explain restrictions in releases, namely that one party cannot authorize release of the full report unless all of the other parties also sign releases. Individuals should be told that:

- They are under no obligation to participate in the evaluation.
- They may decline any further questions if they agree to the evaluation but later change their minds.
- They may refrain from answering certain questions if they wish to keep information private.
- Nothing they say remains “off the record.”

Under the circumstance of a court-ordered evaluation, individuals should be advised that the evaluator will prepare a report that includes information gathered from other resources regardless of whether they choose to participate. For all participants in the evaluation, the notification must be given to satisfy ethical and legal requirements.

*External Validity.* In determining the most appropriate methodology, careful attention should be paid to external validity and its limitations. Contemporary theories and research on parenting behavior continue to focus primarily on optimal or typical parenting rather than the minimal parenting competence needed to satisfy legal standards (Barnum, 1997; Budd, Poindexter, Felix, & Maik-Polan, 2001; Condie, 2003). Few valid indicators of psychological constructs specific to parenting (warmth, nurturance, responsiveness) have been developed for use in forensic assessment (Budd & Holdsworth, 1996). There is little research or clinical consensus as to which psychological constructs, behavioral indices, or functional impairments directly relate to the minimal legal criteria necessary to demonstrate parenting competence (Ayoub & Kinscherff, 2006; Barnum, 1997; Budd et al., 2001; Condie, 2003). Psychological assessment measures, even when specific to parenting behavior, typically were not normed on care and protection samples or other samples of parents thought to be at risk for maltreating their children (Brodzinsky, 1993; Budd & Holdsworth, 1996). Few normative data are relevant to samples of families involved in care and protection matters (Ayoub & Kinscherff, 2006; Barnum, 1997; Condie, 2003). By the same token, there is little basis for conducting care and protection evaluations without turning to psychological assessment measures, except when referral questions touch on issues for which assessment is irrelevant or poorly supported. When appropriately used and interpreted, assessment measures improve the reliability and validity of care and protection evaluations. Although evaluation approaches to care and protection matters take many forms, it is common for psychologists to use some form of psychological assessment in evaluations of parental functioning to enhance the measurement of relevant behaviors and skills, the interfering effects of substance abuse and/or mental illness, cognitive capacities, and general functioning (Ayoub & Kinscherff, 2006; Budd et al., 2001; Condie, 2003). Evaluators should take a multimodal approach to assessment, applying the tradition of seeking converging data (APA Committee on Professional Practice and Standards, 2011; Budd et al., 2001; Condie, 2003). The literature contains suggestions for core features of typical questions asked in care and protection evaluations. Because the band of possible referral questions is not narrow, adherence to a particular methodology in all instances is neither feasible nor indicated. Nonetheless, enough is known about the basic features of commonly recurring referral questions in care and protection matters to develop relatively consistent methodologies.

Some clinics with evaluation contracts face limitations in resources, and thus the scope and feasibility of comprehensive methodology must, unfortunately, take those financial limitations into account. Thus, referral questions are sometimes limited to critical, but highly focused, questions or content areas to accommodate heavy referral loads in the face of scarce resources (Condie, 2003). Evaluators in some settings may pare down evaluation procedures such as multiple sessions or parent-child observations that might improve yield of information but with diminishing returns. For example, although parent-child observations provide useful information about parent-child attachment, they rarely yield critical

data concerning child maltreatment. Although a parent–child observation might contribute to an optimal evaluation, a careful analysis weighing potential information gain against time and labor investment/scheduling issues might lead to a conclusion that it does not meet demands of what is minimally necessary in every evaluation. This particular procedure is highlighted not because it is weaker than other modalities and not because it lacks external validity per se; the same could be said of many other procedures. Evaluators operating with limited budgets often need to make difficult decisions that allow them to meet ethical and legal obligations without producing invalid or unreliable results but also without exceeding budgetary constraints. Researchers and scholars who ignore the reality of limitations in the child protective and court clinic funding mechanisms risk producing methodology recommendations that lack financial feasibility. Sometimes resource limitations spur advances in approaches to court clinic services (Chuang, Moore, Barrett, & Young, 2012).

*Clinical Interview.* Clinical interview comprehensiveness is determined by the referral question. Some interviews might address an extensive range of historical and current factors, with an in-depth focus on particular spheres of functioning. Other interviews might be specific to one or two areas of functioning (Budd, Connell, & Clark, 2011). Regardless of the comprehensiveness of the interview, it is important to include questions that inquire about both strengths and weaknesses of parenting skills (Condie, 2003). Focusing only on parenting or functioning deficits carries the risk of neglecting important protective factors or compensatory skills, alienating the interviewee, and leading to an imbalance in the analysis of positive and negative factors in the interpretive process. A variety of interview strategies incorporate the necessary content domains needed to respond to referral questions. The evaluator should choose an approach with which he or she is well trained and highly familiar and that is easily adapted to a variety of parenting concerns that would be raised in the context of child protection matters (Budd et al., 2011; Condie, 2003).

Clinical interviews ordinarily progress from emotionally neutral topics to more sensitive areas (Ownby, 1997). In care and protection evaluations, however, it is useful to begin with the parent's perspective of his or her history of involvement with the child protective service system. Interviewees tend to focus on this material at the outset of evaluations regardless of whether the interviewer directs them toward or away from it, and they report frustration if the interview deviates too quickly from the centrality of their concern. There is a cathartic quality to interviewees' first accounts of their involvement with the child protective service system, regardless of whether their description is appropriately detailed or even accurate. Many times they report that the evaluation provided them with their first opportunity to provide their description and perspectives of what happened. This approach eases tension and contributes to rapport building, but finesse is required so that the interviewee does not mistakenly view the evaluator as an ally or advocate (Condie, 2003; Crenshaw & Barnum, 2001).

The first account of the parent's history of child protective service system involvement usually lacks some or many details central to the alleged maltreatment (Chuang et al., 2012; Crenshaw & Barnum, 2001). Follow-up questions are needed in order to gather relevant details. Sometimes details will be gathered in different phases of the interview. Inconsistencies and gaps within the interviewee's accounts, and between interviewee accounts and records, should be noted and addressed. Usually a curious or inquisitive approach is sufficient to elicit greater detail and forthrightness, particularly if follow-up questions are directed toward multidimensional facets or elements of a topic and are designed both to provide richness of texture and to complete any gaps in information (Condie, 2003). Eliciting details through the exploration of multidimensional facets has the benefit of uncovering inconsistencies, and interviewees sometimes will move, either abruptly or gradually, toward candid disclosure of information in the context of textured questioning. By contrast, some evaluators find it useful to use a direct or somewhat confrontational approach. Confrontational approaches must be used with caution, particularly when there is a question of cognitive limitations and suggestibility in the interviewee (Sgroi, 1989). With parents who are not cognitively impaired, it is reasonable to approach a topic more than once if there is inconsistency or if the interviewee avoids responding to questions. Persistence typically yields more information than confrontation. Multiple questions and/or interviews sometimes accomplish multiple goals of facilitating rapport, highlighting contradictory information, and generating of details, resulting in gradual acknowledgment of relevant parenting weaknesses and risk factors (Condie, 2003).

Other interview content depends on the nature of the inquiry. If the referral question contains a request for information about parenting abilities or risk of harm, the interview concerning historical data in most cases includes a broad range of questions about parenting skills and schedules, a variety of factors known to contribute to risk of maltreatment, and a variety of protective factors (Condie, 2003). If information in the records reveals a smaller band of potential risk factors (e.g., known relapsing substance abuse in the relative absence of other indicators of risk), there may be less need for a broadly focused interview except as it applies to known risk factors. When comprehensive data are needed, the evaluator typically moves from neutral to potentially emotionally arousing topics. Typical areas of inquiry include:

- Family of origin history (focusing on quality of relationships, loss, and intrafamilial trauma)
- Important adulthood relationships
- Dating and marital history
- The decision process to bear children
- Educational and occupational history
- Mental health and substance use history

- Medical history (including neurological data)
- Psychosexual history
- Neglect history
- Violence history
- Criminal history (Dixon & Hamilton-Giachritsis, 2009)

The depth of inquiry into any topic area depends in part on a preliminary review of records that guide interview content and on information that the individual might divulge in the course of the interview (Condie, 2003). Depth might also be determined by whether a referral question includes a request for data relevant to treatment progress and prognosis. For example, if substance abuse treatment response and prognosis is a question of interest, the interview content typically would contain questions relevant to:

- History of substance use
- Length and quality of periods of sobriety
- Factors that potentiated and hindered sobriety
- Effectiveness or lack thereof of past rehabilitation efforts
- The individual's current level of participation in and stage of rehabilitation
- Motivating influences for remaining sober
- Options available for resisting urges to drink or use drugs
- Relapse prevention plans
- Other relevant information (Connors, Longabaugh, & Miller, 1996)

The modality of treatment would have bearing on follow-up questions. If a self-help group is the main treatment modality, the evaluator would inquire about these areas:

- Nature and frequency of self-help meetings
- Steps or stages of the self-help process
- Identification of and reliance on sponsors
- Reliability and availability of sponsors or other support persons
- Types of meetings attended
- Implementation of recommendations gleaned from self-help books (Condie, 2003)

Questions about relapse prevention planning would center on:

- Comprehensiveness and thoughtfulness of the plan
- Whether elements of the plan are committed to memory or are readily available in written form
- How often the plan is updated
- Whether the individual's relapse prevention therapist believes the plan is appropriately detailed and feasible (Connors et al., 1996)

Regardless of the treatment modality, the interviewer should have an appropriate level of knowledge about the addictive potential and differential impact of various illicit or licit substances and the impact of those substances on the individual's functioning should he or she relapse. Interview questions should also be tailored to other issues of concern, including possible comorbidities (mental illness and substance use, mental illness and cognitive impairments, etc.) having a direct or indirect impact on parenting capacity (Condie, 2003).

*Risk Assessment.* Actuarial methods with varying rates of reliability, validity, and clinical utility have been developed for other forms of violence risk (Borum, Otto, & Golding, 1993; Quinsey, Harris, Rice, & Cormier, 1998) but not for child maltreatment risk. Risk assessment typically is included in the interview process. The level of interviewer concordance and the specificity of risk communication depend on the validity of the methodology. Clinicians reach different levels of concordance based on whether they employ probability equations or rely solely on clinical inference (Borum et al., 1993). Risk matrices specifically designed for predictions of child maltreatment have yet to be developed, but cautious use of research guides the process. Specific studies of risk associated with child maltreatment have been based on small sample sizes and a small dimension of variables compared to broader studies of violence risk. Some wide-scope studies are beginning to appear (Appleyard et al., 2010, 2011). It remains to be determined whether the weight and relevance of risk factors differ when comparing physical violence, neglect, and sexual abuse (Ayoub & Kinscherff, 2006).

*Interview Content for Risk of Physical Abuse.* Physical abuse is a low-frequency act that usually occurs in a private setting. Because of problems with self-report data, it is difficult to demonstrate in applied research whether personality features or behaviors (hostility, criticism, threats) have potent predictive or discriminative validity for physical abuse (Watson & Clark, 1992; Widom, 1989; Zuravin & Greif, 1989). Examples of risk factors that have at least a moderate link to risk of physical abuse (Belsky, 1993; Ertem et al., 2000; Goodman & Tully, 2008; Miller, Cohen, & Wiersema, 1996; Trickett & Kuczynski, 1986) include these:

- Untreated major mood or thought disorders
- Failure to acknowledge a mental illness or the need for treatment
- History of violent outbursts of temper
- Active drug or alcohol addiction
- Childhood history of abuse
- Other adverse childhood experiences (hostile and rejecting family environment, harsh and unfair discipline, placement in foster care or multiple placements, parental discord, institutional upbringing)
- Few ties to neighbors or community

- Violent relationships with intimate partners
- Gross misperceptions about a child or child development
- Gross misperceptions about useful or appropriate discipline strategies
- Unrealistic expectations of children
- Difficulty discerning and responding to cues from the child
- Insecure parent–child attachment
- Role reversals
- Scapegoating the child
- Extreme worry about a child’s well-being
- High levels of parenting stress or social isolation
- Hazardous home environment
- History of violent behavior
- Deliberateness with which the individual harmed the child in the past
- Extent and frequency of harm to the child
- Allowing perpetrator access to the child

Other variables of relevance that sometimes contribute to risk of maltreatment include:

- Adequacy of supervision
- Safety of the home environment
- Age and visibility of the child
- Caregiver age and maturity
- Mental and social development of the child (to better understand variables contributing to a child’s capacity to speak up on his or her own behalf)
- Level of fear the child expresses about the caregiver or the home environment
- Presence of other adequate caregivers
- Level of stress and availability of supports
- Caregiver’s victimization in adulthood by domestic violence

Internal variables include:

- Cognitive appraisals of caregiver–child conflict
- Attributions of blame and responsibility
- Anger management skills
- Recognition of the problem
- Capacity to select suitable substitute caregivers
- Internal response to the child’s misconduct
- Mental appreciation and assignment of family roles (Kim et al., 2009; Kohl et al., 2011; Widom, 1989)

Much attention has been given to substance abuse in maltreating families. For example, Gaudin (1994) reported that it was a factor in 80% to 90% of child maltreatment cases.

Static risk factors are historical factors that cannot be modified. Dynamic or modifiable risk factors that can change over time (Borum et al., 1993) include, among others:

- Caregiver's degree of acknowledgment of the problem
- Intensity of relevant treatable symptoms
- Willingness to take advantage of social support
- Willingness to better understand child development and the needs of children
- Modifiable impinging stress factors
- Cognitive appraisals
- Individual's justification for the maltreatment (Condie, 2003)

Researchers are just beginning to study a number of issues, including:

- How readily these factors are modified
- Which factors tend to be more amenable to intervention
- Whether individual variables contribute to amenability (e.g., would a sociable person isolated because of neighborhood variables rather than individual predilection be more amenable to social skills training)
- Individual potencies of the factors (e.g., the intractable nature of cognitive deficits versus educational background deficits whose outcomes mirror cognitive deficits)
- Potencies of combinations of the factors (e.g., whether certain combinations of risk lead to intractability or certain other combinations lend themselves readily to intervention)
- Desistance of risk in maltreating parents (Appleyard et al., 2010, 2011; Marshall, 2012; Putman-Hornstein et al., 2011)

*Interview Content for Risk of Sexual Abuse.* Risk assessment of sexual offending incorporates specific factors different from those of other forms of violent offending (Hanson & Thornton, 2000). Although some of the predictors overlap between groups of violent offenders and sexual offenders, risk of child sexual abuse is more directly linked to psychosexual history aberrations than to violence risk. Potent predictors include a reduction in family boundaries, symbiosis of relationships, misdirection of sexuality, cognitive distortions in identification and affiliation, hostility, and aggression (Everson & Faller, 2012; Neutze, Grundmann, Scherner, & Beier, 2012). Although all forms of child maltreatment have an individual component, an interview directed toward sex offending and sexually abusive conduct typically focuses more heavily on individual risk variables than other forms of risk factors. Attention is also paid to the circumstances that make it possible for the maltreatment to occur (e.g., isolation, control). In the clinical interview, neither the sexual nature nor other facets (exploitation, power, humiliation, violence) should be ignored in examining the nature of child sexual abuse.

Psychopathological models of deviant sexual arousal and social-cognitive functioning have been developed to explain sexual offending. Theories tend to be based on samples of convicted offenders and therefore may not fully capture the patterns of functioning seen in undetected offenders who remain in the community or who have never been convicted (Hanson & Thornton, 2000). Factors in explanatory theories include:

- Arrested psychological development
- A sense of inadequacy and immaturity
- Deviant patterns of arousal
- Identification with the aggressor
- Imprinting and conditioning from childhood victimization
- Poor or awkward social skill development
- Socialization that values dominance and power (Cohen, Frenka, Mojtabei, Katsavdakakis, & Galynker, 2007)

Areas of clinical interview inquiry relevant to risk assessment and treatment progress as it applies to specific offending behavior include:

- Offender's recall of details
- Degree of aggression or overt violence in offenses
- Seduction and victim grooming strategies
- Frequency and duration of offenses
- Length and progression of history of sexual offending
- Offense characteristics
- Number of victims in relation to victim access
- Victim selection characteristics
- Preferred victim type
- Victim blame
- Appraisal of victim harm
- Acceptance of personal responsibility for offending behavior
- Degree of arousal and habituation
- Exploitative or addictive behaviors related to the offenses
- Criminal arrests and convictions

Social and cultural factors of victim blame and the reluctance of the legal system to prosecute and punish offenders are hypothesized to contribute to the disinhibition of offenders. Typologies have been developed based on victim gender preference, offender gender, level of fixation for a particular form of offending, degree of regression of the offender, and incest versus extrafamilial victims (Waterman, 1986). There is disagreement over shared features that cut across groups of offenders.

*Interview Content for Risk of Neglect.* Assessing risk in neglectful parents poses a challenge because of the relative infancy of research relevant to risk of child neglect.

There is enormous heterogeneity among neglectful families (Gaudin & Dubowitz, 1997). Neglect commonly occurs alongside other forms of maltreatment. Researchers have not identified as discrete a set of risk variables as have been identified for physical or sexual abuse. The variability among neglecting families may mask between group differences, correlates or causal factors specific to subtypes of neglecting parents, and the relevance or potency of risk variables across types of neglecting parents (Condie, 2003). Neglect does seem to be associated with these issues:

- Blunted affect
- Apathetic or passive-dependent interaction styles between parents and children
- Nonreciprocal relationships among family members
- Cycling between passive and aggressive behavior
- Critical dispositions (Gaudin & Dubowitz, 1997)
- Chaos and poor planning capabilities
- Impulsive actions
- Conflict-laden relationships between parents
- Social isolation
- Poor quality of social support
- Poor social skills
- Rejection by community members (Mennen, Kim, Sang, & Trickett, 2010)

*Protective Factors.* Protective factors influence a reduction in or desistance of risk (Lodewijks, de Ruiter, & Doreleijers, 2010; Loeber, Pardini, Stouthamer-Loeber, & Raine, 2007). Protective factors associated with lowered risk of child maltreatment include:

- Social support
- Good parenting role models
- Acknowledgment of parenting problems
- Recognition of the impact of parenting problems on the child's development and functioning
- Adherence to recommended interventions
- Identification of compensatory strategies
- Utilization of community resources
- Positive rehabilitation progress reports
- Stable and consistent visitation with the child
- Recognition of the impact of separation on the child
- Separation from abusive partners
- Strong postreunification after-care plan (Condie, 2003)

Applied clinical and prospective studies of maltreating parents involved with the child protective service system are needed to better understand the relevance and

potencies of individual protective factors or combinations of factors (Colman, Kim, Mitchell-Herzfeld, & Shady, 2009).

*Caregiver–Child Relationships.* Evaluation of the caregiver–child relationship usually involves a combined approach utilizing parent interview data, child interview data, observational data, record review of historical data, and collateral interviews. Typical inquiries focus on the:

- Strength and quality of the relationship
- Presence and degree of emotional closeness
- Parental perceptions of the child (and child perceptions of the parent)
- Parent’s ability to promote appropriate development in the child
- Parental responsiveness to the child’s needs (Stahl, 1994)

Parents play a role in assisting children through developmental stages. When more than one child is involved in a care and protection petition, the evaluator should individualize the assessment of the parent’s relationship with the child and examine the parent–child relationship and other family dynamics when all children are present (Condie, 2003; Stahl, 1994). Inquiries of a parent might include the:

- Parent’s description of the child
- Awareness of the child’s activities
- Expectations of the child
- How the parent responds when the child seeks attention
- Concern for the child
- Negotiation of parent–child conflict
- Reports of close calls of maltreatment
- Capacity to set a daily routine
- Repertoire of discipline strategies
- Awareness of the child’s friendships and school activities (Budd et al., 2011; Condie, 2003)

*Caregiver–Child Visitation.* The criteria that visitation agency representatives use to determine the nature and extent of contact between parents and children in foster or residential care are sometimes idiosyncratic. Some agencies form internal standards, but there is little consensus across agencies about criteria for determining frequency of contact, whether contact ought to be supervised, who qualifies as appropriate supervisors, and whether visitation should take place in a natural setting or a visitation center. There is limited information concerning the predictive utility of parent–child visitation reports or observations for determining the quality and safety of supervised or unsupervised visitation contact. Children with histories of intrafamilial trauma report a variety of responses to visitation (Johnston & Goldman, 2010; Pearson & Theonnes, 2000). Evaluators sometimes rely on visitation

supervisors as collateral contacts. It is appropriate to seek visitation observations from collateral contacts who have had an opportunity to view parent–child visits. It is best to seek data that are observational and not conclusory regarding the appropriateness of the visitation plan, reunification, or termination of parental rights. If data gathering is kept at an observational level, it preserves the roles of the visitation supervisor and the evaluator (Pearson & Theonnes, 2000). Parents report mixed experiences at visitation centers. Some parents prefer visitation center supervisors to other supervisors because such supervisors are trained to remain neutral during supervision, because parents feel less awkward in the presence of a professional supervisor compared to other supervisors, and because parents find it is easier to reschedule missed appointments. Concerns about visitation centers include geographic distance from the caregiver’s home or child’s foster home, formality that contributes to the discomfort of being scrutinized, and insufficient staffing. Regardless of the method of supervision, keeping foster children connected to parents through visitation and other forms of contact is essential for successful reunification because it facilitates ongoing family relationships and has the potential to set the child at ease in foster care (Cantos, Gries, & Slis, 1997).

*Observations and Home Visits.* Observed sessions are a useful aspect of multimodal assessment, but they are readily influenced by social desirability. Most parents are on their best behavior when observed. Observations are illustrative when young children have not yet developed the linguistic capacities to express their level or quality of attachment to parents or when there is obvious conflict between a child and a parent. They may help illustrate how much of the conflict is initiated by the parent and how much it is linked to an adolescent’s struggle for autonomy and independence (Stahl, 1994). Observed sessions can be useful in rare instances in which the parent cannot conduct themselves appropriately even under observation (Condie, 2003; Stahl, 1994). Evaluators have a choice of using structured and unstructured visitation methods. It is difficult to control for reactivity effects when using observational measures due to the lack of blindness of raters to hypotheses concerning why the observation is taking place (Ronay, 2011).

*Caregiver Relationships With Helping Sources.* Referral questions sometimes address the impact of social isolation or access to social support on parenting. Particularly in cases of neglect, social isolation often is a prominent feature of child maltreatment (Runyan et al., 2005). The caregiver’s capacity to develop relationships with helping sources, positive support individuals, mentors, and nonneglecting role models might be a main goal of an intervention plan. When the caregiver’s relationships with helping sources are examined, inquiry should focus on the breadth and depth of social contacts (Zuravin & Greif, 1989). The reasons for limitations in quality or persistence of constructive relationships should be queried. The quality of relationships whose onset occurred during the pendency of care and protection

oversight should be carefully examined because they could indicate that the caregiver is making a meaningful attempt to develop relationship skills, or they could be transient or superficial relationships meant to mollify child protective service workers (Condie, 2003). Collateral contacts with those helping sources often serve to clarify whether the caregiver is meaningfully forging relationships, learning when and how to take advantage of and rely on helping sources. Similarly, contacts may serve to clarify whether the caregiver is working to curtail or end relationships that pose a maladaptive influence on parenting.

*Readiness for Transitions.* Referral questions sometimes center on what the parent is doing to prepare for reunification or, conversely, whether the parent has made a competent decision to release his or her child for adoption. Parental self-report data help clarify (1) the parent's own appraisal of skills and limitations in parenting, (2) the degree to which the parent believes he or she has met intervention goals, (3) the degree to which the parent has meaningfully addressed the original problem of maltreatment and factors that led up to it, and (4) the realistic nature of the parent's readiness to regain custody of the child (Ayoub & Kinscherff, 2006). Competence to release a child for adoption requires inquiry into:

- The rationality of the parent's reasons for giving up custody
- Whether his or her decision is voluntary or unduly influenced by other individuals
- The parent's immediate and long-term goals in his or her own life and relationships
- Whether regaining custody is a viable possibility (and, if so, why the parent would choose otherwise)
- Whether a clear process has taken place in which the parent has considered all possible ramifications
- The realistic nature of the parent's wish to have posttermination contact

Courts do not always allow posttermination contact, and when they do, they usually set strict limitations (Condie, 2003).

*Psychological Measures and Tools.* Psychological measures and tools have the potential to yield useful and relevant data when used appropriately. When measures are used out of context, overinterpreted, or otherwise misinterpreted, assessment data can be a serious drawback to the utility of forensic assessment (Ayoub & Kinscherff, 2006). The utility of any assessment measure or procedure rests on its reliability and validity as it applies to the specific assessment context. When choosing psychological measures, it is best to begin with theoretically or logically derived hypotheses concerning behavioral features or possible causal or explanatory variables that are relevant to the referral question. The evaluator should carefully consider the degree to which the measure demonstrably corresponds to the behavior or set of behaviors

of interest. It is unproductive to use traditional measures indiscriminately, but they can be quite useful if selected carefully based on research or theories supporting a relationship between the indices and specific behaviors of concern in a parent's history or current functioning (Condie, 2003). For example, global indices such as intelligence, diagnostic status, or personality functioning might be used as explanatory data for parenting problems, maltreatment risk, or suitability of interventions. A stronger analysis would integrate indices of judgment and reasoning relevant to the parenting problems (Budd & Holdsworth, 1996). The intellectual, adaptive, and judgment/reasoning indices themselves are not sufficient, in and of themselves, however. They must be meaningfully linked to the maltreating behavior(s) of concern (Condie, 2003).

Psychological assessment data are useful in evaluating a number of issues, including:

- The relationship between current and premorbid functioning
- Specific potential that could contribute to the development of adequate parenting competence
- Specific deficits likely to impair parenting competence
- Global functioning problems that might contribute to parenting deficiencies
- Reasons why a particular parenting intervention might be suitable or not for a given parent
- Problems and deficits that might explain intractability
- Skills and compensatory strategies that could be capitalized on (Ayoub & Kinscherff, 2006; Condie, 2003)

In making a determination of the appropriateness of using psychological assessment measures, it is important to remember that not all parents with cognitive limitations, mental health problems, or a history of using substances engage in child maltreatment. There must be a clear link between those issues and the child maltreatment in order to justify highlighting their hypothesized contributions to the parenting behaviors of concern. For example, limited intellectual functioning of a parent, as assessed by intelligence quotient and scales of adaptive behavior, would be insufficient to explain limitations in parenting capacity unless those indices serve as a framework for understanding specific functioning limitations directly relevant to the parenting behaviors of concern. When relevant, however, assessment measures might prove useful. For example:

- Intellectual and adaptive behavior measures may provide useful information relevant to a parent's specific strengths and weaknesses.
- Achievement and basic skills assessment measures may provide information about why a parent might benefit from or struggle through a particular intervention relevant to parenting.
- Neuropsychological assessment of executive functions may provide a framework for better understanding a parent's capacity for self-control.

- Cognitive and memory assessment may illustrate whether deterioration has resulted from chronic substance abuse (particularly when premorbid indices are available).
- Personality or psychopathology assessment may highlight the ongoing nature or severity of specific facets of interfering mental health or personality impairment on parenting behaviors (Condie, 2003).

Measures should be chosen based on reasonably formed hypotheses about possible causal variables that might contribute to parenting deficiencies or patterns of maltreatment. The need for psychological assessment often is reasonably drawn from the degree and credibility of prior documentation of issues that might be relevant to parenting concerns. Records help highlight the chronic versus episodic nature of problems that interfere with adequate parenting. They help illustrate the plausibility of hypothesized causal links. Diagnostic information alone is not an automatic indicator of the potential for maltreatment, but records help to clarify the extent to which a linkage between symptoms of mental illness or substance abuse and problems in parenting ought to be explored further (Ayoub & Kinscherff, 2006). Assessment data supplement the interpretive process, but they do not prove or disprove allegations of child maltreatment or parenting capacities. Data must be integrated with historical patterns of deficits and potentials and interpreted carefully (Budd & Holdsworth, 1996).

Care and protection cases focus on minimal parenting competence rather than ideal parenting abilities. Because definitions of minimal parenting competence are legally derived and vary from state to state, those definitions may not translate well into theories or techniques that lend themselves to scientific scrutiny. The relevance of any assessment measure, whether global or specific, to parenting behaviors of concern in care and protection matters must be determined on a case-by-case basis, using theory to guide hypotheses and to choose appropriate measures in specific cases. Most experts recommend that the assessment of parenting abilities and capacities be based on a functional set of behaviors in a specific context, with due attention to cultural variations in parenting (Condie, 2003; Weiss & Rosenfeld, 2012). Caution is in order because cultural variations should not be used to divert attention from maltreating behaviors that obviously are serious and deviate from cultural norms. A behavior or style of parenting that is normative should not be used to defend or excuse a parent who takes advantage of that norm in order to seriously harm a child. The evaluator should take steps to understand cultural norms, relying on local experts when necessary, to understand how to interpret measures validly in light of differing standards of behavior (APA Committee on Professional Practice and Standards, 2011).

*Records and Collateral Reports.* Child protective service records should be reviewed with three goals in mind: (1) documentation of the maltreatment, (2) service plan utility and integrity, and (3) documentation of parental self-reports of maltreatment.

The original allegations of child maltreatment are documented in those records, along with investigation summaries and an indication of why the allegations were supported. Records of allegations and investigations help illustrate the original concerns, whether social services representatives and attorneys have remained focused on the original maltreatment, and the degree to which a parent's report of maltreatment in the context of a clinical interview comports with or deviates from documented information (Condie, 2003). The records illustrate the frequency with which there have been supported allegations of maltreatment. When records are descriptive and accurate, they can be used to gauge parent progress in acknowledging the frequency and severity of maltreatment, a hypothesized necessary step in seeking meaningful treatment (Hardt & Rutter, 2004).

Child protective service records usually contain a service or intervention plan for both parents and children. If only one caregiver is accused of maltreatment, a second caregiver might be included because of concern about tolerance of maltreatment or pathological passivity toward the maltreating caregiver. Another biological parent not living with the family of concern may be identified and included in the intervention phase as well. Children are included in service plans so that interventions can be identified to help them recover from the effects of child maltreatment and remain safe from any further maltreatment. A parent's awareness of the details of the service plan is usually informative. A parent with little awareness of the service plan is unlikely to have taken it seriously whereas a parent who supplements the service plan with other similar services is likely to be serious about change. As in the assessment phase, the issue of social desirability is a necessary component of this phase of the evaluation (Gaudin, 1994).

The service plan sometimes highlights the degree of comportment with identified service goals and the goals of the evaluator's referral question. Agencies sometimes operate with competing goals, providing a service plan that focuses on reunification but looking ahead to a legal process that anticipates a hearing on termination of parental rights. The dual goals are necessary in cases in which statutory provisions highlight reunification, while realistic goals require planning for possible permanent separation of parents and children or even termination of parental rights. Some state statutes call for reunification planning in the early stages of cases and a permanent separation or termination of parental rights hearing after a specified period of time (Condie, 2003). Thus, the intervention planning phase may have two competing goals. A referral question in the early phase of intervention might highlight a parent's amenability to treatment, a referral question in the midphase might highlight parental responses to treatment and whether the quality of the parent-child relationship has improved demonstrably, and a referral question in the latter phase might emphasize a child's attachment to substitute caregivers or the psychological impact of termination of parental rights on a child (Condie, 2003). Sometimes these evaluation goals might be posed concurrently with the same or different evaluators. The service plan may be a launching point to determine if appropriate services have been recommended or neglected in the plan (Gaudin, 1994). The plan

yields information about the identities of service providers who should be included in the list of collateral contacts. Contact with service providers sometimes yields data relevant to whether a parent is accessing services appropriate to his or her level of intellect, whether the parent is benefiting from services, and whether the services are directly or indirectly relevant to the parenting behaviors that led to the allegations of maltreatment. Occasionally service plans neglect specific concerns that ought to be addressed before reunification, because of lack of knowledge about risk factors, funding limitations, or other factors. Thus, the evaluator may make recommendations for other services (Condie, 2003).

Other records that tend to be useful include:

- Records of participation in and response to rehabilitation
- Mental health and substance abuse evaluation and treatment records
- Any records describing premorbid functioning (used to aid in determinations of deterioration or improvement in functioning)
- Educational and vocational records
- Medical records
- Visitation center records
- Police investigation reports relevant to child maltreatment or related offenses
- Frequency of substance-abuse related convictions

Rehabilitation nonattendance should not be taken at face value. Parents sometimes face transportation problems and other legitimate barriers to services (Ayoub & Kinscherff, 2006; Babiker & Herbert, 1998).

In advance of contact, the evaluator should develop the scope of questions appropriate for each collateral contact. Possible sources of information include teachers, child care workers, foster parents, residential placement staff members, extended family members, child maltreatment investigators, pediatricians, mental health and substance abuse service providers, and visitation supervisors (Stahl, 1994). Collecting information relevant to substance abuse rehabilitation for adults or psychotherapy of children sometimes may require a special release or court waiver because of higher privilege protections. Collateral contacts should be informed that the information they provide may appear in the forensic evaluation report. Releases should provide for a one-way release of information from the collateral contact to the evaluator unless a two-way release is indicated for some reason. A two-way release should not serve to compromise the integrity of the evaluation process or the roles even when the collateral sources are professional. The neutrality of the evaluator's position should be preserved (Condie, 2003).

*Evaluating Children.* The main goals in the initial appointment with a child are to set the child at ease, develop an understanding of the child's linguistic abilities, and provide a notification of the limits of confidentiality suitable to the child's comprehension (Condie & Koocher, 2008). It is helpful to begin with innocuous questions,

but the questions should not inadvertently confuse the child's understanding of the purpose of the evaluation. Similarly, the evaluator should not immediately launch into discourse or questions that will raise the child's anxiety about loyalty bonds with parents. The evaluator must be alert to the possibility that some children will have been notified in advance of the evaluator's role and evaluation goals, either with accurate information or misinformation. Thus, gleaning information from the child about his or her preconceived notions of the evaluation should take place at the outset. Some children may hold clear goals of what they wish to convey to the evaluator. An artful approach is required to determine if information provided by a child has been unduly influenced by other individuals due to recent contact, gifts, promises, or other methods of persuasion (Stahl, 1996).

A child-centered office environment helps set children at ease. Children should feel comfortable without becoming distracted. They should be allowed time to become accustomed to the evaluator and the context. Respect should be given to personal space, boundaries, and bodily integrity. Children should be encouraged to ask questions and seek clarification. It is important to avoid emotionally or morally laden phrases, such as "Bad things that happen to children." Developmentally, children are likely to blame themselves for "bad things," and they are unlikely to desire permanent separation from parents even when those parents have maltreated them (Condie, 2003). From their limited points of reference and experiences, "bad things" might be interpreted quite differently by children, or may pale in comparison to other events or qualities of individuals. There should be an assumption that their egocentric interpretation sometimes precludes comparisons and contrasts. Appropriate care should be used in designing questions that will allow children to voice their concerns without facing fear of moral or other approbations (Waterman, 1986).

Specific standards have been developed in some jurisdictions for audio- or video-recording interviews of children, particularly children whose families are involved in criminal or care and protection proceedings (Saywitz, 1994). Because of concern over the capacities of evaluators to record complete information in written form (Lamb, Orbach, Sternberg, Hershkowitz, & Horowitz, 2000), it is good practice to record interviews in some fashion, taking care to gather special permission in the informed consent process. An explanation of the use of the devices should be given in language the child comprehends. A contingency plan should be available for children who are intimidated by recording devices if it would compromise their willingness to provide relevant information. Recording increases the completeness of information, preserves information that might be used as legal evidence of abuse, promotes the use of proper interview techniques, records nonverbal facets of communication, and precludes or minimizes the need for multiple interviews (Lamb et al., 2000; Saywitz, 1994). Disadvantages include intrusiveness and possible compromises to children's willingness to divulge information, logistical and technological complications, loss of data through equipment malfunctions, focus on technique at the expense of issues of relevance, and release of recordings to

inappropriate sources such as the media (Berliner, 1992). In the absence of electronic recording, detailed written documentation is needed.

*Interviewing Children.* Whether children should be asked to provide demographic data depends on their age and level of linguistic development. The degree to which narrative accounts of maltreatment or other family interactions should be sought depends on their reporting capacities (Saywitz, 1994). When children cannot credibly report data, other sources of information must be relied on. When they can provide narrative accounts, their accounts should be compared to other reports and checked for consistency (Lamb et al., 2000). Inconsistency may reflect dissimulation, but it can occur for more innocuous reasons, such as a lack of appreciation by the child for salient details and insufficient developmental readiness to report a temporally organized narrative (Saywitz, 1994). Depending on the referral question, relevant content for child interviews may include a description of the child's view of family structure and relationships, other relationships important to the child, historical information (usually relevant only for preadolescents and adolescents), the child's view of his or her treatment needs and treatment progress, and the child's comprehension of the construct of trauma and its relevance or lack thereof to his or her life. Children are unskilled at providing details related to symptoms and behaviors of trauma reactions, chiefly because of their lack of comparative experience base and vocabulary for the terms and behaviors of relevance. Even when provided with symptom checklists, they may shy away from endorsing relevant items because they do not wish to view themselves as impaired. Even the best-designed measures for children contain terms that do not fall neatly within the linguistic capabilities of children (Condie, 2003).

There is no entirely flawless method of determining a child's capacity to provide accurate reports of maltreatment. Evaluators strive to minimize influences that might result in data that lack credibility, but it is important to remember that even the highest professional standards do not require an evaluator to be a good judge of a child's truth-telling capacity (APA Committee on Professional Practice and Standards, 2011). That task is left to the fact finder, and it lies beyond the scope of current scientific research and practice. When estimates of a child's capacity to report trauma are requested, they should be based on the best available empirical data. Examples include:

- Examining the child's account of maltreatment for the development of context
- Use of idiosyncratic words or descriptive phrases
- Inclusion of peripheral or unnecessary information
- Explicit details
- Details that exceed the child's developmental level
- A progression of "grooming" for maltreatment (seduction, isolation, escalation of threats and aggression)
- Other engagement processes

- Strategies designed to discourage the child from reporting maltreatment (secrecy, threats, coercion, pressure, bribes, rewards)
- Affective responses or details congruent with the reported maltreatment
- Consistency of salient details
- A narrative clearly emanating from a child's perspective rather than a rehearsed litany
- Details of attempts to resist or avoid the maltreatment (Heiman, 1992)

There are no pathognomonic signs of maltreatment, nor is there evidence that a particular type of interview response or set of tools or measures will yield data establishing that a child has been maltreated. Referral questions that go directly to this point should be rephrased in a professional consultation and negotiation process before the evaluation proceeds (Condie, 2003). Neither maltreatment nor the identity of a perpetrator can be confirmed or disconfirmed solely by the presence or absence of psychological symptoms or patterns of behavior.

When the child's psychological functioning is part of the referral question, interview data should focus on symptoms and behaviors of relevance to diagnostic criteria for child behavior disorders and trauma reactions (George & Solomon, 1999; Heiman, 1992). Because of the difficulty children have self-reporting data of relevance, it is important to include other sources of observation and information (Condie, 2003; Heiman, 1992). Measuring the impact of child maltreatment does not involve merely rendering a diagnosis. Descriptive information is needed about the impact of trauma on a particular child, the link between maltreatment and the child's reactions (if any), and the child's existing vulnerabilities (Everson & Faller, 2012).

When the child's view of parents, other caregivers, adaptation to placement, and substitute caregivers is central to a referral question, examiners must avoid any attempts to elicit abstract descriptions of relationships. Even when children have the capacities to respond meaningfully to questions about their relationships, their responses might be influenced by loyalty bonds, recent visitation with particular caregivers, and developmental limitations in making comparisons or appreciating potential alternatives to their own experiences (George & Solomon, 1999; Stahl, 1994). Evaluators should be prepared for some inconsistencies because of children's tendency to respond to recent events or points of contact, children's concerns about threats to their stability, distress reactions, conflicted views and ambivalence, and limitations in appreciation of temporal events or the passage of time ("a long time" to a child might be 5 minutes). Sometimes eagerness to reunify with a parent is merely a reflection of a child's indiscriminate attachment behavior (George & Solomon, 1999) or a desire to reunite with school friends (Stahl, 1994).

*Psychological Measures.* As with adults, assessment measures to be used in the evaluation of children should center on (1) the referral question, (2) the relevance of global and specific indices to the question, (3) theoretically and empirically derived

hypotheses, (4) the validity of the measures in the specific assessment context, and (5) whether the data would add meaningful utility to the evaluation process (Ayoub & Kinscherff, 2006; Barnum, 1997). The developmental readiness of a child for assessment participation is an added consideration. Even when measures are designed for specific age ranges, children sometimes may not be developmentally, cognitively, or linguistically prepared for the process (Condie, 2003). Assessment measures do sometimes yield useful data on the child's capacity to report information of relevance, to benefit from relevant treatment, or to tolerate a foster placement (Everson & Faller, 2012). If adequate pretreatment data are available, it is sometimes possible to measure treatment progress using psychological assessment measures. Assessment measures can highlight these issues in a child:

- Strengths and weakness
- Approach to relationships
- Level of trust in individuals in roles of authority
- Willingness to engage in treatment
- Linguistic capacity to provide a narrative
- Mental health functioning
- Views of helping sources and friendships

Measures sometimes illustrate why a child has had a poor or failed response to a particular treatment approach, why a child might distort reports of relationships or events, or why a child might show a relative lack of resilience in the recovery process (Condie, 2003). As with the evaluation of parents, specific measures relevant to a child's view of parent-child interactions, attachments to parents, and other specific factors should be used and interpreted conservatively unless specific norms are available for the population of interest.

## CONCLUSIONS

During any phase of a child protection proceeding, a psychologist may be asked to evaluate different parties for different purposes. As evaluators, psychologists frequently are asked to address these and other issues:

- The impact of child maltreatment
- The risk that it might recur
- How seriously the child's well-being has been affected
- What therapeutic or intervention strategies would be recommended to assist the child and/or family
- Whether parents or other caregivers can be rehabilitated such that risk of maltreatment is reduced
- What the psychological effect on the child would be if the child were returned to parents or other caregivers
- What the psychological effect on the child would be if parental rights were terminated

To understand risk of maltreatment, it is important to understand research on a variety of factors contributing to risk and mediation of risk. Psychologists seek to gather information on:

- Family history
- Personality functioning
- Social and other contextual circumstances
- Developmental needs of the child
- Nature and quality of the parent–child relationship
- Reactions to trauma
- A variety of factors contributing to risk of child maltreatment

They seek to understand risk in the context of sociocultural factors, physical disability, and other extenuating factors of relevance. Evaluation methodology, data interpretation, and procedures for reaching recommendations are derived from codes of ethics, standards of practice, and relevant research literature. Multimodal assessment is the primary buffer against data misinterpretation, overinterpretation, or underinterpretation. Interpreting interview and assessment data may occur in actuarial methods or the context of the examinee’s history. Both approaches facilitate meaningful data interpretation. Risk assessment matrices should include factors identified in empirical studies of risk assessment that are relevant to samples of parents involved in the care and protection system. Analysis of child maltreatment risk should acknowledge appropriate caveats. Further research is needed to better understand the degree of concordance or possible discordance in risk studies relevant to other samples of individuals and those involving risk of child maltreatment.

Although many existing measures and methods are designed to assess the nature and quality of the parent–child relationships, parent–child attachment, and parent–child interactions, their applicability to care and protection cases depends on the availability of relevant supplementary norms. Data interpretation and recommendations made via multimethod approaches that incorporate specific parenting measures should include appropriate cautionary procedures and comments. Similarly, global measures of functioning should be used when judged to be appropriate based on the referral question and other relevant considerations related to reliability and validity of application to care and protection samples. Dissimulation is an issue that is potentially endemic to care and protection evaluations, but methods for detecting dissimulation that are specific to care and protection samples have not been developed. Evaluators should make reasonable efforts to detect dissimulation but without overreliance on measure-specific methods that have no demonstrated validity or reliability in care and protection samples. Methods for minimizing the influence of children’s suggestibility and other impediments to reliability and validity should be used when indicated. Many care and protection cases involve children with cognitive limitations, mental health issues, and other special needs. Assessment methods and procedures should be developed on a case-by-case basis.

Appropriate modifications should be made when needed. Novel procedures should not be used in forensic cases unless they reflect converging professional consensus, research, and scientifically based judgment. The breadth and depth of interview content and indications for the use of forensic assessment measures are drawn from the referral question.

Key approaches to data integration and organization of presentation include (1) providing a specific answer to referral questions (when results are inconclusive, it is best to say so directly), (2) using theory as a template to guide data integration and interpretation, (3) interpreting data in light of the examinee's history, and (4) describing the strengths and limitations of the data. Relevant risk factors should be described in terms of their static and dynamic nature. Mediators and protective factors should be included in any risk analysis. Some risk factors relevant to child maltreatment vary, depending on the type of child maltreatment. Most risk factors are nonspecific. In studies of risk factors, it is difficult to control for concurrent types of maltreatment and their influence on research results.

Recommendations for service plan interventions and modifications sometimes must take statutory provisions about availability of services into account. The statutorily defined need to provide only those services that are available poses a challenge for evaluators asked to make recommendations for optimal intervention approaches. Specific recommendations tend to be more useful than general recommendations. For example, a recommendation for a specific form of intervention for a parent with a specific set of circumstances, symptoms, or problematic behaviors is more useful than a broad recommendation for mental health treatment. Recommendations concerning parental or caregiver amenability to rehabilitation often must be given with statutory time frames for service provision in mind. Statutory time limits for successful rehabilitation pose a challenge for parents who learn at a slow pace, who have transportation or other financial limitations, or who face other challenges to rapid treatment progress. Interpretations and recommendations for children should be made in the context of their levels of developmental maturity, their capacities to benefit from recommended interventions, and any special needs they might have.

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