THE ADVISOR

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AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

FROM THE PRESIDENT

ON THE BACKLASH

With this last column I end my term as APSAC President. My own children tell me that I am not really as old as I often exclaim, so I will try to forgo the sentimental farewell of a retirement. Indeed, I look forward to being an active member of APSAC for some time, so this is anything but a good-bye! Nevertheless, I will take this last opportunity to share a few thoughts about our society and our mission.

I recently had the good fortune to spend a few days in Australia with Patty Toth, of the National Prosecutors Research Institute, and Astrid Heger, of the USC's Medical School (both newly-elected APSAC Board members). One of my most disturbing realizations while in Australia was the extent to which backlash is organizing there. Efforts to reframe child abuse as a threat to men's rights; efforts to misuse knowledge of child development by suggesting that young children cannot remember sexual abuse, hence their reports must be facetious; and many of the other symptoms of backlash here in the U.S. are spreading in Australia almost as fast as recognition of the problem of child abuse.

The backlash in the U.S. presents a number of troubling aspects.

First, it seems clear to me that part of the backlash is the direct result of poor practice, the occasional overstatement of the knowledge which supports our practice, or well-intentioned but nevertheless wrong decisions made in the course of our work. That professionals make incorrect decisions is not news; poor decisions are made all too often in every profession. I think it is clear that most professionals in this field, aware of the potentially devastating effects of a wrong decision, are scrupulous to ensure that as many of their decisions as possible are correct. Nevertheless, wrong decisions do get made.

To the extent that poor decisions result from poor practice, it seems to me that APSAC's efforts to develop a Code of Ethics and Standards of Practice are among the most important tasks we face over the coming months and years. I hope that the new Board will give these efforts high priority.

Wrong decisions sometimes are made, however, despite the greatest care. When we make mistakes, we would do well to attend more closely to those who are harmed as a result. First, we might help them see that their vindication is a triumph of the American system, and rejoice with them in its fair operation. Second, to prevent their attacks on the system that effectively protects children and vindicates the innocent, we need to do more to recruit them to our point of view. By more vigorously pursuing a dialogue with those who have been suspected but determined not to have abused a child, we may not only begin to stem the backlash, we may gain some valuable insights from their views of how the system operates.

Finally, I fear that we have not taken the backlash seriously enough. Many of us have assumed that knowledge and right will prevail. But increasing tenacity, slick organization, and the appeal to those who would prefer to believe that children are not abused makes the backlash a far greater threat than I heretofore imagined. Very well-financed, they have launched what often has the tone of a holy war to misrepresent and distort in the effort to exculpate adults accused of abusing children.

Clearly, those who direct their efforts to helping alleged perpetrators are not our enemies. Many of our colleagues participate in these efforts, which are necessary for a system that effectively protects children. Our enemies are those who distort or lie for personal gain or to protect those who are guilty.

"The price of freedom is constant vigilance." Efforts to educate the public about child abuse and to control the false

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Opinions expressed do not reflect APSAC's official position unless otherwise stated.

FROM THE EDITOR

THE ADVISOR -- *A FORUM FOR SHARING*

One of the most significant challenges facing our interdisciplinary field is to facilitate the rapid dissemination of new information, discussion, and individual perspectives among the many different professionals engaged in preventing, identifying, and coping with child abuse and neglect.

You can help APSAC's *Advisor* serve this important function. As its editor, I urge you to send in new research findings, interesting case reports, questions and viewpoints for possible publication in future issues.

To the left is a list of our outstanding colleagues who have agreed to serve as Associate Editors for *The Advisor*. To submit an item for publication, determine which Associate Editor would most appropriately review it, and send one copy to that Editor, one copy to me, and one copy to the Manuscript Editor, Theresa Reid, at APSAC's Chicago offices.

If you wish to share an idea, an opinion, a conference date, or a question, with other APSAC members, ***please*** feel free to submit it to *The Advisor*. Together, we will produce a newsletter that helps all of us in our work on the problems of child abuse and neglect.

--Dave Corwin, MD, Editor

NEWS

WHAT'S HAPPENING

--by Dan Sexton

* Two public hearings on ritualistic/satanic abuse were well-received by both the lay and professional communities. Held in northern California in December and in Southern California in January, the hearings were sponsored by the Committee on Child Abuse Prevention, State Social Services Advisory Board, and the California Consortium of Child Abuse Councils.

* The Canadian Children's Foundation, a non-profit organization based in Toronto, plans a national hotline for children and parents. For information call Heather Sproule, 416-920-5437.

* A Child Protection Handbook has been developed by the National Association of Councils for Children, headed by Don Bross at the Kempe Center in Denver. For more information, call 303-321-3963.

* Illusion Theatre, which has done very strong work on child abuse prevention through live plays and videotapes, has come up with another powerful vehicle for the field. Their newest training is on the issues around sexual assault and AIDS. For information, call 612-339-4944.

* David Summers, an attorney from Washington state, won one of the largest known civil awards for an adult survivor of sexual abuse: $778,000. The litigant began her suit at 20, after watching a TV program on abuse. Confronted and offered no prosecution in exchange for a full confession, her father opted for confession. Because strong evidence implicated the mother as well, the jury awarded the judgment against both parents. The award is currently under appeal.

NEWS

FIFTH NATIONAL SYMPOSIUM ON CHILD SEXUAL ABUSE

--by Susan Kelley

The Fifth National Symposium on Child Sexual Abuse, held March 1-3, 1989, in Huntsville, Alabama, attracted over 800 participants. The symposium was sponsored by the National Children's Advocacy Center and co-sponsored by APSAC and the U.S. Department of Justice.

The Symposium offered something for everyone, regardless of discipline or level of expertise, with a combination of panel discussions, workshops, research presentations, and advanced level training. Topics covered included the treatment of child sexual abuse victims and offenders, children as witnesses, medical evaluation and treatment of victims, ethical issues related to use of expert witnesses, issues related to AIDS, and grantspersonship. Two research breakfasts, one featuring Ann Burgess and Susan Kelley, the other featuring David Finkelhor, attracted large numbers of early risers eager to learn about current research findings and trends.

Prominent luncheon speakers were featured each day. In a moving speech, Pat Conroy, author of *Prince of Tides* and *The Great Santini* shared the personal insight gleaned from painful family experience with child abuse. Judge Charles Schudson, an outstanding advocate of children's rights in the courtroom, provided an overview of the current legal rights of sexually abused children. Andrew Vachss, an attorney practicing in New York city, recounted some of his vast legal experience in the field of sexual abuse.

Participants in the symposium found Southern hospitality at its best while in Huntsville. Social functions included an evening at NASA's Alabama Space and Rocket Center for a movie, tour, and dinner and an evening of live music at the historic Depot.

On Saturday, March 4, the National Children's Advocacy Center sponsored three highly productive "think tank" sessions: Allegations of child sexual abuse in custody hearings; Child protective services: A system in crisis; and Judicial response to child sexual abuse.

APSAC Activities

APSAC-sponsored activities were highly visible at the symposium. Numerous workshops were sponsored by APSAC, featuring prominent experts and members such as Ken Lanning, Lucy Berliner, Ann Burgess, David Corwin, David Chadwick, Jon Conte, Joyce Thomas, Kee MacFarlane, and Roland Summit.

The first Annual meeting of APSAC was held on March 3, 1989, with over 75 APSAC members and interested parties in attendance. President Jon Conte reported on APSAC's impressive progress over its first three years. Current membership stands at around 790, with approximately 25 new members joining each month. Dr. Conte stressed that, good as these numbers are, all members need to recruit vigorously among their colleagues in order to keep APSAC strong and growing.

Chairpersons of APSAC Task Forces presented reports. Lucy Berliner, Chair of Evaluation of Suspected Sexual Abuse in Young Children, reported that a survey will be sent to expert clinicians. The purpose of the survey is to obtain information necessary to develop guidelines for mental health professionals engaged in interviewing children under 7 years of age who are suspected of having been sexually abused. Reporting for the Task Force on Assessment and Treatment of Perpetrators of Child Sexual Abuse, Tim Baker revealed plans to conduct a national survey to establish minimum criteria for evaluating and treating offenders.

APSAC members were invited to present in open forum their suggestions for the future direction of APSAC. Members suggested a variety of ways in which the organization could be useful: by providing legal advice, technical assistance, and peer consultation.

The New APSAC Board

Results of the recent Board of Directors election were announced in Huntsville. The following nine Board members, just elected by the membership, began their terms on March 1: **Linda Blick**, LCSW, MSW, Executive Director, The Chesapeake Institute, Wheaton, MD; **Barbara Bonner**, Ph.D., The University of Oklahoma, Department of Psychiatry and Behavioral Science, Oklahoma City, OK; **John Briere**, Ph.D., USC School of Medicine, Dept. of Psychiatry (Psychology), Los Angeles, CA; **Richard Cage**, Montgomery County Police Department, Wheaton, MD; **Astrid Heger**, M.D., USC School of Medicine, Dept. of Pediatrics, Los Angeles, CA; **Mireille Kanda**, M.D., Director of the Division of Child Protection, Children's Hospital National Medical Center, Washington, DC; **Susan Kelley**, RN, Ph.D., Boston College School of Nursing, Chestnut Hill, MA; **David Lloyd**, JD, Project Director for the National Resource Center on Child Sexual Abuse, The Chesapeake Institute, Wheaton, MD; and **Patricia Toth**, JD, National Center for the Prosecution of Child Abuse, Alexandria, VA.

The following Board members recently completed their terms, and are thanked for their important contributions to

continued on next page

MEDICAL PRACTICE

ATLAS OF PHYSICAL FINDINGS AND CHILD SEXUAL ABUSE

--reviewed by Martin A. Finkel

David Chadwick, MD, Carol Berkowitz, MD, and co-authors make a significant contribution to the field with the upcoming *Atlas of Physical Findings and Child Sexual Abuse*. As all professionals in the field know, validation of an allegation of sexual abuse can be quite difficult. Since the failure to recognize either the medical history or current medical findings which confirm or deny a suspicion of sexual abuse may have dire consequences, all medical professionals must increase the precision with which they complete a forensic medical examination when a child is alleged to have been sexually abused. But to date, the medical literature has offered little to help physicians hone their physical examination skills referrable to the context of sexual abuse.

Chadwick *et al*'s publication promises to fill this need. The *Atlas* is a reference work that includes sections on normal anatomy, pathology from nonsexual events, injuries from sexual abuse, and sexually transmitted disease. It contains 100 photographs of the genital and anal areas of children of various ages. Captions provide the consensus opinion of the authors regarding the import of the photographic evidence.

During the last ten years, the number of children having careful and thorough genital-anal examinations for any reason increased from a handful to thousands each year. Those physicians who wanted to learn more about abnormal findings in cases of sexual abuse have been frustrated by textbook descriptions of children's genitalia which were inadequately detailed and often inaccurate.

The current authors, and others who have tried, have found quite difficult their attempts to ascertain the significance of small variations and of various types of scars and other signs of injuries to the genitalia and anus. This difficulty is in part due to the need for retrospective interpretation of anatomical changes without knowledge of the premorbid state. Finding it nearly impossible to convey in words the highly visual information they were accumulating, the authors eventually decided that the use of pictures was necessary.

This *Atlas* was begun in 1986 with the financial assistance of the California Medical Association and the Stuart Foundation of Palo Alto. The authors met repeatedly to discuss case photographs and reach a consensus interpretation of the significance of the findings illustrated. The authors realize that the *Atlas* does not illustrate all the traumata that clinicians may encounter, but they do expect that it will provide more guidance in diagnosis than is currently available.

I encourage all clinicians who examine children to include the genital and anal examination as part of their routine health maintenance assessment. Only through experience examining normal genital and anal areas will the physician become comfortable identifying the acute or chronic effects of trauma and deciding what conclusions and options are reasonable. Sensitivity, skill, experience, and this excellent reference will greatly enhance the possibility of accurate diagnosis.

Atlas authors are Drs. David Chadwick, Carol Berkowitz, David Kerns, John McMann, Michael Reinhart, and Sylvia Strickland. Anticipated publication date is April, 1989, from Year Book Medical Publishers, 200 N. LaSalle, Chicago, 60601. To order, call toll-free during business hours 1-800-622-5410. In Illinois, call collect 312-726-9746.

Martin A. Finkel, D.O., is professor of Pediatrics at the University of Medicine and Dentistry of New Jersey, and The Advisor's *Associate Editor for Medicine.*

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APSAC: Tom Birch, Don Bross, Fern Ferguson, James Garbarino, Gail Goodman, Ken Lanning, Helen Rodriguez Triez, and Toby Tyler.

In the near future, the Board of Directors will elect ten Board members to serve as the Executive Committee. The Executive Committee will then elect its own officers. Results of this internal Board election will be reported in the next issue of *The Advisor*.

The Fifth National Symposium on Child Sexual Abuse was an enriching professional experience. Congratulations are in order for dedicated staff of the National Children's Advocacy Center for an exceptional conference, with special recognition going to Bud Cramer, President, and Marilyn Grundy, Conference Coordinator, for their fine efforts in bringing together such a large, diverse, and dedicated group of professionals in the field of child sexual abuse.

Susan Kelley, RN, Ph.D., is Assistant Professor in the School of Nursing, Boston College, and a newly-elected member of APSAC's Board.

LEGAL NOTES

THE SHIFTING BOUNDARIES OF MEDICAL NEGLECT

--by John E.B. Myers

Eric, who is one year old, was born with hydrocephalus (water on the brain). Pressure is gradually building inside Eric's skull, which will likely cause mental retardation and cranial deformity. Doctors propose an operation to relieve the pressure and reduce the risk of permanent damage. But Eric's parents refuse to permit the operation because their religion prohibits such treatment. Can the juvenile court authorize the operation over the parents' objection?

Parents have primary responsibility for the care and protection of their children, including decisions about medical care. In *Prince v. Massachusetts* (321 US 158, 166 [1944]), the U.S. Supreme Court wrote, "It is cardinal with us that the custody, care, and nurture of the child reside first in the parents." But parental authority is not absolute: in *Wisconsin v. Yoder* (406 US 205, 233-34 [1972]), the Court specified that the limits of parental authority are reached "if it appears that parental decisions will jeopardize the health or safety of the child."

Although the Supreme Court has made clear that the right of parents to make decisions for their children is fundamental, a long line of authority holds that, under certain circumstances, parental refusal to permit medical care constitutes neglect (see R. Horowitz and H. Davidson, *Legal Rights of Children* §7.08 [1984]). For balanced against the adult's parental and religious beliefs is the state's inherent *parens patriae* authority to protect children (*Custody of a Minor*, 379 NE2d 1053 [Mass. 1978]).

In deciding whether to override parental objection to medical care, courts balance competing rights and interests in light of the unique facts of each case. When a parent's refusal is predicated on genuinely-held religious beliefs in addition to parental authority, the argument against state intervention is particularly strong (*Yoder*, 406 US at 233). But, while religious belief is beyond government control, harmful acts that flow from religious belief are not. One of the clearest statements of this position is in *In re Appeal of Cochise County Juvenile Action* (650 P.2d 459, [Ariz. 1982]): "If there is a direct collision of a child's right to good health and a parent's religious beliefs, the parent's rights must give way."

A unified and accepted theory of children's rights has yet to emerge. The scope and definition of children's rights is particularly problematic when the interests of children and parents collide. (See Wald, *Children's Rights:A Framework for Analysis*, 12 U. Cal. Davis L.Rev. 255 [1979]). There is general agreement, however, that children have a right to freedom from abuse and neglect, including unnecessary harm, suffering, and death.

Most courts divide medical care cases into two categories: Those in which the child is likely to die unless care is provided, and those in which the child's life is not at risk.

In life-threatening cases courts consider (1) the likelihood that the child will die without treatment; (2) the probability of successful treatment; (3) the risk involved in the treatment; (4) the side effects of treatment; (5) the efficacy of alternative modes of treatment favored by parents; (6) the child's wishes, and (7) the best interest of the child.

When a child's life hangs in the balance, and the proposed treatment carries acceptable risk and a significant likelihood of success, courts usually override parental objections to medical care.

When a child's life is not in danger, judicial decisions are anything but uniform. Although some authorities argue that state intervention should never be permitted in non-life-threatening cases (J.Goldstein, A.Freud, and A.Solnit, *Before the Best Interests of the Child* 194 [1979]), most if not all courts permit court-ordered medical care in some non-life-threatening cases.

A core of basic principles underlies decision-making when a child's life is not in immediate peril. The most important factor is the degree of harm the child will suffer without court-ordered medical care. The greater the harm, the more likely the court is to intervene. Also important are the risks involved in the proposed treatment and the likelihood of success. As the degree of risk inherent in treatment increases or the likelihood of successful outcome decreases, judges bow more frequently to parental judgment.

In Eric's case, should the court override the parents' objection and permit the operation in order to spare Eric mental retardation and deformity? In a simlar case, the Oregon Court of Appeal said yes (*Matter of Jensen*, 633 P.2d 1302 [Or.Ct. App. 1981]). Other courts, on other precedents, might very well say no.

John E.B. Myers, JD, is Associate Professor of Law at University of the Pacific and is The Advisor's *Associate Editor for Legal Affairs.*

RESEARCH

IMPACT OF LEGAL INTERVENTION ON SEXUALLY ABUSED CHILDREN

--by Desmond Runyan, Mark Everson, Gail Edelsohn, Wanda Hunter, and Martha Coulter

This prospective cohort study was designed to assess the impact of the intervention process on the child victim of sexual abuse.

Eleven county social service departments in North Carolina referred intrafamilial sexual abuse victims for study. Children were eligible if they were 6 to 17 years old and had been confirmed as abuse victims by the local CPS unit.

The children were evaluated first within a few weeks after disclosure, and again about five months later. The same battery of instruments was administered at both interviews. The children were administered the Child Assessment Schedule (CAS), a psychiatric screening evaluation, and the PPVT-R, a test of receptive vocabulary as an estimate of verbal IQ. The non-perpetrating parent completed the Child Behavior Checklist (CBCL-P) during the child's interview. At the five-month follow-up we administered as well a questionnaire about criminal justice and social service interventions the child had experienced in the interim.

The analysis focused on identifying changes in the initial to 5-month CAS and CBCL-P scores that might have been associated with court proceedings and foster placement.

Results

Sample. One hundred eligible subjects were recruited into the study. Complete follow-up evaluations were completed on 75.

The final sample was 82% female and 66% white, with a mean age of 11.9 years. The perpetrator was the biologic father for 31%, a stepfather for 43%, and the mother's boyfriend for 15% of the children. In one case the mother was the sole perpetrator, and in three other cases the mother was an active partner along with another person.

At the time of the first examination, the CAS mean total score, or "global pathology" score, was 44. This score is almost identical to that of child psychiatric inpatients. The mean CBCL initial behavior problem score was 66.6, with the range extending from 40 to 89.

Teacher behavior ratings were obtained at the time of the initial examination for 43 of the children; the mean t-score by teacher rating was 63.6. According to published norms, children with t-scores above 67 on either parent or teacher form should be referred for clinical evaluation.

Interventions experienced. Fifty children (63%) were removed from the abusing home as a result of the reported abuse. Ten children had been returned home at the time of the five-month examination. Thirty-four children (45%) had juvenile court hearings by five months after the report. Twelve children (15%) were asked to testify in juvenile court.

By the time of the follow-up examination, 44 victims were involved with the criminal justice system. In 22 cases, adjudication was complete: 17 perpetrators entered guilty pleas, four trials resulted in guilty verdicts, and one trial resulted in acquittal. Twenty-two cases were still pending criminal trial.

Impact of interventions. No clear pattern of changes emerged at the time of the five-month interview that could be related to foster care placement. Neither changes in the total CAS score nor the subscale scores suggested that foster care was either harmful or beneficial.

No differences were observed between children who had juvenile court hearings and those who did not. However, we found that the children who *testified* in juvenile court resolved their anxiety (as measured by a CAS subscale) more rapidly than their peers who did not have juvenile testimony experience.

We were not able to examine the effects of criminal court testimony because only five trials had taken place by the time of the follow-up. Several children were still anticipating involvement in a criminal trial. Categorical analysis, controlling for potential confounders, revealed that these children were only 8% as likely to improve on the CAS Depression subscale as were children not involved in the court process (p = 0.013).

Discussion

Our subjects' scores on both the CAS and CBCL indicate significant psychological distress. Indeed, the scores indicate greater distress than has been reported previously. The most encouraging aspect of these data was the overall improvement in the cohort between the first and second interviews. This difference indicates both that the CAS was sensitive enough to pick up changes, and that some resolution of acute distress occurred even in the short run.

Our data indicate that the child is adversely affected by lengthy delays in the resolution of criminal prosecution of CSA. This finding appears to be robust, persisting after control for potential confounders. Protracted involvement with the criminal justice system, especially when a trial is pending, may increase feelings of powerlessness and subject the child to stigmatization by family, public, and self. The reduced improvement may represent either a delay in the resolution of the adverse effects or an actual exacerbation by this intervention process.

In contrast, our hypothesis that a child's testimony would

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RESEARCH

PSYCHOBIOLOGICAL EFFECTS OF CHILD SEXUAL ABUSE

--by Penelope K. Trickett and Frank W. Putnam

NIMH and the Chesapeake Institute are cosponsoring the first controlled, longitudinal study of the psychobiological effects of child sexual abuse on female development. The current research focuses on the physical, social, and emotional development of sexually abused girls between the ages of 6 and 15, with an emphasis on how puberty may mediate the effects of the abuse.

The sample consists of girls who have been sexually abused by a family member. A non-abusing parent or guardian also participates in the study. These families are being recruited from a number of protective service and mental health treatment agencies in the greater Washington metropolitan area. A comparison group will consist of families matched on the basis of the child's age and race, single- or two-parent family status, and family social class.

The cross-sequential research design combines cross-sectional and longitudinal components and assesses both immediate and long-term impact of the abuse. Participants are being recruited to provide approximately 25 girls in each of five age ranges (6-7, 8-9, 10-11, 12-13, and 14-15). Approximately 25% of the sample has been seen to date; recruiting the whole sample is expected to take until 1990.

Except for the oldest group, participants will be followed for two years, tested at yearly intervals.

The study's multi-method approach includes standard psychological tests of social, emotional, and cognitive development; psychiatric screening; staging of pubertal development; measurement of blood hormone levels; assessment of school functioning; and structured observation of the child and of child/adult interaction. The participating parent or guardian provides information on family demographics and on the psychological environment of the home. All information is obtained in two testing sessions lasting a total of five or six hours. Each participant is paid on an hourly basis.

Table 1: Cross-sequential design time line

Year 1: Initial Evaluation	6-7	8-9	10-11	12-13	14-15
Year 2: First Year Follow-Up	7-8	9-10	11-12	13-14	
Year 3: Second Year Follow-Up	8-9	10-11	12-13	14-15	

Three major hypotheses are being examined:

The first is that psychological puberty (the child's response to her developing sex characteristics and libido and to others'responses to these physical changes) will produce significantly more stress and disruption in coping for sexually abused females than for comparison group children.

The second hypothesis is that the highly sexualized and aggressive behavior commonly reported in sexually abused children are associated with elevated levels of adrenal androgenic hormone, which may also contribute to early onset of puberty.

The third major hypothesis is that sexually abused girls preserve normal childhood dissociative capacities which usually decline markedly in adolescence.

This study should provide important initial responses to such questions as (1) What factors (e.g., age of child, type of abuse, family characteristics) are associated with increased mental health problems and vulnerability to reabuse among female victims? (2) When are these problems short-term, and what is their developmental course? and (3) Is child sexual abuse associated with atypical hormonal and/or pubertal development in females and, if so, under what circumstances? Such information will be important for victims and their families as well as for all professionals who deal on a daily basis the the complicated issues associated with child sexual abuse.

Financial support for this research comes from the W.T.Grant Foundation and the Intramural Research Program of the National Institute of Mental Health. More information about the project can be obtained from either of the Principal Investigators at Chesapeake Institute, 11141 Georgia Av., #310, Wheaton MD 20902.

Frank W. Putnam, MD, and Penelope K. Trickett, Ph.D., are respectively Director and Co-Director of Research at The Chesapeake Institute.

Impact of Legal Intervention, continued from p. 6

result in greater harm to the child was refuted, at least for juvenile court testimony. This finding is consistent with Finkelhor and Browne's suggestion that the opportunity to testify in court may counter the sense of powerlessness that is a concomitant of child sexual victimization.

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LEGAL

PRESERVING VERBAL EVIDENCE OF CHILD ABUSE: A CRITICAL RESPONSIBILITY

--by John E.B. Myers

Professionals are increasingly sophisticated in their ability to detect and treat child sexual abuse. Yet one important aspect of the professional response to abuse is frequently overlooked in practice and in the literature: the critical importance of eliciting and documenting statements from children in such a way that the statements will be admissible in evidence in subsequent legal proceedings. The purpose of this article is to acquaint professionals with the vital role they play in eliciting and preserving *verbal* evidence of maltreatment.

Child sexual abuse is often exceedingly difficult to prove in court. Physical evidence may be lacking or equivocal. Because the victim is usually the only eyewitness, the prosecutor's ability to prove abuse and establish the identity of the offender may turn on the child's ability to testify. There is no minimum age below which children are automatically disqualified from testifying, and children as young as three and four sometimes take the witness stand. Unfortunately, however, many preschool children are unable to testify effectively or at all. While nearly all school-age children possess the psychological capacity to testify, some are intimidated into silence, some recant, and others are poor witnesses. The inability of so many children to testify undermines our ability to protect them through the legal system.

When a child's inability to testify is coupled with a lack of physical evidence, attention turns to alternative sources of proof. In particular, a child's description of abuse to a professional takes on extraordinary significance. A child who cannot testify at trial may nevertheless have provided a professional with a detailed and compelling account of abuse. The state's ability to protect a child may turn on whether the child's statement to a professional can be considered in court.

Rules of Hearsay

A child's statement to a professional is hearsay if the statement is offered in court to prove abuse. Hearsay is generally excluded from evidence because it is often less reliable than other forms of evidence. Some hearsay statements are more reliable than others, however, and the law has long recognized exceptions to the rule excluding hearsay. If a particular hearsay statement meets the requirements of a hearsay exception, the statement is considered sufficiently reliable to gain admission in evidence.

The rules governing hearsay are among the most complex in the law. Many lawyers have but a tenuous grasp of the subject. If attorneys have difficulty understanding the hearsay rule, how can clinicians be expected to master it? Fortunately, understanding the nuances of hearsay is not necessasry to deal effectively with its implications for clinical practice.

Basically, a statement is hearsay if it is made before the trial begins, and is later offered at the trial to prove what the statement describes.

Consider this example: During a play therapy session, five-year-old Sally describes sexual abuse. Two months later, the prosecutor calls the therapist to testify as a witness during the trial of the alleged offender. After the therapist is sworn in, the prosecutor asks the therapist to repeat what Sally said, but before the therapist can answer, the defense lawyer objects, arguing that Sally's statement is hearsay. Is the defense attorney correct?

Yes.

Sally's statement was made before the trial began, and her statement is being offered by the prosecutor to prove what the statement described, that is, that Sally was sexually abused.

The scenario in Sally's case is very common: a child's statement to a therapist is often hearsay. Unless the prosecutor can persuade the judge that Sally's hearsay statement falls within an exception to the rule against hearsay, the therapist will not be permitted to repeat Sally's statement for the jury. If therapists understand the need to watch for and document factors governing admissibility of hearsay, they will be able to preserve information the prosecutor can use to convince the judge that a child's statement fits within an exception to the hearsay rule.

The hearsay exception most frequently used in relation to statements by abused children is called the "excited utterance exception." This exception authorizes admission of hearsay statements made while a child is under the stress and excitement of a traumatic event. Excited utterances are considered sufficiently reliable to be admitted in evidence.

Another important exception existing in many states authorizes admission of hearsay statements made for purposes of receiving treatment or diagnostic services. Such statements are considered reliable because patients have an incentive to be truthful and accurate with professionals providing diagnostic and therapeutic services. For example, a child's description of sexual abuse probably fits within this exception if the statement is

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made to a physician performing a vaginal examination. Similarly, a child's description of abuse to a treating psychotherapist may be admissible.

Beginning in 1982, legislatures in a rapidly growing number of states created special hearsay exceptions for statements of child victims. Under such child hearsay exceptions, *any reliable* hearsay is admissible.

The judge must determine whether a child's statement is hearsay and, if so, whether the statement fits within an exception. In reaching these difficult decisions, the judge considers an array of factors relating to the reliability of the statement. Professionals are in a unique position to increase the likelihood that a child's hearsay statement is admitted in evidence by carefully observing and documenting these factors.

"Excited Utterance"

The following factors are considered in determining whether a statement is an excited utterance:

1. Whether the abuse induced a state of stress, excitement, or trauma in the child.
2. Whether the statement was made while the child remained under the stress and excitement induced by the abuse.
3. Whether the statement was spontaneous, or whether the child thought about or reflected upon the statement before making it.
4. Whether a period of calm or sleep intervened between the traumatic event and the child's statement.
5. The *exact* amount of time that elapsed between the abuse and the child's statement.
6. Whether the child made the statement at the first safe opportunity. For examaple, did the child describe abuse shortly after leaving the custody of the abuser?
7. Whether the statement was made in response to questioning by adults. The fact that a child's statement is in response to questioning does not necessarily defeat the admissibility of the statement as an excited utterance. The type of questioning is important, however. General, nonleading questions like "What happened?" are proper. If the interviewer asks many leading questions, or "drags" the answer out of the child, then the child's statement may not be an excited utterance.
8. Whether the professional was the first person the child told. If not, whom else did the child tell, and when?
9. The child's emotional condition when the statement was made. For example, was the child upset, crying, afraid?
10. The manner in which a child makes a statement may indicate excitement, e.g., by speaking hurriedly or as if under pressure.
11. The child's physical condition is important. For example, was the child injured or in pain?

The professional should look for these and any other factors that indicate excitement, stress, or trauma at the time the statement is made. Immediately following a child's statement, it is vitally important to prepare a written record of precisely what the professional observed. It is a mistake to think that months later, when you are called to testify, you will be able to rely on memory to reconstruct the precise circumstances surrounding the child's statement--*and precise detail is essential.* It cannot be emphasized too strongly that paraphrasing is unacceptable: The clinician must document *the child's exact words* and *the exact wording of any questions directed to the child.*

General Reliability

As mentioned earlier, the increasingly widespread child hearsay exceptions are designed to admit any reliable hearsay. The child need not be excited or traumatized at the time of the statement. When considering the admissibility of a statement under a child hearsay exception, the judge is concerned primarily with the statement's reliability. In assessing reliability, the judge considers many factors, including several of those discussed under the excited utterance exception. In addition, the judge considers:

1. Whether the child's description of abuse remained consistent over time.
2. Whether the statement reveals age-inappropriate sexual knowledge or awareness.
3. Whether the child uses age-appropriate terminology, and whether the statement is made from a child's perspective
4. Whether the child has a motive to fabricate.
5. Whether there is evidence that the child was coached or subjected to other improper influence.

The professional should observe and document any factors related to the spontaneity and reliability of a child's statement. Again, a record of the child's exact words, and the exact wording of any questions, is critical.

When a judge considers the admissibility of a child's hearsay statement under the treatment or diagnosis exception, the judge considers:

1. Whether the professional was responsible for diagnosis alone, or provided treatment as well.
2. Whether the child understood the professional's role as diagnostician or therapist. If the child does not understand the professional's diagnostic or therapeutic role, the child may not understand the need to be especially accurate and truthful with the clinician. Thus, the special indicia of reliability pertaining to statements for diagnosis or treatment may be lacking.

To increase the probability that a child's statement will be admitted under the diagnosis or treatment exception, the professional should determine and document whether the child understands the need to be accurate with the professional.

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LEGAL UPDATE

SUPREME COURT DECIDES MAJOR CHILD PROTECTION CASE

--by John E.B. Myers

"I just knew the phone would ring some day and Joshua would be dead." So said the CPS case worker assigned to protect four-year-old Joshua DeShaney. When the phone finally rang, Joshua was not dead, but he was permanently brain damaged as a result of a beating by his father. Joshua's father, who had custody of the child following a divorce from Joshua's mother, had abused Joshua for several years. CPS knew of Joshua's danger for more than two years prior to the final beating. Joshua is now profoundly retarded, and will probably spend the rest of his life in an institution.

Following Joshua's tragic injury, his mother sued the department of social services and the CPS professionals involved in Joshua's case. The lawsuit charged that the professionals' failure to protect Joshua at a time when they knew he was in danger deprived him of his liberty in violation of the due process clause of the U.S. Constitution. The Constitution provides that "No State shall . . . deprive any person of life, liberty, or property, without due process of law."

Joshua's case went all the way to the U.S. Supreme Court, and on February 22, 1989, the high court ruled against Joshua (*DeShaney v. Winnebago County Social Services Department*, 109 S. Ct. 998 [1989]).

The Supreme Court ruled that the due process clause does not impose a general obligation on states to protect children from private violence such as abuse inflicted by parents. The court reasoned that because the state had no due process obligation to protect Joshua, the state and its employees could not be liable when they failed to protect him.

Joshua's attorneys sought to persuade the Supreme Court that even if the due process clause imposes no general duty on the state to protect children from private acts of violence, such a duty does arise when a "special relationship" exists between the state and a particular child. CPS knew that Joshua was an abused child, and assigned a case worker for the specific purpose of monitoring Joshua's welfare. Having actually undertaken to protect Joshua, the state acquired a duty to do so in a competent fashion. Thus, the failure to act competently violated Joshua's due process rights.

Joshua's attorneys pointed to earlier Supreme Court cases in which the Court ruled that the state does have a due process obligation to protect persons in state custody, such as prisoners and committed mental patients. Joshua's attorneys argued that the relationship between Joshua and the state was sufficiently similar to the state's relationship to prisoners and mental patients to give Joshua a due process right to protection.

The Supreme Court rejected this argument. The Court ruled that prisoners and mental patients are entitled to state protection because the state has deprived them of their liberty against their will. By contrast, Joshua was not in state custody when his father beat him. Furthermore, the state played no part in creating Joshua's danger. Under such circumstances, the state had no due process duty to protect Joshua.

The *DeShaney* case is a disappointment to most child advocates. As a result of *DeShaney*, children living in the community do not have a constitutional due process right to protection from private violence. When children are injured by private persons such as parents, the children will not be able to bring suit under the due process clause against CPS or state employees who fail to protect them, regardless of how negligent the failure may be.

It is ironic that if the state takes a child into its custody, it may have a due process obligation to protect the child, but if the state does nothing, and stands by while a child is injured or killed, the due process clause is not offended.

It is important to note that the Supreme Court did not decide whether a child in foster care has a due process right to state protection from abuse. The Court wrote that foster care may be sufficiently analogous to incarceration or institutionalization to give rise to an affirmative duty to protect foster children.

It should also be observed that *DeShaney* does *not* mean CPS agencies and individual professionals are immune from liability if they fail to protect children like Joshua. The Supreme Court wrote that "It may well be that, by voluntarily undertaking to protect Joshua against a danger it concededly played no part in creating, the State acquired a duty under state tort law to provide him with adequate protection against that danger." Thus, even though Joshua did not have a right to sue under the due process clause of the U.S. Constitution, he and other abused children may be able to sue under the tort law of individual states.

Another ray of hope: despite the setback in *DeShaney*, children like Joshua may still be able to sue under the equal protection clause of the U.S. Constitution.

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CHILD CUSTODY ISSUES IN CASES OF SUSPECTED CHILD SEXUAL ABUSE

--*by Linda Canfield Blick*

Child custody cases involving allegations of child sexual abuse are extremely complex. The animosity between opposing spouses and the weighty decisions at issue concerning parent/child relationships make these disputes innately difficult. Especially when sexual abuse disclosures are not properly investigated, these cases can become protracted and the difficulties compounded over time. Multiple appeals and multiple hearings can make the emotional life of the disputed child a nightmare.

Among the most difficult decisions faced by the judge in these cases is whether to grant the accused parent's request for visitation rights. Denying these rights seems clearly to violate the assumption that a defendant is innocent until proven guilty. Denying alleged victims access to one of their parents may cause further emotional harm as well. But granting suspects access to the children they have allegedly abused is to risk exposing the children to further physical and/or emotional trauma.

Control was taken away from the child during the victimization experience. Safe, supervised visits in which the parent/child interaction is positive and nonsexual can provide corrective emotional experience: such visits can help children create realistic versions of their parents as people who fall somewhere between saviours and monsters, and they can help children learn that they can control their bodies and their decisions about whether or not to show affection.

When visits are prematurely forced or are physically or emotionally unprotective, however, the results can be disastrous. Risks include reabuse, reinforcement of children's feelings of physical and emotional vulnerability, and confirmation of children's suspicion of adults. Ill-planned visits can force children to compartmentalize their emotions, leading to dissociation that can make the child more vulnerable to reabuse. Having to anesthetize their feelings during visits, children may generalize this defense to other, non-threatening situations.

Which of these two potential evils should the judge choose for the child?

Clinicians can help judges and themselves resolve this profound dilemma by recommending a compromise designed to meet as nearly as possible the child's emotional needs: creatively structured, supervised visits.

Creative Visitation Plans

Each situation must be assessed on an individual basis: specifics of each plan should be determined by the specifics of each situation. But general guidelines can provide a starting point and safety net for individualized plans.

In each case, three steps are crucial: ensuring the child's willingness to see the alleged abuser, evaluating the alleged abuser's readiness to see the child, and structuring the context in which visits take place.

Evaluating the child. Visitation during the initial period from the time of disclosure until the end of the evaluation should always be carefully structured and monitored, if indeed it is allowed at all. The Chesapeake Institute withholds visits with the alleged offender during the investigation and evaluation stages.

This respite allows children unpressured, unconflicted time to recall the extent and specific details of the alleged abuse, to express their feelings--both positive and negative--about the alleged abuser, to discuss existing behavior problems and issues such as self esteem, and to explore their own readiness to reestablish visitation.

Children should always be asked by the therapist during this evaluation period if they want visits. But children's verbal responses must be considered along with behavioral symptoms. If children do not want visits, their decision must hold. If children say they want visits but exhibit negative behavior, the appropriateness of visits requires careful consideration.

As part of this assessment, the supervisor must obtain frequent reports from the child's therapist, non-abusive caretaker, and outside observers such as day care providers or kindergarten teachers. Presumably, the supervisor has at hand a chronological record of behavior problems before and immediately after disclosure of the abuse. Now, reports from other professionals should pay close attention to behavioral symptoms, both positive and negative, noted while the child is contemplating the possibility of visitation.

Evaluating the abuser. Evaluating the abuser's readiness for visits is crucial also. If the complaint is substantiated, the offender's therapist should assess the offender's ability to take responsibility for his/her abusive behavior, the offender's perception of the seriousness of the sexual abuse, the use of violence (overt or covert), and the strengths and weaknesses in the offender/child relationship.

If, after careful assessment, therapists for the offender and for the child think that visits

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Questioning

When professionals examine or treat a child for suspected child abuse, they must ask questions about the suspected abuse. A child's statement that fits perfectly within an exception to the hearsay rule, and which may be the strongest or even the only legal evidence of abuse, will be excluded from evidence if it is elicited through improper questioning.

The best approach to questioning is to let the child tell the story in his or her own words. Start with questions such as, "Did anything happen?" "Tell me what happened." "Did anything else happen?" If more specific and directed questioning becomes necessary, avoid leading and highly suggestive questions. A question is leading if it both asks a question and suggests an answer. Examples of leading questions include, "Your brother hurt you, didn't he?" and "I guess it hurt when the man put his peepee inside you, didn't it?" *As a general rule, if it contains a significant amount of detail about abuse, and can be answered with a simple yes or no, the question may be leading.*

While professionals must be aware of the legal implications of leading and suggestive questions, they should not become so hesitant to question children that they lose effectiveness as interviewers or therapists. With young children, direct and even leading questions are sometimes developmentally appropriate and legally proper. The point is to use such questions sparingly, and only after nonleading questions have proven ineffective.

Conclusion

While professionals are keenly aware of their role as diagnosticians and therapists, many have little understanding of the important forensic implications of their work with children. The ability of the state to take legal action to protect children often stands or falls on a professional's understanding of the importance of proper questioning technique and immediate recording of precisely what is said. The professional's response to the legal issues involved in abuse can be as important as clinical intervention.

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can be conducted in a physically and emotionally safe environment and the child states a desire to see the abuser and exhibits no severe behavioral symptoms, some arrangement for supervised visitation should be made.

Supervised visitation. We recommend as a model the following supervised visitation plan:

1. While supervised visits are taking place, children should be seen in an ongoing treatment setting by a mental health professional specializing in child sexual abuse.

2. The visit should occur initially at an agency, for a limited time (1-1/2 hours).

3. The visit *must* be observed by a mental health professional who is well trained in all aspects of child sexual abuse, particularly in the topologies of offenders, the impact of victimization on the victim, and developmentally normal and abnormal behaviors for the child's age.

4. The observer *must be present at all times.*

5. Certain rules must be followed:
(a) no whispering;
(b) no note passing;
(c) no foreign languages in which the observer is not proficient;
(d) no physical contact not initiated by the child and not deemed appropriate by the observer.

The observer must enforce these rules during visits, document violations, and, if necessary, terminate the visit. These rules, designed because of repeated violations witnessed during actual supervised visits, are necessary to prevent the offender from threatening or coercing the child into recanting the sexual abuse allegations.

6. The child's caretaker, observer, and therapist should carefully document both normal and abnormal behaviors occuring before, during, and after the visits. These professionals should meet regularly to assess the effect of visits and to review their advisability.

7. Phone calls should not be allowed if the offender is denying or minimizing the abuse.

8. Visits should be terminated immediately if:
(a) the above rules are violated;
(b) the child requests termination;
(c) severe negative or dissociative behaviors are observed in the child.

The first responsibility of clinicians, courts, and nonoffending family members is to protect and support the abused child psychologically and physically. Ultimately, we would all like to see as well the rehabilitation of the child and the offending parent and the emergence of a safe, healthy relationship between them. If carefully supervised and constantly evaluated, parent /child visits *can* help meet both goals.

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RESEARCH

FIXATION REVISITED: A SECOND LOOK AT A SACRED CALF

--by Robert A. Prentky and Daniel L. Carter

As Cervantes observed, "There is a strange charm in the thought of a good legacy." The enduring fascination with the notion of the "fixated" child molester may arise from a similar "strange charm."

The classification of child molesters into categories roughly analogous to fixation and its counterpart, regression, is the most common discrimination in the clinical literature on such offenders. By standard definition, "fixated" offenders are those with long-standing, exclusive preferences for children as sexual and social companions, and "regressed" child molesters are those whose offenses are a departure under stress from a more age-appropriate social and psychosexual adaptation.

We have lived with these descriptive terms for over a quarter of a century, using them in the courtroom, in the lab, and in treatment. Sometimes we show due consideration for "criteria"; but our more frequent casual use of these terms reveals that "fixation" and "regression" have become part of the clinical lore.

Current research suggests that this dichotomy may be misleading. Our intent here is to explore the historical roots and use of the concept of fixation in taxonomies of child molesters and to discuss current thinking about its role.

The first two noteworthy classification systems of child molesters were reported in 1962, one by J.H. Fitch, another by Sheldon Kopp. Each implicitly incorporated a "fixated" type. For Fitch's "Immature type" (fixated), molestation was a preferred and long-standing form of sexual behavior. For his "Frustrated type," offending was a reaction to some sexual or emotional frustration at the adult level.

Kopp's "Type I" is similar to Fitch's Immature type: timid, passive, and somewhat withdrawn with peers. Kopp's "Type II" is similar to Fitch's Frustrated type: actively participating in the adult community, even marrying one or more times, his sexual offenses are incongruous with his general psychosexual adaptation.

In 1965, Paul Gebhard, John Gagnon, and their colleagues presented a highly elaborated classification system based on victim gender, victim age (0-11 & 12-15), and presence or absence of force. Their "pedophile" is similar to Fitch's Immature and Kopp's Type I. The pedophile is distinguished primarily by the absence of the use of force, the extent of the offender's sexual activity with children, and the ease with which he accepts children as sexual partners. In contrast to the fixated type in the other systems, the pedophile need not show exclusive preference for children or develop affectionate relationships with them.

Charles McCaghy (1967) considered the *meaning* of the child for the offender by looking at the extent of non-offense interactions with children. Of his three types--"High," "Limited," and "Minimal" interaction molesters--the "High" is similar to other systems' fixated types. Similarly, David Swanson outlined four groups of child molesters in 1971, of which the "Classic Pedophiliac" is the fixated type, and the "Situational Violator" is the "frustrated" or regressed type.

Although most systems included the concept of fixation, the use of the terms "fixation" and "regression" in connection with child molesters first came into prominence in the writings of Murray Cohen and his students Wilfred Calmas, Theoharis Seghorn, and Nicholas Groth. In their 1969 paper Cohen, Seghorn and Calmas described three offender types (Fixated, Regressed, and Aggressive) and initiated current descriptive usage: the offender is fixated *at* or has regressed *to* some earlier stage of psychosexual development.[1]

These three types became the first Massachusetts Treatment Center classification system for child molesters (MTC:CM1). A 1981 revision, MTC:CM2, expanded the taxonomy by introducing a series of three hierarchical, dichotomous distinctions: 1) the meaning and amount of aggression in the offense; 2) the motivation for the act (including the quality of the offender's perception of the child as a sexual object); 3) fixation or regression.

In 1978 Groth, Burgess, Homstrom and Sgroi maintained the classic fixation/regression distinction, identifying the offender who demonstrated a persistent pattern of molesting from the offender whose molestation represented a regression from a more mature level of psychosexual adaptation. The authors added a category in their 1981 revision, classifying offenders as either child molesters (fixated or regressed) or child rapists (acting out of anger, power, or sadism).

As can be seen, the fixated and regressed types have been represented in virtually every classification system described so far. Despite the remarkable durability of this legacy, a few intrepid souls have recently suggested that the venerable concept may have shortcomings. Jon Conte pointed out that the fixated/regressed dichotomy

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evolved solely from clinical experience and had never been subjected to empirical validation.

David Finkelhor and Sharon Araji raised a more theoretical problem, suggesting that social and interpersonal competence may have to be considered independently of fixation. The systems that describe fixated and regressed types implicitly or explicitly assess social and interpersonal competence: fixated offenders are typically differentiated from regressed offenders by marital status, number and quality of age-appropriate heterosexual relationships, and achieved levels of education and skill. The fixated child molester is expected to have a negligible history of dating or peer interaction in adolescence or adulthood and, if married, to have a very low-quality relationship. Finkelhor and Araji suggest these associations may be ungrounded.

Our efforts to verify empirically the MTC:CM2 suggest that Finkelhor and Araji are right. Consistent with generally accepted practice, we had combined in MTC:CM2 primary sexual object choice (children or adults) and achieved social competence in order to differentiate fixation and regression. But a serious reliability problem was created by the large number of cases in which object choice and social competence were *not* coupled (e.g., cases where the primary object choice was children, but level of social competence was high).

We reasoned that *all* child molesters manifested some degree of fixation simply by virtue of their choice of children as sexual partners. Thus, it seemed to make sense to conceive of fixation as occurring on a continuum rather than as being present or absent (as is implied by the term "regression").

We further reasoned, with Finkelhor and Araji, that social competence and fixation may be confounded and that independent assessments of these two dimensions might enhance reliability as well as validity.

Thus, in the current version of our classification system (MTC:CM3), fixation and social competence are independent, dichotomous decisions yielding four types (see figure).

		Fixation: High	Fixation: Low
Social Competence	Low	0	2
	High	1	3

In our own research we have defined fixation as "unequivocal, direct evidence that children have been a central focus of the offender's sexual and interpersonal thoughts and fantasies for a period of at least six months." This definition pinpoints an exclusive preference for children as social and sexual companions and does not include competency in any other sphere of human endeavor. The "classic" fixated offender in this system would be classified "0," while the "classic" regressed offender would be classified "3." Of a sample of 177 offenders, one-third were classified into one of the other two categories ("1" or "2").

The present forum does not permit any detailed discussion of our current classification system.[2] Disentangling social competence and fixation has, however, increased interrater reliability to an acceptable level. In addition, and most important, a recent validity study has supported many *a priori* speculations about how these groups would differ.

An interesting historical example of a type "1" (high social competence, high fixation) was Charles Dodgson, *a.k.a.* Lewis Carroll. Dodgson taught mathematics at Christ Church College, Oxford, for nearly three decades, contributed prolifically to the scientific literature, wrote six children's books and other works of fiction, was an ordained deacon in the Church of England and a prominent Tory.

Yet Dodgson was never fully at ease in the company of adults. At social gatherings he was acutely shy, sitting for hours contributing little to conversation. His scientific contributions were said to have suffered from his reluctance to engage in active dialogue with his colleagues. He never considered marriage despite numerous friendships with women (including with the well-known actress, Ellen Terry). Throughout his life the only objects of his love were girls 12 years or younger. Reportedly the only time when he did not stutter was when he was in the company of his much-loved young friends.

Dodgson is a classic example of a highly fixated pedophile who also achieved a high level of competence in many spheres of his life. Although he would have to be considered highly fixated, he clearly differs in very important ways from the prototypic fixated offender. (For instance, while he sketched and photographed girls in the nude, he reportedly never had sexual contact with them.) Placing men like Dodgson in an undifferentiated pool of fixated offenders would undermine the efficacy of our forensic and clinical decisions.

We have outgrown our earlier, simpler notions about how the world of child molesters is organized. We must continue examining a variety of factors that may contribute--independently or in combination--to our understanding of child sexual abuse. Fixation is one such factor, capturing an important albeit smaller part of the world than we previously thought. As long as it is well-defined and its boundaries well-drawn, fixation remains a useful organizing tool. Other potentially useful factors, however, include social competence, the amount of contact

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RESEARCH

FALSE ALLEGATIONS OF SEXUAL ABUSE

--by Mark D. Everson and Barbara W. Boat

As part of a study of false allegations of child sexual abuse (CSA), we surveyed all 100 county child protection services (CPS) agencies in North Carolina. We asked the CPS worker in each agency with particular experience in CSA to provide information for the previous year about the number of CSA investigations they were involved in, the rate of substantiation of these cases, and the number of cases in which a child or adolescent made an allegation of CSA believed to have been false. Completed questionnaires were returned by workers in 88 of the 100 CPS units surveyed.

A total of 1,249 cases of CSA were reported. The substantiation rate varied somewhat across ages: only 48% of cases involving children under age 3 were confirmed, while the average rate across ages was 56%. The rate of perceived false allegations was estimated to be under 3% for children below age 6 and between 8% to 12.7% among adolescents. The estimate across all ages fell between 4.7% and 7.6%. This overall false allegation rate compares favorably with the 2% to 8% incidence rate of false reports by children and adolescents in other studies with moderate to large samples. (See our original article for a review.)

Next, we conducted phone interviews with 23 CPS workers who reported at least one false allegation by a child or adolescent in their case load (False Report, or FR group), and with 23 workers who reported no such cases (True Report, or TR group). Workers in the FR group described 29 cases in which an account of abuse was determined to be false. The two groups did not differ in number of years in CPS, experience with CSA cases, or self-reported "comfort" with CSA cases.

The FR and TR groups differed significantly in their rates of substantiation of CSA cases: 45% vs. 63%, respectively ($t [46] = 2.44, p < .02$). The two groups also differed in their general perception of the veracity of child allegations of abuse, with CPS workers in the FR group expecting significantly higher rates of false allegations than workers in the TR group (M's 12.2% and 5.2%, respectively; $t [27] = 2.13, p < .05$).

The question arises: did CPS workers in the FR group expect higher rates of false allegations because they had recently seen more such cases, or did they "see" more cases of false allegation because they expected more?

In an effort to answer this important question, we asked during the phone interviews for the evidence that was used to determine that an allegation was false. As shown in Table 1, the most frequently-cited reason for disbelieving the child's report of abuse was a later retraction by the child (55% of cases). In several cases, the child recanted only after being pressured by others. Typically, this pressure came from disbelieving family members, but in some cases the child was confronted by seemingly skeptical professionals during the course of the investigation and subsequently withdrew the allegation.

In 14 or just under 50% of the cases, the child's report was believed false because it was improbable, inconsistent, or lacking in sufficient detail, or because conflicting evidence existed (e.g., the alleged abuser's spouse denying that the child and alleged abuser were home alone at the time of the reported abuse).

Other reasons for questioning the veracity of the child's report included the failure of others (e.g., siblings) who might be expected to be knowledgeable about the abuse to corroborate the child's report; the shocked, outraged reaction of the alleged perpetrator to the charges; and the absence in the child of fear or anger toward the alleged perpetrator.

Finally, in two cases, the results of polygraph tests were considered persuasive evidence against the child. (In one case the accused perpetrator "passed" the polygraph, and in the other

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TABLE 1: Reasons for Determining Allegations of CSA to be False

	n	%
Retraction	16	55
Insufficient credibility	14	48
--improbability of report	*6*	*20*
--insufficient details	*3*	*10*
--inconsistencies in report	*2*	*10*
--conflicting evidence	*3*	*10*
Failure of others to corroborate	5	17
Credibility of alleged abuser	4	14
Absence of child's fear of alleged abuser	3	14
Absence of physical (medical) evidence	2	7
Polygraph tests results	2	7

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the 12-year-old accuser "failed" the test.)

Examination of the criteria used in assessing the validity of the child's allegation raises serious questions in several of the cases about the adequacy of the evaluation and the accuracy of the ultimate determination.

The "eye of the beholder" phenomenon does seem to be significant among a number of CPS workers. Our data suggest that the FR group's predisposition to disbelieve allegations of sexual abuse lead them to interpret ambiguous or inconsistent evidence as proof that the child's report is false, even though interpreting the evidence to support the child's word is equally compelling.

This bias, suggested in the FR group's higher expectations of false allegations and lower substantiation rates, is apparent in their failure to question the validity of the child's retractions despite obvious evidence of pressure to recant. Bias can also be seen in the incomplete or insensitive manner in which some investigations were conducted; in the reliance on simplistic assessments of alleged perpetrators; and in the assumption that the existence of a possible motive proves that an allegation is false.

The most extreme instance of this bias was one CPS worker's adamant denial of the truth of a 9-year-old's allegation despite the perpetrator's admission of guilt and subsequent imprisonment.

Although this study focused on CPS investigations, similar bias against believing the child's account of abuse can undoubtedly be found in some members of all professional groups involved in the investigation or evaluation of CSA allegations. In workshops the authors conduct on CSA, we consistently find a significant number of professionals from various disciplines who expect false allegations from 25% or more of children and up to 80% of adolescents.

Even if one argues that current research underestimates the rate of false allegations, such excessive skepticism is difficult to reconcile with the research evidence.

No doubt the "eye of the beholder" phenomenon works in both directions: surely some professionals believe allegations too readily. Which error is the more common must be explored by further research. Both excessive skepticism and uncritical belief of allegations of sexual abuse are, however, sure to create misery for the people we are trying to help. Only informed clinical judgment and rigorous adherence to reasonable standards of evidence adequately protect children and alleged perpetrators alike.

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OPINION

CRIMINAL INVESTIGATION AND CLINICAL ASSESSMENT IN CHILD SEXUAL ABUSE CASES: MAKING A DISTINCTION

--by Stanley R. Friedman

Mental health clinicians are often asked to provide expert testimony in child sexual abuse trials. On the basis, usually, of psychological testing and/or one or more interviews with the alleged offender, clinicians are asked to provide the court with answers to such questions as, Is the defendant remorseful? Dangerous? Likely to reoffend? Is the defendant amenable to treatment?

Unfortunately, however, clinicans' testimony is often presented or used as an answer to an entirely different question: Is the defendant guilty?

Answering that question lies in the domain, not of the mental health clinician, but of the criminal investigator. Clinical skills may be a useful addition to the investigator's repertoire, but they are no substitute: although the goals and tools of criminal investigation and clinical assessment may overlap, they are essentially different.

The goal of criminal investigation is to provide an objective answer to a matter of fact: Did the accused commit the alleged sexual abuse? In their attempt to answer this question investigators will undoubtedly question the accused. But they will also examine the scene(s) of the crime(s), scrutinize medical reports, evaluate alibis, investigate other possible perpetrators, and do everything else in their power as agents of the State to discover the truth of who did what to whom.

Although the base rate of valid allegations seems to be

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extremely high (see Jones & McGraw, *The Journal of Interpersonal Violence,* 2[1], 27-45, 1987), investigators are expected to maintain a healthy skepticism toward the veracity of allegations, to protect both the accused and present and future victims of sexual abuse from the devastating consequences of unwarranted indictments.

Clinicians are not vested with the powers of the State necessary to complete a criminal investigation, and frequently do not have the requisite skills. Clinicians' tools do not equip them to determine guilt or innocence.

First, the clinician has no way of determining with certainty whether the accused's statements are true or false. In addition to lying outright, the accused may make statements that diverge from those made by the accuser because he has different perceptions of the same events. Although they may have very strong feelings about the accused's veracity, nothing in clinicians' repertoire of tools enables them to determine for certain when and whether the accused is being truthful.

Second, even if we were to develop psychometric instruments and interview techniques which provide us with a valid and reliable profile of the sexual offender, we could not use them to argue that an individual was innocent or guilty *of a particular act*. Even with perfect validity and reliability we could not make such a judgment.

Imagine an instance in which an individual falsely alleges that a chronic sex offender has initiated sexual contact with a minor. Our assessment tools correctly reveal that the client perfectly matches the profile of a child sexual offender: he abuses alcohol and other drugs, exhibits deviant arousal patterns, poor social skills and little empathy for others, even has a long criminal record of child sexual abuse. Still, it is inappropriate, and in this case incorrect, to infer his guilt in the current allegation.

Determination of guilt or innocence must remain the provence of the jury, based upon objective evidence assembled by the criminal investigator.

Where, then, do we clinicians properly enter the picture? In the effort to determine competence to stand trial. In assessing the probability of success in treatment and selecting the appropriate treatment method(s). In assessing the likelihood of recidivism.

We clinicians must remember that criminal conviction demands due process and demonstration of guilt "beyond a reasonable doubt." Until we can demonstrate our ability reliably to determine beyond a reasonable doubt when someone is telling the truth or lying, we are stating little more than personal opinion under the weighty guise of expertise.

Stanley Friedman, Ph.D., is a field-unit supervisor with the Bureau of Clinical Services of the Wisconsin Division of Corrections.

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expert are key if we are to defuse the backlash. I hope that APSAC will continue to find ways to increase the knowledge of experts, to define what expert knowledge is, and to develop standards for practice which will protect both children and adults.

As I watch the membership grow and hear the interest from professionals across the country when they learn of this society, I realize that APSAC can become ever so much more a voice for abused children, the adults who share and influence their lives, and the professionals who serve them. The sense of togetherness which is clear in APSAC members and in those interested in APSAC nationwide is our strength. Our need is to realize the difficulty of our task and the determination of our foes, and to keep steadily in sight that our purpose is clear and that we can succeed.

Jon R. Conte, Ph.D.
President

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October 27-30. *Fifth Annual Meeting of the Society for Traumatic Stress Studies.* San Francisco. Call 717-396-8877.

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with children, the nature of the sexual acts and the degree of injury to the victim.

1Although Benjamin Karpman used the term "fixation" in the mid-fifties, he applied it in the psychodynamic sense: i.e., the offender was fixated *on* someone, often his mother.

2Interested readers may drop a note to the Research Department, Massachusetts Treatment Center, Box 554, Bridgewater MA 02324.

Robert Prentky, Ph.D., is Director of Research at the Massachusetts Treatment Center, where Daniel Carter is Grant Research Coordinator. Both authors are Research Associates in the Psychology Department at Brandeis University as well.

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