APSAC
AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

THE ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

Volume 2, Number 3 "July" 1989

BULLETIN: SAN DIEGO, JANUARY 17 - 20, 1990

SECOND ANNUAL MEETING FEATURES NATIONAL AND INTERNATIONAL EXPERTS, INTERACTIVE FORUMS, RESEARCH REVIEWS

APSAC's Second Annual Meeting promises to be a major event, stimulating, enlightening, and encouraging attendees and planners alike. Workshops are already scheduled on a wide range of medical, legal, therapeutic, and social concerns, including psychotherapy for survivors from preschool age to adulthood; medical findings in child sexual abuse; criteria for reunification of the family following incest; issues in the assessment of child abuse, including culture-sensitivity; forensic interviewing of abuse victims; ritualistic abuse; ecological and political issues in inner-city child abuse; child abuse and borderline personality; prevention; the different demands of diagnosis for legal evidence and diagnosis for treatment; dealing with the backlash, and many more.

Among the distinguished faculty involved are Bessel Van der Kolk, Ruth Kempe, John McCann, John E.B. Myers, Harry Elias, Roland Summit, Hanita Zimrin, Mary Meinig, Dominique Cattaneo, Donna Montegna, Barbara Orr, C.J. Hobbs, Eliana Gil, Deborah Davies, Donald Duquette, Boyd Stephens, Inger Davis, and Michelle Chadwick. APSAC Board Members on the faculty include Sandra Butler Smith, Kee MacFarlane, Lucy Berliner, David Finkelhor, Joyce Thomas, David Corwin, David Chadwick, and Jon Conte.

One of the invaluable features of the conference are numerous interactive sessions scheduled to enable conferees to get feedback from peers on issues in practice. Interviewers are invited to bring 10-minute video clips for presentation and discussion in peer review sessions. Likewise, medical examiners are invited to bring 10 slides of findings to review and discuss with their colleagues.

Another conference highlight will be research presentations. In two afternoons, a total of 14 reports on previously unpublished research will be heard. Reports will be 20 minutes long, with 10 minutes for discussion. (See "Call for Research Papers" on the Conference page in this newsletter.) In addition, experts' reviews of relevant research in child protection, incidence of abuse, and other crucial areas affecting practice will be offered.

Of major interest to members will be the open meetings of APSAC's guidelines Task Forces, scheduled to solicit input and reflection on the groups' work in progress. The Task Forces are on the Assessment and Treatment of Perpetrators of Child Sexual Abuse, chaired by Judith Becker; the Medical Evaluation of Suspected Child Abuse, chaired by David Chadwick; and the Evaluation of Suspected Sexual Abuse in Young Children, chaired by Lucy Berliner. Ms. Berliner's Best Practice Survey--a national survey of clinicians working in the field of child sexual abuse--will be submitted for review by APSAC members. A new Task Force will also hold an open meeting in January: the Task Force on the Peer Review of Expert Testimony, chaired by Anna Salter. Task Force chairs and members are excited about this opportunity to learn from the feedback of other APSAC members.

The possibility of growth from these open meetings is enhanced by CAPSAC's holding open meetings of its guidelines Task Forces as well. John E.B. Myers, JD (*The Advisor*'s Associate Editor for Legal issues), chairs CAPSAC's Task Force on Expert Testimony in Child Sexual Abuse Litigation; David Corwin, MD, chairs the Task Force on Psychosocial Evaluation in Cases of Suspected Child Sexual Abuse; and A. Rodney Nurse, Ph.D., chairs CAPSAC's Task Force on Psychological Assessment in Cases of Suspected Child Sexual Abuse.

By jointly holding open Guidelines meetings and by holding their Annual Meetings at the same conference, APSAC and CAPSAC maximize the potential for both individual professional development and for development of understanding in the field as a whole this January. *continued on p.13*

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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*

--by Dave Corwin, MD, Editor-in-Chief

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, announcements, 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, send one copy to the appropriate Associate Editor, one copy to me, and one copy to the Manuscript Editor, Theresa Reid, at APSAC's Chicago offices.

Together, we will produce a newsletter that helps all of us in our work on the problems of child abuse and neglect.

FROM THE PRESIDENT

LETTER FROM A NEW PRESIDENT

--by David Chadwick, MD

Following in the footsteps of Jon Conte is a formidable task. Jon's leadership during the first two years of APSAC's existence has made it clear that the organization can exist and can grow to be a real professional society, encompassing all the disciplines that become involved in child protection practice. Jon did everything that needed to be done, and he did it all very well. Knowing that he will be able to continue as Treasurer is a great comfort to your new president, giving me reassurance that our finances will be carefully managed, and that Jon will always be available for his wise and seasoned counsel.

In order for APSAC to be important enough so that persons from all child protection disciplines will wish to become members, it is vital that we state and restate our goals and our purposes, especially those that differentiate APSAC from other fine organizations which have developed in response to recognition of child abuse. The American Human Association, the National Committee for the Prevention of Child Abuse, and the International Society for the Prevention of Child Abuse and Neglect all provide advocacy and education. Other professional societies open to licensed and certified persons who work with abused children have begun to recognize child abuse, but rarely give this area much of their time or resources.

The large void that should be filled by APSAC is to take the leadership role in establishing standards and guidelines for child protection practice in the various disciplines, and for interdisciplinary practice as such. Our standards should be internally generated determinants of professional behavior, with wide acceptance by peers in all disciplines. Specific standards must first exist as "guidelines," in order that they may be tested in practice before they can have wide accceptance, and we must be careful not to impose unbearable burdens upon ourselves, a mistake which would be easy to make in the present circum-

NEWS

APSAC EXECUTIVE COMMITTEE ELECTS OFFICERS, PLANS FOR APSAC'S FUTURE

At their July 15 meeting in Chicago, APSAC's Executive Committee elected new officers. They are as follow: *President,* David Chadwick, MD; *First Vice-President,* Joyce Thomas, RN, MPH; *Second Vice-President,* Charles Wilson; *Treasurer,* Jon R. Conte, Ph.D.; *Secretary,* Linda Blick, MSW, LCSW.

Directors at large include Lucy Berliner, MSW; Barbara Bonner, Ph.D.; David Corwin, MD (Editor-in-Chief of *The Advisor*); Bud Cramer, JD; Kee MacFarlane, MSW; and Sandra Smith, JD.

In a lively 7-hour session, the Executive Committee discussed many issues. Among these was the growth of APSAC's membership. The Committee was pleased to note that APSAC now has over 1000 members. APSAC has been in existence for only three years, so all present felt that the rapid growth in membership reflects the need for APSAC and the success of the organization's early efforts.

The Committee also stressed that APSAC must continue to grow in order to better serve the needs of its members and of abused children and their families. If each current member recruited one new member by Christmas, APSAC would be in the swim.

The next opportunity for APSAC members to meet each other and the Board will be during the Eighth National Conference on Child Abuse and Neglect, to be held in Salt Lake City, Utah, October 22-25. The membership meeting will be held on Monday, Oct. 23, from 5-7. See the conference page (p.14) for further details.

Another major topic for discussion was the upcoming Annual Meeting, to be held in San Diego next January. The Committee is very excited about creating a stimulating, interactive forum for APSAC members. For details on the planning, see the lead article in this newsletter.

Looking into the long-range future, the Committee agreed to move toward APSAC's production of position papers on such sensitive topics as the use of anatomical dolls, peer review of expert testimony, and the definition of emotional abuse. The Committee decided as well to begin producing occasional papers 5-10 pages in length on major areas of concern to the field. Lucy Berliner is working on a Therapy Notebook--a compilation of techniques used by APSAC members--for distribution to the membership in early 1990. Jon Conte is heading a committee to produce a code of ethics. The next two meeting dates for APSAC's Board of Directors are October 22, in Salt Lake City, and on January 18 in San Diego.

Work on the membership directory is continuing. As a bit of preliminary information, below is a breakdown of APSAC members by states, as of July 15, 1989.

APSAC Membership by State

CA	151	MO	13
IL	69	AZ	12
NY	69	KS	12
TX	60	CT	11
MA	55	GA	11
NC	50	IN	10
FL	40	NH	10
CO	27	UT	10
WA	27	ID	9
MI	24	OK	9
AL	22	AK	8
VA	21	SC	8
TN	20	KY	7
WI	20	IA	6
MN	18	HI	4
PA	17	AR	3
LA	16	NE	3
MD	16	ND	3
OH	16	RI	3
NV	15	NM	2
NJ	14	VT	2
OR	14	DE	1
DC	13	MT	1
ME	13	WV	1
MS	13		

From the President, cont.

stances, in which visible needs for children's services vastly exceed the resources available to meet them.

A general standard that we can meet immediately is the insistence upon intellectual honesty in our work. We can and must commence to perform peer review of expert testimony in child abuse cases in order to discourage some of the really outrageous statements being made under the pressure of no-holds-barred adversarial proceedings. We must consistently exercise care to differentiate what we know from what we only believe.

We must become more precise and more consistent in our definitions of the various forms of child abuse, and improve our methods for counting cases. While acts that are illegal and socially stigmatized can never be counted with absolute accuracy, much improvement over present methods is possible, and APSAC needs to take the lead in this process. We must not condone the tempting sophistry to make an intolerable, debilitating societal problem disappear by redefining it into invisibility.

We must avoid the natural tendency of each discipline to regard its own contribution to child protection as the most important one. We all "own" the problem, and so far no one "owns" the solution. We must find ways to communicate about the problem to all members of our communities. Children are safest in places where everyone takes responsibility for their welfare,

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MEDICAL

PITFALLS IN THE DIAGNOSIS OF SEXUALLY TRANSMITTED DISEASES IN CHILDREN

--by Margaret Hammerschlag

Associate Editor's Notes

I requested the following brief article from Dr. Margaret Hammerschlag, a pediatric infectious disease specialist and a nationally-recognized authority on Chlamydial infections in children. She discusses some common pitfalls in the diagnosis of sexually transmitted diseases in prepubertal children, focusing on *Chlamydial* and *Neisseria gonorrhoeae* infections.

As Dr. Hammerschlag's article makes clear, all physicians should make certain that the appropriate microbiologic diagnostic tests are being used for evaluation of sexually transmitted diseases in their community. In spite of the CDC's recommendations for a second confirmatory test for the identification of *Neisseria gonorrhea* species, few hospital labs are likely to do such a routine except to pharyngeal cultures.

Please advocate that all specimens submitted for the diagnosis of sexually transmitted diseases in children be handled with special care, and that a second confirmatory test be completed on all specimens submitted for the diagnosis of gonorrhea. The misidentification of gonorrhea might explain the not-uncommon case in which a child presents with a vaginal discharge identified as gonorrhea but does not manifest behavioral or other indications of sexual abuse.

Case workers and law enforcement professionals must also get clear information about the diagnostic tests that have been utilized. If a gonozyme or Chlamydiazyme is the primary forensic indicator of sexual abuse, all should proceed with caution.

--Martin Finkel, DO, Associate Medical Editor

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Feature

Finding a sexually transmitted disease (STD) in a young child is troubling. In addition to the medical implications there are serious legal implications. Frequently, the presence or absence of an STD is used to prove or disprove that abuse occurred, or can prompt an investigation of possible abuse where it was not previously suspected. A false negative on a test for STD in a child may expose that child to ongoing sexual abuse. A false positive, on the other hand, may expose innocent parents to unwarranted legal action.

Because of these legal repercussions, accurate diagnosis of STD in children is essential. But many physicians, lawyers, and law enforcement personnel are often confused about the nature of the test that has been done to detect STD in children. Even if they are aware of the type of test that has been used, they may not know that the standards adequate for presumptive diagnosis of STD in adults is not adequate for the identification of these infections in children.

Diagnosis of Gonorrhea

Although infection with *Neisseria gonorrhoeae* appears to be the best understood of all STDs in children, many laboratories still have difficulty identifying this organism in specimens from children. During 1983-4, approximately 1/3 of the presumptive isolates of *N.Gonorrhoeae* from children submitted to the CDC for confirmation were determined to be other species, including *N. meningitides* and *Brahamella Catarrhalis* (Whittington et al., 1988).

The presumptive identification as G.C. of the majority of these isolates was based on the Gram stain morphology (Gram-negative diplococci) and on their being oxidase positive.

The problem is specificity. If one isolates such an organism from a urethral culture of a sexually active adult, the overwhelming probability is that it is *N. gonorrhoeae*. However, if it is from a throat culture of a child, it very well may be another organism altogether. *B. Catarrhalis*, for instance, a common colonizer of the pharynx, is also an oxidase positive Gram-negative diplococcus.

The CDC recommends that any bacterial isolate from a child presumptively identified as *N. gonorrhoeae* be confirmed by at least 2 tests that use different principles. The 3 types available are biochemical sugar (fermentation), enzyme substrate, and serologic. The latter is a monoclonal antibody as a coaglutination or direct fluorescent antibody (FA) test. This is meant to be used to confirm a bacterial isolate, *not* for direct examination of a smear from a clinical site.

Gonozyme (Abbott Diagnostics) is an enzyme immunoassay (EIA) for the detection of *N. gonorrhoeae* in clinical specimens. It has been evaluated mainly in adult populations. The test appears to perform very well for diagnosing gonococcal infections in the male urethra, but does not present any marked improvement over a Gram stain of a urethral discharge. Gonozyme performs less well for cervical infection. The specificity is not 100%: 2-5% false positives limits its usefulness to high prevalence populations (Schachter, 1985).

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Gonozyme should not, then, be used for the diagnosis of gonorrhea in children. It is simply not accurate enough.

Diagnosis of Chlamydia

The detection of *C. trachomatis* presents more problems because culture facilities are not as widely available as they are for gonorrhea and require tissue culture techniques. As a result, many practitioners have been using antigen detection tests for genital and rectal specimens in children, even though antigen tests are not approved for those sites. Two other tests are currently available. Chlamydiazyme (Abbot Diagnostics), an EIA similar in principle to Gonozyme, and several direct FA tests. The latter uses fluorescein conjugated monoclonal antibodies to identify *C. trachomatis* directly in smears from clinical sites. Several are now available including MicroTrak (Syva) and Pathfinder (Kallestad Diagnostics). These tests are suitable alternatives to chlamydial culture in adults, and especially in high prevalence populations.

But use of these tests at genital and rectal sites in children have been associated with a large number of false-positive results (Hammerschlag et al., 1988): the EIA and DFA are not accurate enough for use at these sites in children. Some parents, however, have been prosecuted on the results of these tests alone. False positives are frequently caused by cross reactions with other bacteria that are common colonizers of the genital tract in children, including *E. coli*, group B *streptococcus* and *Acinetobacter* species. The direct FA presents additional problems because the reading of these slides has a large subjective component. There can also be significant variation in the staining characteristics from reagent to reagent.

Considering the relatively low prevalence (2-5%) of chlamydial infection in abused children and the poor performance of antigen detection tests in this setting, one should only use chlamydial cultures to detect *C. trachomatis* in these children.

In short, when testing for *N. gonorrhoeae* in children, **DO** demand at least 2 of the 3 available tests: biochemical sugar; enzyme substrate; serologic. **DON'T** rely on Gonozyme.

When testing for *Chlamydia* in children, **DO** use only chlamydial cultures to detect *C. trachomatis*. **DON'T** rely on Chlamydiazyme (an EIA--enzyme immunoassay) or MicroTrak, Pathfinder, or other direct FA's.

If all professionals in this field observe these guidelines, we'll be a lot closer to the all-important accurate diagnosis.

References

Hammerschlag, M.R., Rettig, P.J., Shields, M.E. (1988). False positive results with the use of chlamydial antigen detection tests in the evaluation of suspected sexual abuse in children. *Pediatr Infect Dis J* 7:11-14.

Hauger, S.B., Brown, J., Agre, F. et al. (1988). Failure of direct fluorescent antibody staining to detect *Chlamydia trachomatis* from genital sites of prepubertal children at risk for sexual abuse. *Pediatr Infect Dis J* 7:660-1.

Schachter, J. (1985). Immunodiagnosis of sexually transmitted disease. *Yale J Biol Med* 58:443-52.

Whittington, W.L., Rice, R.J., Biddle, J.W., Knapp, J.S. (1988): Incorrect identification of *Neisseria gonorrhoeae* from infants and children. *Pediatr Infect Dis J* 7:3-10.

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LEGAL

DOLLS IN COURT?

--by John E.B. Myers & Sue White

Anatomically detailed dolls are commonly used by professionals working with sexually abused children. With increasing frequency, courts are asked to consider the legal implications of the use of these dolls (White, 1988). From a legal standpoint, three uses of the dolls are noteworthy: 1) use of dolls to assist child witnesses to testify in court; 2) use as an aid to communication during investigative and/or therapeutic interviews conducted by police, child protection workers, physicians, and others; and 3) use as a diagnostic or interpretive tool to help determine whether sexual abuse occurred. These uses are discussed below.

1) Judges generally permit children testifying in court to use dolls or other devices, such as anatomically complete diagrams, when such aids are needed to help children describe sexual abuse. This use of dolls (called "demonstrative evidence") is not controversial. Witnesses of all types are permitted to use props to help them communicate effectively in court. Children are no exception.

2) Use of the dolls during investigative and/or therapeutic interviews would raise little controversy or concern if all the individuals doing such interviews were trained in proper interview technique. Unfortunately, research by Boat and Everson(1988) indicates that while many professionals use the dolls, relatively few have received training in their proper use. Defense attorneys sometimes complain that interviewers misuse the dolls to coach children and to suggest sexual abuse that did not occur. This possibility cannot be dismissed, and it is not improper for defense attorneys to inquire into interview techniques used by professionals who interview children.

At the same time, however, research does not support the argument sometimes raised by the defense that the anatomical dolls stimulate in nonabused children sexual fantasy play which is misinterpreted as evidence of sexual abuse (Yates & Terr, 1988a, b). Nor is there research support for

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Dolls in court? cont. from p. 5

the assertion that merely exposing children to anatomically detailed dolls increases suggestibility.

Undoubtedly, some interviewers use the dolls improperly, and some draw unwarranted conclusions from children's interaction with the dolls. For example, untrained or biased interviewers may combine doll play with improperly suggestive questions to lead children into inaccurate statements. Some interviewers probably misinterpret behavior seen in nonabused children (e.g., exploratory behavior such as putting fingers in orifices) as evidence of sexual abuse. Clearly, professionals who use anatomically detailed dolls should receive training in the uses and limits of the dolls.

Equally clearly, however, when the dolls are used by properly trained and objective professionals, they are a useful aid to communication with children who have difficulty expressing themselves verbally. In the hands of properly trained interviewers who limit their use to facilitating communication, the dolls raise few legal issues.

3) The third use of anatomical dolls ventures beyond an aid to communication during the interview, and contemplates use of the dolls as a diagnostic or interpretive tool. When dolls are used for diagnostic or interpretive purposes, the professional draws inferences about sexual abuse from a child's interaction with the dolls.

This use of the dolls has generated concern among experts on child sexual abuse, and among judges (*United States v. Gillespie*, 1988; *In re Amber B.*, 1987). In particular, judges question whether sufficient research has been conducted to justify use of the dolls for diagnostic or interpretive purposes.

Research to date clearly supports the conclusion that the dolls are not a litmus test for child sexual abuse (Goodman & Aman, 1987; Jampole & Weber, 1987; Sivan, Schor, Koeppl & Noble, 1988; White & Santilli, 1988; White, Strom, Santilli & Halpin, 1986). That is, one can't conclude that a child was or was not sexually abused solely on the basis of the child's interaction, or lack thereof, with the dolls.

While the dolls are not a test for sexual abuse, there is widespread agreement--supported by research--that the dolls are a useful adjunct to the interview process. That is, use of the dolls during the interview process is clinically appropriate. Information gleaned from a child's interaction with the dolls is useful, to be evaluated along with a host of other factors to reach clinical decisions about a child. Not a litmus test, a child's interaction with the dolls is a useful piece of a complex puzzle.

Anatomical dolls need not be abandoned because of fear that their use will undermine legal efforts to protect children and punish wrongdoing. Professionals must be prepared, however, to respond to questioning about use of the dolls. Defense attorneys may be expected to inquire about doll use in an effort to determine whether improper interview techniques were used. Indeed, defense counsel may well attempt to weaken the expert's opinion by criticizing his or her use of anatomical dolls.

In light of legitimate questions about the uses and limits of anatomical dolls, and the increasing tendency of defense counsel to attack professionals who interview sexually abused children, it is advisable to prepare a threefold response to criticism. *First,* be prepared to describe precisely how and why the dolls were used in particular cases. *Second,* be familiar with the research on the use of dolls so you can discuss their uses and limits, and can demonstrate that your use of the dolls falls within acceptable practice. *Third,* be willing to concede the limits of the dolls' use, and readily acknowledge that the dolls are not a test for sexual abuse. When the judge and jury are made aware of the limited role played by the dolls, attempts to criticize their use are placed in proper perspective.

References

Boat, B., & Everson, M. (1988). Use of anatomical dolls among professionals in sexual abuse evaluations. *Child Abuse & Neglect, 12,* 171-179.

Goodman, G., & Aman, C., (1987, April). Children's use of anatomically correct dolls to report an event. In M. Steward (Chair), *Evaluation of suspected child abuse: Developmental, clinical, and legal perspectives on the use of anatomically correct dolls.* Symposium conducted at the Society for Research in Child Development, Baltimore, MD.

In re. Amber B., 236 Cal.Rptr.623 (1987).

Jampole, L., & Weber, M. (1987). An assessment of the behavior of sexually abused and nonsexually abused children with anatomically correct dolls. *Child Abuse & Neglect, 11,* 187-192.

Sivan, A., Schor, D., Koeppl, G. & Noble, L. (1988). Interaction of normal children with anatomical dolls. *Child Abuse & Neglect, 12,* 295-304.

United States v. Gillespie, 852 F.2d 475 (9th cir.1988).

White, S., Strom, G., Santilli, G. & Halpin, B. (1986). Interviewing young children with anatomically correct dolls. *Child Abuse & Neglect, 10,* 519-529.

White, S. & Santilli, G. (1988). A review of clinical practices and research on anatomical dolls. *J. Interpersonal Violence, 3,* 431-442.

White, S. (1988). Should investigatory use of anatomical dolls be defined by the courts?, *J. Interpersonal Violence, 3,* 471-475.

Yates, A. & Terr, L. (1988a). Debate forum: Anatomically correct dolls: Should they be used as a basis for expert testimony? *J. of Am.Acad. of Child & Adol. Psychiatry, 27,* 254-257.

Yates, A. & Terr, L. (1988b). Debate forum: Issue continued: Anatomically correct dolls: Should they be used as a basis for expert testimony? *J. of Am. Acad. of Child & Adol. Psychiatry, 27,* 387-388.

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LEGAL

LIVING UP TO THE "REASONABLE EFFORTS" REQUIREMENT OF THE FEDERAL ADOPTION ASSISTANCE AND CHILD WELFARE ACT

--by Joseph L. Spaeth

In 1980, Congress passed the Adoption Assistance and Child Welfare Act (Public Law 96-272), articulating our nation's policy preference to preserve the nuclear family, and to protect children consistent with an emphasis on family preservation. To be certain that this preference was heeded, the federal law required courts to ensure that "reasonable efforts" be made to prevent removal of a child from his or her family. After several years of little more than lip service to the "reasonable efforts" requirement, a number of states have recently enacted legislation requiring courts to ascertain fully, and evaluate carefully, what "reasonable efforts" have been made to avoid removing a child from a neglectful or abusive home, and what "reasonable efforts" have been made to reunify a detained child with the child's natural family. The law makes clear that rote recitals of the appropriate buzzwords on the record will no longer pass muster.

Although many professionals are apprehensive about stricter adherence to the "reasonable efforts" requirement, now is the time for enforcement to occur. The explosive growth of child abuse reports in recent years has strained the social welfare agencies and juvenile and family courts beyond their capabilities to deal effectively with the problem. Given this overload, one might well ask: How can demanding more from governmental agencies possibly help an already overburdened system?

The answer lies in the conviction that appropriate services, applied in a timely fashion to families at risk, can substantially help a large number of dysfunctional households, thereby rescuing a system currently in chaos. Whether or not this conviction is misguided remains to be seen; but it is clear that our present methods are not accomplishing the task. Professionals in all disciplines are increasingly frustrated, disillusioned and overburdened. But let us examine why it is necessary to enforce the "reasonable efforts" standard.

It is appropriate to place great emphasis on preserving and strengthening families. The family is the basic focal point of our personal lives--the major training and nurturing ground for our children. Murdock, in *Social Structure*, stated that "no society has succeeded in finding an adequate substitute for the nuclear family to which it might transfer [sexual, economic, reproductive and educational] functions."

Whenever possible, government agencies should attempt to eliminate family dysfunction before removing a child. This does not mean that it will never be necessary to remove abused and neglected children from families, but children should never be separated by default, or because of inattention to the real causes of the family's problems. Likewise, when removal is necessary, agencies should make every effort to correct the family difficulties in order to restore the child to the family as quickly as possible. Separation of child and parent generates animosity between parent and social worker, generally resulting in distrust, resentment and lack of cooperation on the part of parents. Inevitably, court intervention becomes necessary.

Let us also not forget that a free society requires that government not intervene unnecessarily in the intimacies of family life. Our basic freedoms include a broad panoply of family lifestyles, mores and customs, and the freedom to make choices without government interference. Government has no business and, under our Constitution, no right to set standards for families without some overriding need to protect children from parental neglect or abuse. We must all recognize that changes in a family's lifestyle must not be demanded in order to meet some standard which is arbitrary, unrealistic or unattainable in a particular family's circumstances. The "reasonable efforts" mandate protects against this kind of governmental abuse of authority.

Perhaps the most important goal in this time of great demand on the limited public monies available for social services is to persuade our politicians that in the long and the short term, we can expect more for our money from intensive in-home services than from the more expensive shelter and foster care network. With the necessary seed money, savings ought to be achieved in a relatively short time. The policy mandate of "reasonable efforts" can provide the impetus and the guarantee the politicians require.

Viewed in this context, it becomes evident that the "reasonable efforts" requirement is more than just a government mandate. It is a vital step toward an attainable solution to a rapidly escalating problem. The employment of a meaningful "reasonable efforts" requirement will provide the blueprint for a service delivery system--identifying the services needed, evaluating the quality of available services, and suporting advocacy for additional needed services to serve

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RESEARCH

DOES REHABILITATING CHILD MOLESTERS PAY?

--by Robert A. Prentky & Ann Wolbert Burgess

The escalation of sexual aggression over the last several decades has become an increasingly acute problem, manifested in costs to both victims and society at large. The long-term psychological impact of sexual assault on adult and child victims has been documented many times. The costs incurred by society include a network of medical and psychological services provided to aid victim recovery; the investigation, trial, and incarceration of offenders, often in segregated units or special facilities; and the invisible blanket of fear that forces potential victims to schedule normal daily activities around issues of safety. Everyday decisions for parents, such as choosing daycare or babysitters or permitting unsupervised outside play, or equally common questions for adult women, such as when to leave work in the evening, what mode of transportation to use, where to park the car, where it is safe to walk or jog, and whether to use a first name on the mail box or in the phone book become major concerns, especially in larger cities.

Exploring strategies that may effectively reduce victimization rates is an obvious response to these massive costs. One such strategy is offender treatment. The critical questions about such a strategy are what it costs to rehabilitate and whether rehabilitation reduces the risk that an offender will recidivate. How much risk of reoffending must decrease in order to justify the cost of treatment is essentially a social policy question. While we cannot answer the question, "Is it worth it?" we can tentatively address these questions: Does treatment decrease the risk of reoffending? and, What are the relative monetary costs of victimization and of treatment?

Of all the applications of cost-benefit analysis to rehabilitation and resource allocation in correctional institutions, applications to sex offenders are a noteworthy omission. In fact the only study we are aware of that has looked at the monetary cost to society of sexual victimization is Frisbie's (1969) study of 887 sex offenders in California. Chapter 4 in Frisbie's monograph, entitled "Society pays and pays," delineates the lengthy and expensive process begun when a sex offender is charged with a crime. Frisbie concluded that "The magnitude of measurable and hidden costs implicit in processing a sex offender's case from apprehension, through trial, jail, institutionalization at Atascadero or prison or both, and final discharge from probation or parole, cannot but jar society into more vigorous concern over the tax dollars which are channeled into financing the present system" (1969, p.99).

We set out to design and implement a cost-benefit model to examine the question, "Is offender treatment cost effective?" Although space does not permit a detailed description of the model or of procedures for calculating costs, we would be happy to discuss these issues with readers who write to us at the address given below.. For the remainder of this column we will discuss the outcome of the study.

The model proposes in the first case that a convicted child molester is committed to the Massachusetts Treatment Center. He spends 5.1 years at the Center at a cost of $118,146. He is released to the street with a .25 risk of reoffending within the first five years. The cost of reoffense is $183,333.

The model proposes in the second case that a convicted child molester is sent to prison. He serves 2/3 of his minimum sentence (7 years) at a cost of $158,635. He is released to the street with a .40 risk of reoffending within the first five years. The cost of reoffense is $183,333.

The expected cost associated with a treated child molester was determined to be $163,979.25 ($118,146 + [$183.333 x .25]). The expected cost associated with a non-treated child molester was determined to be $231,968.20 ($158,635 + [$183,333 x .40]). The difference is $67,988.95.

The difference of $67,989 represents the additional cost of *one* victim in the event of reoffense by *one* offender. Hypothetically, if 1,000 untreated child molesters were released from prison, the actual cost incurred by society over a period of five years would be $67,989 x 1000, or about $68,000,000.

The reliability of probability estimates of reoffense is critically dependent on the accuracy of available data. Given that there are no absolute probabilities or risks associated with reoffense, it makes sense to ask what the *minimal* difference in reoffense rates between treated and non-treated groups would be for the cost difference to be negligible.

If we hold constant the recidivism rate of .40 for non-treated child molesters, the recidivism rate for treated child molesters would have to be approximately .62 for there to be no difference in cost. Stated alternatively, if the recidivism rate for nontreated child molesters is .40, there will be no difference in cost if the recidivism rate for treated child molesters is 22% higher ($\geq$.62).

If we hold constant the reci-

divism rate of .25 for treated child molesters, the recidivism rate for nontreated child molesters would have to be approximately .03 for there to be no difference in cost. That is, if the recidivism rate for treated child molesters is .25, there will be no difference in cost if the recidivism rate for nontreated child molesters is 3% or lower. In other words, if the recidivism rate for treated child molesters is .25 and if the recidivism rate for nontreated child molesters is higher than 3%, then treatment is cost effective.

We set out to design a stringent model, one that would be as blind to preconceptions and bias as possible and one that would, if anything, underestimate costs. Our assessment of recidivism was as rigorous as possible: We considered all charges for a large domain of criminal conduct, regardless of arrest or conviction, to be evidence of recidivism. Moreover, the population on whom we gathered recidivism data (129 child molesters at the Treatment Center) can reasonably be considered the most dangerous--i.e., at the highest risk of reoffense--in the Massachusetts penal system.

We did not, and realistically could not, assess and quantify the long-term psychological costs of victimization. Such costs are levied not only against the child who was victimized but against society as a whole. Indeed, it may be argued that these emotional costs far outweigh the monetary costs in their impact on society. If treatment is effective in reducing victimization rates, as it has been shown to be, the potential savings, human as well as monetary, given crude estimates of victimization rates, would be incalculable.

Given the magnitude of the costs of sexual victimization, the social and political response to the problem has been remarkably deficient. Why? Perhaps because, despite our common-sense appreciation of what impedes and what facilitates behavior change, our instinctive need is to exact our pound of flesh in response to wrongdoing, particularly when the perpetrator is a stranger and the act is as incomprehensible as child molestation is to most of us.

The most rudimentary response to those who violate the law appears in the Old Testament as *lex talionis*, or the law of "An eye for an eye, a tooth for a tooth." Our language teems with colloquial expressions that convey this sense of justice: The wrongdoer, for instance, should get "a taste of his own medicine," or his "just deserts," or his "comeuppance," or simply "what's coming to him." We note with approval that "What goes around, comes around."

Psychologically, we may need to see wrongdoers punished; the desire for retaliation is almost an instinctive response to those who hurt us. But the effectiveness of this response in redressing wrong is limited. Those of us who have developed a long-term attachment know the limited utility of punishment as a way to mitigate hurt or achieve restitution. Those of us who have acquired some expertise in modifying behavior, whether as parents, teachers, or therapists, appreciate the liabilities of punishment in affecting long-term behavior change.

We appear to resist treating child molesters because it is a "humane" response to egregious behavior. If the overriding goal, however, is reducing the rates of victimization and the costs incurred by victimization, and if rehabilitation of offenders can clearly be shown to reduce the likelihood of reoffense over time, then it is imperative that we overcome our resistance to treating child molesters, not for the sake of the offenders but for the sake of the victims.

This study was supported by the National Institute of Justice (82-IJ-CX-0058), the National Institute of Mental Health (MH32309), the Office of Juvenile Justice and Delinquency Prevention (84-JW-AX-J010) and the Commonwealth of Massachusetts. The study is in press in *The American Journal of Orthopsychiatry*. Interested readers may direct correspondence to the Research Department, Massachusetts Treatment Center, Box 554, Bridgewater MA 02324.

Robert A. Prentky, Ph.D., is Director of Research at the Massachusetts Treatment Center, is in the Department of Psychiatry at Boston University School of Medicine, and is affiliated with New England Forensic Associates in Arlington, MA. Ann W. Burgess, RN, D.N.Sc., is van Ameringen Professor of Psychiatric Mental Health Nursing, University of Pennsylvania.

CALL FOR RESEARCH PAPERS

Two afternoon sessions of about 3-1/2 hours each have been scheduled during ***APSAC's second annual meeting*** *for 20-minute presentations of research papers, each followed by a 10-minute period of discussion.*

Papers should present original scientific research, not previously published, pertaining to child abuse. Thematic areas to be covered at the Conference include survival and long-term effects, medical diagnosis of sexual abuse, fatal cases of physical abuse, cultural issues, cults and rituals, and reunification vs. permanency planning. Research in these areas is likely to receive favorable consideration. Research may be from any discipline. Previous presentation (as opposed to publication) will not be disqualifying.

Submit 300-word abstracts to:
David Finkelhor, Ph.D.
Associate Director
Family Violence Research Program
University of New Hampshire
Durham NH 03824

Fourteen abstracts can be accepted by the committee which Dr. Finkelhor will chair. Papers that are worthy of presentation but cannot be be accomodated in the schedule will be assigned to poster sessions during the meeting.

NEWS

CPS MISSES LARGE AMOUNT OF SERIOUS CHILD ABUSE KNOWN TO OTHER AGENCIES

--by David Finkelhor

The second National Incidence Study of Child Abuse & Neglect, (NIS-2), released in the summer of 1988, did not draw a great deal of media or professional attention. The main findings--that between 1980 and 1986 the number of cases of child abuse known to professionals increased 64% and that sexual abuse increased 221%--were not big surprises to anyone.

Now a supplementary analysis of the NIS-2 data has been released, authored by Andrea Sedlak, of Westat, the director of the original study. The new analysis presents a wealth of welcome details from the study. It, too, contains a few surprises.

The NIS is of particular interest because it used systematic definitions and data collection procedures to look at the problem of child abuse on a national basis. In 29 randomly selected counties around the country, NIS researchers obtained reports of child abuse and neglect from official reporting agencies like CPS, as well as from a large number of non-CPS agencies like schools, hospitals, and police departments.

One of the main strengths of the NIS-2 study is to document the amount of child abuse and neglect known to professionals that never gets into the official county-level child protection systems. According to one of the main study findings, only 40% of cases known to professionals which met the study's definitions of abuse actually ended up in CPS records. This is a huge volume of known child abuse and neglect cases that are never officially reported. Moreover, in spite of the large increases in cases coming to CPS attention in the years between 1980 and 1986, the percentage of these known but officially unreported cases did not decline to any appreciable extent. Apparently the barriers to CPS reporting--suspicion of CPS, CPS overload--have not yet been broken down.

The new report does show that some types of maltreatment are more likely than others to get into the CPS system: for example, abuse more frequently than neglect (52% vs. 23% known to CPS); sexual abuse (62%) and physical abuse (53%) more frequently than emotional abuse (40%). This is probably because sexual and physical abuse are the types of child protection problems about which professionals have been most educated.

Moreover, certain agencies seem to be reliably better at getting the cases of which they are aware recognized by CPS. Cases known to hospitals, law enforcement, and mental health agencies seem to get into the CPS system more frequently than cases known to schools, day care centers, public health, juvenile probation, or social service agencies. Schools know about the largest number of maltreated yet unreported children. The reluctance of schools to refer cases to CPS is well-recognized in the child protection field; it seems to reflect suspicions schools traditionally have had about CPS, as well as school administrators' ambivalence about how much they want, are able, or are supposed to act as a social service agency.

While most child welfare officials believe CPS should try to motivate agencies to report officially all child abuse of which they are aware, some observers are wary about this prospect. NIS-2 figures clearly show that investigating all child abuse currently known to other agencies would more than double CPS's workload. Hoping to avoid this expansion of responsibility, some of these observers both within and outside CPS have argued that it is primarily the less serious cases that are currently going unrecognized.

Unfortunately, NIS-2 data do not support this conclusion. Sixty-five percent of the maltreatment resulting in fatal or serious injuries were not recognized by CPS, about the same level of CPS recognition as for maltreatment in general. Physical neglect resulting in fatal or serious injuries was particularly likely to be ignored (an estimated 55,000 cases). Also, an estimated 50,000 cases of sexual abuse are known to non-CPS agencies but not to CPS.

The findings of the supplementary analysis seem inescapable, if not surprising. A substantial amount of serious child maltreatment is known to agencies in this country but is not, despite mandatory reporting laws, being recognized and investigated by state child protection authorities.

What are the policy implications of this? Before we assume that we know what to do, many more questions must be answered. For example, how many of these unrecognized cases get reported and recognized by CPS months or maybe even years later? How many of these unrecognized cases get some kind of attention or resolution outside of the CPS system entirely? What more can we learn from agencies about why their cases are not getting into the CPS system?

For copies of the report, "Supplementary Analyses of Data on the National Incidence of Child Abuse and Neglect," write to Andrea Sedlak, Ph.D., Westat, 1650 Research Blvd., Rockville MD 20850.

David Finkelhor, Ph.D., is Director of the Family Violence Research Program at the University of New Hampshire and The Advisor*'s Associate Edit for Research.*

JOURNAL HIGHLIGHTS

--by Susan Kelley

Journal Highlights, a new feature of *The Advisor*, is an effort to alert readers to current literature on child abuse. Selected articles from journals representing the variety of disciplines that comprise APSAC's membership will be presented in the form of an annotated bibliography. Because of space limitations, the citations listed cannot possibly be all-inclusive, but rather will provide a sampling of the current literature related to various aspects of child abuse.

Readers are encouraged to send copies of articles they believe would be of value to *Advisor* readers, accompanied by a two-sentence summary of the article, to the Section Coordinator: Susan Kelley RN, Ph.D., Assistant Professor, School of Nursing, Boston College, Chestnut Hill MA 02167.

Sex Offenders

Conte, J.R., Wolf, S., and Smith, T. (1989). What sexual offenders tell us about prevention strategies. *Child Abuse and Neglect, 13,* 293-301.

Results of this study, based on interviews with 20 sex offenders, suggest that offenders claim an ability to identify children vulnerable to sexual abuse and manipulate that vulnerability as a means of gaining sexual access to children. Offenders were found to use a wide range of coercive behaviors, including separating children from other adults who might protect them, conditioning victims through the use of reward and punishment, and letting the child view violence toward the child's mother. Important implications for prevention programs are discussed.

Knight, R.A., Carter, D.L., and Prentky, R.A. (1989). A system for the classification of child molesters: Reliability and application. *Journal of Interpersonal Violence, 4* (1), 3-23.

The authors present a child molester typology developed to fulfill the need for an operationalized, reliable, valid system to address the problem of the manifest diversity of offenders.

Child Sexual Abuse

Hanson, R.M., Glasson, M., McCrossin, I. and Rogers, M. (1989). Anogenital warts in childhood. *Child Abuse and Neglect, 13,* 225-233.

The authors present fifteen cases of anogenital warts in children and discuss their association with sexual abuse. Sexual abuse was established as the cause of the warts in 50% of the cases, and suspected in another 8%. Nonsexual transmission was established in 25% of cases. In 17% the source could not be established. The nonsexual transmissions included two cases in which infants were infected at birth; the remaining case involved auto-inoculation. The value of human papillomavirus DNA typing in sexual abuse case assessment is presented. The authors conclude that the presence of anogenital warts alone is sufficient grounds to pursue the possibility of sexual abuse.

Krug, R.S. (1989). Adult male report of childhood sexual abuse by mothers: Case descriptions, motivations, and long-term consequences. *Child Abuse and Neglect, 13*, 111-119.

Eight case histories of sexual abuse of sons by their mothers are presented in this article. In seven of the cases, the mother began the seduction and sexual abuse while the son was prepubescent and continued the abuse until at least early adolescence. The long-term negative impact on these victims as adult males is described.

Montan, C., Burgess, A.W., Grant, C.A., and Hartman, C.R. (1989). The case of two trials: Father-son incest. *Journal of Family Violence, 4* (1), 95-103.

This article analyzes a case in which outcome was reversed at retrial in a case of child sexual abuse. Poll results of the jurors' opinions suggest the need for testimony from law enforcement and child sexual abuse experts to explain a child's perception, memory, and recall of a reported sexual abuse experience.

Muram, D., Elias, S. (1989). Child sexual abuse genital tract findings in prepubertal girls: Comparison of colposcopic and unaided examinations. *American Journal of Obstetrics and Gynecology, 160*(2), 333-5.

In a prospective study, 130 sexually abused prepubertal females were evaluated both by an unaided

examination and by colposcopy. In 96% of the subjects with abnormalities, the abnormalities were observed during the unaided examination. In only one case was there a physical abnormality which could be seen only with the use of the colposcope. The authors conclude that unaided examination is adequate for the evaluation of most victims of sexual abuse.

White, S.T., Ingram, D.L., and Lyna, P.R. (1989). Vaginal introital diameter in the evaluation of sexual abuse. *Child Abuse and Neglect 13*, 217-224.

The authors studied the genitalia of 242 females, ages 1-12, and found that a vaginal introital diameter of >4mm was more prevalent among children with a history of sexual abuse (94%) than in children considered at risk for sexual abuse (5%) or in nonabused children (0%). They also found that 88% of sexually abused children who complained of penile-vaginal penetration had a vaginal introital diameter >4mm compared to 18% with no history of penetration. The authors conclude that a vaginal introital diameter of >4mm is highly associated with sexual contact in children under 13 years of age, but that an introital diameter < or = 4mm does not negate of history of vaginal fondling or penetration.

Ritualistic Abuse

Kelley, S.J. (1988). Ritualistic abuse of children: Dynamics and impact. *Cultic Studies Journal 5* (2), 228-236.

This article describes the nature and impact of intrafamilial and extrafamilial ritualistic abuse of children. The phenomenon's implications for policy, practice and research are discussed.

Physical and Emotional Abuse

Camras, L.S., Ribordy, S., Hill, J.O., Martinao, S., et al. (1988). Recognition and posing of emotional expressions by abused children and their mothers. *Developmental Psychology, 24* (6), 776-781.

Twenty abused and 20 nonabused pairs of children, aged 3 to 7, and their mothers participated in a facial expression posing task and a facial expression recognition task. Abused children and their mothers were found to pose less recognizable expressions than nonabused children and mothers. Although abused children were less accurate than nonabused children in recognizing emotional expressions, there was no difference in recognition accuracy between the two groups of mothers.

Hughes, H.M. (1988). Psychological and behavioral correlates of family violence in child witnesses and victims. *American Journal of Orthopsychiatry, 58* (1), 77-90.

Abused and nonabused children who witnessed parental violence were compared to children from nonviolent homes on several measures. Significantly more psychological distress was found in the abused-witness children than in the comparison group, with nonabused children who witnessed parental abuse scoring higher in psychological distress than the comparison group, but lower than the abused-witness group.

Sturm, L. and Drotar, D. (1989). Prediction of weight for height following intervention in 3-year-old children with early histories of nonorganic failure to thrive. *Child Abuse and Neglect, 13* (1), 19-28.

This study assessed the weight for height outcome of 59 3-year-old children who had been hospitalized as infants for NOFTT. While the majority of children attained normal weight for height at 3 years of age, 1/3 demonstrated inadequate growth. Shorter duration of NOFTT prior to diagnosis and greater initial rate of weight gain following hospitalization predicted weight for height at 36 months.

Widom, C.D. (1989). The cycle of violence. *Science, 244*, 160-166.

Findings from this cohort study involving 1575 subjects indicate that being abused or neglected as a child increases one's risk for delinquency, adult criminal behavior, and violent criminal behavior. Childhood victims of physical abuse had the highest level of arrest for violent criminal behavior, followed by victims of neglect. However, the majority of subjects who were abused as children did not engage in violent, delinquent, or criminal behavior as adults.

Second Annual Meeting, cont. from p. 1

APSAC and CAPSAC members will enjoy a $40 discount on the cost of registration. *To qualify for the discount, you must be an APSAC member by December 1.* Now is the time to join APSAC yourself and/or to urge your colleagues to become members. A membership application can be found in this newsletter.

Once again: San Diego, January 17 to 20, 1990. Co-sponsored by Children's Hospital of San Diego, Center for Child Protection; the San Diego Child Abuse Council, APSAC, and CAPSAC.

The conference promises to be a landmark. Hope to see you there!

"Reasonable Efforts", cont. from p. 7

more families. If the "reasonable effort" requirement is taken seriously, it will provide the means to reduce the number of court cases, while empowering families with the tools to remain intact.

In *Making Reasonable Efforts: Steps for Keeping Families Together*, published jointly by the National Council of Juvenile and Family Court Judges, the Child Welfare League of America, Youth Law Center, and the National Center for Youth Law, experts from several disciplines set forth guidelines and responsibilities for social workers, attorneys and judges to fulfill the requirements mandated by federal and state laws. The experts view the "reasonable efforts" requirement not as a burden on the system, but as an "opportunity for effective advocacy for children and their families, an occasion for open examination of community options, and a tool for sensible fiscal policy in which scarce funds are spent on the most cost effective and appropriate services."

Indeed, the measure of the success of mandating "reasonable efforts" will be the quality of the government and community programs it fosters. The rewards of "reasonable efforts" can be many, including better functioning families, more children remaining in their natural homes (and conversely fewer children in shelter and foster homes), and fewer dependency cases in court. Long term, it is not too optimistic to expect child abuse and neglect to decline--and to see the incidence of violent crime reduced.

It cannot be emphasized enough that professionals from all disciplines must enthusiastically endorse the need to make "reasonable efforts" a priority for the 1990's.

Social workers must not advocate for removal unless and until they can truly establish that all viable alternatives have been attempted, or determined to be legitimately inappropriate or impossible. When programs do not exist, funding must actively be sought to begin them. When programs are not effective, steps must be taken to improve or replace them.

Attorneys for children and parents must hold the social service agencies and the courts accountable for any failure to seek or provide the necessary services and programs. Social workers and attorneys must actively encourage judges to use their considerable power to demand that the legislative and executive branches of government establish needed services and programs and provide necessary funding.

The outcome of these combined pressures and efforts will be a system more capable of making a positive impact on achieving the goal of family preservation. The rewards will be reduced caseloads for all, fewer cases to be resolved in court, and more children residing with their natural parents--all at less cost, in human as well as monetary terms.

Joseph L. Spaeth, JD, is Managing Attorney of the Juvenile Division of the Public Defender's office in San Francisco, California.

From the President , cont. from p. 3

not just those who are paid to do so. Perhaps we need "Good Samaritan laws" to protect citizens who protect children, or perhaps we just need to make everyone aware of the need for each adult to protect the child who is nearby.

APSAC must continue to seek and find efficient and effective ways for professionals from all the disciplines that encounter child abuse to communicate with each other and to work to improve the protection of children in our society. Accomplishing these goals requires that APSAC greatly increase its membership over the next few years and become a force in the protection of children. I look forward to masking a contribution to this growth, and I will try to be responsive to the needs of all APSAC members.

CONFERENCES

September 14-15. ***Stopping the Sexual Abuse Cycle: Treatment of Non-Offending Parents and Adult Survivors.*** Charlotte, NC. Cosponsored by the Charlotte Area Health Education Center & the Family Support Center. Faculty includes Stephanie "Pepper" Hair, MSW; Jan Keny, MS; and Tim Lemmond, MA. Contact Sara Grode or Kate Haigler at 704-338-3757.

September 21-23. ***The Male Survivor: Assessment and Treatment of Male Sexual Abuse Victims.*** Atlanta, GA. Sponsored by the Atlanta Coalition of Sexual Abuse Professionals. Contact Jim Struve, LCSW, Metropolitan Psychotherapy Associates, 1649 Tullie Circle NE, Suite 112, Atlanta GA 30329. 1-800-345-9775, ext. 3700-3025.

October 1-2, 1990. ***Fifth National Task Force on Juvenile Sexual Offending Training Conference.*** Albany, NY. Co-sponsored by the National Adolescent Perpetrator Network of the Kempe Center, & the NY State Alliance of Sex Offender Service Providers. Contact Gary Gook, 518-473-1775. NY State Executive Dept., Division for Youth, 84 Holland Av., Albany NY 12208.

October 5-8. ***Shall You Betray Me with a Kiss? Ethical & Religious Response to Sexual Abuse.*** Boston. Sponsored by Spirit of Survival, a coalition to heal the effects of sexual abuse and to articulate the survivor's perspective in the healing professions. Conference faculty includes Mike Lew, Sandra Butler, Ellen Bass, Loretta Kowal, Marie Fortune, Carole Fontaine, Joanne Carlson Brown, Mary Pellauer. More than 40 workshop choices. Contact conf. coordinator, 617-353-4275.

October 22-25. ***Off the Beaten Path: Putting an End to Child Abuse & Neglect.*** Salt Lake City. Eighth National Conference on Child Abuse and Neglect. Sponsored by the National Center on CAN, the American Association for Protecting Children, the Kempe Center, Utah Department of Social Service, and Utah Coalition of Child Advocates. **APSAC MEMBERSHIP MEETING: MONDAY, OCT. 23, 5-7.** Contact Marilyn Sandberg, 801-626-3300, or Daryl Barrett, 801-538-4100. Write c/o 8th National Conf. on CAN, PO Box 45500, Salt Lake City, UT, 84145.

CALL FOR PAPERS,
stories, art, music, rituals, poetry, and other expressions of hurt and healing from survivors of sexual abuse. Spirit of Survival, a coalition to heal the effects of sexual abuse and to articulate the survivor's perspective in the healing professions, is looking for contributions to an anthology of survivors' expressions of their pain and healing, to be entitled *Spirit of Survival.* For information contact Spirit of Survival, c/o BCMHE, 735 Commonwealth Av., Boston MA 02215; 617-353-4275.

APSAC PINS NOW AVAILABLE!

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Show your proud support of APSAC by wearing a beautiful, jewelry-quality pin. Burnished gold letters, logo, and border on matte gold background. $8.00 each, $15.00 a pair (they make great earrings!). Send check or money order to APSAC office. Add $0.50 for gift box.

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APSAC's 2d ANNUAL MEETING
CAPSAC's Annual Meeting
January 19 & 20, 1990

*

at the 4th Annual Health Science Response to Child Maltreatment

*

January 17-20, 1990
San Diego, California

*

Workshops on medical, legal, and cultural issues in identification, assessment, prevention and treatment: psychotherapy for survivors from preschool age to adulthood; evaluation of medical findings; forensic interviewing of children; criteria for reunification of the family after incest; diagnosis for legal evidence vs. diagnosis for treatment; child abuse and borderline personality, dealing with the backlash, and more.

*

Faculty include Bessel Van der Kolk, Ruth Kempe, John McCann, John E.B. Myers, Harry Elias, Roland Summit, Hanita Zimrin, Mary Meinig, Eliana Gil, Donna Montegna, David Finkelhor, Lucy Berliner, Kee MacFarlane, Sandra Butler Smith, David Chadwick, Joyce Thomas, David Corwin, Jon Conte, Barbara Orr, C.J. Hobbs, Dominique Cattaneo, Deborah Davies, Donald Duquette, Boyd Stephens, Inger Davis, Michele Chadwick, and others.

*

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APSAC's *Advisor* is a quarterly publication (January, April, July, October) with a national circulation of approximately 2000. Readers include social workers, psychologists, attorneys, psychiatrists, pediatricians, teachers, law enforcement officers, researchers, and other professionals who work with victims and/or perpetrators of child abuse.

We welcome your display advertising for goods, services, publications, and conferences that may be of interest to *Advisor* readers. Display advertisements should be submitted in camera-ready copy, accompanied by a check made payable to APSAC, to the attention of Theresa Reid, Manuscript Editor, at *The Advisor*'s Chicago offices.

Classified advertising is also available. Cost is $2.00 per line (or any fragment of a line), at 30 characters per line, including spaces and punctuation. Classified ads need not be camera-ready, but must be accompanied by a check. *Be sure to include identifying information as part of your ad, so respondents can contact you directly.*

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POSITIONS AVAILABLE

Chief of Therapy for new model Family Treatment Program for Sexually Abused Children. Opportunity to develop this new program, to engage in patient care, teaching, and research. Funding includes positions for additional therapists and clerical support staff. Salary highly competitive. Position available immediately. Call Dr. Jerry G. Jones, 501-370-1018; or write c/o UAMS Dept. Pediatrics, Arkansas Children's Hospital, 800 Marshall St., Little Rock AR 72202. UAMS is an equal opportunity employer.

Ph.D. Psychologist. Child abuse counseling agency seeks psychologist interested in working with children and families. Requires skills in assessment, individual, group, and family therapy for abuse-related problems. The agency is located in the heart of the picturesque White Mountains of New Hampshire offering four seasons of outdoor recreation activities. Send resume to: Center for New Beginnings, PO Box 935, Littleton NH 03561.

ANNOUNCEMENTS

* APSAC's next membership meeting will be held in Salt Lake City on October 23, from 5-7, during the Eighth National Conference on Child Abuse and Neglect. See p.14 for more details on "Off the Beaten Path: Putting an End to Child Abuse & Neglect."

* ***Betty Johnson***, a cheerful and efficient young woman, has replaced Margie Vaughn as APSAC's office manager. Margie got us back on our feet, then left to pursue her career in fashion merchandising after training Betty to fill her shoes. Betty is enthusiastic about APSAC's goals, and proud to be part of the organization. If you have a question about membership or meeting dates, she will be delighted to help, at 312-702-9419.

APSAC
The American Professional Society
on the Abuse of Children
c/o The University of Chicago
School of Social Service Administration
969 East Sixtieth Street
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School of Social Service Administration
969 East 60th
Chicago, IL 60637
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