APSAC

Volume 2 Number 4 , 1989

THE ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

FROM THE PRESIDENT

When Jon Conte and the rest of APSAC's Executive Committee decided (without my input) to hold APSAC's 1990 annual meeting in San Diego, they may or may not have been thinking of the boon it would be for me. Regardless of their reasoning, holding APSAC's annual meeting in conjunction with the Fourth Annual Conference on the Health Science Response to Child Maltreatment (sponsored by the Center for Child Protection and Family Support of San Diego's Children's Hospital) presents me with the wonderful opportunity to promote my own program and APSAC's interests at the same time.

A great deal of planning and hard work are going on to make the meeting memorable. APSAC members should have received the first flyer by now. A detailed program is enclosed in this newsletter.

I encourage APSAC members to participate actively in all of APSAC's business to be conducted in San Diego. Meetings of the Board and Executive Committee will be held and are open to the membership. A Membership meeting will be held as well, so the Board can report on progress and projects to members unable to make the smaller meetings.

One of the areas in which we seek your input is the planning for our first "solo" national conference. Before long, APSAC will hold its annual meeting independently of other sponsoring institutions. Reports on preliminary inquiries into the feasibility of a solo conference will be presented in San Diego. Members interested in providing input regarding meeting sites and/or program content should contact Charles Wilson, APSAC's Second Vice President, at the Tennessee Dept. of Human Services, 400 Deaderick St., Nashville, TN 37219; 615-741-3443. Bud Cramer, who gave APSAC an enormous boost at the Huntsville meeting last March, is also involved in planning for our solo conference. He's available at the District Attorney's Office, Madison County Courthouse, Huntsville AL 35001; 205-532-3460.

The Board also encourages members to participate in the ongoing process of guidelines development. Progress on this front will be clearly visible in San Diego, when the three Task Forces engaged in this work will hold meetings with the membership during the evening of Thursday, January 19, 1990. Should you wish to provide input before this meeting, Task Force chairs' names and addresses are as follow: Assessment & Treatment of Perpetrators of Child Sexual Abuse, Judith Becker, Ph.D., New York Psychiatric Institute, 722 W. 168th, NY NY 10032; Evaluation of Suspected Sexual Abuse in Young Children, Lucy Berliner, MSW, Sexual Assault Center, Harborview Medical Center, 325 9th Av., Seattle WA 98104; Medical Evaluation of Suspected Child Abuse, David Chadwick MD, Center for Child Protection, Children's Hospital, 8001 Frost St., San Diego CA 92123.

Next to joining APSAC yourself, recruiting other members and attending the Annual Meeting may be your most effective means of advancing the cause of professionalism in child protection practice. We must all work together to build a stable corps of secure and competent professionals from a variety of disciplines who are willing to devote their careers to making children safe.

Come to San Diego in January. Bring a friend. I look forward to seeing you there.

--David Chadwick, MD

IN THIS ISSUE:

The Advisor

Editor-in-Chief
David Corwin, MD
11 Moraga Way #3
Orinda CA 94563
415-254-0674

Executive & Legal Editor
John E.B. Myers, JD
Univ.of the Pacific, McGeorge School of Law
3200 Fifth Av.
Sacramento CA 95817
916-739-7176

Associate Editors
Book Reviews
Barbara Bonner, Ph.D.
University of Oklahoma
Heath Science Center, Psychiatry
Box 26901
Oklahoma City OK 73190
405-271-4415
Evaluation and Treatment
Mark Everson, Ph.D.
University of North Carolina
Clinical Research Program on Childhood
Maltreatment, Dept. Psychiatry, CB# 7160
Chapel Hill NC 27599-7160
919-966-5277
Investigation
Detective Rick Cage
Montgomery County Police Youth Division
2300 Randolph Rd.
Wheaton MD 20902
301-217-4300
Journal Highlights
Sue Kelley, RN, Ph.D.
Boston College School of Nursing
Chestnut Hill MA
Medical
Martin Finkel, DO
Univ.of Medicine & Dentistry of New Jersey
301 S. Central Plaza, Laurel Rd., #2100
Stratford NJ 08084
609-346-7032
News
Dan Sexton
Childhelp USA
1345 El Centro Av.
Hollywood CA 90028
213-465-4016
Perpetrators
Robert Prentky, Ph.D.
Massachusetts Treatment Center
PO Box 554
Bridgewater MA 02324
617-727-6013, ext.1527
Prevention
Deborah Daro, DSW
NCPCA
332 S. Michigan Av., #950
Chicago IL 60604-4357
312-663-3520
Research
David Finkelhor, Ph.D.
Family Research Laboratory
128 Horton Social Science Center
Durham NH 03824
603-862-2761

Manuscript Editor
Theresa Reid, MA
Executive Director, APSAC
312-702-9419

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, and one copy to the Executive Editor, John Myers.

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

NOTES FROM THE FIELD

--by Dan Sexton

* NCPCA has just completed a national teacher survey to assess teachers' knowledge, attitudes, and beliefs about child abuse. A total of 568 first through sixth grade teachers from 40 randomly selected school districts across the country responded to a questionnaire. For additional information, contact NCPCA, 332 S. Michigan, Suite 1600, Chicago, IL 60604. Cost is $2.00 for working paper #846, "Teachers confront child abuse."

* Current legislation is being addressed in California which would extend the statute of limitations for civil actions based on childhood sexual abuse. The bill, SB108, recognizes that victims need more time in which to become aware of psychological damage and to bring suit. The bill provides that commencement of such actions shall be either 8 years from the victim's majority (18 yrs. old) or 3 years from the time the plaintiff discovers or reasonably should have discovered that his/her psychological injuries were caused by the sexual abuse, whichever occurs later. For additional information, contact Mary Williams, 1727 Martin Luther King Jr. Way, # 107, Oakland CA 94612. 415-893-7120.

* The new NCCAN Advisory Board, appointed this year by Secretary of HHS, has elected as its chair Dr. Richard Krugman, Director of the Kempe Center, and as its vice-chair Howard Davidson, Director of the ABA Center for Children and the Law.

* Mary Gall has been appointed the new Assistant Secretary for Human Development Services in HHS. Gall comes to the position from the President's Task Force on Adoption, which she chaired since 1987. Before that she worked as a domestic policy advisor to then Vice-President Bush.

* The Canadian Children's Foundation has opened a

continued on p.14

LEGAL

LEGAL EVIDENCE OF PHYSICAL CHILD ABUSE

--by John E.B. Myers

Physical child abuse is legally defined as nonaccidental physical injury. From a legal standpoint, physical abuse is often difficult to prove. Maltreatment occurs in secret, and the child is usually the only eyewitness. Tragically, some victims do not live to tell their story, and others are too young to testify. Often, the only evidence is a child's bruised and battered body. The most common defense to accusations of physical abuse is that a child's injuries were accidental.

When allegations of physical abuse result in litigation, the attorney attempting to prove abuse faces two primary evidentiary hurdles. First, the attorney must prove that the child's injuries were nonaccidental. Second, the attorney must establish the identity of the perpetrator.

Proof of nonaccidental injury

Expert testimony on battered child syndrome plays a key role here (Ellerstein, 1981; Helfer & Kempe, 1987; Myers & Carter, 1988). The term "battered child syndrome" was coined by Kempe and his colleagues (Kempe, Silverman, Steele, Droegemueller & Silver, 1962). Children with battered child syndrome usually show signs of repeated abuse, with injuries typically in different stages of healing.

Courts acknowledge battered child syndrome as a recognized medical diagnosis, and expert testimony on the syndrome is routinely approved (*State v. Dumlao,* 1985). In fact, every appellate court to consider expert testimony on the syndrome has approved such testimony (*State v. Tanner,* 1983).

The primary function of expert testimony on battered child syndrome is to establish that a child's injuries were not accidental. A legal finding of nonaccidental injury may be predicated partially or *entirely* on expert testimony on battered child syndrome (*State v. Moyer,* 1986; *State v. McClary,* 1988).

It is important to note that battered child syndrome is not found in all physically abused children. In particular, the syndrome is absent in a substantial percentage of child abuse fatalities. Zumwalt and Hirsch write that "in our experience approximately 15-20 percent of child abuse fatalities fulfill the . . . criteria for the battered baby syndrome. . . . Fatalities from an isolated or single beating are as common as fatalities from repeated physical assault" (Zumwalt & Hirsch, 1987, 251, 258).

A properly qualified physician may testify that a child should be diagnosed as suffering from battered child syndrome, and that the child's injuries were probably nonaccidental. In addition, many courts permit physicians to render opinions on the means used to inflict injuries (*People v. Jackson,* 1971; *State v. McClary,* 1988; *State v. Jurgens,*1988; *State v. Tanner,* 1983). For example, a physician may state that a skull fracture was probably caused by a blow from a blunt instrument such as a fist. Some courts permit doctors to testify that an injury was probably caused by "a person of mature strength" (*State v. Mulder,* 1981, p.463). Courts generally allow a physician to indicate whether injuries could occur in a particular way. For example, a physician may answer the following question: "Could an injury of this type be caused by throwing a child against a wall?" Additionally, a physician may indicate "whether the explanation given for the injuries is reasonable" (*State v. Tanner,* 1983, p.544).

A key diagnostic feature of battered child syndrome is a "marked discrepancy between clinical findings and historical data as supplied by the parents" (Kempe, Silverman,Steele, Droegemueller & Silver, 1962, p.17). Schmitt observes that an important indicator of nonaccidental injury is an explanation "which is implausible and inconsistent with common sense and medical judgment"(Schmitt, 1987, p.179). For example, caretakers may describe a minor accident to explain major injury. Caretakers may state that a child with a severe skull fracture and multiple body bruises fell from a couch onto a carpeted floor. Alternatively, caretakers may state that injury occurred when a child engaged in activity the child could not perform (Schmitt, 1987). For example, caretakers may state that a four-month-old baby climbed onto a stove and turned on the burner.

Because an implausible explanation offered for a child's injuries is critically important to a diagnosis of battered child syndrome, someone should promptly visit the scene to document plausibility. In addition, all professionals should take care to document the exact words caretakers use to explain a child's injuries.

When child abuse is suspected, it is useful to interview caretakers in separate locations. Since abusive adults seldom reveal the real cause of a child's injuries, they must invent excuses. When caretakers are interviewed separ-

continued on next pg.

continued from p. 3

ately, their excuses may reveal an inconsistency that undercuts the validity of both explanations, pointing to abuse.

In many cases, photographs are taken of children's injuries. Such photographs are helpful in proving nonaccidental injury, and courts generally permit physicians to use them to explain and illustrate their testimony (*United States v. Bowers,* 1981; *State v. Swafford,* 1974; *Watson v. State,* 1986; *In re Brooks,* 1978; *State v. Conlogue,* 1984; *State v. Durfee,* 1982; *Wetz v. State,* 1987; *State v. Hotchkiss,* 1987).

Proof of identity of batterer

Documenting improbable explanations is again critical when attention turns to identifying the perpetrator. As evidence of consciousness of guilt, implausible explanations may be admissible in evidence as an admission. In *Payne v. State,* for example, the defendant was convicted of abusing an 11-month-old infant. The doctor discovered a broken neck in addition to bruises on her head, face, tongue, forearms, chest, abdomen, shoulders, hip, and genitals. She also had multiple rib fractures. The defendant told the doctor that the child hurt herself falling off a porch step several days earlier. Defendant also told the doctor that the child fell off a couch the night before she was taken to the doctor's office. In light of the medical facts, the defendant's explanation was absurd. The court concluded that defendant's explanation was admissible against him, writing that "a jury may consider and give weight to any false and improbable statements made by an accused in explaining suspicious circumstances" (*Payne v. State,* 1987, p.236).

In addition to documenting implausible explanations for children's injuries, professionals should look for and document other behavior and statements by caretakers that one would not expect from an innocent person. When a seriously injured child is rushed to the hospital, or when paramedics arrive at the home, abusive caretakers sometimes behave in odd ways that suggest consciousness of guilt. In *People v. Henson,* a severely ill and battered 4-year-old was rushed to the hospital, where he was pronounced dead on arrival. When the mother was informed that her child was dead, she cried, "Oh God, what will they do to us now?" (*People v. Henson,* 1973, p.659). This is hardly the cry of anguish one expects from a bereaved parent. In *State v. Johnson,* the prosecutor offered testimony from a fire fighter who responded to a call for emergency medical help. The fire fighter was permitted to testify that "the actions of [defendant] did not seem . . . to be the usual actions or concerns of a parent with a child in that situation" (*State v. Johnson,* 1986, p.506).

Of course identity may also be established through the testimony of eyewitnesses, including child victims. Sometimes a caretaker acknowledges that a child's injuries were nonaccidental, but denies responsibility for inflicting the injuries. In such cases, identity may be established with evidence that the caretaker had exclusive custody of the child when the injury occurred (*People v.Henson,* 1973; *People v. M.V.,* 1987; *State v. McClary,* 1988). Such evidence often takes the form of a process of elimination in which all potential perpetrators except the accused are systematically excluded.

In some cases it is possible to prove that a child suffered nonaccidental injury, but the identity of the perpetrator cannot be established. In criminal litigation, the prosecutor must prove identity beyond a reasonable doubt, and inability to do so requires a verdict of not guilty.

It is important to point out, however, that in juvenile court proceedings to protect abused children, inability to identify the perpetrator does not necessarily mean the court is powerless to protect the child. In some states, a juvenile court can assume protective jurisdiction over a child despite lack of evidence identifying the perpetrator.

References

In re Brooks, 379 North Eastern 2d. 872 (Ill. Ct. App. 1978).

Ellerstein, N.S. (ed. 1981). *Child abuse and neglect: a medical reference.* New York: John Wiley.

Helfer, R.E., and Kempe, R.S. (eds. 1987). *The battered child: fourth edition.* Chicago: University of Chicago Press.

Kempe, C.H., Silverman, F.N., Steele, B.F., Droegemueller, W., & Silver, H.K. (1962). The battered child syndrome. *J.A.M.A., 181,* 17-24.

Kleinman, P.K., Blackbourne, B.D., Marks, S.C., Karellas, A., & Belanger, P.L. (1989). Radiologic contributions to the investigation and prosecution of cases of fatal infant abuse. *New England J. Med., 320,* 507-511.

Myers, J.E.B., & Carter, L.E. (1988). Proof of physical child abuse. *Missouri Law Review, 53,* 189-225.

Payne v. State, 731 South Western 2d 235 (Ark. 1987).

People v. Henson, 349 New York Supplement 2d. 657 (1973).

People v. Jackson, 95 California Reporter 919 (Ct. App. 1971).

People v. M.V., 742 Pacific 2d 326 (Colo. 1987).

Schmitt, B.D. (1987). The child with nonaccidental trauma. In Helfer, R.E. & Kempe, R.S. (eds. 1987), *The battered child: fourth edition.* Chicago: University of Chicago Press, pp.178-196.

State v. Conlogue, 474 Atlantic 2d 167 (Me. 1984).

State v. Dumlao, 491 Atlantic 2d 404 (Conn. Ct. App. 1985).

State v. Durfee, 322 North Western 2d. 778 (Minn. 1982).

State v. Hotchkiss, 525 Atlantic 2d. 270 (N.H. 1987).

State v. Johnson, 400 North Western 2d. 502 (Wis. Ct. App. 1986).

continued on p.14

PRACTICE

INVESTIGATING MACRO CASES

--by Donna M. Pence

Abuse of children in out-of-home settings has long been recognized by social workers and law enforcement officials in the child protection field. The old stereotype of the single "stranger" offender who abuses a lone victim has increasingly proven to be unrealistic. Many out-of-home cases now being properly investigated show that a single offender probably has a number (perhaps hundreds) of victims, and that many of these offenders communicate and/or associate with others of like interest. Some investigations involve multiple offenders, multiple children, and multiple jurisdictions.

These cases are the most complex and time-consuming that an investigator is likely to work. Handling this type of situation correctly from the outset is of utmost importance.

Scrupulous care is especially prescribed given the tactics defense attorneys will use to destroy your case. Acts such as those we investigate can defy not only the public's imagination but our own as well. This "incredibility factor" is easily exploited by defense attorneys. A primary defense strategy is to identify the principal investigators as the problem, rather than the offender. The defense will try to convince the jurors that the investigators are misguided zealots who have for some reason induced innocent children to recite this preposterous tale. By diverting attention away from the defendant, the defense clouds the issue of who in fact is on trial. The defense task becomes to convince the jury that one or possibly two well-intentioned but inept investigators planted the story in the children's minds--often an easier task than making jurors face the reality of large-scale, methodical abuse of children.

One of the obstacles to thorough investigation is media attention. Reporting on alleged sexual acts committed against children in out-of-home settings does not stop with the initial complaint, but continues through the investigation and trial stages. Such attention elevates public and professional concern about investigative procedures and the safety of children in general. Putting pressure on the investigators, media attention may prompt them to move more rapidly than the case and caution warrant. It is critical that, especially in the face of such pressure, investigators proceed methodically and in an organized manner, pausing to plan, prepare, and proceed carefully.

To best protect both children and themselves, investigators working on macro-cases are urged to multiply their numbers, establishing two or more separate teams and involving multiple medical examiners when possible.

Investigative teams and design

Timeliness. As soon as you become aware that you may be investigating a macro case, request that additional personnel be assigned. While supervisors may initially be reluctant to commit many investigators to a single case, they should realize that such a commitment makes sense both in the long and in the short run.

One big advantage of using multiple investigators is that individuals are less likely to feel overwhelmed and confused by the magnitude of the case and the profusion of evidence. Investigative teams break the tasks into manageable blocks and keep the chain of command clear.

Another major advantage to teams is that, although more people are involved, time is used more efficiently. Rather than tying up one or two investigators for an inordinate period of time, an investigation using teams can be accomplished swiftly.

Speed is often essential to these cases, too: once the word is out that an investigation is underway, evidence is routinely removed or destroyed by likely defendants. The more quickly and efficiently an investigation can be completed, the greater the likelihood of finding evidence in the condition children have described it.

Team work. Investigative teams should be divided into separate units acting independently, with no direct exchange of information between the teams. If possible, a different qualified physician should be assigned to each team so that the defense attorney has to discredit more than one physician to significantly injure the case. The overall investigation and the work of each team should be coordinated by a central team leader.

The team leader should assign to each team potential victims to interview. It is wise to assign the high risk population to different teams. Prior to interviewing children, investigators should ascertain special activities, if any, that have involved the children, such as movies, television shows,games, visits by clowns, magicians, or other similar events. Documenting special events may be important in separating fact

continued on next pg.

continued from p. 5

from fantasy and in corroborating children's statements. Statements that mix actual abuse with a special event may mislead investigators to conclude that ritualistic abuse has occurred.[2]

The interviewing styles followed are consistent with normal child sexual abuse investigations. In macro cases in which perpetrators have used extraordinary coercion to enforce the children's silence, the victims will be slow to reveal what has happened, so multiple interviews may be necessary. These children may initially deny all knowledge of abuse. As they feel more comfortable with the interviewer, children may say, "It happened to someone else," then, "It happened to Bobby," and finally "It happened to me." Because the defense will later use these inconsistencies to its advantage, it is essential that interviewing methods be demonstrably above reproach.

Coordinating findings. While each team should validate its own interviews (including those with parents) using established procedures which can later be articulated in court, it is the team coordinator who assembles the whole puzzle and validates that it is a macro case rather than an isolated case or cases within a single population. Under no circumstances should members of different teams be aware of the results of the others' investigation.

The team coordinator should take the information submitted by investigators, and with the aid, if possible, of a charting specialist, prepare association and/or flow charting of all the activities and relationships the interviewees disclose. A summary of each interview should list the name of the interviewee, the primary offender, other victims and offenders that the interviewee names, potential witnesses, items of physical evidence mentioned, and locations where the abuse occurred.

As part of this tabulating phase, the coordinator may well decide that certain interviews need to be corroborated or continued, or that new children or witnesses need to be interviewed, and will assign this interviewing to be done by members of different teams.

Also, the coordinator should keep the district attorney's office apprised of all developments, so the DA can determine when enough information exists to obtain search warrants, for what evidence, at what locations. If multiple locations have been exposed as abuse sites, the possibility of simultaneous raids should be explored.

Working with parents.

Mismanagement of parents of potential victims may be the single most common mistake and the most damaging to a successful investigation. We have identified the following types of parental reactions:

Intrusive. These parents feel that the current efforts of investigators are inadequate and that it is necessary for them to take the lead or augment the investigation. They may conduct repeated interviews with their own children or other children, using leading questions that tell the children what they expect or want to hear. They may show the children photographs of possible offenders or drive them to locations where the abuse might have occurred. They may meet with other parents to exchange information about things the other children have said or done.

All of these activities can invalidate statements taken from these children and their parents at a later date. Yet such parents justify their actions by saying that they are the only ones really interested in the welfare of their child and they want to make sure that all is done properly.

When dealing with intrusive parents, be aware that they may have unresolved feelings about sexual abuse in their own lives.

Uncooperative. These parents refuse to allow their children to be interviewed at all. Some parents base this refusal on their feeling that the children will be more traumatized by the investigation and possible prosecution than they were by any type of abuse. If they note behaviors that suggest that abuse has occurred, they may feel that the child is young enough that it's best to let them forget the abuse rather than "dwell" on it.

Some uncooperative parents may have had prior contact with CPS involving allegations of sexual or physical abuse or neglect charges. This past contact may have so alienated the parents from CPS and/or the police that, no matter what their belief about the possibility of abuse, they will refuse to cooperate. It's also possible that an abusive situation currently exists in the home that the parent is afraid will come to light if the child is interviewed.

Retributive. These parents are enraged and want immediate and forceful action. They frequently inundate CPS and police investigators with telephone calls and unannounced visits, demanding progress reports. They are, for the most part, unfocused in their anger and do not engage in direct activities such as the intrusive parent does. The primary damage this parent can do to a case is disclose to the media either the existence of the case or details of the case that investigators are keeping under wraps. They may also turn against investigators and publicly blast their efforts if they think the investigation is not moving swiftly enough.

Some of this rage may be directed at investigators to

continued on next pg.

cover the parent's feelings of guilt for failing to protect their children or to recognize signals the child may have been sending regarding the abuse. Parents may feel impotent about their ability to prevent abuse. Especially if they had trusted the offenders, had had a friendly relationship with them, parents may question their ability to judge people. All of these possibilities may trigger deep anger. Investigators should not discount the possibility that such parents may attempt to kill or injure the offenders.

Disbelieving. These parents refuse, sometimes in the face of irrefutable evidence, to believe that any abuse actually took place or that the offenders had anything to do with it. They disregard their children's statements about who the abuser was and how and when the abuse took place. The primary damage these parents can do to an investigation is to pressure disclosing children into recanting. Such pressure may be nonverbal (e.g., withdrawal of affection when the child mentions abuse), verbal (e.g., "Reverend Jones didn't *really* do those things, did he? You know what a nice man he is."), or physically abusive (e.g., hitting, slapping, or confining the children).

This disbelief may derive in part from the retributive parent's issues: guilt over failure to protect the child, to pick up cues, or to believe initial reports; inability to deal with the possibility that they placed their child at risk. Disbelieving parents may have decided that maintaining their relationship with the abuser is more important than believing their child's word or other evidence.

Supportive. These parents focus their concern on their child's welfare. They are good about keeping appointments and supporting the goals of both investigators and therapists. They may question their children or take them to places where the abuse occurred, but their motivation is to help clarify what happened for themselves rather than to assist with the investigation. If told that this is counterproductive they will generally cease. They seem to have accepted the events and are looking for ways to constructively cope.

Any given parent may behave differently at different times, as he or she reacts to this complex and threatening situation. Many parents who are initially obstructive or disbelieving gradually come around and become supportive. Others, however, will make no movement towards healthy resolution.

Meeting with parents. An effective investigation attends to parents, helping to move them toward a more supportive mode. It falls to the team coordinator to initiate this process. As soon as the initial validation of the case has been made, the coordinator should send a letter calling all parents whose children may be victims to a meeting. (See sample letter below.)

One or more mental health practitioners should assist in leading the discussion. The purpose of this meeting is to inform the parents of the investigation and to request their cooperation. Concern for the children's well-being should be stressed.

Parents will show a wide range of emotions. Some may be distrustful of each other, fearing that information shared will get back to the alleged offenders. The investigator leading the discussion should be very clear about what parents can and can't discuss with others. Smaller parent groups should be established at this meeting and assigned to the different teams. The purpose of these groups is to help parents deal with specific issues as they arise and to keep them informed of the progress of the investigation. If possible, a mental health practitoner should be available to them at every stage.

Summary

Key points in successfully investigating a macro case include:

* Plan carefully, but react quickly, particularly in regard to possible physical evidence.

* Resist the temptation to respond to media pressure. Develop a strategy for all investigative agencies on how to respond to inquiries, designating one person as the media contact.

* Establish an investigative team large enough to properly interview all possible victims in a timely manner. Don't be afraid to ask for help.

* Appoint a team leader and break the team into isolated units to avoid cross-contamination.

* Expect the children to reveal the abuse slowly.

* Chart and carefully document which child alleges what activity: these cases get complex quickly.

* Understand parental reaction and try to harness their energy so it won't work against you.

References

Wilson, Charles. *Investigation of Sexual Abuse in Daycare.* Child Welfare League of America, 1986.

Donna M. Pence is a Special Agent in the Tennessee Bureau of Investigation.

Suggested Notification Letter

Dear Parent:

The (law enforcement agency) and the Tennessee Department of Human Services in cooperation with the District

continued on p.14

MEDICAL

PRINCIPLES AND PITFALLS IN FORENSIC EVIDENCE COLLECTION

--by Allan R. DeJong

Associate Editor's Notes

Forensic evidence often lends powerful credibility to a child abuse allegation. Unfortunately, opportunity to collect forensic evidence is limited. Worse, forensic evidence collection is often done haphazardly.

Generally, if an opportunity to collect forensic evidence occurs during the course of a child abuse investigation, it occurs only once. Every medical examiner should remember that this chance is the *only* chance to record vital evidence.

The following brief article by Allan R. DeJong, MD, provides important guidelines for the collection of evidence. Another helpful protocol is the 1987 publication by the State of California's Office of Criminal Justice Planning. It is called *The Medical Protocol for the Examination of Sexual Assault and Child Sexual Abuse Victims: Informational Guide.* APSAC will be happy to send you the relevant pages (61-72) if you send $1.00 for xeroxing and postage to the Chicago office.

--by Martin Finkel, DO, Associate Medical Editor

***

Feature

One purpose of the physical evaluation of the sexually abused child is to collect forensic specimens for documentation of sexual contact. The major evidence sought is sperm or seminal fluid on the victim's skin, body openings, or clothing. Although clinical studies typically report only a 2% to 16% rate of detection for sperm or seminal fluid in child victims, careful preparation of the child and careful collection and handling of the specimens will maximize the yield of useful information.

All sexually abused children should have a medical evaluation, but collection of specimens to detect sperm or seminal fluid is not warranted in all children. Sperm and seminal fluid are most likely to be found immediately; rarely are they detectable for more than 72 hours following their deposition on or inside the body. Therefore, specimens need not be collected if it's clear that the contact occurred more than 72 hours earlier; immediate collection is indicated in cases where les than 72 hours is known to have elapsed. Collection is also indicated when timing is uncertain or if physical findings such as fresh injuries or suspicious stains suggest the possibility of more recent contact.

A routinized approach to specimen collection is required to maintain the validity of the evidence. Specific details of collection, labeling, and packaging of specimens will be dictated by the laboratory processing the specimens. Lab techniques may vary somewhat, so it's critical that you **have clear information from your lab** regarding the number and type of specimens required.

Based on the laboratory's requirements, **a specimen collection protocol and/or checklist should be used** to insure that all appropriate specimens will be collected. The protocol should include provisions both for the routine situation and for situations requiring special handling. You should **work with a standardized collection kit,** whether one of the commercially available "rape kits" or one assembled on site.

Finally, **the number of personnel handling the specimens should be limited,** and each separate handling of specimens should be documented to maintain a "chain of evidence." Clearly document names and locations of handlers from the time of collection through the processing of the specimens in the lab. Actual contamination can occur from mishandling specimens, but even suspected mishandling can both legally invalidate the results of the tests and raise questions about the validity of other aspects of the evaluation.

Seminal fluid is usually identified by testing for sperm; acid phosphatase, an enzyme found in high concentration in semen; and in some cases semen glycoprotein (P30), a protein uniquely manufactured in the male prostate gland. The The tests your lab uses will determine the details of your evidence collection procedure.

Handle specimens *only* with gloved hands, both to protect yourself and to avoid contaminating them.

Most specimens can be obtained using dry or slightly moistened cotton swabs. Some authors suggest that smaller nasopharyngeal swabs or male urethral swabs may be easier to use for vaginal specimens in prepubertal girls. Some experts recommend using a small catheter to obtain vaginal washings using 2cc of sterile saline or water. Vaginal washings can help obtain a larger sample, but perhaps at the cost of

continued on next pg.

diluting specimens for acid phosphatase beyond the cutoff levels. Swabs should be taken as well for screening for sexually transmitted diseases.

A Woods lamp may help identify semen stains on skin or clothing because the semen may fluoresce with a blue or blue-green color under the ultraviolet light. However, fluorescence under UV light is nonspecific. Various skin infections, congenital or acquired skin pigmentary changes, and chemicals including systemic and topical medications, cosmetics, soaps and industrial chemicals may fluoresce under UV light. Use fluorescence to help direct specimen collection, but do not overinterpret its meaning.

Stains suspected to be dried seminal fluid can be scraped off the skin with the back of a scalpel blade into a clean envelope or tube, or lifted with swabs moistened with sterile water or saline. Often it is best to collect stained, torn or bloody clothing to allow the forensic laboratory to remove samples rather than try to remove them yourself. If the victim was wearing a tampon, pad, or diaper during assault, or if a fresh tampon, pad, or diaper was used following the abuse, save this for analysis for the presence of semen. These objects may retain semen longer than body openings, thus providing indispensable evidence.

Appropriately collected samples can be ruined by improper handling. Most labs require air dried specimens, which must be dried for 60 minutes before they can be packaged. Heat should not be used to facilitate drying, but a cool air fan can be helpful. Heat and moisture both can promote the growth of *Candida* or other organisms which may destroy the evidence. Swabs for sexually transmitted diseases should *not* be air dried, since air drying will kill the organisms and cause the cultures for these diseases to be falsely negative.

Dry specimens are stable: dry sperm may be detected for up to 12 months, acid phosphatase may be detectable for months or even years, and P30 is detectable for up to 12 years on dried seminal fluid stains on clothing. The key word is **dried.** Don't place damp clothing in a sealed plastic bag: moisture destroys the evidence.

In summary:

* Specimens for detecting sperm or seminal fluid need not be collected on all sexually abused children.
* Collect them properly when they need to be collected.
* Know how your laboratory processes its samples, so you can submit proper specimens.
* Do not ruin properly collected evidence by improper handling that destroys the semen or legally invalidates the detection.
* Finally, remember the child. Be sensitive, be gentle, and be efficient.

Allan R. DeJong, MD, is Clinical Professor of Pediatrics at Jefferson Medical College and Director of the Pediatric Sexual Abuse Program at Thomas Jefferson University Hospital, in Philadephia.

LEGAL

PROSECUTING CHILD ABUSE: OLD PROBLEMS AND NEW CHALLENGES

--by Patricia Toth and Janet Dinsmore

Ten years ago there was little to say about child abuse victims in the criminal justice system. Child abuse was largely ignored as a crime, and children were rarely seen in criminal court. Police and prosecutors had little experience dealing with children as victims, and almost no contact with the variety of child welfare, medical, mental health, and other professionals working with abused children.

Today, however, the picture is dramatically different. Building over the past decade, an avalanche of cases now reach law enforcement for investigation and possible prosecution.

The great majority of district attorneys view enforcement of criminal laws prohibiting child abuse as one of their most important and demanding responsibilities. District attorneys generally agree that child abuse is a criminal offense for which offenders must be held accountable, and that child abuse victims deserve equal justice under law.

The volume of cases and the complexity of child abuse investigation and litigation have generated many innovations. Among them are court reforms and new rules of evidence, new types of training for prosecutors and other professionals working in the courts, interdisciplinary teams to investigate and review cases, specialized child abuse units, vertical prosecution (in which one prosecutor is responsible for a case from beginning to end), and child victim-witness support units within prosecutors' offices.

A number of individual and community interests are well-served by prosecuting appropriate cases of child abuse.

1) Prosecution clearly establishes that perpetrators are responsible for their actions, and that victims are innocent. Validating innocence is especially important for children who need to minimize feelings of self-blame and regain a sense of control over their lives.

2) Punishment confirms the principle that adults have no right to exploit children, informing the public that the legal system takes child abuse very seriously.

3) Prosecution may have a deterrent effect on child abuse.

4) As part of the sentencing process, judges can require offenders to participate in treatment. Treatment of offenders is seldom effective until the offender accepts responsibility for his acts. For many perpetrators, meaningful treatment comes only in the shadow of possible incarceration.

5) Given the high risk of recidivism among sex offenders, incarceration is sometimes the only effective way to protect children.

6) Criminal conviction gives the perpetrator a criminal record that follows him wherever he goes, making it more difficult for him to abuse more children by disappearing into a community where he is not known.

All of these benefits make clear that, while prosecution is not a panacea, the criminal justice system plays an important and necessary role in the response to child abuse.

Significant challenges and problems remain, however, despite considerable progress during the past decade.

1) Some professionals still resist recognizing child abuse as a criminal offense. This resistance sometimes translates into failure to report cases of suspected child abuse, reluctance to seek legal redress, and lack of cooperation with law enforcement personnel.

2) A growing number of child protection agencies have adopted policies that narrow the definition of child abuse. One of the rationales for a narrower definition is to reduce the number of cases that must be investigated, taking a load off badly overextended CPS resources.

But defining children out of the system does not necessarily mean that abuse has not occurred. Unless prosecutors and police receive independent notification of all official reports of child abuse, perpetrators invariably go unpunished in those cases that CPS declines to investigate.

Coordination between law enforcement and social services can be strengthened by requiring cross-reporting between agencies. Law enforcement should be informed of all reports of suspected abuse so that cases that are appropriate for prosecution do not fall between the cracks.

3) The legal response to child abuse is uneven due to lack of specialization, training, and interdisciplinary cooperation and communication. A recent survey of prosecutors handling child abuse cases revealed that most were inexperienced, many were rotated frequently to other assignments, and many expected to leave government service or move from trial work to an administrative assignment (Nat-

continued on next pg.

continued from p. 11

ional Center for the Prosecution of Child Abuse, 1988). Even in offices with stable work forces, the need for continuing training in legal and nonlegal aspects of child abuse is critical because of changes in the law and rapid developments in the medical and psychological literature.

4) The sharp backlash against the effort to protect abused children threatens to undermine progress in responding to child abuse. The backlash is at its height in relation to sexual abuse. Faced with shocking statistics on the prevalence of child abuse, and an increased response from CPS and the legal system, some segments of the lay and professional communities are moving to cast doubt on the validity of incidence statistics, to discredit the reliability of child witnesses, and to accuse professionals of distorting the truth for personal or political gain.

5) Many professionals cling to the notion that courtroom testimony is always harmful to children and should be avoided at all costs. Rather than emphasize reforms designed to reduce delay and make courts more comfortable places for children, some professionals concentrate their efforts on keeping children out of the courtroom altogether. As a consequence, many criminal cases cannot go forward, or are inappropriately plea bargained.

Certainly, there are children whose mental health would be seriously jeopardized by testifying in court. And there is no denying the trauma that can occur when cases are poorly handled or improperly delayed. Research and experience teach, however, that when skilled prosecutors respond promptly and sensitively, testifying is a positive experience for many children (Berliner and Barbieri, 1984). The greatest need of many victims is to have a voice and to feel that they are treated fairly. Children who are spared the "trauma" of the witness stand may be denied the opportunity to be heard and believed.

6) Inadequate attention is curently paid to physical abuse, severe neglect, fatal child abuse, and drug-abuse-related child abuse. Recent efforts have concentrated heavily on child sexual abuse. Focusing on sexual abuse is entirely appropriate, but revitalizing the response to other forms of maltreatment is equally important.

Physical abuse and neglect still constitute the majority of reported cases. Research indicates that child homicide is the leading cause of injury death of children under age one (Baker and Waller, 1989). Many child homicides are mistakenly identified as accidental or SIDS deaths.

The rising tide of substance abuse related child abuse cannot be ignored either. In 1988, more than 73% or New York's neglect-related child fatalities were tied to parental drug abuse, and over 90% of caretakers reported in the District of Columbia for child abuse were substance abusers (Daro and Mitchel, 1989).

How can society respond to these challenges? One essential need is for professionals from all disciplines to recognize and support the role of law enforcement and prosecution in child abuse intervention. Professionals downplay the seriousness of child abuse, particularly intrafamilial abuse, when they work to keep cases out of court. While criminal prosecution is not the answer in all cases, prosecution is a critical element of an effective response to child abuse.

References

Baker, S., & Waller, A. (1989). Childhood injury: State-by-state mortality facts. Johns Hopkins Univ. School of Public Health. Baltimore, MD.

Berliner, L. & Barbieri, M. (1984). The testimony of the child victim of sexual assault. *J. Social Issues 40*: 125-135.

Daro, D. & Mitchel, L. (1989). Child abuse fatalities continue to rise: The results of the 1988 annual fifty-state survey. National Committee for Prevention of Child Abuse. Chicago, IL.

National Center for Prosecution of Child Abuse. Survey reveals attitudes of child abuse DAs. *NDAA Bulletin 7*, 1-4.

Patricia A. Toth, JD, is Director and Janet L. Dinsmore is Communications Director of the National Center for Prosecution of Child Abuse, 1033 N. Fairfax St., Suite 200, Alexandria VA 22314.

JOB BOARD

POSITIONS AVAILABLE

Family Violence Research Fellowships

The Family Violence Research Laboratory at the University of New Hampshire has 3 or 4 fellowships available starting in the summer or fall of 1990. These NIMH-funded positions are open to new and experienced researchers with doctorates in the fields of psychology, sociology, social work, law, nursing, public health and medicine. The fellowships are intended for work in the areas of child abuse, domestic violence, elder abuse, sexual abuse, rape, homicide, and other family violence related topics, with special attention to mental health impact. Scholars may use the one-year fellowships (with possible one-year extension) to work on their own projects, to collaborate with FRL staff on ongoing projects, or to work on one of the many data sets archived at the FRL. Fellows must be able to reside close enough to UNH (1-1/2 hours from Boston) to attend the weekly Family Violence Research seminar. Annual stipends run from $17,000 to $31,500, depending on number of years since receipt of doctorate. For more information, contact David Finkelhor or Murray Straus, co-directors, Family Research Laboratory, University of New Hampshire, Durham NH 03824; (603) 862-1888.

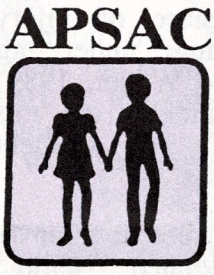
Social Service Practitioner

$2489 to $3022 per month
(plus benefits)

San Bernardino County, Department of Public Social Services, is expanding its Child Welfare Program and has immediate openings for Social Service Practitioners. Positions require: (1) an MSW, no experience necessary; (2) a BSW and two years of post-Bachelor casework experience; or (3) a Master's degree in Counseling with either a 500-hour clinical internship or two years of post-Master's casework experience. All casework experience will be evaluated for acceptability upon receipt of application materials. Interviews may be conducted in an area near you. For more information and/or an application, contact Sally Richter (collect) at 714-387-3084. Or write:

San Bernardino County
Personnel, 157 W. Fifth St.
San Bernardino CA 92415-0440
714-387-5597
(EOE, m/f/h)

APSAC PINS NOW AVAILABLE!



(Facsimile slightly larger than actual pin.)

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.

APSAC OFFICE HOURS

Either Theresa Reid, Executive Director, or Betty Johnson, Office Manager, is in APSAC's Chicago office from 10 a.m. to 6 p.m. CST on Mon., Weds., Thurs., & Fri. An answering machine is working whenever we aren't around, 24 hours a day, 7 days a week. We like hearing from you. Please feel free to call at any time with questions or suggestions.

YOUR AD HERE

Full page . . .	***$250***
2/3 page . . .	***$165***
Half page . . .	***$125***
1/3 page . . .	***$85***
1/6 page . . .	***$45***
30-character line .	***$2***

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.*

To ensure that your ad is included in the nearest quarter's issue, submit it no later than six weeks before the first day of the month of publication.

To respond to an ad, write or call the advertiser directly.

*** *PLAN AHEAD!* ***

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.

*

co-sponsored by
Children's Hospital of San Diego Center for Child Protection; San Diego Child Abuse Council; APSAC; and CAPSAC

*

*** *SEE YOU THERE!* ***

CONFERENCES

November 18. ***Victims no longer: A seminar for men recovering from incest and other childhood sexual abuse.*** Norwalk, CA. Sponsored by PLEA. Contact 213-465-5435.

November 29 - December 1. ***The war against ourselves: Addiction and violence conference.*** Boston. Contact 508-774-0815.

December 1 - 2. ***Representing Children in Dependency Cases.*** San Diego. Sponsored by The Child Advocacy Office of the San Diego Law Offices of the Public Defender; Legal Services for Children, Inc.; and Voices for Children. Contact Ann Espana, 619-565-5519.

January 17 - 20. ***Fourth Annual Health Science Response to Child Maltreatment. San Diego.*** Sponsored by Center for Child Protection of Children's Hospital, San Diego Child Abuse Council, APSAC, and CAPSAC. **APSAC ANNUAL MEETING JANUARY 19 - 20.**

April 26 - 28. ***Keepers of the children: National symposium on child victimization.*** Atlanta, GA. Sponsored by Children's Hospital National Medical Center. Contact 202-939-4960.

May 29-31, 1989. ***Governor's conference on victim services and public safety: A cross-disciplinary commitment to service.*** Anaheim, CA. Sponsored by the California Office of Criminal Justice Planning. Contact 324-9100.

continued from p. 2

national hotline. The service, called KIDS HELP PHONE, has received more than 30,000 calls in the first 4 months of operation. In Canada, the number is 800-668-6868.

* The National Victim Center (formerly the Sunny Von Bulow National Victim Advocacy Center) is receiving strong support from actress Kelly McGillis. Ms. McGillis has agreed to serve as a national advocate for the center, which produces a valuable newsletter and other services for victims of crime and professionals. Membership is only $10. Call 817-877-3355.

* *Speaking for Ourselves*, a newsletter written by and for people with multiple personality disorder, no longer exists. A new newsletter for multiples, called *Many Voices*, is now available. Besides first-person articles, *Many Voices* has articles by therapists, book reviews, and other relevant information. A one-year subscription is $30. Write PO Box 2639, Cincinnati OH 45201-2639.

* The American Prosecutor's Research Institute's National Center for the Prosecution of Child Abuse publishes an excellent newsletter, *Update*. They also offer training on fundamentals of prosecuting physical and sexual child abuse. For further information contact APRI, 1033 Fairfax St., Suite 200, Alexandria VA 22314. 703-739-0321.

* Three new videos on ritualistic child abuse are available from Cavalcade Productions. They are *Identification of the ritually abused child, Treatment of the ritually abused child,* and *A professional overview*, a dialogue from eight clinicians about hundreds of case histories. Contact Cavalcade Productions, 7360 Potter Valley Road, Ukiah CA 95482. Call 800-345-5530, or in CA 707-743-1168.

* The National Association for Children of Alcoholics Annual Convention was held in San Diego late this summer. Over 1000 attendees at *Joining hands to heal the child* focused on uniting work on chemical dependency and child abuse. Childhelp USA and NCPCA were two of the co-sponsors. APSAC Board members Jon Conte, Lucy Berliner, and Dan Sexton gave strong presentations arguing the need for professionals in these fields to work together.

Macro Cases, cont. from p.7

the investigation.

We realize that such an investigation causes parents great concern, and we want to meet with all those involved to explain the situation. We would like to ask you to come to (location) at (time) on (day, date). We will provide you with as much information as we can at this meeting. We will also be contacting you regarding an interview with your child if we have not already done so.

We must ask you to resist the natural temptation to question your child or discuss the investigation with others. It is our goal to determine accurately what, if anything, has happened. That job will be complicated if you discuss the situation with others or interview your child before the trained investigators have an opportunity to do so. We hope you will be able to attend the meeting.

Sincerely,

Notes

1. Corwin, David. Presentation at the Invitational Forum on Ritualistic Abuse of Children. Sacramento, California, March 11, 1986.

2. Cage, Richard. Personal communication, January, 1988.

Legal Evidence, cont. from p.

State v. Jurgens, 424 North Western 2d. 546 (Minn Ct. App. 1988).

State v. McClary, 541 Atlantic 2d. 96 (Conn. 1988).

State v. Moyer, 727 Pacific 2d. 31 (Ariz. Ct. App. 1986).

State v. Mulder, 629 Pacific 2d. 462 (Wash. Ct. App. 1981).

State v. Swafford, 520 Pacific 2d. 1151 (Ariz. Ct. App. 1974).

State v. Tanner, 675 Pacific 2d. 539 (Utah 1983).

United States v. Bowers, 660 Federal Reporter 2d. 527 (5th Cir. 1981).

Watson v. State, 720 South Western 2d 310 (Ark. 1986).

Wetz v. State, 503 Southern 2d. 803 (Miss. 1987).

Zumwalt, R.E., & Hirsch, C.S. (1987). Pathology of fatal child abuse and neglect. In Helfer, R.E., & Kempe, R.S. (eds. 1987). *The battered child: fourth edition*. Chicago: University of Chicago Press, pp. 247-285.

John E.B. Myers, JD, is Professor of Law at McGeorge School of Law, University of the Pacific, and Executive Editor of The Advisor.

ONGOING APSAC TASK FORCES

Assessment and Treatment of Perpetrators of Child Sexual Abuse
Judith Becker, Ph.D., Chair
New York State Psychiatric Institute, 722 W. 168th St., NY, NY 10032

Evaluation of Suspected Sexual Abuse in Young Children
Lucy Berliner, MSW, Chair
Harborview Medical Center, 325 9th Av., Seattle, WA 98104

Medical Evaluation of Suspected Child Abuse
David Chadwick, MD, Chair
Center for Child Protection, Children's Hospital, 8001 Frost St., San Diego, CA 92123

JOURNAL HIGHLIGHTS

--by Susan Kelley

The purpose of **JOURNAL HIGHLIGHTS** is to alert readers to current literature on child abuse. Selected articles from journals representing the variety of disciplines that comprise APSAC's membership are presented in the form of an annotated bibliography. Readers are encouraged to send copies of articles they believe would benefit *Advisor* readers, accompanied by a two-sentence summary of the article. Mail your contributions to Susan Kelley, R.N., Ph.D., Assistant Professor, School of Nursing, Boston College, Chestnut Hill, MA 02167.

CHILD ABUSE AND THE LEGAL SYSTEM

Forman, E. (1989). To keep the balance true. The case of Coy v. Iowa. *The Hastings Law Journal 40*, 437-456.

This discussion and critique of the Coy opinion assess its probable effect on future child sexual abuse adjudications. The problems of child victims testifyin in court and the efforts of states to address these problems are also examined.

Peters, J., Dinsmore, J., Toth, P. (1989). Why prosecute child abuse? *South Dakota Law Review 34*, 649-659.

The application of different standards for intrafamilial child abuse is examined with reference to informed opinion, a case example, and research findings. Among the authors' conclusion is that no legal or moral justification exists for considering intrafamilial child abuse a less serious crime than abuse committed by strangers, and that investigations of intrafamilial abuse must be conducted and coordinated by specially trained law enforcement, social service, medical, and criminal justice professionals.

Thuman, S.A. (1989). Admitting videotaped testimony in cases involving sexual abuse of a minor: A model statute. *Columbia Journal of Law and Social Problems 22*, 489-549.

A model statute prescribing the permissible use of videotaped testimony in child abuse cases is presented with analyses both of factors which result in low prosecution rates and of the charges of unconstitutionality that have been made against existing statutes. State-by-state outlines of the provisions of existing competency and videotape statutes are included.

PHYSICAL AND EMOTIONAL ABUSE

Ammerman, R.T., Van Hasselt, V.B., Hernsen, N., McGonigle, J.J., & Lubetsky, M.J. (1989). Abuse and neglect in psychiatrically hospitalized multihandicapped children. *Child Abuse and Neglect 13*, 335-343.

Data analysis for 150 cases revealed considerably higher incidence levels for all types of maltreatment than for non-handicapped children. Important child protective service practice and policy considerations for handicapped children are discussed.

Goetting, A. (1988). When parents kill their young children: Detroit 1982-1986. *J. of Family Violence 3* (4), 339-346.

Various demographic and social characteristics of 34 children killed by their parents are examined. Data call for renewed attention to abuse prevention and early intervention services.

Hill, S.D., Bleichfield, B., Brunstetter, R.D., Hebert, J.E., & Steckler, S. (1989). Cognitive and physiological responsiveness of abused children. *J. of the Acad. of Child & Adol. Psychiatry 28*, 219-224.

Videotaped scenes of everyday events were shown to abused and nonabused hospitalized children and to a comparison group of nonhospitalized children to determine differences in cognitive-physiological responses. Hospitalized children reported more negative outcomes to the scenes and had greater decrease in heart rate than did nonhospitalized children. Abused children reported more negative outcomes to the scenes and more negative feelings than either comparison group.

Kaufman, K.L, & Coury, D. (1989). Muchausen syndrome by proxy: A survey of professionals' knowledge. *Child Abuse and Neglect 13*, 141-147.

Survey results indicate that, despite its ten-year history in the literature, only 50% of 86 professionals (86% of whom reported working in medical settings) had ever heard of Muchausen Syndrome by Proxy (MSBP). Important recommendations are made for increased CPS training in the detection and investigation of MSBP.

Zuravin, S. and Grief, F.L (1989). Normative and child maltreating AFDC mothers. *Social Casework 70* (2), 76-84.
Samples of 237 maltreating and 281 non-maltreating AFDC mothers were compared in an effort to develop a picture of the little-mentioned "normative" AFDC mother. Significant personal and family differences between the two groups emerge; important intervention recommendations are made.

Zuravin, S. (1989). The ecology of child abuse and negelct: Review of the literature and presentation of data. *Violence and Victims 4* (2), 101-120.
This exceptionally well documented analysis of the significance of certain neighborhood conditions on abusive and neglectful behaviors provides a valuable resource for practitioners and students of the etiology of child maltreatment.

PROFESSIONAL ISSUES

Erez, E. and Tontodonato, P. (1989). Patterns of reported parent-child abuse and police response. *J. of Family Violence 4* (2), 143-159.
Analyzes determinants of intervention in parent-child abuse incidents known to 28 police departments during a one-year period. Family status, the race of the offender, and the responding officer's personal beliefs regarding family roles appeared to influence strongly the likelihood of an arrest.

Fryer, G.E., Poland, J.E., Bross, D.C. & Krugman, R.D. (1988). The child protective service worker: A profile of needs, attitudes, and utilization of professional resources. *Child Abuse and Neglect 12*, 481-490.
Discusses results of a nationwide Kempe Center study, finding an urgent need to lighten protective service caseloads, improve peer support mechanisms, and enhance access to training and other resource materials. Very important reading for administrators and supervisors.

RITUALISTIC ABUSE

Cozolino, L.J. (1989). The ritual abuse of children: Implications for clinical practice and research. *The J. of Sex Research 26* (1), 131-138.
Review of information currently available on ritualistic child abuse. Diagnostic and therapeutic issues are addressed, as are immediate and long-term effects.

SEXUAL ABUSE

Herman-Giddens, M.E. & Berson, N.L. (1989). Harmful genital care practices in children: A type of abuse. *J. of Am. Med. Assoc. 261* (2), 577-579.
Describes three categories of genital care practices that produced physical and emotional problems in 17 mostly female, middle to upper class children.

Hoagwood, K. & Steward, J.M. (1989). Sexually abused children's perception of family functioning. *Child and Adolescent Social Work 6* (2), 139-149.
Sexually abused children were found to have more problems in the areas of problem solving, rules, and general functioning than non-sexually abused children.

Massie, M.E. & Johnson, S.M. (1989). The importance of recognizing a history of sexual abuse in female adolescents. *J. of Adolescent Health Care 10*, 184-191.
A thorough and practical review of some psychosocial dynamics of child sexual abuse, devoting special attention to the impact of adolescent female victimization. Assessment, intervention & treatment issues unique to this commonly-overlooked victim group are discussed.

Wild, N.J. (1989). Prevalence of child sex rings. *Pediatrics 83* (4), 553-558.
Detailed description of 31 child sex rings identified by police in Leeds, England during 1984 and 1985. Detailed analysis of ring categories, victim characteristics, and perpetrator pattern. Very important detection and prevention strategies are discussed.

Journal reviewers for this issue: Thomas F. Curran, MSW, Camden Area Health Education Center, Camden, NJ; Jennifer Locke and Suzanne White, Office of the District Attorney, Middlesex County, Cambridge, MA.

BIBLIOGRAPHY

CONTROLLED STUDIES ON THE EFFECTS OF SEXUAL ABUSE ON CHILDREN AND ADOLESCENTS

--by David Corwin

Aiosa-Karpas, C., Pelcovitz, D., Kaplan, S., et al. (1987). Psychosocial functioning of sexually abused adolescents, paper presented at Am. Acad. Child and Adolescent Psychiatry 34th Annual Meeting, Washington, DC, October 21-25. (Ages 12-18.)

Basta, S.M., Peterson, R.F. (1985). Personality characteristics of molested children, paper presented at National Summit Conference on Diagnosing Child Sexual Abuse, Los Angeles, CA, October. (Ages 6-10.)

Burgess, A.W., Hartman, C.R., McCormack, A. (1987). Abused to abuser: antecedents of socially deviant behaviors. *Am. J. Psychiatry 144,* 1431-1436. (Ages 14-21.)

Cavaiola, A.A., Schiff, M. (1988). Behavioral sequelae of physical and/or sexual abuse in adolescents. *Child Abuse and Neglect 12,* 181-188. (Ages 13-18.)

Cavaiola, A.A., Schiff, M. (1989). Self-Esteem in abused chemically dependent adolescents. *Child Abuse and Neglect 13,* 327-334. (Ages 13-18.)

Cohen, J.A., Mannarino, A.P. (1988). Psychological symptoms in sexually abused girls. *Child Abuse and Neglect 12,* (4), 571-577. (Ages 6-12.)

Conte, J.R., Schuerman, J.R. (1988). The effects of sexual abuse on children: a multidimensional view, in *Lasting Effects of Child Sexual Abuse.* Edited by Wyatt G.E., Powell G.J. Newbury Park, CA: Sage Publications. (Ages 4-17.)

Deblinger, E., McLeer, S.V., Atkins, M.S., et al. (1989). Post-traumatic stress in sexually abused and non-abused children. *Child Abuse and Neglect 13,* 3, 403-408. (Ages 3-13.)

DiPietro, S.B. (1987). The effects of intrafamilial child sexual abuse on the adjustment and attitudes of adolescents. *Violence and Victims 2,* 59-78. (Ages 11-21.)

Einbender, A.J., Friedrich, W.N. (1989). Psychological functioning and behavior of sexually abused girls. *J. Consulting and Clinical Psychology 57,* 155-157. (Ages 6-14.)

Friedrich, W.N. (1988). Behavior problems in sexually abused children: an adaptational perspective, in *Lasting Effects of Child Sexual Abuse.* Edited by Wyatt G.E., Powell G.J. Newbury Park, CA: Sage Publications. (Ages 3-12.)

Friedrich, W.N., Beilke, R.L., Urquiza, A.J. (1988). Behavior problems in young sexually abused boys. *J. Interpersonal Violence 3,* 21-27. (Ages 3-8.)

Friedrich, W.N., Grambsch, P., Koverola, C., et al. (1989). The Child Sexual Behavior Inventory: A comparison of normal and clinical populations. Presented at International Academy of Sex Research. Princeton, NJ, June 20-24. (Ages 2-12.)

Gale J., Thompson R.J., Moran T., Sack W.H. (1988). Sexual abuse in young children: its clinical presentation and characteristic patterns. *Child Abuse and Neglect 12,* 163-170. (Ages 2-7.)

Gomez-Schwartz, B., Horowitz, J., Sauzier, M. (1985). Severity of emotional distress among sexually abused preschool, school age, and adolescent children. *Hospital and Community Psychiatry 36,* 503-508. (Ages 1-18.)

Grogan, M.C. (1988). A comparative investigation of the behavioral and projective patterns of three groups of latency age females, unpublished doctoral dissertation, California Graduate School of Family Psychology, San Rafael, CA. (Ages 8-10.)

Jampole, et al. (1987) An assessment of the behavior of sexually abused and nonsexually abused children with anatomically correct dolls. *Child Abuse and Neglect 11,* 187-192. (Ages 3-8.)

Janus, M.D., Burgess, A.W., McCormack, A. (1987). Histories of sexual abuse in adolescent male runaways. *Adolescence 22,* 405-417. (Ages 12-18.)

Kolko, D.J., Moser, T.M., Weldy, S.R. (1988). Behavioral/emotional indicators of sexual abuse in child psychiatric inpatients: a controlled comparison with physical abuse. *Child Abuse and Neglect 12,* 529-541. (Ages 5-14.)

Lipovsky, J.A., Saunders, B.E., Murphy, S.M. (in press). Depression, anxiety, and behavioral problems among victims of father-child sexual assault and nonabused siblings. *J. Interpersonal Violence.* (Mean age 11.2.)

Livingston, R. (1987). Sexually and physically abused children. *J. Am. Acad. Child and Adol. Psychiatry 26,* 413-415. (Ages 6-12.)

Mannarino, A.P., Cohen, J.A., Gregor, M. (in press). Emotional and behavioral difficulties in sexually abused girls. *J. Interpersonal Violence.* (Ages 6-12.)

McLeer, S.V., Deblinger, E., Atkins, M.S., et al. (1988). Post-Traumatic Stress Disorder in sexually abused children. *J. Am. Acad. Child and Adol. Psychiatry 27,* 650-654. (Ages 3-16.)

Orr, D.P., Downes, M.C. (1985). Self-concept of adolescent sexual abuse victims. *J. Youth and Adolescence 14,* 401-410. (Ages 9-15.)

Rimsza, M.E., Berg, R.A. (1988). Sexual abuse: somatic and emotional reactions. Child Abuse and Neglect 12, 201-208. (Ages 2-17.)

Sansonnet-Hayden, H., Haley, G., Marriage, K., et al. (1987). Sexual abuse and psychopathology in hospitalized adolescents. *J. Am. Acad. Child and Adol. Psychiatry 26,* 753-757. (Ages 12-18.)

Scott, L.R., Stone, D.A. (1986). MMPI Profile constellations in incest families. *J. of Consulting and Clinical Psychology 54,* (3), 364-368. (Ages 15-20.)

Stiffman, A.R. (1989). Physical and sexual abuse in runaway youths. *Child Abuse and Neglect 13,* 417-426. (Ages 12-18.)

Tong, L., Oates, K., McDowell, M. (1987). Personality development following sexual abuse. *Child Abuse and Neglect 11,* 371-383. (Ages 5-19.)

Waterman, J., Kelly, R., Oliveri, M.K., et al. (1989). Manhattan Beach Molestation Study. Summary for NCCAN Grantees Meeting, Washington DC, March. (Ages 5-14.)

White, et al. (1988). Behavioral comparisons of young sexually abused, neglected, and nonreferred children. *J. Clinical Child Psychology 17,* 53-61. (Ages 2-7.)

White, et al. (1986). Interviewing young sexual abuse victims with anatomically correct dolls. *Child Abuse and Neglect 10,* 519-529. (Ages 2-5.)

Yates, A., Beutler, L.E., Crago, M. (1985). Drawings by child victims of incest. *Child Abuse and Neglect 9,* 183-189. (Ages 3-17.)

NEW NATIONAL SEXUAL ABUSE RESOURCE CENTER OFFERS TRAINING, TECHNICAL ASSISTANCE, AND CONSULTATION TO PROFESSIONALS: CALL 1-800-KIDS006.

ANNOUNCEMENTS

INTERDISCIPLINARY BOOK REVIEWS COMING IN JANUARY ISSUE

--by Barbara Bonner

In January, *The Advisor* will add a new feature consistent with APSAC's interdisciplinary membership: two reviews, written by professionals from different disciplines, of the same book.

The first book to be reviewed is Underwager's *Accusations of Child Sexual Abuse*. The reviewers will be David Chadwick, MD, and Diane Willis, Ph.D.

If you know of a book you would like to have reviewed for *The Advisor*, or if you would like to write a review, please fill out the appropriate form and mail it to me, Barbara Bonner, the Book Review Editor.

Thanks for your help!

I would like to suggest this book for review in *The Advisor.*

Title: _____

Author(s): _____

Year Published: _____ Publisher: _____

*****

I would like to write a book review for *The Advisor.*

Name: _____ Discipline: _____

Agency: _____

Address: _____

_____ Phone(s): _____

Mail to: Barbara Bonner, Ph.D.
Department of Psychiatry & Behavioral Sciences
South Pavilion 5 -- Rooom 214
P.O. Box 26901
Oklahoma City OK 73190

Do you have questions about the field that you'd like to see addressed in *The Advisor*? We're eager to hear what you need. Please write your concerns in the space below, and mail the form to:

John E.B. Myers, JD, Executive Editor
McGeorge School of Law
3200 Fifth Avenue
Sacramento CA 95817

I'd like to see an *Advisor* article on _____

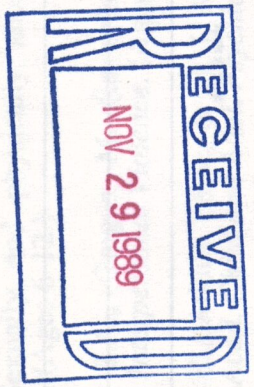
_____

_____

_____

Address Correction Requested

APSAC
The American Professional Society on the Abuse of Children
c/o The University of Chicago
969 East 60th Street
Chicago IL 60637
(312) 702-9419



Non-profit Organization
U. S. POSTAGE
PAID
CHICAGO, ILL
PERMIT No. 7664

Membership Plans

Life Membership
Includes framed membership certificate.
(033) Flat rate regardless of income. $750

Regular Membership
Includes membership certificate.
(053) Over $50,000 annual income. $75
(052) $25,000 - $50,000 annual income. $50
(051) Up to $25,000 annual income. $25

Student Membership (Please provide verification.)
(061) Flat rate regardless of income. $15

Application for Membership

(Please provide full information, and print or type clearly.)

Name _____

Academic Degree or Occupation _____

License Type & No. (If Applicable) _____

Office Address _____

_____

Home Address (Optional) _____

_____

Telephone (Office) ( ) _____ (Home) ( ) _____

Field of Specialty _____

Please check the **one** category which most closely describes your field:

___ (001) ADMINISTRATION
___ (002) CHILDREN'S SERVICES
___ (003) COUNSELING, LICENSED
___ (004) EDUCATION
___ (005) JUDICIARY
___ (006) LAW
___ (007) LAW ENFORCEMENT
___ (008) MEDICINE
___ (009) MINISTRY
___ (010) NURSING
___ (011) OFFENDER TREATMENT
___ (012) PROBATION
___ (013) PSYCHIATRY
___ (014) PSYCHOLOGY
___ (015) RESEARCH
___ (016) SOCIAL WORK

Plan Code Number (Circle One)
033 051 052 053 061
Enclosed is a check for $ _____ Check Number _____

Mailing Address:
American Professional Society on the Abuse of Children
University of Chicago
School of Social Service Administration
969 East 60th
Chicago, IL 60637

In order to be enrolled as a member, please enclose your check with this form.