MEMBERSHIP DRIVE BEGINS !! See Page 9.

APSAC

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THE ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

EDITORIAL

THE LEGACY OF MCMARTIN

—by John E.B. Meyers

After six years and fifteen million dollars, the first trial in the McMartin preschool case is finally over. The jury considered mountains of evidence, and returned a verdict of not guilty. Is the McMartin case a setback for efforts to protect sexually abused children? Just the opposite: McMartin has advanced the child protection movement. As the case worked its way through the ponderous legal system, it spawned important advances in the way the law responds to children, in knowledge about sexual abuse in day care, and in society's willingness to deal with sexual victimization of its most vulnerable members.

The allegations of sexual abuse raised in McMartin prompted David Finkelhor to launch a major study of sexual abuse in day care. (Finkelhor and Williams. 1988. *Nursery crimes*. Beverly Hills: Sage.) Finkelhor and his associate Linda Williams discovered that between 1983 and 1985 there were 270 substantiated cases of sexual abuse in day care, involving 1,639 victimized children. While sexual abuse in day care is uncommon, it is a serious problem. Finkelhor and Williams's important study, which has much to teach parents, educators, and policy makers, might never have materialized without McMartin.

In the legal arena, McMartin engendered a nationwide effort to make testifying less traumatic for children.Testifying is frightening for many adults. Imagine the fear of a five-year-old testifying in a crowded courtroom just a few feet from a person who hurt her and threatened dire consequences for revealing abuse. In part because of McMartin, California and many other states enacted statutes allowing selected children to avoid the trauma of a face-to-face encounter with the defendant. Under these statutes, a traumatized child testifies in a small, nonthreatening room, and the child's testimony is viewed in the courtroom on TV monitors.

In the past five years, judges and attorneys have become more sensitive to the unique needs of child witnesses, and are increasingly willing to alter time-honored courtroom practices to accommodate children. For example, judges permit children to be accompanied to the witness stand by a trusted and supportive adult. In some cases, young witnesses testify while seated in a parent's lap. Judges more often insist that lawyers avoid legal terms, and question children in words they understand. On occasion, judges even bring child-sized furniture into court to make young children more comfortable. These simple but important changes in courtroom procedure help children testify more effectively, and like closed circuit television, are an outgrowth of McMartin and cases like it.

The McMartin case also led to changes in the way allegations of child sexual abuse are investigated. In the early stages of the McMartin investigation, Kee MacFarlane, who is a nationally respected expert on child abuse, videotaped her interviews with many of the children. At the trial, the jury viewed the tapes, and defense lawyers criticized the way MacFarlane questioned the children. While some aspects of the McMartin interviews can be questionedwith the perfect 20-20 vision of hindsight, at the time Mac Farlane interviewed the children there were no standards governing how to question children. Indeed, there are no standards today, because there is no one "right" way to interview children. The controversy surrounding interviews in cases like McMartin, Country Walk, and Jordan, Minnesota has had a positive rather than a negative effect. Professionals are increasingly aware of the forensic implications of questioning children. APSAC now has a task force working on guidelines for interviewing. The result of increased attention to interviewing will be enhanced skills for the thousands of professionals who interview children who may be abused.

Finally, McMartin played a role in forcing society to open its eyes to the cruel reality of child sexual abuse. Tragically, girls and boys by the thousands are sexually abused each year. McMartin put that abuse on the front page where it could not be ignored. The courage of the McMartin children and their parents has not been in vain. Because of McMartin, we know more about sexual abuse than ever before, and we are better at protecting children. Rather than undermining the child protection movement, the McMartin case renewed and invigorated the drive to remedy the tragedy of child sexual abuse.

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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.

FROM THE PRESIDENT

A COMMENT ON THE SAN DIEGO MEETING

—by David Chadwick

The APSAC Annual Meeting in San Diego combined with the Center for Child Protection at Children's Hospital and the CAPSAC Annual Meeting turned out to be a riveting four-day event. About 600 professionals attended, representing many disciplines, including law, medicine, social work, psychology, and criminal justice. At least six juvenile court judges were present for some part of the meeting, as were four members of the San Diego County Grand Jury Committee on Social Services. Almost all parts of the U.S. were represented, and registrants came from England, Scotland, Ireland, Germany, Sweden, and The Netherlands as well. With many members attending, ample time was made for highly productive Board and membership meetings of both APSAC and CAPSAC.

The McMartin trial verdicts came on the morning of the second day of the meeting. The San Diego media were pleased to find 600 child abuse experts together, and interviewed many about their reactions to the verdicts. Jon Conte spoke for many of us when, in his wind-up talk on Saturday, he expressed support for Kee MacFarlane and the other professionals who have given so much in their effort to assist the children and families involved in that difficult case.

The meeting had many high points; any attempt to summarize all the presentations must fail to recognize a lot of outstanding work by a faculty of sixty. Hanita Zimrin's discussion of the characteristics of persons who survive child abuse was extremely well-received, and the scholarly debate between Roland Summit and Kenneth Lanning about the occurrence of child abuse in the context of cults and rituals put brackets around an acceptable range of certainty and uncertainty on this subject. The two participants were exemplary in disagreeing with one another while maintaining mutual respect and the ability to argue this question intelligently in the future. An experiment—providing space and time for the presentation of 14 papers describing original and unpublished research—was highly successful thanks to the able researchers who presented and to David Finkelhor and John Landsverk, who chaired the sessions.

APSAC's next Annual Meeting will be held in the Spring of 1991, at the conference APSAC is co-sponsoring with the National Children's Advocacy Center (see "Board" article, p. 3). Let's all do our best—by sending suggestions for workshops and presenters, and by attending the conference—to make that meeting as successful and stimulating as this year's.

NEWS
BOARD ENACTS MAJOR CHANGES

The APSAC Board and various of its committees met for over 14 hours in San Diego to act on several critical issues facing the organization. Major decisions about membership structure, dues, benefits, and programming were made to strengthen the organization and keep it growing.

State Chapters

The Board approved a plan to encourage and guide the formation of state chapters. Under the plan, 20 APSAC members from a U.S. state, territory, or Canadian province can petition the Board for state chapter status. Once chapter status is granted, people who join APSAC at the national level are automatically members of the state organization as well. Every member pays dues to the national organization, which will provide *The Advisor*, brochures, lists of state members, bookkeeping services, consultation, and, beginning next year, a percentage of national dues as financial support. State chapters can then hold support groups, meetings, and conferences on issues that, while furthering APSAC's primary goals, are of particular importance locally.

Members from Nevada, North Carolina, Virginia, Ohio, Maryland, Massachusetts, Pennsylvania, Alaska and the D.C. area who attended the San Diego conference have already expressed enthusiasm for forming chapters in their states.

Anyone who has energy, vision, and time can act as *de facto* state coordinator. If you are interested in forming an APSAC chapter in your state, begin by calling or writing the national office. We'll be delighted to send you a list of the members in your state and a copy of the approved guidelines for chapter information right away, and to answer questions and provide suggestions as you go.

Beginning with this issue, we'll publish a list of APSAC members by state so you can keep an eye on the growth of APSAC in your area (see page 9).

Institutional Memberships

Institutional memberships are now available as well. Institutions can buy memberships in APSAC for five employees or more at the discounted rate of $50 per person. Institutional memberships come with full benefits and priveleges. Please call the Chicago office for further information.

Dues and Benefits Increases

An analysis of the membership statistics at the end of 1989 revealed that 44% of APSAC's membership pays dues of $25 or less. Of those who joined APSAC in 1989, even more—52%—paid $25 or less. We know too well that most social service providers make very little money. Unfortunately, APSAC can't quite meet expenses with dues so low. So we have good news and bad news.

The bad news is that, as of April 1, 1990, the current dues structure of $25, $50, and $75 will be discontinued. Dues will increase to $55 for people making up to $50,000 per year; to $85 for people making over $50,000; and to $850 for Life membership. A special student rate of $35 will be available to people without advanced degrees who can prove full-time student status.

The good news is that the higher dues will cover the cost of a subscription to the *Journal of Interpersonal Violence*. Currently, JIV is available to members at a 25% discount. As of April 1, everyone who pays APSAC dues will automatically receive a subscription to JIV. Before April 1, anyone can *opt* to renew or join APSAC at the new rate and take advantage of the new benefit immediately. The Board hopes that this very substantial new benefit will soften the blow of increased dues.

Program Planning

As announced in the last *Advisor*, the Board had hoped APSAC could sponsor its first "solo" national conference in 1991. Unfortunately, current budgetary constraints have made that venture impossible. In lieu of a solo conference, planning is underway to co-sponsor two national conferences.

The first, to be held this Fall, is in conjunction with the Tennessee Department of Human Services. APSAC's Second Vice-President for Program Planning, Charles Wilson, is Director of Tennessee's Child Welfare Services. More information on that conference will be published in the next *Advisor*.

The second conference, to be held in the Spring of 1991, is in conjunction with the National Children's Advocacy Center, headed by APSAC Executive Committee member Bud Cramer. Details on planning for that conference will be made available as we have them.

Planners definitely want to hear your ideas for workshop and plenary topics for both of these important conferences. Please send all suggestions to Charles Wilson at the Tennessee Department of Human Services, 400 Deaderick St., Nashville TN 37219. The more input members provide regarding their needs, the more successful these conferences can be for everyone. Please make your needs known loudly and clearly!

Dates for Next Meetings

The next Board and membership meetings will be held during the **National Symposium on Child Victimization**, sponsored by the Children's Hospital National Medical Center Division of Child Protection. The symposium, cosponsored by APSAC and several other groups, will be held in **Atlanta, April 25 - 28.** The Hyatt Regency is the conference hotel. APSAC's membership meeting will be held on **Friday, April 27, from 6 - 7 p.m.** APSAC's Board meeting will be held on **Sunday, April 29, from 9 a.m. - 4 p.m.**

The enclosed brochure offers full information about the Atlanta conference.

COMING NEXT ISSUE:

* Next is a SPECIAL ISSUE on interviewing children, with articles by Lucy Berliner, Mark Everson, Kathleen Coulborn Faller, Gina Richardson, Karen Saywitz, Dave Beers, and others.

* Plus, the first installment of *The Advisor's* new feature, interdisciplinary book reviews.

* Plus, suggestions from John E.B. Myers on coping with cross- examination.

* Plus, the conclusion of David Finkelhor's bibliography on incest offenders.

RESEARCH

THOUGHTS ON THE DEVELOPMENTAL ROOTS OF SEXUAL AGGRESSION

—by Robert A. Prentky & David D. Cerce

Why do some people become sexually aggressive while others become nonsexually aggressive? If we had answers to this question, we might be able to tailor much more effectively our efforts to intervene in the course of habitual aggressive behavior. Further, being able to predict with some accuracy who would become dangerous, we could more confidently develop early intervention and treatment programs.

Our knowledge of the developmental roots of sexual and nonsexual aggressiveness remains rudimentary. Recent research at the Massachussetts Treatment Center, however, may have brought us somewhat closer to identifying these roots. Looking for precursors of the severity of both sexual and nonsexual aggression in a sample of 81 sex offenders, we examined four areas of developmental pathology during childhood and adolescence: Caregiver Instability, Institutional History, Sexual Abuse, and Physical Abuse.

Our findings revealed the following: severity of sexual aggression was predicted by Caregiver Instability and Sexual Abuse; severity of nonsexual aggression was predicted by Institutional History and Physical Abuse. That is, people who spent less time with individual caregivers, experienced frequent changes in caregivers, and grew up in a sexually deviant or abusive context were likely to become sexually aggressive. People who spent long periods of time in institutions, frequently changed institutions, and experienced physical abuse and neglect in childhood were likely to become nonsexually aggressive.

We further explored the relationship between these significant predictors and sexual or nonsexual aggression by examining how well each set of developmental variables identified extreme sexual or nonsexual aggressors. Here is what we found for nonsexual aggressors:

* 39.1% were high in nonsexual aggression when neither Institutional History nor Physical Abuse were above the sample mean;

* 46.5% were high when one variable was above the mean;

* 81.2% were high when both vaiables were above the mean.

Here is what we found for sexual aggression:

* 22.6% were severely sexually aggressive when neither Caregiver Instability nor Sexual Abuse were above the mean;

* 51.4% manifested extreme sexual aggression when one of these two variables was above the mean;

* 87.5% of the offenders manifested extreme sexual aggression when both variables were above the mean.

Thus, when both predictor variables were above the sample mean, the observed number of "correct hits" for high sexual aggression was 39.9% above the 47.6% baserate for high sexual aggression in this sample. Moreover, it appears that the contribution of these two variables in predicting sexual aggression is additive, while the contribution of the two variables predicting nonsexual aggression is noninteractive.

The relation between Institutional History in childhood and be accounted for by multiple determinants. First, institutional settings (in this study, most often secure residential facilities such as reform schools) may teach aggressive behavior both by providing models of it and by rewarding it as a defense against victimization. Second, more aggressive children are more likely to be institutionalized. Thus the destructive social learning atmosphere of the institution may have an even more harmful impact on those children already prone to be aggressive. Third, family dynamics that increased the probability of early or prolonged institutionalization (other than Cargiver Instability, Physical Abuse, and Sexual Abuse, which were controlled in the regression analyses) might make the child a more ready student of the institution's lessons. For instance, hostilely controlling, rejecting parents who are lax in their discipline may be more likely to have aggressive children who would be very susceptible to the violent lessons of this institution. An added history of nonsexual aggression in adulthood could Physical Abuse and neglect and the modelling provided by that history may increase the probability that a child who has been institutionalized will become an adult who engages in general, nonsexual aggression.

Caregiver Instability, on the other hand (which measured the frequency of changes in primary caregivers and the longest tenure with a single caregiver), reflects the permanence and consistency of the child's interpersonal relationships with significant adults. Frequent changes in caregivers disrupt the child's most important intimate relationships, making impossible the formation of long-term, supportive relationships with significant caregivers. A history of repeated losses and broken relationships is likely to engender distrust in the stability of any living situation and in the permanence of any relationship. The fact that repeated interruptions in relationships with caregivers predicted greater sexual violence suggests that the quality of early childhood attachments may be important in modulating aggression in adult heterosexual relationships. That is, being shuttled from one unrewarding and apparently uncaring relationship to another is likely to engender low self-esteem and a distrust of and hostility toward others that increases the potential for anger and aggression in intimate relationships.

An added history of Sexual Abuse increases the likelihood of sexual aggression, again in part due to modelling. That is, sexual abuse and deviation in the family become a model for the expression of hostile and violent impulses. By adding family sexual deviation and abuse to the developmental palette, we may be, in effect, filling with sexually pathological experience a void left by disrupted or unformed relationships. Thus, either providing a model for sexual aggression or interfering with the formation of long-term, supportive relationships with significant caregivers increases the likelihood of the development of sexually aggressive behavior, and the two conditions taken together are powerful predictors.

The research reported here, which is published in the journal *Development and Psychopathology* (1989, 1, 153-169), is the subject of ongoing inquiry with larger samples of sex offenders.

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RESEARCH

ADULT MALE VICTIMS OF CHILD SEXUAL ABUSE

—by Robert J. Kelly, Virginia MacDonald, & Jill Waterman

One on the most underresearched and clinically underserved populations is that of adult males who were sexually abused during childhood. While there has been a growing literature on the initial and long-term effects of sexual abuse on females (for a review see Browne and Finkelhor, 1986), few studies have examined the effects of child sexual abuse on males. Most surveys of nonclinical samples have found that between 2.5% and 8.7% on men are sexually victimized in childhood (Bell and Weinberg, 1981; Finkelhor, 1979; Finkelhor, 1984; Fritz, Stoll and Wagner, 1981; Kercher and McShane, 1983), although a recent Los Angeles Times survey estimated that this prevalence rate may be as high as 16%, depending upon the definition of child sexual abuse that is used (Timnick, 1985). According to Finkelhor (1984), even if we assume that the true prevalence rate for boys under age 13 is between 2.5% and 5%, this would mean that between 550,000 and 1,100,000 boys in the United States would eventually be victimized before age 13, with approximately 46,000 to 92,000 new victimizations occurring each year.

Despite the magnitude of this problem, both clinical services and empirical research focusing on the trauma suffered by these males are lacking. Our best estimate from networking with other professionals in the field is that probably fewer than 50 therapy groups for adult male victims exist throughout the country. From a research perspective, few published empirical reports focus on the long-term effects of child sexual abuse in adult males.

We are in the process of conducting a comparison study focusing on the symptomatology of men who seek services at a community clinic, comparing those who do and do not have histories of child sexual abuse. The abused sample consists of men who applied to join the clinic's Men's Abuse Survivor's Group. This sample was screened to exclude men who were attracted to or had molested children. To date, we have calculated statistics on the first thirty-eight men who have been interviewed for our group program.

We devised a 35-item symptom checklist based upon the symptoms reported in research studies on female victims. No formal scale development was conducted on this measure. At least half of the men reported previous or current suffering from 27 of the 35 symptoms. These symptoms and percentages of men reporting them are as follows:

* low self esteem (95%)
* depression (92%)
* feelings of being different (90%)
* feelings of isolation (87%)
* discomfort in social situations (82%)
* difficulty trusting men (82%)
* discomfort in intimate relationships (79%)
* extreme anxiety (79%)
* extreme guilt or shame (76%)
* suicidal thoughts (76%)
* flashbacks of abuse incident (74%)
* difficulty maintaining friendships with men (71%)
* sexual preoccupations (71%)
* family problems (71%)
* confusion about sexual identity (68%)
* difficulty establishing romantic relationships (64%)
* nightmares (61%)
* sleeping problems (58%)
* extreme anger (58%)
* difficulty maintaining romantic relationships (54%)
* compulsive sexual behaviors (53%)
* difficulty trusting women (50%)
* eating problems (50%)
* employment problems (50%)
* aversion to sexual intimacy (50%).

We also administered the MMPI to 37 of these men and found that most profiles were characterized by multiple clinical-scale elevations (T>70) Twenty-nine profiles (78%) had three or more of the eight primary clinical scales elevated (excluding scale 5, Masculinity-Femininity, and scale 0, Social Introversion), and 22 profiles (59%) had five or more elevated scales. For 21 of the 37 profiles (57%), scale 2 (Depression), scale 4 (Psychopathic-deviate), and scale 8 (Schizophrenia), were all significantly elevated. Scale 5 (Masculinity-Femininity), the highest mean scale, was elevated for 31 (84%) of the profiles.

Until we analyze comparable date from a control group we cannot discuss the relative frequency of these symptoms in abused versus non-abused men. Nevertheless, from our research and our therapy sessions with this population, we have observed that these men tend to have a definite cluster of problems, and that they attribute many of these problem to their abuse. Male survivors experience the same dynamics that female survivors report, such as betrayal, powerlessness, stigmatization, and traumatic sexualization (see Finkelhor and Browne, 1986). However, the psychological impact of thesedynamics may be different because of the very different socialization process males undergo. Research that focuses on the gender-specific effects of child sexual abuse is badly needed. Knowledge of these gender-specific effects could be incorporated into clinical interventions designed especially for male or female victims.

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PRACTICE

PROBLEMS OF BELIEF IN APPROACHING PATIENTS' ACCOUNTS OF RITUAL ABUSE

—by Jean Goodwin

"How do you tell if what I say is real?" asked a patient.

"I more or less assume that everything is real," I said. "It has to be unwrapped, of course, whether it's a dream, or a sudden wave of fear, or your boss's evaluation of your work. Then it has to be integrated into everything else you know about yourself."

Then she told me about some memories she thought were not real, memories of being 10 and taking part in some kind of ritual. She thought her parents were present, that there were robes and blood, and that sexual things were done to her.

How do I evaluate the veracity of her report? Should I believe it or not?

Would a physical exam help? Perhaps there still some physical signs of the abuse she describes. Should she be separated from family members with whom she remains in contact? Does she need to be persuaded to contact police or other law enforcement?

As I try to evaluate her report, I ask myself dozens of questions: How disjointed is her account? Could it be an account of a daydream that took place while she was being traumatized or in a trance state? Could it be a posttraumatic nightmare that uses symbolism, displacement and condensation to depict an actual traumatic event? Or an hallucination of hysterical psychosis constructed on the same principles? Are there now or were there at the time of the abuse organic factors that could have produced hallucinations? Such factors could include sleep deprivation, head trauma, malnutrition, electrolyte imbalance, extreme pain, administered substances, infections, mania, depression, and many more—all conditions that are more likely to occur in abused children.

Does the account fit in with what we already know about the family? In this case, for example, we have documented the parents' joint alcoholism, and the sadistic physical and sexual abuse of all children in the family, half of whom have already acquired dissociative disorder diagnoses (the other half are diagnosed as borderline plus substance abuse). Is the patient still trying to absolve the parents from personal responsibility for their actions? Is that part of the appeal of the notion of cult involvement? Could it represent a later paranoid pseudoexplanation for years of pain, an explanation that covers a still more humiliating and destructive reality that remains to be unwrapped?

How does this account mesh with the patient's symptoms? Does it connect to her sadistic sexual fantasies? Her fascination with blood? Her genital self-mutilation? Is there a psychotic process that I've missed? Is there more projection, suspiciousness, and grandiosity in this patient than I recognized previously?

All of these questions offer themselves for exploration when a patient begins recounting an experience with ritual abuse. Sorting them out is invariably a lengthy task, fraught with long periods of uncertainty when many different conflicting versions remain simultaneously possible.

While I listen to the patient, I am also listening to myself and asking a different set of questions: Am I approaching this disclosure any differently from the way I approach other accounts of violence? What if the patient were describing the same scenes but said she had participated as an adult? What if she described the same scenes but with pleasure instead of fear? What if she'd described the same feelings and actions and sensations, but without the ritual details? The same ritual details but with no violence?

As I try to evaluate my patient's startling disclosures, I have to remain aware of my own biases. I know that one of my core biases is that people do dreadful things to each other with great regularity: I am predisposed to believe her. I have to make an effort to keep in focus some optimism about as-yet-undiscovered positives in these childhoods. I remind myself that, even with a parent who is antisocial, sadistic, and occasionally psychotic, there are moments of tenderness, even if only of anticipated tenderness; there may be scores of those moments, hundreds, and hundreds of hundreds.

But I have colleagues whose bias is to believe the world to be a much safer place than I do, colleagues who must remind themselves to ask routinely about arrests, alcohol and substance abuse, about weapons, violence history, pornography, suicidality. Colleagues who know they would prefer to believe child abuse to be an occasional and solitary affair, but must remind themselves of the reality by reading the personal ads in the pornography magazines or by watching the passengers in a bus or the shoppers in a grocery store tacitly approve as a parent emotionally or physically abuses a child.

As we try to deal with our tendency not to believe some of the shocking disclosures we hear, we can use statistics as a good centering device. In a survey of college students, 5.4% said they'd been kicked by parents, 12.1% said parental discipline had caused injuries (bruising or beyond), 1.2% had been locked in closets by parents; 8.8% said parents abused each other. Yet only 2.9% of these respondents felt they were abused. The optimist will look at these data and see children surviving significant quantities of violence even without intervenion. The pessimist will wonder if all this worry about patients' overreporting abuse is not just a vain hope: patients, like college students, may be willing to put up with almost any level of violence as long as they don't have to call it violence.

I remember Hippocrates's dictum: "First, do no harm." This remains my responsibility whether I'm acting as a consultant or as a therapist.

If this patient has not yet dealt with her parents' alcoholism as a reality, will shifting the focus to their possible practice of ritual group sex simply prolong her successful use of derealization to keep in limbo her childhood pain?

Therapeutic aims should always take precedence over our attempt to disprove or prove a patient's description of a prior traumatic experience. Posttrauma syndromes consist of both reliving and suppressing. Recovery also consists of reliving and suppressing, each hopefully practiced with ever-greater autonomy and mastery. Keeping the two in balance is the key to increasing function and decreasing disability.

Patients need our help in finally re-

Continued on page 9

TRADE SECRETS

AN ADULT-TO-CHILD APOLOGY LETTER FOR SEXUAL ABUSE

—by Barbara A. Rutter

(APSAC member Barbara Rutter submitted the following letter for consideration for publication, initiating a new feature, "Trade Secrets," a forum for APSAC members to exchange practice ideas they have found particularly effective. If you have a "trade secret" you'd like to share with other APSAC members, please send it in. Type it double-spaced, in 250-750 words, and submit it to John E.B. Myers, Executive Editor (address on p. 2)

When an adult has sexually abused a child, an apology to the child can be very helpful for the child's recovery. A letter which can be read to the child by the child's therapist or another supportive adult is often a good first step because it is not too intense an experience for the child and may be repeated as many times as necessary for the child to process the information.

The following mock letter addresses the various issues with which the sexually abused child must deal. Of course, each adult writing such a letter will make it specific to the child, that child's level of understanding, and the particular situation.

Dear _____ ,

(Apology) I want to tell you that I am sorry for what I did to you. You remember when I _____ *(specific description of all physical acts, verbal threats or promises)* at *(give where and when events occurred)*

(Moral statement) What I did was wrong. Grownups are not supposed to do that to children. I should not have done that to you.

(Assumption of responsibility) I am the one who should have known better because I am the adult. I should have stopped myself. It was not your fault. It was my fault.

(No intent to do harm) I did not *(do the action)* to try to hurt you. I did it because I liked to do it for myself. That was selfish, because I wasn't thinking about what it was like for you. Now I am really sorry because now I know that I did hurt you.

(Permission to be angry) I know that you are probably angry at me because I hurt you. I would be angry, too, if somebody did that to me. If you are angry, that is OK. I understand. You have a right to be angry.

(Relief from forgiveness) I am not going to ask you to forgive me, because I have to work out my problem myself. It isn't your job to make things better again. And I know that you may need a long time to figure out how you feel about what I did and how you feel about me now. You should have all the time you need. You don't have to hurry.

(Blame off of others) My therapist tells me that often when a *(dad, etc.)* hurts a child like I did, the child gets angry at her mother because she thinks her mother really knew about it, or should have found out about it, and just didn't care. Please don't be mad at your Mom. I was always careful to keep what I was doing to you a secret. She did not know. What happened was not Mom's fault. It was all my fault so please don't blame Mom.

(Blame off of the child) My therapist also tells me that children sometimes blame themselves for what has happened. Maybe they liked receiving special attention, or the excitement of a secret, or maybe they liked how their body felt with some of the touching—which is normal. Sometimes, I guess, kids have even thought that if they hadn't hugged their dad, or ever been naked around the house, or just even been cute, then their dad wouldn't have thought of doing such things. But you need to know that what I did happened because I have a problem about liking to have sex with children, and I had this problem from even before you were born. You didn't make me do anything. Children are supposed to be cute, and give hugs and kisses, and be naked sometimes, and grownups are supposed to care for them and protect them—not use them for what they want to do or hurt them. And because grownups are bigger, a child can't make them stop something or know what to do if a grownup is misusing them like I did.

(The future) I want you to get better from being hurt, and I know that you will. You are strong, and you are smart. Please talk to your therapist. I know that you will feel better again after a while, and that you will grow up to be a wonderful, loving, happy woman. What happened to you was my problem, not yours. You are OK. I am glad that you are here in the world. I am glad that you are a girl. Whatever you need is OK with me. You don't have to hurry to grow up. It is right for you to be held safely and hugged lovingly—don't give that up. I know that someday, when you are grown, you will find a loving relationship with someone you choose and that you will be able to enjoy good touching with that person.

(A completion) You are a wonderful girl. You deserve to be protected and cared for and loved. What I did was wrong, and I am very sorry.

Barbara A. Rutter, Ph.D., is a clinical psychologist in private practice in Honolulu, Hawaii.

MEDICAL

GUIDELINES FOR HIV TESTING OF SEXUALLY ABUSED CHILDREN

—by Martin Finkel

The following guidelines were developed based on the experience of Dr. James Oleske, Director of the Division of Allergy, Immunology and Infectious Disease at the University of Medicine and Dentistry of New Jersey, New Jersey Medical School. Dr. Oleske is a nationally recognized authority and clinical pioneer in the treatment of AIDS.

Many clinicians working with children alleged to have been sexually abused are looking for criteria on which to base their decisions regarding whom to test for AIDS and how often to retest. I asked Dr. Oleske for his perspective on this issue. I hope his recommendations will trigger a response from other clinicians.

Please provide your institution's clinical perspective on this issue by writing to Martin A. Finkel, DO, Associate Medical Editor, APSAC, UMDNJ-SOM, Dept. Pediatrics, 301 S. Central Plaza, Suite 2100, Stratford NJ 08084. Responses will be published in a subsequent issue of The Advisor, in hopes of stimulating further discussion.

Should sexually abused children and adolescents be screened for HIV antibody, and if so, what studies should be performed and when should they be repeated?

Conservative estimates indicate that over 200,000 children are sexually abused each year in the U.S., and that over 20% of all children may be sexually abused before they reach adulthood. The rate of HIV infection in the U.S. is expected to be simlarly high. By 1991, from 3 to 13 million Americans (1% - 5% of the total U.S. population) may be HIV infected.

Our experience in Newark, New Jersey reflects that the incidence of HIV among heterosexuals is rising. Prior to 1984, 15% of women who had AIDS got it through heterosexual activity; by 1988, that number had increased to 45%.

Should all children alleged to have been sexually abused be tested, or only some? No prospective data document the actual risk of transmission of HIV by sexual abuse. Clearly, however, the abused individual's exposure (rectal, vaginal, or oral) to semen or other HIV positive body fluids is a prerequisite for HIV transmission: children known not to have experienced such contact can be assumed to be safe.

Further sorting of abused children who have come into contact with semen could be made on the basis of the severity of their physical trauma: the greater the trauma, the higher the chance of transmission, and the more important the HIV test.

But until we know more about transmission, deciding to test or not to test based on the severity of physical trauma is not advisable. Although broken skin increases chances of transmission of the AIDS virus, broken skin is not a necessary condition of transmission. Of 15 children and adolescents who were sexually abused by a perpetrator known to be HIV positive, three who were tested in our program became HIV positive.

The history alone is unreliable too in determining whether or not the child has come in contact with body fluids that may be HIV positive. Accurate details concerning the type of abuse experienced is not available from all sexually abused children.

Surely it is better to err on the side of safety. Every sexually abused child or adolescent, as well as the alleged perpetrator, should be screened for HIV at the time the assault is reported, and again at three and six months. Testing should be done after six months only if any symptoms of HIV infection occur.

Screening at these intervals is indicated because the latent period between infection and development of positive serological response is usually three months, although a one-year delay in development of antibody has been rarely reported. (The incubation period for the onset of symptoms of HIV infection may be as long as seven to ten years.)

Universal testing is recommended in part because assays testing for both antibody and antigent to HIV-I have improved our diagnostic accuracy. False positive screening ELISA assays that reduce the positive predictive values in low risk the patient's true HIV status determined in most cases by these newer HIV assay systems. People are identified as HIV infected if they produce a Positive ELISA HIV Ab assay confirmed by either Western Blot/immunofluorescence Ab assay or with culture evidence of viral infection.

Universal testing is recommended also because presently constituted sexual abuse clinics usually have appropriately trained medical and social staff to economically add HIV testing and counseling to those tests now being performed on abused children and adolescents.

Finally, universal HIV testing of sexually abused juveniles and their alleged abusers is recommended because the sooner infected individuals are identified, the sooner they can be helped. Both the quality and the length of HIV patients' lives have gradually improved with comprehensive support programs and the use of the antiviral drug AZT. Individual education regarding prevention of spread and available health care can only be effective when an individual is identified as being HIV infected.

Fear and confusion still abound regarding HIV testing because of past stigmatization of HIV infected individuals. Unfortunately, this has inhibited appropriate public health responses to this disease. All individuals at risk for developing HIV should be tested and given appropriate counseling regarding test results. Those individuals identified as HIV positive should receive compassionate health care and sound public health advice and counseling. They should be given access to all new treatment programs, and be spared stigmatization and loss of civil rights. We must all fight irrational fears in ourselves, our colleagues, and the general public, and watchdog legal and moral issues surrounding this disease.

Finally, we should seek funding for multicenter projective studies to define the exact magnitude of HIV infection in sexually abused children and adolescents.

Martin Finkel, D.O., is Associate Professor of Clinical Pediatrics at University of Medicine and Dentistry of New Jersey, and ***The Advisor's*** *Associate Medical Editor.*

NEWS

FREE MEMBERSHIP!

The key to APSAC's success is a dynamic, vocal, and **large** membership! The McMartin case has dramatized, among other things, our need for interdisciplinary support—one of the needs APSAC was founded to address. To meet program and budget goals, we need to sign up 1,000 new members this year: twice the number we signed up last year! Enthusiasm for APSAC's mission is growing across the country, however, so we think we can meet this ambitious goal. To ensure APSAC's success, a membership drive begins today.

Every member who signs up 10 new members by June 1, 1990, receives one year's free membership.

Here's how it works:

* Call the Chicago office for a supply of brochures, if you need them. Or xerox the membership application from the back of this newsletter.

* Tell your colleagues about APSAC. Urge them to join. If several of you work together, you may be able to take advantage of the new institutional memberships for 5 or more people—see "Board" article, page 3.

* Have everyone you recruit write your name clearly at the top of his or her application. Remember: *until April 1*, new members can choose to sign up at the old rates or at the new rates. After April 1, new rates kick in for everyone.

We'll keep tabs on the number of people who sign up under your name, and award you free membership for one year when that number hits 10. In the Spring and Summer newsletters, we will publish a list of names of people who have recruited new members, and the number they've recruited. Every member you sign up gives the field and APSAC an important boost.

Please feel free to call the office if you have any questions. We look forward to hearing from you. Good luck!

APSAC MEMBERSHIP BY STATE

CA	179	ME	15
IL	83	LA	13
NY	68	MO	12
MA	64	DC	11
NC	59	KS	11
TX	41	MS	11
FL	38	CT	10
CO	28	IA	10
WA	31	IN	10
WI	27	HI	9
PA	25	NH	9
MD	24	NM	8
NJ	23	UT	8
OK	23	SC	7
OH	22	RI	6
VA	22	CN	6
AL	21	AK	5
AZ	20	KY	5
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MN	20	AR	3
MI	19	ND	3
TN	19	VT	2
NV	18	DE	1
OR	17	WV	1
ID	15		

States with no members: Montana and South Dakota
Members with no states: 3 (England), 1 (Australia), 1 (Guam), 1 (Israel).
TOTAL: 1,114

PRACTICE Continued from page 6

viewing, exploring, unwrapping these experiences in all the ways they've alredy learned to process other mental contents that were not freighted with secrecy prohibitions, trance distortions, or organic distortions. Given encouragement, dialogue, and latitude to explore, the patient can submit emerging memories to the same critical processing that has shaped the other impressions and memories that make up her sense of self. This emerging reality is the one that truly belongs to the patient and, to my mind, the one that is most "real."

Regarding the role of the therapists's credulity in this process, I can think of no better advice than that an old Tibetan teacher of meditation gave his students: "Incredulity comes sometimes. Indeed it is one of the ultimate objects. But if the disciple reaches this state of mind before the proper time, he misses something which these exercises are designed to develop: fearlessness."

Jean Goodwin, MD, MPH, is a faculty member of the Medical College of Wisconsin, Department of Psychiatry, and a member of APSAC's Board of Directors.

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

JOB BOARD

POSITION AVAILABLE

EXECUTIVE DIRECTOR for growing national child abuse prevention organization. Three years' non-profit management experience required, including Board and program development. Sensitivity to self-help philosophy and knowledge of resource development required. Master's degree; travel required.

Send resume and salary requirements to Parents Anonymous, Inc. 6733 S. Sepulveda, Suite 270, Los Angeles CA 90045. *Deadline: February 28, 1990, or until filled.*

SPECIAL OFFER TO APSAC MEMBERS

NEBRASKA LAW REVIEW (V. 68 [1989], nos. 1 & 2) article, "EXPERT TESTIMONY IN CHILD SEXUAL ABUSE LITIGATION," by John E.B. Myers, JD; Jan Bays, MD, FAAP; Judith Becker, Ph.D.; Lucy Berliner, MSW; David L. Corwin, MD; and Karen Saywitz, Ph.D.

A comprehensive review of the state of the art and the law, with major sections on "The admissibility of expert testimony," "Expert testimony based on novel scientific principles," and "Categories of expert testimony on child sexual abuse." Opening and closing overviews bring the issues into clear focus.

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ANNOUNCEMENTS

INTERDISCIPLINARY BOOK REVIEWS COMING IN SPRING ISSUE

—by Barbara Bonner

With this issue, The Advisor meant to add a new feature consistant with APSAC's interdisciplinary membership: two reviews, written by professionals from different disciplines, of the same book. Unfortunately, the first review has had to be delayed until Spring. Anna Salter, Ph.D., and John Myers, JD, will review Underwager's *Accusations of Child Sexual Abuse* in that issue.

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 write a book review for *The Advisor*.

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APSAC's *Advisor* is a quarterly publication (January, April, July, October) with a national circulation of approximately 3000. 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 allcheck made payable to APSAC, to the attention of Theresa Reid, Manscript Editor, at *The Advisor's* Chicago offices.

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MOVING?

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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 reflected in APSAC's membership are presented in the form of anannotated bibliography. Readers are encouraged to send copies of current 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, Massachusetts, 02167.

Emotional Abuse

Forehand, R., Long, L., Zogg, C., and Parish, E. (1989). Child Abduction: Parent and child functioning following return. *Clinical Pediatrics, 28 (7),* 311-316.

An examination of the functioning of 17 children who had been abducted by one parent but subsequently returned revealed that the children were functioning worse immediately post-abduction than at pre-abduction. Parents reported a decrease in psychological functioning during abduction. (SJK)

Garbarino, J. (1989). The psychologically battered child: Toward a definition. *Pediatric Annals, 18 (8),* 502-504.

This concise article defines the role and possible effects of psychological or emotional abuse in relation to other forms of child maltreatment. Five categories of psychological abuse are discussed, along with detection and intervention strategies for a wide range of professionals. (TFC)

Physical Abuse and Neglect

Burke, A. E., Crenshaw, D. A., Green, J., Scholosser, M. A., and Stocchia-Rivera, L. (1989) Influence of verbal ability on the expression of aggression in physically abused children. *Journal of the American Academy of Child and Adolescent Psychiatry 28 (2),* 215-218.

This study examined the relationship between verbal ability and aggressive behavior in 53 physically abused children. Verbal ability was found to be similar in aggressive and nonaggressive abused children, while reading and expressive language deficits were more prevalent in the highly aggressive abused child. (SJK)

Dubowitz, H., Zuckerman, D. M., Bithoney, W. G. and Newberger, E.H. (1989). Child abuse and failure to thrive: Individual, familial and environmental characteristics. *Violence and Victims, 4 (3),* 191-201.

The goal of this study was to compare important individual, familial and environmental similarities and differences between 25 abused children and 41 non-organic failure to thrive cases. Considerable similarity was found, except that the abuse group lived in greater poverty and more crowded conditions. Very important intervention and treatment policy issues are raised by this article. (TFC)

Sato, Y., Yuh, W.T.C., Smith, W.L., Alexander, R.C., Kao, S.C.S., Ellerbroek, C.J. (1989). Head Injury in Child Abuse: Evaluation with MR Imaging. *Radiology. 173,* 653-657.

When magnetic resonance imaging (MRI) and computed tomography (CT) were compared in 19 children with head injuries, subdural hematomas (n = 15), cortical concussions (n = 6), and shearing injuries (n = 5) were either better visualized with MRI than CT, or were only able to be detected by MRI. MRI was superior in imaging the posterior fossa, but CT was best at detecting subarachnoid hemorrhage. CT is important in identifying neurosurgical emergencies, but for medical-legal purposes, MRI offers the mostcomplete and clear study of intracranial injuries. (RCA)

Wilkinson, W.S., Han, D.P., Rappley, M.D., Owings, C.L. (1989). Retinal Hemorrhage Predicts Neurologic Injury in the Shaken Baby Syndrome. *Arch Opthalmol. 107,* 1472-1474.

The severity of retinal hemorrhage was compared to the severity of acute neurological injury in 14 children who were victims of shaken baby syndrome. Blinded ratings revealed that children with bilateral retinal hemorrhages tended to have more severe neurologic injury; retinal injury score correlated with acute neurologic injury score; and the presence of sub-hyaloid hemorrhage greater than 2 disc areas in size, vitreous hemorrhage, or diffuse hemorrhage involving all three fundus regions (peripapillary, macular, and peripheral retina) was associated with a high acute neurological injury score. It is possible that retinal hemorrhage may provide an estimate for the degree of neurologic damage to be expected in such cases. (RCA)

Sexual Abuse

DeJong, A.R., Rose, M. (1989). Frequency and significance of physical evidence in legally proven cases of child sexual abuse. *Pediatrics, 84(6),* 1022-1026. (RCA)

In a retrospective review of 45 legal cases of alleged sexual abuse with penetration, 39 (87%) resulted in felony convictions. Physical evidence (e.g. presence of seminal fluid, sexually transmitted diseases, or physical injury) was present in 29% of the cases. The presence of physical evidence (at least in Philadelphia) did not result in higher conviction rates, suggesting historical information is a more important determinant.

Dominelli, L. (1989). Betrayal of trust: A feminist analysis of power relationships in incest abuse and its relevance for social work practice. *British Journal of Social Work, 19,* 291-307.

In her presentation of feminist theory and its application to the phenomenon of incest and its treatment, the author redefines incest as a social problem. She challenges traditional assumptions and myths about the family, parental power structure, and the role of children in society. (HJ)

Gilbert, C. M. (1989). Sibling incest. *Journal of Child Psychiatric Nursing, 2 (2),* 70-73.

This clinical article reviews the paucity of literature currently available on sexual abuse among siblings. Brother-sister incest is the most reported form of sibling sexual abuse and typically occurs in dysfunctional families, in which parents are physically or emotionally unavailable. Many of these homes are highly sexualized, with children witnessing adults engaged in sexual intercourse. The clinical and research implications of sexual activity between siblings are discussed. (SJK)

Goff, C.W., Burke, K.R., Rickenback, C., Buebendorf, D.P. (1989). Vaginal Opening Measurement in Prepubertal Girls. *Am J. Dis Child, 143,* 1366-1368. RCA)

The apparent transverse diameter of the vaginal opening was measured in 254 prepubertal girls less than 8 years of age, in both the supine frog-leg and supine knee-chest positions. No attempt was made to assess whether any had been sexually abused since this was a normative study of what constituted an unusually large vaginal opening in a white, middle class population presumably containing both abused and non-abused girls. Although there was a tendency for vaginal opening size to increase with age, no child measured more than 4 mm. in the supine frog-leg and 5 mm. in the supine knee-chest positions, supporting previous studies that large vaginal openings (greater than 4-5 mm.) are distinctly rare.

Kelley, S. J. (1989). Stess responses of children to sexual abuse and ritualistic abuse in day care centers. *Journal of Interpersonal Violence 4, (4),* 502-513.

Sixty-seven children who were sexually and ritualistically abused demonstrated significantly greater child behavior problems than a comparison group of nonabused children. Sexual abuse involving ritualistic abuse was associated with increased impact and increased severity in the extent of abuse. (SJK)

Leventhal, J. M., Hamilton, J., Rekedal, S., Tebano-Micci, A. and Eyster, C. (1989). Anatomically correct dolls used in interviews of young children suspected of having been sexually abused. *Pediatrics, 84 (5)*, 900-906.

A study of 83 children was conducted to determine the value of using anatomically detailed dolls in diagnostic interviews. It was found that substantially more information was provided by the children when the dolls were used in the interview. Strong support for the communicative function served by anatomical dolls is provided by this article. (TFC)

Sex Offenders

Bethea-Jackson, G. and Brissett-Chapman, S. (1989). The juvenile sexual offender: Challenges to assessment for outpatient intervention. *Child and Adolescent Social Work, 6*, 127-137.

The authors provide a comprehensive, structured assessment tool from which to establish etiology of offensive behavior and to establish treatment goals and techniques. (HJ)

Kahn, T. J. and Lafond, M. A. (1988). Treatment of the adolescent sexual offender. *Child and Adolescent Social Work, 2*, 135-149.

Drawing from their experience in a state correctional institution, the authors present a framework for treating adolescent sexual offenders. Five essential tasks are identified: addressing the juvenile offender's denial; taking a history of the offender's own victimization; breaking through dysfunctional attitudes and values that maintain sexual molestation; educating the offender about social competence, and altering deviant arousal patterns. (HJ)

Pietz, C. A. and Mann, J. P. (1989). The importance of having a female cotherapist in a child molesters' group. *Professional Psychology: Research and Practice 20 (4)*, 265-268.

This article discusses the therapeutic advantages of having a female cotherapist in group treatment of child sex offenders. The authors argue that the female therapist acts as a living personification of women in the child molester's past and that child molesters harbor many misconceptions about women that interfere with their ability to form a healthy relationship. (SJK)

Stermac, L. and Hall, K. (1989). Violence among child molesters. *Journal of Sex Research, 26 (4)*, 450-459.

This study examined the nature of sexual contact with children among a clinical sample of incest and non-incest sex offenders. In 89 cases, perpetrators were found to have used physical violence or aggression. The common belief about child molesters being non-violent is directly challenged. (TFC)

Child Abuse and the Legal System

Audson, S. S. (1989) The Broadening Scope of Liability in Child Abuse Cases. Journal of Family Law, University of Louisville 27, 697-713.

Case law is reviewed that demonstrates a trend towards broadening the scope of criminal liability in child abuse cases to include "passive partners" and instances in which no specific findings of intent or malice are involved. Conviction is found to be more likely in states that have penal statutes specifically prohibiting child abuse as contrasted with outcomes in states that do not have clear prohibitive statutes and require prosecution under criminal statutes of general application. (DP/SW)

Goodman, R. S. (1989). The Battered Child - Too Little, Too Late: The Historical Development of a Legal Diagnosis. *Legal Aspects of Medical Practice 17*, 2-8.

The evolution of the medical and legal definitions of the diagnosis of the "battered child syndrome" are compared and contrasted. The author concludes that the diagnosis of the battered child is one of three instances in which legal definitions of medical diagnoses occur. The other two instances are life and death. (DP/SW)

Moreno, J. A. (1989). Killing Daddy: Developing a Self Defense Strategy for the Abused Child. *University of Pennsylvania Law Review 137*, 1281-1307.

Judicial resistance to child abuse-parricide self defense claims continues although battered women who have killed their abusers have been allowed in certain instances to develop self-defense strategies by the courts. This has occurred despite the traditional premise of self defense which assumes male, stranger-to-stranger, isolated assault. This article analyzes this trend and presents five case studies which provide perspective on the legal problems that confront child abuse-parricide defendants. (DP/SW)

Myers, J.E.B. (1989). Protecting Children from Sexual Abuse: What does the Future Hold? *Journal of Contemporary Law, University of Utah School of Law*, 31-50.

A historical review of the cycles of emergence and suppression of child sexual abuse as an acknowledged societal issue is presented. Factors which are currently contributing to attempts to suppress the issue including arguments commonly heard from opponents of child protection efforts are analyzed. (DP/SW)

Gelles, R. J. (1989). Child abuse andviolence in single-parent families. *American Journal of Orthopsychiatry, 59 (4)*, 492-501.

Data gathered from 6,000 households concluded that single-parent households are at significantly higher risk for physical child abuse than are dual-caretaker families. This study also found an exceptionally high rate of abuse among single, poor fathers. Important treatment and policy issues are discussed. (TFC)

Korbin, J. E. (1989). Fatal maltreatment by mothers: A proposed framework. *Child abuse and Neglect, 13*, 481-489.

The author proposes a framework for recognizing warning signals of potential fatal child abuse. Fatal abuse is presented as an exit point of a recurring pattern of abusive incidents. CPS investigators and police should find this article most useful. (TFC)

McKibben, L., De Vos, E. and Newberger, E. H. (1989). Victimization of mothers of abused children: A controlled study. *Pediatrics, 84 (3)*, 531-535.

In acomparison of medical records of mothers whose children had been abused and mothers whose children has not been traumatized, the author found that the records of mothers of abused children were highly diagnostic or suggestive of present or past victimization. (HJ)

Zuravin, S. (1989). Child neglect research findings: Some implications for the delivery of child protective services. *Protecting Children, 6 (3)*, 13-18.

This very important article, in the American Humane Association Quarterly (Denver), examines the major causes and effects of child neglect, particularly the relationship between neglect and maternal depression. This enormously informative and practical article should be required reading for all protective services policy makers, as well as investigators and mental health professionals. (TFC)

Journal reviewers for this issue included Randall C. Alexander, M.D., Assistant Professor of Pediatrics, The University of Iowa; Thomas F. Curran, MSW, LSW, Coordinator, Child Sexual Abuse Curriculum Project, Camden, NJ; Helene Jackson, Ph.D., Boston College School of Social Work, Chestnut Hill, MA; Susan J. Kelley, RN, Ph.D., Boston College School of Nursing, Chestnut Hill, MA; Daniel Pitcher, Office of the District Attorney, Middlesex County, Cambridge, MA; and Suzanne White, MSW, Office of the District Attorney, Middlesex County, Cambridge, MA.

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To be concluded in the Spring issue. David Finkelhor, Ph.D., is Associate Director of the Family Violence Research Program at the University of New Hampshire, and a member of APSAC's Board of Directors.

CONFERENCES

March 22 - 24. ***Sixth Annual Conference on Abuse andVictimization in Life-Span Perspective: Violence and Victims.*** Directed by Carolyn Moore Newberger, Ed.D., and Eli H. Newberger, MD. Sponsored by The Children's Hospital of Boston, and Harvard Medical School Department of Continuing Education. Featured speakers: Judith Becker, Angela Browne, Chris Butler, Wendy Chavkin, Philip Greven, Susan Schechter, Kersti Yllo and Paul Wise. Call Cherry Manuel, 617-432-1525.

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April 29 - May 2. ***Ninth Annual Conference of the National Court Appointed Special Advocate (CASA) Association.*** New Orleans. A chance for CASAvolunteers, judges, attorneys, social workers and other child advocates to join forces for abused and neglected children. Call 206 328-8588.

June 6 - 8.*Third Annual East-Central U.S. Conference on Sexual Abuse: Forensic Issues in the Treatment of Child Sexual Abuse.* South Bend, Indiana. Sponsored by Family & Children's Services of St. Joseph County, Inc.Contact Melissa McDermott: 219-259-5666.

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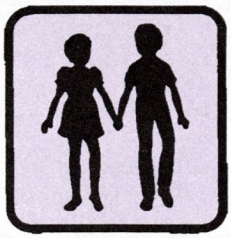

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