APSAC

Volume 3 Number 3, Fall, 1990

THE ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

LAW

COPING WITH CROSS EXAMINATION

—by John E.B. Myers

Professionals from medicine, psychiatry, social work, and psychology often testify for the state as expert witnesses in child abuse litigation. For professionals new to the role of expert witness, and for many veterans of the witness stand as well, no aspect of testifying causes more anxiety than cross-examination. Anxiety results because cross-examination is both adversarial and a bit mysterious. Non-lawyers generally are not privy to the cross-examiner's art. The purpose of this article is to reduce that anxiety by going behind enemy lines, if you will, to demystify the process. The expert witness who knows the cross-examiner's techniques and strategies is able to deal with him or her on more equal terms.

Testifying in court begins with direct examination. During direct examination, the district attorney calling the expert witness asks the questions. Following direct examination, the attorney defending the alleged abuser has the right to cross-examine.

No two cross-examiners are alike, of course, and each attorney's technique is influenced by her personality and experience. Nevertheless, most cross-examiners rely on some combination of the following principles.

Principle #1: Avoid the Frontal Attack in Most Cases.

When people think of cross-examination, they remember Perry Mason ruthlessly burrowing in on a witness until the beleaguered chap finally blurts out, "All right! You win! I did it." That may be the way it is on TV, but such dramatic cross-examination is seldom seen in real courtrooms, especially with expert witnesses.

The competent cross-examiner seldom attempts a frontal attack on an expert in the hope of destroying the expert's credibility or getting the expert to change her opinion. Why do cross-examiners avoid the frontal attack? Because it usually fails. Furthermore, jurors may react negatively to a cross-examiner who ruthlessly attacks an expert, especially an expert in the business of helping children, and the jury's discontent with the defense attorney may generalize to the defendant. Thus, skilled cross-examiners seldom use the sledgehammer approach, preferring instead more subtle techniques.

Principle #2: In Appropriate Cases, Conduct Only a Positive Cross-Examination, and Avoid or at least Postpone Negative Cross-Examination.

There are two basic types of cross-examination: negative and positive. The purpose of negative cross-examination is to attack the expert's credibility, impartiality, or competence, and to undermine the believability of the expert's testimony. In positive cross-examination, on the other hand, the attorney avoids attacking the expert, and attempts instead to elicit from him or her information favorable to the defendant.

Negative cross-examination is risky. When a witness knows she is being attacked, she resists providing testimony that is favorable to the attacker. Furthermore, a witness under attack is prone to look for—and find—opportunities to refute points the cross-examiner is trying hard to make.

In some cases, the cross-examiner avoids the risks of negative cross-examination altogether, and limits herself to the positive approach. For example, the attorney may reemphasize with the expert any parts of the expert's direct testimony that may be favorable to the defendant.

Naturally, when the attorney's questions are fair and accurate, the expert agrees with them. There is nothing wrong with agreeing with the cross-examiner. In fact, an expert who stubbornly refuses to give an inch in the face of reasonable questions from the cross-examiner undermines her own credibility in the eyes of the jury.

When the cross-examiner intends to conduct a negative cross-examination, she may begin with the positive approach, hoping to elicit favorable information before the expert is alerted, and perhaps alienated, by the onset of negative or attacking questioning. Remember then: even though the cross-examiner begins on a positive note, the negative segment may be just around the corner.

Principle #3: Raise Just Enough Doubt about the Expert's Testimony to Give Yourself Ammunition for Your Clos-

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NEWS

APSAC's OFFICES MOVE; NEW TASK FORCES FORMED; STATE CHAPTER FORMATION GOING STRONG

—by Theresa Reid

As of July 1, APSAC had a new address: 332 South Michigan Avenue, Suite 1600, Chicago, 60604. Our new phone is 312-554-0166. You may see stationery and brochures bearing our old, University of Chicago, address for months yet—we have a lot of stock. Please just ignore them. Anne Cohn and the National Committee for the Prevention of Child Abuse have kindly provided us with space in their offices at very reasonable rates, and we'll be here for the duration.

Task Forces

At its meeting in Atlanta in April, APSAC's Board authorized the formation of two new Task Forces: one, on Psychological Maltreatment, is being co-chaired by Stuart Hart and Marla Brassard, from Indiana University-Purdue University and the University of Massachusetts at Amherst, respectively (see article, page 3); the other, on Assessment and Treatment of Adult Survivors of Abuse, is being chaired by Dan Sexton of Child Help USA (213-465-4016). Dan will write soon about the specific objectives to be addressed by the Adult Survivor Task Force. Meanwhile, he would

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

LEGAL NEWS

SUPREME COURT DECIDES TWO IMPORTANT CHILD ABUSE CASES

—by John E.B. Myers

On June 27, 1990, the U.S. Supreme Court decided two important child abuse cases in ways professionals who work with abused children can feel good about: one case dealt with children's statements during interviews, and the other with the constitutionality of allowing traumatized children to testify via closed circuit television.

The first case, *Idaho vs. Wright*, spurred APSAC to file an *amicus* brief with the court (see Spring, 1990, *Advisor*, p. 1). This case concerned the admissibility in court of children's statements to interviewers such as CPS workers, physicians, police officers, and mental health professionals. The Idaho court overturned a conviction of child sexual abuse because it was based on statements a 1-1/2-year-old child made to a physician who (1) did not videotape the interview, (2) asked leading questions, and (3) knew prior to the interview that the child might have been sexually abused.

The Idaho court's decision was frightening because it seemed to create a broad rule that nothing children say during interviews is reliable unless the interview is videotaped and the interviewer is ignorant of the reason for the interview and asks no leading questions. If the U.S. Supreme Court had upheld the procedural requirements maintained by the Idaho court, they would have applied in all states, leading to the exclusion of a tremendous amount of reliable hearsay evidence in child abuse prosecutions nationwide.

APSAC acted quickly and filed a "friend of the court" brief (signed as well by the AMA, NOW, the American Academy of Pediatrics, the National Association of Counsel for Children, the State of Rhode Island Office of the Child Advocate, and the Support Center for Child Advocates) that seems to have had a positive influence on the outcome of this case. Using language that appears to derive from APSAC's brief, the Supreme Court stated that hearsay statements "made by children regarding sexual abuse arise in a wide variety of circumstances, and we do not believe the Constitution imposes a fixed set of procedural prerequisites to the admission of such statements at trial. The procedural requirements identified by the [Idaho court], to the extent regarded as conditions precedent to the admission of child hearsay statements in sexual abuse cases, may in many instances be inappropriate or unnecessary to a determination whether a given statement is sufficiently trustworthy" to be admitted in evidence. The Court went on to write that, "We decline to read into the [Constitution] a preconceived and artificial litmus test for the procedural propriety of professional interviews in which children make hearsay statements."

The bottom line of the *Wright* decision is that professionals can continue to talk to children. Videotaping is often appropriate, but the Supreme Court recognized that children's statements don't have to be videotaped to be reliable.

Furthermore, while leading and suggestive questions should be used sparingly, there are cogent developmental and psychological reasons for selective use of directive and, at times, even leading questions with sexually abused children. The Supreme Court did not mention the Idaho court's concern about interviewer knowledge of the reason for the interview, but the prevailing practice of proceeding with full information can continue after the Wright decision. (For further information, see the Spring, 1990, issue of *The Advisor*, which is dedicated to interviewing issues.)

The Wright decision reemphasizes the importance of carefully documenting every aspect of the interview situation. Interviewers should preserve a record of exactly what children say and exactly what questions elicit children's reponses. In particular, interviewers should document children's mental and emotional state while disclosing abuse. Interviewers should also determine whether children or adults have reason to fabricate allegations of abuse. In the end, the ability to use children's statements describing abuse often hinges on how well interviews are conducted and documented. (For further information on hearsay evidence and the importance of documentation see "Preserving verbal evidence of child abuse" in *The Advisor*, V.2, n.2.)

In the second case, *Maryland vs. Craig*, the U.S. Supreme Court upheld the constitutionality of allowing selected children to testify via closed circuit television so that traumatized children do not have to face the defendant. In criminal trials, the Constitution provides that "the accused shall enjoy the right . . . to be confronted with the witnesses against him." In *Craig*, the Supreme Court held that although the right to confront one's acusers is very important, it is not absolute.

If the trial judge determines after a hearing that a particular child would be traumatized by face-to-face confrontation with the defendant, the judge may authorize televised testimony in which the child testifies from another room. The judge may not dispense with face-to-face confrontation on the generalized assumption that testifying is traumatic for all children. There

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NEWS

APSAC ESTABLISHES A PSYCHOLOGICAL MALTREATMENT TASK FORCE

—by Stuart N. Hart

During its January 1990 meeting, APSAC's Executive Committe established a task force on psychological maltreatment. The decision reflects the growing interest in the topic among child abuse and neglect specialists, and recognizes that important relationships exist between psychological and other forms of maltreatment.

NCCAN's second incidence study (1988), applying very conservative standards, found psychological maltreatment to represent a much larger portion of total child maltreatment in 1986 than was reported to CPS. Experts generally agree that psychological maltreatment almost always accompanies other forms of child abuse and neglect; is more prevalent than other forms of maltreatment; and is often more destructive in its impact on the lives of its victims (Brassard, Germain, and Hart, 1987; Egeland, Sroufe, and Erickson, 1983; Garbarino, Guttman, and Seeley, 1986).

Present evidence suggests that psychological maltreatment is inherent in all maltreatment (Erickson and Egeland, 1987); that sexual abuse is primarily psychological maltreatment (Brassard and McNeil, 1987; Hart and Brassard, 1990b); and that the psychological maltreatment associated with physical abuse, not the severity of the physical abuse, predicts the behavioral delays and developmental disorders which follow physical abuse (Claussen and Crittenden, in press).

From the beginning of our nation's involvement in child welfare, professionals have been concerned about psychological damage to maltreated children. But the quantity and quality of social services devoted to psychological maltreatment have been low (Hart and Brassard, 1990a,b). The major impediment to effective handling of psychological maltreatment has been the lack of operational definitions. One Federal statute on child abuse and neglect, Public Law 91-247, uses the term "mental injury" but fails to define it. Although a number of states have written standards for casework with emotional abuse, all have failed to provide adequate definitions for identification and assessment (Corson and Davidson, 1987). Research surveying expert opinion has identified the need for operational definitions as a first priority issue for advancing work in psychological maltreatment (Turgi, 1989).

Recently, a generic definition (Hart and Brassard, 1987) and operational definitions, decision-making standards, and associated instrumentation have been developed to guide the assessment of the presence and severity of psychological maltreatment (Claussen and Crittenden, in press; Hart and Brassard, 1986, 1990a). These measures and procedures are sufficiently well developed to provide direction for researchers and direct service personnel interested in assessing and studying psychological maltreatment (Crittenden and Hart, 1989).

These new developments and the encouragement provided by national centers (DHHS, 1990; NCPCA, 1987) have energized researchers and practitioners concerned with psychological maltreatment. The APSAC Executive Committee envisions coordination and cooperation between professionals that can be instrumental in producing new advances.

APSAC's Psychological Maltreatment Task Force (PMTF) is co-chaired by Stuart Hart and Marla Brassard (Directors of the Office for the Study of the Psychological Rights of the Child at Indiana University - Purdue University and the University of Massachusetts at Amherst, respectively). Membership on the PMTF is open to all interested APSAC members.

During 1990 and 1991, the PMTF will develop its priorities for the next three to five years of operation. Among the objectives to be considered are the following: (1) Conduct a national research symposium to clarify the present state of knowledge and produce an agenda and collaborations for research within and across maltreatment forms. (2) Produce and conduct training seminars on definitional issues, instrumentation, and assessment. (3) Produce, publish, and distribute written guides or training materials for recognizing, assessing, reporting, and treating psychological maltreatment.

PMTF business will initially be conducted by mail, telephone and telefax. Meetings of the PMTF will be conducted at each of the national meetings of APSAC. During the next year, meetings are planned to take place during the January (San Diego) and March (Huntsville, Alabama) APSAC national conferences. Invitations and reminders will be published in the newsletter and sent to those who have indicated an interest. Those interested in working with PMTF should contact Stuart Hart (OSPRC, School of Education, IUPUI, 902 W. New York St., Indianapolis IN 46202-5155. 317-274-6801 [w]; 317-255-5584 [h]; 317-274-0492 [FAX]; INDYCMSIMQM 100 [BITNET]).

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MYERS ***(Continued from page 2)***

must be solid evidence, which goes beyond mere speculation, that a particular child would be traumatized.

How traumatic must testifying be to dispense with a defendant's right to confront his accuser? The Supreme Court did not decide this question. The Court did state that at a minimum, "the trial court must find that the emotional distress suffered by the child witness in the presence of the defendant is more than *de minimis*, i.e., more than 'mere nervousness or excitement or some reluctance to testify'." The Supreme Court emphasized that one important consideration is whether face-to-face confrontation would undermine a child's ability to communicate effectively in court. The Supreme Court noted that the Maryland statute, which requires serious emotional distress that would interfere with effective testimony, is sufficient. In the final analysis, the difficult task of determining how much trauma is required to dispense with face-to-face confrontation is left to state courts. Generally speaking, state courts require a fairly high showing of trauma to the child before they are willing to deprive a defendant of the right to face-to-face confrontation.

The decisions in *Wright* and *Craig* further the legal effort to protect abused children. The U.S. Supreme Court was good to children this year.

John E.B. Myers, JD, is Executive and Legal Editor of The Advisor.

MEDICINE

SOME THOUGHTS ON CHILD NEGLECT

—by Howard Dubowitz

Editor's Comments

—by Martin Finkel

In an effort to prevent the neglect of neglect, Howard Dubowitz, MD, Assistant Professor in the Department of Pediatrics at the University of Maryland School of Medicine, raises provocative and insightful questions about this widespread phenomenon. He challenges practitioners to ascertain whether or not neglect has occurred or potentially could have occurred in any given set of circumstances. Dr. Dubowitz illustrates that validating this complex form of maltreatment requires considerable skill.

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A majority of reports of child maltreatment and about half of the fatalities due to child maltreatment involve child neglect (1,2). Despite its apparent importance, neglect has been largely ignored in favor of abuse, and its definition and assessment remain matters of considerable confusion. The neglect of neglect is not altogether surprising, given that neglect is inherently quite abstract and little research has addressed the issue (3). Although a coherent definition of neglect would certainly aid our efforts to protect children, many complex factors impede efforts to formulate such a definition.

In any society, the definition of child neglect rests upon agreed-upon values concerning adequate, not optimal, care. Parents who do not provide at least a minimum threshold of care are deemed neglectful.

However, in the pluralistic United States, many views regarding the appropriate care of a child coexist. For example, some families would not consider leaving their four-year-old in the care of a ten-year-old for a few hours in the afternoon, whereas their neighbors do it routinely. Some parents might religiously follow the American Academy of Pediatrics's guidelines for periodic check-ups while the people down the block don't even know they exist.

In addition to myriad individual differences, some differences in viewpoint are systematic, based on cultural or religious practices. In a recent case in Boston, for example, a child died needlessly because his parents, who were Christian Scientists, allowed only prayer-based treatment for a bowel obstruction. To call such action child neglect is to impose the will of the majority on the minority. Should we do that?

Questions about what constitutes neglect are complicated by the fact that child neglect is such a heterogeneous phenomenon. A number of typologies of neglect include categories pertaining to physical and mental health, child supervision and custody, hygiene, nutrition, housing hazards and sanitation, and education (6).

Definition is further complicated because much neglect does not inhere in specific behaviors. Whether a behavior is neglectful or not depends in part on the child's age and developmental level: newborns and adolescents have very different minimal needs. Too, different professionals and agencies use differing definitions of child neglect to serve specific purposes (2,6). Such differing perspectives and agendas make establishing standards of adequate care difficult.

Nevertheless, Polansky found that considerable agreement on child neglect does exist among subjects representing rural and urban living and a range of socioeconomic status (4,5). For example, most people agreed that leaving an infant alone in a bathtub is negligent. Consensus also seems to be that neglect occurs when important needs of the child are not met due to acts of omission by the caretaker which result in actual or potential harm to the child. Those areas in which a substantial consensus exists among both lay people and professionals provide a useful foundation on which to build a working definition, a definition flexible enough to allow for varied approaches, yet clear enough to provide a useful conceptual scheme for guiding assessments and research, and shaping interventions and public policy.

One question on which consensus seems to be growing is whether harm to the child is a necessary criterion of neglect. Most state laws recognize either actual harm (e.g., failure to thrive) or potential harm (e.g., the probable sequelae of not attending school). To restrict neglect to instances where actual harm has occurred would exclude many neglectful situations in which harm is not obvious but might be apparent in the long-term. In addition, the criterion of potential harm (endangerment) allows for preventive intervention.

Other important points in most definitions of neglect are the frequency and duration of a neglectful behavior. A child who is occasionally filthy is in a very different situation from a child who is continually filthy. Sometimes, a single lapse in supervision places the child at risk for significant harm, or causes actual harm. Leaving an infant alone in a bathtub is a good example. Even if a terrible outcome ensues, this would probably be seen as tragic—an occasional lapse being only human—and not neglectful. Generally, neglect would be inferred if a pattern of behavior is established that is inappropriate for given circumstances. For a child struggling to breathe, a few hours' delay in seeking health care might be considered neglectful; for a school-aged truant, days or weeks of failing to ensure that the child goes to school might be needed to qualify as neglect.

Substantial agreement exists as well on the question of whether parents are responsible when they have delegated their child's care to another person who is then neglectful or abusive. In most working definitions, parental responsibility hinges on what efforts have reasonably been made to ensure the adequate care of the child. If reasonable measures have been taken, the parent can't fairly be considered neglectful. In addition, although the parents have primary responsibility for the child's care, the caretaker who accepts temporary responsibility for a child also has an obligation, sometimes legal, to provide adequate care.

The issue of reasonable efforts raises questions about the parents' ability to protect their children. The role of poverty in child maltreatment has been controversial (7). Although poverty *per se* is not the cause of maltreatment, a strong association exists between poverty and neglect. Within a sample of impoverished families, neglect was associated with the most desperate poverty (8). Most poor families do not neglect their children; nevertheless, the burdens and stresses of poverty can compromise the nurturant abilities of parents.

One type of neglect that differentially affects impoverished families concerns safety hazards in the home. Parents who are grateful to have an apartment might not be able to fix, or get fixed, the peeling lead paint or rickety bannister. Are they neglectful? Should homeless parents be found neglectful for failing to provide adequate shelter for their children? What if a mother with post-partum depression inadequately responds to her infant's hunger cues, or a first-time mother incorrectly mixes her infant's formula?

From the child's viewpoint, crucial needs are not being met. But the question is, who is neglectful? Sometimes it's not meaningfully the parents' responsibility, but that of landlords, governments, and the society at large. If a city lacks decent low-income housing or pre-partum and post-partum care and education for impoverished mothers, labelling the consequences parental neglect seems unfair if not cruel. Our awareness of underlying causes should shape intelligently helpful and not punitive responses.

The heterogeneity of neglect requires various approaches and interventions that take into account both important needs of children and reasonable expectations of parents. Research is needed to refine our understanding of what factors contribute to child neglect, what child outcomes are associated with certain parental behaviors,

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MEDICINE

MEDICAL SIGNS WHICH MAY MIMIC SEXUAL ABUSE

—by Jan Bays

Editor's Comments

—by Martin Finkel

Dr. Bays and her colleague, Dr. Jenny, in this article bring to light the spectrum of anogenital complaints which to the untrained eye might be misconstrued as due to sexual abuse. In light of the seriousness of the allegation of possible sexual abuse, it is appropriate for all disciplines to be aware of those medical problems that raise false suspicion of sexual abuse.

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Between ten and twenty-five percent of children are sexually abused. Not surprisingly, physicians are increasingly asked to examine children for physical signs of possible sexual abuse. A diagnosis of sexual abuse has serious consequences for the child, family, and suspected offender. Physicians should be familiar with conditions causing physical signs in the genital and anal areas which might be confused with the physical findings due to child sexual abuse. *The Color Atlas of Child Sexual Abuse* (see references) is a helpful resource, presenting color picture of normal anatomical findings, findings due to abuse, and findings that commonly result from nonsexual or indeterminate etiology. In an article to be published in *American Journal of Diseases of Children* (v.144, 1990), Carol Jenny and I review the existing literature on such conditions and present representative cases from our clinical practice at sexual assault centers in the Pacific Northwest. Six general categories of conditions are discussed in the article: dermatologic, traumatic, congenital, anal, urethral, and infectious. This newsletter article is a condensation of the journal article.

Dermatologic. Dermatologic conditions range from the common, such as genital redness due to bubble bath or yeast diaper rash, to the uncommon, such as a disease called *lichen sclerosis*, which can cause bleeding in the genital area from such mild trauma as wiping with toilet paper.

Traumatic. Marks which mimic bruises can be caused by the juice from plants like limes, figs or celery contacting the skin prior to sun exposure. One child was reported for possible abuse when an adult who had been squeezing limes at a tequila party grabbed the child's arm, leaving a hand print in lime juice, which developed into a dark "bruise" after sun exposure.

Labial fusion is a common finding in nonabused girls who are still in diapers, but may indicate abuse if seen in an older girl.

Straddle injuries are usually easy to diagnose as they involve a dramatic and acute history, and involve injuries which are usually unilateral, anterior, and external.

Masturbation is not reported to cause genital injuries except in children who self-mutilate, are severely developmentally delayed, or have been abused.

Congenital. Congenital conditions include red birthmarks on the genitalia and a variety of midline structures such as tags, pits, epispadius and failure of midline fusion.

Anal. A number of anal conditions may raise concerns about possible abuse. Anal changes mimicking abuse can be caused by Crohn's disease, hemolytic uremic syndrome, *lichen sclerosis*, and neurogenic *patulous anus*. Perianal streptococcal cellulitis is an infection which can cause a painful perianal rash and bleeding.

Urethral. Bleeding and pain with urination can be caused by urethral prolapse, polyps, hemangiomas, and carbuncles.

Infectious. Sexually transmitted infections like genital warts and Chlamydia in children out of infancy should raise concerns about abuse. An infant, however, may be infected at birth but not show symptoms for several months.

Conclusion

A physician who discovers a condition which may be due to sexual abuse should take a complete medical history to rule out other diagnoses. The child may be interviewed alone to ask about touching in her "private parts." Different examination positions and manipulative techniques should be used to determine that the exam is truly abnormal (Bays, J., et al., 1990). Referral for a second exam and an in-depth interview by trained experts may be appropriate.

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and what interventions are effective for different types of neglectful situations. To address adequately the complex and widespread problem ofchild neglect, professionals, communities, and governments must share responsibility with parents.

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RESEARCH

TEACHERS AND CHILD ABUSE

—by Kathleen Casey

Introduction

As institutions serving children of every race, creed, ethnic, and socio-economic group, schools are ideal settings in which to combat the widespread problem of child abuse. Teachers are the primary agents in this struggle. Because they have frequent, ongoing, and long-term contact with children, teachers have the opportunity, as well as the legal mandate, to report any child they suspect as being abused and/or neglected. In addition to their responsibility for identifying and reporting child abuse, teachers also play a pivotal role in preventing child abuse and neglect. Moreover, by resolving not to use corporal punishment, and modelling non-violent conflict resolution, educators create an environment conducive to the overall well-being of children.

In light of the enormous burden placed upon teachers as key actors in identifying, reporting, and preventing child abuse, research has suggested some disturbing trends. First, while the number of reports of child abuse continues to increase, the preparation of teachers to confront the problem remains inadequate. In one survey of teachers in Illinois, 81% of the teachers responding reported that they had received no child abuse information during college; 66% had received no education on abuse and neglect during in-service training (McIntyre, 1987).

Additionally, only 21% of the teachers reported that they were "very aware" of the signs of physical abuse, 19% of emotional abuse, and 30% of physical abuse and neglect. Seventy-six percent indicated that they would be unable to recognize indicators of sexual abuse. Another study of teachers in Atlanta indicated that 68% of the teachers responding had only received three or fewer hours of education about child abuse (Hazzard, 1984).

Another source of concern involves the apparent failure of teachers to report suspected cases of child abuse. Although 57% of the over 2.1 million reports of child abuse and neglect in 1986 involved school-aged children, only 16.3% of all reports originated from school personnel (AAPC, 1988). Further, the most recent National Incidence Study found that only 24% of suspected child abuse and neglect cases known to school personnel were reported to child protective services for formal intervention (Westat, 1988). From the limited amount of research examining educators as agents in the struggle against child abuse, several questions emerge:

* What education on identifying, reporting, and preventing child abuse are teachers provided in order to address this problem?

* How sufficient do teachers feel this education is in enabling them to address child abuse issues?

* How frequently do teachers encounter and subsequently report suspected cases of child abuse and neglect?

* What are the policies of schools with respect to reporting child abuse and neglect?

* What are some of the barriers to teachers' willingness to file a report on child abuse and neglect?

* What are teachers' views concerning child assault prevention programs, and what are the scope and extent of the school policies concerning these programs?

* What are teachers' views on the use of corporal punishment in the classroom and other prevention issues? The answers to these and other questions were sought through a National Teacher Survey (NTS) conducted by the National Center on Child Abuse Prevention Research, a program of the National Committee for Prevention of Child Abuse (NCPCA).

Method

The NTS drew its sample from the random stratified 29 counties utilized in the federally funded National Incidence Study (NIS), including both urban and rural communities throughout the U.S. (Westat, 1988). In each of these 29 counties, with the exception of those with only one unified school district, both the largest and smallest school districts were contacted. Approximately 1,694 questionnaires mailed to the school districts and 575 surveys were completed; of these 568 were completed by elementary or middle school teachers. This represents a response rate of approximately 34%. The respondents included 501 females (88%), 47 males (8%), and 20 (4%) who did not indicate their gender. The mean age of the sample was 40 years. The responding teachers were geographically distributed across the nation with 27% in the Northeast, 19% in the Midwest, 40% in the South, and 14% in the Southwest. Of the 568 teachers in the sample, 20% taught first grade, 9% second, 22% third, 17% fourth, 12% fifth, 16% sixth, and 1% special education.

Survey Findings.

Teacher Education. Results of the NTS reveal that, overall, teachers are receiving little education on identifying, reporting, and intervening in suspected cases of child abuse and neglect. Only 49% of teachers reported that their schools provided in-service workshops on child abuse and neglect related topics. Of those teachers who had been offered such workshops, 62% reported that the in-services were mandatory for all teachers, but were typically offered only once a year or on an "as needed" basis. Only half of all teachers (51%) reported that their school circulates any written material on child abuse and neglect.

In view of the minimal level of child abuse information NTS educators reported receiving, it is by no means surprising that the majority of teachers (approximately 66%) felt that the child abuse education provided them by their school was not sufficient in enabling them to identify cases of abuse. Even considering only those teachers who reported actually receiving in-service workshops, approximately half believed such brief instruction was not enough.

Reporting behavior. The pervasiveness of child abuse and neglect was attested to by the almost three-quarters (74%) of the NTS sample who indicated that they had suspected a child of having been abused or neglected at one time or another. Of the teachers who noted that they suspected child malteratment, 90% indicated that they reported the case, a surprisingly high figure in light of previous research. These reports were most commonly made to other school system personnel such as the school principal, social worker, or nurse. Only about 23% of teachers indicated reporting cases directly to CPS, a figure consistent with the NIS finding (Westat, 1988).

The fact that so many teachers in the NTS sample reported suspected cases of abuse is interesting to note when considering that only 57% indicated that their school district had a clearly-defined procedure for identifying and reporting suspected child abuse and neglect cases. Furthermore, it is particularly striking that 24% of the teachers were not even aware if their school had such a procedure.

Barriers to child abuse reporting. Because previous research has shown that school personnel report only a small percentage of the child abuse and neglect cases reported, the NTS queried teachers on their perceptions of potential barriers to consistent reporting. Two-thirds of the teachers (65%) felt that a significant obstacle was the lack of sufficient knowledge on how to detect and report cases of child abuse and neglect, and 63% indicated that the fear of legal ramifications for false allegations may impede their reporting. More general fears concerned the consequence of reporting (52%), such as reprisals against the child and damage to parent-teacher and teacher-child relationships. Other potential barriers included parental denial and disapproval of reports (45%), interference in parent-child relationships and family privacy (35%), lack of community or school support in making such allegations (24%), and school board or principal disapproval (14%).

Child assault prevention programs. Despite controversy over the efficacy and impact of child assault prevention programs, 65% of teachers reported having no reservations about teaching these types of pro-

OPINION

THE MCMARTIN CASE AND THE PARENTS' DILEMMA

—by Carolyn Moore Newberger

Should parents let their children testify in cases of child sexual abuse? The verdicts from the McMartin Preschool case must telegraph to every parent doubt about whether the agony is worth it. Often in the months following disclosure children appear to be recovering well from their experience, and both they and their parents want nothing more than to put the experience behind them. So why cooperate in a prosecution? Involvement is necessary because there is a need to let people who would hurt children know that they will be held responsible for their actions. Furthermore, people who molest one child appear likely to molest other children unless stopped.

Although testifying is stressful for everyone, testifying is not necessarily bad for a child. Participating in the legal process gives the child an opportunity to tell her story and to make a contribution to serving justice. The McMartin case, however, underscores for parents the uncertainty of our legal system and the potential pain, exposure, and disruption associated with a public trial. Fears that one's child could be devastated by an acquittal are inevitable in the face of such a verdict, and may tip the balance of parents' decision-making away from cooperation with prosecution. I hope this will not be so.

Sincere and courageous acts, even by young children, and even if not successful, may have positive longer-term effects. In part, this is because major experiences in children's lives, including traumatic experiences, are not lived once, but many times. As children grow older, their capacity to understand experience changes, allowing them to revise earlier impressions. For example, young children are egocentric; they believe that they cause the events in their lives. Thus, preschool children whose parents divorce typically feel that the divorce is their fault. As children grow older, however, parental divorce is usually reinterpreted from a broader perspective, and divorce comes to be understood as a consequence of the parents' own feelings and behavior. During adolescence, children can comprehend social and economic forces which may have put stress on the parents' relationship,.

In addition to being egocentric, young children also judge an act by its outcomes rather than by the intentions of the actor. In his studies of the moral development of children, for example, Jean Piaget found that children under the ages of six or seven, when asked whether it is "naughtier" to break fifteen cups by accident or one cup on purpose, replied that breaking more objects was "naughtier." In contrast, older children considered the child who broke one cup on purpose as more blameworthy.

When applied to children testifying in court, developmental theory would suggest that young children judge their testimony, and perhaps themselves, by the outcome of the trial. If a defendant is acquitted, the child may conclude that her testimony was bad and the verdict her failure. Cognitive-developmental theory also suggests, however, that as children grow older, they become able to understand that testifying in court was an act whose merit lay less in its outcome than in its intentions: to tell the truth and to do one's part in influencing justice. In adolescence, the child should also be able to take a broader, legal perspective to know that acquittal does not prove innocence, but indicates that guilt was not proved beyond a reasonable doubt.

Although children at any age will be outraged and pained by seemingly unjust resolutions, children at all ages can be helped to understand that their testimony was good and important, and that the bad outcome was not their fault. On the other hand, children denied the opportunity to tell their story may later feel disappointment and anger at not having been allowed to try to make a difference.

Whether or not to allow a child to testify is not an easy decision. Each case is different, and every child is different. Parents facing this agonizing decision should obtain, in my view, psychological consultation and legal counsel. In coming to a decision, however, it is important to recognize that the court process, although stressful and uncertain in outcome, may give the child an opportunity to take action on her own behalf, and that development provides renewed opportunities to process that experience and to reach new levels of understanding and resolution.

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CASEY *(Continued from page*

grams. Of the teachers with reservations (35%), the most commonly cited reason (64%) was feeling unqualified to implement such programs. The second most common reservation (51%) concerned time restraints. Further, 31% of the teachers surveyed reported feeling uncomfortable with the subject matter. Still, 92% of all teachers felt child sexual assault prevention programs were effective in teaching children how to protect themselves.

Corporal punishment. In rating the relative importance of certain activities in preventing abuse, only 64% of teachers indicated that stopping corporal punishment was of above average importance. Only 45% felt that talking with other teachers regarding the use of corporal punishment was of above average importance.

Conclusion

The findings from the NTS highlight at least four specific areas needing attention from child abuse prevention advocates:

* expanded training for teachers and school administrators on the identification of child abuse and the mandate to report all suspected cases to CPS.

* expanded training for teachers on how to effectively support victims of maltreatment independent of any actions CPS may or may not take.

* expanded opportunities for teachers to become more familiar and comfortable with the concepts in most child assault prevention curricula.

* general education for teachers and the public on the potential dangers of corporal punishment.

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COMING NEXT ISSUE

The next issue of *The Advisor* will be devoted to burnout among professionals who work with abused children, their families, and perpetrators. Articles will be contributed by ***Cynthia Winn*** and ***Marilyn Peterson*** of the University of California at Davis; ***Lisa McCann*** of the Traumatic Stress Institute in South Windsor, Connecticut; ***Dan Sexton*** of Childhelp USA; ***Sandy Krebs*** of the Torrance, California Police Department; ***Jon Conte***, of the University of Washington; ***Lucy Berliner***, of Harborview Medical Center, and others.

PRACTICE

THE DISSOCIATIVELY DISORDERED CHILD

—by Beverly James

Dissociative disorders, including multiple personality disorder, are frequently associated with chronic childhood abuse. Defensive dissociation keeps overwhelming emotions, thoughts, and sensations from conscious awareness, enabling youngsters in intolerable circumstances to function. Unfortunately, it may become so extreme that it defeats its own purpose and dramatically inhibits functioning and development.

Professionals working with abused children are in a unique position to identify these disorders and to intervene in time to prevent further development and entrenchment. Because we are still in the early phases of understanding dissociative phenomena, particularly in children, our theoretical formulations should be tentative and our clinical approach open and flexible. We should be alert to the possible presence of dissociative disorder, however, because dissociative disorders tend to intensify over time, rather than remain static or improve like many other disturbances. The more current knowledge we have about etiology, diagnosis, and treatment of these disorders, the more effective we will be in our work with abused children.

Etiology.

Dissociative disorders seem to be caused in part by extreme dysfunction in family relationships. Double bind communication, enmeshed family systems, and pseudomutuality, once considered part of the etiology of schizophrenia, may more properly be identified in the family dynamics of those who have multiple personality disorders (Spiegel, 1984). Hornstein (1989) notes that confusing, contradictory relationships within the family are often preserved in alter personalities' relationships with each other and in the child's relationship with the therapist. Hornstein identifies the following categories of dysfunctional behavior by caregivers of children with dissociative disorders:

Emotional fragility: The caregiver's mental disorders, substance addiction, personality disturbance, and suicidal behaviors demand that the child assume responsibility for the caregiver's physical and emotional care. Instead of being reliably nurtured, the child becomes highly attuned to the caregiver's needs, both to prevent her or his own abuse and to safeguard the parent's life and health.

Unpredictable responses: Caregivers may respond to the same behavior with lavish rewards one day and savage punishments the next, leaving the child with no idea how to behave. The parent alternately rejects the child and fosters intense dependence.

Repetitive abuse and obliteration of boundaries: The caregiver's abuse of the child has a compulsive, sadistic quality. The caregiver overidentifies with the child, relentlessly projecting his or her emotions onto the child, failing to recognize the child's separate existence.

Malicious overinvolvement: The caregiver rigidly controls all aspects of the child's life, including affective expression. The caregiver may punish the child, for example, for spontaneously laughing or crying. These parents are anything but neglectful: they rigidly control the child's dress, actions, friendships, etc. Yet they often ignore the child's basic needs for nutrition, medical attention, and physical safety.

In addition, dissociative children may have been raised by caregivers who themselves suffer from multiple personality disorder. In such cases, children may learn their caregivers' dissociative behavior (Coons, 1985 Hornstein, 1989). Such learning may be facilitated by dissociative parents who label their children's normal behaviors as manifestations of different entities existing within the youngster. Some dissociative parents may have alters who are abusive to the child, or may confuse their child by switching to alters of various ages and sexes, each of whom relates differently to the child.

Diagnosis.

What do childhood dissociative disorders look like? Dissociative behaviors that are persistent and impair children's functioning include the following:

Involuntary detachment: entering into trance states in response to stressful stimuli.

Depersonalization: feeling detached from oneself, or unreal, alien, mechanical.

Repression: being unable to recall important events. The memory of a specific event may not be consciously available, while memories temporally surrounding the event are recollectable.

Psychogenic amnesia: being unable to recall important personal information, such as one's age, name, parents' names, etc.

Dissociative splitting: disowning experiences or behavior, attributing them to someone or something else "not me."

Incipient multiple personality disorder: the presence of a consistent, unintegrated personality fragment (person, animal, cartoon character, for example) that may or may not be consciously recognized. The fragment functions as a repository for unacceptable experiences but is not sufficiently developed to take full control.

Multiple personality disorder: perceiving oneself, or being perceived by others, as having two or more distinct and complex personalities. Behavior is determined by the personality that is dominant at the time.

Successful work with dissociative disorders begins with diagnosis. But accurate diagnosis is not easy. Caregivers often don't help. They may not recognize symptoms as unusual, and commonly do not report symptoms that may seem strange but are not troublesome. Caregivers who want to hide their own dysfunction or abuse generally won't report their children's symptoms no matter how glaring. In addition, children have difficulty describing their internal experiences even when they want to, and may not be willing to reveal or discuss a dissociated part until they believe it is safe to do so.

Clinical assessments often miss dissociative disorders for several reasons. For one, dissociative episodes are not always disordered states: many are benign and pass unremarkably. Further, a normal child's behavior and temporary response to extreme stress can mimic some symptoms of dissociative disorder. In addition, some symptoms of dissociative disorder can be seen in normal children and adolescents, and many of these symptoms occur as well in children with other problems. We may overlook symptoms of a dissociative process until the child relives a traumatizing event and responds by revealing another personality or fragment. Some children may not be diagnosed until they create a new identity to deal with a current problem.

Clinicians can, however, be on the lookout for a number of behaviors that are more specific to the dissociatively disordered child. Both Kluft and Putnam have generated predictor lists for childhood multiple personality (see both in Kluft, 1984). Behavioral checklists specifically designed to identify dissociative disorders in children have been developed by Fagan and McMahon (1984) and Dean (1989). Among the behaviors warranting attention are the following:

* spontaneous trance states, when the child "spaces out" or stares off into space;
* denial of behavior that has been observed by others;
* description of self as "unreal" or "an alien";
* feeling remote from the environment or that surroundings are altering;
* getting lost coming home from school or from a friend's house;

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* use of another name;
* claiming that she's not herself, or has a dual identity;
* reference to self as "we";
* change in ability to perform tasks;
* sudden changes in vision, handwriting, style of dress;
* auditory hallucinations;
* loss of time;
* drawing self as more than one person.

A diagnosis of dissociative disorder should be seriously considered if the child manifests several of these behaviors over a substantial period of time. Still, other possible explanations should be ruled out before a diagnosis is made. Competing explanations include the following:

* Allergic reactions to foods, plants, and other substances. Caregivers sometimes describe allergic children as suddenly changing behavior for no apparent reason. Allergic children may show significant changes in handwirting, attention span, and learning ability.

* Organic disorders related to stress whose symptoms include memory difficulties and clouding of consciousness.

* Drug use, which can cause dramatic behavioral changes, blackouts, and failure of recall. Clinicians working with children under medical care should consult with the supervising physician to learn of any drug use and possible side effects of any prescribed medications. Drug use may also be recreational, even in young children, or deliberately induced by ignorant or abusive parents or as part of a ritual.

* Other psychic problems that may involve attention deficit, conduct disorder,and eating disorder.

Treatment.

Treatment should begin as soon as possible after competing explanations are ruled out and a diagnosis of dissociative disorder is made with some confidence. Youngsters with dissociative disorders need specialized treatment interventions in addition to those regularly used to help abused and traumatized children (Kempe and Helfer, 1972, Pynoos and Eth, 1985, MacFarlane and Waterman, 1986; James, 1989).

A first step in beginning treatment is to assess the home situation for the presence of abuse. If abuse is incipient or ongoing, steps must be taken to ensure the child's safety. The initial assessment should also ascertain whether the child is a danger to herself or to others.

Ensuring the child's safety is not only a legal and moral imperative, but a prerequisite for effective therapy. The treatment goal is to help children feel safe enough to give up psychic separation. This task is sufficiently complex given these children's profound feelings of helplessness and distrust, and their great difficulty tolerating emotions: if they are not even physically safe, it is highly unlikely that treatment will be successful.

Ideally, a therapeutic alliance will be built with the child and her caregivers. Caregiver support can be a critical element of treatment, since caregivers can extend the treatment process into the home environment. If caregivers are highly dysfunctional, working with them may be impossible or impracticable. Whether or not caregivers can be part of the therapeutic alliance, treatment of the dissociative child should concern itself with the issues discussed below.

The child's dissociative experiences and disowned parts must be revealed in the treatment environment. Here they are safely contained while the therapist helps the child toward integration. Resistance comes, however, when the child lacks trust in the therapist's ability to accept her. Many dissociative children project their own self-blame, thinking that if the therapist knew everything—how she feels, what she did, exactly what happened—the therapist would blame her, dislike her, and turn away in disgust. Those thoughts, feelings, and memories the child experiences as too overwhelming or too dangerous to acknowledge are hidden behind amnestic or dissociative barriers.

A central therapeutic task, therefore, is to help the child feel safe. The best response is to begin where the child already feels safest, most often in areas of physical mastery and cognitive structuring. Through the use of music, movement,and physical games, the child can playfully be guided to increase her range of movement and to feel ownership of her body. Having the child show nonverbally what it may be like to be a lion, a tree, a robot, or a piece of bubble gum can be a helpful means to the same ends.

Cognitive structuring techniques can teach important information about feelings and can help the child learn to talk about feelings without being overwhelmed by them. The child and therapist together can name, sort, discuss, and explore the nature of emotions without the youngster experiencing them. The child can learn that one person can have several feelings concurrently, and that some of those feelings may conflict. She can come to understand that feelings and actions are not the same, and that her feelings or thoughts will not get her into trouble. As therapy proceeds, the clinician needs to begin to delineate the child's awareness of, understanding of, and attachment to dissociative behavior. Using the child's own terms for dissociation will help promote trust and mutual understanding. Therapy can proceed along these general lines:

1. Help the child delineate and identify feelings that all children have, as well as the feelings the child will acknowledge she has. Do the same with the feelings of the split-off "parts" which she may have identified. Then examine together how the split-off feelings differ from her owned feelings, and what would happen if she claimed them.

2. Discuss together the function of the split-off part, perhaps using simile or metaphor. Show acceptance of the child's dissociative behavior and enable her to own it by helping her understand its positive aspects. You might tell her, for example, that she has protected herself, and possibly others, in creative, inventive, courageous, and caring ways.

3. Establish the child's ownership of the split-off part and her power over the splitting process. Acceptance of the splitting will facilitate this step, as will gradual reference to the dissociative split as being her creation and part of her.

4. Thoroughly investigate the child's dissociative process, working as a co-detective with the child. Together, child and therapist can identify and monitor the conditions that trigger dissociative responses, and differentiate between the different responses. Take care during this process not to reinforce the mechanism further. Do not, for instance, question so closely that the child is called upon to elaborate a more complex identity or fragment than already exists.

5. Help the child examine the advantages and disadvantages of "going away." If she can be convinced that there are more disadvantages (which will depend in large part upon her being in fact sure of her physical and emotional safety), work can progress toward controlling and lessening defensive dissociative responses. Begin to present dissociation as a protection that was once needed but is now superfluous since the child is no longer at risk (if it's true that she isn't) and can cope in other ways when feeling really frightened. This idea may be experienced as criticism if presented before the child has other coping skills in place.

6. Ready the child to give up this obsolete coping mechanism. One way to do this is to have her recall and reexperience a time when she successfully coped with loss. For example, she probably gave up a baby bottle or a favorite blanket.

Quietly remind her that these things once provided comfort, as splitting does, but are no longer needed. Therapist and child together acknowledge that we do miss such things for awhile, but get over it.

7. As a joint effort, create a treatment plan aimed at gaining control of the behav-

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ior. Including her in the planning process helps her gain a much-needed sense of control. Therapist and child should concurrently work on ongoing conflicts, on alternative ways the child can cope, and on ways to change the environment so that the need for dissociative defense lessens.

The therapist will have to help caregivers, teachers, and others learn to accept dissociation without promoting it. The child's behaviors may make her the center of attention. Some who focus on her may do so out of curiosity or meanness, others to prove or disprove the diagnosis, others in a misguided attempt to cure the child by ridicule, harrassment, or shock. Adults in close contact with the child should be sufficiently familiar with the dissociative process and its appearances so that any fascination is defused. Remind them, for instance, that we all dissociate to some degree when watching a movie, or driving a long, straight, boring road, or listening to a symphony.

8. Integration (uniting of the split-off parts) is a long, slow process that can't be forced. It occurs with the reduction or resolution of conflicts and the learning of new coping skills. Although spontaneous integration may occur after a release of strong feelings related to traumatic events, it shouldn't be interpreted as a spontaneous cure: much conflictual material may still remain hidden. The therapist needs gradually and carefully to determine this possibility through discussion and directed play.

To be as helpful as possible, therapists should make sure to deal with the feelings of loss they may experience initially in relation to the process. Children, too, should be encouraged to talk about what integration will mean to them.

Integration will occur gradually as a result of the child's desire for normalcy, her participation in a healing environment, her freedom from abuse, and her evolution of new coping skills. Integration can be boosted and reinforced with visualization exercises. For example, have the child close her eyes and, through vivid imagery, bring together the separated parts of herself. Each part might be a color, which joins all the others to form the rainbow of self.

Continued support is necessary for some time, while the clinician helps the child solidify gains and supports her in using her new coping skills to negotiate the inevitable bumps along the developmental road.

The identification and treatment of dissociatively disordered children requires complex clinical skills, of which this article is only a brief overview. If we learn to recognize dissociative disorders promptly and to provide or secure appropriate treatment, however, we will be doing a great deal for the children we have chosen to serve.

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MYERS ***(Continued from page 1)***

ing Argument to the Jury.

As mentioned above, many people think the goal of cross-examination is to get the expert to change her opinion or admit she might be completely wrong. Cross-examination sometimes has this dramatic effect, but not very often. The skillful cross-examiner knows she is not likely to get the expert to change her opinion, so she takes a more subtle approach.

The goal of cross-examination is usually not to score a direct hit on the expert, but to poke a few holes in her testimony. The cross-examiner hopes to raise questions about the expert's testimony—questions that are deliberately left unanswered until the cross-examiner's closing argument to the jury.

How does the cross-examiner raise doubts about the expert's testimony? By controlling the witness during cross-examination. Control of the witness is ac-

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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, 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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CORRECTIONS

In the last issue of *The Advisor*, a typo was made at the end of Karen Saywitz's article, "Developmental considerations for forensic interviewing." On p. 15, the last sentence in the third paragraph from the end of the article should read, "Be sure to praise the children for their effort—working hard during the interview—*not* for the content of what they say." In the published version, "and" was substituted for that "*not*"—a critical difference. We're sorry for the mistake.

Also: *The Advisor*, V.3, n. 1 & 2, contained a bibliography of selected studies on "Incestuous Fathers and Families" by Linda Meyer Williams and David Finkelhor. Dr. Williams's name was inadvertently omitted from the byline. Additional information on the topic can be found in: L.M. Williams and D. Finkelhor (1990), "The characteristics of incestuous fathers: A review of recent studies," in Marshall, Laws, and Barbaree (eds.), *The Handbook of Sexual Assault: Issues, Theories, and Treatment of the Offender* (NY: Plenum).

complished in three ways: First, through the use of leading questions; second, by limiting the expert's opportunity to explain her answers; and third, through the technique of hiding the ball.

Leading questions. Unlike the attorney conducting direct examination, the cross-examiner is permitted to ask leading questions: questions that suggest their own answers. For example, suppose the cross-examiner wants the expert to acknowledge that a child recanted her allegations of sexual abuse. The cross-examiner will control what the expert says by using leading questions that require the expert to give short, specific answers: answers the attorney wants the jury to hear.

The attorney might ask, "Now doctor, it's true, isn't it, that Sally recanted her allegations?" The cross-examiner controls what the expert says by asking leading questions that permit only short, specific answers, preferably limited to a simple yes or no. The cross-examiner keeps the expert hemmed in with leading questions, seldom asking why or how something happened. How and why questions permit the expert to explain, which is precisely what the cross-examiner does not want the expert to do.

Limiting the expert's opportunity to explain. Naturally, when an expert is asked a leading question that limits her to a yes or no answer, she wants to expand on the answer so the jury can understand fully. For example, with Sally, who recanted her allegations of sexual abuse, the jury would benefit from knowing that she recanted because her life was threatened. If the expert tries to explain, however, the attorney may interrupt and say, "Doctor, please just answer yes or no." If the expert persists in trying to explain herself, the attorney may ask the judge to admonish the expert to limit her answers to the specific questions asked.

Experts find cross-examiners' efforts to thwart their explanations very frustrating. "How can this process possibly lead to the truth?" many experts find themselves thinking. But before you give up on our adversary system, remember three things:

(1) The cross-examiner's job is to represent her client zealously—to present her client's view of the facts—not to permit the expert another opportunity to repeat the unfavorable testimony given during direct examination. To present her client's viewpoint adequately, the cross-examiner must have fairly wide latitude to control the course of cross-examination, and to control what the expert—an adverse witness—is permitted to say.

(2) It is sometimes quite proper to say, "Counsel, it is not possible for me to answer your question with a simple yes or no. May I explain myself?" Many judges will permit the expert to explain herself during cross-examination if the jury needs more information to make sense of the expert's testimony.

(3) After cross-examination comes "redirect" examination, when the prosecutor is permitted to ask further questions, and the expert has an opportunity to clarify matters that were left unclear during cross.

Hiding the ball. In this technique, the cross-examiner's goal is to hide from the expert the real purpose of the cross-examination.

Suppose the cross-examiner wants the expert to agree with something she knows the expert is unlikely to agree with. For example, the cross-examiner wants the expert to agree that Sally could well have been telling the truth when she recanted her allegations. The attorney knows that if she asks outright whether Sally's recantation was truthful, the expert will say no. So the cross-examiner uses an indirect approach instead. With this indirect approach, the attorney conceals her ultimate objective, so the expert is not alerted to the need to answer carefully. Essentially, the attorney sets a verbal trap, leading the witness to agree with the defense before she can figure out what's happening. How exactly does an attorney hide the ball? She may ask a series of seemingly innocuous leading questions; since the expert can't tell what bearing these apparently innocent questions have on the case, she may comply with the attorney's ploy.

To keep the expert off balance, and to keep the ultimate objective hidden, the cross-examiner may bounce from topic to topic, always returning to questions that lead to the ultimate goal. Gradually, the attorney tries to lock the expert into a predetermined position. Only when the expert is painted into a corner does the cross-examiner raise the subject she had in mind all along.

The skilled cross-examiner is like a good chess player, always thinking two or three moves ahead. It is usually unwise to attempt to out-lawyer the lawyer by guessing where her questions are going. Experts get into trouble when they stop concentrating on the question at hand. The best course is simply to listen carefully to each question as it comes, and answer accordingly. In nearly all cases, the expert will see what is developing and have little difficulty coping with the attorney's questions.

Principle #4: Undermine the Expert's Assumptions.

One of the most common techniques of cross-examination is to commit the expert to the facts and assumptions that support her opinion, and then to dispute some or all of those facts and assumptions.

Consider a child sexual abuse trial in which a physician testifies on direct examination that in her opinion a child experienced vaginal penetration. The cross-examiner begins by committing the doctor to the facts and assumptions underlying her opinion. The attorney says, "So doctor, your opinion is based exclusively on the history, the physical examination, and on what the child told you, is that correct?" She continues, "And there is nothing else you relied on to form your opinion in this case, is that correct?" By committing the expert to a specific set of facts and assumptions, the attorney deprives her of justifying her opinion on some other basis should this one be undermined.

Once the cross-examiner pins down the tenets of the doctor's opinion, she attacks one or more of them. The attorney might ask the expert if her opinion would change if certain facts were different. Or she might press the expert to acknowledge alternative explanations for the expert's assumptions. Or she might ask whether qualified experts could come to different conclusions based on the same facts. Or, having pinned down the expert's assumptions, the attorney may wait until after the expert has left the stand, then offer evidence to disprove the assumptions.

The expert could think of her testimony as a three-legged stool. The seat is the testimony, the legs are the facts and assumptions that support it. The cross-examiner's job is to knock away one or more of the legs so the testimony comes tumbling down.

With this technique of cross-examination in mind, it is easy to see the importance of thorough preparation before setting foot in the courtroom. The expert must possess a thorough knowledge of the facts of the case, and must be confident in the inferences, assumptions, and conclusions she draws from the facts.

Principle #5: Raise the Possibility of Bias or Partiality.

The cross-examiner is permitted to inquire about possible bias. For example, the attorney might proceed as follows: "You met with the district attorney prior to testifying today, didn't you? And during that meeting you discussed the testimony you gave on direct examination today, didn't you?" (Meeting with the district attorney to discuss testimony is perfectly proper.) "Now doctor, you work at Children's Hospital, don't you? You work in the child abuse unit of the pediatrics department, don't you? And you regularly perform evaluations at the request of the district attorney, don't you? You often

Continued on next page

REID ***(Conitnued from page 1)***

be delighted to hear from you—what do you think such a task force should accomplish? John Briere (213-226-5697) would like to hear from you on adult survivor issues too: he has agreed to be *The Advisor's* Associate Editor for Adult Survivors, and is interested in hearing what topics you'd like to see addressed.

State Chapter Progress

APSAC members from 15 states have expressed an interest in organizing chapters in their states. Some are forging ahead with organizational efforts, some are more tentatively exploring the role of a state chapter and their role as organizers. These wonderful people are listed below. If you're interested in helping get a state chapter off the ground, give the person(s) in your state a call—they'll surely be happy to hear from you. If your state isn't listed here, and you're interested in forming a state chapter, give the office a call. We'll be *delighted* to hear from you!

AK - Regina Asaro
Victims for Justice
619 E. 5th Ave.
Anchorage AK 99501
907-278-0977

AR - Carolyn Layman
306 Midland
Little Rock AR 72205
501-666-5563
Louanne Lawson
800 Marshall
Little Rock AR 72207
501-370-1013

AZ - Harriette Grammer, M.Ed.
7711 N. 51st Ave. # 3040
Glendale AZ 85301
602-842-3713

CT - Cheryl Burack-Lynch
Coordinating Council for
Children in Crisis
900 Grand Av.
New Haven CT 06511
203-624-2600

IL - Erin Sorenson
Children's Advocacy Center
2121 Lake St.
Hanover Park IL 60103
708-213-3900
Susan Liuzzo
PO Box 353
St. Charles IL 60174
708-584-4465

MA - Suzanne White, MSW
Middlesex Co. DA's Office
21 McGrath Highway
Somerville, MA 02143
617-666-2101
Susan Kelley, RN, PhD
Boston College School of Nursing
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NV - JoAnn Behrman-Lippert, PhD
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NC - Carolyn Cole, MSW
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Guidance Clinic
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Chapel Hill, NC 27599-7160
919-966-5277

MS - Paul Davey
Region I Mental Health
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Clarksdale, MS 38614
601-627-9449

OH - Robert Reece, MD
Rainbow Babies & Children's Hospital
2101 Adelbert
Cleveland, OH 44106
216-844-3754
David Gemmill, MD
and ***Linda Lewin, RN***
Medical College of Ohio
Unit 6B P.O. Box 10008
Toledo, OH 43699
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(lives in PA)
Toni Seidl, MSW
Children's Hospital
34th and Civic Center Bl.
Philadelphia, PA 19104
215-520-1000

TX - Nancy DeWees
TX Dept. Human Services
2700 Ben Ave.
Fort Worth, TX 76103
817-921-3411

VA - Cathy Krinick and Francine Ecker
Assistant Commonwealth's Attorneys
247 28th St.
Newport News, VA 23607
804-244-0941

MYERS ***(Continued from page 11)***

testify for the prosecution in child abuse cases, don't you, doctor? Thank you, doctor, I have no further questions."

Note that the attorney did not ask the final question. She did not say, "So, doctor, your close working relationship with the DA's office biases you in favor of the prosecutor, doesn't it?" She knows the doctor will say no to such a question, so she simply implies the possibility of bias, raising it again during her closing argument. The attorney might conclude by describing the relationship as "just a little bit too cozy." Cross-examination is usually not a very pleasant experience. But the right to cross-examine is vitally important to the discovery of the truth. Armed with greater understanding of the principles and goals of cross-examination, the expert can become less anxious and more effective.

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

MEMBERSHIP DRIVE NEWS

APSAC's first membership drive netted, officially, 39 new members. The top recruiter was ***Barbara Bonner,*** a Board member from Oklahoma City, who recruited 13 new members. Next was ***Mark Everson,*** from Chapel Hill, North Carolina, who brought in 8 new members. ***Carolyn Cole*** of Durham, North Carolina, recruited 5 new members. Other members who sucessfully recruited were ***Geri Beattie,*** of El Cajon, CA; ***Tom Curran,*** of Philadelphia; ***Deborah Doane*** of Bellevue, WA; ***Barbara Boat*** of Chapel Hill, NC; ***John Briere*** of Los Angeles; ***David Corwin*** of St. Louis; ***Paul Davey*** of Clarksdale, MS; ***J. Don Everhart*** of Camp Lejeune, NC; and ***Lois Kyes,*** of Framingham, MA.

Many more members must be spreading the word about APSAC besides those listed here: membership growth for the year has been excellent, half again what the Board expected. Many thanks to those of you who exerted yourselves during the membership drive, and to those of you who regularly talk to colleagues about APSAC. You play a crucial role in the organization's continued success.

APSAC MEMBERSHIP BY STATE

CA	213	ID	16
NC	98	HI	14
IL	87	MS	14
MA	77	LA	13
NY	77	MO	13
TX	52	DC	12
OK	40	KY	12
FL	39	IN	11
WA	38	NH	11
PA	34	CT	10
CO	31	IA	10
VA	30	NM	10
WI	29	KS	9
AZ	28	UT	8
GA	27	NE	7
MD	27	SC	7
OH	27	AK	6
MN	25	RI	6
NV	24	AR	4
NJ	24	VT	4
AL	23	WY	3
MI	21	DE	2
TN	21	ND	2
OR	20	WV	2
ME	17	MT	1

States with no members: South Dakota.
Members with no states: 10—Canada; 2—Puerto Rico; 2—Scotland; 1—Australia; 1—Guam; 1—Israel.
TOTAL: 1,353

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 an annotated bibliography. Readers are encouraged to send copies of current articles they beleive would benefit *Advisor* readers, accompanied by a two-sentence summary of the article. Mail your contributions to Susan Kelley, R.N., Ph.D., Associate Proffesor, School of Nursing, Boston College, Chestnut Hill, MA 02167.

PHYSICAL ABUSE AND NEGLECT

Bruce, D.A. and Zimmerman, R.A. (1989). Shaken impact syndrome. *Pediatric Annals, 18*, 482-494.

The authors provide an excellent overview and analysis of a very serious form of physical abuse: shaken baby syndrome. Complete with data and x-ray reprints of nonaccidental head trauma in children under two years, this is a very thorough treatment of shaken baby syndrome. Both medical and non-medical professionals will find this article very useful. (TFC)

Burgess, A.W., Hartman, C.R., and Kelley, S.J. (1990). Assessing child abuse: the TRIADS checklist. *Journal of Psychosocial Nursing, 28* (4), 6-14.

Traditionally, we have tended to assess and treat physical, sexual, and psychological abuse as separate entities. The premise of this article is that these three dimensions of abuse frequently coexist and, determining the cues that maintain fear and symptoms after the trauma has ended, affect the meaning of the abuse for the child. The TRIADS checklist assesses the range of abusive acts that affect the child on sensory, perceptual/ cognitive, and interpersonal levels. (SJK)

Crittenden, P.M. and Craig, S.E. (1990). Developmental trends in the nature of child homicide. *Journal of Interpersonal Violence, 5* (2), 202-216.

This study differentiated among neonatal, early, and middle childhood deaths. Neonatal deaths were related to maternal isolation during the birth; early childhood deaths were usually the result of parental attempts to control child behavior; middle childhood deaths were usually accidental, and resulted from gunshot wounds. Few children of any age were unsupervised or killed by strangers. The data suggest that identifying preventively specific cases of incipient homicide is nearly impossible, and recommend an epidemiological approach to prevention tailored to each age group. (HCJ)

Howing, P.T., Wodarski, J.S., Kurtz, D.P., Gaudin, J.M., and Herbst, E.N. (1990). Child abuse and delinquency: The empirical and theoretical links. *Social Work, 35*, 244-249.

This article reviews the literature linking child abuse to aggression and delinquency, addressing definitional and methodological limitations. The authors suggest that the connection between child abuse and aggression is bi-directional and reciprocally interactive. (HCJ)

Klein, M.J. (1990). The home health nurse clinician's role in the prevention of nonorganic failure to thrive. *Journal of Pediatric Nursing, 5* (2), 129-135.

This article describes the role of home health nurses in the prevention and treatment of Nonorganic Failure to Thrive (NOFTT). Because many of the most important interventions need to take place in the child's home setting, the home health nurse is in a critical position to assess the home environment for dysfunctional family interactions and behaviors and then to use the ongoing relationship with the family to implement interventions that include teaching, advocacy, and role modeling. (SJK)

Milner, J.S. (1989). Applications and limitations of the Child Abuse Potential inventory. *Early Child Development and Care, 42*, 85-97.

This article provides an excellent overview of the Child Abuse Potential (CAP) inventory. A 160-item questionnaire designed to screen potential perpetrators of child physical abuse, the CAP consists of a primary clinical scale, a physical child abuse scale, and six factor scales measuring distress, rigidity, unhappiness, problems with child and self, problems with family, and problems with others. In addition, the CAP inventory contains three validity scales: the lie scale, the random response scale, and the inconsistency scale. (SJK)

Pollack, J., and Levy, S. (1989). Countertransference and failure to report child abuse and neglect. *Child Abuse and Neglect, 13*, 515-522.

The role of countertransference in mandated reporters' failure to report suspected abuse and neglect cases is very thoroughly examined in this article. After a succinct review of empirical literature on failure to report, the authors analyze how countertransference influences reporting. Very practical suggestions are offered to address and remedy the problem. (TFC).

Zellman, G.L. (1990). Child abuse reporting and failure to report among mandated reporters: Prevalence, incidence, reasons. *Journal of Interpersonal Violence, 5* (1), 3-22.

This article presents data from a national survey of mandated reporters about their reporting behavior. Reasons for failure to report were factor analyzed and formed three clusters. Most commonly, respondents chose reasons from the "not reportable" cluster (e.g., lacked sufficient evidence). A substantial number failed to report because of perceived problems with CPS. These people often felt they could help the child better by not reporting. The authors recommend that efforts to increase compliance with reporting laws focus on the uncertainties and concerns expressed by this sample. (HCT)

Zuckerman, B., Frank, D.A., Hingson, R. et al. (1989). Effects of maternal marijuana and cocaine use on fetal growth. *New England Journal of Medicine*, 320 (12), 762-768.

Based on maternal self report and positive urine assays, this prospective study of 1226 mothers and infants at Boston City Hospital found that 27 percent of mothers used marijuana during pregnancy and 18 percent used cocaine. Based only on positive urine assays, it found 16 percent positive for marijuana, and 9 percent for cocaine. Maternal use of marijuana as determined by positive urine assays was associated with a significant decrease in birth weight and length. Women with positive screens for cocaine had infants with decreased birth weight, length, and head circumference. (SJK)

SEXUAL ABUSE

Bays, J. (1990). Are the genitalia of anatomical dolls distorted? *Child Abuse and Neglect, 14*, 171-175.

This article reports the findings of a novel study in which the genitalia and breasts of 17 different sets of anatomical dolls were measured to determine if they were disproportionately large. The study findings indicate that the genitalia are, on the whole, appropriately proportioned. (SJK)

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

The purpose of this study of 45 criminal cases of legally proven child sexual abuse was to determine the frequency and significance of physical evidence. Of the 39 cases which resulted in conviction, 32 had no physical evidence. This article presents a well-documented examination of the uncertain impact of physical evidence and the critical importance of the child's testimony in criminal sexual abuse cases. (TFC)

Duthie, B. and McIvor, I.D. (1990). A new system for cluster-coding child molester MMPI profile types. *Criminal Justice and Behavior, 17* (2), 199-214.

This study was designed to determine if the MMPI is useful in classifying child molesters utilizing cluster analysis methodology. An analysis of 90 child molester MMPI profiles produced eight MMPI cluster types. Each cluster type is described. The authors suggest that the findings may help make sense out of the tremendous variety of child molesters whose MMPI profiles are not unlike those of many non-child molesters. (SJK)

Finkelhor, D., Hotaling, G., Lewis, I.A., and Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. *Child Abuse and Neglect, 14* (1), 19-28.

This study was the first national survey on the prevalence and characteristics of childhood sexual abuse in adults. Researchers used the Los Angeles Times Poll, based on a random sample of all residential phones in the U.S., to conduct half-hour telephone interviews with 2,626 American men and women 18 years of age or older. A history of childhood sexual abuse was reported by 27% of women and 16% of men. Men and women who lived for some period of time without one of their natural parents were more likely to have been victimized. A markedly higher rate of abuse was found for Pacific states, especially California.

Gordon, B.N., Schroeder, C.S., and Abrams, J.M. (1990). Children's knowledge of sexuality: A comparison of sexually abused and non-abused children. *American Journal of Orthopsychiatry, 60* (2), 250-257.

This study compared knowledge related to sexuality in a sample of 22 sexually abused and 22 nonsexually abused children. Children were asked to respond to questions related to black and white line drawings of nude children and adults. Pictures and questions covered the areas of gender identity, bodily parts and functions, sexual behavior and abuse prevention. No differences between the groups in knowledge related to sexuality was found. The authors suggest that if precocious sexual behavior is a result of sexual abuse, it may not necessarily be accompanied by increased understanding. (SJK)

Hazzard, A.P., Kleemeier, C.P., and Webb, C. (1990). Teacher versus expert presentation of sexual abuse prevention programs. *Journal of Interpersonal Violence, 5* (1), 23-36.

This study contrasted three treatment conditions: (1) 15 regular teachers with their own classes (237 children); (2) eight lead teachers with unfamiliar classes (114 children); and (3) expert consultants with unfamiliar classes (201 children). All trainers used an adaptation of the Feeling Yes, Feeling No prevention curriculum, and both lead teachers and classroom teachers went through extensive training before implementing the program. No significant differences were found in the relative efficacy of using teachers versus expert consultants to present the program, with children demonstrating equivalent knowledge gains and equivalent skill scores on a videotape vignettes measure. Children in each condition had similar positive reactions to the programs.

Kalichman, S.C., Craig, M.E., and Follingstad, D.R. (1990). Professionals' adherence to mandatory child abuse reporting laws: Effects of responsibility attribution, confidence ratings and situational factors. *Child Abuse and Neglect, 14*, 60-77.

Using a sample of 295 licensed psychologists from two states, this article examined the relationship between decisions to report and responsibility attribution in child sexual abuse cases. The results of this study indicate that family members other than the perpetrator are often blamed for sexual abuse, and professionals continue to disregard abuse reporting laws and make personal judgments regarding the accuracy of their suspicions. (TFC)

Kelley, S.J. (1990). Responsibility and management strategies in child sexual abuse: A comparison of child protective workers, nurses, and police officers. *Child Welfare, 69,* 43-51.

This article describes a study of 228 professionals regarding their attribution of responsibility for child sexual abuse. While the offender was assigned the most responsibility for sexual abuse, only 12% of the sample held offenders totally responsible. This important study should inspire a renewed attention to the significance of professionals' attitudes in the management of sexual abuse cases. (TFC)

Milner, J.D. and Robertson, K.R. (1990). Comparison of physical child abusers, intrafamilial sexual child abusers, and child neglecters. *Journal of Interpersonal Violence, 5*, (1), 37-48.

150 subjects (30 physical child abusers, 15 intrafamilial sexual child abusers, 30 child neglecters, and three matched comparison groups) were compared on levels of distress, unhappiness, loneliness, rigidity, negative concept of child and self, child problems, and problems from family and others. All child maltreatment groups reported elevated levels of personal distress, unhappiness, loneliness, and rigidity, and overlap on a number of personal characteristics. However, sexual child abusers reported more positive views of their children and self than did either physical abusers or neglectors, and reported fewer family problems than did physical abusers. These differences may prove useful in the differential screening and treatment of sexual child abusers. (HCJ)

Reynolds-Mejia, P., and Levitan, S. (1990). Countertransference issues in the in-home treatment of child sexual abuse. *Child Welfare, LXIX* (1), 53-61.

This article is based on the authors' and supervisees' countertransference reactions, clinical observations, and discussions with other clinicians who provide in-home family treatment of child sexual abuse. They suggest that incomplete processing of introjected client material can result in anxiety and behavioral and somatic symtomatology in the therapist. They recommend that therapists maintain ongoing supervision and peer review. (HCJ)

CHILD ABUSE AND THE LEGAL SYSTEM

Jones, J.G., Rickert, C.P., Balentine, J., Lawson, L., Rickert, V.I. and Holder, J. (1990). Residents' attitudes toward the legal system and court testimony in child abuse. *Child Abuse and Neglect, 14*, 70-85.

The attitudes of 42 pediatric and medicine/pediatric residents about court testimony and the legal system were examined in this study. Senior residents who had considerable experience as a court witness expressed very strong disillusionment with child abuse laws and the courts. Very practical court training recommendations are made which offer promise for ameliorating dillusionment and anxiety associated with a court experience. (TFC)

Myers, J.E.B., Bays, J., Becker, J., Berliner, L., Corwin, D.L, and Saywitz, K.J. (1989). Expert testimony in child sexual abuse litigation. *Nebraska Law Review, 68*, 1-145.

This article is an unparalleled treatment of the subject of expert testimony in child sexual abuse cases. The authors present a clear description of all the major legal elements of expert testimony, including medical evidence, the various types of behavioral science testimony, and offender profiling. Exhaustive in its scope yet uncomplicated in its analysis, this article should be studied carefully by any attorney who handles sexual abuse cases or professionals who testify in court. (TFC)

Journal reviewers for this issue included Susan Kelley, RN, Ph.D., Associate Professor at Boston College School of Nursing, Chestnut Hill, MA; Thomas F. Curran, MSW, LSW, Philadelphia, PA; and Helene Jackson, Ph.D., Boston College School of Social Work, Chestnut Hill, MA.

CONFERENCES

September 1 - 6. ***International Conference on Child Abuse and Neglect.*** Hamburg, Germany. Write c/o Hamburg Messe und Congress Gmbh, Congress Organization, PO Box 302480, D-2000, Hamburg 36, Republic of Germany.

September 18 - 20. ***Child Assault Prevention Training for the Elementary School Age Model.*** Columbus, Ohio. Sponsored by the National Assault Prevention Center. Call Quincella Ferguson, 614-291-2540.

NOVA Trainings: ***The Horizon Series.*** Washington, DC.
9/24 - 9/26: Victim Counseling and Advocacy
10/1 - 10/5: Program Management
10/15 - 10/19: Training Skills and Methods
10/29 - 11/3: Public Policy and Legislation.
Call 202-393-6682.

October 1 - 2. ***Fifth Annual National Task Force Training Conference: Confronting Sexual Offending.*** Albany, NY. Sponsored by National Adolescent Perpetrator Network and the NY State Alliance of Sex Offender Service Providers. Call Marilyn Etcheverry, 518-489-7411, ext. 200.

October 7 - 8. ***Many Voices of Survival: A Conference on Child Sexual Abuse.*** Boston. University of Massachusetts Harbor Campus. Panels and workshops on Healing from Child Sexual Abuse in a Racist and Anti-Semitic Society; Ritual Abuse;and Abuse and Persons with Disabilities. Call 617-787-5164.

October 7-9. ***Representing Children in Court: Advocacy Techniques for Lawyers and Expert Witnesses.*** Seattle,WA. Sponsored by the National Association of Counsel for Children. Supported by National Council of Juvenile and Family Court Judeges. NACC's Annual Meeting. Call Peggy Moir, at 303-321-3963.

November 6 - 10. ***NCPCA National Leadership Conference.*** Chicago. Sponsored by the National Committee for the Prevention of Child Abuse. Call 312-663-3520.

November 15 - 16. ***Managing Abusive Sexuality: A Systems Approach.*** Starved Rock State Park, Illinois. Sponsored by Institute for Stress Management, Bloomington, Illinois. Featuring Richard Laws, William Pithers, James Wake and Allison Stickford. Call 309-664-0558.

November 15-18. ***1990 Male Survivor Conference.*** Tucson. Sponsored by Behavior Associates, Arizona & Southern Arizona Pyschological Association, Parents Anonymous & the Arizona Governor's Office for Children. Call 602-323-3156.

November 18-21. ***Networking in the '90's.*** Nashville. Sponsored by the Tennessee Network for Child Advocacy and APSAC. Including sessions on child homicide, minority issues in child abuse, offender treament, DNA "fingerprinting," confronting defense experts, post-plea treatment agreements, investigative interviewing, preparing child witnesses, case management in the real world, and many more. Speakers include Lucy Berliner, MSW; Linda Blick, MSW; Detective Rick Cage; David Chadwick, MD; Jon Conte, Ph.D.; David Corwin, MD; Don Dutton, JD; Harry Elias, JD; Charles Gentry, MSW; Astrid Heger, MD; David Lloyd, JD; Kee MacFarlane, MSW; David Muram, MD; FBI agent Ken Nimmich; CPS investigator Donna Pence; Joyce Thomas, RN, MPH; Patti Toth, JD, and others. Call 901-327-0893.

APSAC DISCOUNTS AVAILABLE:
October 28 - November 1. ***Midwest Conference on Child Sexual Abuse and Incest.*** Madison, Wisconsin. Sexual Attitude Reassessment Seminar to be held 10/29-30; Advance Training Institute to be held 11/30; 36 workshops and plenaries to be held 10/31-11/1: $20 discount for APSAC members; student rates available. Outside Wisconsin call 1-800-262-6243, in Wisconsin, 1-800-362-3020; ask for Buxton Workshops.

November 8-9. ***A Short Course in the Psychotherapy of Sexually Abused Children and their Families.*** Virginia Beach, Virginia. Sponsored by Old Dominion University. With William Friedrich, Ph. D., of the Mayo Clinic. $140 for APSAC members. Call 804-683-4256.

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