APSAC

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THE ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

NEWS

NEW BOARD AND OFFICERS ARE ELECTED; APSAC HAS A WINNING YEAR; PROJECTS FOR 1991 SET AT ANNUAL MEETING; TASK FORCES HOLD MEETINGS, NEW COMMITTEES FORMED; NORTH CAROLINA GRANTED FIRST STATE CHARTER

—by Theresa Reid

New Board, Officers

Congratulations to the following members, who were elected to APSAC's Board for three-year terms beginning on January 1, 1991 and ending on December 31, 1993:

- Patricia Crittenden, PhD
- Thomas Curran, MSW, LISW
- Deborah Daro, DSW
- Mark Everson, PhD
- Kathleen Coulborn-Faller, MSW, PhD
- Martin Finkel, DO
- Hon. Sol Gothard, MSW, JD
- Carole Jenny, MBA, MD
- Richard Krugman, MD
- Paul Stern, JD
- Linda Williams, PhD

Each of these new Board members has already worked hard for APSAC: Pat Crittenden, Kathleen Faller, Paul Stern, and Linda Williams have submitted articles to *The Advisor* and actively participated on Task Forces and Board committees; Tom Curran, Deborah Daro, Mark Everson, and Martin Finkel are serving as Associate Editors of *The Advisor*; Mark and Martin co-chair different Task Forces as well, and Mark has been instrumental in forming the North Carolina state chapter; Carole Jenny co-chairs (with Martin Finkel) the Task Force on Medical Evaluation of Suspected Sexual Abuse in Young Children; Richard Krugman has agreed to be one of the editors of the forthcoming *APSAC Handbook on Child Maltreatment* (see below); Sol Gothard is serving on Board committees and—like all of his colleagues on the Board and many members not yet elected to the Board—takes news and information about APSAC to all of his professional engagements.

The organization welcomes this excellent new group of Board members, who will undoubtedly help ensure that APSAC's strength and influence grow steadily.

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FROM THE PRESIDENT

CULTURAL DIVERSITY AND ORGANIZATIONAL RESPONSIVENESS

—by Joyce Thomas

As the incoming APSAC President, I have given much thought to what I might say in my first message in *The Advisor*. Let me begin by saying that I am delighted and honored by the opportunity to serve in this leadership position, and I feel strongly that both past presidents (Jon Conte, Ph.D. and David Chadwick, MD) have provided us with a blueprint of excellence which now serves as the foundation of strength for our future development. Much has happened in the last few years, and APSAC can be proud of its contributions to increasing state-of-the-art knowledge in the field of child abuse and neglect.

As an African-American professional, one of the founders and current President, and, now, Project Director of "Child Abuse and Neglect: People of Color Leadership Institute" (POCLI), I want to share my thoughts on the issue of cultural diversity in the field and on the need for each of us to become more culturally competent in our intervention with clients who are people of color. In future issues of The Advisor, the new POCLI section will, I hope, do much to promote insight and knowledge about this complex topic. As the wearer of so many hats, however, I feel compelled to make my own position clear up front.

"Cultural competence" refers to our recognition and management of the often-unacknowledged beliefs that may influence our attitudes, behaviors, and decisions in cross-cultural situations. Let's look at some facts. People of color are tremendously over-represented in the public protective service system. Although no reliable evidence shows a higher rate of child abuse among people of color, the percentage of people of color in the child protective service system is much higher than their percentage in the general population. Over and over again, we see that people of color are more likely to be removed from their families, less likely to receive adequate mental health services, more likely to get involved in both the criminal justice and the juvenile justice systems, and highly likely to remain in our systems longer.

This over-representation of people of color illustrates, among other things, the fact that what gets defined and reported as child abuse depends to some extent on the biases of the beholder. Many professionals tend more readily to see child abuse in families of color than in families who represent the American majority.

The same professionals—undoubtedly well-meaning—may make two further mistakes that help to perpetuate the involvement of families of color in the child protective system: they may misinterpret some of their clients' practices and values, and they may design interventions that are ineffective because they're based on these misinterpretations. Our best efforts at prevention, case management, intervention, and treatment must be tailored to our clients' beliefs about such important issues as discipline, loyalty,

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JOYCE *(continued from page 1)*

communication, nurturing, morality, spirituality, and education. Understanding the world from our clients' point of view is essential if we want to develop helping strategies that really help. In fact, "helping" strategies that don't reflect an understanding of the cultural differences between ourselves and our clients may actually hurt: strategies that negate clients' perceptions and experience alienate and implicitly stigmatize clients. By causing clients to withdraw, such strategies may contribute both to immediate and long-term dysfunction and to the cycles of victimization we see so often.

We can't all be expected to know everything about other cultures; but if we want to be effective we need basic knowledge of the cultural groups with whom we routinely work. One way to foster better understanding of clients of color is to foster the development of professionals of color, to provide direct service to clients, to inform policymaking efforts, and to help educate others to issues of cultural sensitivity. One of POCLI's major goals is to encourage the participation of people of color in the field. One of the primary means to this end is a mentorship program, in which senior professionals of color encourage, support, and help educate entry-level professionals of color. At the recent APSAC-sponsored conferences in Nashville and San Diego, the lack of professionals of color both as presenters and as attendees demonstrated the field's enormous need for greater cultural diversity among our professionals. There may be few opportunities for leadership development for people of color in this field. The POCLI mentorship program is designed in part to remedy this problem. But it's also true that some people of color have been reluctant to pursue administrative or supervisory positions. Whether they are reluctant because they view the systems as hostile and culturally incompetent or for other reasons is difficult to say at this time. Nevertheless, the problem exists: there are far too few professionals of color in leadership positions in this field.

But the field cannot be made culturally competent simply by matching professional people of color with clients of color. Even if the ratio of professionals of color to clients of color were not so small, the matching would not solve the problem because people of color do not necessarily, automatically, understand other people of color. To suggest that they do is to suggest that skin color contributes more to our world-view than upbringing, education, socio-economic class, and other experiences. Middle-class professional people of color might have as much trouble as their Caucasian colleagues understanding the beliefs and behaviors of their underprivileged clients of color.

We all need to work to understand our clients' values and world views. We all need to make ourselves aware of the cultural and political factors that influence our own decision-making and the decision-making of the policymakers who influence us. When problems get resolved, where families are served, and how families are approached depend upon who is sitting at the decision-making table and what he or she understands about the issues at hand.

Misunderstanding of and inattention to cultural differences make it nearly impossible to provide responsible and effective services to many of our children and families in need. Unfortunately, all too often only lip service is given to the need for "cultural sensitivity." I would like to see APSAC take a leadership position in making the vague phrase, "cultural sensitivity," a working reality. The establishment of the APSAC Ethnic Minority Task Force is an important start. But we need greater ethnic diversity both on the Board of Directors and within the various committees and in the general membership. I would like to see APSAC members reaching out to recruit emerging leaders of color in this field and encouraging them to participate in conferences, to develop articles for publication, and to conduct demonstration projects on a diverse client population. I would like to see professionals of color who are already in the field step forward and make their voices heard, vigorously pursuing leadership positions. We have very little literature of any kind, and still less good research literature, on cultural factors in the perpetration, definition, and treatment of child abuse and neglect. I would like to see APSAC actively encourage the development of good research projects on these very complicated issues. Finally, I hope all APSAC members will make use of the information to be presented in the POCLI section of *The Advisor*, and will communicate to me specific questions or comments that may make that section more responsive to your needs.

This is a major challenge, but one that can be met. I look forward to meeting it with you in the coming months and years.

Joyce Thomas, RN, MPH, is President of the Center for Child Protection & Family Support in Washington, DC.

APSAC FACTS:

- ✓APSAC was incorporated in 1987.
- ✓ current membership is more than 1,500.
- ✓ nine Task Forces are currently at work to establish Best Practice Guidelines.
- ✓members in 20 states are actively forming state chapters.
- ✓APSAC has members in 50 states and in Puerto Rico, Guam, Jamaica, the Virgin Islands, the Bahamas, Canada, Scotland, Australia, Belgium, New Zealand, England, and Israel.

LAW

SURVIVING IN THE COURTROOM: TEN RULES OF TESTIFYING AS AN EXPERT WITNESS

—by Paul Stern

It scares both parties, but for different reasons. When the "expert witness" takes the stand in a criminal trial both the witness and the prosecutor generally panic a little. And for good reason.

For expert witnesses the fear is that they will say something wrong and all the lawyers will jump up and start carrying on, screaming and pointing shaking fingers in their general direction. As the prosecutor, the fear is that what the witness has told me in my office five minutes ago are words I may never hear again. Worse yet, that the witness will fall easy prey to the defense attorney's cross-examination, sometimes even before the second question is asked.

Fear no longer.

If both the witness and the prosecutor understand what is expected of them there is no reason to fear. First, learn how the criminal justice system works and learn how to testify without hoping the earth will open up and swallow you whole. Here then to help you through are Ten Rules of Testifying as an Expert Witness.

Rule #1: Know why you are in court.

The expert is in court for one reason: to educate. This is true whether the expert is a doctor, psychologist, social worker, forensic scientist, or any other professional. As you recreate for the jury what occurred, you educate them. First on the facts of what you saw, heard, smelled, felt, etc. And, that you have the expertise (you do, as we will learn in Rule #2) to educate the jury about what all these observations mean.

The expert is not there to convict anyone. You are not there to defend the victim. You are not there to justify another person's actions. You are there to educate. You are to give facts to the jury and, when asked, and only then, to offer your opinions about the meaning and significance of those facts. This is all in the process of education. And that is the only reason you are in court.

Rule #2: You are an expert.

In legalese an expert means someone who has skills, training, or specialized knowledge sufficient to "assist the trier of fact to understand the evidence or to determine a fact in issue." An individual may be deemed an expert based upon his or her knowledge, skills, experience, training, or education. In translation, it means someone who has an opinion that is worth listening to.

You went to college to get specific education and training in your profession. You have read text books and professional journals. You have attended seminars and talked with peers. You likely work in an area of specialization within your profession. You have experience working with some cases similar to the one that has brought you to court. If you have done any one of these you have some knowledge, skill, training or education sufficient to assist the trier of fact to understand the evidence or a fact in issue in the trial.

(Suggestion: keep a file listing every relevant training, seminar, etc. you have attended. You may think it is unimpressive, but it's more training than the jurors have had. If it's presented right, the judge and jury will be duly impressed.)

You will be asked to outline all of your training to the judge and jury. Then, you will be able to tell us what you think the facts you talked about (Rule #1) mean. What you think the facts mean is your opinion. Your opinion, based upon your experience. That makes you an expert. The jury will decide if it wants to accept your opinion or reject it. But the fact that you have an opinion that is based on information outside the general knowledge of the average juror is what makes you an expert. And you are.

CAUTION: Never give an opinion about matters in which you are not trained. Never give an opinion you cannot support. Which brings us to . . . .

Rule #3: Don't get carried away.

Now that you have been allowed to give an opinion, don't get carried away. Giving an opinion can be addicting. You might start thinking this is fun. You might start thinking that now that you're an expert, you're an expert on everything. When that happens, you are about to become an easy mark. With that attitude, a competent defense attorney will soon have you picking stocks for us.

Limit yourself to those areas in which you really, really are trained. Don't get greedy, or you'll get humbled. Fast.

Rule #4: Don't be a sucker. Shop before you buy.

By this point you will have been permitted to testify about some of your opinions and interpretations of the evidence. You have also properly limited your expertise to only specific areas. You have shown competence and humility. Now show wisdom.

An opposing attorney may try to cross-examine you with articles, books, other people's opinions, even things you have said previously. You will be confronted with something that appears contradictory in an effort to show that your opinion is inconsistent with these other sources. For example:

Attorney: Do you know of The Book by Dr. I.M. Agenius?

You: Well, yes. It is *the* book in the field.

Attorney: Well, at page 497 Dr. Agenius says "xyz," which is exactly the opposite of what you have told us.

You now have three options. You can say:

1. "Well, I'm right and he's wrong." Do this and you sound like a smart-alec and are only 3-4 questions away from being humiliated. Or picking stocks.

2. "Oh. Well, I guess I'm wrong then. Never mind." Thank you for coming in; I can't wait to work with you again. Do send me a bill for your services.

3. "Really? May I see that? Perhaps you are taking something out of context, or have misunderstood what the doctor has said." Bingo!

Ask to see it (sometimes the attorney may not even have the book or article with him), read it, consider it, compare it, and almost every time you'll find that something has been taken out of context or misrepresented by the attorney. When that happens you can demonstrate that not only are you right (and the other attorney devious), but even Dr. Agenius agrees with you.

Rule #5: Prepare.

The prosecutor will have read your reports many times. The other attorney will have read your reports many times. When you are fumbling through pages giving us lots of, "It's in here somewhere," and, "I think I remember . . . ," you sure won't look very professional.

You will be expected to have read your notes and reports and to know the facts cold. Remember you are an expert. You need to look, sound (and dress) like one. If you do not know what is in your report, stay home. You'll be of no help.

Rule #6: Speak English.

Talking to a jury is like explaining your diagnosis to your client. Talk to the jury as you do when you explain to your client what has happened and what he or she needs to do. Keep it simple. Make it easy to understand. Talk at the same level as when you are talking to your 12-year-old nephew. If you use technical words, define them. Look the jurors in the eye (it's okay to turn you body to make eye contact) and make sure they are understanding what you say.

Use analogies or examples whenever possible. If you can explain your observations, medical terminology, syndromes, untraditional behavior, etc. by making comparisons to everyday events, you convey your point more graphically.

Continued on next page

NEWS

A LITTLE HELP FROM FRIENDS HELPS APSAC BEGIN ENDOWMENT FUND

—by Theresa Reid

$25,000 was the fundraising target unanimously agreed upon by APSAC's Board at its November 18, 1990 meeting in Nashville. Within six weeks, Board members—who already contribute their time and speaking fees, and pay for their own travel to meetings—had themselves contributed over $1600, and had solicited donations from friends and colleagues that continue to come in. At its January 22, 1991 meeting in San Diego, the Board again unanimously agreed on a $25,000 fundraising goal, to be raised from among friends, relatives, and colleagues.

The Endowment Fund is intended to provide stability for APSAC's future. We signed up nearly 50% more new members than anticipated last year, and accomplished a great deal as an organization—filing an influential *amicus* brief with the U.S. Supreme Court, issuing an impressive set of Guidelines from our Task Force on the Psychosocial Evaluation of Suspected Sexual Abuse in Young Children, publishing two special issues of *The Advisor*, offering the *Journal of Interpersonal Violence* as a benefit of membership, and establishing several new Task Forces. We are much more stable financially than we were a year ago.

Still, APSAC needs a more substantial financial base from which to achieve its long-range goals. Among these goals are to launch our own national conference, to produce *The APSAC Handbook on Child Maltreatment* (see "News," p.1), to offer scholarships for professionals who can't afford to pay membership dues. Many of you have already demonstrated your enthusiasm for APSAC in a variety of very helpful ways: by distributing brochures at conferences you attend, by calling in with ideas for *The Advisor*, by starting chapters in your states. Those members who are inclined to do so are invited to join the Board's effort to raise $25,000 as well. By doing so, you will help ensure that APSAC continues to improve communication, practice, and peer support among professionals who respond to child abuse. Ultimately, as you well know, by furthering APSAC's critical services to professionals, you ensure improved services to abused children nationwide as well.

You can help by urging your friends, colleagues, and relatives to make APSAC their favorite charity. Letters explaining APSAC's goals, accomplishments, and role in the field are available on request from the office (312-554-0166). Potential "Friends of APSAC" will be happy to know that all contributions to APSAC are tax-deductible.

Beginning with this issue, a list of contributors to APSAC's Endowment Fund will be listed in each issue, with a report on progress of the effort. The people listed on page 14 have generously contributed money—a total so far of $2,515—to guarantee APSAC's future.

MOVING?

Please notify the office and save us the time and trouble of tracking you down.

STERN *(continued from page 3)*

Rule #7: Say it three times. At least.

The prosecutor should be able to get you to get your opinion across to the jury at least three separate times. That, if nothing else, increases the odds that all jurors were awake and listening when you offered your opinion. More important, it shows you did your job right. Observe:

1. The first time through you talk about the overall theory of your work—what you are trained generally to look for and why. This educates the jury to the field.

2. The second time through, you talk about either a hypothetical case or a prior, similar one and what you would look for in that case. The jury is educated a second time about what you, as an expert, should do.

3. The third time you'll talk about this case. When you explain what you did, what you looked for, what you observed, etc., the jurors will think, "Ah, she did it right. She did it exactly the way she's supposed to." Your opinion carries even more weight now.

Rule #8: Be yourself.

It's nice to go and listen to your colleagues testify so you have an idea of what a courtroom looks like, and what might happen. (And to be assured that, yes, you will come out alive.) But when you testify do not copy someone else's style.

Sit back. Listen to the questions. Think about your answer before you give it. Relax. And tell the truth. Do not try to be anything, or anyone, you're not. All you are doing is having a nice, albeit formal, chat with the 12 people who comprise a jury.

Rule #9: There is no such thing as a bad transcript.

In criminal cases, if the defendant is convicted he can appeal. If he is acquitted the State can not appeal. When he is convicted and appeals, a transcript of your testimony will be prepared. If you have done your job properly, i.e., prepared the case, offered an informed, honest opinion, without over-reaching, then, if you're right and everything else works, the defendant may well be convicted and a transcript of what you said will be prepared. If you have not done your job, not prepared, or have offered opinions in a lazy, unsupported, or over-reaching manner, then your testimony may sound unprofessional and unconvincing, and there will be no transcript, because there will be no conviction.

Rule #10: Understand that the jury system is, by definition, illogical.

The first thing that happens when a criminal trial starts is that both sides get to inquire of the prospective jurors whether they know the defendant, the victim, or any of the witnesses. If so, they are not allowed to serve as jurors. We then eliminate those who have had experience with the particular type of offense involved in this trial. Next we get rid of those with strong feelings about it. In time, we insure that no one sits on the jury if they know anything about the case, the people involved, or the issues at stake.

Next, we bring before the jury, as witnesses, all the people who were present when the crime was committed and know what happened. But the jury is not allowed to ask these witnesses any questions.

We also make sure that the jury is not allowed to know the answer to the one question they most want to ask: Has this defendant done this stuff before?

When it's all over, the jury, those people we select because they know nothing and weren't there, tell all those people who were there what really happened by their verdict.

Understand this and you can see why bizarre verdicts can occur. But you can also understand why so much of the witness's job is to be a re-creation expert. Understanding this will also allow you to realize that care as you might, and try as you might, the criminal justice system can not be expected always to get it right. This system works better than any other we can create, but it is not always able to guarantee an infallible judgment, or always properly solve a dispute.

The best chance for success, however, is for the prosecutor and the expert to be fully and properly prepared.

Paul Stern, JD, Deputy Prosecuting Attorney for Snohomish County, Washington, is newly elected to APSAC's Board and a member of APSAC's Task Force on the Peer Review of Expert Testimony, chaired by Anna Salter, Ph.D.

MEDICINE

IDENTIFYING MUNCHAUSEN SYNDROME BY PROXY

—by Alex V. Levin

Editor's Comments
—by Martin Finkel

Dr. Alex Levin has developed considerable expertise in a very difficult and usually bizarre form of maltreatment—Munchausen Syndrome by Proxy. He has done a superb job of characterizing this syndrome by providing the essential components of the syndrome and a profile of the perpetrators. This syndrome represents another form of maltreatment for which a multidisciplinary team is essential.

Munchausen Syndrome by Proxy (MSP) is a form of child abuse in which the perpetrator, who is almost always the mother, causes her child to come under intense and prolonged medical scrutiny as a result of her falsification of history, covert alteration of laboratory specimens, or covert creation of unusual physical findings which create the appearance of illness in the child.

The most common manifestations of this syndrome include: 1) repeated covert suffocation which creates a clinical picture of recurrent cyanosis, apnea, or gastroesophageal reflux, 2) factitious bleeding from body orifices due either to direct covert injury or to the use of substances such as maternal menstrual or animal blood, which create the appearance of what is thought to be the patient's blood, or 3) laboratory manipulations such as the addition of sugar or salt to body fluid samples. Covert administration of drugs such as insulin, anticonvulsives, and even common household foods such as table salt or pepper have been well recognized as manifestations of MSP.

Although these bizarre clinical scenarios have been noted by many authors, a more common form of MSP may involve the behavior of "doctor shopping," wherein the child is taken from physician to physician with vague and nonspecific complaints, in particular symptoms related to allergic illness or fatigue. Well-meaning medical professionals become entangled in the scenario created by the perpetrator in an attempt to understand what seem to be symptoms of an elusive and rare medical disorder. Therefore, it is especially important for medical caretakers to be aware of this syndrome, as early recognition will prevent continued abuse of the child which can potentially lead to death in approximately 10% of cases.

The profile of an MSP perpetrator is very characteristic, and in and of itself should raise the level of suspicion regarding the possibility of this diagnosis. She most often

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MEDICINE

SHAKEN BABY SYNDROME

—by Alex Levin

Editor's Comments
—by Martin Finkel

Parents and non-medical professionals may be unaware of the significant morbidity and mortality which can result from the shaking of a baby. This parental response to the unrelenting cries of a baby frequently presents without obvious injuries and may create a diagnostic dilemma for the clinician. This article by pediatric ophthalmologist, Alex Levin, MD, is an excellent introduction to the problem of Shaken Baby Syndrome.

The Shaken Baby Syndrome (SBS) is a form of child abuse almost exclusively affecting children under the age of three years, with the majority of victims under 18 months of age. The clinical triad of brain injury, skeletal injury, and retinal hemorrhages is the hallmark of SBS. However, only brain injury is required when making this diagnosis. There is currently much controversy regarding the role of blunt head trauma in the causation of the injuries seen in SBS (2,3). However, my own clinical experience, and that of many others, suggests that head trauma is not required to generate the types of brain injuries seen in SBS. These injuries can result from the violent shaking of an infant during which the head is caused to move in many directions in an uncontrolled fashion. Children of this age have relatively large heads, immature brains, and weak neck muscles, all of which contribute to the injuries.

As the brain is caused to accelerate and decelerate within the skull, veins may be torn, resulting in the accumulation of blood within (parenchymal) and around (subdural and subarachnoid) the brain. Contusion and laceration of the brain may also occur. Although the brain injuries of SBS may be fatal, a "subclinical" form of shaking may occur in which the infant presents to a caretaker with more nonspecific complaints such as irritability or vomiting. These injuries are most often detectable by CAT scan. However, in some patients, these hemorrhages will only be apparent with MRI scans. MRI also allows for better dating of these injuries.

The skeletal manifestations of SBS include small chip fractures of the ends (epiphyses) of the bones of the arms and legs and/or multiple posterior rib fractures. These latter fractures are caused by compression of the chest between the perpetrator's hands. The extremities are affected when a child is grasped by the arm or leg while the shaking occurs. Despite these multiple fractures, most children who are victims of SBS present with no external evidence of trauma. It should be remembered that rib fractures are an extremely unusual injury in this age range and are rarely produced even with the most severe blunt trauma.

Retinal hemorrhages within the eye occur in over 80% of affected children. They may be few in number or widespread throughout the retina. Dome-shaped blood-filled cystic cavities within the layers of the retina (traumatic retinoschisis) may be diagnostic for SBS. Although the retinal hemorrhages usually resolve without visual sequelae, visual loss or blindness is not uncommon in this syndrome due to injuries to the optic nerve or brain. An ophalmologist should be consulted to perform complete retinal examination in all cases of suspected SBS. Postmortem removal of the eyes, and perhaps the entire orbital soft tissue contents, can be extremely important in recognizing that nonaccidental injury has occurred. In particular, our recent research suggests that hemorrhage behind the eyeball may be characteristic of SBS.

It is always important to rule out accidental trauma or medical illness when faced with findings compatible with SBS, in particular the brain and eye injuries. Coagulopathies, spontaneous intracranial hemorrhage (e.g., aneurysm), or meningitis might rarely mimic SBS without fractures. These can usually be ruled out by noting the patterns of physical, radiologic, and ophthalmologic findings. Of course, social history is of utmost importance when trying to rule out accidental injury. The astute clinician must recognize the possibility of abuse based on the total clinical scenario. Whenever retinal hemorrhages are seen, a CAT scan or MRI should be performed. If the CAT scan is normal, I suggest that an MRI be used. A complete skeletal survey, looking for occult fractures, is also indicated.

SBS is a devastating form of child abuse, responsible for the majority of infant homicides. Survivors may be left with severe neurological and visual handicaps. Detection and prompt intervention may be life-saving.

References

1. Dykes, LJ: The whiplash shaken infant syndrome: What has been learned? *Child Abuse Negl 1986 10:* 211-221.
2. Duhaime, AC, Gennarelli, TA, Thibault, LE, et al.: The shaken baby syndrome: A clinical, pathological, and biomechanical study. *J Neurosurg 1987 66:* 409-415.
3. Alexander, R., Sato, Y., Smith, W., Bennett, T.: Incidence of impact trauma with cranial injuries ascribed to shaking. *Am J Dis Child 1990 144:* 724-726.

LEVIN (continued from page 5)

has some type of medical training in her background. As a result, she has access to and familiarity with medical knowledge which facilitates her ability to carry on this ruse. Although the child is often hospitalized at many different institutions, during each hospitalization the mother appears as the "perfect parent." She is often overly involved in her child's care, volunteering to help nurses with their duties and perhaps even assisting with the care of other children in the room. She is constantly at the child's bedside, which reflects the enmeshed dynamics of the maternal-child relationship seen in this syndrome. However, the father is often absent, visiting infrequently, and exhibiting very little knowledge of the nature and severity of his child's condition. In fact, it has been theorized that the mother may be causing the child to have frequent admissions in an effort to avoid a home situation which may include an alcoholic or abusive spouse. In addition, the unusual and undiagnosed illness which she has created in her child affords her tremendous attention, as multiple caretakers and consultants become involved in her child's care.

Many of the perpetrators establish social networks within the hospital. When the diagnosis becomes clear, these caretakers and hospital staff may spring to the defense of the mother, incredulous of the possibility of such bizzarre accusations against her. The perpetrator adamantly denies her acts. A child victim is often pre-verbal, therefore unable to contribute history which would allow medical professionals to recognize readily the mother's pattern of covert behavior. Even when verbal, the children may be depressed or so passively involved in the clinical manifestations of MSP created by the mother that they become unwittingly complicit. Once this disorder is suspected, the mother must be separated from the child. Almost instantaneously, the child's symptoms will disappear.

Careful and complete documentation regarding the factitious nature of the child's condition must be obtained before multidisciplinary confrontation of the perpetrator. Such evaluations as serial blood levels of prescribed drugs related to the time of maternal care, serum analysis to distinguish porcine insulin from human insulin, blood typing of red blood cells found in specimens, and pharmacokinetic studies have been used in these situations. The meticulous and extensive review of the child's medical records at all involved institutions and private offices will often help to establish certain patterns. Clinical manifestations such as seizures or cyanosis will not have been witnessed by any other observer besides the mother. No inpatient manifestation of these medical symptoms outside of the mother's care will have been noted. Unexplained drug levels or rapidly appearing mucosal membrane or skin lesions may be noted. One should also attempt to uncover past medical records on the mother as she often will have a history of having factitious illness or Munchausen Syndrome herself.

Perhaps the most difficult manifestation of MSP is that of recurrent covert suffocation. Such behavior has been documented on both video tape and pneumogram recordings. In view of the legal considerations concerning covert videotaping, one must consult with hospital administrators, attorneys, and police before proceeding. Similarly, some authors have reported cases in which a search of the mother's personal belongings has revealed syringes, drugs, or other paraphernalia which has been used in the perpetration of MSP. Again, legal and law enforcement consultations are necessary before conducting such a search.

MSP is a potentially fatal syndrome which may affect siblings in serial fashion. Unfortunately, treatment of the perpetrator has been almost uniformly unsuccessful. Separation of the victim child and siblings from the perpetrator may be essential for adequate protection. However, if the new caretaker is a family member, he or she must be reliably cognizant of the reality of MSP and the perpetrator's role in the child's factitious illness. Otherwise, protection cannot be guaranteed since the perpetrator will be as adept at making the caretaker believe her innocence as she was at having the medical caretakers believe that her child had a real illness.

Perhaps the strongest obstacle to the diagnosis of MSP is the failure to believe that such an entity could exist or the failure to have the proper index of suspicion when confronted with a complex clinical situation that "just doesn't make sense." MSP should be considered in all cases of chronic, unremitting, unpredictable clinical manifestations which have been presented to multiple caretakers without diagnosis despite thorough and exhaustive medical testing, and which respond inconsistently to treatment.

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UPDATE

A DECADE OF PREVENTION

—by Nicole Romano

One of the biggest advances the field of child abuse prevention made during the 1980s was the advent of the Children's Trust and Prevention Funds. Through passage of state level legislation, 49 states (all but Wyoming) established Funds between 1980 and 1989. The mission of these funds is to generate and distribute money for community level child abuse prevention programs, such as parent education, parent support, child sexual assault prevention, and public information programs. Twenty of the Funds also deposit a percentage of their revenue into interest-bearing trust accounts, in order to establish permanent funding mechanisms for child abuse prevention.

The number of Funds and their revenues increased steadily through 1989. In Fiscal Year 1990, however, fundraising leveled off: approximately $28 million in state revenues and $5 million in Federal Challenge Grant monies were generated. Virtually the same amount of money was raised in Fiscal Year 1989. Nonetheless, over 1350 grants were given to fund local programs.

With the beginning of a new decade, Trust and Prevention Funds must renew their challenge and commitment. Perhaps new funding sources or increasing state and federal appropriations should be sought. Two specific planning initiatives have been developed. The National Alliance of Children's Trust and Prevention Funds was established in October of 1990. It is an independent organization whose mission is to engage cooperatively in national efforts to assist Trust and Prevention Funds. A Second Decade Task Force, organized by the National Committee for Prevention of Child Abuse (NCPCA), and consisting of Trust Fund staff, board members and grantees, is now trying to discern methods of sustaining past momentum and facing new challenges, especially in the areas of research and evaluation, resource and program development, and public policy. A document based on the work of the Task Force will be disseminated in the Fall of 1991.

For more information about the National Alliance, contact David Mills, Executive Director of the Michigan Children's Trust Fund, at (517) 373-4320. Those interested in more information about the Second Decade Task Force should contact January Scott, NCPCA's Director of Training and Technical Assistance, at 312-663-3520.

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RESEARCH

PARENTAL STRESS RESPONSE TO SEXUAL ABUSE AND RITUALISTIC ABUSE OF CHILDREN IN DAY CARE CENTERS

—Susan J. Kelley

The sexual abuse of a child constitutes a major crisis for child victims and their parents. It is a generally-held belief that sexually abused children incorporate their parents' reactions to the abuse (Esquilin, 1987; MacFarland and Waterman, 1986). Friedrich and Reams (1987) suggest that the symptoms seen in sexually abused children reflect not only the trauma they have experienced directly, but also their family environment, the amount of support the child feels, and the level of disruption that follows the disclosure of abuse.

While the majority of sexual abuse is committed by relatives, there has been a sharp rise in the number of reported cases of sexual abuse occurring in day care centers. In a national study of sexual abuse in day care centers (Finkelhor, Williams, and Burns, 1988), researchers identified 270 day care centers where sexual abuse occurred from 1983 to 1985, involving a total of 1,639 child victims. Thirteen percent of these cases involved ritualistic abuse.

Although existing empirical evidence indicates that sexually abused children are negatively affected by the experience, to date there has been no systematic examination of parental responses to sexual abuse. The purpose of this study was to empirically validate parental stress responses to sexual abuse and ritualistic abuse of children in day care settings.

The sample consisted of the parents of 134 children, 67 of whom were sexually abused in day care centers, 67 of whom were a carefully matched nonabused comparison group. A total of 132 mothers and 99 fathers participated, representing all 134 children. The abused subjects were from sixteen different day care centers. The mean age of the children at the time the abuse began was 2.8 years. The mean time elapsed since the abuse ended and data were collected was 2.2 years. The types of sexual abuse the children experienced ranged from fondling of the genitals to vaginal and rectal intercourse.

Parents completed the Symptom Checklist - 90 - Revised (SCL-90-R) (Derogatis, 1977), a measure of psychological distress; the Child Behavior Checklist (Achenback and Edelbrock, 1983); and the Impact of Event Scale (IES) (Horowitz, 1979), which indexes symptoms that characterize posttraumatic stress disorder. The impact of the sexual abuse on children is reported elsewhere (Kelley, 1989).

As predicted, parents of sexually abused and ritually abused children reported greater psychological distress than parents of nonabused children as indicated by their significantly higher mean scores on the General Severity Index (GSI) of the SCL-90-R ($p < .0001$). Fifty-two percent of parents of abused children had GSI scores considered to be in the clinical range. Parents of ritually abused children reported the most psychological distress, with significantly higher mean GSI scores than parents of children abused without rituals ($p < .05$). Sixty-five percent of parents whose children were abused with rituals scored in the clinical range, compared to 40 percent of parents whose children were abused without rituals. Scores obtained on the IES indicate that although an average of 2.2 years had elapsed since the sexual abuse of their child, parents continued to experience intrusive thoughts and images as well as conscious avoidance of ideas and emotions related to their child's abuse.

Parental psychological distress was moderately correlated with child behavior problems ($r = .30, p < .01$). There was a weak but significant inverse relationship between GSI scores and time elapsed since the sexual abuse ($r = .22$, $p < .05$), indicating that parental stress decreases with time elapsed since their child's sexual victimization. Mothers who had themsevles been sexually abused during childhood experienced increased pscyhological distress ($p < .05$). However, no significant difference was found between GSI scores of fathers who had been abused and those who had not been abused.

The increased psychological distress found in parents of sexually abused children in this study empirically validates the clinical literature, which asserts that sexual victimization is a major stressor for nonoffending parents. The parents of children abused in day care centers were found to be highly symptomatic and present strong evidence of experiencing post traumatic stress disorder. When parents are overwhelmed by the discovery that their child has been abused, the child may be deprived of needed emotional support.

In order to intervene effectively, professionals need to recognize sexual victimization as both an acute and chronic stressor for parents. During the acute phase, parents are dealing with feelings of shock, anger, denial, and guilt as well as entanglement in the complex legal, mental health, and social service systems. Parents also experience sexual abuse as a chronic stressor due to the long-term impact on the child, the need for extended therapy, and in many instances, lengthy legal proceedings that may prevent the family from achieving closure on the event. Even when a guilty verdict is rendered, most cases end up in a lengthy appeal process that further prolongs the stress reaction.

For mothers victimized as children, the sexual abuse of their child precipitates a twofold crisis in which they must deal simultaneously with their own unresolved trauma as well as with the knowledge that their child has been sexually abused, resulting in a compounded stress reaction. It is therefore imperative for professionals to elicit parental histories of childhood sexual abuse when assessing families of child victims and to provide appropriate support to adult survivors of sexual abuse.

Parents of ritually abused children may have experienced the greatest psychological distress for many reasons: their knowledge of the severe forms of abuse their child suffered, the increased impact on the child associated with ritualistic abuse (Kelley, 1989; Finkelhor, Williams, and Burns, 1988), lack of information currently available to parents and professionals on ritualistic abuse, and the skepticism with which reports of ritualistic abuse are often met (Kelley, 1988).

Unfortunately, attention in the past has focused almost exclusively on the treatment needs of incestuous families, while overlooking the needs of families who experience extrafamilial abuse. More extensive research needs to be conducted on the effects of extrafamilial abuse. Factors which may mediate parental reactions to sexual abuse, such as coping style, family dynamics that predate the abuse, cultural and religious influences, and social supports need to be carefully examined, so we can give these families the most effective help.

References

Achenback, T.M. and Edelbrock, C.S. (1983). *The child checklist manual.* Burlington, VT: University of Vermont.

Derogatis, L.R. (1977). *The SCL-90-R: Administration, scoring, and procedures manual.* Baltimore: Clinical Psychometrics Research.

Esquilin, S.C. (1987). Family response to the identification of extra-familial child sexual abuse. *Psychotherapy in Private Practice, 5* (1), 105-113.

Finkelhor, D., Williams, L., and Burns, N. (1988). *Nursery crimes: Sexual abuse in day care.* Newbury Park: Sage.

Friedrich, W.N. and Reams, R.A. (1987). Course of psychological symptoms in sexually abused children. *Psychotherapy, 24* (2), 160-170.

Horowitz, M., Wilner, N., and Alvarez, W. (1979). Impact of event scale: A measure of subject stress. *Psychosomatic Medicine, 41* (3), 209-218.

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

Kelley, S.J. (1989). Stress responses of children to sexual abuse and ritualistic abuse in day care centers. *Journal of Interpersonal Violence, 4* (4), 503-512.

Kelley, S.J. (1990). Parental stress response to sexual abuse and ritualistic abuse in day care centers. *Nursing Research, 39* (1), 25-29.

MacFarlane, K. and Waterman, J. (1986). *Sexual abuse of young children.* New York: Guilford Press.

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OFFENDERS

CHILD MOLESTERS AND THE SEX OF THEIR VICTIMS

—by Robert A. Prentky and Raymond A. Knight

The division of child molesters into subgroups on the basis of the sex of their victims was one of the earliest taxonomic distinctions to be examined empirically. The trichotomization of these offenders into same-sex ("homosexual"), opposite-sex ("heterosexual"), and mixed-sex ("bisexual") groups has become somewhat of a taxonomic "standard" against which other proposed subdivisions should be compared.

Child molesters' sexual preference appears to be stable over time, and covaries systematically with the measurement of sexual arousal to stimuli depicting specific ages and sexes. Such preferences have also proven useful in predicting the course of subsequent offending and are apparently related to a constellation of offender characteristics. Same-sex child molesters have been found to be less aggressive, younger, better educated, more often single, and more frequently diagnosed as sociopathic than opposite-sex child molesters. Same-sex molesters choose older victims, more frequently abuse children who are not related to them, less frequently consume alcohol during their offenses, and report different sexual histories from opposite sex offenders.

Unfortunately, not all of these purported differences have been replicated across samples. Two major problems have clouded the distinction and may have contributed to the discrepant results. The first difficulty involves the definition of sexual preference itself. Although it has been defined in a variety of ways, the most common definition has focused on the sex of victims in reported crimes. Several factors have contributed to the unreliability of assignment of offenders to sexual preference categories on the basis of such reports, including: the large number of unreported sexual assaults on children, possible biases against reporting homosexual encounters, situational variables that might encourage assaults on the less preferred sex, and the incarceration of an offender after a single assault masking a tendency among some offenders to change sexual preference and thus appear as "bisexual" rather than homo- or heterosexual.

The second problem involves confounding variables that may artifactually contribute to sexual preference group differences. For instance, some studies have not distinguished between incest and nonincest offenders. Incest offenders are disproportionately heterosexual in their choice of victims and would therefore be included in opposite-sex groups in any analyses of sexual preference. But "true" (i.e., exclusive) incest offenders have been found to differ from extrafamilial child molesters on important characteristics such as social and interpersonal competence. Consequently, the proportion of such incest cases in any particular sample might falsely produce differences between same- and opposite-sex groups because of the disproportionate assignment of incest cases to opposite-sex groups. Studies that fail to take this potentially confounding factor into account may attribute to sexual preference differences that are partially or totally due to the offender's relationship to his victims.

Despite these potential problems, the grop differences that have emerged between sexual preference groups suggest that the distinction warrants further scrutiny. Consequently, in a sample of 174 child molesters (50 same-sex, 66 opposite-sex, and 58 mixed-sex offenders), we examined the differences among sexual preference groups in their developmental histories and adult adaptations. The approximately equal distribution of offenders into this trichotomy reflects the relative frequencies of these groups in an incarcerated, nonincestuous population, and differs radically from both the distribution of sexual preferences among incestuous offenders and, of course, the distribution among individuals with age-appropriate preferences.

The sample comprised child molesters who had been found "sexually dangerous" and who had been committed to the Massachusetts Treatment Center. The determination of sexual preference was based on extensive clinical and criminal file data that contained information gathered from multiple sources and that documented both charged and uncharged sexual offenses (the latter occasionally revealed in-treatment progress reports), thereby reducing the report bias problem discussed above. To avoid any possible confounds with incest, we excluded all incest cases from the study. We also omitted both cases where victim age selection appeared indiscriminate (i.e., men whose victims were both under and over the age of 16), and where only nuisance sexual offenses (i.e., in which there was no physical contact with the victim) were committed.

Despite the three sexual preference groups' comparable IQs, the mixed group was somewhat lower in education and achieved skill level than the two pure sexual preference groups. The mixed group also had more adult penal offenses and more known victims. Whereas the mixed group selected younger victims, the victims of the same-sex group tended to be older.

Although few noteworthy differences were found between the same-sex and mixed-sex offenders, a variety of interesting differences emerged between the opposite-sex and the mixed-sex offenders. In their childhoods the mixed-sex group experienced more family pathology and evidenced more academic and behavioral management problems than child molesters who had only female victims. In adulthood, the mixed-sex offenders were lower than opposite-sex offenders in interpersonal and professional competence, and higher in alcohol abuse, aggression, impulsivity, and psychiatric disturbance.

Same-sex and opposite-sex offenders also manifested notable differences, the former showing more emotional and behavioral instability in their childhoods, and less interpersonal competence and more evidence of psychiatric disturbance in adulthood. These results are consistent with the findings of Ronald Langevin, et al., that same-sex child molesters presented as more emotionally disturbed on the MMPI than a group of opposite- sex child molesters (Langevin et al., 1985).

Although no significant group differences in family pathology were noted, the mixed-sex offenders were somewhat higher than the other two groups on the three aspects of family pathology we examined. Moreover, mixed-sex offenders evidenced significantly higher childhood and juvenile acting out and behavioral management problems, which in turn correlated with aspects of family disturbance. The most important group differences, however, arose during adulthood, when both the same- and mixed-sex groups were characterized by less interpersonal competence, less academic and vocational competence, and more psychiatric disturbance than their opposite-sex counterparts.

Same-sex preferences among child molesters have frequently been associated with higher offense rates and a greater potential for recidivism. Preliminary criminal follow-up of our incarcerated sample suggests that such differential recidivism may not apply to select samples, like the one we examined (i.e., exclusively nonincestuous, and committed as "sexually dangerous").

Results on the early sexual victimization of our sample of child molesters were noteworthy. When compared to the incidence of sexual victimization in opposite-sex offenders, the rate for the same-sex offenders was over 2.5 times greater and for the mixed-sex offenders twice as great (24.5%, 68%, and 49%, respectively, for opposite-, same-, and mixed-sex groups). Although there do not appear to be any reports in the literature addressing this specific issue, David Finkelhor has reported that boys who were sexually abused by older men were more than four times more likely to engage in homosexual activity than were non-victims.

How all these differences interrelate to form a cohesive picture of these groups and which of these group discriminators might have causal implications are questions that await further study. Certainly, our preliminary examination of the validity of the victim sex distinction supports its viability as a potential taxonomic construct and encourages continued study. If we are to make progress, however, it is critical that the methodological problems we have mentioned be addressed and cross-sample comparability be established.

References

Finkelhor, D. (1984). *Child Sexual Abuse* (NY: Free Press).

Langevin, R., Hucker, S.J., Handy, L., Hook, H.J., Purins, J.E., and Russon, A.E. (1985). Erotic preference and aggression in pedophilia: A comparison of heterosexual, homosexual and bisexual types. Chapter in R. Langevin (Ed.), *Erotic preference, gender identity, and aggression in men: New research studies.* New Jersey: Lawrence Erlbaum Associates.

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RESEARCH NEWS

MISTAKES FOUND IN NATIONAL CHILD ABUSE STUDY STATISTICS: WESTAT RELEASES REVISED ESTIMATES FOR 1986

—by David Finkelhor

Researchers at Westat, Inc., the firm that conducted the Second National Incidence Study of Child Abuse and Neglect (NIS-2) in 1986, have discovered errors in their original calculations. As a result of these errors, the estimates for all categories of abuse and neglect in that study—the most scientifically-derived estimates currently available—were too high. Many other figures in the official report released in 1988 (*Study Findings,* 1988) are now incorrect.

The error resulted from the inadvertent omission of a step in the complex weighting process in the NIS- 2's methodology. The study derived estimates from a sample of 29 counties, and from subsampling the source of information within those counties, all of which required complex weighting.

Westat has now released a report correcting a few of the most important statistics from the 1986 study (Sedlak, 1990). However, this report has not been widely circulated, and there was very little publicity surrounding the corrections. Moreover, no plans are currently underway to correct other information in the original report.

As a result of the corrections, the increase in total child abuse and neglect between 1980 (the date of the NIS-1) and 1986 is now estimated at 49% rather than at the originally reported 66%. The increase for sexual abuse is now estimated at 178% rather than at 221%.

The new totals for various categories of abuse and neglect are shown in tables below. Note that NIS-2 made estimates according to two definitions: the *original definition*, which allowed exact comparison to NIS-1 data, and the *revised definition*, a broader definition that is more consistent with current child protection standards. It is best to use the revised definition except when discussing comparisons to 1980.

The discovery of these mistakes in the original report adds yet one more obstacle to the general availability of trustworthy national child abuse statistics. The federal government ended its contract with the American Association for the Protection of Children, which had collected national child abuse statistics since 1976, so that no statistics will now be available for 1988 or 1989. A new data collection system was supposed to be in place to collect and publish statistics for 1990 and beyond, but many observers believe that the earliest possible statistics will be for 1991 or maybe even 1992. There are also indications that NCCAN will go ahead with plans for a third national incidence study, probably for 1992.

References

Sedlak, A.J. (1990). *"Technical Amendment to the Study Findings—National Incidence and Prevalence of Child Abuse and Neglect: 1988."* Rockville, MD: Westat, Inc.

U.S. Department of Health and Human Services (1988). Study Findings, *Study of National Incidence and Prevalence of Child Abuse and Neglect,* 1988. Washington, D.C.

Table 1: Corrected Estimates from National Incidence Study: Original Definition

Type	Estimate 1980	Previous Estimate 1986	Corrected Estimate 1986	Corrected % Change 1980
Total	625,100	1,025,900	931,000	+49%
Abuse				
Physical	199,100	311,200	269,700	+35%
Sexual	42,900	138,000	119,300	+178%
Emotional	132,700	174,400	155,200	+17%
Neglect				
Physical	103,600	182,100	167,800	+62%
Educational	174,000	291,100	284,800	+63%
Emotional	56,900	52,200	49,200	-14%

Table 2: Corrected Estimates from National Incidence Study: Revised Definition

Type	Previous Estimate 1986	Corrected Estimate 1986
Total	1,584,700	1,424,400
Abuse		
Physical	358,300	311,500
Sexual	155,900	133,600
Emotional	211,100	188,100
Neglect		
Physical	571,600	507,700
Educational	292,100	285,900
Emotional	223,100	203,000

RESEARCH NEWS

THE NATIONAL INCIDENCE STUDY (NIS-2) AS A PUBLIC USE SAMPLE

—by Elizabeth D. Jones

It was hoped that the National Incidence Study of Child Abuse and Neglect (NIS-2) would be and accessible and useable source of secondary data on child abuse and neglect for the public. Unfortunately, the NIS-2 failed in this area. Since the release of the second National Incidence Study on Child Abuse and Neglect as a public use data set in December of 1987, only 19 copies have been purchased from the Clearinghouse at NCCAN. Of those requesting copies, only a small minority have actually worked with the data.

Many problems inhibit the use of these data by other researchers. First, the NIS-2 is not as well documented as it could be. The complex weighting scheme of the NIS-2 further prohibits its use.

To address the underutilization of the NIS-2, the National Data Archive on Child Abuse and Neglect at Cornell held a Special Research Meeting in June of 1990. The purpose of the meeting was to provide an opportunity for researchers who have worked with NIS-2 to share their results, discuss methodological issues and generate ideas to increase the dissemination and usage of the NIS-2. As a result of this meeting, The National Data Archive has decided to prepare a supplemental instruction manual to accompany the codebook and three publications which are provided when the data tape is purchased from the Clearinghouse. This "how to" guide, to be available in the Spring of 1991, will simplify the process of working with the NIS-2 and will address specific questions such as, "Do I need to weight the data?"

Another option for increasing the use of the NIS-2 is to analyze the unweighted data as a nonrepresentative sample of maltreatment. The NIS-2 contains information on 3270 countable cases of child abuse and neglect drawn from 29 counties through out the U.S. Even with the unweighted data, a number of interesting and useful questions can be examined, such as:

- How do cases of neglect and abuse seen at schools differ from those seen in hospitals or social service agencies?
- In what ways are victims and perpetrators of maltreatment in rural areas different from those in urban areas?
- How do neglect cases differ from other types of maltreatment with regard to demographic characteristics?

Continued on page 11

BOOK REVIEW

THERAPY FOR ADULTS MOLESTED AS CHILDREN: BEYOND SURVIVAL

(BOOK BY JOHN BRIERE, PH.D. 1989, 219 PAGES, SPRINGER PUBLISHING CO. $29.95 HARDBACK. REVIEWS BY JEANNE WALSH, MSW, LSW, AND SARAH W. WING, PH.D.)

REVIEW #1

—by Jeanne Walsh

In recent years the number of clinical books on the sexual abuse of children has grown. However, scant attention has been focused on the long-term impact these traumas have on the victim's functioning as an adult. John Briere's book not only addresses the topic but goes far beyond the usual listing of signs and symptoms of sexual abuse to deal with the psychological impact and therapeutic issues in a comprehensive and concise manner. Each chapter is replete with basic principles, good clinical examples and excellent treatment guidelines that will help the reader be a more effective therapist.

Chapters 1 and 2 provide a comprehensive discussion of post-sexual-abuse trauma and its effects on the person's functioning as an adult. The author addresses cognitive, emotional, and interpersonal effects of abuse, and the long-term impact on the developing personality of the victim. Briere reframes the symptoms of two commonly diagnosed disorders, Hysteria and Borderline Personality Disorders, as adaptive responses to the physical and psychological trauma of sexual abuse. When sexual abuse is acknowledged as the source of the symptoms associated with these disorders, then those symptoms can be understood as reasonable, adaptive responses to the trauma. An abundance of specific references to the sexual abuse literature is cited in Chapter 1 and 2 along with suggestions for further research.

In Chapter 3, "Philosophy of Treatment," Briere presents a conceptualization of the basis and guidelines for treatment of the abuse survivor from a philosophical and socio-cultural perspective. He emphasizes the reactions and accomodations victims make in order to survive their toxic environment. There is no place in this framework for viewing the survivor as "sick," much less as blameworthy.

Transference, countertransference, boundaries and the repetition compulsion are addressed in Chapter 4. Briere discusses how and why these concepts present unique challenges to the therapist-client relationship when the issue is post-abuse trauma. Suggestions are set forth for parameters of abuse-focused psychotherapy.

The following three chapters concentrate on specific treatment techniques which are innovative yet theoretically, empirically and clinically well-grounded. Briere's method is inherently positive and empowering. His techniques focus on converting "symptoms" into strategies for recovery by reframing the survivor's current "bad" experiences into powerful, positive opportunities for integration and recovery. The author presents a new perspective for dealing with forms of dissociation, commonly viewed as client resistance. One chapter is devoted to family and group therapies. The section on group therapy describes screening procedures and various ground rules that are particularly relevant to group work with adult survivors of sexual abuse. Another chapter is devoted to the impact of client gender on reaction and accomodation to sexual abuse and on the therapeutic process. Dynamics of power rooted in various client-therapist gender configurations are thoroughly discussed.

The final chapter provides an overview of therapist issues resulting from continued work with survivors of sexual abuse. The author offers specific suggestions to assist the therapist in dealing with his/her own strengths and limitations with the intensity of work with this population.

A few weaknesses apparent in this book are of omission rather than comission. The impact of the developmental stage of the victim at the time of the abuse as it affects future personality organization and accomodation could be addressed in more detail, as could the victim's role in his/her family of origin. Survivor confusion with respect to sexual orientation is reviewed for male victims but not for females.

This book is an outstanding contribution to the field of sexual abuse treatment for all of the mental health disciplines. The author has the unique ability to assume the perspective of not just the clinician but also the victim. As the title suggests, the author offers hope for more than just survival for victims of sexual abuse: he offers hope for integration and recovery for victims and clinicians.

Jeanne Walsh, MSW, LSW, works at Hartgrove Hospital in Chicago, Illinois.

REVIEW #2

—by Sarah Wing

John Briere is a clinical psychologist and Assistant Professor of Psychiatry at the University of Southern California School of Medicine. He addresses his book to psychotherapists working with clients who were sexually abused in childhood or early adolescence. The principal emphasis of his volume is treatment strategies, including an innovative chapter on strategies for the therapist to avoid.

Briere's discussion of both short-term and lasting post-traumatic stress lays the foundation for his objection to diagnostic labels which locate pathology in the victim rather than in the external stressors. He briefly describes symptoms such as recurrence of trauma in flashbacks or nightmares, memory loss, self-blame, mistrust of others, depression, excessive sexual activity, and self-mutilation. The concurrence of such symptoms and diagnoses of histrionic and borderline personality are then detailed.

Briere emphasizes the importance of empowering clients by helping them to recognize and develop strategies for coping with the consequences of abuse. He clearly locates the cause of both positive and negative therapeutic transference in the client's previous experiences with persons in authority. What others might see as "crazy" symptoms, Briere normalizes as a response to stress. Therapists are cautioned about projecting their own gender-related and other biases upon clients, and guidelines are offered regarding limits to length and duration of sessions, explicit discussion of confidentiality and its exceptions, and avoidance of dual relationships. Briere counsels therapists not to move too quickly, and to provide continuing safety and supportiveness to the client. His summary of "a therapist who is caring, nonexploitive, and reliable" and "a therapeutic environment that fosters self-awareness, self-acceptance, and individuation/independence" (p.110) is thoroughly presented. The question of family therapy is dealt with briefly. Briere's view is that, "the sexual abuser forfeits the possibility of reconciliation" (p.138). He does, however, promote the supportiveness of concurrent group therapy, depending upon the client's strengths.

The format of the book includes a detailed table of contents and a brief summary at the end of each chapter to highlight major points. There are 15 pages of references and a detailed index. Briere moves from the theoretical and empirical findings in his initial chapters to principles and practices of therapy. Two appendices consider typical responses to psychological testing and present a newly developed trauma symptom checklist, for which Briere offers preliminary data.

The "new" conceptualization of victim behaviors as expected reactions to stress rather than pathology will likely not be new to many practitioners. Thus, Briere could be seen as reacting at excessive length against therapist insensitivity instead of simply letting his well-written and useful book speak for itself. Briere has presented well-documented reasoning for his position on pathology and for his treatment techniques, providing a useful volume for practioners.

Sarah Wing, PhD, is a licensed psychologist in independent practice in Bellevue, WA.

BOOKS REVIEWED ELSEWHERE

Accusations of child sexual abuse (1988), by Ralph Underwager and Hollida Wakefield (Springfield, IL: Charles C. Thomas. 499 pp., $68.50 hardback): Reviewed by David Chadwick, MD, in the May 26, 1989 *Journal of the American Medical Association, 261,* 20, p. 3035, and by John E.B. Myers, JD, in the May, 1990 *Michigan Law Review, 88,* 6, pp. 1709-1733.

Child sexual abuse: A handbook for health care and legal professionals (1988), by Diane Schetky and Arthur Green (New York: Brunner/Mazel. $27.50 hardback): Reviewed by Monica Benton in the May-June 1989 *Children Today,* p. 31.

The Clinical Interview (film and manual) (1986), edited by Kee MacFarlane (New York: Guilford), and *Child sexual abuse assessment: The investigatory interview (videotape) (1988),* by Sue White (Cleveland: Child Guidance Center): Comparatively reviewed by William Friedrich in the June, 1990 *Pediatric Psychology, 15,* 3, pp. 408-411.

POLICIES

NCPCA POSITION STATEMENT ON CORPORAL PUNISHMENT RECOMMENDED FOR APPROVAL BY APSAC BOARD

The National Committee for Prevention of Child Abuse has produced a position statement on corporal punishment that the APSAC Board would like to endorse. The Statement reads:

"The National Committee for Prevention of Child Abuse opposes the use of corporal punishment in schools and custodial settings and supports the use of appropriate disciplinary alternatives, and further supports the adoption of state and local legislation to prohibit corporal punishment in schools and all other institutions, public or private, where children are cared for or educated."

In accordance with the democratic principles on which APSAC is founded, the Board requires the membership's approval before it can officially issue or endorse position statements. At its April, 1990 meeting, APSAC's Board approved the following procedures for issuing "Statements on Issues of Social Concern or Public Policy":

I. Statement of Policy: APSAC may issue statements or issues of social concern or public policy, and may endorse such statements of other organizations.

II. Rationale: As an interdisciplinary society, APSAC should inform the public and professional community as to its views on issues or policies that affect the goals of the Society.

III. Implementation: Such statements of endorsements shall be issued according to the following procedures:

1. Any member desiring APSAC to issue or endorse such a statement shall submit it to the Policies, Procedures and Bylaws committee for consideration.

2. The Chair of the Policies, Procedures and Bylaws committee shall distribute the proposal to the members of the committee and the Chair of the People of Color Task Force, who shall distribute it to the Task Force, for review. The Chair of the People of Color Task Force shall give the Task Force's recommendation to the Chair of the Committee.

3. If a majority of the Policies, Procedures and Bylaws committee agrees that the issue is appropriate for APSAC to issue a statement of endorsement upon, and the proposal is in accordance with the aims and purposes of the Society, the Chair shall submit the proposal, accompanied by a notice, to the Editor-in-Chief of *The Advisor* for publication in the next available issue. The notice shall advise any member disapproving such proposal to notify the Chair of the Policies, Procedures, and Bylaws Committee.

4. Based upon the number of negative comments, the Policies, Procedures and Bylaws committee shall decide whether to submit the proposal to the Board of Directors with a recommendation to approve it.

5. The Board shall vote upon the proposal at a meeting, by mail, or by telephone.

6. If approved by a majority of the Board, an announcement of the statement or endorsement will be published in the next issue of *The Advisor*. Notice of the endorsement will be sent to appropriate individuals, agencies and organizations by the Chair of the Policies, Procedures and Bylaws committee.

7. The foregoing procedures will be published once a year in *The Advisor* to provide notification to all members as to how they may initiate policy statements and endorsements.

The next step is for APSAC members who have objections to APSAC's endorsing the NCPCA position statement on corporal punishment to put those objections in writing and send them to David Lloyd, Chair of the Policies, Procedures and Bylaws Committee. His address is National Resource Center on Child Sexual Abuse, 5 Whitestone Court, Silver Spring, MD 20901-2743. Please contact David by Friday, May 3 if you have objections. Based on member's response, the APSAC Executive Committee will vote to endorse or not to endorse the position statement during its next meeting.

JONES (continued from page 9)

Though the NIS-2 contains useful information, its complexity should make us begin to explore better ways of obtaining child abuse and neglect information. While it is important to obtain an incidence rate, it is equally important to have a product which many researchers can use to contribute to our knowledge of child abuse and neglect. Given that the Request for Proposals for the next incidence study will be released soon, we need to think about what the end product should include. Conducting an in-depth review of a smaller number of counties over a six month period may be more useful. Or, in addition to determining the incidence of maltreatment, background information on the professional observing the cases, and information about agencies' policies with respect to observed cases of abuse and neglect could be collected. If we hope to successfully prevent child abuse and neglect in the United States, we must use the experience we have gained from the First and Second Incidence studies to ensure that the Third National Incidence Study results in a data set that can be used and understood by researchers everywhere.

Elizabeth D. Jones, Ph.D., is Associate Director of the National Center on Child Abuse Prevention Research at National Committee for Prevention of Child Abuse in Chicago.

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REID *(continued from page 1)*

In their own elections, the Board chose the following Executive Committee, and the Executive Committee the following officers (all of these individuals have served on the Board for at least one year):

- **President**: Joyce N. Thomas, RN, MPH
- **First Vice President** (President-Elect and Chair of the Membership Committee): Charles Wilson, MSW
- **Second Vice President** (Chair of the Program Committee): Patricia Toth, JD
- **Treasurer** (Chair of the Finance Committee): Barbara Bonner, PhD
- **Secretary**: Lucy Berliner, MSW

Directors at Large include:

- Linda Blick, MSW, LCSW
- David Chadwick, MD (Past President)
- Astrid Heger, MD
- Susan Kelley, RN, PhD (Editor-in-Chief of *The Advisor* and Chair of the Publications Committee)
- David Lloyd, JD (Chair of the Policies, Procedures, and By-Laws Committee)
- Kee MacFarlane, MSW

With this experienced group of professionals at the helm and the energetic new Board coming in (for a complete list of addresses, see p.14), 1991 promises to be a banner year for APSAC. Which will take some doing, because 1990 was a very good year.

1990 a Winning Year

In January of 1990, APSAC's Board approved a budget that projected 500 new members, a 60% renewal rate for existing members, and a total of $70,885 in income. By December 31, 1990, APSAC had enrolled 718 new members, renewed a remarkable 68% of existing members, and earned $97,433.

As projected in the approved 1990 budget, expenses for the year virtually equalled income: our 1990 expenses, like our income, were higher than anticipated. Major expenses were incurred as a result of APSAC's unexpected July 1 move. Computers, a printer, and office furniture (all of which had been supplied by the University of Chicago) had to be purchased, moving costs had to be paid, and rent and telephone bills started coming in for the first time in APSAC's brief history. Staff received raises, and printing costs were higher than projected in the 1990 budget as well, largely because of APSAC successes: so many members were handing out brochures to colleagues and at conferences that an additional 10,000 had to be printed. Further, the Task Force on the Psychosocial Evaluation of Suspected Sexual Abuse in Young Children produced a sterling set of Guidelines, which cost $1,000 to print. When all our bills are paid, we will have ended 1990 pretty much as we began: with approximately $18,000 in the bank.

The 1991 budget projects 750 new members, a 65% renewal rate, and total revenues of $138,950 (including the carryover from 1990). Our major source of income, as always, is membership dues, both new and renewal, accounting for nearly 64% of our total projected income. Sales of APSAC products (*The Advisor*, the Guidelines, the *Nebraska Law Review* article on expert testimony [see ad on p.13], pins, etc.) are an increasingly important source of income. Another important projected source of income is the conference in Huntsville, Alabama, March 20-23, which APSAC is co-sponsoring with National Children's Advocacy Center (see p.19). Income anticipated from donations to APSAC's new Endowment Fund (see story, p.4) has been set aside for special use, and is not being counted as income for the general operating budget.

Projected expenses for 1991 are $129,343. Major expense categories are staff salaries (43%), printing (17%), membership benefits (JIV and state chapter support—16%), rent, phone, postage, and xeroxing (13% total). Other expenses include office supplies, advertising, and conference travel.

If we manage to enroll 1,000 to 1,200 new members this year—and unexpected expenses are not too heavy — we should find ourselves with a comfortable margin of financial safety by December 31.

Enthusiasm for APSAC is definitely snowballing, largely because of dedicated members' successful efforts to spread the word about the organization. By urging friends and colleagues to join, you play a major role in the success of the organization.

In addition to increasing new memberships, APSAC may realize unbudgeted income from exciting new projects approved by the Board at the annual meeting.

New Projects Underway

The *APSAC Handbook on Child Maltreatment* will be an edited collection of original and reprinted articles donated by APSAC Board and members on a variety of multidisciplinary topics. The *Handbook* was proposed by John Briere, Ph.D., and was unanimously approved by APSAC's Board. The volume will be edited by several people (including, so far, John Briere, Ph.D., Richard Krugman, MD, Lucy Berliner, MSW, and David Finkelhor, Ph.D.). Among the topics to be covered are incidence of physical, sexual, and psychological abuse; short-term and long-term psychological effects; medical examination of suspected child abuse; psychotherapy with child victims; psychotherapy with adult survivors; prevention; cultural sensitivity in responding to child maltreatment; legal issues in collecting and preserving evidence of abuse and serving as an expert witness; and methodological issues in child abuse research.

The proposal is that authors and editors will donate their work, so that all proceeds from sale of the Handbook directly benefit APSAC. Also in the interest of maximizing profits, the Board is exploring the possibility of self-publishing the *Handbook*, that is, paying a printer up front to print it, and marketing it ourselves. Self- publishing requires that we pay for a large initial print run, but promises to bring in so much more per book (50 - 70% of the sale price, versus the 15% offered by most publishing houses) that it seems to be the best route in the long run.

The *APSAC Handbook on Child Maltreatment* promises to be a significant contribution to the information- base on child abuse available to professionals. We hope to see it in print by the end of 1991 or early in 1992, and to realize some income from advance sales this year.

Another important project approved by the Board in January is the audiotaping of APSAC's Advanced Training Institutes, to be presented for the first time on March 22 and 23 in Huntsville, Alabama (see ad, p. 17, for a list of titles and an order form). Each Institute will be offered for sale on six one-hour tapes, packaged in an attractive, book-sized folder. Gaylor Multi-Media Communications, of Nashville, will produce the tapes, and APSAC will offer them for $24.95 a set to members and $29.95 a set to non-members. Training Institutes on additional topics are being considered; call or write if you have ideas for new Institutes. Current plans are to offer a day of APSAC Advanced Training Institutes before or after major conferences in different regions of the country.

Finally, the *APSAC Study Guides* are well under way. As was reported in an earlier column, the Board last year unanimously approved a proposal by Jon Conte, PhD, to develop a series of *APSAC Study Guides* on a variety of topics, including Evaluating Allegations of Sexual Abuse, Assessment of Sexual Offenders, Psychological Assessment of Abused Children, Adult Survivors of Childhood Abuse, Medical Evaluation of Abused Children, and Legal Issues in Child Maltreatment. The *Study Guides* are to be approximately 150-page monographs covering seminal knowledge areas for each topic. The *Guides*, to be published by Sage Publications with a 10% royalty to APSAC, will be updated every three years. Attached to each *Study Guide* will be a coded card that will enable the bearer to enroll for a competency test written by the *Study Guide's* author and approved by APSAC's Board. APSAC will administer the tests, issue certificates to professionals who pass, and deposit test fees directly into its operating budget.

A direct extension of APSAC's mission to further multidisciplinary professional education, these three projects promise to bring APSAC significant attention as a major source of professional training in this field.

Continued on next page

REID *(continued from page 12)*

Task Forces Set to Work, New Committees Formed

The chairs of four Task Forces held open meetings in San Diego: Dan Sexton and Linda Blick, co-chairs of Assessment and Treatment of Adult Survivors of Childhood Abuse; Jon Conte and Kee MacFarlane, co-chairs of Ethical Practice; Carole Jenny and Martin Finkel, co-chairs of Medical Evaluation of Suspected Child Abuse; and Stuart Hart and Marla Brassard, co-chairs of Psychological Maltreatment all held well-attended, energetic meetings. Specific news about each of the Task Forces' progress will be reported in future issues of the newsletter. If you want to participate in the exciting formative stages of these Task Forces, the chairs would be happy to hear from you (phone numbers on p.11).

In addition, two new standing committees were authorized by the Board. One, a Research Committee, was proposed and will be chaired by Ben Saunders, PhD, of the Crime Victims Research and Treatment Program in Charleston, SC. The Research Committee has been established to ensure that a healthy, prominent research component is part of every conference with which APSAC is involved.

The second new committee is the Awards Committee. The Awards Committee, proposed by President Joyce Thomas, was established to ensure that, at every future annual meeting, members who make outstanding contributions to APSAC—and there are many of you—are suitably recognized and thanked by the organization.

State Chapter News

The Board approved the development of state chapters just a year ago, at its 1990 annual meeting. At the 1991 meeting, the Board had the pleasure of granting the first state charter to North Carolina. In 19 other states as well, dedicated members have begun organizing chapters (for a full list of state chapter coordinators, see below). The Illinois chapter has submitted a charter sure to be approved, and Oklahoma organizers will submit theirs this Spring. Ohio coordinators are holding a major organizing meeting at "Through the Eyes of the Child," a conference to be held in Toledo in April, and organizers in several other states are busy too.

In a move designed to provide moral as well as financial support for state chapter organizers, the APSAC Board allocated funds for state chapter development in 1991: a proposed allocation of $4 per person per state chapter was approved. APSAC's Membership Committee will work out details of the disbursement by the time of the Executive Committee meeting in Huntsville in March. The disbursement is meant to help defray the costs of communicating with members and holding organizing meetings. Hopefully, APSAC's coffers will swell enough this year to enable support to state chapters to be substantially increased in 1992.

All of these are exciting developments to watch in the coming year. The San Diego conference was remarkable for the enthusiasm it generated about APSAC. Thirty new members joined at the conference, many more took home brochures for themselves and colleagues, and everyone was talking about APSAC's projects and its increasingly important role in the field. With every member's help—telling friends and colleagues about APSAC, volunteering to serve on Board committees and Task Forces, calling the office with suggestions and information, organizing a chapter in your state—APSAC will quickly become the force it is destined to be.

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JOURNAL HIGHLIGHTS

—by Thomas Curran

The purpose of **Journal Highlights** is to alert readers and APSAC members to current literature and research on child maltreatment. Selected articles from journals representing APSAC's multidisciplinary membership are presented in the form of an annotated bibliography. Readers are encouraged to send copies of current articles they believe would benefit *Advisor* readers, accompanied by two to three-sentence summary of the article. Mail your contributions to Thomas F. Curran, MSW, LISW, Executive Director, Children's Advocacy Center, 4000 Chestnut Street, Philadelphia, PA 19104.

PHYSICAL ABUSE AND NEGLECT

Alexander, R., Smith, W. and Stevenson, R. (1990). Serial Munchausen Syndrome by proxy. *Pediatrics, 86* (4), 581-585.
This article outlines five cases of Munchausen Syndrome by proxy (MSBP) in which more than one child in the family was victimized. Interesting patterns of this recently-observed type of MSBP are described, including the serial perpetrators' increased psychopathology and likelihood of killing their children compared to mothers in non- serial MSBP cases. (TFC)

Alexander, R., Sato, Y., Smith, W. and Bennett, T. (1990). Incidence of impact trauma with cranial injuries ascribed to shaking. *Am. J. of Diseases in Children, 144* (6), 724-726.
This study presents data from 24 infants initially diagnosed as having Shaken Baby Syndrome, half of whom showed no visible evidence of direct impact or external trauma. The findings suggest that shaking by itself is sufficient to cause severe or fatal intracranial injury. (MC)

Briere, J. and Runtz, M. (1990). Differential adult symptomatology associated with three types of child abuse histories. *Child Abuse and Neglect, 14* (3), 357-364.
Using a specially designed Family Experiences Questionnaire with a sample of 277 female college students, this study examined retrospective reports of childhood sexual, physical and psychological abuse as they related to three types of current psychological dysfunction. Significant findings revealed unique associations between a history of psychological abuse and low self-esteem, childhood physical abuse and adult aggression towards others, and child sexual victimization and maladaptive sexual behaviors. (TFC)

Cantrell, P.J., Carrico, M.F., Franklin, J.N., Grubb, H.J. (1990). Violent tactics in family conflict relative to familial and economic factors. *Psychological Reports, 66,* 823-828.
This study examined the social, economic, and family process factors which may be associated with families' use of violent tactics in conflicts in a population in the Appalachian region of West Virginia. Subjects studied, utilizing a questionnaire format, were 114 boys and 161 girls ranging in age from 15 to 17. The researchers state confirmation of their primary hypothesis that in families where the father is unemployed, there is greater than expected frequency of violent interactions. Additional findings indicated that violent behaviors are replicated intergenerationally. (GBW)

Cohen, S. and Warren, R.D. (1990). The intersection of disability and child abuse in England and the United States. *Child Welfare, 69* (3), 253-262.
This article provides compelling support for improvements in current American systemic response to and public awareness of the abuse of developmentally disabled children. This article holds particular significance for abuse investigators and policy makers. (TFC)

Milner, J.S. and Robertson, K.R. (1990). Comparison of physical abusers, intra-familial sexual child abusers and child neglecters. *J. of Interpersonal Violence, 5* (1), 37-48.
This article reports on a study of 150 subjects, including 30 physical abusers, 15 sexual abusers, 30 child neglecters and three matched non-abusing comparison groups for their levels of reported distress, unhappiness, loneliness, self- concept and family-related problems. While all the abuser groups reported higher levels of distress, loneliness and unhappiness, the sexual abusers reported positive views of their children and themselves, and fewer family problems. The use of these findings in the treatment of sexual abusers is discussed. (TFC)

Milner, J.S., Robertson, K.R., and Rogers, D.L. (1990). Childhood history of abuse and adult child abuse potential. *J. of Family Violence, 5* (1), 15-34.
Utilizing the Childhood History Questionnaire (CHQ) and the Child Abuse Potential (CAP) Inventory, 375 adults were questioned in this study to measure adult physical child abuse potential. Consistent with other research on this question, findings revealed a very significant relationship between being abused as a child and perpetrating abuse as an adult. Of particular significance in this study was the finding of a strong and direct relationship between chronicity of abuse experienced in childhood and adult abuse potential. (TFC)

Stevenson, R. and Alexander, R. (1990). Munchausen Syndrome by Proxy presenting as a developmental disability. *Developmental and Behavioral Pediatrics, 11* (5), 262-264.
This brief report presents the case history of one 11-year child diagnosed with Munchausen Syndrome by Proxy (MSBP) who was portrayed by her mother as suffering multiple developmental disabilities. The complexity of the mother's psychopathology and the usefulness of multidisciplinary team evaluations in MSBP diagnoses are highlighted. (MC)

Wolke, D., Skuse, D., and Mathisen, B. (1990). Behavioral style in failure-to-thrive infants: A preliminary communication. *J. of Pediatric Psychology, 15* (2), 237-254.
This article reports the findings of a pilot study involving nine infants with nonorganic failure to thrive and nine matched comparisons. Nonorganic failure to thrive infants were found to be more fussy, demanding, and unsociable as well as less task-oriented and persistent. They were also more likely to be developmentally delayed. The study's findings suggest that nonorganic failure to thrive infants' temperamental characteristics could be important contributions to poor infant-mother relationships. (SJK)

SEXUAL ABUSE

Berliner, L. and Conte, J. (1990). The process of victimization: The victim's perspective. *Child Abuse and Neglect, 14* (1), 29-40.
Twenty-three child victims of sexual abuse were interviewed about their victimization process, their perpetrators, and how their abuse might have been prevented. The results of this work indicated that the child sexual victimization process appears to include sexualization of the relationship, justification of the sexual contact, and maintenance of the child's continued cooperation. Sexual abuse investigators should find this article particularly useful. (TFC)

Deblinger, E., McLeer, S., Henry, D. (1990). Cognitive behavioral treatment for sexually abused children suffering Post-Traumatic Stress: Preliminary findings. *J. of the Am. Acad. of Child and Adolescent Psychiatry, 29* (5), 747-752.
The effectiveness of a cognitive-behavioral treatment program designed specifically for sexually abused children suffering from full diagnostic criteria of Post Traumatic Stress Disorder (PTSD) was examined in this study of 19 female victims. Using a combination of child and non-offending parent behavioral intervention strategies, this study compared pre- and post- assessment of PTSD symptoms in the child victims. While all PTSD symptoms were not eliminated, none of the children continued to meet full PTSD diagnostic criteria following treatment. (TFC)

Everson, M. and Boat, B. (1990). Sexualized doll play among young children: Implications for the use of anatomical dolls in sexual abuse evaluations. *J. of the Am.Acad. of Child and Adolescent Psychiatry, 29* (5), 736-743.
This study examined the incidence of sexual play with anatomical dolls in a sample of two to five year olds. Only six percent of the 209 non-abused children observed with anatomical dolls demonstrated behavior depicting sexual intercourse. The findings suggest that explicit sexual play with anatomical dolls is a very uncommon occurrence among non-abused children. (SJK)

Hibbard, R. and Hartman, G. (1990). Genitalia in human figure drawings: Childrearing practices and child sexual abuse. *J. of Pediatrics, 116,* 822-8282.
This article describes a comparison study of 109 alleged child sexual abuse victims with a matched group of 109 non-abused children to examine the associations of drawing genitalia on a human figure, child rearing practices, and a history of sexual abuse. Study findings suggested that the presence of genitalia spontaneously drawn on a child's human figure drawing is positively associated with alleged sexual abuse, but not associated with child rearing practices (e.g., bathing, nudity, etc.) or a medical history (e.g., enuresis). (MC)

Hunt, P. and Baird, M. (1990). Children of sex rings. *Child Welfare, 69* (3), 195 - 207.
This article presents some very important general information about child sex rings. Differences in the victimization process and coping behaviors observed in victims of single-offender abuse and sex rings are highlighted. Guides for therapeutic intervention with victims of sex rings are also discussed. (TFC)

Jaudes, P.K., Morris, M. (1990). Child sexual abuse: Who goes home? *Child Abuse and Neglect, 14,* 61 - 68.
Based on a study of medical records of 180 children hospitalized over a 7 year period (1979 - 1986) with a diagnosis of possible sexual abuse, the authors conclude that there is no clear systematic relationship between risk factors and court decisions to change a child's custody. (GBW)

Kaplan, M.S., Becker, J.V. and Martinez, D.F. (1990). A comparison of mothers of adolescent incest vs. non-incest perpetrators. *J. of Family Violence, 5* (3), 209-214.
One hundred and thirty mothers of adolescent sexual perpetrators were interviewed in this study: 48 mothers of incest perpetrators and 82 mothers of non-incest perpetrators. Results indicated that significantly more mothers of incest perpetrators reported having been abused, having a sexual dysfunction, and having been in prior therapy. The mothers of the incest perpetrators also reported that they believed their son actually committed the charged offense, needed treatment, and had a history of being physically abused. (TFC)

Ogata, S.N., Silk, K.R., Goodrich, S., Lohr, N.E., Westen, D. and Hill, E.M. (1990). Childhood sexual and physical abuse in adult patients with borderline personality disorder. *Am. J. Psychiatry, 147* (8), 1008-1013.
The child abuse and neglect experiences assessed in 24 adults diagnosed as having borderline personality disorder and in 18 depressed control subjects without borderline disorder are presented. Significantly more of the borderline patients reported childhood sexual abuse, abuse by more than one perpetrator and both sexual and physical abuse. An important contribution to the controversy surrounding the etiology of borderline personality disorder and its relationship to severe or traumatic childhood maltreatment. (TFC)

Pellegrin, A., Wagner, W. (1990). Child Sexual Abuse: Factors Affecting Victims' Removal from Home. *Child Abuse and Neglect, 14,* 53 - 60.
The goal of this study was to identify factors associated with the removal of child sexual abuse victims from the home. An analysis of 43 substantiated cases of sexual abuse in which the child victims were removed from the home yielded 5 factors (mothers' compliance, mothers' belief, severity of abuse, mothers' employment status, frequency of abuse) which were found to be significantly related to the child protective service workers' decision to remove the child. (GBW)

Rew, L. and Espararza, D. (1990). Barriers to disclosure among sexually abused male children. *J. of Child and Adol. Psychiatric Mental Health Nursing, 3* (4), 120-127.
This article describes factors that may account for the reluctance of male victims to disclose sexual abuse. Implications for early identification and treatment of male victims and for further research are discussed. (SJK).

CHILD ABUSE AND THE LEGAL SYSTEM

Clark, C.A. (1990). Religious Accommodation and criminal lability. *Florida State University Law Review, 17,* 559-590.
This article examines the criminal liability under one state's religious accommodation statute for parents who rely on spiritual healing in lieu of medical treatment for their ill children. The various types of accommodation statutes, their application and recent Supreme Court decisions on this issue are discussed. While the author's conclusions may not be widely supported by child abuse professionals, her argument and reasoning deserve the attention of child abuse policy makers. (TFC)

McEwan, J. (1990). In the Box or on the Box? The Pigot Report and Child Witnesses. *Criminal Law Review,* June, 363-370.
This article summarizes the recommendations of a British Advisory Committee on Children's evidence, presenting a fascinating look at how another country treats some of the most pressing child witness testimony and evidence issues commonly encountered in abuse prosecutions. Several of the suggestions deserve serious consideration by American courts. (TFC)

Mindlin, J.E. (1990). Child sexual abuse and criminal statutes of limitations: A model for reform. *Washington Law Review, 65,* 189-207.
This Comment examines the increasingly pressing issue of child sexual abuse prosecutions that are blocked by state criminal statutes of limitations. Concluding that such statutes represent a formidable legal obstacle to the prosecution of many sex offenders, the author proposes several possible solutions, including a model legislative amendment. (TFC)

Journal reviewers for this issue included Thomas F. Curran, MSW, LISW, Children's Advocacy Center, Philadelphia, PA; Mark Chaffin, Ph.D., Arkansas Children's Hospital, Little Rock, AR; Susan J. Kelley, RN, Ph.D., Boston College School of Nursing, Chestnut Hill, MA, and Gail B. Wangerin, RN, MS, Associate Director, HRI Counseling Center, Lawrence, MA.

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PAST

Barbara Sinatra Children's Center Third Conference on Child Sexual Abuse, Rancho Mirage, CA, February, 1989.

5th Annual Symposium on Child Abuse, Huntsville, AL, March, 1989.

4th Annual Health Science Response to Child Maltreatment, San Diego, CA, January, 1990.

Midwest Conference on Child Sexual Abuse and Incest, Madison, WI, October, 1990.

A Short Course in the Psychotherapy of Sexually Abused Children and Their Families, Virginia Beach, VA, November, 1990.

Networking in the Nineties, Nashville, TN, November, 1990.

The San Diego Conference on Responding to Child Maltreatment, San Diego, CA, January, 1991.

FUTURE

March 20 - 22. ***7th National Symposium on Child Sexual Abuse.*** Huntsville, Alabama. Co-sponsored by the National Network of Children's Advocacy Center, APSAC, and the National Resource Center on Child Sexual Abuse. **APSAC INSTITUTES to be held Friday and Saturday, March 22 & 23. APSAC MEMBERSHIP MEETING to be held Thursday, March 21, 5 - 7 p.m.** See p.17 for details. Call Marilyn Grundy, 205-533-6129 for more information.

April 10 - 12. ***Power and Control in Family Violence: Implications for Treatment.*** The Seventh Annual Conference on Abuse and Victimization in Life-Span Perspective. Boston. Sponsored by Harvard Medical School Department of Continuing Education. Workshop series on Dynamics and Dimensions of Power and Control; Development, Treatment, and Control; Women, Power, and Control; and Addressing Control in Practice. Call Cherry Manuel, 617-432-1525, 10 a.m. to 4 p.m.

April 11 - 14. ***First National Congress on Child Sexual Trauma and Adult Sexual Victimization.*** Grand Traverse Village, Michigan. Sponsored by the Committee on Child Sexual Abuse and Adult Sexual Victimization. Focusing on incest and child sexual abuse; cults and ritual abuse; rape; pornography and sex rings. Call Barbara Kennison, 616-941-4140.

April 14 - 18. ***The American Society of Clinical Hypnosis 33rd Annual Scientific Meeting and Workshops on Clinical Hypnosis.*** St. Louis, MO. Call 708-297-3317.

April 18 - 20. ***Through the eyes of the child: Abused and neglected children and their families.*** Toledo, Ohio. Sponsored by the Medical College of Ohio. Featured speakers include Ohio Supreme Court Justice Herbert Brown, David Chadwick, MD, Mary de Chesnay, DSN, Ray Helfer, MD, Richard Krugman, MD, and State Senator Betty Montgomery. Ohio state APSAC chapter meeting will be held. Call 419-381-4237.

April 22 - 24. ***National American Indian Conference on Child Abuse & Neglect.*** Minneapolis. Call Anita Chisolm, 405-325-4298.

April 27. ***Second Annual National Vigil: A Candle-light Vigil in which We Can Grow.*** Marietta, GA. Sponsored by Coalition Against the Sexual Abuse of Children. Call Diane Koehler, 404-565-7547 for information on how to organize a vigil in your community.

April 27 - 30. ***10th Annual Conference of the National CASA Association. Boston.*** Call Sue Shecket, 206-328-8588.

May 2 - 3. ***National Conference on Cults and Ritualistic Abuse.*** Sponsored by Community Program Innovations. Boston. Call Lisa Kaplan, 508-774-0815.

May 12 - 18. ***7th International Institute on Victimology, Physical and Sexual Abuse of Children, Advocacy, Law Reform, and Public Policy.*** Onate, Guipuzcoa, Spain. Sponsored by The American University, Department of Justice, Law, and Society. Call Emilio Viano, 202-885-2953.

May 16 - 18, June 27 - 29: ***Tough Guys. Wounded Hearts. Pathways for Men: Healing Self and Relationships in Recovery.*** Phoenix in May, San Francisco in June. Sponsored by Focus Magazine and U.S. Journal. Call 1-800-851-9100.

May 17-18. New Issues for Child Advocates. Tucson. Call Ann Haralambie, 602-327-6287.

May 19 - 22. ***Child Welfare League of America Southern Regional Training Conference.*** Louisville, KY. Contact Mark Riley, 202-638-4004. In Kentucky, call Ann Henry, 502-564-5813.

June 6 - 8. ***The First North American Conference in Child Abuse and Neglect, including The Fourth Annual National (USA) Child Abuse Conference.*** Toronto, Ontario, Canada. Co-sponsored by Children's Hospital of Philadelphia, Supportive Child Adult Network, Inc. (Philadelphia), SCAN Program of Toronto's Hospital for Sick Children, and the University of Toronto. See Call for Papers, this page. Call 416-978-2718.

June 20 - 24. ***Eastern Regional Conference on Abuse and Multiple Personality: Training in Treatment.*** Alexandria, VA. Sponsored by Abuse and Dissociative Disorders Recovery Program, HCA Dominion Hospital, Falls Church, VA. Faculty of 36 includes John Briere, Anne Burgess, Sandra Butler, David Calof, James Chu, Christine Courtois, Denis Donovan, Lisa McCann, Roland Summit, and Joan Turkus. Keynote Address by Andrew Vachss. Call Barry Cohen, 800-950-6463.

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THERAPISTS. University of Michigan Clinical Psychology Doctoral Candidate researching effects of child sexual abuse (intra- or extra-familial) on women's object relations. Participants needed to complete six questionnaires. If you have suggestions or access to potential participants, please contact Donna Silbert, MA, Jewish Board of Family and Children's Services, 244 E. 93rd St., NY, NY, 10028. 212-888-1594.

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