APSAC

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THE ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

NEWS

APSAC SENDS TIME *MAGAZINE STRONG MESSAGE; APSAC MEMBERS URGED TO PARTICIPATE IN BOARD COMMITTEES; NOMINATIONS SOUGHT FOR 1991 ELECTION, AWARDS; STATE CHAPTERS ON THE MOVE; CONGRATULATIONS AND THANKS*

—by Theresa Reid

***APSAC Responds to* Time**

Time magazine ran an article on March 4 entitled, "Why Children Lie in Court," which many APSAC members and Board found poorly researched and harmful both to child witnesses and to the professionals who advocate for them. The APSAC Board voted on March 23 to send the following letter in response:

"We strongly object to *Time* magazine's March 4 publication of the improperly researched and misleadingly titled article, 'Why Children Lie in Court,' by Jerome Cramer. By misrepresenting a significant body of scientific evidence, the article may seriously harm children who most need the help of caring adults such as the readers of *Time*.

Contrary to Mr. Cramer's statements, the respected scientific research literature reveals that children rarely lie about traumatic events. In the research by Drs. Karen Saywitz and Gail Goodman, cited by Mr. Cramer to show that children do lie in court, none of the 72 five- and seven-year-old children given medical exams made false reports of genital touch when asked to describe the exam or demonstrate it with dolls. Across all forms of questioning—including direct and even leading questioning about genital touch—the risk that children would *not* report genital touch that *did* occur was 64%, whereas the risk of their falsely reporting genital touch was only 1%. Suggesting that children regularly falsely claim to have been sexually touched is a clear distortion of this research.

Further, Mr. Cramer cites a study "conducted by the American Academy of Child Psychiatry" which "found that in custody disputes involving charges of sex abuse, as many as 36% of the allegations were later proved to be untrue." That study was not only not conducted by AACP, it is notorious in the field for its low sample size and poor methods: only 11 children were interviewed, and their allegations were found to be "true" or "untrue" solely on the strength of the author's opinion.

There are legitimate controversies about the best way to respond to allegations of child sexual abuse. But biased and inflammatory articles such as Mr. Cramer's are not constructive. Indeed, by distorting the research and using a patently misleading title to encourage adults to discount the generally reliable testimony of children—who are often the only witnesses to the crimes perpetrated against them—Mr. Cramer's article does active harm.

The overwhelming facts are that hundreds of thousands of American children are physically and sexually abused every year; that the vast majority of perpetrators of this abuse go unapprehended; that the social costs of child abuse are staggering; that it is the responsibility of every American adult to help stop this national tragedy.

We call upon *Time* magazine to meet its responsibility to the American public in the future by providing fair, accurate, and balanced coverage of the complex issue of child sexual abuse.

Sincerely,

The American Professional Society on the Abuse of Children"

In addition to being signed by APSAC, the letter was signed by individual Board members attending the meeting. It was also

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SPECIAL ISSUE

PROMISING PROGRAMS AND APPROACHES IN CHILD MALTREATMENT

—by Susan Kelley

Only in the past decade have the prevalence and impact of child maltreatment been empirically validated. As a result, professionals all over the country have established specialized treatment programs for victims, their families, and offenders. The purpose of this special issue of *The Advisor* is to bring together in one source overviews of the most effective programs and approaches for the prevention and treatment of child maltreatment.

But how do we know that what we are doing really makes a difference for child victims, adult survivors, and abusers? When *The Advisor*'s Executive Editor, John E.B. Myers, our Managing Editor, Theresa Reid, and I began to work on this special issue we planned to entitle it, "Programs that Work." But we soon realized that the title was overly optimistic. Although the prevalence and impact of child maltreatment have been empirically validated, the effectiveness of our treatment approaches has not been systematically tested. As we assessed the lack of empirical evidence, the title for this special issue became more humble, evolving from "Programs that Work" to "Programs We Think Might Work," to "Programs We Hope Work," to, finally, "Promising Programs and Approaches"!

We are fortunate to have several leading experts share their insights about the programs and approaches that, according to the evidence available—including experienced clinical judgment—appear to be most promising. We hope that this issue of *The Advisor* will provide further direction for treatment and prevention programs. We also hope that it will stimulate clinicians and researchers to conduct the much-needed studies to empirically validate the effectiveness of our interventions.

Please let us know your thoughts on this special issue, and in fact on every issue of *The Advisor*. If you have an idea for an article you or a colleague would like to submit for publication, please contact the appropriate Associate Editor, the Executive Editor, Managing Editor, or myself. Articles undergo a peer review process to determine which are most suitable for publication in *The Advisor*. Publishing *The Advisor* four times a year is a major effort for the editors and many APSAC members. If you are looking for a way to become more involved in APSAC, consider contributing to *The Advisor*!

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sent to Board members who weren't in Huntsville, and to as many APSAC members as possible through state chapter coordinators, with the request that they circulate the letter among their colleagues and send it to *Time* with additional signatures.

We urge you to reproduce this letter and send it to *Time* asking that your name be added to the list of signatories. Although it is too late to get a letter published, it is not too late to make an impression on the editors at *Time*: the more people they hear from, the better. The original letter was sent to Reginald K. Brack, Jr., President of *Time* Inc. Magazines, and at *Time* to Henry Muller, Managing Editor; Claudia Wallis, Senior Editor; and Amy Musher, Letters Editor. All receive letters at the Time and Life Building, 1271 Sixth Av., New York NY 10020.

This incident has spurred APSAC to begin organizing a Media Relations Committee. The Committee's task is ultimately to reduce the number of damaging and misinformed articles such as Mr. Cramer's by forming positive relations with writers and editors for major national media and making APSAC known as a source of balanced and accurate information on the volatile issues around child abuse and neglect. The first task of this committee is to create a mailing list of reporters and editors who write on child welfare for major newspapers, magazines, television and radio programs. You can provide critical help by calling or writing Linda Blick, MSW, LCSW, the chair of the new committee, with names and addresses of reporters and editors working in this field. Linda is Executive Director of the Chesapeake Institute, 11141 Georgia Av., Suite 310, Wheaton MD 20902. Her phone is 301-949-5000. Please help APSAC extend its clout by calling Linda with this important information.

Members Urged to Participate on Board Committees

Members who want to take a more active role in the leadership of APSAC are urged to choose a committee to join. In addition to the **Media Relations Committee** (above) and the **Nominations Committee** (below), the following committees and their chairs would welcome your involvement:

- **Awards Committee,** chaired by Susan Kelley, RN, PhD, 617-552-4250. This new Committee is charged with establishing awards for excellent service to APSAC and choosing members to receive them.
- **Fundraising Committee,** chaired by Charlie Gentry, MSW, 615-524-7483. The Fundraising Committee is responsible for planning and implementing all of APSAC's efforts to raise funds over and above membership dues.
- **Membership Committee,** chaired by Charles Wilson, MSW, 615-741-3443. The Membership Committee is concerned with the recruitment and retention of members and the formation of state chapters. If you have any ideas for cost-effective ways to publicize APSAC and recruit members, please give Charles a call.
- **Program Committee,** chaired by Patricia Toth, JD, 703-739-0321. The Program Committee concerns itself with workshops, plenaries, training institutes, and other forums offered at conferences in which APSAC is closely involved. Anybody with ideas for topics that should be addressed at conferences and speakers who should have more exposure are invited to call Patti and volunteer to serve on this committee.
- **Publications Committee,** chaired by Susan Kelley, RN, PhD, 617-552-4250. The Publications Committee is responsible for *The Advisor*, APSAC's brochure and flyers, and all other printed material.
- **Research Committee,** chaired by Ben Saunders, PhD, 803-792-4037. The Research Committee was established in January, 1991, to oversee the research component of conferences in which APSAC is closely involved to make sure that research is given adequate attention. This committee may be involved as well in presenting workshops on conducting research and preparing findings for publication.

Nominations Sought for 1991 Election and Awards

A very important way for you to participate in the direction of APSAC is to nominate people to stand for election to the Board. Although the results of the 1990 election were just announced, it's not too soon to begin thinking about nominations for 1991, and getting together the list of signatures you need to nominate a colleague or yourself.

The Nominations Committee is co-chaired by Lucy Berliner, MSW (206-223-3047) and Barbara Bonner, PhD (405-271-8858). The Committee is directed by the By-laws to nominate at least two candidates for each of the available slots on the Board, and to "consider geography, ethnicity, and fair representation of all relevant disciplines in its deliberations and selections."

If you wish to nominate a colleague or yourself directly, you can do so by getting 5% of the regular membership to sign a petition in support of the nomination. Currently, 5% of the regular membership is about 80 people; by election time, it may be 90 or 95. If you wish to *recommend* one or more people for nomination, send their names to Barbara or Lucy. Nominations by petition must be submitted no later than August 1 to allow time for verification of the signatures before the election.

The Awards Committee is also seeking

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ADULT SURVIVORS

TREATMENT FOR THE LONG-TERM EFFECTS OF CHILD ABUSE

—by John Briere

Recent studies suggest that perhaps one fifth of all adults were sexually abused by their mid-teens, and roughly equivalent numbers were physical maltreated to the point of, at minimum, bruises or bleeding (Briere, in press). Other types of victimization are everyday experiences for many children, including psychological abuse, emotional neglect, maltreatment by substance abusing parents, witnessing domestic violence, and the diffuse effects of cultural racism and sexism on child development.

A variety of long-term psychological and psychosocial problems appear to arise from childhood maltreatment. As outlined in various reviews (e.g., Briere, in press; Browne & Finkelhor, 1986), these include posttraumatic stress, cognitive distortions, anxiety, depression, somatic concerns, dissociation, eating disorders, sexual dysfunctions, and impaired self-relatedness. Also present may be behavioral difficulties, including relationship problems, various forms of aggression against others, substance abuse, suicidality, self-mutilation, and indiscriminate sexual behavior.

Given the known prevalence and effects of the various forms of child abuse and neglect, one might assume that mental health practitioners have a wide variety of resources to draw upon in their work with adult abuse survivors. Unfortunately, because child abuse and its effects have been acknowledged only recently, there is a great paucity of information regarding how to treat post-abuse trauma. In fact, prior to the last five years there were almost no book-length treatises available on abuse-focused psychotherapy.

With the recent advent of a small group of volumes (e.g., Briere, 1989; Courtois, 1988; Gill, 1988; Jehu, 1988; Maltz & Holman, 1987; Meiselman, 1990), however, it has become possible at least to identify those treatment approaches that may be most effective in the resolution of long-term abuse effects. The reader should recall, however, that the crucial work of therapeutic outcome research has, in most cases, yet to be done.

Social perspective

A major difference between traditional therapeutic approaches and modern abuse-focused treatment is the latter's consideration of social dynamics. As noted above, child abuse is so common that the clinician is inevitably confronted with the social contributions to child victimization. As a result, feminism, child advocacy, and similar social perspectives are common among abuse-focused therapists. Such philosophical bases tend to support interventions that engender survivor empowerment and self-determination, as opposed to passive involvement in therapy. Aspects of this perspective are present in many of the approaches presented below.

Trauma-related interventions

Trauma theory, adapted from work with victims of major stressors such as war or natural disasters, emphasizes the defensive and adaptive components of response to child abuse. Childhood victimization is seen as an event that would induce significant psychological disturbance in almost anyone, such that later "abnormal" behavior is reinterpreted as situationally appropriate coping responses, and/or normal reactivity to an overwhelmingly aversive event. Often, such postabuse reactions are conceptualized as involving "posttraumatic stress," or its later elaborations into dysfunctional personality traits.

> ***"The crucial work of therapeutic outcome research has in, most cases, yet to be done."***

Trauma theory posits that memories of victimization are often repressed, compartmentalized, or otherwise dissociated from thought in order to reduce painful abuse-related affect. Trauma-based interventions therefore tend to focus on two tasks: 1) the recovery of previously repressed memories of childhood maltreatment, and 2) the "working through" of feelings and thoughts associated with new abuse-related awareness. This approach is thought to permit integration of previously split-off cognitions, affects, and memories, resulting in decreased need for "symptoms" to control abuse-related distress.

In practice, survivors spend considerable time "revisiting" childhood trauma — struggling to recall and re-experience those aspects of their early life that they, in some sense, want least to confront. Fortunately, as this process continues posttraumatic memories gradually lose their distress-producing potential, and survivors are better able to gain perspective on the basis for their current difficulties.

Cognitive interventions

Victimization early in life appears to distort subsequent assumptions and perceptions of self, others, the environment, and the future. As a result, the survivor may experience guilt, low self-esteem, helplessness, hopelessness, and overestimation of the amount of danger present in the environment.

Cognitive therapeutic approaches typically involve working with the survivor to update her/his abuse-related assumptions. The survivor learns to recognize and alter cognitive distortions and erroneous beliefs through what is referred to as "cognitive restructuring." As noted by Jehu (1988), this procedure helps clients "a) to become aware of their beliefs; b) to recognize any distortions they contain; and c) to substitute more accurate alternative beliefs" (p. 57).

The survivor is encouraged to examine the objective and historic basis for his/her most painful abuse-related assumptions. For example, Jehu (1988) suggests intervention in beliefs like "I am worthless and bad," "I must have been seductive and provocative when I was young," and "I am inferior to other people because I did not have normal experiences" (p. 319). In each of these instances, a cognitive restructuring approach might lead to therapist responses such as "I wonder how/where you learned to see yourself like that?" "What about being abused makes you inferior?" and "Last week we talked about how scared and helpless you felt as a child — how does that fit with what you're saying now about being seductive?" Thus, the therapist offers gentle challenges to survivors' abuse-distorted view of themselves and others, so that survivors may begin to construct a world view less influenced by childhood oppression.

Modified psychodynamic interventions

Abuse-focused psychotherapists often draw on psychodynamic principles in their work with survivors, although not all such practitioners identify themselves as psychodynamic. While hopefully eschewing Oedipal interpretations, the clinician may find it useful to consider recent work in object relations and attachment theory when addressing the survivor's impaired self-reference. Similarly, psychodynamic concepts of transference, projection, and self-other differentiation may be of considerable assistance in helping the survivor to resolve problems in her/his relations with others. It is important, however, that such perspectives and techniques be examined carefully for the remnants of less enlightened Freudian contributions, such as anti-survivor biases, victim blaming, sexism, homophobia, etc.

Perhaps the most important contribution of psychodynamic theory is its focus on the therapeutic relationship, wherein the survivor can be expected to project his/her fears, needs, fantasies, and cognitive distortions onto the therapist. Because many of the survivor's most pressing issues relate to

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early childhood trauma, this projection will often take the form of abuse-related transference — the client will tend to perceive the therapist as if he or she were the survivor's original abuser, and respond accordingly. The therapist, in turn, is expected to provide caring, supportive, and clarifying interventions which, over time, allow the client to relearn important interpersonal lessons about trust, safety, boundaries, and individuation. Thus, psychodynamic processes can serve as powerful routes to early abuse-specific states, during which time important new learning and further psychological development may take place.

Group therapy

As important as individual psychotherapy may be in the intensive treatment of post-abuse trauma, there are certain therapeutic goals best met by group therapy. These include decreased isolation and stigmatization, the development of interpersonal trust, connection with a supportive group of individuals who have similar histories, and the opportunity to help as well as to be helped — a process that supports self-esteem and lessens the sense of being a mere recipient of treatment. Group therapy may be especially effective as an adjunct to (rather than a replacement for) individual psychotherapy in work with survivors of more severe childhood trauma. Group treatment alone, for example, may stimulate flashbacks, severe anxiety, new memories, and other intense or extended psychological phenomena that may not be optimally addressed in a group context. Individual therapy without group treatment, on the other hand, may run the risk of depriving the client of important experiences to be derived from interactions with other survivors. There are several books that specifically address the structure and process of group treatment with abuse survivors (e.g., Briere, 1989; Courtois, 1988), as well as a number of important articles detailing specific group treatment approaches (e.g., Courtois & Leehan, 1982; Herman & Schatzow, 1984).

Couple's therapy

Clinicians working with survivors have recently discovered the importance of addressing the survivor's relationship with her/his partner or spouse. Because survivors may have difficulties with trust, intimacy, and/or sexuality in relationships, the survivor-partner dyad (if there is one) may be a source of considerable stress for each member. Clinical interventions that focus on this relationship may assist the survivor by a) decreasing the tension and dysphoria brought about by relationship discord, b) increasing the likelihood that the relationship can become a significant source of support, and c) allowing the survivor to work through chronic interpersonal difficulties in a relatively safe context. The partner may also experience benefits, including support and education regarding the basis for his/her lover's sometimes disturbing behavior. The reader is referred to Follette (in press) and Maltz and Holman (1987) for specific information on the conduct of survivor-oriented couple's therapy.

Self-help programs

All of the interventions cited thus far share at least one characteristic: the involvement of trained mental health professionals. There are many survivors, however, who have derived significant growth and development through self-help groups or associations (e.g., the "twelve-step" programs). Such programs offer the survivor a strong support network of others with similar interests and needs, as well as a concrete system of interventions and rules for living that provide structure and guidance. In the past, child abuse survivors gravitated to such groups by virtue of their focus on issues especially relevant to post abuse trauma, such as alcoholism, drug abuse, or eating disorders. More recently, however, specialized groups such as Incest Survivors Anonymous have come into being, potentially offering the survivor more specific assistance for her abuse-related difficulties.

"Ultimately, by virtue of the prevalence of child abuse in the general population, further work in this area may yield new approaches to a number of the mental health problems currently confronting psychotherapists"

Some abuse-specialized clinicians are uncomfortable with such programs, citing, for example, the frequent focus on Christianity, forgiveness, institutionalized self-blame, explanatory concepts that stress addiction as the primary cause of most other difficulties, and the tendency to demand conformity to an inflexible set of expectations. While these concerns have merit, self-help programs offer benefits typically unavailable from mental health specialists: participation is free, support is potentially on a 24 hour basis, stigmatizing labels (i.e., psychiatric diagnoses) are conspicuously absent, and the focus on abstinence from self-destructive behaviors often provides needed external controls. For these reasons, it is often helpful to refer survivor clients to self-help programs when indicated, while simultaneously providing abuse-focused psychotherapy.

Self-help books

The last approach presented here represents a relatively new development in the abuse field: abuse-specific self-help books. These volumes are written directly to the survivor, and provide assistance in several areas: they normalize the survivor's self-perceptions by emphasizing the commonness of child abuse; they explain the various "symptoms" and difficulties experienced by survivors in a nonstigmatizing, legitimizing manner; they offer concrete advice regarding common abuse-related problems; and they convey hope by stressing growth and recovery. Although sometimes used independent of therapy, these books are frequently quite useful during the treatment process. Among the best books in this area are those of Bass and Davis (1988), Gil (1983), and Lew (1988).

Conclusions

As was noted at the outset, the field of child abuse trauma is in its relative infancy. Interventions in this area are, by definition, new and of untested utility. Nevertheless, the approaches outlined in this paper appear to have merit, especially when applied from a perspective that honors the courage, strength, and right to dignity inherent in survivorhood. Although each of these approaches "belongs" to a specific system of therapeutic thought, the complexity of long-term abuse effects requires the clinician to adapt a variety of different techniques to the specific needs of abuse survivors. Ultimately, by virtue of the prevalence of child abuse in the general population, further work in this area may yield new approaches to a number of the mental health problems currently confronting psychotherapists.

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CHILD VICTIMS

PROMISING TECHNIQUES AND PROGRAMS IN THE TREATMENT OF CHILD SEXUAL ABUSE

—by William N. Friedrich

More than ever before, sexually abused children are being seen in therapy by individuals who not only know that sexual abuse of children exists and is a very common contributor to the child's clinical presentation, but who have also attended workshops and/or read books on the therapy of these children and their families. This represents considerable progress over the past ten years.

Thus, on one hand, it is possible to state that we are better able to treat sexually abused children and their families. However, it is also possible to make a contradictory statement. Given that there is an almost total lack of empirical research documenting successful outcome of treatment in this area, it is possible to state that we still do not know how or if our treatment is helpful to these children.

While we may believe that clinical evidence supports our effectiveness, until we can demonstrate this empirically, we fail our clients because we can never be *sure* that what we are doing works. Without empirical proof of the success of our efforts, therapists will legitimately question their own utility, will not be able to learn from the efforts of others and, in this day and age of tightening psychotherapy finances, will find it increasingly difficult to secure funds for therapy for children who need it.

Treatment literature

A number of published studies have attempted to examine treatment outcome in this area, but most of these studies would probably not have been published in mainstream psychotherapy or psychological journals. The available studies lack such essential elements as random assignment to specific treatments and the use of standardized pre-, post-, and follow-up assessment measures. Sample sizes also tend to be very small. For example, although group therapy is seen as valuable treatment, only two published studies, one with six young girls (Nelki and Watters, 1989) and another with ten adolescent girls (Furniss, Bingley-Miller, and Van Elburg, 1988) have attempted to evaluate pre- and post-functioning, utilizing either an unstandardized symptom checklist or a semi-structured interview. No effort was made in either study to compare one form of treatment with another or to utilize more subjects and standardized outcome measures.

In addition, the available literature includes two behaviorally-based single-subject treatment designs. One reports on the treatment of a 15-year-old girl's functional blackouts presumed to be related to an incestuous experience (Dollinger, 1983). The second reports on the successful treatment via parent training of the negative emotional arousal and verbal ruminations in a 5-year-old sexual abuse victim (McNeill and Todd, 1986).

Although not an outcome study, another paper utilized a standardized behavior checklist with eight young children to document the variable course of improvement and deterioration in sexually abused children who had either received or not received treatment (Friedrich and Reams, 1987), with treated children showing greater resolution of behavior difficulties. A more recent paper reports on 19 girls, ages 3 to 16 years. Short-term cognitive-behavioral treatment was utilized and the authors found significant improvement from pre- to post-test on both internalizing and externalizing behavior problems (Deblinger, McLeer, and Henry, 1990). The authors of this study utilized a PTSD formulation in designing their cognitive-behavioral treatment.

> ***"Our field is overdue in the rigorous evaluation of our efficacy as therapists."***

A final study examines the effects of a wide variety of interventions on a group of 42 treatment resistant sexually abused preadolescent boys (Friedrich, Luecke, Beilke, and Place, under review). A large number of individual and family-based standardized measures were used to assess these children prior to therapy and at the end of therapy, and a smaller subset of children three months after the end of therapy. While this paper documents positive behavior change over time in two thirds of these boys, it is impossible to state whether or not therapy or the passage of time was the critical element in these boys' improvement, because no comparison group was utilized and no random assignment to treatment groups was done.

Our field is overdue in the rigorous evaluation of our efficacy as therapists. In a survey of 758 child sexual abuse treatment programs, Cicchinelli, Keller, and Gardner (1987) found that fewer than half of the programs responding indicated that they regularly use standardized or program-specific tools at any time to evaluate clients, and fewer than a third use measures to determine outcome. Two programs in our country that appear to be quite large, based upon their descriptions in the clinical literature, are programs developed by Henry Giaretto (Giaretto, 1982) and the Midwest Family Resource Center in Chicago (Trepper and Barrett, 1986). However, neither program has published peer-reviewed empirical outcome data that can be used to guide our treatment planning.

Large numbers of children and their families are being seen, and child-sensitive treatment programs can be developed that allow all children in need to receive timely treatment. We should no longer tolerate the absence of data on most effective treatment modalities. If you are involved in a treatment program that sees more than a handful of children a year, it is important for you to lobby your program to begin evaluating your treatment effectiveness.

Children could be randomly assigned into individual versus group therapy, enabling a determination of which therapeutic method is more effective. Another study could contrast children who are seen either individually or in group, versus children who are seen in the same modality, but in which a carefully planned parent training element was an additional component. This would enable a contrast between victim-focused and victim- and system- focused therapy.

A number of valid outcome measures exist, and these can be made part of the pretreatment assessment and the post-treatment termination interview. Additional follow-up 6 to 12 months later is recommended, whether by conducting telephone interviews or by paying the families to complete a similar set of measures to the ones that they completed at pre- and post.

Promising Approaches

In the absence of reliable outcome data, I describe approaches in this section based on my belief that treatment should be specific, should be sensitive to the child's needs, and should emphasize the interpersonal either via group or family-based interventions. In addition, since multiple systems are routinely involved in these children's lives, I believe that proactive treatment coordination is a necessary part of the treatment process.

Research on the impact of sexual abuse in children indicates that a significant percentage of sexually abused children do not exhibit overt distress. While internal, less noticeable distress does exist in some of these nonbehaviorally disordered children, sexually abused children frequently fall between nonreferred children and psychiatric outpatient children with regards to severity of behavior problems (Friedrich, Beilke, and Urquiza, 1987). Thus, lengthy treatment of

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a nonsymptomatic child may not be sensitive to the child's real needs.

Much child therapy is nondirective, often because therapists fear that more directive therapy will further victimize the child. But specific, directive therapy is likely to be more effective, although this clinically-based observation is subject to empirical validation. Because sexual abuse does not result in a homogeneous syndrome or constellation of behaviors, we may be able to make very productive use of techniques focused on a variety of specific effects. In the absence of clear indications that long-term intensive psychotherapy is required, it is important to develop minimal interventions for some children, such as preparing the child for court testimony (Kids in Court Program). Other interventions may target the child's parents, teaching them to monitor their child's behavior, and providing support and possible consultation around behavioral techniques. The child and family could return on an as-needed basis after the initial brief therapy, possibly at developmentally important times such as major life transitions and the onset of dating.

An extensive literature exists on specific behavioral treatments for such common abuse sequelae as sleep disturbance, toileting difficulties, depression, and aggressive behavior. In addition, treatment can focus on those child-based and family-based variables that exacerbate the abuse impact, such as pre-existing conduct disorder in the child, impaired peer relationships, marital distress, and depression in the parent. Sexual abuse concerns can be made a focus initially in the therapy, which may help create a more supportive and safe environment for the child's future development. Sexual behavior problems are abuse-specific sequelae that are baffling to many therapists. However, inappropriate sexual behavior can be managed behaviorally, as can intrusive thoughts that result in the child's increased distractability in the school setting. Several specific treatment suggestions for sexually aggressive children are available (Friedrich, 1990; Johnson and Berry, 1989).

Because a wide variety of specific approaches targeting a variety of specific behaviors is often required, outcome can be evaluated using Goal Attainment Scaling (Justice and Justice, 1979). Specific goals are targeted initially and progress towards them is determined at the end of therapy. This enables outcome assessment of a wide variety of children and their families, each receiving various treatment.

Many child victims are involved in group therapy, and my experience suggests that this can be a very effective technique for the majority of victims and their parents. Empirical research is needed to clarify which is most effective with which clients: short-term or long-term group therapy, and group therapy that is specific or less specific to the child's abuse experience. Agencies that see large numbers of children could research the above questions. The efficacy of 10-session versus 24-session therapy can be contrasted with a sample of children randomly assigned to either. As another manipulation, both the briefer and longer-term technique could have either less or more direct content focused on the sexual abuse experience, allowing an examination of four different approaches at once: brief-direct, brief-indirect, extended-direct, and extended-indirect. A study with 15 to 20 children in each group assessed on several variables obtained at pre-, post-, and follow-up would be both valid and highly publishable.

Other approaches that show promise but await empirical research include:

- Pair-therapy, in which two developmentally similar victims are seen together. This is useful for children who cannot tolerate the intensity of a larger group, or who would easily be scapegoated in a larger group (Selman and Schultz, 1990).
- Parallel group therapy, in which children and nonoffending parents are seen in different groups processing similar issues, may be successful in correcting both individual issues and parent-child relationships (Mandell and Damon, 1989).
- Using a child who has completed therapy as a "graduate assistant" to aid in the treatment of another child may have therapeutic benefits to both children (James, 1989).
- Relaxation training warrants further investigation as a means of alleviating the child's acute distress following sexual abuse.

Cognitive behavioral therapy with children is a proven approach for treating conduct disorder, attention deficit hyperactivity disorder, and depression. There is every reason to believe that a cognitive behavioral approach modified for use with sexually abused children would be effective in relieving the feelings of powerlessness and the negative attributions about their efficacy as individuals often reported by victims. A study comparing cognitive and noncognitive approaches could expand on the initial study conducted by Deblinger, et al. (1990).

"Because sexual abuse does not result in a homogeneous syndrome or constellation of behavior, we may be able to make very productive use of techniques focused on a variety of specific effects."

Most therapists agree that family therapy is necessary, but we don't know what components of family therapy are important. Is it the repair of the nonabusive parent-abused child relationship? Is it the removal of the father from the family? Is it the resolution of the abuse and victimization history of the nonabusing parent? Empirical evaluation of each of these important components of therapy will help us direct our interventions more effectively.

In short, victim-focused treatment benefits from the use of specific interventions that borrow from the available child treatment literature. Treatment is enhanced further by parent-training, group therapy including pair groups and parallel groups, and family-based therapy. The more specifically the treatment is targeted to the child and parents' strengths and needs, the more respectful it is and the more likely to be effective. For a partial listing of centers doing innovative clinical work with sexually abused children and their families, contact the author.

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PREVENTION

REPLICATING CHILD ABUSE PREVENTION PROGRAMS: A WORD OF CAUTION

—by Deborah Daro

The past twenty years have seen a rapid growth in the number of prevention programs nationwide and a corresponding increase in their assessment. The literature is replete with examples of programs which have successfully mitigated the risk for maltreatment. These program models include:

- home visiting services, particularly those offered prior to or at birth and continuing for a one- to two-year period (Lutzker, 1984, 1987; Gray, Cutler, Dean & Kempe, 1979; Olds, Chamberlin & Tatlebaum, 1986);
- group-based educational and support programs targeting parents with children of various ages (Bavolek & Dillinger-Bavolek, 1985, 1988; Ellwood, 1988; Levin, 1988; Miller, 1988; Rodriguez & Cortez, 1988);
- self-help groups such as Parents Anonymous (Cohn, 1979; Fritz, 1986; Juneqicz, 1983; Moore, 1983);
- family resource centers which serve as clearinghouses for various educational and support services utilized by at-risk families (Kagan, Powell, Weissbourd & Zigler, 1987);
- crisis intervention services and respite care nurseries (Cherry & Kirby, 1971; Green, 1976; Kempe & Helfer, 1976; Vaughan & Loadman, 1987);
- child assault prevention programs (Fryer, Kraizer and Miyoski, 1987; Harvey, Forehand, Brown & Holmes, 1988; Hazzard, 1990; Kolko, Moser & Hughes, 1989; and Wurtele, Saslawsky, Miller, Marrs & Britcher, 1986).

While it is tempting for those interested in expanding local prevention efforts simply to select one or more of these models for replication, such action is unwise. Effectively using available research to enhance child abuse prevention efforts requires more than replicating a promising intervention. The process involves careful attention to the context in which the program will be placed, the proposed target population it will serve, and the broader social service environment in which it will operate. While planning is always necessary when establishing a service delivery system, it is particularly important for child abuse prevention programs for a number of reasons.

First, it is often unclear how a given family, culture or community will respond to different interpersonal and environmental causes of maltreatment. While some causal factors have universal effects, most influence parenting patterns in diverse ways. Planners of prevention services need to consider the full range of causal factors and their potential effects.

Second, prevention efforts need to be particularly sensitive to cultural and community differences in parenting style, family structure, family privacy and parent-child relationships. Because intervention occurs prior to any notable misconduct on the part of parents, prevention programs must be non-judgmental, offering assistance rather than reform or "cure". Tailoring efforts to the normative standards of care found within a specific community or target population is critical to making interventions comprehensible and effective within the target community.

Finally, effectively preventing child abuse requires a combination or continuum of services. While a single service may effectively address a particular causal factor or parenting need, it cannot adequately protect the family from the wide range of stress factors it will ultimately encounter. To a large extent, prevention programs rely on the overall community response system to sustain their gains over time. Therefore, the eventual success of an individual program is largely dependent upon the resources and effectiveness of other local efforts.

Program evaluations that document changes in specific outcome measures provide only one important standard for determining whether a given program is a promising candidate for replication. Far more important is understanding whether the successful program's organizational auspice, client characteristics, and community service system mirror the conditions in the community seeking a new prevention program. Rather than offering clear models for replication, research on child abuse prevention programs provides service planners with numerous building blocks for constructing the most relevant prevention system for their particular situation.

Promising Service Features

On balance, two major prevention avenues have generated the most interest in terms of the number of providers and researchers they have attracted (Daro, 1989). The first group, the parenting enhancement models, includes a wide range of programs designed to expand and strengthen the capacity of parents to better care for their children. The second group, the child empowerment service models, is a more homogeneous cluster of strategies that target the potential victims of abuse, enabling them to resist threats of maltreatment, particularly sexual assault. While no prevention program is universally successful, several components of these service models have been identified as increasing the probability of success with diverse populations.

The most promising feature of parenting enhancement services include:

- initiating services prior to or as close to the birth of the first child as possible.
- tying the service to the child's developmental level, recognizing the unique challenges involved in caring for and disciplining children of various ages.
- providing opportunities for parents to model the interactions or discipline methods being promoted through the intervention.
- maintaining the intervention for at least six months.
- complementing educational and therapeutic efforts with self-help groups, such as Parents Anonymous.
- balancing home-based and group-based interventions in order to address those isolated and uncomfortable in group settings as well as those who appreciate opportunities to share problems with other parents.
- teaching parents how to make use of existing social supports and community services.

Research on child assault prevention programs reveals that most programs which work:

- provide children an opportunity to rehearse prevention strategies and receive feedback on their performance.
- are developmentally tailored to a child's cognitive characteristics and learning ability.
- present material for younger children in a stimulating and varied manner in order to maintain their attention and to reinforce the information learned.
- teach children generic concepts such as assertive behavior, decision-making skills, and communication skills which can be used in everyday situations.
- develop longer programs which are better integrated into regular school curricula and practices.
- create more formal and extensive parent and teacher training components.
- offer booster sessions to reinforce the concepts presented.
- include extended after-school programs and in-depth discussion opportunities for certain high risk groups (e.g., former victims, teen parents).
- involve all significant adults (e.g. teachers, parents, extended family, community leaders) in learning about sexual abuse and how to respond to reports.

Conclusions

Selecting a prevention program for replication is more than simply identifying the program with the most promising outcomes. Program structure, staffing and content must always be arrayed against the characteristics of the client population being assisted and the community in which the services are delivered. In reviewing model programs for possible replication, the following questions should be asked:

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DARO (continued from page 7)

- Does the program address the risk factors you want to address (i.e., parenting knowledge, parenting skills, education for children, etc.)?
- Can the intensity and duration of the intervention be sustained with the resources you have available?
- Does your staff need additional training or skill building in order to provide adequate service?
- Has the program been successful with the types of families or individuals you anticipate serving with your intervention (i.e., with people of the same race, culture or family structure)?
- Is the program's success dependent upon the availability of other services in the community?

Successful prevention efforts require careful planning both prior to and after their implementation. While program evaluation findings can provide a useful framework for structuring this planning activity, they cannot replace it. Preventing child abuse remains largely a community-specific activity which requires continuous attention to shifting population, agency and community service characteristics.

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PRACTICE

STRATEGIES FOR CHANGING PARENTAL BEHAVIOR

—by Patricia M. Crittenden

Teaching parents new skills is a difficult task. Program evaluation, which identifies programs that work, rarely indicates which aspects of those programs were most effective. This article will focus on five commonly-used strategies for helping mothers change aspects of their parenting behavior. The strategies evaluated were (1) positive reinforcement, (2) demonstration/modeling, (3) self-rating, (4) role-playing, and (5) instructional booklets. Surprisingly, some of these were not only ineffective but actually counterproductive.

The setting for testing the effectiveness of these instructional strategies was a parent group. Over a period of three years, 107 mothers, most of whom abused and/or neglected their children, participated in the parent group. Data on their behavior with their children were used to evaluate the effectiveness of each strategy. Before each parent group meeting, each mother was videotaped briefly playing with her child. During the subsequent meeting, she viewed her tape along with those of the other mothers; the group leader used the viewing to carry out a teaching strategy.

The tapes were later coded for maternal and child behavior by research assistants who were blind to the identity and maltreatment status of the mothers, the date and order of the tapes, the intervention used, and the hypotheses tested. The code focused on discrete behaviors, coded sequentially, such as smile, speak, demand, correct, comply, etc.

Positive reinforcement

The first strategy used and tested was direct and modeled positive reinforcement. For thirteen weeks, the mothers were reinforced for behavior which was sensitively responsive to their child's signals. Insensitive behavior was ignored. Mothers not only received reinforcement for their own behavior, they also observed other mothers being reinforced for similar behavior.

At the end of three months, the tapes were coded and early tapes compared with later tapes. There was absolutely no evidence of change in any maternal behavior across the three-month period of intervention. It was concluded that sensitive responsiveness was too complex and variable a behavior to be identified by the mothers as the focus of reinforcement.

Demonstration/modeling

More powerful procedures were clearly needed. A series of tests of intervention strategies was begun. On several occasions, the group leader, taking a more instructional role, demonstrated a positive, skill-building activity with a child and, using a videotape of her performance, discussed the interaction with the mothers.

Comparisons of the mothers' videotaped behavior with their children before the demonstration with similar behavior one week after the demonstration revealed that the mothers had become more demanding, intrusive, and punitive and less gentle and pleasant. Apparently, the mothers tried to duplicate the demonstrator's skilled performance without recognizing that the demonstrator's skill depended upon sensitive reading of, and response to, the child's signals.

Self-rating

Another strategy was tried and tested. Before viewing their tapes, mothers were given a set of two or three questions, such as: Did you face your baby? Did you smile at him/her? Did you talk to him/her? The mothers were asked to answer these questions privately as they viewed their own tape. Discussion was kept briefer than usual in order to facilitate observation. The mothers were reminded several times to rate their own tapes. After just one week, before-and-after comparison showed that the follow-up tapes were much improved with respect to the behaviors on the self-rating sheet. In addition, sometimes related behaviors improved simultaneously: for example, mothers who faced their babies also talked and smiled more (Crittenden and Snell, 1983).

Role-playing

In other attempts to change mother's parenting behavior, the group leader and one parent role modeled an activity. First, the group leader pretended to be a mother. The group member pretended to be her child. After they had enacted a sequence (e.g., playing ball, bringing a toy to mommy), the leader asked the "child" how what the "mommy" had done had made the "child" feel. Then the former "child" became the "mommy" and a new "child" was selected from the group. As "children," the mothers reveled in being obstreperous; with discussion, they easily recognized what in the "mother's" behavior had irritated them and given them license to be difficult.

Again after just one week, pre-post test of mothers' videotaped behavior with their children showed consistent increases in positive behavior and reductions in undesirable behavior. Moreover, their children were more cooperative in the tapes taken after the role playing.

Instructional booklets

Finally, the effectiveness of instructional booklets about parent-child relationships was assessed in two ways. One was the videotaping procedure. The tapes made one and two weeks after the distribution of the booklets were compared to those made before the distribution. There were no differences in maternal and child behavior. This was true even though the booklets were written in simple language, illustrated, and discussed in the group meeting.

On the other hand, more informal analysis of the use of the booklet alone suggested some detrimental effects. Several protective service workers noted that some abusive mothers were citing the information in the booklet (which was given by the hospital to all new mothers) as evidence that their behavior was correct. For example, one mother and her husband engaged in a dispute over the mother's overfeeding of the baby. The mother asserted, "You should *always* feed a baby when he cries. The booklet says so!" A number of such instances highlighted the rigid mothers' search for prescriptives regarding the "right" way to rear children and their propensity for applying advice which is generally correct to the wrong specific situation. The problem was not the advice but rather the mothers' lack of judgment regarding its use. This suggested a danger in offering educational services to abusive mothers who lack judgement regarding its application. Therapeutic services or services focused on helping mothers interpret child behavior and evaluate conflictual situations may be more appropriate. Neglectful mothers did not misapply instructional information, as abusive mothers did; rather, they seemed unable to benefit from it at all.

Conclusions

What do these findings say about how to change maternal behavior? First, approaches in which parents are passive recipients of the technique (e.g., positive reinforcement, demonstration/modeling, and instructional materials) were both ineffective and sometimes counterproductive. These techniques are, however, generally the least difficult for professionals to implement, the least expensive to deliver, and the most easily used with large groups.

Second, effective strategies involved direct work with each parent and the opportunity for each to exercise judgment and receive feedback on that judgment in a non-threatening context. The evidence suggested that even the models and examples provided should be only a little better than the mothers' own behavior. Expert models were too complex and intimidating for the mothers; in trying to match such models, the mothers became coercive with their children and insensitive to their cues. Using other, slightly more competent mothers as models, was more effective.

These findings emphasize the importance of small groups with individualized intervention to abusing and neglectful mothers and suggest the inappropriateness of offering maltreating simple parent education and large group interventions.

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OFFENDERS

EVALUATING SEX OFFENDER TREATMENT PROGRAMS

—by Robert Prentky

Broadly speaking, sex offender treatment programs employ three approaches: (a) insight-oriented and/or evocative therapy, which focuses on understanding the causes and motivations leading to maladaptive behavior, increasing offender empathy for the victims of sexual assault, and increasing offenders' sense of responsibility for their sexual crimes; (b) behavioral therapy, which focuses on techniques that attempt to remedy deficits in social and interpersonal skills, alter cognitions that serve to justify and perpetuate sexually aggressive behavior, and modify deviant patterns of sexual arousal or preference, and (c) pharmacological treatment, which focuses on reducing sexual arousability and the frequency of deviant sexual fantasies through the use of anti-androgens and, recently, anti-depressants.

These approaches are not mutually exclusive. The trend in recent years has been for treatment programs to employ all three approaches to varying degrees. Due to space considerations, however, this article will focus on behavioral techniques, including the cognitive-behavioral technique generally known as relapse prevention (RP). These are the most widely-used techniques and, as a result, the most carefully studied. It should be said at the outset, however, that not enough data exist to make clearcut evaluations of treatment efforts.

Behavior Therapy

Behavioral techniques for modifying sexual arousal may be grouped into two categories: techniques aimed at decreasing deviant arousal (e.g., covert sensitization, aversion, masturbatory satiation, biofeedback, shame therapy) and techniques aimed at increasing appropriate arousal (e.g., systematic desensitization, fantasy modification and orgasmic reconditioning, "fading" techniques, exposure to explicit appropriate sexual material). Most behavioral research on methods for eliminating inappropriate sexual behavior has focused on covert sensitization and/or aversion therapy. Fay Honey Knopp and her colleagues (Knopp et al., 1986) reported that 190 of the 297 (or 64%) of the identified service providers for adult sexual offenders employed behavioral methods, and 95 of those service providers (50%) used aversion therapy as part of the behavioral program.

Both covert sensitization and aversion therapy follow a standard classical conditioning paradigm in which a noxious stimulus is paired with auditory or visual stimuli of deviant sexual content. In aversion therapy, the deviant stimuli typically are paired with noxious odors or sine wave shock. In covert sensitization, the deviant stimuli typically are paired with negative mental images (e.g., a physically unpleasant experience such as vomiting or having a cavity filled or a psychologically unpleasant experience such as being apprehended by the police and going to prison). Although over 20 different behavioral techniques have been reported in the literature, the most widely used methods have involved some variant of aversion. The relative efficacy of the different aversive techniques with different types of offenders remains an empirical quesion. Moreover, the extent to which response inhibition after repeated exposure to aversive experiences generalizes to different (albeit related) deviant stimuli and to different situations remains to be demonstrated.

Relapse Prevention

Cognitive behavioral techniques such as relapse prevention are employed in many treatment programs. In such efforts, sexually aggressive behavior is conceptualized as an addiction with most of the properties of other addictions, namely a compulsion or urge to engage in inappropriate behavior that is sparked by an antecedent (signal) event. Although the precise nature of the event is unique to each individual, the most common class of such events anteceding relapse among sex offenders is thought to be a negative emotional state. Bill Pithers and his colleagues in the Vermont Treatment Program for Sexual Offenders have reported (Pithers et al., 1988) that for rapists the most frequently described emotional experience just prior to the offense was generalized, global anger (88% of sample) and anger towards women (77% of sample). For child molesters, on the other hand, the most frequently identified experience just prior to the offense was not an emotional state but planning the offense (73% of sample) and low victim empathy (71% of sample).

The relapse prevention model targets three areas of assessment: 1) those situations that place an individual at risk for relapse, 2) the adequacy of the individual's skills for coping with high risk situations, and 3) the identification of those antecedent events that permit hypotheses about why the maladaptive coping response is to aggress sexually. Once this information is elicited, two interventions are employed: 1) strategies that help the individual avoid high risk situations, and 2) strategies that minimize the likelihood that high risk situations, once encountered, will lead to relapse. In the jargon of sex offender treatment, high risk situations are referred to as "warning signals," "red flags," or "lapses." This "internal self-management" system has been extended by Dr. Pithers to include an "external supervisory dimension." Because offenders can be unreliable informants with regard to "lapses," this new dimension is intended to provide an additional source of information from "collateral contacts" in the community.

Treatment Programs in Two States

One of the preeminent residential treatment and evaluation programs in the U.S. at this time is in California under the baton of Janice Marques (Marques, 1988). The program, initiated in 1985 by the California Department of Mental Health, was designed as a six-year project, with a recently extended sunset date of June 30, 1995. The program, which is geared toward men who are 1.5 to 2.5 years away from discharge from the residential facility, includes three groups: 1) an experimental group consisting of those men who volunteered and who were randomly selected for the project, 2) a matched control group of men who volunteered but were not randomly selected for treatment, and 3) a matched control group of men who did not volunteer for treatment. The centerpiece of the program is relapse prevention. In addition, it includes an aftercare component in which, as a condition of parole, offenders must attend two treatment sessions a week for the first year. Although it is too soon to draw any reliable conclusions, the last report to the California State Legislature (July 1, 1989) revealed a "treatment effect" of 11.4% (i.e., a reduction in recidivism of 11.4%). This is based upon a heterogeneous sample of 47 treated offenders and 49 control subjects. For both groups, the average amount of time "at risk" was only about one year. Clearly, the small size of the discharge samples and the short at-risk period preclude any verdicts at this time. The next report to the State Legislature will be available in the late summer of 1991 and should include data on 80+ treated offenders. Thus far, preliminary results are encouraging.

It may be instructive to compare Dr. Marques' program with another, equally well-known and highly regarded, program directed by Dr. Pithers in Vermont. The Vermont program is a combination of community-based outpatient and residential inpatient therapy groups. Dr. Pithers reported a 4% relapse rate from a five-year follow-up of 167 treated offenders (Pithers et al., 1988).

These two programs provide an excellent example of the problems encountered when trying to make cross-study comparisons. Both treatment programs employ relapse prevention as their model. But the similarity stops at that point. Although neither project incorporates taxonomic differentiation, we may reasonably infer that the Vermont sample is less "hard core" than the California sample, since the California sample is incarcerated. Dr. Marques randomly assigns subjects while Dr. Pithers screens subjects. Although the core of the relapse prevention model is fundamentally the same in both programs, the full treatment regimen and the manner and duration of its implementation are not the same. The assessment instruments are different, as are the procedures for follow-up and the definition of relapse (i.e., arrest in California and incarceration in Vermont). Taken independently, both programs are well-known, highly-respected, and generally considered "models." Yet no accurate outcome comparisons can be drawn between them.

Outcome Evaluation

Variations in recidivism rates associated with different treatment programs are extremely difficult, if not impossible, to interpret. Recidivism rates across studies are confounded by numerous factors, including the criterion for reoffense, duration of follow-up, the domain of criminal behavior surveyed, the sources used to document reoffense, offender characteristics, differential attrition rates, differences in program integrity and amount of treatment, amount and quality of post-treatment supervision, and a host of other variables. In addition, recidivism measures tend to be hard to assess, and result in comparisons of low statistical power. Even without attempting to attribute variations in recidivism to treatment program characteristics, the variation in recidivism rates in the published literature

Continued on next page

PRENTKY (continued from page 10)
are truly remarkable.

Although there have been no comparisons of different treatment approaches within the same study using random assignment of offenders to treatment conditions, there have been some treatment/no treatment comparisons using matched designs or convenience samples. Two recent studies will be described and discussed.

Using a sample of 126 treated and untreated child molesters, Marshall and Barbaree (Marshall and Barbaree, 1988) obtained large differences in recidivism rates (as estimated by official police records and unofficial records of police and child protective agencies) between clients given cognitive-behavioral treatment in a community clinic and similar but not randomly assigned clients given no treatment. Among extrafamilial heterosexual child molesters, recidivism rates over approximately four years were 43% for untreated and 18% for treated molesters. Among extrafamilial homosexual child molesters, recidivism rates were 43% for untreated and 13% for treated molesters. For heterosexual incest offenders, recidivism rates were 22% for untreated and 8% for treated offenders.

Rice, Quinsey and Harris (Rice, Quinsey, and Harris, 1989) estimated the recidivism rates of 136 extrafamilial child molesters over an average 6.3 year follow-up period. These men were incarcerated in a maximum security psychiatric institution between 1972 and 1983. Fifty of these offenders had participated in a behavioral program designed to alter inappropriate sexual age preferences. Following release from the institution, 31% of the total sample were convicted of a new sexual offense, 43% were known to have committed a violent or sexual offense, and 58% were arrested for any offense or returned to the maximum security institution. On the basis of a number of comparisons, the authors concluded that behavioral treatment did not affect recidivism.

The differences between the outcomes of the quasi-experimental treatment evaluations reported by Drs. Marshall and Barbaree and Drs. Rice, Quinsey, and Harris illustrates the difficulties in arriving at definitive conclusions concerning treatment efficacy. Among the more important of the myriad of differences between the studies are the locus of the program (maximum security psychiatric facility versus the community), severity of the offense history of those treated in the program, and differences in the nature and amount of treatment received. Any or all of these (or other) confounded variables could be responsible for the markedly different results. Perhaps the strongest conclusion that one can draw from this literature is that treatment can reduce recidivism, but that the aspects of treatment, client population, supervision, and setting characteristics related to successful outcome remain, at present, an empirical question.

Overview

Despite the weakness of the outcome literature, scientific progress, however limited, has been made, and more certain conclusions from future investigations are likely. This conclusion rests upon a number of considerations. *First*, there has been a burgeoning of interest in the issue of sexual assault. Talented therapists and researchers have been attracted to the field, and more offenders are currently receiving some form of treatment than before. Even allowing for the faddishness of clinical and scientific interest in this area, the sheer number of professionals now working in the field assures no future dearth of programs to evaluate.

Second, the apparent failure of more traditional correctional remedies, such as deterrence and incapacitation, to reduce reported frequencies of sexual assault or recidivism rates means that other interventions must be actively considered. In addition, and perhaps more importantly, even relatively small reductions in recidivism rates occasioned by treatment result in significant savings, given the great expense of legal and correctional intervention, and the incalculable human costs of recidivism.

Third, advances have been made in assessment that are directly relevant to the future development of treatment programs. Noteworthy progress has been made in the development and validation of classification systems, offering the promise of differential treatment programming and reduction in the heterogeneity of treated samples. Similarly, progress has been made in the development and validation of risk assessment instruments and self-report inventories designed for sex offenders. In addition, the discriminant validity and the limitations of the phallometric assessment of sexual age preferences have now been solidly and replicably established.

Fourth, it is now well established that pre-post treatment effects can be obtained on phallometric measures of sexual preference, sexual knowledge, and heterosocial skills training. Treatment-induced changes in beliefs and values have not received as much study. These sorts of demonstrations that treatment can achieve at least proximal goals are encouraging.

Fifth, treatment manuals now beginning to emerge are of sufficient specificity to permit standardization of procedures and thus cross-site replication and monitoring of treatment. These manuals are a prerequisite for the advancement of knowledge in the treatment of sex offenders.

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NETWORKING

CHILDREN'S ADVOCACY CENTERS

—by Judy Lind

In 1985 a frustrated district attorney in Huntsville, Alabama revolutionized the field of child sexual abuse by creating an entire new approach to the problem—the Children's Advocacy Center. Little could Bud Cramer (now a U.S. Congressman) have known that his pioneering effort would lead to the existence of over 50 CACs today.

It is painful to remember how disorganized the system response can be to allegations of child abuse. There is little need to rehash the problems in great detail: lack of communication and outright competition and animosity between agencies and disciplines; practices based on little research or knowledge; inadequate or no training for professionals; lack of coordination and cooperation among investigating agencies, which revictimized children through multiple interviews by unskilled interviewers; lack of appropriate therapy resources—the list seems endless.

These were the problems Bud Cramer and a growing number of professionals around the country sought to address through creation of Children's Advocacy Centers. What is a CAC? How should a CAC be structured? These are the questions this article addresses, with some examples taken from the CACs that have been developed in Hawaii.

A CAC is, first and foremost, a supportive environment for child victims and their protective family members that provides a bridge to new persons and services as they move through the child protective system. CACs generally have the following program components: (1) a designated neutral facility, (2) a case review process, (3) joint investigations between law enforcement and protective services, (4) a case tracking system, (5) medical examination and evaluation, (6) mental health treatment, (7) victim advocate support services, (8) training, and (9) community education.

CACs provide the first four components at their facility; the rest are available on site or through community resources. There is no right or wrong way to organize a CAC. They come in a variety of shapes and sizes geared to the pecularities of their communities, sponsorship, and resources. Some handle only sex abuse; others handle all child abuse. Some are publicly funded and are placed in agencies such as district attorney's office, while others are independent non-profit organizations. The wide variety of CACs attests to the many creative ways communities have built on their own strengths and resources.

Many of the CACs that developed around the country resulted from Bud Cramer's direct involvement and from the help of the staff at the National Children's Advocacy Center in Huntsville. For example, following Bud's visit to Hawaii in 1986, our Legislature passed HRS 588 creating and funding the first CAC in Hawaii. Since that time the program has expanded to include five CACs statewide under a single director.

We feel very fortunate, because the fact that our CACs are required by statute and are part of the judiciary seems to have eliminated some of the problems faced by CACs in other states. Perhaps most important, it has all but eliminated the problem of agency unwillingness to participate. Even here, however, the degree of participation and cooperation depends upon the good will and commitment of the participants. One reality that is too often ignored is that although CACs are very good for children, they are not always so good for staff. Like every CAC, we had to work through resistance to the team approach with all the problems inherent in it. We ask people to leave their customary place of interviewing and use a new facility—not very convenient when the client doesn't show up. We ask them to submit their agency's decision-making to a tracking system and a case review process, which requires a careful and lengthy process of trust building. We also ask them to adopt a multidisciplinary approach, and that has its ups and downs as well.

We found that in this model the stronger agencies inherited the problems of the weakest agencies. For example, when we wanted to create a unit of detectives who specialize in child abuse cases, it seemed that insufficient manpower might scuttle the idea. But we persuaded the Chief of Police to support the plan, and he was instrumental in persuading the city administration to fund the three necessary additional positions. A similar process occurred in our Department of Human Services: once we were able to convince the department's administrators and supervisors of the need for specialized child abuse units, they took the necessary action to make their weak link a strong one. Interestingly, these specialized units have been among the most stable in their respective agencies, indicating that the professional support provided by participation in the CAC may help reduce retention problems.

This process of the stronger helping the weaker has helped everyone. It has led to increased funding for our private treatment agencies and local rape crisis center, and has improved agencies' access to each other. We now have shared responsibility for each other's problems, which has greatly increased the level of cooperation and support. Now, we can attack problems we share in common. For example, we have developed a protocol for handling sex abuse allegations in contested custody cases which has finally brought order to the usual chaos of those cases. Promulgated by our Senior Family Court Judge, the protocol is binding on all parties. Similarly, representatives of our 15 agencies together drafted a bill for alternative sentencing for intrafamilial sex abuse cases which remedies many of the problems inherent in the different approaches and goals of the civil and criminal courts. Likely to pass this year, this effort has already created a specialized sex offender probation unit with publicly funded evaluation and treatment.

How can CACs make participation and cooperation worthwhile for their member agencies? We do it by giving support and resources they can't provide themselves. For example, we have brought national experts to Hawaii to help with our initial training effort. Realizing that reliance on "mainland experts" does not provide continuity, we have developed a locally-based training program, complete with manual and conducted by Dr. Barbara Rutter and Beverly James, which can be repeated as new staff require it.

Nationally, CACs have chosen to expand on the basic concept in various ways. Hawaii's has been to involve the business and volunteer community to the greatest extent possible and to bring them aboard as child advocates. We solicited the support of two powerhouse organizations, the Rotary Club and the Junior League, and have thereby created a private/public partnership made in heaven. The Rotary Clubs created a "Friends of the CAC" organization for each of our five centers. They exist to do for clients and agency staff what they cannot do for themselves. For example, the Friends raise money, pay for training, provide the CACs with funds for all the extras and, in fact, renovated and furnished each of them. Their lobbying efforts in the state legislature have really paid off as well, resulting in increased funding for treatment programs, more personnel for agencies, and needed changes in the law. Having the Rotarians take on our lobbying efforts has been a tremendous help for overworked professionals in the system, and a nice change for our politicians, who are used to dealing with the usual agency representatives. To provide further help, the Rotary Friends contracted with the Junior League for trained League volunteers to work at the CACs. These volunteers are invaluable. They respond to requests from professionals in the community who need an array of services to help children and families. Within limits, the Friends can provide emergency funds for clothing, housing, food, child care, and transportation. They also have funds for scholarships, treatment, tutoring, and programs that build self-esteem such as sports, modeling, music and dance lessons: all the things kids lose, or never had, and which they so badly need to be whole again. The motto of our "Friends" group is, "Help a Victim Become a Child Again." The volunteer efforts of these two groups have tremendously expanded the impact of the centers.

Developing a CAC is never easy. Change is difficult, both for individuals and systems. But we would never go back to the days of poor communication and coordination in which the system designed to help kids often wound up hurting them. There will be stumbling blocks including turf issues, inadequate funding, and resistance to change. But the payoff at the end is well worth the effort. Children and families are better off, and we are now part of a system we can be proud of. It's not perfect, but it's a lot better than it used to be.

NOTE: For more information about CACs, contact the National Children's Advocacy Center, 106 Lincoln St., Huntsville AL 35801. 205-533-5437.

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LAW

VERTICAL PROSECUTION OF CHILD ABUSE

—by John E.B. Myers

Imagine yourself with a serious medical condition requiring hospitalization and surgery. Your prognosis is guarded, and your future is in the doctor's hands. But you never see the same doctor twice! At each stage of your care a new doctor appears—a medical stranger whose knowledge of your case is gleaned from a brief review of your medical chart, and who has little sensitivity to your fears and concerns. The medical care you receive may be competent, although one wonders. There is little doubt that your psychological needs are not being met. Now, contrast this splintered health care with the daily attendance of one physician who knows your case by heart, and whose constancy and support lifts your spirits and those of your family. Which would you prefer?

Change the scene. Two young sexually abused children are about to enter the bewildering world of interviews, social workers, police officers, attorneys, judges, and courtrooms. Six-year-old Mary lives in one county, six-year-old Sally in another. Sally meets prosecutor Becky Row at the initial investigative interview, shortly after the abuse is reported. Becky introduces herself to Sally and they get acquainted. Becky tells Sally a little about the legal system. Armed with the police report and her first-hand knowledge of the child, Becky decides to file criminal charges against Sally's perpetrator. After charges are filed, Sally's first appearance in court is the preliminary hearing, where she must testify in front of the person accused of abuse, and endure cross-examination. A few days prior to the preliminary hearing, Sally has a "practice visit" to the courthouse. Becky is there to greet her and conduct the tour. Sally's fear of the unknown is lowered. Becky and Sally share a soda and discuss the upcoming preliminary hearing. As Sally struggles to testify, Becky is there to lend reassurance. As the day for trial approaches, Sally is increasingly apprehensive, but Becky—"the nice prosecutor lady"—is there, as always, to help her through. And when the big day arrives, Sally finds Becky on the courthouse steps to hold her hand on the long walk to the courtroom.

In the neighboring county, Mary does not meet a prosecutor at the initial investigative interview. The first prosecutor to become involved in the case is the one who decides whether to file criminal charges. This prosecutor does not meet Mary. Ten minutes before the preliminary hearing, a second prosecutor steps into the reception area where Mary is fidgeting nervously on her mother's lap. The prosecutor looks around the crowded room and, seeing only one child, asks, "Mary?" On the way to the courtoom, the prosecutor describes what is about to happen. As the trial approaches, a third prosecutor meets Mary a few days prior to trial for a "practice visit." This prosecutor does her best to help Mary through the trial, but it is difficult for Mary to gain much comfort from this "nice new lady." Which county would you prefer to live in if you were a sexually abused child or the parent of such a child?

The benefit of consistency is just as great in the legal context as in the medical setting. Fortunately, increasing numbers of prosecutors are providing consistency for children by practicing "vertical prosecution" (VP). With VP, "one prosecutor is assigned to handle a case at all stages of the proceedings" (Bulkley, p. 11, 1982). According to Patricia Toth, Director of the National Center for the Prosecution of Child Abuse, VP is one of the best things a prosecutor can do to increase the chances of success in child sexual abuse cases. The child is usually the most important—and uncertain—witness. With VP, the prosecutor gets to know the child early in the process, and can assess the child's strengths and weaknesses as a potential witness. At trial, the prosecutor who knows a child's developmental and linguistic levels is in a good position to ask questions the child understands. The child is more likely to perform well on the witness stand. Whatever the outcome of the litigation, the child and her family are likely to feel that they were treated fairly and with respect.

Is there a down side to VP? From a purely economic perspective, VP may be less cost effective than assigning each stage of a case to a different prosecutor. VP is more time-consuming, therefore caseloads have to be lower and prosecutors more numerous. But even by those who have to toe the bottom line, lower caseloads should be viewed as a plus rather than a minus. Child sexual abuse is exceedingly complex. More time is required to prepare these cases than for many other crimes handled by the prosecutor's office. In addition, sex offense cases place great emotional demands on prosecutors. According to Judge Harry Elias, burnout is common with prosecutors working in this area. Lower caseloads forestall the onset of burnout, lowering the costs involved in hiring and retraining an ever-changing prosecutorial staff.

Judge Elias (himself a former prosecutor) also notes that prosecutors who specialize in child sexual abuse cases enjoy greater credibility with defense attorneys. When the defendant's attorney knows the prosecutor is an expert, the defense attorney is more likely to persuade the client that the best course of action is to plead guilty. Of course, when the defendant pleads guilty, the child is spared the ordeal of testifying at trial.

As is true with most aspects of responding to child sexual abuse, there is no one "correct" way to structure vertical prosecution, and every prosecutor's office is a little different. The key is assigning one prosecutor as early as possible. The consistency of "the nice prosecutor lady" helps children through the often difficult processes of the law.

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BOOK REVIEWS

—edited by Mark Chaffin

UNDERSTANDING CHILD SEXUAL MALTREATMENT

(by Kathleen Coulborn Faller, 1990. Newbury Park, CA: Sage Publications. 251 pages. Hardback, $36.00. Paperback, $17.95.)

Review #1

—by Thomas F. Curran

In the preface to *Understanding Child Sexual Maltreatment,* Kathleen Coulborn Faller notes the purpose of the book is "to serve as a resource for mental health professionals who must address the problem of child sexual abuse." Drawing upon her years of experience as a clinician and leading researcher in the field of child abuse, Faller clearly accomplishes and exceeds this stated purpose. This is not a book that will benefit only mental health professionals: it is a comprehensive and practical text suitable for use by child abuse professionals from all disciplines. Few child sexual abuse texts can match the expansive scope or the clear and balanced analysis of the material presented in this book. In addition, by including many actual case examples which demonstrate various issues or situations germane to the specific content in each chapter, Faller provides the reader with useful real world perspectives.

The book is organized into four sections. The first consists of two chapters aimed at introducing the reader to the problem of child sexual abuse. Chapter One describes what Faller terms a "victim-centered approach" to sexual abuse intervention and case management. This chapter also provides a thorough review of child sexual abuse incidence and prevalence studies, as well as a practical analysis of various indicators of possible abuse. Chapter Two is an excellent treatment of the complexities involved in defining sexual abuse, including the parameters and different patterns of sexually abusive relationships. Faller's conceptual framework, based on proximity, and her organized analysis of why adults sexually abuse children are among the best that I have seen in the sexual abuse literature.

Section Two contains two chapters which describe the duties, responsibilities, and rules of protective service workers, law enforcement officers, attorneys, and the courts in sexual abuse cases. Although both chapters provide general and at times simplified descriptions of the different players and their roles, this information will assist mental health practitioners or professionals inexperienced in working with investigators and the courts. Chapter Four contains a particularly good section on testifying in court, and even the most experienced professional will find this material useful.

The two chapters in Section Three present an excellent discussion of sexual abuse assessment and case decision-making. In Chapter Five, Faller provides detailed guidelines for assessing whether sexual abuse has occurred. A protocol for determining the likelihood of sexual abuse is outlined, but with a refreshing cautionary note that the absence of validation from such an instrument does not necessarily mean that abuse did not occur. Chapter Six contains a similar protocol for risk assessment in sexual abuse cases. Once again, Faller rightly cautions against exclusive reliance on the instrument's scoring system until it has been field tested and validated. Nonetheless, keeping the lack of empirical validation in mind, the risk assessment tool can be useful for investigators and clinicians.

The three chapters in the last section of the book address child sexual abuse in three particular settings: foster family care, day care, and divorce cases. Sexual abuse cases during the past several years have given ample evidence of the reality, unparalleled complexity and controversial nature of allegations originating from each of these settings. Faller's treatment of sexual abuse in each setting is exhaustive and balanced. Each chapter contains current research, a discussion of characteristics that distinguish sexual abuse in each context from the more commonly found patterns of abuse, and invaluable investigation and assessment strategies.

Understanding Child Sexual Maltreatment should rank as one of the most significant works in the child sexual abuse literature. It is clearly written and extensively researched, and it presents dissimilar viewpoints in an objective manner. Professionals with little training and experience in sexual abuse and those whose background is considerable will find this book very informative and useful in their daily practice.

Thomas F. Curran, MSW, LSW, JD, is Executive Director of the Children's Advocacy Center in Philadelphia.

Review #2

—by Candace McCaffrey

Dr. Faller had lofty intentions for this publication when she stated in the Preface that her intent was to write a book that would "serve as a resource for mental health professionals who must address the problem of child sexual abuse." That is an extremely varied group of individuals with differing needs and differing involvement. Readers may be skeptical as they begin but most likely will end up pleasantly surprised. It seems clear in the final analysis that this book is particularly geared for those professionals who are involved in the investigation of abuse and case management of the child and family after disclosure (likely the responsibilities of child welfare workers). However, the book provides enough well-organized, well-thought out material to provide clinicians with valuable information when involved with these complicated cases.

Dr. Faller begins by setting a framework from which to conceptualize sexual abuse, including current information on prevalence, incidence, indicators, and what she describes as a "victim-centered approach" to this problem. While this is basically a sound clinical description, she suggests taking this approach a bit too far when she encourages the professional to proceed according to what the child says she wants to happen, particularly in regards to the offender (e.g., if the child wants him in jail, then the professional should move toward a more punitive stance). While listening to the child is of course extremely important, this suggestion often leaves the child believing that she must decide the punishment. Particularly in intrafamilial abuse, when the child's feelings about the offender are typically mixed, children often are relieved to let the adults make the highly fraught decisions about appropriate treatment of the offender.

Dr. Faller tackles another difficult job in attempting to pull together a cogent description of why offenders molest. The literature has been so varied, the theories so diverse, that this is quite an undertaking. Her theory, which she admits is still "in progress," is very promising. She presents a framework structured enough to have meaning but fluid enough to take into account the many faces of child molesters. From here the book moves into areas such as collaboration among agencies, and gives specific and good advice concerning court testimony. Faller goes point by point through case management issues of assessment of the child and alleged perpetrator, the risk of reoffense, and damage to the child. This part of the book is excellent, covering a lot of ground concisely, from obvious first-hand experience.

The last section takes a look at sexual abuse in special contexts, namely foster care, day care, and allegations made during divorce proceedings. This is an area which has long been overlooked in the literature but is of growing concern for all professionals. Dr. Faller presents a picture that encompasses even the most extreme cases without overdramatizing the realities.

In all, *Understanding Child Sexual Maltreatment* is informative and particularly useful in its concise presentation of complex issues. One word of warning concerns Professor Faller's global presentation of the mental health professional's role. Because of the difficulties in these cases, in and out of court, it is often prudent for clinicians to differentiate their roles as treater and investigator. This differentiation is not made in this publication, which may tempt clinicians with little experience to involve themselves in investigation without the necessary training. While the reality is that clinicians are often asked to serve both roles, there is an inherent and perhaps countertherapeutic bind in trying to wear both hats. Clinicians are advised to read this book for valuable information about the complexities of child sexual abuse, but should be careful not to confuse investigation and treatment.

Candace McCaffrey, PhD, is Executive Director of Bethesda Alternative, Inc., a comprehensive sexual abuse treatment program located in Norman, OK.

MOVING?

"Please notify the office in plenty of time so you don't miss any issues of *The Advisor* or the Journal of Interpersonal Violence."

PRACTICAL PROGRAM EVALUATION: EXAMPLES FROM CHILD ABUSE PREVENTION (by Jeanne Pietrzak, Malia Ramler, Tanya Renner, Lucy Ford, and Neil Gilbert, 1990. Newbury Park, CA: Sage Publications. 284 pages. $35.00 hardcover, $16.95 paper.)

Review #1

—by Elizabeth Jones

The purpose of *Practical Program Evaluation* is to encourage and equip all community-based child abuse prevention programs, regardless of size, to conduct their own evaluations. The book is organized in a simple and straightforward manner. The first section, divided into five chapters, is devoted to a discussion of program evaluation models. Chapter One's overview of program evaluation outlines the successive steps in the evaluation process, beginning with planning the evaluation and ending with reporting the findings. In the next four chapters, the authors describe four types of program evaluation: input evaluation, process evaluation, group-level outcome evaluation, and client-level outcome evaluation. For each type, discussion is offered about devising the evaluation question, obtaining data collection instruments, and selecting evaluative criteria. At the end of each of these chapters, the authors provide case studies of each type of evaluation drawn from a wide range of evaluations. Additionally, examples of each type of evaluation instrument are presented in appendices.

The second part of the book focuses on the more technical aspects of program evaluation. The three chapters in this section cover research designs, data collection instruments, and data analysis, respectively. The chapter on research designs explains the three basic designs and sampling techniques. It also provides examples of data collection plans as well as information about training data collectors. The next chapter gives information on developing data collection instruments, assessing instrument quality, and pre-testing. It includes guidelines for constructing self-administered surveys and tests. The final chapter presents a description of appropriate statistical tests for useful analysis along with case examples of data analysis. The authors also discuss the analysis of qualitative data and present guidelines for interpreting the results. At the end of the book, the reader can find an annotated list of practical books on evaluation and a glossary of terms.

Overall, this book is quite useful as a "how to" manual. For those unfamiliar with the topic, it does an excellent job of "demystifying" evaluation by providing the information in an easy-to-read manner. For those accustomed to evaluation, it is useful to have a book with information specifically for child abuse and neglect prevention programs. The book's greatest asset is the rich resource information it provides. These are numerous lists with information on where to obtain data collection instruments as well as appendices containing instruments for input evaluations, process evaluations, and client-outcome evaluations. Additionally, the appendices contain sections, with examples, on establishing program goals, conducting community needs assessments, adhering to best practice standards, and determining unit cost. The compilation of examples and case studies makes the book an important contribution to the field.

A drawback of *Practical Program Evaluation* is that the distinction between group-level and client-level outcome evaluation may be somewhat confusing. The authors explain that group-level evaluation involves applying one standard measuring tool to the entire population to be evaluated where the same criteria apply to all recipients of a given program. Client-level evaluation, on the other hand, involves the development of individualized criteria for each client. The confusion here is that what the authors call group-level outcome evaluation is generally referred to as client-level outcome evaluation because it can, in fact, measure changes in the client.

Further, the authors limit their discussion of client-level outcomes to Goal Attainment Scaling (GAS), a method in which mutually agreed upon goals between the client and provider are placed on a five-point scale measuring the possibility of attainment of that particular goal. An assessment is made at intake and at some later date, usually termination of services. While the authors make a strong case for GAS, it may be inappropriate for community-based prevention programs, most of which are not clinically focused. The authors do not make clear that group-level outcome evaluation, such as administering any number of standardized instruments (e.g., the Child Abuse Potential Inventory or the Michigan Screening Profile of Parenting) to clients at the beginning and ending of services is also a valid way to assess the degree of change in a client. While GAS may be appropriate for some agencies, program staff need to know that there are other options to measure client change.

Nonetheless, the book is an excellent resource guide for all programs wanting to conduct their own evaluations. Although some of the chapters are technical, it provides a solid starting point. The appendices and resource lists are a must for anyone conducting evaluations of child abuse and neglect prevention programs.

Elizabeth Jones, PhD, is Associate Director of the National Center on Child Abuse Prevention Research, Chicago, IL.

Review #2

—by Naomi Haines Griffith

Seeking to provide both a theoretical base for research and detailed examples of useable research models, the authors of *Practical Program Evaluation* have attempted to produce a primer that is easily understood and practical. Considering that persons working in child abuse prevention in the U.S. are from a wide variety of professional backgrounds, the authors initially teach the basics of research before proceeding to apply them to prevention as it is currently practiced.

After a detailed discussion of the general steps involved in evaluation, the book covers three types of evaluation—input, process, and outcome—explaining the use and giving detailed examples of each. The authors follow a systematic process with each model, including a discussion of evaluation questions, strategies, data collection, and evaluation criteria. Particularly helpful are examples of both group-level and client-level outcome evaluations. Although the book examines evaluation for primary, secondary, and tertiary child abuse prevention programs, it could have given more information in the primary area, since this is where the evaluation of child abuse prevention is generally the weakest. Primary prevention, the most recent area of prevention efforts, is also the area in which providers are most vulnerable to questioning.

The strongest aspect of the book is its breadth of scope. Time and effort is given to a wide variety of evaluation questions child abuse prevention specialists might ask. With only a basic research background, the reader can understand and apply the principles presented. Yet more experienced researchers can get excellent ideas about evaluating child abuse prevention programs as well.

Practical Program Evaluation is an overview of evaluation which is particularly timely for the field of child abuse prevention. An evaluation primer for some, a handy reference for others, this volume is rich with useful examples as the field seeks to upgrade child abuse prevention programs and secure renewed program funding in the 1990's.

Naomi Haines Griffith, MSW, is the founder and director of Parents and Children Together, a primary prevention organization in Decatur, Alabama.

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People of Color Leadership Institute

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WELCOME

POCLI: AN INTRODUCTION

—by Joyce N. Thomas

"Child Abuse and Neglect: The People of Color Leadership Institute" is a four-year NCCAN-funded project which represents a collaborative effort of major national professional and advocacy organizations in the field of child abuse and neglect. The Center for Child Protection and Family Support of Washington, D.C. will serve as the lead agency and will work closely with the American Association for Protecting Children (Denver), APSAC (Chicago), the National Committee for Prevention of Child Abuse (Chicago), and the Northwest Indian Child Welfare Association (Portland, Oregon).

The overall intent of the project is to promote the development of leaders of color and to improve the cultural competence and sensitivity of agencies and organizations affecting families of color involved in child protective systems. Families of color are overrepresented in child welfare, juvenile justice, and criminal justice systems. It is important to examine and understand all of the various factors that lead to this disproportionate representation. Among these factors are almost certainly biased reporting and treatment practices. Cultural competence on the part of system professionals and leaders of color can help clients in the protective service system by creating more enlightened program planning, intervention and treatment practices, and prevention efforts.

Specific POCLI objectives include:

- Expansion and enhancement of the role of professionals of color at all leadership levels within the largest national membership organizations in the field of child abuse and neglect: the American Professional Society on the Abuse of Children, the National Committee for Prevention of Child Abuse, and the American Association for Protecting Children.
- Provision of concrete assistance to emerging professional leaders of color through a mentoring program.
- Development, field testing, refinement and dissemination of a protocol for agency, organization, and self assessment of cultural competency.
- Training of professionals in techniques for assessing and strategies for enhancing agency or organizational cultural competency.
- Development and dissemination of a series of professional monographs addressing organizational cultural competence and child abuse and neglect within Black, Hispanic, Native American, and Asian communities.
- Development and dissemination of an annotated bibliography on materials about cultural competence in the field of child abuse and neglect.
- Provision of various forums within which professional leaders of color can affect current public child welfare policy and practice.
- Development of a special section of *The Advisor*, the quarterly publication of the American Professional Society on the Abuse of Children, designed to increase awareness of cultural issues related to treatment and prevention of child abuse and neglect, to improve the cultural competency of child protective systems, and to increase the visibility of professionals of color working in the field of child abuse and neglect.

With this issue of *The Advisor*, we inaugurate the POCLI News. Each subsequent edition of POCLI News is to have five major sections: (1) a feature article on one of the major issues in the field; (2) "Meet the Task Force," a section introducing members of the APSAC Task Force on Ethnic Minority Affairs; (3) feature-length descriptions of programs in the field that are striving for cultural competency; (4) "Meet the Mentoree," introducing participants in the POCLI Mentorship Program; and (6) "Resources," which will list conferences, special meetings, information, and publications relevant to POCLI's aims.

This issue we're missing a few pieces, but by next quarter we should be fully up to speed. We hope you find POCLI News stimulating and informative. If you have any questions or suggestions, please don't hesitate to call me or the Assistant Project Director, Cheryl Rust, who is introduced on page 18.

Joyce N. Thomas, RN, MPH, is President and Cofounder of the Center for Child Protection and Family Support .

FEATURE

WORKING TOWARD CULTURAL COMPETENCE: ONE AGENCY'S EXPERIENCE

—by Terry Cross

Our country is experiencing dramatic demographic changes. The latest U.S. Census (1990) revealed that nearly one in four Americans is now a person of color. This fact marks the biggest one-decade change in the racial composition of the U.S. in the 20th century. As a result of this change, mainstream private non-profit agencies are increasingly serving children of diverse cultural backgrounds. Minority communities and professionals are demanding services responsive to the unique needs of these children. The following discussion summarizes the efforts of one private agency to meet these needs, highlighting the elements of policy, structure, practice, and values which are believed to promote more effective services for children and families of color.

Until recently, most agencies have assumed that services should be culturally blind, provided without regard for cultural differences. The result of this admirable attempt at fairness in service delivery, however, has too often been ethnocentric services inappropriate to families of color. Numerous studies have documented the differential treatment of children of color in the child welfare system (Cross, et al., 1989; Cummins, 1986; Katz-Leavy, Lourie, and Kaufmann, 1987; Stehno, 1982; Sue, 1981). Unfortunately, few published sources have provided concrete direction for change. Through early recognition of the issues and by trial and error, some agencies have been in the vanguard of development of culturally competent services. The Casey Family Program is one such agency.

Neither systems, agencies, nor individual professionals become culturally competent overnight. It is a developmental process aimed at implementing and maintaining a set of congruent policies, structures, values, and practices which enhance the organization's capacity to serve people of color effectively. The organization cited in this article would be the first to say it is not "there" yet. It does, however, illustrate important steps in the process and provides a model for other organizations as they begin their movement toward cultural competence.

The Casey Family Program

The Casey Family Program (TCFP) is headquartered in Seattle, Washington and has division offices in 18 locations in 13 states. TCFP is unique in several respects:

Continued on next page

***CROSS** (continued from page 16)*

It provides only long-term planned foster care and related services, and it serves children for whom adoption is neither advisable nor feasible and for whom a return to biological parents has been ruled out. Serving over 932 children nationwide, over 50% of whom are children of color, TCFP has made extensive efforts to enhance its cross-cultural services over the last ten years. Our discussion will highlight only a few of the steps taken by TCFP.

Perhaps the most important example of the inclusion of cultural issues into the policy of the agency are TCFP's "Standards for Services to Children of Color." These written standards, effectively communicated throughout the agency, clearly delineate the policy of the agency's services to children of color. Placement guidelines, case review procedures, and other organizational structures are mandated by the standards, ensuring that cultural issues are considered as part of every case decision.

Among the requirements established by the Standards is that the treatment plan for all children of color include a "cultural plan." Case workers required to devise such plans become knowledgeable about particulars of cultural differences in the groups with whom they work. For example, positive identity formation in children of color is complicated by a number of factors. These children are often subject to conflicting demands for identification from their own ethnic group (e.g., to preserve customs of dress or hairstyle) and from the dominant culture (e.g., to conform to fashion). At the same time, elements of the dominant culture openly or subtly disparage the ethnic group to which they belong. As a result, children may resist identifying with their own cultural group, yet they may never make a comfortable identification with the dominant cultural group. A cultural plan can address these conflicts in a number of ways. It can seek to build positive group self-esteem by teaching the child about positive role models, both present and past, and about the history and culture of their group. In addition, it can seek to resolve the child's confusion over conflicting demands for identification by helping the child clearly articulate both the demands and his or her feelings about them. The cultural plan can include provisions for helping the child avoid denial of his or her culture and for facilitating conscious, constructive choices about group identification.

Another organizational structure supporting TCFP's policy is the "cultural specialist" position within each division. Cultural specialists review intakes for cultural implications, plan and schedule culturally-related training, and conduct periodic reviews of cultural plans.

One example of a practice adaptation developing within TCFP is the use of extended family placements as long-term resources. In both Native American and African American communities the program has found a great deal of success in working with the natural systems of support, most important of which is the extended family. Extended family placements have presented unique recruitment and service delivery issues which the TCFP has had to overcome, often through trial and error. To recruit extended family care providers, TCFP has had to rethink the recruitment process. While cultural values and historic distrust often inhibit potential relative care providers from voluntarily seeking out the agency, they seldom say no when the agency approaches them. Through use of respected community members as "home finders" and through direct personal contact, TCFP has disproven the myth that minority foster homes are unavailable. Today, within TCFP a child of color in a Caucasian home is the exception.

TCFP is learning how to help relative care providers work out functional relationships and boundaries with biological parents. Support activities and issue-focused training have proven very helpful in this effort. In addition, social workers are learning how to help biological parents develop positive non-custodial roles with their children. The agency is still learning, but is making clear progress in understanding the support needs of these families and the children they care for.

The value base that has driven this development in TCFP has been modeled by management and spread throughout the agency by use of training and by diversifying the staff culturally. The agency maintains a cultural advisory committee, and has recently opened a dialogue with people of color on staff regarding the attitudes they encounter within and outside the agency. By keeping the issue open for discussion at every meeting or event, the agency continues to grow and develop toward cultural competence. The growth has not been all smooth sailing, however. With divisions in 13 states, the organization has faced problems with consistency of application of the policies and diverse levels of commitment to the effort. With the growth of new practice adaptations, the agency has occasionally faced its own identity crisis struggling with conflicting internal views of what constitutes good practice. For example, supervisors have sometimes not known how to judge the clinical implications of indigenous healing practices and have therefore been cautious about their use. As the staff has become more diverse in its ability to draw on the natural helping practices and resources of the communities it serves, the supervisors' need for cultural knowledge has become increasingly acute.

Also, with an increase in the diversity of staff, the agency has encountered a new generation of issues. While the early step was hiring a diverse staff, the next set of problems arose around retention of such a staff. Experiencing a high turnover rate among minority staff, division directors found that cross-cultural supervision skills had to be carefully cultivated. To cope with these second-generation issues, TCFP is drawing on cultural consultants and providing cross-cultural supervision training to managers and supervisors.

TCFP illustrates different aspects of the effort to enhance service delivery for children of color in the context of a changing world. Observers from inside and out of TCFP would judge the agency's progress differently. Yet over the long range these efforts represent significant progress. Each organization will approach the task differently. Some will make changes in response to community advocacy efforts. Some will change because funding sources or accrediting bodies demand it. All can take comfort in the experience of TCFP, however, which promises to show that improved services for people of color enhances benefits for all consumers.

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Terry L. Cross, ACSW, is Director of the Northwest Indian Child Welfare Institute in Portland, Oregon. He is profiled in "Meet the Leaders" elsewhere in this section. For more information about the Casey Family Program, write or call Ruth Massinga, Executive Director, at 2033 6th Av., Suite 1100, Seattle, WA 98121; 206-448-4620.

RESOURCES

—compiled by Terry Cross and Char Tong

In the last 15 years the literature on minority mental health and on the dominant culture's perceptions of and responses to it has grown quickly. The field now has access to a broad base of information about practice, policy, and epidemiological issues in minority mental health. References to this literature will be published in this section over the months to come. Below are listed three valuable annotated bibliographies.

1. **Selected Citations from Afro-American References, An Annotated Bibliography of Selected Resources. Nathaniel Davis (Ed.), Greenwood Press CN, 1985.** These citations were taken from a bibliography citing some 642 selected resources. Items listed include bibliographies, indexes, directories, and almanacs. Available from Greenwood Press, 88 Post Road West, Box 5007, Westport CN 06881.
2. **Annotated Bibliography on Cultural Competence. Mary Elizabeth Ryder (Ed.), Portland State University, Regional Research Institute, 1989.** This bibliography is likely the most useful and comprehensive of the resources available for use in the development and evaluation of culturally competent human services. The citations are not specific to mental health: they discuss all aspects and considerations in agency cultural competency. Available from Portland State University, Regional Research Institute for Human Services, PO Box 751, Portland OR 97207-0751. 503-464-4040.
3. **Annotated Bibliography on Minority Mental Health Issues. Educational Resource Information Center (ERIC) Data Base. Compiled July 1989 at Portland State University library by C. Tong.** A search through the ERIC data base led to 29 annotated bibliographies which include position papers, journal articles, directories, literature reviews, project descriptions and legal material. They are available for purchase from ERIC Document Reproduction Services (EDRS), 3900 Wheeler Av., Alexandria VA 22304-6409. 800-227-3742.

INTRODUCTIONS

MEET THE STAFF

Cheryl Rust, MPH, is Assistant Project Director for POCLI. Cheryl received her Master's of Science in Public Health from the University of North Carolina, Chapel Hill, and her Master's of Science in Special Studies from the George Washington University, Washington, DC.

Involved in the public health field for many years, Cheryl has focused her efforts on improving the socioeconomic and health status of children. She has had extensive training and professional experience in issues surrounding child maltreatment in families of color.

Before coming to POCLI, Cheryl served as the Special Projects Assistant for the Division of Child Protection, Children's National Medical Center, Washington, DC. As Special Projects Assistant, Cheryl was responsible for coordinating several child abuse and neglect conferences and prevention projects. Before working at Children's National Medical Center, Cheryl worked for several years as the Health Policy Specialist for the National Medical Association (NMA). At NMA, Cheryl developed several forums that examined and addressed the impact of socioeconomic factors and family behaviors on the health status of children of color. Cheryl has also served as the Health Planner for the Metropolitan Washington Council of Governments, Washington, DC, where she was responsible for developing and coordinating regional health plans to address child welfare issues.

Mareasa R. Isaacs, PhD, President of the Isaacs Group, a private consulting firm specializing in minority health care issues and mental health services, is the Technical Specialist for POCLI. She will assist staff with program implementation and evaluation.

Prior to opening the Isaacs Group in April, 1990, Dr. Isaacs spent three years as the Administrator, Child and Youth Services Administration, Commission on Mental Health Services, in the District of Columbia. As the Administrator, she was directly responsible for the design and development of a community-based system of mental health care for children and families in the District of Columbia. She established effective interagency linkages and joint program and financing initiatives with other child-serving agencies including the schools, courts, and systems surrounding juvenile justice, foster care, child protection, and alcohol and drug rehabilitation.

Dr. Isaacs received her doctorate from Brandeis University's Florence Heller School for Advanced Studies in Social Welfare, and her MSW in psychiatric social work from Simmons College in Boston. As part of her training at the Cambridge City Hospital, Department of Psychiatry, Dr. Isaacs was one of the few social work students to receive specialized training in alcoholism under the direction of George Vaillant, MD. She has an undergraduate degree in English Literature from Clark University in Worcester, MA.

As a consultant for the Child and Adolescent Service System Program Technical Assistance Center of the Georgetown University Child Development Center, Dr. Isaacs was one of the authors of the monograph, *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed.* This document, published in March, 1989, provides theoretical underpinning for approaching the needs of minority children and families in the mental health system.

From 1985 to 1987, Dr. Isaacs served as the Associate Commissioner, Child and Youth Services, New York State Office of Mental Health. In this capacity she was very successful in creating additional legislative and executive support for the development of community-based child mental health services throughout the state; securing new funding for family-based treatment services, including single entry-point systems for severely emotionally disturbed children; and developing a continuum of residential services for children in Brooklyn, including a legislative allocation of over $33 million to develop and design Brooklyn Children's Psychiatric Hospital.

INTRODUCTIONS

MEET THE LEADERS

John K. Holton, PhD, is a member of POCLI's Expert Task Force. Executive Director of the Greater Chicago Council (GCC) of the National Committee for Prevention of Child Abuse, Dr. Holton is a developmental psychologist who has specialized in urban education, juvenile delinquency, infant mortality, and child abuse. Dr. Holton is the author of numerous articles in professional journals, and has lectured for parents, practitioners, and researchers throughout the U.S., Europe, and the Third World, including China, the Barbados, and the Ivory Coast. He recently attended two conferences in Europe on child labor in the developing world and child abuse and neglect throughout the world, and spoke on international adoption and child maltreatment in Brazil.

A native of Philadelphia, Dr. Holton attended Howard University, where he received a bachelor's degree in political science, and the University of Hartford, where he received a master's degree in education. He completed his doctorate in the College of Human Development at Pennsylvania State University. Dr. Holton serves on the faculty of DePaul University in Chicago and the Illinois School of Professional Psychology, and is a member of APSAC, the American Public Health Association, the National Black Child Development Institute, and the Society for the Study of Social Problems.

One of the projects of GCC is the North Lawndale Family Support Initiative. The following description of the North Lawndale Family Support Initiative is taken from a document written by Dr. Holton in September, 1990:

The North Lawndale Family Support Initiative

With the goal of developing a model, comprehensive, community-based prevention strategy in a high-risk area, the Greater Chicago Council of NCPCA has been working intensively in the North Lawndale community since 1986. This community has been identified by the Illinois Department of Children and Family Services (DCFS) as among the top three areas of highest risk for child maltreatment in Illinois. The risk may be attributed to the persistence of stress factors that place families at risk of child abuse and neglect, including chronic low income, isolation from effective support systems, high rates of violence and crime, few educational and employment opportunities, inadequate housing, and a high incidence of alcohol and substance abuse.

The first step taken by GCC in North Lawndale was to identify services already available and develop a network of concerned professionals, ministers, parents, and volunteers working and/or living in the community. These efforts led to the creation of the "North Lawndale Community Resource Directory" and the North Lawndale Family Support Initiative Task Force, formerly the North Lawndale Child Abuse and Neglect Task Force. By sponsoring community meetings and public forums, the Task Force has raised the community's level of awareness of child abuse and has influenced the community's involvement in facilitating the planning of a comprehensive prevention strategy.

With the support of federal funding from NCCAN, GCC has continued its work with the community to implement comprehensive, community-based prevention programs and activities. To maximize the effectiveness of the project, the staff completed a prevention service needs assessment during the first year of this five-year initiative. Information for the assessment was gathered through:

- interviews with key informants representing community leaders, professionals, and residents.
- a service needs survey distributed to over 50 agencies and organizations serving North Lawndale residents;
- reviews of discussions that took place at several community forums;
- a recapitulation of a special town meeting that focused on the community's child abuse and neglect issues;
- relevant statistical information from census data, state and local public service agencies, and the University of Illinois at Chicago.

As a result of this comprehensive assessment, efforts over the next four years will be focused on using existing community resources to create programs and activities suitable to the uniqueness of the North Lawndale community. The prevention service will include the development of:

1) perinatal health care with parenting education and support programs for all new parents.

Continued on next page

LEADERS ***(continued from page 18)***

2) education and support services accessible to all parents experiencing stress.
3) age-specific, school-based prevention education programs for all school-age children.
4) child abuse and neglect services in domestic violence programs.
5) therapeutic intervention for all victims of abuse.
6) substance abuse prevention and treatment information as a component of parenting education and curriculum training programs.
7) public awareness programs to inform citizens about positive family support.

We expect a measurable reduction in the amount of child abuse and neglect in the North Lawndale community and a heightened community awareness of the value of child abuse prevention as a result of implementing these programs. NCPCA's Center on Child Abuse Prevention Research will help evaluate the project's success.

Terry Cross, LCSW, is Director of the Northwest Indian Child Welfare Institute, a project of the Northwest Indian Child Welfare Association (NWICWA), one of the POCLI sub-contractors. A member of the Seneca Tribe, Mr. Cross has 16 years' experience working with children and families in both Indian and non-Indian settings. Since the Board of Directors of NWICWA is community-based and has members from several tribes, Mr. Cross is very immersed in the realities Indians face. As Adjunct Assistant Professor at Portland State University, Mr. Cross teaches a graduate level course in cross-cultural social work. Mr. Cross has published numerous papers dealing with positive Indian parenting, cross-cultural skills in Indian child welfare, and other Indian social issues. He has lectured internationally on services to Native American children.

Mr. Cross keeps his constituency aware of developments in Washington, DC, regarding the Indian Child Welfare Act (a law which, recognizing that children are Indian tribes' most valuable resource, explicitly strengthens the tribes's authority). He also facilitates the implementation of the Indian Child Welfare Act when working with state agencies, such as the Children's Services Division. Mr. Cross has been a caseworker for Mercer County, Pennsylvania, Child Welfare Services; a counselor at the Chemawa Indian School in Salem, Oregon, and a clinical social worker for the Parry Center for Children, Portland, Oregon. Mr. Cross belongs to NASW, CASSP Technical Assistance Center and the Minority Resource Committee of Georgetown University, and the Minority Resource Council of Portland State University. He has also served as Vice-President for the Association of the American Indian and Alaskan Native Social Workers, as a Board member for the National Committee for Prevention of Child Abuse (NCPCA), and as treasurer of the Oregon chapter of NCPCA.

A description of NWICWA's organization and activities follows:

NWICWA was incorporated in March, 1987 as a community-based, Board-directed, non-profit organization. Together, tribal programs and Indian professionals created NWICWA, the only regional child welfare organization operated by and for Indian people. Affiliated with the Regional Research Institute for Human Services (RRI) at Portland State University's School of Social Work, NWICWA benefits from the resident expertise, exposure to current developments in the field, and access to technology which would be beyond its means to procure.

NWICWA's mission is to promote information sharing among Indian child welfare programs; to provide education and leadership opportunitites for Indian child welfare workers; to develop resources for programs relating to Indian children, youth, and families; and to advocate for proper implementation of the Indian Child Welfare Act of 1978. To accomplish these goals, NWICWA engages in several activities:

- Maintains and operates a resource library with over 2,000 entries.
- Holds an annual conference averaging over 200 participants.
- Provides workshops for Indian parent trainers using its own Positive Indian Parenting curriculum.
- Develops and disseminates training curricula and child abuse prevention materials.
- Conducts an awareness campaign.
- Provides workshops for tribal Indian child welfare workers in culturally-specific practice skills.
- Publishes a quarterly newsletter and an annual parents' magazine, *Honoring the Children.*

To promote adequately funded and culturally competent services for American Indian children and families by tribal and public child welfare agencies, NWICWA has:

- Provided seven cultural competence workshops to a total of 241 participants in 1990.
- Co-sponsored a Native Youth Conference in Portland informing youth on their rights to services.
- Conducted a tribal leaders' forum on children's issues and facilitated a follow-up visit with congressional representatives and staff in Washington, DC.
- Kept membership and tribal leaders informed of national and regional policy developments and funding issues affecting Indian children.
- Provided testimony to congressional committees on Native American children.

Among specific projects developed by NWICWA to protect and preserve Indian children through development of community responses are:

- Helping the Siletz tribe of Oregon develop a local child abuse prevention committee and providing technical assistance for a community-based prevention campaign (1990).
- Helping the Nez Perce tribe of Idaho conduct a "Walk for Pride and Child Abuse Prevention," hold a community forum on child abuse, pass a tribal resolution on the rights of children, and develop a children's shelter care facility (1989).
- Conducting focus groups of Indian parents at the Burns Paiute reservation in Oregon to assist the tribe in the development of volunteer parent support groups (in progress).

Also in progress is a three-year research project on child neglect, being conducted in cooperation with the National Resource Center on Family Based Services of the University of Iowa. The study will examine 100 families, half of them Indian, comparing families with no history of substantiated child neglect to families with substantiated child neglect who are at risk of subsequent neglect. The objective of the research is to examine differences between the Indian-neglecting, Indian-non-neglecting, non-Indian neglecting, and non-Indian non-neglecting families to determine the role of support networks, family cohesion, and other variables in producing child neglect.

INFORMATION

MENTORSHIP PROGRAM

In an effort to provide concrete assistance to professionals of color, we are excited to offer an opportunity for emergent leaders in the field of child abuse and neglect to participate in an innovative one-on-one role model and mentorship program as part of the POCLI project. We hope that this program will help bridge the gap between the over-representation of clients of color in the system and the under-representation of professionals of color in senior practice, research, and policy-level positions. Although we realize that the ultimate decision as to who is selected for senior positions within a given organization involves a number of complex factors, mentoring may help professionals of color develop a stronger sense of community, purpose, and identity within the field, thus reducing burnout and making more professionals of color available and prepared to take leadership positions. The purpose of mentorship is to provide nurturing support, to share ideas and informal advice, to teach new problem-solving approaches, to boost confidence, and to recognize and respond effectively to limitations—both internal and external—to career development in the field.

POCLI will recruit as mentors professionals of color who by virtue of their accomplishments, experience, and wisdom are recognized leaders in the field of child abuse and neglect. These are individuals who are active at the national level: members of the POCLI Expert Task Force, Members of the APSAC Ethnic Minority Affairs Task Force, members of the NCPCA Board Committee on Cultural Diversity, POCLI Consultants, etc.

The highly-motivated volunteers who will function as mentors will make a commitment to our mentorship efforts and will establish a relationship with a mentoree. We are seeking mentorees who are committed to a career in the area of child protection and who wish to advance their knowledge and skills in such areas as research, management, and policy formulation. For additional information on how to become involved in the mentoring program, contact Cheryl Rust at 202-544-3144.

REID ***(continued from page 2)***

nominations from the membership. It is looking for people who have made outstanding contributions to APSAC and to the field in the last few years. We want to thank them in style. Please call Susan Kelley, 617-552-4250 with your suggestions.

State Chapters on the Move

Illinois, Oklahoma, Colorado, & Massachusetts have all been granted state charters since February! Congratulations to the hard-working members who made those chapters happen. Colorado's state chapter (COPSAC) and APSAC will co-host a luncheon membership meeting on Monday, September 16, at the conference to be held in Denver (sponsored by NCCAN, AHA, & the Kempe Center). I hope you'll make plans to join us.

On p.8 is a list of each state chapter's two top officers, and a list of energetic members organizing chapters in other states. If no chapter is being organized in your state, and you have a little extra time, please give the office a call. We're assembling a good-sized packet of resources for new coordinators, thanks to the trail-blazing efforts of these early groups.

Congratulations and Thanks

Congratulations to **Robert "Bud" Cramer, JD,** who was recently elected to the U.S. Congress from the 5th Congressional District in Alabama. Congressman Cramer was one of the founders of APSAC, and until this year was a member of APSAC's Board. As District Attorney in Huntsville, Alabama, Congressman Cramer was also the founder of the first Children's Advocacy Center in the U.S., and was instrumental in the establishment of dozens of CACs across the country, and of the National Network of Children's Advocacy Centers. Children and the child welfare profession couldn't have a better representative in Congress. We wish him all the best.

Congratulations also to **David Lloyd, JD,** who was recently chosen to be Director of the National Center on Child Abuse and Neglect. Mr. Lloyd has served the field of child abuse and neglect in many capacities for more than 20 years, most recently as Director of the National Resource Center on Child Sexual Abuse. Currently a member of APSAC's Board, Mr. Lloyd has logged many hours as Chair of the Policies, Procedures, and By-Laws committee writing policies to guide APSAC's actions in such critical areas as issuing statements on matters of social concern or public policy, adopting guidelines for professional practice, and forming state chapters. We are delighted that Mr. Lloyd, with all his expertise in the field, has been selected to head the federal agency on child abuse and neglect.

Last but hardly least, thanks to all those dedicated members who have called the office asking for brochures to distribute. In March, a record 85 new members joined APSAC! Members who have taken the trouble to distribute brochures and talk to their colleagues about APSAC are undoubtedly responsible for many of these new members. Please keep up the great work!

NEWS

ENDOWMENT FUND CONTINUES TO GROW

—by Theresa Reid

The list of people contributing to APSAC's Endowment Fund is getting longer. Our initial goal is to raise $25,000 to help APSAC achieve financial stability and meet its long-range goals. Among these goals are to launch our own national conference, to produce The APSAC Handbook on Child Maltreatment, and to offer scholarships to professionals who can't afford to pay membership dues. Many members demonstrate their extraordinary commitment to APSAC by forming state chapters, distributing brochures and flyers, urging colleagues to join, writing for *The Advisor*, or serving on APSAC's hard-working Board. You can help by doing any of these things, and by urging your friends, colleagues, and relatives to make APSAC their favorite charity or by making a donation yourself. Potential "Friends of APSAC" will be happy to know that all contributions to APSAC are tax-deductible. The people listed below have generously contributed a total of $3,250 to help APSAC toward its $25,000 goal.

APSAC FRIENDS

Thomas V.P. Alpren, MD
Janet Adams-Wescott, PhD
Linda Blick, MSW, LCSW
Barbara Bonner, PhD
Mark Chaffin, PhD
Anne Harris Cohn, DPH
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Patricia Toth, JD
Nancy Walentiny, MSW
Diane J. Willis, PhD
Martha K. Wilson, DSW

JOURNAL HIGHLIGHTS

The purpose of "Journal Highlights" is to alert readers 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 a two-to three - sentence summary of the article. Mail your contributions to Thomas F. Curran, MSW, JD, Executive Director, Children's Advocacy Center, 4000 Chestnut Street, Philadelphia, PA 19104.*

PHYSICAL ABUSE AND NEGLECT

Hibbard, R.A., Ingersol, G.G. and Orr, D.P. (1990). Behavioral risk, emotional risk and child abuse among adolescents in a nonclinical setting. *Pediatrics, 86* (6), 696-699.

This replication study of nearly 4,000 adolescents in a nonclinical setting examines the prevalence of repeated problem behaviors, emotions, and abuse, plus the impact of abuse on multivariate emotional and behavioral risk. The results clearly indicate that while some behavior problems are common among adolescents (e.g., alcohol abuse), other behaviors were strongly associated with a history of abuse (e.g., attempting suicide, running away). Higher emotional and behavioral risk scores among the abused students were also confirmed. (TFC)

Kolko, D.J., Moser, J.T. and Weldy, S.R. (1990). Medical/health histories and physical evaluation of physically and sexually abused child psychiatric patients: A controlled study. *Journal of Family Violence, 5* (4), 249-267.

This study examines parent-reported developmental and medical characteristics of 105 outpatient and 105 inpatient children who were classified on the basis of their history of physical and sexual abuse. The overall pattern of findings in this study indicated that physically abused children showed more developmental problems and histories of multiple physical injuries, whereas the sexually abused children evidenced more sexually acting out behaviors and involvement in drug use. (TFC)

Mehl, A.L., Coble, L. and Johnson, S. (1990). Munchausen Syndrome by Proxy: A family affair. *Child Abuse and Neglect, 14* (4), 577-585.

An unusual case of Polle syndrome (Munchausen syndrome by proxy present when a parent also has Munchausen syndrome) is presented along with detailed medical histories in this informative article. The discussions of Polle syndrome and Munchausen syndrome by proxy are thorough and contain important information for health care professionals and child abuse investigators. (TFC)

Sugan, M. (1990). Abuse and neglect in schools. *American Journal of Psychotherapy, 44* (4), 484-498.

This article provides a very interesting review of the maltreatment of school children by their teachers. Various approaches for addressing this type of abuse and neglect are presented. The author's problem analysis and management recommendations merit the attention of education and child abuse professionals. (TFC)

SEXUAL ABUSE

Anechiarico, B. (1990). Understanding and treating sex offenders from a self-psychological perspective: The missing piece. *Clinical Social Work Journal, 18* (3), 281-292.

By contrasting the view of sex and aggression from the perspective of classical psychoanalytic drive theory (Freud) with self-psychological theory (Kohut), this article provides an interesting view of the treatment of sex offenders. The author advocates treating offenders from a self-view or self-psychological perspective and describes its successful application at one treatment center for sex offenders. (TFC)

Boat, B.W., Everson, M.D. and Holland, J. (1990). Maternal perceptions of nonabused young children's behaviors after the children's exposure to anatomical dolls. *Child Welfare, 69* (5), 389-400.

The purpose of this important study was two-fold: to determine whether non-abused young children found exposure to anatomical dolls to be a negative experience; and to describe types of post-doll interview behaviors that mothers believed were caused by or related to their children's exposure to the dolls. Although nearly half of the mothers of the three-year olds and three-fourths of the mothers of the four-year olds believed that exposure to the dolls contributed to more sexually focused behaviors in their children, these behaviors were described by the parents as relatively benign and centering on heightened awareness of sexual body parts. None of the five-year olds exhibited increased sexualized behaviors after using the dolls. Also, not a single mother expressed concern about their child's behavior or comments after their exposure to the dolls. This study supports the claim that non-abused young children are not "traumatized" by exposure to anatomical dolls or by direct questions about sexual body parts, and that the dolls are not suggestive of sexual behaviors. (TFC)

Coleman, H. and Collins, D. (1990). Treatment trilogy of father-daughter incest. *Child and Adolescent Social Work, 7* (4), 339-355.

This article provides thought-provoking examination of three different perspectives on father-daughter incest: Child advocacy, family systems, and reconstructive. The etiology, relationship with the criminal justice system, treatment approaches and research evidence presented for each perspective offer strong support for more research on the problem of father-daughter incest. (TFC)

Elvik, S.I., Berkowitz, D.C., Nicolas, E. Lipman, J.L. and Inkelis, S.G. (1990). Sexual abuse in the developmentally disabled: Dilemmas of diagnosis. *Child Abuse and Neglect, 14* (40, 497-502).

Although this article describes the team examination of 35 mentally retarded females, most of whom were adults, it contains important intervention suggestions for professionals who investigate abuse allegations of developmentally disabled children and youth. Some of the more significant yet unanticipated dilemmas encountered by the authors are especially worthy of consideration by all professionals, including what significance, if any, healed genital or anal lesions in developmentally disabled abuse populations have without other findings, forensic material or a history of abuse. (TFC)

Gordon, M. (1990). Males and females as victims of childhood sexual abuse: An examination of the gender effect. *Journal of Family Violence, 5* (4), 321-332.

A 585 respondent sub-sample of the *Los Angeles Times* 1985 nationwide poll to determine the prevalence of child sexual abuse was used to examine gender differences in the nature and context of sexual abuse. Several gender related differences were discovered; most notably male and female child sexual abuse victim profiles appeared fundamentally related to their relationship with the offender. Many of the well-documentated difference between male and female victims appeared to gain or lose significance when relationship to the offender was held constant. This article explores the complex relationship between sexual abuse and gender and clearly points out the need for additional research on this topic. (TFC)

Greenward, E., Leitenberg, H., Cado, S. and Tarran, M. (1990). Childhood sexual abuse: Long-term effects on psychological and sexual functioning in a nonclinical and nonstudent sample of adult women. *Child Abuse and Neglect, 14* (4), 503-513.
This study examined how child sexual abuse is related to long-term psychological and sexual functioning in a sample of adult women abused as children and a matched control group of non-abused women. Study findings strongly suggest that childhood sexual abuse adversely affects long-term adult psychological adjustment. (TFC)

Wurtele, S.K. (1990). Teaching personal safety skills to four year old children: A behavioral approach. *Behavior Therapy, 21*, 25-32.
This controlled study examined the effectiveness of a behavioral sexual abuse prevention program for a small sample of middle-class preschool children. Contrary to concerns about negative effects and the capacity of this age-group to understand abuse prevention material, study subjects demonstrated increased self-reported knowledge, discrimination of appropriate vs. inappropriate contact and safety skills, while evidencing no negative effects relative to controls. (MC)

CHILDREN'S MEMORY

Price, D.W. and Goodman, G.S. (1990). Visiting the wizard: Children's memory for a recurring event. *Child Development, 61* (3), 664-680,
The development of pre-school aged children's scripts for a novel recurring event (a trip to the "wizard's room") was examined in this study. Among the more significant results was the finding that children's abilities to mentally organize and control script content varies according to the external cues and verbal demands utilized. Professionals required to interview pre-school aged children would benefit from a careful reading of this study. (TFC)

CHILD ABUSE AND THE LEGAL SYSTEM

Besharov, D.J. (1990). Combating child abuse: Guidelines for cooperation between law enforcement and child protective agencies. *Family Law Quarterly, 24* (3), 209-245
Guidelines for improved cooperation and collaboration between law enforcement and child protective services agencies in handling child abuse cases are outlined in this article. The recommendations presented deserve careful consideration by all child abuse professionals, not just mandated and criminal investigators. (TFC)

Bischoff, K.S. (1990). The voice of a child: Independent legal representation of children in private custody disputes when sexual abuse is alleged. *University of Pennsylvania Law Review, 138* (5), 1383-1409.
A thorough examination of children's right to independent legal representation when sexual abuse is alleged during a custody dispute is presented in this article. The author's discussion of precisely what role a child's representative should play in such proceeding is particularly good. Attorneys who routinely handle such cases and child abuse professionals with no legal training will find this article helpful in understanding the legal dilemmas faced by judges and children's attorneys in custody cases when child sexual abuse is alleged. (TFC)

Contributors for this edition were Thomas F. Curran, MSW, JD, Executive Director, Children's Advocacy Center, Philadelphia, PA and Mark Chaffin, PhD, Department of Pediatrics, Arkansas Children's Hospital, Little Rock, AR.

CONFERENCES

APSAC DISCOUNTS

PAST

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

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

6th National Symposium on Child Sexual Abuse, Huntsville, AL, March 1990.

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.

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

7th National Symposium on Child Sexual Abuse. Huntsville, Alabama. March, 1991.

FUTURE

Oct, 1991. ***Midwest Conference on Child Sexual Abuse & Incest.*** Madison, WI. Call Jill Cohen Kolb, 608-244-4022.

June 6 - 8, 1991. ***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.

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, Ann 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.

June 31 - July 2. ***Restoration Retreats: Burnout Prevention and Recovery for Therapists.*** Hume Lake, CA. Contact Retreat Coordinator, 24050 Madison, Suite 218, Torrance, CA 90505.

July 19 - July 21. ***Building Alliances for Healing.*** Lincolnwood, IL. Sponsored by VOICES in Action, Inc. (Victims of Incest Can Emerge Survivors). Faculty includes John Briere, Jon Conte, Roberta Sachs, Mary Jo Barrett, Ellen Ratner, E. Sue Blume, Karen Lison, Walter Young. Call Phyllis Froehle, 708-257-8755.

August 7 - August 10, 1991. ***Advanced Sexual Abuse Treatment Symposium.*** Breckenridge, CO. Sponsored by META Resources. Call Barbara Murdock, 404-390-9318.

September 14 - 17. ***Reaffirming Our Roots: 9th National Conference on Child Abuse and Neglect.*** Denver, CO. Sponsored by American Humane Association, C. Henry Kempe Center, and NCCAN. **APSAC Institutes, Membership Meeting, Task Force Meetings, Executive Committee Meeting to be held.** See display ad below for more information. Call 312-554-0166 for more information about APSAC activities.

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APSAC is pleased to participating in **"Child Abuse and Neglect: The People of Color Leadership Institute" (POCLI).** The goal of POCLI is to promote the leadership of people of color in child protective systems and to improve the cultural competence and sensitivity of those systems that affect families of color. As part of the effort to evaluate the effectiveness of POCLI, APSAC would like to gather baseline information on the cultural diversity of its membership. Although your participation is strictly voluntary, we would appreciate your assisting in this effort by filling in the form below.

I consider my cultural group identification to be: ____ African-American; ____ Asian-American/Pacific Islanders; ____Latino; ____Native American; ____ European; Other (please specify) _____

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