APSAC

Volume 4 Number 3 Summer 1991

THE ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

NEWS

JIV POLICY CHANGED TO MEET MEMBERS' NEEDS; NOMINATIONS SOUGHT FOR 1991 ELECTION, AWARDS; PREPARATIONS BEGIN FOR ANNUAL MEETING IN SAN DIEGO, JANUARY, 1992

—by Theresa Reid

APSAC members will get their issues of the *Journal of Interpersonal Violence* in a more timely fashion as a result of a June 1 policy shift. Before June 1, we went to a lot of trouble to ensure that members received complete four-issue volumes of *JIV* (e.g., all of the 1990 volume, all of the 1991 volume, etc.). When members joined or renewed between April 1, 1990 (when our agreement with Sage Publications began) and November 1 (when members were slated to receive the entire 1991 issue), they received all of the 1990 issues that had already been published, and any that were published after. So if you joined or renewed in October, 1990, you were slated to receive the March, June, and September, 1990 issues immediately, and the December, 1990 issue when it was published. When you renewed the following year, the same thing was supposed to happen: you would receive the March, June, and September issues in October when you renewed, and the December issue in December.

While this practice had the advantage of providing members with complete sets of the journal, it had a major disadvantage: most members received one or more issues of *JIV* several months late.

Many members have called the office confused as a result of this policy. So we're changing it. As of June 1, APSAC members will receive the four consecutive issues of *JIV* published after they pay their dues.

As a result of this policy shift, APSAC members will now receive their *JIV*s according to the calendar below:

Pay dues in:	Receive these issues:
Nov., Dec., Jan.	Mar., June, Sept., Dec.
Feb., Mar., April	June, Sept., Dec., Mar.
May, June, July	Sept., Dec., Mar., June
Aug., Sept., Oct.	Dec., Mar., June, Sept.

To find out what issues to expect to get, look at your membership card: the expiration date in the lower right hand corner tells you the month in which you originally joined and are expected to renew. There is at least a five-week lag, and potentially as long as a four-month lag, between the time you join and the time you get your first journal, because Sage needs to know a full month before publication how many copies of each issue we will need. No matter when you join, however you will get a full year's worth of current journals for your membership dues.

The down side of this policy shift is that some members will miss some 1991 issues (because they have already received the four issues—all 1990—that their dues paid for), and a few members will miss the March, 1992 and June, 1992 issues (because they received the March and June, 1991 issues under the old policy). In the first year of the new policy, members will miss the following issues:

Pay dues in:	Miss these issues:
Nov. '90, Dec. '90, Jan. '91	none
Feb., Mar., April, '91	Mar. '92
May 1-17, 1991	Mar. and June 1992
May 18-June, July, '91	Mar. and June 1991
Aug., Sept., Oct., '91	Mar., June, Sept., '91

To minimize members' frustration, APSAC has arranged with Sage Publications to provide APSAC members with copies of the back issues they miss for a flat $5.00 each—less than half the cost to non-members. APSAC members can send a check directly to APSAC with a note re-

Continued on page 7

CONTENTS

PREVENTION

TOWARD NEW WAYS OF CARING: LESSONS FROM INTERGENERATIONAL RESEARCH ON MALTREATMENT

—by Martha Farrell Erickson and Byron Egeland

One of the greatest challenges in the field of child abuse prevention is breaking intergenerational cycles of maltreatment, enabling victims to rise above their past as they become parents themselves. The challenge is to prevent not only overt physical or sexual abuse, but also more subtle forms of maltreatment that may go undetected but nevertheless have lasting psychological consequences for the child. Stated more positively, we need to support and empower parents to provide the kind of sensitive, predictable, loving care that will promote competence and well-being in their growing children. Findings from recent research provide a helpful framework for examining intergenerational patterns of parenting and beginning to identify preventive intervention strategies aimed at new parents who experienced maltreatment in their own childhood.

Findings on Intergenerational Cycles of Maltreatment

Clinicians have long believed that parents who abuse their children were abused as children. Empirical support for this intergenerational hypothesis comes from studies of case histories or child protection reports. For example, Steele and Pollock (1968) found that all 60 abusing parents in their study were abused as children. The problem with findings from retrospective studies, however, is that one cannot determine how many adults who had similar childhood experiences do not go on to abuse their children. As part of an ongoing longitudinal study of 267 low-income women and their firstborn children (Minnesota Mother-Child Project), we have had an opportunity to examine the cycle of abuse across generations using a prospective approach. Among mothers in our study who were abused as children, 34% maltreated their child in some way, 6% were in an "other problem" group (e.g., abandoned their child), and 30% were in a category described as borderline caretaking (Egeland, 1988). Among mothers with a history of being sexually abused, 61% maltreated their children. In contrast, of 35 mothers in the study who were judged to have been raised in a family that was

Continued on page 2

THE ADVISOR

Editor-in-Chief

Susan Kelley, RN, PhD, FAAN
Boston College School of Nursing
Chestnut Hill MA 02167
617-552-4250

Executive Editor

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

Managing Editor

Theresa Reid, MA
Executive Director, APSAC
312-554-0166

Associate Editors

Adult Survivors
John Briere, PhD
LAC/USC Medical Center
Department of Psychiatry, Box 106
1934 Hospital Place
Los Angeles CA 91330
213-226-5697

Book Reviews
Mark Chaffin, PhD
Arkansas Children's Hospital
Department of Pediatrics
800 Marshall St.
Little Rock AR 72202
501-320-1013

Evaluation and Treatment
Mark Everson, PhD
University of North Carolina
Program on Childhood Trauma and
Maltreatment, Dept. Psychiatry, CB# 7160
Chapel Hill NC 27599-1760
919-966-5277

Journal Highlights
Thomas F. Curran, LCSW, JD
Executive Director
Children's Advocacy Center
4000 Chestnut St.
Philadelphia PA 19104
215-387-9500

Legal
Josephine Bulkley, JD
ABA Center on Children & the Law
1800 M St. NW
Washington DC 20036
202-331-2654

Medical
Martin Finkel, DO
Univ. of Medicine & Dentistry of New Jersey
301 S. Central Plaza, Laurel Rd., #2100
Stratford NJ 08084
609-346-7032

News
Dan Sexton
Childhelp USA
1345 El Centro Av.
Hollwood CA 90028
213-465-4016

Perpetrators
Robert Prentky, PhD
Massachusetts Treatment Center
PO Box 554
Bridgewater MA 02324
617-727-6013, ext. 1527

POCLI
Cheryl Rust, MPH
CCPFS
714 G Street SE
Washington DC 20003
202-544-3144

Prevention
Deborah Daro, DSW
NCPCA
332 S. Michigan Av., #1600
Chicago IL 60604-4357
312-663-3520

Research
David Finkelhor, PhD
UNH Family Research Laboratory
128 Horton Social Science Center
Durham NH 03824
603-862-2761

ERICKSON *(continued from page 1)*

emotionally supportive and clearly not abusive, only one mother was currently maltreating her child. We conclude from these findings that a history of abuse is a major risk factor for abuse in the next generation. However, the rate of maltreatment across generations is not perfect, leading us to a question with important implications for preventive intervention: How do some individuals who were abused as children manage to break the cycle of abuse?

To address that question we examined case histories, as well as objective data, of mothers who broke the cycle of abuse, comparing them to mothers who did not break that cycle (Egeland, Jacobvitz, and Sroufe, 1988). Three variables were most important in distinguishing these two groups. Mothers who broke the cycle of abuse were more likely (1) to be in an intact, stable, and satisfying relationship; (2) to have experienced a supportive, close relationship in childhood with a relative, foster parent, or some other significant adult; and (3) to have been involved in long-term therapy that had enabled them to integrate their early experience of abuse.

In contrast, mothers who were not able to break the cycle of abuse had not integrated their own childhood experiences. These mothers tended either to idealize their past, unrealistically viewing it as all good, or to be consumed by negative feelings about their past, viewing it as all bad. Furthermore, these mothers did not see a connection between their own childhood history and how they currently were raising their children. They tended to repeat the abusive pattern in their relationships with their partners and with their child, but they did not see the link between their current behavior patterns and their past. The abusive experience was not a memory on which the individual could reflect, but instead was repeatedly acted out. These mothers often talked about their history of abuse in a vague, disconnected fashion, as if it did not really happen to them.

Main and Goldwyn's (1984) study of adults' representations of their early attachment experiences converges with our findings and provides further evidence of the link betwen a mother's thoughts about her own history and the quality of her relationship with her child. The important variable is not the actual care a mother received in childhood, but rather the way she has come to think about that care. Specifically, mothers who deny the pain of their own history and/or dismiss the effect of that experience on the way they function now are likely to form an "anxious attachment" with their own children. Anxious attachment typically arises when a child does not receive sensitive, predictable care during the early months of life. Best assessed when the child is 1-2 years of age, anxious attachment is characterized by the child's difficulty in being comforted by mother during times of distress, and an inability to use the mother as a secure base from which to explore. The anxiously attached child is at risk for emotional and behavioral problems later in childhood (Erickson, Sroufe, and Egeland, 1985.)

Likewise, a mother who is still preoccupied with past experiences, perhaps caught up in rage or shame about that past, is likely to have trouble being sensitive to her baby's needs and responding to them in a way that facilitates secure attachment. On the other hand, mothers who have arrived at a coherent, integrated, autonomous way of thinking about their past most often develop a secure relationship with their own child.

For parents who have not worked through the pain of their own abusive childhood, it is important to consider how preventive intervention might help to bring about that integration and resolution. In the STEEP program (Steps Toward Effective, Enjoyable Parenting), a prevention program we developed and are evaluating at the University of Minnesota (Erickson, 1989), a major goal is to help the new mother look honestly at her own childhood in a way that frees her to respond in the best possible way to her children. We seize every opportunity to tie a mother's current experiences with her baby to her own experiences in childhood, striving to help her move beyond global generalizations about the past to specific anecdotal memories of experiences with caregivers. For example, as we watch a mother comfort her tired, cranky baby, we raise questions about what the baby might be feeling, share memories of similar experiences from our own childhood, and ask such questions as, "Can you remember a time when you were little and needed to be comforted? What happened? How did you feel?" And we acknowledge how trying it can be to provide for a child what seldom was (or is) provided for us. As Selma Fraiberg and her associates described so eloquently in "Ghosts in the Nursery" (Fraiberg, Adelson, and Shapiro, 1980), spending time in the home with mother and baby can help both the therapist and the mother make important discoveries about the mother's past, and major breakthroughs in her ability to rise above that past with her own child.

Furthermore, we have found group activities to be especially powerful in bringing about a realistic examination of the past. In one exercise we place written messages on a table—messages conveyed to children in overt statements or implicitly through parents' actions. We then ask the parents to choose the messages they remember hearing as children (e.g., "You're so cute," "I can't believe you would do that," "You sure are strong," "If you do that again I'm leaving for good"). Discussion follows, focusing on the feelings those messages evoked, both positive and negative. Then mothers are asked to choose other messages they wish they had heard. Finally, they are asked to choose the messages they want to pass on to their child, symbolically discarding the messsages they do not want to repeat from their past. Mothers practice conveying those positive messages to their own child during mother-child play time. As some mothers begin to talk openly about the pain of their past, others may remember an incident or a feeling for the first time, amazed at how they had blocked it from memory for so many years. Within this context, we discuss the defenses that we

ERICKSON *(continued from page 2)*

all use to protect ourselves from pain, acknowledging the value of such defenses in enabling us to survive some terrible experiences. We also talk explicitly about the research findings which indicate that facing painful memories is a critical step in avoiding repetition of the past. This is important in helping parents recognize that the past does have a powerful influence on their present relationship and that, if they remain aware of the past, they do not have to repeat it with their own child.

Toward New Models of Self and Others

To enter into such intimate therapeutic work requires that we first build a relationship of trust. For people with a history of being maltreated, such a trusting relationship is often hard to create. Children who are abused by their caregivers grow up expecting that their needs will not be met, and that others will be hostile, rejecting, or unavailable. Abused children learn to see themselves as unlovable and unable to get what they need in a relationship. These models of other and self are carried forward, influencing abuse survivors' expectations in other relationships (Bowlby, 1980). Even when someone behaves in a loving, caring manner toward them, they may discount or defensively exclude the experience as a way of maintaining the existing models. In fact, abused children often develop behaviors that make it difficult for others to respond in a caring, supportive way. For example, children who are physically abused tend to develop aggressive, noncompliant behaviors that provoke anger from peers and teachers (e.g., Erickson, Egeland, and Pianta, 1989). We know also that infants who are not nurtured or comforted during times of distress will learn to avoid their caregiver when they're distressed. We have found that avoidant babies continue to avoid close relationships as they get older (Sroufe, 1983).

As these children grow up and become parents themselves, they may bring with them 20 years of experience that has reinforced those early negative models of other and self. It takes special effort to overcome such anger or avoidance and help the abuse survivor move toward more positive models. This is one of the major challenges for preventive intervention aimed at helping abuse survivors deal with the transition to parenthood.

Our research and intervention experience suggest that the time just before the birth of a first child is a special window of opportunity for building such a relationship of trust and supporting the young mother as she embarks on the new adventure of parenting. In the STEEP program, the participant is recruited through her obstetric clinic during the second trimester of pregnancy, before she could have been judged in any way as a failure as a parent. We have observed that most women, during this time in their pregnancy, perceive a need for some additional support and recognize the offer of such a service as an opportunity to address their own needs and to try to give their children a good start in life. They in no way seem to see the offer of this service as a judgment that they have done something wrong. The program begins with home visits during the remaining months of pregnancy, visits that are extremely flexible and allow the facilitator to meet the mother where she is, to address needs as identified and defined by the participant, and to move as slowly as necessary in developing a relationship of trust. After several weeks of relationship building through home visits, the young mother is invited to join in a group with seven to nine other mothers with due dates close to her own. The group is led by the same facilitator who makes home visits to that mother. Many mothers have affirmed our belief that their already established connection with the facilitator helped them muster the courage to join a group of strangers in talking about their children and issues from their own lives.

Facilitators do not give up on a STEEP participant, even if she misses home visits and group sessions repeatedly. If a mother says that she wants to participate, we continue to show up for home visits and to offer rides to group, just as we have promised. Several women have commented that STEEP was their first experience with someone who did not give up on them, and our persistence has paid off in many cases. Through her behavior, the STEEP facilitator in many ways contradicts the mother's models of others as unavailable and unaccepting and her model of self as unworthy of being cared for.

A strong theme throughout the STEEP program is empowerment. The message we try consistently to give to mothers is, "I believe that you can do it." The concept of empowerment is central to the way we work with the mothers around issues they face in their everyday lives, such as finding adequate housing, asking questions of health care providers, choosing child care, pursuing educational or work goals, and communicating effectively with friends and family. We constantly ask ourselves, "What does this mother need to allow her to address this issue herself?" She might need information, transportation, support, or encouragement—rarely does she need us to solve the problem for her. An empowerment approach is critical to our efforts to modify the working models that mothers with a history of abuse and neglect have of themselves. For example, if we do too much for a mother, we are reinforcing a model that she is incapable of doing things on her own. On the other hand, if we do too little, we may reinforce her model of others as unavailable and unsupportive, and we also may set her up for another failure experience that will perpetuate her model of self as incompetent and powerless.

Implicit in an empowerment approach is a focus on strengths rather than deficits. One example of a strength-focused strategy that we have found to be quite effective is the therapeutic use of videotaping of parent-child interaction. By videotaping the parent and infant together, and then viewing the tape with the parent immediately afterwards, we are able to focus on what the parent knows about her child and on behavioral strengths in both the parent and the child. Avoiding a directive, expert-type approach with the parent, we instead make comments such as, "You knew just what your child needed there, didn't you? How did you know?" Of course, there are times when we see something that we know was aversive for the baby. When we would like to see a parent try a different behavior, we might say, "I wonder what he would do if you were to try _____?" Or we ask, "What do you think your baby was feeling there?" which usually taps into the parent's ability to read the baby's signals and discover another way of responding.

In summary, research and intervention experience suggest that preventive intervention should focus on an honest examination of past maltreatment and its influence on parenting, balanced by a clear message that the participant can move beyond the past and be the parent he or she wants to be. All of this needs to happen, we believe, within a framework of a relationship of trust and support, a relationship built on the recognition that the parent's own emotional needs are valid, as are the baby's. Although there is still much to learn about breaking intergenerational cycles of maltreatment, we are hopeful that such relationship-based interventions will help parents move toward new ways of caring for their children, and for themselves.

Note: Portions of this article appeared previously in Egeland, B., and Erickson, M.F. (December, 1990). Rising above the past: Strategies for helping new mothers break the cycle of abuse and neglect. *Zero to Three, 11* (2), 29-35.

Martha Farrell Erickson, PhD, is coordinator of Project STEEP at the University of Minnesota, supervises implementation of the STEEP program in community agencies, and consults with various healthcare and social service organizations on preventive intervention and program evaluation. Byron Egeland, PhD, is a professor in the Institute of Child Development at the University of Minnesota and a principal investigator on Project STEEP and the Minnesota Mother-Child Project.

References

Bowlby, J. (1980). *Attachment and loss. Vol. 3. Loss, sadness and depression.* NY: Basic.

Egeland, B. (1988). Breaking the cycle of abuse: Implications for prediction and intervention. In K.D. Browne, C. Davies, and P. Stratton (Eds.), *Early prediction and prevention of child abuse.* NY: J. Wiley and Sons.

Egeland, B., Jacobvitz, D., and Sroufe, L.A. (1988). Breaking the cycle of abuse. *Child Development, 59* (4), 1080-1088.

Erickson, M.F. (1989). The STEEP Program: Helping young families rise above "at-risk." *Family Resource Coalition Report,* No.3, 14-15.

Erickson, M.F., Egeland, B., and Pianta, R.C. (1989). The effects of maltreatment on the development of young children. In D. Cicchetti and V. Carlson (Eds.), *Child maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (647-684). NY: Cambridge University Press.

Erickson, M.F., Sroufe, L.A., and Egeland, B. (1985). In I. Bretherton and E. Waters (Eds.), *Monographs of the Society for Research in Child Development, 50* (1-2), 147-166.

Fraiberg, S., Adelson, E., and Shapiro, V. (1980). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired mother-infant relationships. In S. Fraiberg (Ed.), *Clinical studies in infant mental health: The first year of life* (164-196). NY: Basic.

Main, M. and Goldwyn, R. (1984). Predicing rejection of her infant from mother's representation of her own experiences: Implications for the abused-abusing intergenerational cycle. *Child Abuse and Neglect, 8,* 203-217.

Sroufe, L.A. (1983). Infant-caregiver attachment and patterns of adaptation in preschool: The roots of maladaptation and competence. In M. Perlmutter (Ed.), *Minnesota Symposium in Child Psychology, 16,* 41-91. Hillsdale, NJ: Erlbaum.

Steele, B.F. and Pollock, C.B. (1968). A psychiatric study of parents who abuse infants and small children. In K.E. Helfer, and C.H. Kempe (Eds.), *The battered child* (89-133). Chicago: U. of Chicago Press.

RESEARCH

BELIEVING CHILDREN VS. BEING NEUTRAL: WHAT YOU THINK CAN INFLUENCE YOUR JUDGMENTS ABOUT SUSPECTED VICTIMS OF SEXUAL ABUSE

—by Kathleen Kendall-Tackett

Over the last few years, professionals have heard two contradictory messages about children's truthfulness regarding sexual abuse. Some writers have encouraged professionals to believe that children rarely lie about sexual abuse, while others emphasize the importance of maintaining a neutral stance when approaching suspected child victims. People who argue for believing children state that children are more likely to open up to someone who approaches them with an attitude of belief rather than skepticism. On the other hand, others point out that interviewers need to be neutral because the possibility of false allegations looms large, especially in cases involving custody or a preschool-age child.

Does it make a difference whether interviewers tend to believe children or interview them neutrally? A recent survey indicates that it does (Kendall-Tackett and Watson, in press). The authors asked 201 Boston-area professionals to describe how they interviewed suspected victims of child sexual abuse. In addition, subjects were asked to describe their initial expectation when approaching children by asking them to answer the following question: "When you talk to children about sexual abuse, do you tend to believe the child unless there is evidence to the contrary, doubt the child unless there is evidence to the contrary, or start with no opinion one way or another?"

One hundred-thirty (65%) professionals indicated that they tend to believe the child, and 70 (35%) indicated that they are neutral (one person did not answer the question). Table 1 shows how subjects of all different professions answered this question.

Interestingly, the two different expectations cross all professional boundaries. We expected that law enforcement professionals would tend to be more neutral in their approach and that mental health workers would tend to believe children. By and large this is true; however, in many instances it is not. These differences would only be academically interesting if they had not been shown to influence perceptions of behavioral indicators of sexual abuse.

The most striking example of the influence of expectation was seen in perceptions of children's behavior with anatomical dolls without verbal description of abuse. Subjects were asked to rate various behaviors as to whether they were convincing that abuse had occurred. (Subjects answered questions and did not view actual children.) Not surprisingly, people who believe children tended to rate these indicators as more convincing than those who started from a neutral position. The effect of expectation appeared even after gender and profession of the interviewer, and purpose of the interview (investigative vs. therapeutic) were statistically controlled for.

Table 1

Professionals' Expectations about Children's Truthfulness about Being Sexually Abused

PROFESSION	EXPECTATION			
	Believe		Neutral	
	#	%	#	%
Mental Health Professionals				
Psychologist	26	74	9	26
Psychiatrist	3	75	1	25
Therapist	4	44	5	56
Social Worker	51	78	15	22
Intern	1	50	1	50
Nurse Clinical Specialist	5	71	2	29
Other Mental Health Professions	3	75	1	25
Law Enforcement Professionals				
Asst. District Attorney	4	40	6	60
Law Enforcement Officer	22	44	28	56
Victim/Witness Advocate	5	83	1	17
Other DA Employee	6	86	1	14
Total	**130**	**(65%)**	**70**	**(35%)**

One caution is in order for interpreting these findings, however. Some people assume that professionals who believe children are misleadingly biased. Unfortunately, the data available from this study cannot tell us whether professionals who believe children or those who are neutral are inaccurate in their judgments: we can't tell which expectation leads to misleading bias. Indeed, future research might reveal that people who are neutral are misleadingly biased against children, because the neutral position mistakenly assumes that there is only a 50-50 chance that the child is telling the truth.

Interestingly, in another analysis of this data, professionals' expectations were not related to the number of false reports that they reported in their total caseloads. Both subjects who believe children and those who are neutral reported that a very small percentage (approximately 5%) of children they worked with had said they were abused when they were not. Expectations about children's truthfulness appear only to influence perceptions of behavioral indicators.

These findings suggest that we should be aware that expectations can influence our perceptions of symptoms of abuse. Perhaps more important, persons who train interviewers should be aware that if they encourage either believing children or being neutral, they are influencing the future perceptions of their trainees. We currently act as if differing expectations do not matter, but the present research indicates that they do. Finally, these findings indicate a need for more detailed research on interviewers' expectations. We need to know whether believing or being neutral leads to the most accurate information, and which has the least damaging effect on suspected victims.

References

Kendall-Tackett, K.A., and Watson, M.W. (in press). Factors that influence professionals' perceptions of behavioral indicators of child sexual abuse. *Journal of Interpersonal Violence.*

This research was supported by grants from the National Institute of Justice, the American Psychological Association, and the Association for Women in Science. Preparation of this manuscript was supported by funds from NIMH grant T 32 MH15161 for Family Violence Research Training.

Kathleen A. Kendall-Tackett, PhD, is a Research Associate at the Family Research Laboratory, University of New Hampshire.

CALL FOR RESEARCH PAPERS

The San Diego Conference on Responding to Child Maltreatment, to be held January 22-25, 1992, is seeking papers pertaining to child abuse. One of four research sessions will be devoted to foster care issues; the other three will be open. Papers should present original research, not previously published. Research may be from any discipline, and previous presentation will not be disqualifying. Graduate students are encouraged to submit. Four-hundred word abstracts should be mailed to John Landsverk, PhD, Center for Child Protection, Children's Hospital of San Diego, 8001 Frost St., San Diego CA 92123. **Deadline for submission is November 1, 1991.** Presentations will be chosen by November 15, 1991.

PRACTICE

COMMUNICATING WITH TROUBLED CHILDREN THROUGH EXPRESSIVE ARTS

—by Mary Jean Meyer

The use of expressive arts therapy is gaining acceptance as an adjunct to more traditional therapeutic interventions, particularly in the field of child abuse. Children who have been victims of physical and sexual abuse frequently have trouble with impulse control, defensive functioning, reality testing and speech and language development. These children are often unable to verbalize thoughts and feelings surrounding traumatic life experiences. The fear, pain, and anger they feel may be expressed more readily through a variety of art forms such as drawing, painting, sculpting with clay, playing in the sand, making puppets or woodworking.

Therapists do not need to be directly involved in creative expression, but they must feel comfortable allowing a child to use such means of expression. By receiving the messages that are either too painful or too dangerous to verbalize, or for which there are, as yet, no words, the therapist conveys a sense of acceptance and provides an otherwise missed opportunity for advancing the goals of therapy. Below are some art therapy techniques which have proven effective in working with victimized children.

Engaging a child in a conversation about his or her artwork is key to understanding the content. When talking to a child about his or her art, one must employ genuine listening, unintrusive observation, and gentle verbal intervention. Ask the child to describe in his or her own way a drawing, painting, or clay project. The question, "What is this?" sometimes shuts a child down. Instead, you might ask, "Tell me about this," or, "Can you give this a title?" Children are usually quite willing to tell a story about their pictures. Art form descriptions are often like dream descriptions: they contain omissions, strange wordings, and interesting affect. Note the inclusion and exclusion of specific items as a child makes choices based on what is emotionally meaningful. Be aware of the choice of, lack of, and unusual use of color. You can promote further self-discovery by asking a child to elaborate on specific aspects of an art object. Show enthusiasm for a child's willingness to share his or her art, and write down everything he or she says about his or her art projects: this is rich information about his or her perceptions and feelings.

Some children are hesitant to begin a therapeutic relationship, but even the most resistant ones can be persuaded to engage in a simple activity called the squiggle game (Winnicott, 1971). Request that the child make a free spontaneous scribble on a piece of paper, with eyes open or closed. Then create something from the child's scribble in a contrasting color. Next, reverse the procedure: the therapist draws a scribble and the child creates something from it. This exercise can be repeated rapidly through several sequences, with the therapist asking the child to share what she has drawn. The squiggle game helps children overcome their inhibitions about drawing, and encourages free expression of ideas and fantasies. As a process without rules, it is an excellent exercise for children who are fearful of making mistakes. I have seen many children reveal conflicts in their lives through this process: squiggles become instruments of abuse such as belts, whips, and sticks, or become body parts which concern the child. Some children have created graphic pictures from squiggles and disclosed physical and sexual abuse.

Children may also reveal significant information through the social atom technique. This exercise, developed by Vander May (1975) on the basis of Moreno's concept of the social atom and the sociogram (1946), is valuable as a regular intake procedure. The approach is to present the child with glue, markers, a large circle of drawing paper, and a wide selection of colored construction paper cut into circles (to represent women) and triangles (to represent men). The therapist asks the child to imagine that the circle of paper represents his or her world, and requests that she put herself at the center, and place around his or her family members and others (including pets) who have been involved in his or her life, both positively and negatively, irrespectively of death, distance, or other factors. Persons with whom the child feels closer should be placed nearby, and those with whom the child feels distant should be further away. When children have finished, they are quite willing to identify people and explain the reason for their placement and their color, revealing a wealth of information about their thoughts and feelings. When used in family therapy, parents can gain a great deal of perspective on the differences in their own and their children's perceptions of family dynamics.

Sandplay is a wonderful medium for working with troubled children. One of its advantages is the ease with which a child can present his or her situation. The sand box requires no skills—just a desire to play. In sandplay, no instructions are given. The child is simply encouraged to create a sand world with miniatures and small symbolic objects. Dealing with small inanimate things gives a child a chance to gain control over situations that are overwhelming. The child may repeatedly bury abusive parents in the sand, where they have much less power to hurt the child. Some children give a running commentary about events in their sand world, both ventilating feelings and providing the therapist with valuable information. Other children may be silent as they play. Engaging the child in conversation about his or her sandplay can elicit important clarifications and provide insight about his or her activity.

Of all the materials I use with children, clay is the most popular. Clay is useful for its tactile and kinesthetic qualities. For borderline children who are struggling to maintain a hold on reality, the malleable cohesive quality of clay conveys a sense of reality and substance (Kramer, 1979). Aggressive children can pound clay, anger can be ventilated through clay, children with low self-esteem can gain a stronger sense of self by shaping and reshaping clay, making mistakes less noticable. The similarity between clay and body products can exert a regressive pull stimulating memories and feelings from early childhood. Although some therapists are put off by the apparent messiness of clay, in fact it's the cleanest material I use with children. It dries to a fine dust, and easily washes off hands and clothes.

Footprints is a technique I have found particularly useful in allowing victimized children a non-threatening way to get in touch with the reality of past experiences. Unroll a long sheet of white paper on the floor (shelf paper will do, or a roll of drawing paper from an art store). Ask the child to take several slow steps on the paper, and as she does, draw around his or her feet to make footprints. Eight footprints are usually ample, but leave extra paper in case more are needed. Explain to the child that the footprints represent his or her life from birth until now, and ask him or her to fill them up with good and bad memories. Begin with the earliest happy memory, as children often find it difficult to share sad feelings until they have shared the safer happy ones. In the second footprint, ask for an unhappy memory, going back and forth between positive and negative as they fill up. I have found that victimized children often run out of good memories, and use the footprints to record the reality of traumatic events in their lives.

Using expressive arts techniques is an appropriate way for victimized children to begin externalizing some of the trauma they have experienced. Neither the therapist nor the child need to be skilled in the use of art materials to use art techniques effectively. With every technique, be sure to write down everything the child says for your own and your agency's records. The various art forms serve as a bridge to verbalization so that a child can become more effectively involved in the therapeutic process.

Mary Jean Meyer, MA, is an expressive arts therapist who provides consulting and therapeutic services to child care facilities, state agencies, and private agencies in New England.

References

Kramer, E. (1979). *Childhood and Art Therapy.* NY: Schocken Books, Inc.

Moreno, J.L. (1946). *Psychodrama.* First Volume. NY: Beacon House.

Vander May, J. (1975). Perceptual social atom sociogram. In *Group psychotherapy and psychodrama, 28,* 128-134.

Winnicott, D.W. (1971). *Therapeutic consultations in child psychiatry.* NY: Basic Books, Inc.

PRACTICE

WORKING WITH RESEARCHERS: A GUIDE FOR CLINICIANS

—by Kathleen Kendall-Tackett

In the last issue of *The Advisor*, dedicated to "Promising Programs and Approaches in Child Maltreatment," several contributors urged professionals in the field to produce more research, specifically more outcome studies that enable us to assert with confidence that certain therapeutic approaches work better than others. To be fully accountable to both our clients and our critics, we need to have more than clinical impressions, however powerful, to demonstrate that our therapeutic interventions have a positive effect. Clinicians are in an excellent position to produce these studies, since we have ready access to clinical populations and records. But clinicians often don't know how to begin or conduct research, and often find researchers difficult to work with and insensitive to clinical needs and concerns. This article is intended to introduce clinicians to research basics, so clinicians can better evaluate whether their organization has the resources necessary to launch a research project; what sort of research project they might reasonably undertake; and what researchers are appropriate for them to work with.

The first step—one that is, surprisingly, often overlooked—is to decide which specific research questions you want to address. Many people approach research with the idea of asking "everything," only to be rudely suprised when they don't have the data they need to answer what they find out too late is their most important question. You must carefully articulate your research question so you know what type of data you need to collect. Some examples of research questions are: What are the effects of abuse on children, adults abused as children, or family members? Which treatment paradigms are most effective? How effective are various intervention strategies? You must think about what you will try to measure (what you measure is called the "dependent variable"—e.g., the effects of abuse; the effectiveness of a treatment program; the effect of exposure to anatomical dolls, etc.), and how you will go about measuring this variable. Say, for example, you want to measure the effect of abuse on a child's social adjustment: how will you measure social adjustment? Will you use a paper-and-pencil inventory, or a more concrete measure, such as the number of friends the child has? Will you use the child's self-report of symptoms or get measures from parents, teachers, or clinicans? These decisions will influence the specific questions you can address.

While you are considering which research questions you want to address, you must also consider how much time and trouble you are willing to dedicate to data collection. The amount of time and trouble you're willing to take will help determine your data collection procedure, which in turn strongly influences the types of questions you can ask. There are three general types of data collection: from least strenuous to most strenuous these are data collection from clinical records, one-time data collection, and longitudinal research.

Using clinical records as a source of data is widely practiced because it is non-invasive and inexpensive. To collect these data, clinicians work with researchers to quantify information that already exists in clinical files. Clinicians don't have to bother their clients, and data collection can be accomplished relatively quickly. This method has some drawbacks, however. The major problem is a lack of control of data collection. In order to get data that are truly comparable, we need to ask, as nearly as possible, the same questions, in the same order, in the same manner. Generally when we're talking to clients we are free to follow leads and ask questions about whatever seems relevant to the client at that time. But such nonstandardized clinical interviewing can not only result in a lot of missing data, it can bias the data so thoroughly that it's unusable. Nevertheless, data collected from clinical records can provide descriptions of demographic characteristics of victims, perpetrators and abuse experiences. The descriptive data alone are interesting, but these data can also allow examination of the relationship between variables. For example, how do the abuse experiences of males differ from those of females? What are some of the differences between older and younger victims? What is the relationship between identity of the perpetrator and other abuse characteristics such as duration, frequency, severity, or age of the victim? Many of these types of questions can be addressed with data in clinical files.

One issue you need to consider with the use of clinical records (or any data collection involving your clients) is confidentiality. You must carefully limit the number of people who will view your records, and should never allow coders to connect names with the data they are coding. One way to do this is to copy any records you want researchers to see and black out any identifying information. Also, everyone associated with the study should exercise care when handling records, and lock them up when they are not in use. By exercising these types of precautions, research can be accomplished without compromising the confidentiality of your clients.

Another research option is one-time data collection. This method offers the advantage of control over data collection, but is more costly and time-consuming than data collection from clinical records. If your data collection procedure is very involved, you may need to seek outside research funding to pay for added staff, printing, and equipment. Your research question will determine the appropriate time for collecting data. If you want to know about the effect of abuse before treatment, you must collect data at intake. If you want to study the effects of treatment or other types of intervention, you will want to collect data either at a specified point during treatment or upon completion.

When you know what data you need and when you need to collect it, you must make plans to get it in a standardized format. You may choose to use an existing, easily-available standardized measure such as the Child Behavior Checklist (Achenbach and Edlebrock, 1984). Or, you may decide that your research question requires use of a specialized interview. If an interview is required, you need to ensure the interview is "user-friendly" for the interviewer, for the client to be interviewed, and for the person who is going to collect the data from the recorded or written responses to the interview. A qualified researcher can help you devise an interview that meets all these requirements. The interview should be read to the clients, so all subjects hear the same questions in the same order. A well-designed interview yields valuable clinical information and data for research purposes, furthering both therapeutic and research needs.

The final method, longitudinal data collection, requires data collection at more than one point for each subject. For instance, research on therapeutic effectiveness may require data collection at intake, at periodic intervals during the course of therapy, immediately after therapy and for periodic intervals after therapy has ended. This is the best way to collect information on questions such as the effectiveness of treatment and the long-term effects of abuse, court intervention, maternal support, prevention curricula, etc. Longitudinal studies yield very good data, but are substantially more costly and invasive than one-time data collection studies. Most organizations need separate outside funding to conduct longitudinal research.

In addition—and this is one of the points of most friction between clinicians and researchers—the demands of longitudinal research may dictate how you conduct your clinical practice. Indeed, as the variables get more complicated (for instance, specific treatment interventions and their effects), the research "protocols" that tell investigators what they must do to further the research get more detailed and exacting. Some clinicians balk at having to modify their practice to conform to what they see as

continued on next page

TACKETT *(continued from page 7)*

the rigid demands of research. Many feel a sense of loss at having to give up their spontaneous, intuitively guided interaction with clients, and worry that their effectivness as therapists is being undermined. Research protocols devised by researchers who haven't consulted sufficiently with therapists inevitably lead to complaints that researchers make impossible demands and don't know what it's like "out there" in the field. Researchers, for their part, are often frustrated by the lack of rigor in clinical procedures that prevents the collection of usable data.

The value of longitudinal research is that it can yield critical, reliable guidance for policymakers and practitioners who are seeking the most effective means of working with the people we spend our lives trying to help. Resolving perhaps the most important conflict between researchers and clinicians requires two steps: that clinical staff understand and be committed to the goals of the research, and that researchers understand clinicians' concerns and be committed to creating protocols that respect them. If researchers and clinicians truly collaborate, both of these steps can be taken.

A critical part of deciding whether to undertake a research project is evaluating your resources: do you have, or can you get, sufficient office space, supplies, funding, computer equipment, access to a good library, and the cooperation of your staff? If you are on a tight budget, with an overburdened staff, you will probably want the easiest and least invasive type of data collection, if you want to do research at all. Also, you need to consider whether you will benefit sufficiently from your efforts. What exactly are you hoping to gain by doing research? What do you expect in terms of involvement, authorship on papers, participation in conferences, and so forth? Thinking about these questions ahead of time can save a lot of emotional energy and disappointment later on.

Once you have decided that you can undertake research and have given serious thought to your research question and method of data collection, you need to locate a researcher with whom you can collaborate. A qualified researcher can help you clarify your question, choose data collection methods and instruments, devise an instrument if necessary, collect and analyze data, identify and approach potential funding sources, and locate appropriate outlets for publication of your findings. If you are in the proximity of a university, you might consider approaching faculty in psychology, sociology, social work, medicine, or other research-oriented fields. If this is not feasible, consider fellow APSAC members in other parts of the country. Long-distance collaborations can be complicated, but are not impossible, especially for clinical-record or one-time data collection studies. Evaluate whether your potential partner has the necessary skills to conduct a research project. Find out about his or her formal educational background in research methodology and statistics. Perhaps more importantly, find out if your potential partner has a history of completing projects and getting articles published. Ask to see his or her curriculum vita and copies of current articles. All the research knowledge in the world will do you no good if your partner has a history of collecting data and doing nothing with it. Finally, use your clinical skills to determine whether or not you can work with this person. Like most professions, research has its share of egotists. It's important that you find someone who will respect you as a colleague and be willing really to collaborate with you. Your partner should take your needs and the limitations of your clinical practice into account, while encouraging you to make the compromises that may be necessary to produce high-quality data.

Although the hurdles can be numerous, the rewards of good clinical research are great. The ultimate beneficiaries are clients, present and for years to come.

References

Achenbach, TM, and Edlebrock, CS, (1984). *Child Behavior Checklist.* Burlington VT: University of Vermont.

Kathleen Kendall-Tackett, PhD, is a Research Fellow at the Family Research Laboratory, University of New Hampshire, Durham, NH. *Preparation of this manuscript was supported by funds from NIMH grant T32 MH15161 for Family Violence Research Training.*

REID *(continued from page 1)*

questing the copies they've missed, and we'll send these issues out first class.

I hope you will bear with us during this period of transition. Within a year, everyone will be getting their *JIV*s on time, and the travail will be a thing of the past.

Nominations Sought for 1991 Board Election and Membership Awards

You still have time to nominate yourself or a colleague for election to APSAC's Board of Directors. APSAC's bylaws direct the Nominations Committee (co-chaired by Barbara Bonner, PhD, University of Oklahoma Health Science Center, and Lucy Berliner, MSW, University of Washington Harborview Medical Center) 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 supporting your nomination. At our current rate of growth (about 70 new members each month!), 5% of the membership should be about 95 people by election time. Nominations by petition must be submitted no later than September 1 to allow time for verification of the signatures before the election. If you wish to *recommend* one or more people for nomination, send their names to APSAC in care of the co-chairs of the committee.

The Awards Committee is also seeking 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. Please call or write committee chair Susan Kelley, RN, PhD (c/o APSAC) with your suggestions.

Planning for Annual Meeting in San Diego Underway

For the third year in a row, APSAC will hold its annual meeting at the San Diego Conference on Responding to Child Maltreatment, co-sponsored by APSAC and the Center for Child Protection of Children's Hospital of San Diego. The conference will be held January 22 - 25, 1992. On January 21 (the day after the Martin Luther King holiday), APSAC will offer its all-day Advanced Training Institutes. In addition to those currently offered on audiotape (see ad on p. 15), APSAC's Task Force on Psychological Maltreatment will offer an Advanced Training Institute. Intended particularly for specialists who are expected to conduct evaluations, the Institute's goal will be to clarify and provide guidance regarding the following dimensions of assessment: criteria, techniques, processes, organization and interpretation of findings, and presentation of findings.

Additional information on the content of the other Institutes and on how to register for them will be published in the next issue of *The Advisor*. In addition to the Institutes, the conference will feature a strong research component, and APSAC-sponsored sessions focused on the practical applications of current research . Look for an early mailing of the conference brochure soon. We hope we'll see you there!

A NOTE ON MEASURES

—by William N. Friedrich

When conducting research, you need to look for published measures that have two key features: documented reliability and validity. "Reliability" means that the measure consistently measures what it purports to measure, and the various items within the measure reflect a coherent conceptual understanding of the entity to be measured. "Validity" refers to the degree to which an instrument measures what it is intended to measure.

Measures that could be useful can be divided into "self-report" and "other report" for both parents and children.

Self-report by parents

For personality functioning, the MMPI and the SCL-90 are widely used.

Researchers interested in parents' coping skills can borrow from Rudolf Moos's Health and Daily Living Manual, which assesses such useful dimensions as social support and coping style.

For parents' report on the quality of their family environment, Moos's Family Environment Scale is useful.

A good abuse-specific measure is the Trauma Symptom Checklist-40, developed by John Briere and Marsha Runtz.

Self-report by children

The Child Depression Inventory, the Piers-Harris Self-Esteem Inventory, the Harter Self-Concept Scales, or John Briere's newly developed Trauma Symptom Checklist—Children are all good measures.

Good projective measures for children are the Rorschach, the Roberts Apperception Test for Children, and Family Drawings.

Other report on children

Researchers who want to ask others' opinions of particular children often use the Achenbach Child Behavior Checklist (which has both the teacher and parent form), the Louisville Behavior Checklist, and the Child Sexual Behavior Inventory, developed by Bill Friedrich and available from the author.

Clinicians undertaking a collaborative effort with researchers are in a stronger position if they know of these basic measures and what they are meant to do.

William N. Friedrich, PhD, is Associate Professor and Consultant, Section of Psychology, the Mayo Clinic, and is Diplomate in Clinical Psychology/Family Psychology by the American Board of Professional Psychology.

NEWS

ENDOWMENT FUND, STATE CHAPTERS CONTINUE 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 $4,435 to help APSAC toward its $25,000 goal. Those people listed as State Chapter Contacts have contributed untold hours to make APSAC chapters happen in their states. Our thanks to all of them!

APSAC FRIENDS

Thomas V.P. Alpren, MD
Trina Menden Anglin, MD, PhD
Janet Adams-Wescott, PhD
Linda Blick, MSW, LCSW
Barbara Bonner, PhD
Renee S.T. Brant, MD
Mark Chaffin, PhD
Dawn Clarke Palchikoff, MA
Anne Harris Cohn, DPH
Dorothy Conzelman, MD
David Corwin, MD
Thomas Curran, LCSW, JD
Harry Elias, JD
Claire Ellis, MA
Mary Z. Farrell
Lorraine E. Fox, PhD
Agnes Franz, MD
Terri Gallmeier, PhD
Charlie Gentry, MSW
Jean Goodwin, MPH, MD
Sol Gothard, MSW, JD
Carole Jenny, MBA, MD
Phyllis Kaufman, PhD, LCSW
Susan J. Kelley, RN, PhD
Robert Kellner, MD
G. Richard Kishur, PhD
Elizabeth L. Linder, PhD
David Lloyd, JD
Kee MacFarlane, MSW
Jamshid Marvasti, MD
Ronald D. Matthews, PhD
Rebecca L. McNeese, JD
Irene L. Mellick, LCSW
Simon B. Miranda, PhD
Frances L. Morris, MA
David Muram, MD
L. Dennison Reed, PhD
Theresa Reid, MA
Benjamin E. Saunders, PhD
Judith Schechtman, MSW
Mary Ellen Shields, MD
Roland Summit, MD
John Stuemky, MD
Muriel Templeton, MS
Patricia Toth, JD
Nancy Walentiny, MSW
Diane J. Willis, PhD
Martha K. Wilson, DSW

STATE CHAPTER CONTACTS

States with approved charters:

CO - Elise Katch, PhD
950 S. Cherry St., Suite 1004
Denver CO 80222
303-759-8200

Philip Madonna, MSW
U. Colorado Health Science Ctr.
4200 E. 9th Av., Box C-259
Denver CO 80262

IL - Erin Sorenson
Children's Advocacy Center
2121 Lake St.
Hanover Park IL 60103
708-213-3900

Susan Liuzzo
PO Box 353
St. Charles IL 60174
708-584-4465

MA - Suzanne White, MSW
Middlesex Co. DA's Office
40 Thorndille Street
Cambridge, MA 02141
617-494-4335

Susan Kelley, RN, PhD
Boston College School of Nursing
Chestnut Hill, MA 02167
617-552-4250

NC - Tim Lemmond, MA
2012 E. 9th St.
Charlotte NC 28204
704-333-2751

Carolyn Cole, MSW
Durham Community Guidance Clinic
Trent & Elba Streets
Durham, NC 27705
919-286-4456

OK - Janet Adams-Wescott, PhD
Family & Children's Services
650 S. Peoria
Tulsa OK 74120
918-587-9471

Rebecca Katz, MEd
2713 NW 20th St.
Oklahoma City OK 73107
405-321-4211

AR - Louanne Lawson, RN
800 Marshall
Little Rock AR 72207
501-370-1013

AZ - Larry Morris, PhD
5190 E. Farness Dr., #112
Tucson AZ 85712
602-323-3156

CT - Barbara Bunk, PhD
200 Oak St., A
Glastonbury CT 06033
203-659-0579

DC - Rosemary Behney, MS
Culpeper Family Guidance Clinic
650 Laurel St.
Culpeper VA 22701
703-825-5656

FL - Donna Watson Lawson, MSW
PO Box 2578
Gainesville FL 32602
904-332-5723

L. Dennison Reed, PsyD
Plantation Psychological Associates
8551 W. Sunrise Blvd., Suite 206
Plantation FL 33322
305-475-0333

HI- Beverly James
James Associates
P.O. Box 148
Honaunau HI 96726

MD- Gail Bethea-Jackson
Psychological Assoc. of Oxon Hill
6178 Oxon Hill Road
Oxon Hill MD 20745

MO - David Corwin, MD
Washington University Medical School, Department of Psychiatry
4940 Audubon Av.
St. Louis MO 63110
314-454-2605

NJ - Susan Cohen Esquilin, PhD
129 Valley Road
Montclair, NJ 07042
201-744-1720

NY- Leah Harrison, RN, MSN, CPNP
Montefiore Medical Center
111 E. 210th St.
Bronx NY 10467
212-920-5833

Don J. Lewittes, PhD
165 N. Village Ave., Suite 118
Rockville Ctr. NY 11570

OH - Robert Reece, MD
Rainbow Babies & Children's Hospital
2101 Adelbert
Cleveland, OH 44106
216-844-3754

David Gemmill, MD and Linda Lewin, RN
Medical College of Ohio
Unit 6B (Child & Family Assessment)
P.O. Box 10008
Toledo, OH 43699
419-381-4403

OR - Betty Reiss, MD
19500 SE Stark
Portland OR 97233
503-669-3900

PA - Thomas F. Curran, LCSW, JD
Children's Advocacy Center
4000 Chestnut St.
Philadelphia PA 19104
215-387-9500

TX - David Cory, MSSW
Texas Dept. Human Services
P.O.Box 6635
Abilene TX 79608
915-695-5750

Nancy DeWees
2932 6th Avenue
Fort Worth, TX 76110
817-926-5618

VA - Cathy Krinick, JD
Commonwealth Attorney's Office
30 King's Way
Hampton VA 23669
804-727-6442

Francine Eckert
Dept. Criminal Justice Services
805 E. Broad St.
Richmond VA 23219
804-786-3967

Michelle Zimmerman, MA, RN
Psychiatric Associates of Chesapeake
1401 Greenbriar Parkway, Suite 175
Chesapeake VA 23320

VT - Alan Rosenfeld, JD
Vermont Children's Rights Center
PO Box 1540
Montpelier VT 05601
802-229-2220

WA - Debbie Doane, MSW
Eastside Sexual Assault Center
925 116th St. NE, Suite 211
Bellevue WA 98004

Florence A. Wolfe, MA
Northwest Treatment Associates
315 W. Galer
Seattle WA 98119

WI- John M. Bailey, PhD
Family Therapy Center of Madison
700 Rayovac Dr., #220
Madison WI 53711
608-276-9191

JOURNAL HIGHLIGHTS

—edited by Thomas Curran

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. All APSAC members 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, to Thomas F. Curran, LCSW, JD, Executive Director, Children's Advocacy Center, 4000 Chestnut Street, Philadelphia, PA 19104.*

PHYSICAL ABUSE, EMOTIONAL ABUSE AND NEGLECT

Claussen, A.H. and Crittenden, P.M. (1991). Physical and psychological maltreatment: Relations among types of maltreatment. *Child Abuse and Neglect, 15*(1/2), 5-18.
This study investigated the hypothesis that psychological maltreatment would be present in almost all cases of physical maltreatment and that it would be more related to detrimental outcomes for children than would severity of injury. Using data collected from two samples of families, one including 175 families referred for CPS investigations in Dade County, FL and the other 215 volunteer normative and disturbed families from the community who were not under investigation for child abuse, both hypotheses were supported. Some important child abuse policy and intervention considerations are discussed, including the apparent need to focus more attention and services on the psychological maltreatment of children, regardless of the presence of physical abuse. (TFC)

Famularo, R., Kinscherff, R., Fenton, T. and Bolduc, S. (1990). Child maltreatment histories among runaway and delinquent children. *Clinical Pediatrics, 29*(12), 713-718.
This study examined the records of 378 children involved in a juvenile court system for histories of child abuse. The results indicate that physical and sexual child maltreatment appear to contribute very significantly to delinquent behavior. Juvenile court attorneys, judges and clinicians are among the professionals who should carefully examine the findings presented. (TFC)

Graziano, A. M. and Namaste, K.A. (1990). Parental use of physical force in child discipline: A survey of 679 college students. *Journal of Interpersonal Violence, 5*(4), 449-463.
This article describes a survey of 679 college freshman about their personal beliefs and experiences with parental force used to discipline them as children. Over 93% of the respondents indicated that they were spanked as children. Perhaps even more important was the high level of acceptance for parental spanking by the respondents who were spanked as children. Important policy and value considerations are discussed.

Kaufman, J. (1991). Depressive disorders in maltreated children. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*(2), 257-265.
This study examined the prevalence of depressive disorders in a sample of fifty-six 7 to 12 year old maltreated children (29 girls and 27 boys) and their mothers. As predicted, a disproportionate number of the maltreated children met the diagnostic criteria for one of the major affective disorders, with many of these children also meeting the diagnostic criteria for dysthymia. A thorough analysis of the study's findings explores important policy, clinical and research considerations. (TFC)

Myers, J.E.B. (1990). Intervention: The best of bad options. *Journal of Interpersonal Violence, 5*(4), 532-535.
This brief article presents a refreshingly well-reasoned and balanced analysis of the role that state intervention should play in cases of maternal drug use during pregnancy. Legal, moral and medical reasons justifying limited state intervention in such cases are outlined. (TFC)

Schellenbach, C.J., Monroe, L.D. and Merluzzi, T.V. (1991). The impact of stress on cognitive components of child abuse potential. *Journal of Family Violence, 6*(1), 61-80.
This article describes research conducted to assess the effects of situational stress on the expectations, interpretations and responses of a group of (16) abusive mothers. Four hypotheses were tested: 1) That parental expectations of child behavior would be more rigid as the potential for abuse increased; 2) That interpretations of child behavior would be more negative as child abuse potential increased; 3) That parental responses would be more controlling, punishing and negative as abuse potential increased; and 4) That stress would affect parents differentially such that expectations, interpretations and responses would become negative as abuse potential increased. While all four hypotheses were supported by the data, the findings from this study did not support a relationship between parental affect and abuse potential. (TFC)

Wesch, D. and Lutzker, J.R. (1991). A comprehensive 5-year evaluation of Project 12 - Ways: An ecobehavioral program for treating and preventing child abuse and neglect. *Journal of Family Violence, 6*(1), 17-35.
This article examines the impact of Project 12 - Ways on treating abusive families, compared to a sample of families served conventionally by the state child protection agency. While data from both samples revealed equivalent rates of child abuse after intervention, in the Project 12 - Ways sample the severity of child abuse had decreased more significantly and families prioritized child abuse as a concern more frequently than did the conventionally treated families. The findings suggest that ecobehaviorial services can be successful in reducing child maltreatment. (TFC)

Wodarski, J.S., Kurtz, P.D., Gaudin, J.M. and Howing, P.T. (1990) Maltreatment and the school-aged child: Major academic, socioemotional, and adaptive outcomes. *Social Work, 35*(6), 506-513.
This study reports differences among 22 physically abused, 47 neglected, and 70 comparison school aged children on child behavior problems, school performance, self-esteem, and independent behavior. Results indicate that the abused children displayed academic and sociemotional problems and neglected children displayed academic delays. (SJK)

SEXUAL ABUSE

Faller, K.C. (1991). Possible explanations for child sexual allegations in divorce. *American Journal of Orthopsychiatry, 61*(1), 86-91.
This article proposes four possible explanations for child sexual abuse allegations in divorce cases. The classifications are based on a clinical sample of 136 cases. While the author acknowledges the limitations of this particular sample, the proposed categories should provide practical and useful assistance to all professionals who encounter such cases. (TFC)

Snow, B. and Sorensen, T. (1990). Ritualistic abuse in a neighborhood setting. *Journal of Interpersonal Violence, 5*(4), 474-487.
This study describes the characteristics of 5 cases of ritualistic abuse that occurred in 5 neighborhood settings involving 39 children. Characteristics shared by all victims included forced sexual activity, threats, and sexual abuse by multiple perpetrators. Seventy-four percent of the children reported Satanic aspects to the abuse. (SJK)

MEDICAL MANAGEMENT OF ABUSE

American Academy of Pediatrics, Committee on Child Abuse and Neglect (1991). Guidelines for the evaluation of sexual abuse of children. *Pediatrics, 87*(2), 254-260.
Although these guidelines were prepared for use by primary care pediatricians who do not "specialize" in chid sexual abuse examinations, they offer general procedural information which should be helpful to all health care professionals. (TFC)

De Jong, A.D. and Finkel, M. (1990). Sexual abuse of children. *Current Problems in Pediatrics, 20*(9), 495-567.
This issue of *Current Problems in Pediatrics* provides comprehensive information for health care providers who treat sexually abused children. Detailed information is provided on conducting the medical exam, obtaining and interpreting forensic evidence, and diagnosing sexually transmitted diseases. (SJK)

Elner, S.G., Elner, V.M., Arnall, M. and Albert, D.M. (1990). Ocular and associated systemic findings in suspected child abuse. *Archives of Opthalmology, 108,* 1094-1101.
This article reviews autopsy findings of 10 children who died of head trauma in which child abuse was the suspected etiology. The authors describe ocular pathology formed in 7 of the 10 cases. All 10 children had evidence of blunt head trauma noted at autopsy, although not all had obvious signs of such trauma during physical examinations before death. (CJ)

Meadow, R. (1990). Suffocation, recurrent apnea and sudden infant death. *Journal of Pediatrics, 117*(3), 351-357.
Twenty-seven cases of young children suffocated by their mothers are reviewed in this article. Nine of the children died. Twenty-four of the 27 had previous episodes of apnea, cyanosis or seizures that were either invented or caused by their mothers. The 27 children in this sample had a total of 18 siblings who died suddenly and unexpectedly early in life. After discovery, 8 of the mothers threatened to kill themselves, and 2 of the fathers committed suicide. (CJ)

LEGAL ISSUES IN CHILD ABUSE

Romer, S. (1990). Child sexual abuse in custody and visitation disputes: Problems, progress, and prospects. *Golden Gate University Law Review, 20*(3), 647-680.
This "Comment" presents a general but useful analysis of child sexual abuse allegations arising out of custody or divorce proceedings. Analyzing and contrasting California and New York case law, statutes, and procedures throughout, the section on validation methodology in child sexual abuse cases provides a very good review of how courts in these states have treated the admissibility of expert testimony, children's testimony, the Child Sexual Abuse Accommodation Syndrome and anatomical dolls. Attorneys with minimal experience handling child sexual abuse cases will find this "Comment" most useful. (TFC)

OTHER ISSUES IN CHILD MALTREATMENT

Crittenden, P.M. and Craig, S.E. (1990). Developmental trends in the nature of child homicide. *Journal of Interpersonal Violence, 5*(2), 202-216.
Neonatal, early and middle childhood homicides in a sample of 171 cases were analyzed in this important study. Age of the child victims was the most significant factor affecting homicide risk. Child age was directly related to the rate of homicide, reason for the death, means of death, relation of victim to perpetrator and legal consequences. Of the infant and young children's homicides examined in this study, 40% had physical evidence of previous abuse at the time of their deaths (TFC).

Dhooper, S.S., Royse, D.D. and Wolfe, L.C. (1991). A statewide study of the public attitudes toward child abuse. *Child Abuse and Neglect, 15*(1/2), 37-44.
A telephone survey of 742 randomly selected adults in Kentucky examined the respondents' knowledge of child abuse, their reporting duty, characteristics of abused children, and characteristics of perpetrators. Although survey results indicated that the respondents were correctly informed about many aspects of child abuse and neglect, only 31% of those (20% of the total sample) who admitted having had reasonable suspicion of child abuse in the past two years actually reported it to the authorities. Important policy issues regarding the public dissemination of child abuse information are discussed. (TFC)

Urquiza, A.J. (1991). Retrospective methodology in family violence research: Our duty to report past abuse. *Journal of Interpersonal Violence, 6*(1), 119-126.
Conflicts between the use of retrospective designs in child abuse research and current child abuse reporting laws are discussed in this brief article. While researchers are not specifically identified as mandated reporters, it is argued that they nonetheless have a legal and ethical duty to report any "reasonable suspicion" of child abuse or neglect derived from their research. Among the recommendations made for child abuse researchers using a retrospective design is that sufficient information be obtained from study subjects to make a determination of their current safety and the safety of others. (TFC)

Contributors for this issue were Carole Jenny, MD, Director of Child Advocacy and Protection Team and Associate Professor of Pediatrics, The Children's Hospital, Denver, CO; Susan J. Kelley, RN, PhD, Associate Professor, Boston College School of Nursing, Chestnut Hill, MA; and Thomas F. Curran, MSW, JD, Executive Director of the Child Advocacy Center in Philadelphia, PA.

CALL FOR PAPERS AND POSTERS

The 8th National Symposium on Child Sexual Abuse invites the submission of papers and posters on all relevent topics, to be presented in Huntsville, Alabama, February 19-22, 1992. **Submission of original research papers is strongly encouraged.** Research papers which are accepted will be considered for a special issue of the *Journal of Interpersonal Violence*. Submissions will be reviewed by APSAC. Send a one-page abstract to Ben Saunders, PhD, Medical University of South Carolina, Crime Victims Research and Treatment Center, 171 Ashley Av., Charlston SC 29425-0742. **Deadline for submission is October 1, 1991.** Presentations will be chosen by November 15, 1991.

Child Abuse and Neglect

People of Color Leadership Institute

714 G STREET, SE ■ WASHINGTON, DC 20003 ■ (202) 544-3144

MEET THE MENTORS

A CONVERSATION WITH GAIL WYATT

This section will introduce the participants in the POCLI Mentorship Program and present ideas on cultural issues relating to child maltreatment in order to raise awareness and stimulate discussion.

Good research is essential to good policy development. In May, 1991, Joyce Thomas, RN, MPH, interviewed Gail Wyatt, PhD, about research relating to families of color. What follows is an excerpt from that interview. Dr. Wyatt is a member of POCLI's Expert Task Force and a prospective mentor for POCLI's Mentorship Program. Dr. Wyatt is a psychologist with the Neuropsychiatric Institute at the University of California. At the Institute, Dr. Wyatt supervises the psychological assessment and treatment of children and families. She also serves as a consultant to the Family Support Program for sexually abused children at the Neuropsychiatric Institute. Dr. Wyatt has taught numerous courses relating to the assessment and treatment of African American families and has presented to community and professional organizations on sociocultural topics relating to the African American family.

In this interview, Dr. Wyatt highlights current research practices in the field of child maltreatment and suggests alternative methods for conducting research with families of color.

JT: What do you see as the critical problems of conducting research on victims of child abuse and neglect who are people of color?

GW: One critical problem is our ability to gain access to a representative sample of people who have been victimized in childhood or who have been neglected. Clinical samples are automatically biased: they are people who seek services at that particular facility. When we draw conclusions from clinical samples, and apply those conclusions broadly, we are generalizing from the most dysfunctional families. Community studies are perhaps the best way to get access to a broader range of populations of people of color. Schools are another source of less biased samples. The more affluent would be in private schools, but at least schools provide the opportunity to get a wider range of youngsters in low and middle income groups. Unfortunately, schools are not usually very supportive of this kind of research, and it is difficult to get parental consent.

JT: Do you believe that certain ethnic groups have been overly studied to document negative characteristics of a particular group?

GW: I don't think people intend to point out the negative. I think, in part, they don't understand how to conduct research on people with a wide range of demographic characteristics, and in part, probably, controlling for those demographics might reduce their findings to insignificance. Sometimes, too, demographic differences just get scrambled or lost in the shuffle. I think that often editors and reviewers don't know enough about evaluating ethnic-specific research to demand that research be published that does include this kind of information. Many times important demographic information is available, and authors simply don't include it because they don't think it's important, or don't really know how to handle it in terms of analyzing their findings.

JT: From your perspective, what are the unique factors which have served as a barrier for quality research on clients from ethnic-minority populations?

GW: The basic issue is that, in general, researchers have so little baseline knowledge about African-Americans. In addition to the reasons we've been discussing, there's the fact that many people, who are very well-intentioned, just assume that they can generalize from college student samples to everybody. So we have a tendency either to generalize from highly dysfunctional clinic-based samples, or to generalize from highly biased college student samples, and in general to fail to articulate and systematically control for relevant demographic variables.

I want to add that I think ethnicity has been minimized not because it has been purposely placed below priority. I think the agenda for most people in this area has been to verify and continue to confirm that the physical and sexual abuse of children exist, that people are telling the truth about these experiences—I think most people have been fighting at that level. A lot of people still don't believe what we say. But at some point we have to understand that only so many people can continue to fight that battle 15 or 20 years after it was begun, and that some of us need to move on to begin to refine issues around ethnic differences in these phenomena.

JT: What research approach would you suggest that would help us look at deep-seated cultural and social practices as factors in abusive families?

GW: First, you know, not everyone abuses their children. We need to explore the healthy coping strategies families use. What appropriate demonstrations of discipline, of caring for children do families exhibit? Even families that are dysfunctional may exhibit certain healthy styles. We need to know about these, too, so we can capitalize on them so people aren't in therapy for their whole lives.

JT: Do you think we should focus on a more specific understanding of race?

GW: Not race. I think we need to look at ethnic and cultural issues. It is important for professionals in the field to understand that skin color, facial features, and hair texture are not necessarily the criteria by which they should identify people of color. They need to ask which ethnic group the individual identifies himself with. They need to ask how long they have been in the U.S. They need to ask about generations—how many generations have been in the U.S.? The assumption always is that if you're Black or have the skin and other facial features characteristic of a Black that you've been here for 400 years. That isn't necessarily true. There are people who come from various parts of the world who are people of color. Their issues are not the same as the African-American's issues. First of all, we need to understand the nationality and origin and cultural practices of the group we're dealing with.

JT: Clearly, here in Washington, DC, where we continually hear that the population is 70% Black, people rarely distinguish that a large percentage of these Blacks are not Afro-American. Many of them are native Africans; many are from the Caribbean; many of them are even from Canada.

GW: Yes. The reason that I feel that race is a distraction from the real issues on hand, for social scientists at least, is that we are not talking about genetic and biological entities that are passed through our gene

Continued on next page

MENTORS (continued from page 11)

cells from generation to generation. We are talking about family values. We are talking about parenting styles. We are talking about cultural beliefs. We are talking about spiritual beliefs and life experiences that are passed down from generation to generation. It is critical that we start at that basic level of understanding ethnic and cultural differences and know the issues that we as social scientists need to be addressing and those that we need to place aside. I think race is an issue that we need to place aside. Secondly, I think that we need to understand how to incorporate socio-cultural issues in treatment strategies.

JT: Let's talk about that, about treatment.

GW: There really aren't any training programs that incorporate socio-cultural and ethnic-specific information with information and knowledge about treatment strategy for child abuse. Most people in the area of child sexual abuse and other forms of victimization tend to be very sensitive, very caring individuals. I guess because they are concerned about children, they also tend to be very caring and sensitive about other issues. Unfortunately, you may have all that caring and sensitivity, and advanced degrees, and years of clinical experience, and still overlook very critical issues that allow you to access these families and develop treatment plans that are really helpful. Far too often, people call me and want to be seen by a Black therapist because the therapist they were seeing was treating them in some sort of a well-defined treatment model, maybe a 12-step plan, as if everybody who has had these problems is exactly the same. We homogenize our treatment strategies when we need to customize them for the individual's experience.

But also, I have to add, professionals of color need to be sure they understand socio-cultural issues. Ethnic-minority professionals can't assume that they understand their own cultural group. They need training in this area, too. White professionals often call me up and say, "Give me the name of a Black professional," as if that person would have the training they anticipate they need, or that person feels that socio-cultural issues are important to incorporate the treatment strategy. Those assumptions are not necessarily correct. A basic fact is that there is no assumption that would be true just by virtue of the skin color of the therapist.

JT: What are your feelings about non-persons of color doing research or clinical practice with people of color?

GW: I certainly don't think that we need to match the researcher to the population to be studied. I do think we need to match the researcher with an understanding of that population and how to do appropriate research: Which methodologies and measures are appropriate? How do we interpret findings? I don't believe, either for research or for clinical practice, that you have to be Black to work with a Black family or Latino to work with a Latino family. You do have to have a very finely-tuned understanding of research and clinical socio-cultural issues, and we certainly know that has not been the rule in the past.

One specific example of sensitivity I'd like to bring up is a notion that we might call healthy paranoia—something we see among African-Americans in particular. It just has to do with being suspicious of people. You have to earn an individual's respect and trust in order to get them to come into a large institution and disclose sensitive information that may result in some kind of intervention, even the removal of certain family members. When these families are resistant to coming in and resistant to talking, we may assume it's because they're guilty of child abuse and neglect. We don't ask the family how have they been treated by these large health or welfare institutions in the past. People bring their memories of those past experiences into their present encounter. We have to be able to respect the fact that perhaps they haven't been treated very well in the past, understand what those past situations have been, and then try to work on developing rapport, trust, and cooperation while acknowledging that they have a right to their suspicious feelings.

JT: As a mentor, what advice would you give to emergent professionals in the field who are interested in conducting studies specifically in ethnic-minority populations?

GW: First, I would like to say that it is very exciting to anticipate seeing greater numbers of ethnic-minority professionals in child abuse and neglect. And I guess I would reiterate that professionals of color shouldn't assume that they're culturally competent just because of the color of their skin. They need to be sure that they understand socio-cultural issues. Second, they need to know how to identify and evaluate research that is ethnically and culturally biased. Everybody in the field needs to become attuned to such bias. Many youngsters just read something and absorb it and repeat it because they think it has credibility because it's published and their professors told them to read it. We all need to learn how to evaluate research that is very limited in its appreciation, recognition, and incorporation of ethnic and socio-cultural issues in the findings.

JT: Are there any other critical issues that you feel that POCLI's reading audience should be aware of from your perspective?

GW: In the mid-eighties in California, several other psychologists and I attempted to get a certain hour requirement legislated for socio-cultural coursework, such as we now have for child abuse and drug and alcohol abuse, for mental health professionals. We were unsuccessful in getting that legislation past the governor. I would like to see POCLI attempt to offer this kind of training to professionals. We may end up preaching to the converted, but it has to start somewhere. Professionals must understand that simply because they are well-trained in child abuse does not mean that they are well-trained to address the issues of POCLI, that they need to get additional training in these areas. I think the Institute can do this very effectively, and hopefully, eventually, we will end up converting those who remain skeptics, convincing them that they need to know more.

PROGRAM

THE CWLA CULTURAL RESPONSIVENESS INITIATIVE: A STATUS REPORT

—by Helen Keys

Established in 1920, the Child Welfare League of America (CWLA) is a federation of over 640 public and voluntary community-based and regionally organized agencies working with children and their families on such critical issues as child abuse and neglect, substance abuse, adolescent pregnancy, runaways, adoption, foster care, and homelessness. More than 125,000 professionals work at CWLA member agencies serving two million children and their families each year.

Today, the child welfare field faces a host of challenges in providing quality services to children and their families. One critical challenge is to respond effectively to the striking changes in the multicultural nature of American society. Recent studies estimate that more than 50% of children in out-of-home care are children of color.

Such dramatic demographic changes challenge us to provide culturally responsive child welfare services. While the disproportionate number of minority children in the child welfare system are ethnically diverse (the most significant increase in numbers is from Hispanic, African-American, and Pacific-Asian cultures), they often have poverty in common. The correlates of poverty—under-education, unemployment, underemployment, and welfare dependency—all increase the likelihood that children will be exposed to the child welfare system.

CWLA is committed to the recognition that "culture" is an important ingredient of who we are, and that to provide effective child welfare services we will need to understand our clients' cultural heritage, and that culture and ethnicity must be accepted as a

Continued on next page

KEYS (continued from page 12)

central focus in the planning, policy making, and provision of services to children and their families.

In 1989, the CWLA Board of Directors included a new goal in its Strategic Plan: "Ensure that all activities, services, and programs [of CWLA] are conducted in a manner that is sensitive to and shows respect for the cultural and ethnic diversity of our constituents." A Board Committee on Cultural Responsiveness provides ongoing guidance to the implementation of this goal. On March 12 and 13, 1989, a colloquium, "CWLA Initiative to Promote Culturally Responsive Child Welfare Practice," was held, bringing together over 40 scholars, administrators, and practitioners to develop mechanisms for increasing knowledge, raising sensitivity, improving policy and practice, and facilitating the involvement of minorities in decision-making on child welfare issues. The recommendations resulting from the colloquium address a broad spectrum of policy, administrative, and practice issues, with specific activities for effecting needed change. (See Colloquium Report, March 12-13, 1989, "CWLA Initiative to Promote Culturally Responsive Child Welfare Practice.")

The CWLA National Task Force on Cultural Responsiveness was established in January, 1990, to help prioritize and implement the recommendations of the colloquium. A cross section of member agency executives was asked to serve on the Task Force. At its first meeting in March, 1990, the Task Force was asked to develop a philosophical and policy framework for an agency cultural responsiveness self-assessment tool. The 1989 colloquium participants had indicated that an agency self-assessment tool should examine all aspects of an agency's functioning, including (1) mission; (2) governance; (3) staffing; (4) fiscal allocation and planning; (5) primary service programs; (6) community supports; and (7) evaluation mechanisms. At its September, 1990 meeting, the Task Force divided into three work groups—policy, administration, and practice—and analyzed the pertinent issues and questions involved in understanding the impact of cultural diversity.

The "Cultural Responsiveness Agency Self-Assessment Instrument: Valuing, Managing, and Responding to Diversity" will be designed to help an agency in the following tasks:

- Identifying the impact and relevance of cultural responsiveness on all management and service functions of the agency.
- Preparing specific strategies at all levels of responsibility to improve cultural competence.
- Indicating check points for decision-making, policy implementation, and accountability for cultural responsiveness.

The instrument, due to be completed by late July, 1991, will include a self-assessment checklist and a workbook for deeper study. Additional Task Force projects include developing a package of training and consultation materials to assist agencies with management and practice issues that emerge from the self-assessment process.

Helen R. Keys, MSW, is Program Director of the Cultural Responsiveness and Homelessness initiative of the Child Welfare League of America.

MEET THE LEADERS

Joyce Mahamoud, MA, is Project Director for the Parents Anonymous State Resource Office in New Jersey. Ms. Mahamoud has published papers on training for strengthening parenting skills and has prepared six training manuals for teachers and testing personnel.

Prior to joining the staff of Parents Anonymous, Ms. Mahamoud served as a consultant in program development in the former Protective Services Resource Institute in New Jersey. Her duties included aiding the development of Parents Anonymous chapters and developing a plan for training foster parents. Earlier, in Illinois, Ms. Mahamoud worked for the Department of Child and Family Services, directing a crisis unit serving abused and neglected children and their families. In addition, she was Project Director of a U.S. HEW grant to train parents in parenting skills. Ms. Mahamoud has trained professional and para-professional personnel in behavior modification techniques, and has conducted research on the effects of positive reinforcement on teachers. In addition, Ms. Mahamoud has been an instructor in the Moraine Valley Community College in Palos Hills, IL, and a Research Associate at the University of Kansas in the Dept. of Human Development and Family Life, where she earned her BA and MA degrees.

Parents Anonymous of New Jersey, Ms. Mahamoud's current charge, is a private, non-profit, volunteer-based organization dedicated to prevention and treatment of child maltreatment. PA's goal is to intervene with parents before they abuse or neglect their children, providing training in parenting and coping skills that help parents relieve stress and discipline their children in non-harmful ways.

PA of New Jersey provides a number of groups to help individuals and families under stress:

- PA parent support groups meet weekly throughout the state. These free self-help groups create an environment in which parents help each other find alternative methods of coping with stress and learn to change abusive or potentially abusive behavior. Groups are facilitated by professional volunteers, but are actually run by parent leaders.
- ASAAC (Adults Sexually Abused as Children). These groups provide professionally-facilitated self-help to survivors of childhood sexual assault.
- HOPES (Healing Ourselves Physically, Emotionally, Spiritually). These groups provide professionally facilitated self-help to adults (who may or may not be parents) wishing to deal with the trauma of childhood abuse.
- Children's groups are for the children of PA participants.

PA also provides trainers to schools, churches, community groups, and others who wish to learn about parenting, parental stress, and child abuse. In addition, PA administers the PA Hotline and the Governor's Task Force on Child Abuse Family Helpline. These hotlines, staffed by trained volunteers, provide information, referral, and crisis intervention to families in need. PA of New Jersey is affiliated with the Department of Pediatrics, University of Medicine and Dentistry of New Jersey.

Helen Keys, MSW, has over twenty years of professional experience in the planning, organizing, and administration of programs and services promoting family and community welfare. She has been active in the assessment of client and community needs, the identification of key contact persons vital to supporting organizational goals, and the creation of public/private coalitions to provide financial and community-based sponsorship. Ms. Keys graduated from Howard University in 1969 with a BS in Psychology, and from Catholic University in 1976 with an MSW. She is certified by the State of New York and the District of Columbia social work licensing boards.

As Program Director of the Cultural Responsiveness and Homelessness initiative of the Child Welfare League of America, Ms. Keys is responsible for implementing an advocacy and policy development initiative in these areas. Her responsibilities include organizing meetings, workshops, institutes, and other forums to highlight critical issues and develop innovative programs. In addition, she facilitates and directs the CWLA National Task Force on Cultural Competence, which was established to provide continued guidance to CWLA and its member agencies on the impact of culture on child welfare practice. Ms. Keys has written the description of CWLA's Cultural Competence initiative found on p.12.

BOOK REVIEWS

—edited by Mark Chaffin

VULNERABLE POPULATIONS, V. 2: SEXUAL ABUSE TREATMENT FOR CHILDREN, ADULT SURVIVORS, OFFENDERS, AND PERSONS WITH MENTAL RETARDATION (by Suzanne M. Sgroi, 1989. Lexington, MA: Lexington Books. 406 pages. Hardback, $44.95. Paper, $26.95.)

Review #1

—by Kathleen Coulborn Faller

Suzanne Sgroi's most recent addition to clinical knowledge about child sexual abuse is as important as her previous contributions. The second of two volumes on "Vulnerable Populations," this work by a pioneer in the field is an edited collection of chapters by clinicians with a wealth of experience. Although some chapters are better than others, every one adds something to the knowledge base and deserves mention. Because of lack of space, the chapters will be identified, but only briefly described and evaluated.

Chapter 1, "Play therapy with sexually abused children," by Jamshid Marvasti, MD, discusses the use of play for both diagnosis and treatment, describes play techniques, and outlines the stages of treatment using play therapy. The chapter is delightful, practical, and informative. The author is well organized and thoughtful and provides case examples that illustrate well the points he wishes to make and enliven the material.

Chapter 2, "Innovations in the assessment and treatment of sexually abused adolescents: An in-patient model," by David Hussey, L.I.S.W., and Mark Singer, PhD, describes the authors' experience with adolescent victims in an inpatient psychiatric facility. Their emphasis on integrating sexual abuse and substance abuse treatment with this population is notable. In addition, they discuss an instrument to assess for possible sexual abuse, the Adolescent Sexual Concern Questionnaire (ASC), presenting findings comparing abused and non-abused adolescents by gender. Finally, they present the components of the treatment program.

Chapter 3, "Time-limited group therapy for adolescent victims of child sexual abuse," by Kerry Homstead, EdD, and Lynn Werthamer, MSW, describes an outpatient treatment program for adolescent girls consisting of time-limited groups, each followed by an "intercession." Descriptive information is presented on the clients treated in the program, and issues at various stages of the group process are described.

Chapter 4, "Sexual abuse of boys by males: Theoretical and treatment implications," by Francis Pescosolido, MEd, MSW, MPH, is very useful. Although there are a number of descriptive studies of male victims, little has been written about how to do treatment with this population. The author identifies 10 treatment issues that are particularly salient for boy victims and illustrates them with case examples. Although his discussion of the treatment implications of these observations is rather brief, it is useful.

Chapter 5, "Stages of recovery for adult survivors of child sexual abuse," by Suzanne Sgroi, MD, is based upon her clinical experience. She defines and discusses fives stages of recovery for adult victims.

Chapter 6, "Healing together: Peer group therapy for adult survivors of child sexual abuse," by Suzanne Sgroi, MD, builds upon the previous chapter and argues for the utility of time limited groups of 10 to 14 weeks, structured like our education system, with vacations.

Chapter 7, "Spirituality and adult survivors of child sexual abuse: Some treatment issues," by Norah Sargent, MS, provides useful insights on a topic not ordinarily covered in clinical books on child sexual abuse. She notes that sexual victimization can severely affect spirituality because some victims draw parallels between their offenders and God or Jesus, because some victims confuse notions of sin with their role in the victimization, and because some find that clergy are unhelpful. She proposes and outlines a time-limited group for "women of faith" which focuses on spiritual healing.

Chapter 8, "Sexual abuse avoidance training for adults with mental retardation"; Chapter 9, "A curriculum for adults with mental retardation"; and Chapter 10, "Evaluation and treatment of sexual offense behavior in persons with mental retardation," are either entirely written by Dr. Sgroi or co-authored with Judith Carey, PhD, and Amy Wheaton, PhD. As the chapter titles indicate, they address a population known to be vulnerable but rarely addressed in the literature. Retarded persons as victims and offenders are discussed, and curricula are spelled out for educating this population. Chapter 10 presents a thoughtful framework for differentiating offense from consensual sexual behavior.

Chapter 11, "The Chesapeake Institute," by Linda Blick, MSW, and Thomas Berg, MSW, describes the program at the Chesapeake Institute and offers some information on developmental phases of offender reactions in treatment and guidelines for working with non-offending parents.

Chapter 12, "Understanding sexual offense behavior and differentiating among sexual abusers: Basic conceptual issues," by Nicholas Groth, PhD, and Frank Olivieri, BA, addresses the issue of differences among sex offenders, cataloging the dimensions on which they vary: sexual orientation, types of sexual behavior preferred, frequency and intensity of sexual drive, attitudes toward their sexual preference, and capacity for self control. The authors respond to commonly asked questions about sexual abuse: what causes a person to be sexually attracted to children, whether offenders who victimize same sexed children are homosexual, and whether treatment can be successful.

Chapter 13, "Sexual offenders as victims: Implications for treatment and the therapeutic relationship," by Margaret Vasington, MA, is based upon the author's experience as a volunteer therapist for incarcerated sex offenders and describes an empathic, non-confrontational approach. Taking commonly noted issues for victims, Ms. Vasington describes how these are manifest in victims who become offenders and discusses implications for treatment.

Chapter 14, "Community based treatment for sexual offenders against children," by Suzanne Sgroi, MD, notes that it is not feasible to lock up all sex offenders, and argues for treating some in the community. The author provides guidelines for differentiating those who require a closed setting, parenthetically asserting that a mental health assessment cannot determine whether or not someone is a sex offender. A program of community-based treatment of sex offenders is described.

It should be apparent from the content that the primary audience of this volume is mental health practitioners. However, *Vulnerable Populations, Vol. 2* should be informative to persons from other disciplines involved in sexual abuse and to researchers.

Kathleen Coulborn Faller, MSW, PhD is Associate Professor, School of Social Work, and Co-Director, Interdisciplinary Project on Child Abuse and Neglect, University of Michigan.

Review #2

—by Esther Deblinger-Sosland

Suzanne M. Sgroi, MD, a leading figure in the field of child sexual abuse, gathered together 16 highly experienced clinicians to contribute chapters to her second volume of *Vulnerable Populations.* This volume offers information and guidance on providing sexual abuse treatment for children, adult survivors, offenders and persons with mental retardation.

Clearly, this is a great deal of ground to cover in one volume. Thus, much of the book reads like an overview of treatment methods rather than a more practical treatment handbook. This is particularly true of the first chapter, written by Jamshid A. Marvasti, MD in which therapy methods for child survivors of sexual abuse are described. While there is no question that Marvasti is offering an overview of treatment methods actually practiced, it is quite troubling to note that many of the methods are contradictory and their therapeutic efficacy is not discussed from either a clinical or empirical standpoint.

Two chapters focus on treatment for adolescent victims of sexual abuse. Hussey and Singer's chapter on "Innovations in the assessment and treatment of sexually abused adolescents" deserves particular mention. By effectively integrating empirical research and clinical work, this chapter seems to be one of the few contributions that clearly represents a scientist-practitioner approach. The fourth chapter focuses on the treatment of male victims of sexual abuse and offers interesting insights and data on unique aspects of male socialization and victimization. Overall, however, the chapter seems to offer stronger support for author Pescosolido's suggestion that "certain aspects of sexual victimology transcend gender...."

Continued on next page

REVIEW *(continued from page 14)*

Several chapters focus on the treatment of adult survivors of sexual abuse. While these chapters are clearly written by highly experienced clinicians, much of the information offered is not new, with the exception of a very interesting contribution by Nora Sargent about the impact of child sexual abuse on spiritual development of survivors. The chapters that follow focus on sexual abuse education, evaluation, and treatment for adults with mental retardation. This is an area that has been neglected in the field of child sexual abuse, so it is a welcome surprise to see it addressed in this volume.

Three of the final chapters are devoted to the treatment of sex offenders and offer interesting clinical discussions centering around basic conceptual issues, offenders as victims, and community based treatment. Most powerful is the chapter written by Margaret C. Vasington, herself a victim, in which she discusses her therapeutic work with sex offenders within a prison setting. Vasington offers clear common-sense therapy guidelines that reveal her striking sensitivity and consistency in working with victim/offenders.

Finally, Blick and Berg offer a chapter on the Chesapeake Institute, a private comprehensive treatment program that provides services to child and adult survivors as well as juvenile and adult offenders. In addition to offering an overview of this program, the authors provide well-conceived guidelines for the reunification of families following the discovery and treatment of child sexual abuse.

In summary, this volume offers some insightful and creative clinical discussions on therapeutic issues related to child sexual abuse. As is true for many edited volumes, however, the chapters vary considerably in their style and quality. Unfortunately, few authors integrate the growing empirical literature into their discussions of assessment and treatment methods. In addition, because each of the chapters offers an overview rather than an in-depth discussion, I would recommend that this book be used as a reference volume. While many of the contributions are highly stimulating and thought provoking, practitioners working with any of the populations discussed would be well advised to do a great deal of supplemental reading.

Esther Deblinger-Sosland, PhD, is an Assistant Professor of Clinical Psychiatry and Clinical Director of the Center for Children's Support at the University of Medicine and Dentistry of New Jersey, School of Osteopathic Medicine.

CLASSIFIEDS

The Children's Hospital of Wisconsin and the Medical College of Wisconsin seek a Medical Director for a new Child Protection Center. The new director will participate in planning and establishing this new center, which is now being developed. We seek a physician who is trained and experienced in child development and child abuse. Services at the center will include comprehensive medical evaluation, including treatment and referral as necessary; a collaborative interview process; case coordination, psychiatric and psychological treatment, training of families to prevent child abuse, training of health care professionals; research and publication; consultation to the community and the region; and preventive services. The medical director will hold an administrative position in the hospital and a full-time faculty position in the medical college. Salary and faculty rank will be appropriate for training and experience. Candidates should forward their CV and names of references to Starkey D. Davis, MD, Professor and Chair, Pediatrics, Medical College of Wisconsin, Pediatrician-in-Chief, Children's Hospital of Wisconsin, MACC Fund Research Center, 8701 Watertown Plank Road, Milwaukee WI 53226. 414-266-4110.

SURVIVOR'S JOURNEY: A therapeutic board game for treating survivors of sexual abuse. Child, teen, and adult levels. Can be played one on one or in groups. Endorsed by Laura Davis, author of *The Courage to Heal.* Games are $29.95 + $4.50 s/h in USA (in MI add 4% tax). Burke Enterprises, PO 833, Portage MI 49801.

CONFERENCES

APSAC DISCOUNTS

November 4 - 7. ***Midwest Conference on Child Sexual Abuse and Incest.*** Madison, WI. Call Jill Cohen Kolb, 608-244-4022.

January 21 - 25, 1992. ***The San Diego Conference on Responding to Child Maltreatment.*** San Diego, CA. **APSAC's annual meeting. APSAC all-day Advanced Training Institutes to be held Tuesday, January 21.** For CALL FOR PRESENTATIONS and other information call Diane Martin, 619-576-5814.

February 19 - 22, 1992. ***8th National Symposium on Child Sexual Abuse.*** Huntsville, AL. For information call Marilyn Grundy, 205-533-6129.

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.** Call 312-554-0166 for more information about APSAC activities.

October 12 - 13. ***National Conference to Abolish Corporal Punishment in Schools.*** Columbus, OH. Sponsored by National Committee for Prevention of Child Abuse, National Coalition to Abolish Corporal Punishment in Schools, and over 20 national co-sponsoring organizations. Contact January Scott, NCPCA, 312-663-3520.

October 24 - 27. ***7th Annual Convention for the International Society for Traumatic Stress Studies.*** Washington, DC. "The reality of trauma in everyday life: Implications for intervention and policy," Bessel van der Kolk, MD, President. Call ISTSS headquarters, 312-644-0828.

November 6 - 9. ***Association for the Treatment of Sexual Abusers' 10th Annual Research and Clinical Practices Conference.*** Fort Worth, TX. Pre-conference advanced workshop features specialized training in assessment, comprehensive treatment and relapse prevention by national experts. Contact ATSA, c/o Sharon Siebert, PO Box 66028, Portland OR 97266. 503-494-6144.

November 18 - 19. ***A National Conference on Managing Abusive Sexuality: Integrating Research, Prevention, and Treatment.*** Arlington Heights, IL. Sponsored by the Illinois Network for the Management of Abusive Sexuality and the National Task Force on Juvenile Sex Offending of the National Adolescent Perpetrator Network. Call Robin McGinnis, 708-202-0500.

May 18 - 22, 1992. ***20th National Symposium on Child Abuse & Neglect at Keystone.*** Keystone, CO. Sponsored by the C. Henry Kempe Center. For CALL FOR PRESENTATIONS and other information, call Marilyn Lenherr, 303-321-3963.

May 19 - 22, 1992. ***National Symposium on Child Victimization.*** Washington, DC. Sponsored by Children's Hospital National Medical Center. For CALL FOR PRESENTATIONS and other information call Yvette Washington, 202-939-4950.

APSAC
The American Professional Society on the Abuse of Children
332 S. Michigan, Suite 1600
Chicago, IL 60604
(312)554-0166

Address Corrections Requested

Non-profit Organization
U.S. POSTAGE
PAID
CHICAGO, IL
PERMIT No. 4345

Membership Plans

❑ New Membership ❑ Renewal

Life Membership
Includes framed membership certificate.
Flat rate regardless of income $850

Regular Membership
Over $50,000 annual income $85
Under $50,000 annual income $55

Student Membership
(Verification of full-time student status required.) $35

Group Membership
(**Per person**, for 5 or more individuals from a single institution.)
Over $50,000 annual income $77
Under $50,000 annual income $50

Do you wish to be listed in APSAC's membership directory? ❑ Yes ❑ No
At which address? ❑ Office ❑ Home

Application for Membership

(Please print or type all information clearly)

Name _____ Degree _____

Title _____

Office Address (Agency name) _____

Street _____ City _____ State ____ Zip ____

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

Which is your preferred mailing address? _____

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

(001) Administration	(002) Children's Services	(003) Counseling, Licensed
(004) Education	(005) Judiciary	(006) Law
(007) Law Enforcement	(008) Medicine	(009) Ministry
(010) Nursing	(011) Offender Treatment	(012) Probation
(013) Psychiatry	(014) Psychology	(016) Social Work

Enclosed is check number _____ for $ _____

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

Please accept an additional check of ___$25 - $99; ___$100 - $249; ___$250 - $499; ___ $500 - $999; Other ($_____) as a gift to APSAC's **Endowment Fund**. I understand that the purpose of the Fund is to help APSAC achieve its long-range goals, such as producing *The APSAC Handbook on Child Maltreatment*, offering "scholarships" to professionals who can't afford to pay membership dues, and sponsoring its own national conference. I understand as well that, when my donation is received, my name will be added to the list of "Friends of APSAC" in four consecutive issues of APSAC's newsletter, *The Advisor*.

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) _____

American Professional Society on the Abuse of Children
332 S. Michigan, Suite 1600 • Chicago, IL 60604 • 312-554-0166