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THE ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

SPECIAL ISSUE

TREATMENT EFFORTS IN CHILD ABUSE AND NEGLECT

—by Susan Kelley

The past decade has seen a tremendous growth in the number of programs and clinicians specializing in the treatment of child victims, adult survivors, and perpetrators of maltreatment. While empirical evidence on the prevalence, nature, causes, and impact of child maltreatment has increased dramatically in recent years, there is currently little research on the efficacy of treatment approaches for victims or offenders. Given the lack of research on the outcome of treatment, it is difficult to say with scientific certainty if our treatment of victims and perpetrators is successful. Until results of carefully designed, experimental intervention studies are available, clinical insights and expertise which have rapidly developed in recent years must guide clinical practice, and are the basis for the articles in this special issue. We look forward to the day when we can present a special issue on the results of treatment outcome studies.

The Editors are pleased to present *Advisor* readers with articles from several leading experts in the field of child abuse. Since space does not permit coverage of all of the treatment topics that warrant discussion, we have attempted to address clinical topics which have not previously received the attention they merit. Articles included address therapeutic day care for physically abused children and children from violent families, intervention with substance abusing families, treatment of boy victims of sexual abuse, identification and treatment of child perpetrators of sexual abuse, and assessment and treatment of adolescent sex offenders.

We plan to publish one special issue each year, and would like to hear what themes you would like to see addressed. Please let us know your suggestions for future topics and authors for *Advisor* articles and special issues.

Guidelines for *Advisor* authors are now available by writing to our national office. All submissions undergo a peer review to determine which submissions are most suitable for publication in *The Advisor*.

PHYSICAL VIOLENCE AND PRESCHOOLERS

THE USE OF THERAPEUTIC DAY CARE IN THE TREATMENT OF PHYSICALLY ABUSED CHILDREN AND CHILDREN FROM VIOLENT FAMILIES

—by Catherine Ayoub

Introduction

Epidemiological studies of the incidence of physical maltreatment of children have highlighted the magnitude of what is now recognized as a serious and pervasive social problem. In 1989, at least 1200 and perhaps as many as 5,000 children died as a result of maltreatment, and over 160,000 children were seriously harmed (U.S. Advisory Board on Child Abuse and Neglect, 1990). The consequences of physical child maltreatment affect the individual child in serious and long term ways that can impede psychological and social functioning throughout the life span. Physically abused children are at risk for impaired intellectual, social, and academic functioning. They show disorders such as depression, anxiety, and social withdrawal as well as hyperaggressiveness, acting out, conduct disorders, hyperactivity, and delinquency (Howes & Espinosa, 1985; Wolfe, 1987).

Working with maltreated children in day care requires several major changes in approach and curriculum.

In addition to those children who are abused themselves, Gelles (1985) estimates that 3.3 million children are exposed to parental violence each year. For children who witness violence within their families without being victims themselves, significant behavioral consequences include hypervigilance, secretiveness, aggressive or extremely passive behavior, and often intense and persistent anxiety. Finally, there is evidence that transgenerational transmission of patterns of physical violence is common in both of these groups of children (Rutter, 1989).

Although both clinical and research attention to child physical abuse predates attention to other forms of maltreatment, intervention and prevention, especially with young physically maltreated children, have been limited and their success variable. In studies of abusive families, post-treatment reabuse rates of between 18.5% and 66% have been cited (Herrenkohl, Herrenkohl, Egolf, & Seech, 1979; Ferleger, Glenwick, Gaines, & Green, 1988). Given these alarming figures, treatment for children who have endured or witnessed violence is a critical concern.

Family Centered Treatment Programs for Maltreated Children

Historically, the treatment of physical abuse reflects a variety of theoretical formulations, from early efforts based upon parental personality characteristics (Steele & Pollack, 1976) to ecological (Belsky, 1980) and ecobehavioral models (Lutzker, 1984) that emphasize the multi-faceted and multiply-determined contexts leading to physical abuse. Most of today's multi-faceted intervention programs contain components from a number of these theoretical frameworks. One group of programs that have incorporated a variety of approaches has been called "family preservation" or "family-centered" treatment programs. These diverse programs include as primary goals the development of community networks to support and enhance families in order to prevent out of home placement and to promote family reunification in situations where placement was unavoidable; they also serve as monitors for family violence and provide assessment of the impact of violence on children.

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NEWS

APSAC RESOURCE DIRECTORY SENT TO MAJOR MEDIA; BALLOTS FOR BOARD ELECTION ARE IN THE MAIL; APSAC RESEARCH COMMITTEE IS FORMED; MEMBERS' IDEAS SOUGHT FOR FUTURE CONFERENCE PLANS AND APSAC HANDBOOK

—by Theresa Reid

Resource Directory Sent to Major Media

In response to suggestions made by members at the open meeting held in Huntsville, Alabama, in March, 1991, APSAC has initiated a large-scale effort to ensure that major media outlets have access to the best available information as they prepare articles about child maltreatment. It was the upsetting March 4 *Time* magazine article by Jerome Cramer, misleadingly entitled, "Why Children Lie in Court," that moved members Judy Lind of Hawaii, Phyllis Spinal of Illinois, and others to propose the formation of a Media Relations Committee. During the Huntsville conference, APSAC's Board wrote a strong letter of objection to the editors of *Time* (see *The Advisor*, p.1, Spring, 1991), and authorized the formation of the new committee. The goal of the Media Relations Committee is ultimately to improve the accuracy and comprehension of major media stories about child maltreatment by putting reporters in touch with the latest information.

After a long period of discussion and development, in late August APSAC sent a press packet to writers and editors at more than 350 major newspapers, magazines, and television stations across the country. The packet contained a brief press release explaining how APSAC can help reporters, a rolodex card imprinted with APSAC's address and phone, and a "Resource Directory" of experts in such areas as long-term effects of child abuse, evaluation of suspected sexual abuse in children, treatment of adult survivors, the child welfare system, prevention of child abuse, offender treatment, and research in child maltreatment.

The hardest part of developing the Resource Directory was deciding who should be included. Since most of APSAC's members are experts in the field, we could have proudly sent out a list with hundreds of names on it. But, of course, that would have been prohibitively costly, and would not have been as helpful to reporters as a briefer list. The Committee and Board finally decided to include past and present Board members, committee and task force chairs, and Associate Editors of *The Advisor*. In addition, reporters are informed that APSAC's 1800 members "include the most highly regarded and influential leaders in the field," and are invited to call APSAC's Executive Director for further referrals.

In the first few weeks since the packet was mailed, I have received several calls from reporters. If you have experience talking to the press, and would like to be considered a referral for news stories, please send me a note and your resume or vita. The Resource Directory will be updated as needed (e.g., when new Board members are elected) and sent out under a new press release every few months, to keep APSAC as a source of information fresh in reporters' minds. We hope that, by cutting down on the number of distorted articles on child maltreatment, this effort will ease members' lives and improve public understanding of the complexities of child maltreatment.

Ballots for Board Election Are in the Mail

The 1991 Board election is underway. With members' help, the Nominating Committee has invited many outstanding candidates to stand for election. APSAC would be well served if every one of these candidates could be elected to the Board. We look forward to announcing the results of the election in the next issue of *The Advisor*. If you want to know the outcome before that issue appears in February, feel free to call the office anytime after Thanksgiving.

Rotating off the Board this year are many members of APSAC's original Board:
Lucy Berliner, MSW, of Harborview Medical Center in Seattle;
Josephine Bulkley, JD, of ABA's Center on Children and the Law in Washington, DC;
David Chadwick, MD, of San Diego Children's Hospital Center for Child Protection;
David Corwin, MD, of Washington University Medical School in St. Louis;
David Finkelhor, PhD, of University of New Hampshire in Durham;
Charlie Gentry, MSW, of Child and Family Services in Knoxville;
Kee MacFarlane, MSW, of Children's Institute International in Los Angeles;
Carl Rogers, PhD, formerly of the Center for Child Protection and Family Support in Washington, DC;
Dan Sexton, MS, of ChildHelp USA in Los Angeles;
Hon. Sandra Butler Smith, JD, of the Municipal Court in Stockton, CA; and
Roland Summit, MD, of Harbor-UCLA Medical Center in Torrance, CA.

The dedication and service of these professionals were instrumental in bringing APSAC into being. Their continued, tireless support has enabled the organization to thrive. Everyone who benefits from APSAC's existence owes them thanks. We are happy and relieved to know that their active involvement with APSAC will outlast their Board membership.

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SUBSTANCE ABUSE

INTERVENTION WITH SUBSTANCE ABUSING FAMILIES

—by Robert T. Kinscherff and Susan J. Kelley

Maternal use of drugs and alcohol during pregnancy and child rearing is one of the most significant contemporary problems facing professionals in the field of child maltreatment. Fetal alcohol exposure is the "leading cause of mental retardation in the Western world" (American Medical Association, 1989). The National Institute on Drug Abuse estimates that six million women of childbearing age use illegal drugs, with one million using cocaine (Office of Inspector General, 1990).

Of particular concern is the dramatic increase in cocaine use among pregnant women (MacGregor, Keith, Chasnoff, et al., 1987; Zuckerman, Frank, Hingson et al., 1989). Nationwide, it is estimated that at least 100,000 infants are born annually who have been exposed prenatally to cocaine (U.S. General Accounting Office, 1990). Frank, Zuckerman, Amaro et al. (1988) examined the use of cocaine during pregnancy in a sample of 679 urban women in Boston who were enrolled in prenatal care and found that 17% of the sample used cocaine at least once during pregnancy. In New York City the rate of all drug affected births has more than doubled since 1981, primarily due to increased use of cocaine (Habel, Lee, and Kaye, 1988). And since 1983, cocaine affected newborns have exceeded opiate affected newborns in New York City (Habel, Lee, and Kaye, 1988). The arrival of "crack" cocaine has dramatically altered the picture in substance abusing families. In contrast to the predominance of men among the addicted population when heroin was the drug of choice, women currently abuse crack cocaine at a rate at least equal to to that of men (Daro and Mitchell, 1990). Crack cocaine possesses a combination of two dangerous characteristics: it is highly addictive and relatively inexpensive. Furthermore, users of crack cocaine are typically users of other substances to which the fetus is also exposed during pregnancy.

Although to date no studies have established a cause and effect relationship between maternal substance abuse and child maltreatment, children in substance abusing families are clearly at increased risk for child abuse and neglect (Massachusetts Department of Social Services, 1989; Kelley, Walsh, and Thompson, 1991; Kelley, in press; Famularo, Kinscherff, and Fenton, in press; Chasnoff, 1988; U.S. General Accounting Office, 1990; Famularo, Kinscherff, Bunshaft, Spivak, and Fenton, 1989; Murphy, Jellinek, Quinn, Smith, Poitrast, and Goshko, 1991). It is estimated that 675,000 children are seriously mistreated annually by an alcoholic or drug abusive caretaker (National Committee for Prevention of Child Abuse, 1989). Yet a recent national survey of state child protective services agencies revealed that only fourteen states (28%) routinely collect information on substance abuse (Daro and McCurdy, 1991). Rates of substance abuse in these states ranged from 5% to 78% of confirmed cases of child maltreatment, with the average being 40%. Nineteen states now require that medical personnel and others report drug exposed infants to child protective services (Daro, and McCurdy, 1991).

The dramatic rise in drug abusing parents has placed a serious strain on an already overburdened child protective service system. The demand for foster care nationwide has increased nearly 30% from 1986 to 1989, and is attributed to the increased number of substance abusing families (U.S. General Accounting Office, 1990). In Washington, D.C., during that period, parental substance abuse generated a 58% increase in the number of children placed in foster care (National Committee for Prevention of Child Abuse, 1989).

First and foremost, drug dependent parents must address their chemical dependencies.

A combination of characteristics of drug dependent mothers and drug exposed infants places the mother-infant dyad at increased risk for difficulties during a critical period for attachment. Problems common to drug dependent women, such as depression (Burns, Melamed, Burns, Chasnoff, and Hatcher, 1985; Kelley, in press), lack of confidence in parenting abilities (Kelley, in press), decreased attachment to their children (Kelley, in press) and feelings of guilt concerning their drug use during pregnancy (Griffith, 1988), place drug-dependent women at increased risk for parenting dysfunction. Characteristics of drug exposed infants, such as increased irritability and depressed interactive abilities, may pose special difficulties for their mothers.

Interventions

Drug treatment. First and foremost, drug dependent parents must address their chemical dependencies. In most instances, maternal use of drugs during pregnancy is not a temporary experimentation with drugs, but an enduring pathological dependence (Burns and Burns, 1988). Unfortunately, due to denial and fear, many drug affected parents refuse treatment. Others are unable to find treatment programs without long waiting lists. Women, especially pregnant women, need greater access to drug treatment programs. Unfortunately, many treatment centers are unwilling or unable to admit pregnant addicts. Many drug dependent women will not enroll in residential drug treatment programs because they do not want to be separated from their children, or fear losing their children to foster care. Some mothers have no one with whom to leave their children voluntarily.

Drug treatment programs need to treat drug dependent mothers within the context of their family. A few innovative residential treatment programs do treat drug dependent women during pregnancy, then allow them to keep their infants with them after delivery in order to address issues related to parenting and chemical dependency. Substance abusing parents may benefit from self help groups such as Narcotics Anonymous and Alcoholics Anonymous. Research is needed to demonstrate the efficacy of drug treatment programs with substance abusing parents.

Predominant types of drug use vary geographically and over time. Studies indicate that although cocaine is currently the most commonly used illicit drug, most substance abusing mothers are actually polysubstance abusers (Kelley, Walsh, and Thompson, 1991; Kelley, in press; Famularo, Kinscherff, Bunshaft, Spivak, and Fenton, 1989; Murphy, Jellinek, Quinn, Smith, Poitrast, and Goshko, 1991). It is important, therefore, to elicit careful, detailed histories of drug and alcohol use during pregnancy and childrearing. In addition to determining which drugs are used, it is important to determine the amount and route of administration. Women who use crack cocaine or intravenous drugs are usually the most severely affected by their drug dependency. In a recent study of cocaine exposed infants, 21% of their mothers were found to be intravenous drugs users (Kelley, in press). Maternal use of intravenous drugs greatly increases both the mother's and infant's chance of contracting the human immunodeficiency virus.

Psychological evaluation and treatment. Many drug dependent women are moderately to severely depressed (Burns, Melamed, Burns, Chasnoff, and Hatcher, 1985). The use of stimulants such as cocaine may in some cases be an attempt to self medicate and escape feelings of low energy and depression. Therefore, while substance abuse counselling is important for recovery, a psychological evaluation and therapy are often warranted. Some times, addiction is an attempt to cope with the negative effects of childhood trauma. One study of childhood sexual abuse among patients in an inpatient substance abuse treatment program found that 75% of the female patients had a history of childhood sexual abuse (Rohsenow, Corbett, and Devine, 1988). Other characteristics of drug dependent mothers that place them at increased risk for inadequate parenting include feelings of guilt concerning the harm their drug use during pregnancy may have caused their infant, fear concerning their ability to cope with and successfully meet the demands of their child, and unrealistic expectations about their infants' competencies stemming from lack of basic knowledge regarding infant development (Griffith, 1988).

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KINSCHERFF *(continued from page 3)*

Housing. Helping an addicted mother meet her own needs may give her the stability to better meet the needs of her children. The necessary help includes referral for concrete services such as day care, housing, health care, financial assistance, and transportation to appointments (Walsh, 1991). Drug using mothers are less likely than nondrug using mothers to have a stable place to live. In a study conducted by Kelley et al. (1991), 38% of mothers who used cocaine during pregnancy did not have a stable place to live. Twenty-one percent were homeless and living either in shelters or on the street; 10% were in inpatient drug treatment facilities; and 7% were staying with various relatives and friends without a permanent residence of their own.

Infant health care needs. Drug exposed infants need careful health care supervision. The relationship between retarded intrauterine growth and prenatal drug exposure has recently been well documented. Infants exposed prenatally to drugs are more likely than non-exposed infants to have low birth weight (less than 2500 grams, or 5 pounds, 8 ounces), to have decreased length and head circumference at birth, and to be born prematurely (MacGregor et al., 1987; Chasnoff, 1988; Zuckerman, Frank, Hingson, et. al., 1989; Kelley, Walsh, and Thompson, 1991). Prematurity and low birth weight are considered risk factors for infant mortality and child maltreatment.

A recent study found that even when corrected for prematurity, cocaine exposed infants continue to have growth delays in early childhood (Kelley, Walsh, and Thompson, 1991). The cause for the growth lags may be environmental or related to poor prenatal care and drug exposure. Therefore, professionals need to monitor carefully the drug exposed child's weight gain to assure there is adequate caloric intake. In some instances, drug dependent mothers may be diverting money from the food budget to purchase drugs. Food stamps are often traded for drugs.

Drug exposed infants are more likely than nondrug exposed infants to be medically neglected (Kelley, Walsh, and Thompson, 1991; Kelley, in press). Drug exposed infants are more likely to be inadequately immunized against childhood disease, and their mothers are more likely to miss routine health care appointments and to misuse emergency departments for minor health care problems (Kelley, Walsh, and Thompson, 1991). Innovative approaches to providing health care need to be implemented, such as health care providers going to shelters for the homeless and battered women, and into welfare motels to conduct health assessments and provide immunizations for high risk children. It is useful to have visiting nurses in the home after discharge from the hospital and during the first year of life to monitor the child's and mother's health care needs.

Infant characteristics. Drug exposed infants are often irritable, difficult to console, tremulous, and have difficulties with feeding and sleeping. They often demonstrate depressed interactive abilities and significant impairment in organizational abilities on the Brazelton Neonatal Behavioral Assessment Scale (Chasnoff, Burns, Schnoll, and Burns, 1985; Griffith, 1988). Once past the newborn period, cocaine exposed infants continue to have very low thresholds for overstimulation and quickly achieve an agitated cry state in response to most types of stimulation (Griffith, 1988). Some mothers erroneously interpret their drug exposed infant's attempts to shut out external stimulation as personal rejection of them as mothers. This perceived rejection is thought to increase existing feelings of depression and low self esteem which may lead to ambivalent and sometimes hostile feelings toward the infant (Griffith, 1988). Therefore, mothers of drug dependent infants need to be taught how to interpret and respond to their infant's behaviors. For instance, an infant who avoids direct eye contact may be overstimulated and needs to be held quietly or placed in a crib.

The stakes are high. Children who are left in severely maltreating families have a 40 – 70% chance of reinjury, and a 5% chance of being killed.

Mothers of drug exposed infants need to provide a darkened and quiet environment which will decrease irritability and the likelihood of the infant becoming overstimulated. The use of a soft infant carrier, in which the infant is carried chest to chest with the mother, is believed to have a calming effect on drug exposed infants (Torrence and Horns, 1989).

Drug exposed infants are perceived by their mothers, both biological and foster, to be more distractable, more demanding and less adaptable than non-drug exposed infants (Kelley, in press). Drug exposed infants are often stiff and difficult to cuddle and handle. In a study conducted by Kelley, Walsh, and Thompson (1991) 43% of cocaine exposed infants had hypertonia or increased muscle tone beyond the newborn period. Therefore, it appears that drug exposed infants may be more difficult to parent than non-drug exposed infants.

Protective removal and placement of the child. There are substantial risks to children associated with parental drug and alcohol use, co-morbid psychiatric disturbances, and inadequate shelter and other social supports. These factors, particularly when combined with the special challenges posed to some parents by their substance-impaired infants, result in significant rates of maternal stress and risk of serious child abuse and neglect (Kelley, in press). While it is critical to provide adequate social supports to reduce family stress levels and risks associated with socioeconomic and lifestyle factors, it is also important to appreciate that substance abuse is associated with a higher risk of severe maltreatment of a child *independent* of the family's socioeconomic status (Murphy, Jellinek, Quinn, Smith, Poitrast, and Goshko, 1991).

The stakes are high. Children who are left in severely maltreating families have a 40-70% chance of reinjury (Ferleger, Glenwick, Gaines, and Green, 1988) and a 5% chance of being killed (Schmitt and Kempe, 1975). On the other hand, unnecessary removal of a child can be traumatic for the child, devastating for a family that may already be marginally functional, and burdensome for child protective and foster care systems that are already overwhelmed.

Substance abuse constitutes a high risk variable among parents that have maltreated their children. Substance abusing mothers appearing before courts on charges of severe child maltreatment are much more likely than parents who do not abuse substances to have prior reports of child maltreatment, to be repeatedly before courts after child protective interventions, to receive higher risk ratings from independent court investigators, and ultimately to have their children removed permanently from their care by courts (Murphy et al., 1991). Clearly, drug and alcohol treatment facilities must be made more accessible to substance dependent parents and especially to pregnant addicts. However, there is little empirical evidence that current treatment techniques are reliably effective in the treatment of the chronic polysubstance and/or alcohol dependency characteristic of maltreating parents who come before the courts. While the optimal goal is to be "clean and sober," experience teaches that the more common course is one of repeated relapse with elevated risk of child neglect or abuse particularly during periods of relapse.

Furthermore, among substance dependent parents who do maltreat their children, the rates of treatment compliance are extremely poor. Where courts have ordered drug treatment services, high-risk parents with substance abuse problems are more than three times more likely to reject services than are other maltreating parents (Murphy et al., 1991). In one study, only 21% of parents referred by courts for substance abuse treatment attended even half of the sessions, and less than 10% attended two-thirds of the sessions. There was no difference between the rates of compliance by parents who abused alcohol and by those abusing other substances, but polysubstance abusers had the lowest rate of compliance of any group (Famularo, Kinsherff, Spivak, and Fenton, 1989).

Probably due to attempts to treat the drug or alcohol abuse prior to effecting permanent removal of the child, substance abus-

ing parents appear to be given more chances by child protective and court systems than do parents without chemical dependencies. Nevertheless, the data regarding poor treatment compliance, child reinjury, and ultimate permanent removal of a child from parental custody indicate that these extra chances do not contribute to improved long-term outcome (Murphy et al., 1991; Famularo et al., 1989).

With mounting competition for resources, clinicians and policymakers will increasingly have to consider how to deploy resources and focus interventions most effectively. One approach may be to divert resources from efforts to maintain children in high risk, poor prognosis families in order to pool more resources for families with a better outcome prognosis. Another approach may be to focus upon intensive monitoring and early intervention. These strategies often rely upon risk profiles, bringing families under scrutiny of child protective systems before there is firm evidence of substance abuse or child maltreatment. Therefore, programs stressing monitoring and early intervention must balance the financial and social costs of overinclusiveness against the benefits presumed to flow from this approach.

The greatest controversy surrounds the protective removal of children when there is initially an allegation or evidence of maternal substance abuse but no specific evidence of child maltreatment. State intervention in these circumstances triggers debates beyond the scope of this article regarding child or fetal rights versus parental rights, the appropriate role of clinical personnel, and the deployment of criminal or public health approaches to maternal substance use (Popovits, 1991; Bennett, 1991; Dougherty, 1985).

One increasingly common scenario involves taking custody of an infant that tests drug positive at birth, or shows signs of drug withdrawal shortly afterwards. In some jurisdictions a positive toxic drug screen is legally *prima facie* evidence of child maltreatment. Another common scenario involves removal upon allegations of child maltreatment where the parent is suspected of substance abuse, particularly when the substances involved are illegal, and there is also evidence of domestic violence, use of "crack" cocaine, and/or past or current criminal activity.

Proactive family scrutiny or child removal pending investigation under such circumstances assumes that substance dependence is a legitimate "proxy" strongly associated with other risk variables such as family violence, dissipated family resources, or exposure to criminality. Critics of this approach object to the use of correlational or probablistic risk assessments to justify intruding into families in specific cases. They argue that "statistical evidence that a person demonstrates characteristics associated with parents who have abused or neglected their children should not be a basis for legal intervention" or protective child removal in the absence of evidence of overt and clearly specified kinds of harm (Bowman, 1991).

Relying upon data drawn from families already before the courts because of allegations of severe maltreatment does not validate the use of substance abuse as a "proxy" for maltreatment among a population with no independent evidence of maltreatment. Particularly if reports of parental substance use or fetal exposure are to be used to trigger routine and intensive state intervention, further research is necessary in order to document if or under what circumstances parental substance dependence acts in the general population as a sufficiently powerful risk factor to warrant its use as such a "risk-proxy." Equally important is intensive research that documents what intervention strategies are actually effective in reducing parental substance use and child maltreatment.

In the absence of careful research and public policy planning, the responses of child protection agencies, prosecutors, clinicians, and courts will continue to be erratic. Responses of the legal system to parental substance abuse have varied widely, including criminal prosecutions, probation conditioned upon long-term contraception, incarceration through the completion of pregnancy, referrals for substance abuse treatment monitored by court-ordered urine screens, temporary or permanent removal of children, dismissal of cases because parents cannot be charged under existing law, and enrollment in comprehensive medical-social rehabilitation programs.

In summary, standard evaluation of parent and child must include assessment and appropriate referrals involving these areas: (a) general physical and dental health; (b) drug and alcohol exposure and use; (c) maltreatment history; (d) psychiatric history and differential diagnosis; (e) social welfare and child protection history and current needs. Development of effective and coordinated case management and monitoring strategies are imperative.

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STATE CHAPTER NEWS

STATE ORGANIZATIONS ENERGIZE PROFESSIONALS

—by Theresa Reid

As envisioned by the people who worked so hard to authorize their development (including David Corwin, MD, Carl Rogers, PhD, Joyce Thomas, RN, MPH, and David Lloyd, JD), state organizations have become a vital arena for the realization of APSAC's goals. Now in a majority of states (see list, below), dynamic professional leaders are establishing state organizations dedicated to uniting and supporting multidisciplinary professionals, to disseminating information and education, to helping professionals better serve children and families. State chapters are without any doubt at the cutting edge of APSAC's growth.

Some highlights from state chapter activities: Oklahoma, the first state to be chartered, held a successful first annual meeting in April. Coordinators in Arkansas, Florida, Massachussets, Ohio, New Hampshire, Pennsylvania, Vermont, and Washington state have recently held or are planning organizing meetings. Topics for discussion at these meetings include the needs of the state's professionals, professional ethical and practice dilemmas, goals of the state APSAC chapter, and ways of meeting those goals.

Colorado's chapter (chartered this year), headed by Elise Katch and Phil Madonna, held a highly successful state meeting at the NCCAN conference in Denver in September. They planned a luncheon meeting with two speakers: John Briere, PhD, and Marilyn Van Derbur Atler, a former Miss America(1958) who has recently disclosed a history of incest. Tickets for all the seats, then for all the standing room, sold out, and talk about the meeting was heard all over the conference center for the next two days.

A meeting of state chapter coordinators was held in Denver, attended by Mark Chaffin of Arkansas, Elise Katch and Phil Madonna of Colorado, Susan Kelley of Massachussetts, David Corwin of Missouri, Bob Reece of Ohio, Barbara Bonner of Oklahoma, Debbie Doane of Washington, and APSAC's First Vice President, Charles Wilson of Tennessee, and myself. APSAC's dues structure, the possibility of regional conferences, and the process of filing for 501(c)(3) status were discussed. The reports of enthusiasm generated among professionals by state chapter activity are exciting. Meetings of coordinators will also be held at the San Diego conference in January, and at Huntsville, Alabama, in February.

Every one of the 42 professionals listed below who are making state chapters a reality—and many of their colleagues who have provided indispensable support—deserves special recognition and thanks for their energy and dedication to the field and to APSAC.

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No chapter in your state? Take the lead! Call APSAC's office, at 312-554-0166, and ask for information on how to start a state chapter.

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BOY VICTIMS OF SEXUAL ABUSE

TREATMENT OF BOY VICTIMS OF SEXUAL ABUSE

—by Kathleen Coulborn-Faller

At least 20% of the identified victims of sexual abuse are male (American Association for Protecting Children, 1989). But attention to their treatment needs has lagged behind attention to the needs of females. Although in many respects boys suffer the same trauma from sexual abuse as girls, there are ways in which the impact of sexual abuse is different for boys, either in degree or in absolute terms. This brief article presents an explanation for gender-specific effects of sexual abuse, boy victim treatment issues, and treatment techniques. Unfortunately, space does not permit consideration of the full spectrum of boy victim treatment issues or indepth discussion of the appropriate treatment modalities, which include individual, family, and group therapy.

To a considerable extent the sequelae of sexual abuse differ for males and females because of gender differences in socialization. Traditional expectations for males in our society include the following tenets, which mediate the effects of sexual abuse on boys:

1. A "real man" doesn't cry, and by extension doesn't talk about and display emotion about his problems;
2. A "real man" can protect and defend himself;
3. A "real man" likes sex and looks for opportunities to have sex.

Societal homophobia also mediates the effect of sexual abuse upon boys (Bolton, Morris, and MacEachron, 1989).

Treatment issues for boy victims

Four issues will be described: difficulty with disclosure, emotional reactions to victimization, hypersexual behavior, and sexual identity issues.

Difficulty with disclosure. Societal prohibitions against men talking about their problems can make it more difficult for boys to disclose sexual abuse than girls. Even when there are other victim witnesses, an offender confession, or medical evidence of abuse, boys may still deny having been abused. If boys deny in the face of other evidence, they probably deny even more frequently when no corroboration exists. Societal homophobia may also contribute to boys' difficulty with disclosure. Because boys are abused by males about 67% of the time (Faller, 1989), abused boys must overcome two taboos: that against sex between adults and children, and that against same-gender sexual encounters. Shame over their inability to protect themselves may inhibit boys' willingness to disclose as well. In addition, like girls, boy victims may dissociate and not be able to disclose abuse because it is not among their conscious memories (Hunter, 1990).

Emotional reactions to being sexually victimized. When boys do describe their victimization, they may do so with almost no affect. This may reflect male socialization not to display feelings, and may be accompanied by overt denial of traumatic impact of the abuse. Alternatively, male victims may not evidence distress because they did not perceive the encounter as abusive, but rather as an opportunity to gain sexual experience. This is a consequence of male socialization about sexuality and is particularly likely to be the attribution if the offender was a female (Hunter, 1990).

When boys do demonstrate affect, it is likely to be anger and aggression (Rogers and Terry, 1984), again a consequence of gender socialization. Anger may be expressed directly toward the offender. It is also frequently focused on the therapist, sometimes verbally and sometimes physically. Moreover, boy victims seem more likely than girls to be belligerent with adults, to hurt or bully more vulnerable children, and to harm or mutilate animals. Other antisocial behavior, for example fire-setting and vandalism, may be expressions of anger as well.

> ***To a considerable extent the sequelae of sexual abuse differ for males and females because of gender differences in socialization.***

Sexualized behavior. Sexually abused boys appear to be more likely than girls to engage in hypersexual behavior (Faller, 1989; Rogers and Terry, 1984). There are two common dynamics for this behavior. Boys may gain a sense of control and mastery by sexually overpowering others, dealing with their sense of shame and feelings of vulnerability by identifying with the aggressor and sexually victimizing others, usually younger, smaller, and/or more naive children. The aggression involved in this activity is a manifestation of the boy's repressed anger toward his abuser(s). The other response is seen in children who experience the abuse as ego-syntonic and, as discussed above, view it as an opportunity rather than as abuse. Having experienced the pleasure of sexual activity, the child wishes to repeat it. Often this involves initiating peers and sometimes younger or older children into sexual activity. In many cases, there may be nothing inherently exploitive in this type of hypersexual behavior, because it usually involves children sexually pleasuring one another. Nevertheless, it is likely to have negative consequences for both the initiator and the initiate, because children engaging in sexual activity are stigmatized in most social contexts.

Sexual identity issues. Boy victims are likely to experience confusion about their sexual identity as a consequence of their victimization. This is in part because most boy victims are sexually abused by males. The child and adults in his life may equate a same-gender adult-child sexual encounter with a homosexual encounter. The boy victim commonly wonders why he was targeted, and concludes that something about him attracts males, hence he must be gay. Or he may believe that the sexual experience has made him gay. Because of societal homophobia, caretakers may be even more concerned about this issue than the child.

Even if the offender is a female, however, the boy may question his sexual identity. Because gender role socialization dictates that males should enjoy sex, a sexual encounter with a female which is frightening, overwhelming, or aversive may cause a boy to question his sexuality. The fact that he did not enjoy the abuse may lead him to conclude that he is not a "real man"; therefore he must be gay.

Treatment techniques

Boys' difficulty with disclosure. The author and other clinicians believe (e.g., Friedrich, 1990; Porter, 1986) that full disclosure of sexual abuse is fundamental to successful therapy. Without it, the therapist does not know what should be treated. Moreover, disclosure usually elicits the substance of therapy: the child's perceptions, feelings, and behaviors caused by the abuse.

There are no easy solutions to the problems boys have with disclosure. With some boys, the first six months of treatment is devoted to discovering the extent of abuse. Having the child demonstrate what happened with anatomically explicit dolls, draw a picture, or write what happened may facilitate disclosure. Sometimes drawing a picture of the offender or the self and then talking about the people is easier than actually drawing the abuse. Even more removed and therefore less threatening is drawing a man or a boy and talking about them. In addition, talking to the child about some of the reasons he might be having difficulty discussing his abuse and, if any of these are acknowledged by the boy, discussing them, may assist disclosure. Finally, discussing the benefits of telling may be useful.

Group treatment can be quite helpful, since there are almost always some boys in group who have talked about their abuse. These boys can help both by becoming models and by urging others to disclose. Sometimes group norms that require each boy to describe his victimization work. It may be efficacious to allow reluctant boys to "pass" during the first treatment sessions, as long as it is clear that they will eventually describe their abuse. Porter (1986) suggests that around the fourth group session is an appropriate time for disclosure to occur. Porter

Continued on next page

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helps boys organize their disclosure by providing a "Tell My Story Chart" which specifies the topics disclosure is expected to cover (e.g., identity of the molester, type of abuse, frequency).

Aggression. Anger at the offender is a very appropriate response, and its expression is often a goal of therapy. Anger becomes problematic, however, when it leads to assaultive behavior towards others or animals and when it results in antisocial behavior.

With many victims, the mere act of talking about the person with whom they are angry (the offender) and their reason for being angry (the abuse) will diminish problematic behavior. It can be useful as well to develop avenues for expression of anger toward the offender. With young boys, this may involve acting out feelings using anatomically explicit dolls or a punching bag. The author has a make-believe jail, in which children may lock up the offender. An effective strategy is to have the family obtain a doll that represents the offender; the therapist instructs the victim and family that when he feels angry, he should take out the anger on the offender doll, not on his little sister or the kitten. Being able to express anger toward a doll that cannot manipulate or overpower him may help the victim gain a sense of mastery over the abuse. However, boys should be admonished that in a real-life encounter with the offender, they will not prevail. With older children, keeping a diary, writing a letter to the offender, making a tape for the offender, or directly confronting the perpetrator in treatment may be appropriate ways to express anger. Role play can also be used to facilitate appropriate expression of anger. Competitive sports or karate may provide an acceptable outlet for aggression. These activities have the additional advantages of providing victims a sense of mastery and an opportunity to feel good about their bodies, as opposed to feeling ashamed or uncomfortable.

Re-enacting the boy's aggression toward other children or animals, with either the boy or the therapist playing the victim, can help the child appreciate the effects of his harmful behavior. Writing about his aggressive behavior from the viewpoint of his victim may also help the boy understand the pain he causes. The therapist can also counsel the boy regarding the negative impact on himself of aggression and anti-social behavior. For example, the clinician points out that the boy, rather than the offender, is in trouble because of the boy's aggression.

Hypersexual behavior. Stopping hypersexual behavior is perhaps the most difficult treatment task. Once sexual acts become known, eliminating them from the child's repertoire is very difficult. Yet stopping sexual behavior is crucial to recovery. Every time the boy engages in sexual acts he increases the likelihood of subsequent incidents and, especially if he is caught and chastised, increases the boy's stigmatization in the eyes of others and his own image of himself as a stigmatized sexual being.

Sexual aggression and teaching sexual acts to other children, the hypersexual behaviors most characteristic of boy victims, should be handled differently from masturbation. If the caretakers can tolerate it, private masturbation should be allowed. However, as Ryan (1990) points out, even though masturbation does not hurt others, it may occasion negative feelings for the boy because it reminds him of his abuse. Thus, it may be important to control opportunities to masturbate.

Therapists should be careful not to treat abuse reactive boys like perpetrators. Hypersexual behavior *could be* the precursor to adolescent sexual offending if not treated, but the boy already has the burden of his own victimization to deal with. Under the circumstances, a heavy-handed approach to his hypersexual behavior may be overwhelming. Nevertheless, for the protection of other children as well as for themselves, abuse reactive boys should have their interaction with other children supervised, and they should not be placed in situations in which being sexual is easy. Therefore, they should not babysit. They should bathe and go to the toilet alone. They should not sleep in bed with another child. If they sleep in the same room with another child, that child should be told of the boy's problem and be instructed to "Say no, yell, and tell," should the boy attempt to be sexual.

Caretakers should involve victims in activities that are incompatible with and can compete with sexual behavior, such as sports, hobbies, and group activities. Every hour of satisfying, age-appropriate, non-sexual enterprises is an hour in which the hypersexual child is countering his stigmatized self-concept.

Talking to the boy about the dynamics of his behavior and reminding him of how he felt when he was victimized may terminate the behavior. One six-year-old boy explained, "I was child-abused. They weren't. I want them to know what it feels like," referring to children in his class, who shunned him after he grabbed their genitals. Helping him recall his state of mind when he was being abused ended his sexual acting out. As with aggressive behavior, a re-enactment with dolls in which the boy plays his victim can have considerable impact. An apology to his victim(s) may be in order as well.

Behavioral interventions can be quite successful in stopping hypersexual behavior. Operant techniques work well with young children. With children as young as four, a monitoring system in which they receive a star or sticker for each day in which they do no "bad touching" and then an additional reward, such as a toy, a meal at McDonald's, or a trip to the zoo at the end of a perfect week, can be very effective.

Children who are a little older can understand the chain of events leading to their sexualized behavior and interrupt it by thought-stopping or covert sensitization. An example of the former is an eight-year-old who engaged in episodic sexual acting out after being sexually abused in daycare at age three. He described "getting that feeling" (an urge to molest another child) and decided to hit himself in the forehead with an open hand to interrupt the thought. He successfully used this technique four times in the first week after he devised it. Thereafter, he reported a decrease in "that feeling," and only had to use the technique twice more during the next six months.

Sexual identity issues. Boy victims and their families need education regarding worries about homosexuality. If the offender was male, they can be told that the choice of victim is related to the offender's attraction to children, not to the victim's sexual orientation. Some offenders describe singling out needy, deprived, compliant children—characteristics which have nothing to do with the child's sexual orientation. In some cases sharing this information may be helpful. It may also be useful to explain that sexual attraction to children is different from homosexuality, a point that may be supported by the perpetrator's adult heterosexual relationships. As well, the child and family should be told that being victimized will not make the boy gay.

If the offender is female and the boy questions his sexuality because he found the experience negative, it is important to explain to him that pleasurable sex is usually mutually decided upon between equals.

Conclusion

This discussion of treatment issues and techniques is based upon clinical experience alone. To date, there have been no systematic evaluations of sexual abuse treatment for boys.

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CHILDREN WHO MOLEST CHILDREN

IDENTIFICATION AND TREATMENT APPROACHES FOR CHILDREN WHO MOLEST OTHER CHILDREN

—by Toni Cavanagh Johnson

Do Children Molest Other Children?

Despite the increasing numbers of young offenders being reported for serious sex offenses, professionals involved with the care and protection of children find it difficult to accept that children twelve years and younger can molest other children (Alberton, 1990; FBI, 1990; Peyser, 1989). The general response from some police, protective services, and mental health professionals is that the behaviors of these "child perpetrators" (Johnson, 1990b) is just sex play. This is akin to the response in the 1970's and early 1980's when the sexually coercive behaviors of adolescents was becoming more evident.

During the 1980's numerous studies of adolescent sexual behaviors encouraged a thoughtful look at the range of sexual behaviors in this age group (O'Brien, 1985). Studies by Judith Becker, and others documented the seriousness of the sexual offenses committed by adolescents (Becker, Cunningham-Rathner, & Kaplan, 1987). These studies yielded a better understanding of the problem of adolescent sex offending and a concomitant rise in the number of treatment programs for this population. In the early 1980's there were fewer than 20 treatment programs for adolescent sex offenders; today there are over 600.

As with adolescent sexual behaviors, the sexual behaviors of children twelve and younger must be studied and criteria developed to aid in the proper assessment and treatment of young children whose behavior is sexually abusive. This process will stimulate the development of treatment programs specifically for children who molest, of which there are only a handful in the country.

A Continuum of Sexual Behaviors

Over the last six years it has become evident that the problem of children acting out sexually is highly complex and requires very detailed evaluation. After evaluating and consulting on hundreds of children who were referred due to sexual acting out behaviors, four definable groups of these children have been identified. Group I includes children engaged in normal childhood sexual exploration, Group II is composed of sexually-reactive children, Group III includes children mutually engaged in the full range of adult sexual behaviors, and Group IV includes child perpetrators. This model applies to boys and girls twelve and under who have intact reality testing, are not mentally retarded, and are engaged in sexual behaviors. Each group includes a wide range of children, with some children on the borderline between groups, and others moving between groups over time. The most divergent, groups I and IV, will be described first.

Normal Sexual Exploration	Sexually-reactive	Extensive Mutual Sexual Behavior	Child Perpetrators
Group I	Group II	Group III	Group IV

A Continuum of Sexual Behaviors from Normal to Deviant

Group I - Normal Childhood Exploration

Normal childhood sexual exploration is an information-gathering process wherein children visually and tactually explore each other's bodies, as well as try out gender roles and behaviors (e.g., playing house). Children involved in normal sex play are of similar age and size, generally of mixed sex, and are friends rather than siblings, and they participate on a voluntary basis (Finkelhor, 1979). The affect of the children regarding the sexual behavior is light-hearted and spontaneous. Normal sexual exploration may result in embarrassment but does not usually leave children with deep feelings of anger, shame, fear, or anxiety. If children are discovered in sexual exploration and instructed to stop, the sexual behavior usually diminishes or ceases, to arise again during another period of the child's sexual development. The sexual behaviors are limited in type and frequency. The behaviors engaged in typically include autostimulation and self-exploration, kissing, hugging, peeking, touching and/or exposing genitals to other children, and, perhaps, simulating intercourse (Goldman & Goldman, 1988). Two or three percent of children twelve and younger actually engage in intercourse (Haugaard & Tilly, 1988). The range of sexual behaviors in children is wide: some children will engage in all of the behaviors described above, some children may engage in none, or only a few. There are differences due to the developmental level of the child, the child's level of interest, and the amount of exposure the child has had to adult sexuality, nudity, and explicit television and videos. Parental and societal attitudes and values, as well as the child's peer group and living conditions, also influence the types and range of the child's behaviors.

The sexual behavior of children engaged in the normal process of childhood curiosity is balanced with exploration of other parts of their universe. They want to know how babies are made as well as why the sun disappears. They want to explore the physical differences between males and females as well as figure out how to get their homework done quickly so that they can play.

Group IV - Molestation Behavior

The balance of sexual interest and behaviors in normal childhood development is not present among child perpetrators. These children's thoughts, fantasies, and actions are often pervaded with sexuality. The sexual behaviors, attempts to experiment with or play out these thoughts and fantasies, continue and increase over time; they are not isolated to a few instances or discrete periods of the child's life. The child perpetrator engages in a wide range of sexual behaviors with many children, including siblings. Their behaviors tend to be secretive and manipulative. When child perpetrators are told to stop, they do not, and cannot without professional help.

In many of the children, the sexual acting out is impulsive, compulsive, and aggressive. The child perpetrator is highly confused and anxious about sex and sexuality. Many of these children directly associate feelings of aggression, anger, and sometimes even rage with sex. Others associate sex with feelings of loneliness, fear, or abandonment. Overexposed to sexuality, often to deviant and pathological sexuality such as promiscuity, pornography, incest, and sexualized violence, these children no longer have the normal curiosity of young children.

Child perpetrators seek out children whom they can coerce, fool, bribe, or force into sexual activity with them. The victimized child is not mutually involved in decisions about what the sexual activity will be or when it will end. In sibling incest, when the perpetrator is a boy, the victimized child is often the favored child of the parent/s. In other cases the child is selected due to special vulnerabilities, such as age, intellectual impairment, extreme loneliness, depression, social isolation or neediness. These children often use threats to keep their victims from telling. "I won't play with you ever again, if you tell," said to a child victim abandoned by his parents is a powerful reason to keep quiet. A child perpetrator will engage in coercive sexual behaviors with older, younger, or same age children. The age difference between perpetrator and victim may be as great as twelve years, because some of these children molest infants. The sexual behaviors of these children include peeking, exposing, kissing and hugging, penetration of the vagina or anus of another child with fingers and/or foreign objects, oral sex, vaginal and anal intercourse. Some of the victims suffer physical trauma. Child perpetrators will continue to engage in these behaviors even after harsh punishment.

Some child perpetrators also show a vast array of other behaviors that may not at first appear sexual but are related to their sexual difficulties. Focused on the genitals, these behaviors tend to revolve around

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JOHNSON (continued from page 9)

toileting. Virtually all child perpetrators have behavioral problems at home and at school and have very few friends. These children are frequently physically as well as sexually aggressive, have very limited problem solving and coping skills and little impulse control (Friedrich & Luecke, 1988).

Approximately 25% of child perpetrators are female. In a study of 13 girl perpetrators, ages 10 and under, all had been sexually abused (Johnson, 1989). Approximately 60-70% of boy child perpetrators have been sexually abused. Generally, the abuse is not recent but has occurred years prior to the start of their sexually aggressive behaviors. Many of the children have been physically maltreated. Virtually all of these children have lived in environments that are overtly sexually stimulating, with caretakers who themselves demonstrate extreme emotional confusion, poor impulse control, and little awareness of how their own sexuality and dependency needs affect their children. Most of the parents fail to maintain appropriate boundaries between themselves and their children when it comes to sexually explicit conversations, experiences, and behaviors. Sexual abuse, as well as physical and subtance abuse, is found in the nuclear and extended families of the children. Almost all of the children have witnessed extreme physical violence between their primary caretakers.

Group II - Sexually-reactive

Many children display sexual behaviors more extensive than those found among Group I children but not as extensive or aggressive as those of child perpetrators. Children whose repertoire of sexual behaviors exceeds what is expected for their age (Johnson, 1991a; Johnson, 1991b) can be described as "sexually-reactive" (Group II). Many children in Group II have been sexually abused. Other children in the group have been exposed to pornography, or have lived in households where there was too much sexual stimulation. Young children who watch excessive amounts of soap operas or cable television and videos and who live in sexually explicit environments may display a multitude of sexual behaviors. Many children who have been overstimulated sexually cannot integrate these experiences in a meaningful way. This can result in a child acting out the confusion in the form of more advanced or frequent sexual behaviors than would be expected for a child of that age. The behaviors may include but are not limited to exposing themselves, touching other children's or adults' private parts, imitating intercourse with other children, dolls and stuffed animals; self stimulating with hands and other objects, talking about sex acts; and displays of affection and interest in adults with whom the child is unfamiliar (Friedrich, Grambsch, Broughton, Kuiper, & Beilke, 1991)

Children in Group II may feel some shame or guilt and confusion but they do not display the level of anger and aggression in connection with sex and sexuality that a child in Group IV does. Many of these children's sexual behaviors involve only their own bodies. If they do engage in sexual behaviors with other children, the difference in age is usually not great and they do not force other children into sexual behaviors with them. Group II children are not seeking out children to coerce and victimize and do not threaten other children into silence. The sexual behaviors of these children often represent a recapitulation (often unconscious) of the previously overstimulated sexuality. The time between the sexual overstimulation and the sexual acting out is close, often overlapping or contiguous. The sexualized behavior can be seen as a working through of the confusion around sexuality. After being told, the children acknowledge the need to stop the behaviors and accept help. The sexual behaviors in this group of children are often fairly easy to stop as they do not represent the long pattern of secret, manipulative, and highly charged behaviors commonly found among child perpetrators. Interventions include openly discussing confusion around sexuality/sexual abuse, teaching the child boundaries, and helping the child's caretakers manage the behaviors and structure the living environment to decrease sexual stimulation.

Group III - Extensive Mutual Sexual Behaviors

A third group of children are those who engage in ongoing and extensive sexual behaviors, including oral sex and vaginal and anal intercourse, without apparent guilt, shame, or confusion. Anxiety related to the sexual behaviors is not evident and there is little desire to stop. In most of these children the sexual activity appears to be a way of life and a way of relating to peers. Between the children there are no offenders and no victims. Some persuasion but no force or emotional or physical coercion is used. They conspire together to engage in the sexual behaviors without the knowledge of adults. The children are generally within the same age range. Most of these children have been sexually abused by an adult, adolescent or child prior to this extensive mutual sexual contact with other children.

There are subgroups within Group III. Some Group III children have been sexually abused in a group and then continue the sexual behaviors with one another after the abuse stops. Others are siblings who mutually engage in extensive sexual behaviors as a way of coping in a highly chaotic and/or sexually abusive or dysfunctional family life. Some siblings, those who have been removed from their home repeatedly and placed in multiple foster care situations, cling to one another in this sexual way due to their feelings of fear and loneliness. These extensive mutual sexual behaviors are also seen in unrelated children in foster or residential care who may have begun as Group II children and progressed in the group living situation. This may involve many children at the same time.

Some of the children in Group III move between Group III and Group IV, i.e. betweeen mutually engaging in sexual behaviors and forcing or coercing another child into sexual behaviors.

Assessment

Children who have difficulty in the area of sexuality and sexual acting out need to be evaluated by a mental health professional who specializes in sexual abuse. Although the child may not have been sexually abused, sexual acting out is often a symptom of previous or current sexual abuse and should be considered. Initial assessment to determine where on the continuum the child falls will include:

-an evaluation of the number and types of sexual behaviors of the child (Johnson, 1990a);
-a history of the sexual behaviors;
-whether the child is being sexual alone or with others;
-the motivation for the sexual behavior;
-the other child/ren's description, response and feelings regarding the sexual behavior;
-the child's emotional, psychological, and social relationship to the other children involved;
-if any trickery, bribery, physical or emotional coercion is involved;
-the affect of the child regarding sexuality;
-a thorough developmental history of the child, including abuse and out-of-home placements;
-access and careful reading of reports to protective services, court reports, probation documents;
-an assessment of the child's school behavior, behavior at home, behavior at out-of-home activities, such as day care or recreational programs, and peer relations;
-a history of each family member, the family history and an evaluation of the emotional and sexual climate in the home. Assessment of these areas helps determine if the child falls in Group I, II, III, or IV.

Interventions

Although children in groups II and III need specific types of interventions, discussion of these is beyond the scope of this paper. Interventions for Group IV children include: reporting the behaviors to protective services and the police, collaborating with these agencies to assess the needs of the child regarding placement, evaluating the safety of the child and other children with whom the child comes in contact (school, home, neighborhood), working with the dependency and criminal courts, and providing treatment.

Individual, family, and group therapy are all important to the treatment plan for children who molest other children and their families. Additionally, behavioral, supportive, and protective interventions for the children must be planned with the family, school personnel and at other out-of-home activities. Therapeutic intervention with these children must be specific and focused on the child's problems. Therapy which does not

deal directly, and in an ongoing manner, with the sexual and aggressive issues is not useful to these children. For a more thorough description of a specialized treatment program for children who molest see the author's paper on SPARK, the Support Program for Abuse-Reactive Kids (Johnson & Berry, 1989).

Group Therapy. Emphasis is placed on group therapy due to the nature of the dysfunction of these children. Although they have intrapsychic pain and confusion that must be attended to, these children have chosen to act out this pain in an interpersonal manner. To treat the problem, its interpersonal aspects must be addressed directly. The group format allows the therapists to use the group members to help each other understand and work on their "touching" problems. The aim is to help the children interact with other children without being sexually or behaviorally inappropriate. The group mimics the school and neighborhood environment where these children have great difficulty interacting with other children. The process of the group involves "in vivo" learning. The anxiety, confusion, and shame associated with the sexual acting out is attenuated using the group format. The children feel better knowing that other children have the same problem and are working on it. The group format is very helpful in diffusing the tension and overcoming the difficulty of sustaining discussions about sexuality and the sexual acting out behaviors (Johnson, 1990b) The misinformation and distortions in the children's thinking are more readily available due to the group discussions and interactions. Working in a group the children are helped by recognizing their own denial and minimization of the sexual acting out by identifying and confronting it in the other children. Understanding the feelings and confusion of the other children regarding sexual acting out helps the children understand themselves better. Male-female cotherapy teams can provide a model for positive interactions between males and females which are lacking in the lives of these children.

Separate but parallel therapy groups for the parents, siblings/victims and nonabused siblings are very strongly recommended.

Family Therapy. The development of the sexual dysfunction of child perpetrators is heavily influenced by the environment in which the child lives and the persons who raise the child. If it has been determined that the child perpetrator can remain at home, extensive intervention with the family is essential. If the child has been removed to a group home, residential facility or the home of another family member (where there is adequate supervision and no vulnerable children), the child's surrogate family should be involved in the therapy. It is very important that either child protective services or the juvenile courts provide the authoritative incentive for the child and family to attend treatment.

Of initial importance is to assure that between family members there is clarity and openness regarding the child's sexual behaviors, understanding that it is a serious problem, and that all family members can help the child stop the behavior. Next, comprehensive plans must be made to help the child. These includes:

-identifying the precursors to the child's sexual acting out. These may be feelings of the child in certain situations, words or actions by family members, or other aspects of the child's environment, such as movies, videos, etc.
-planning to alter the situation to eliminate these stimuli.
-planning constructive and consistent responses to the child's sexual behaviors, including distractors and activities to which the child can be redirected.
-identifying the family members to whom the child should go for support and redirection when he/she feels like acting out sexually.
-determining the consequences for sexual acting out.
-agreeing on rewards for no sexual acting out;
-agreeing on any restrictions for the child, such as not being alone, bathing, changing, or sleeping with other children.

These plans should be clear, explicit, and written. Every week there should be discussion regarding problems, successes, and necessary modifications.

The child perpetrator must not be isolated as "bad"; instead the emphasis is more that the child is manifesting some of the problems in the family. It should be anticipated by the therapist and the family members that many other problems will need to be worked on in these sessions to help the child and the family. All issues related to sexuality and aggression, overt or covert, must be discussed. The family history and interactional patterns for several generations provide key insights into the current problems of the child. Previously undisclosed abuse of parents, grandparents, and siblings frequently arises.

The therapist must decide which members of the family should be present during which discussions as some children may be too young to comprehend some of the material that must be discussed.

Individual Therapy. Talking to an adult about sex in a closed room can create tension, anxiety, and confusion in child perpetrators. It is counterproductive to recreate a situation that the child could misconstrue as overtly or covertly sexual. Virtually all of these children have lived with or had interactions with adults whose sexual boundaries were unclear and highly inappropriate. Many of these children have been sexually abused. Because of this, the themes and issues around sex and sexuality are often best handled in group therapy. Individual psychotherapy is most useful for issues that are nonsexual and specific to the child, such as the child's relationship to parents/caretakers, school problems, out-of-home placement problems, specific peer or sibling problems, fears, phobias, depression, suicidal or homicidal ideation, etc. Other family members may also benefit from individual therapy.

School Intervention. It is important to make sure that the child's educational needs are being met. Because virtually all child perpetrators have multiple behavioral problems, their education frequently suffers. Many have severe but undiagnosed learning disabilities. If the child is in need of special education services this should be attended to quickly. These children have experienced so many failures that school failures should not be added.

After extensive evaluation and discussion with the child and family, the appropriate school personnel must be alerted if children at school are at risk for being abused. If necessary, a plan can be worked out with the school personnel for very close supervision or special placement until the child is in better control. It is very important to include the parents in all such interventions to impress them with the seriousness of their child's problems and their responsibility to help their child.

Conclusion

Children twelve and under molest other children. Although we do not know how many of these children there are, we do know that the damage to their victims, and their own distress, is substantial. There is no evidence from the therapeutic work to date that the sexually aggressive behavior of these children will abate without significant and prolonged intervention. We must commit resources to the study and treatment of these children. The National Center on Child Abuse and Neglect's allocation of research monies to study the best treatment approaches to these children is a positive step. If it is to be of any help, however, this research must be guided by what makes theoretical sense and what has been empirically corroborated. The research agenda must be informed and well thought out to ensure that the field and the public at large get maximum benefits from the money spent. Without effective treatment, a substantial proportion of these child perpetrators will go on to become adolescent and adult offenders, leaving as their legacy a long trail of victims.

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Research Committee is Formed, Begins Work

A new APSAC Research Committee will encourage scientific research relevant to child maltreatment, help disseminate the findings of such research, and foster the integration of research findings into the everyday practice of professionals who work in the field. Proposed by Ben Saunders, PhD, of the Medical University of South Carolina's Crime Victims Research and Treatment Center, and co-chaired (with Ben) by Linda Williams, PhD, of the Family Research Laboratory of University of New Hampshire, the Research Committee will work closely with APSAC's Program Committee and coordinators of APSAC co-sponsored conferences to ensure that the research component of conferences is robust and integrated meaningfully into the conference mainstream. The Committee's aim is to highlight at all APSAC co-sponsored conferences the applications of research to clinical practice.

In addition to making conference research components more meaningful for clinicians, APSAC's Research Committee will offer an annual award for Oustanding Career Achievement in Research in Child Maltreatment (see below). The Committee would also like eventually to offer small grants to support doctoral dissertation and post-doctoral research in child maltreatment. At its Denver meeting, however, APSAC's Executive Committee decided that the grant program will have to wait until APSAC has an integrated plan for seeking and disbursing funds. Even without this piece, APSAC's new Research Committee has articulated a well-thought plan for a very important task: it is off to an excellent start.

Members' Input on Conference Plans Sought by Board

APSAC's Board has long thought that APSAC should perhaps—when we have more money in the bank, when we have greater name recognition—establish its own national conference. Happily, the time is approaching when we can seriously consider launching a national conference. As it does, however, pros and cons have come into clearer focus, and other attractive possibilities have been suggested. The most important alternative possibility is for APSAC to sponsor, perhaps in association with several state chapters, four or five regional conferences each year instead of one national conference. APSAC could bring to these regional conferences several of the speakers people travel to national conferences to hear, and could also bring to the fore many outstanding professionals who deserve more recognition but may not be visible at the national level. Hopefully, more members would be able to travel to these regional conferences than to big national conferences. And at smaller conferences, participants would have more opportunity to interact with each other and with speakers.

What do you think of regional conferences vs. one national conference? Please call or write me (at APSAC's office) or Program Committee chair Patricia Toth, JD, at National Center for Prosecution of Child Abuse, 1033 N. Fairfax St., Suite 200, Alexandria VA 22314 (703-739-0321) with your ideas.

Ideas for APSAC Handbook Sought

APSAC and Sage Publications have entered into an agreement for publication of *The APSAC Handbook on Child Maltreatment.* Edited by John Briere, PhD, Lucy Berliner, MSW, Josephine Bulkley, JD, and Carole Jenny, MD, the *Handbook* is to be published in Spring of 1993. The editors seek your input as they plan the content of the *Handbook.* What do you think must be included to make it most useful for you? Is there any feature you'd especially like to see? Please call or write John Briere (at 213-226-5697, LAC/USC Medical Center, Dept. Psychiatry, 1934 Hospital Place, Box 106, Los Angeles CA 91320) with your ideas as soon as possible.

Looking toward 1992

I hope I'll get to see you at one or both of the first two conferences APSAC is co-sponsoring in 1992: the San Diego Conference on Responding to Child Maltreatment, January 21-26 (for information, call Diane Martin, 619-576-5814), and the Eighth National Symposium on Child Sexual Abuse in Huntsville, Alabama, February 19-22 (for information call Marilyn Grundy, 205-533-6129). At both conferences APSAC will hold meetings of the Board, the membership and interested professionals, the task forces, and the state chapter coordinators. I enjoyed meeting many APSAC members at the NCCAN conference in Denver, and getting to see again members I have already met. Where APSAC members gather, there are always lots of good ideas, energy, and laughter. I hope we can meet and work more closely together soon.

In the meantime, best wishes for safe and joyful holidays.

CALL FOR NOMINATIONS FOR 1991 APSAC AWARDS

The Awards Committee, chaired by Susan Kelley, RN, PhD, and co-chaired by Thomas Curran, LCSW, JD, and the Research Committee, co-chaired by Ben Saunders, PhD, and Linda Williams, PhD, are pleased to announce a call for nominations for APSAC's first awards. The purpose of the APSAC awards is to recognize professionals who have made outstanding contributions to the field of child maltreatment. Awards will be presented at the San Diego Conference on Responding to Child Maltreatment in January, 1992. Recipients will be provided with a plaque and a letter of commendation, and will be encouraged to attend the meeting to receive their awards in person. Unfortunately, APSAC cannot afford to provide travel funds to award recipients.

Awards to be given are as follow:

Outstanding Professional Award

This award honors a member of APSAC who has made outstanding contributions to the field of child maltreatment through continued contributions to a variety of areas, including practice, education, or research, and to the advancement of APSAC's goals.

Outstanding Service Award

This award recognizes a member who has made outstanding contributions to APSAC through leadership and service to the Society.

Research Career Achievement Award

This award recognizes an APSAC member who has made repeated, significant, and outstanding contributions to research on child maltreatment over his or her career. Nominees should have devoted a substantial proportion of their careers to conducting original research that has greatly contributed to our knowledge of child maltreatment.

Eligibility for Awards:

At the time of nomination, nominees must be APSAC members. Members of APSAC's Board of Directors or Research or Awards committees cannot be nominated to receive an award.

Procedures:

Completed nomination materials must be received at the national office by November 29, 1991. To be considered, nominations must include the following materials in a single packet:

1. Letter from an APSAC member formally nominating the candidate for one specified award.
2. A 200-300 word statement describing how the nominee meets the award criteria.
3. Two additional letters of nomination written by APSAC members.
4. The nominee's complete, current curriculum vitae or resume.

Recipients of the Outstanding Professional and Outstanding Service awards will be selected by the Awards Committee. The recipient of the Research Career Achievement Award will be selected by the Research Committee.

For your candidate to be considered, send the materials listed above by November 29, 1991, to APSAC Awards, 332 S. Michigan Av., Suite 1600, Chicago IL 60604.

ADOLESCENT PERPETRATORS

ADOLESCENT SEX OFFENDERS: ASSESSMENT AND TREATMENT

—by Barbara L. Bonner

Treatment for adolescent offenders has received increased attention over the past five years, prompted in part by a number of studies indicating that the onset of deviant sexual arousal and behavior often occurs before the age of 18 (Abel, Mittelman, & Becker, 1985; Longo & Groth, 1983).

The exact incidence of sex crimes committed by adolescents is not known (Becker, 1990). However, crime statistics have shown that approximately 30% of rapes and over 50% of child molestations are committed by offenders under the age of 18 (Fehrenbach, Smith, Monastersky, & Deisher, 1986). Studies of adolescent sex offenders have shown that a significant number commit their first sex offense between the ages of 12 and 15 (Deisher, Wenet, Paperny, Clark, & Fehrenbach, 1982).

A 1986 study of 305 adolescent sex offenders found that adolescents commit an array of sexual offenses, that the offenses typically are not isolated incidents, and that the offenses frequently reflect the boys' more general difficulties in adjustment (Fehrenbach et al., 1986). Another study suggested that deviant sexual behavior in adolescents is not experimental and can lead to repeated sexual offenses (Becker, Rathner, & Kaplan, 1987). These findings underscore the need to identify and treat juvenile sex offenders when the symptoms first appear and before the behavior patterns become ingrained and less responsive to treatment.

The assessment and treatment of adolescent sex offenders is a broad, complex clinical area which lacks empirically verified evaluation or therapy techniques. Several programs have published descriptions of their treatment components (Knopp, 1982), but little data regarding treatment outcome are available. In fact, although guidelines for assessment have been suggested by clinicians working with adolescent offenders, and research projects are being conducted to test the efficacy of certain treatment methods, no accounts of controlled outcome studies assessing the effectiveness of treatment programs for juvenile sex offenders are available (Becker, 1988; Davis & Leitenberg, 1987). In the absence of firm empirical guidance, however, adolescent sex offenders must be identified and given problem-specific treatment. Clinicians have reported that there are considerable differences between the assessment of adolescent sex offenders and those adolescents with more traditional mental health problems (Knopp, 1984; 1985). In general, mental health professionals tend to underestimate significantly the risks involved with sex offenders (Knopp, 1985).

A test battery to evaluate adolescent sex offenders might include the Weschler Intelligence Scale for Children-III, Child Behavior Checklist, Rorschach, Thematic Apperception Test, Jessness Inventory, Millon Adolescent Personality Inventory, or Minnesota Multiphasic Personality Inventory, and the Family Adaptability and Cohesion Evaluation Scales.

Additionally, an assessment should include a thorough and detailed sexual history, including information on the normal or non-deviant sexual activity of the adolescent; the extent of the adolescent's deviant sexual interests, the numbers, ages, and gender of the victims and the relationship between offender and victims; the duration and frequency of the deviant behavior; the use of sexually deviant fantasies; the effects of alcohol, other drugs, or pornographic materials on the adolescent's behavior; the degree of force used by the adolescent; the reported ability of the adolescent to control the deviant behavior; a history of sexual or physical abuse; any progression in the nature and frequency of the deviant behaviors; and the adolescent's general knowledge about sexuality.

The clinician should also evaluate the adolescent's social skills, value system, and cognitive distortions. In some cases, the sexual arousal patterns are measured by penile erection responses. As denial is a common feature found in sex offenders in general, it is recommended that clinicians use all available information to evaluate the adolescent offender, including court records, statements or videotapes of the victim, and previous psychological reports. (For additional reading on assessment, see Bethea-Jackson & Brissett-Chapman, 1989; Blaske, Borduin, Henggeler, & Mann, 1989; McCraw & Pegg-McNab, 1989; Smith, Monastersky, & Deisher, 1987).

In general, mental health professionals tend to underestimate significantly the risks involved with adolescent sex offenders.

A recent study by Kavoussi, Kaplan, and Becker (1988) assessed the psychiatric characteristics of a group of outpatient male adolescent sex offenders (N=58) and found that 48% of the sample met the criteria for socialized, nonaggressive Conduct Disorder. This suggested to the authors "... that many sex offenses committed by adolescents are part of a pattern of poor impulse control and antisocial behaviors" (p. 243). The Kavoussi et al. study emphasizes that adolescent sex offenders are a heterogeneous group and that a continuum of severity in psychopathology will be found based on the subset (inpatient, outpatient) being evaluated.

Treatment programs for adolescent sex offenders are typically modified versions of adult offender programs. They are being implemented in both community-based and residential settings (Knopp, 1986). Depending on the program and the needs of the adolescent, one or more of the following treatment modalities are generally employed: (a) individual, group, and family therapy; (b) education in human sexuality; and (c) social skills and assertiveness training. Most programs put a strong emphasis on the involvement of the adolescent's family and some other programs will not accept an offender unless the family is involved.

One model for a community-based treatment program for adolescent sex offenders was established at the University of Oklahoma Health Sciences Center in 1986 (Bonner, 1990). The program is designed as a year long, outpatient program for adolescent offenders and their parents. The boys attend weekly, 1.5 hour sessions and parents are required to attend a monthly, one hour session with the boys. Additionally, parents have the option of attending weekly 1.5 hour parent group sessions. The adolescents are referred from the Juvenile Court, the Department of Human Services, inpatient psychiatric treatment facilities, attorneys, and parents. Their offenses include making obscene phone calls, exhibitionism, fondling young children, anal and oral sodomy, and rape.

This program uses a cognitive-behavioral approach and is divided into treatment components that address the following: a) goal setting; b) disclosure of the abuse; c) effects on the victim, adolescent, and both families; d) victim empathy and restitution; e) sex education; f) normal/abnormal and legal/illegal adolescent sexual behavior; g) values clarification; h) assertion skills; i) anger management; j) impulse control; and k) relapse prevention.

An overall goal of treatment is to increase the responsible behavior of the adolescent in all aspects of his life. Depending upon the boy's age, it is expected that he will maintain part-time employment during some period of his group membership, and all boys on probation with the Juvenile Court are required to perform 60 hours of community service.

Several techniques used in the Oklahoma treatment program appear to be particularly helpful in treating adolescent sex offenders. One has been the use of a group leader. As this is an open group with new members being added throughout the year, members of the group are at different stages of treatment. Once every six weeks, the group elects a new leader. The person selected has typically shown responsibility in terms of attendance, behavior in the group, helpfulness to other group members, and verbal participation. This leadership role is frequently the first experience for these boys

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***BONNER** (continued from page 13)*

in being acknowledged as a leader by their peers, and appears to be a positive experience for the adolescent.

Another technique useful to both adolescents and therapists is a periodic group review of a boy's progress in the group on behaviors such as attendance, participation, and responsibility. The group members' assessment is often remarkably similar to the evaluation the therapists send to the boys' probation officers prior to each court hearing. One other technique that has been found useful is the use of outside speakers, particularly in the parent sessions. At times, the group is characterized by a high level of denial and anger toward the juvenile justice system by both boys and their parents. This issue has been effectively dealt with by having speakers such as a detective from the Sex Crimes Division, a District Attorney from the Juvenile Division, a defense attorney, or a Juvenile Court Judge attend the meetings to explain the laws and procedures that were used to adjudicate the adolescent.

Other observations about effective clinical approaches with these boys have been that a) the use of paper and pencil exercises with objective ratings, such as the progress evaluation, are effective in focusing the group's attention and documenting progress; b) having new members join the group causes some disruption to the group process but this appears to be offset by the benefits of having more experienced members to act as models; and c) the direct involvement of the parents with the boys in group sessions has decreased parental denial and increased communication in the families.

A community-based program implemented by Becker and her associates was designed as a research project to assess the effectiveness of a structured cognitive-behavioral treatment program with an outpatient adolescent offender population (Becker, Kaplan, & Kavoussi, 1988). Based on a treatment model that was found to be effective with adult offenders, the program components are:

a) eight 30-minute sessions of verbal satiation, a technique that teaches the offender how to use deviant thoughts in a repetitive manner to the point of becoming satiated with the stimuli that he may have used to become aroused; this is followed by a group orientation session.
b) four 75-minute weekly group sessions focusing on cognitive restructuring through role playing;
c) one 75-minute group session explaining covert sensitization, a technique used to disrupt behaviors that precede an offender's coming into contact with his victim; the subjects must complete eight 15-minute covert sensitization audiotapes over the next three weeks;
d) four 75-minute group sessions of social skills training;
e) four 75-minute sessions of anger control training through role playing;
f) sex education and values clarification; and
g) two 75-minute sessions of relapse prevention.

Another community-based group treatment program for adolescent sex offenders has been described by Smets and Cebula (1987). The group program is part of a total treatment approach that includes individual and family treatment. In 1987, the program had operated for two years and treated 21 boys. The average age of the boys wass 14.5 years and approximately 70% of the victims were girls between the ages of 3 and 9 years old.

At times, the group is characterized by a high level of denial and anger toward the juvenile justice system by both boys and their parents. This issue has been effectively dealt with by having speakers such as a detective, a district attorney, a defense attorney, or a juvenile court judge attend the meetings to explain the laws and procedures that were used to adjudicate the adolescent.

This program is structured around a five-step "level" system. This program has a beginning "zero" level with five program steps. The group meets weekly for 1.5 hours and the average duration for the group, i.e., the time required for all the boys to reach level five, has been twelve weeks. Of the 21 boys who have completed the program, 14 have continued in individual and/or family therapy after completing the group. One of the 21 boys has had a reported repeat offense. This adolescent had a history of victimization and had previously been considered for inpatient treatment. For additional information on the treatment of adolescent sex offenders, see Abel et al., 1985; Becker, 1990; Hains, Herrman, Baker, & Graber, 1986; Kahn & Lafond, 1988; Lombardo & DiGiorgio-Miller, 1988; National Adolescent Perpetrator Network, 1988; Ryan, Lane, Davis, & Isaac, 1987.

In summary, programs for adolescent sex offenders tend to address a core of significant issues related to sexual behavior. Clinicians think that many of the techniques currently being implemented are useful. More information, however, is urgently needed. Until more data are available, clinicians will be uncertain which techniques are most effective with which adolescent offenders.

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AYOUB (continued from page 1)

Family-centered treatment programs have met with moderate success in treating violent families. Their two pronged approach includes a child focused intervention component, such as therapeutic day care or day treatment, and a parent and family outreach and intervention component. This article will focus on the therapeutic day care component of such programs.

Therapeutic Day Care Component of Family Centered Treatment

A therapeutic day care program component of the service network for children from violent homes is usually part of an intervention framework that includes services based on an ecological model, with the family and the larger social contexts as appropriate targets for intervention. Services may include a variety of components such as child and adult counseling, behavioral parent training, traditional case management services, values clarification, individual mental health services, groups focused on violence prevention, problem solving groups, crisis intervention strategies, and therapeutic day care. In an effort to support the child's development, many centers also offer a variety of services to children on site, including speech and language remediation, child development assessments, and mental health consultation. In an effort to intervene with parents and other family members, these centers provide directly or network to obtain drug treatment, mental health services including psychopharmacology consultation for adults, job training, assistance with housing, child nutrition and food supplement programs, advocates and shelters for battered women and their children, and medical services.

The component of this service network that is the focus of the present discussion is either a part time or full time therapeutic day care center for young maltreated children. Some programs also offer private kindergarten placement and after school programs for older children. Because many young children are in day care today, the placement of children in a therapeutic day care program can be seen as a normalizing experience. Therapeutic day care can provide physically maltreated children and children from violent families with a consistent and nurturing environment. It offers them an alternative to the violence they have experienced or witnessed at home. Secondly, it allows for ongoing monitoring of the child who may still be at risk for physical abuse.

The emphasis in most therapeutic centers is on infants, toddlers, and pre-school children. Kinard (1982) found that maltreated children under the age of 3 are likely to exhibit more emotional prblems than those maltreated at a later age; these younger children have fewer coping mechanisms for defending against stresses in their lives. Based on these findings and ongoing experience, teachers in these special classrooms work with individual children at the children's own pace to help them develop a nurturing relationship with a day-care teacher. The teacher is responsible for making the children feel safe, for giving them a sense of love and belonging, for acknowledging their feelings, as well as for intervening with them to limit aggression or withdrawal with other children and adults in the classroom. Their goal is to provide the vulnerable child with a holding environment in which the child can begin to feel safe and explore alternatives to the affective and behavioral responses developed within the violent context.

Dealing with issues in the therapeutic classroom. Working with maltreated children in day care requires several major changes in approach and curriculum. In the therapeutic classroom, child behaviors are viewed collectively, as patterns providing clues about a child's approach to the world. Because the child's experience has been out of the norm, her behavior does not often carry an expected meaning or follow a predictable cause. Rather, behavior is an adaptive reponse to a difficult emotional and physical environment. The child should be observed over time, so that the meaning and stability of particular behavioral sequences becomes evident. If the symbolic meaning of an act is understood, intervention to alter or extinguish it can be more effective. Once the meaning and adaptive function of the behavior is clear, activities are reframed to help children with their individual issues.

An important difference between therapeutic and normative day care is the continual need to think about what patterns of behavior mean to the child and how they are used by the child to cope with fears, anxieties, and expectations generated by the child's special life experiences. In contrast to early childhood programs for non-traumatized children, therapeutic programs do not focus on group activities or specific educational tasks. Rather, they emphasize monitoring the social-emotional state of each child and meeting safety and security needs so that the child can begin to develop and sustain basic trust and engage in positive social interactions with peers.

Security and safety issues. The most basic concerns of maltreated young children are security and safety. Physically maltreated children often approach normal environmental tasks with limited emotional resources. Trust in relationships is frequently impaired as a result of the child's expectation that the setting and the adults and children in it are unsafe —that is, that they may expose the child to physical assault, failure to have basic needs met, violent encounters between others, unpredictable anger, or erratic adult caregiving. Safety and security needs are the most basic of human needs; if these are not well met, the individual will focus on them, ignoring needs up the hierarchy such as the need for love and belonging. As a consequence, failure to meet safety and security needs impairs the child's ability to develop secure attachments.

There is increasing evidence of the early effects of maltreatment, particularly as they pertain to the development of insecure attachments (Crittenden & Ainsworth, 1989). The vast majority of maltreated infants (70-90%) form insecure attachments to their caregivers (Carlson, Cicchetti, Barnett, & Braunwald, 1989). Young maltreated children have also been found to demonstrate unusual patterns of attachment; they often mix up approach and avoidance behaviors, appear apathetic, exhibit stereotypies, and are prone to noncontextual aggression toward their caregivers. Instead of forming a single organized strategy for maintaining proximity to caregivers, maltreated children are characterized by a marked disorganization of behavior in response to caregivers as the children assess new relationships.

Crittenden and Ainsworth (1989) hypothesize that these seemingly bizarre patterns of attachment result when the caregiver becomes a source of fear. For some children the lack of trust, combined with fear for physical safety, produces high anxiety when they are exposed to anything new, or even in making routine transitions between activities. For others abuse creates an absence of normal anxiety about new situations. As a consequence, attention to the individual child's responses is paramount in working with the physically maltreated child.

In an effort to counter disorganization and mixed approach-avoidance behaviors, children need to be told clearly in words and actions that they will not be allowed to hurt themselves or their peers, and that no one in the center will be allowed to hurt them. Abused children repeatedly need to hear that they are safe. Consistency and clear, firm limit-setting is key in the development of a sense of safety and security. It is sometimes difficult for staff to feel comfortable disciplining children whom they know are victims of violence. For the child, lack of limits may be perceived as another form of abandonment and as confirmation that violence cannot be controlled — that the world is a dangerous place. Kind, clear, firm, nonphysical and developmentally appropriate limits are an important part of a therapeutic environment.

Other guidelines in the classroom include an awareness of the child's need for structure and space. Routines are comforting for most children. Routines can be particularly comforting for chidren from unpredictable environments. Rituals, for example, are often important coping mechanisms in unsafe environments. Seemingly insignificant items (a coin, a piece of paper) can become precious objects of transition between home and day care. It is important not to diminish their value or to insist that they be removed. Similarly, a child who tries to hide items in a pocket may need to be given a concrete reminder of the day care setting to carry home. Routine and verbal preparation which allow children to move through such transitions with knowledge of what to expect can be a vital element in building trust.

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However, the young child is often unable to transfer skills learned in one context to another. For example, children who become less hypervigilant in the classroom may not be able to reduce their hypervigilance when they go on a field trip or outside to play. Maltreated children treat each new situation with suspicion until they can learn that they are safe; such learning may take repeated exposure to experiences. This means that teachers spend a good deal of time helping children learn and relearn basic social interaction skills in new settings.

Attachment issues and adult caregivers. Children with histories of maltreatment, particularly those involved in or exposed to ongoing violence, may tend toward extremes in relationships with adults. For example, a child may cling indiscriminately to one adult after another or immediately climb into a stranger's lap. All of these patterns can be understood as ways of coping with deficits in children's primary intimacy relationships. It is important to offer children struggling with these issues opportunities to explore close relationships with day care staff. There should be one consistent primary caregiver in each classroom who is available to the child with reasonable reliability. It is particularly important that there be a consistent response to the child when anxiety or other signs of distress are displayed.

A primary aim of the therapeutic day care setting is to support and elicit the development of alternative patterns of attachment depending upon the interaction between the young child and a continuous day care teacher. The first goal of intervention is to develop a warm, caring relationship with the child; the second is to support and instruct parents so they may extend similar interactions into their homes. These two interventions are aimed at influencing the child's development of positive models of attachment.

Aggression and peer interaction issues. Main and George (1985) found that maltreated toddlers responded to distress in peers with aggression, anger, fear, or attempts at a mechanical comforting movement. In contrast to other children, maltreated children were less likely to display empathic or genuinely comforting behaviors toward distressed peers. In a therapeutic center, vulnerable children learn to interact with peers and begin to experience positive peer interactions within the safe day care environment; this is a new experience for many children whose siblings as well as parents use physical violence in family interactions.

Toddlers and preschoolers who experience and/or witness repeated violence are prone to express aggression toward peers and adults when they reach the middle of their second year. As a result, the classroom atmosphere can become over-excited and chaotic quite quickly. The combination of caring and clear limits for aggressive behavior help children learn appropriate patterns of interaction.

Support and consultation in the classroom. Teachers perform more effectively when they have a mental health professional with whom they can consult. Consultation should be ongoing and separate from the interaction between the teacher and the parent's therapist, child's therapist, or case manager. Here is an example of a child who was supported through the active work of her teacher and the mental health consultant in the therapeutic classroom:

> Two-year-old Monique was described by her teachers as overactive, unable to sit through a meal or join her peers in "circle activities". She became easily frustrated, but she pushed away anyone who tried to assist her. Instead, she would fall down and cry. Her teachers tried rewarding her for even small successes and minimized efforts to correct her, but there was no improvement.
>
> When observed by the mental health consultant, Monique was noted to be hypervigilant, monitoring anxiously the activities around her. She would position herself in the corner of the room, and when anyone approached, she would defend herself by surrendering, crying, and falling to the ground. It was discovered that this child lived in a very violent home. Her father battered her mother; several siblings had been placed in foster care because they had been maltreated by the parents. Monique also had an older sibling who behaved aggressively toward her. Her behavior in day care could be understood as survival efforts that she had developed to cope with her difficult home environment.
>
> In working with Monique, it was important to help her maintain the behaviors she needed to protect herself at home, while providing an experience of safety at the therapeutic center. Monique's place at the table was changed to a corner position, with the safety of two walls behind her. Circle activities were done in an ellipse with her place against the wall next to "her" teacher. When staff persons approached Monique, they announced their intentions and moved very slowly. Within several months, Monique was less fearful and more trusting, although she still reverted to her old patterns when new situations arose. Her mother made a decision to move to a shelter for battered women with her children. Monique continued in the program during this time and it seemed to serve as a stabilizing force for her. As Monique and her mother worked together each week during "parents' day" classroom visitation, Mrs. C. learned some of the techniques that the staff had used and was able to begin to rebuild her relationship with her daughter.

Parent Involvement in Therapeutic Day Care Settings

When children enter therapeutic day care, they do so as part of a family. One aim of family centered treatment is to enhance each parent's ability to care for their child by providing outreach, individual and group support, and casework services to the family unit.

Parents are included in the classroom on a regular basis. By using the teacher as a role model abusive parents begin to change their interaction patterns with their children. The most effective techniques for working with parents are: (1) direct work with each parent; (2) opportunity for continuous practice at exercising judgements about parent-child interactions followed by feedback offered in a non-threatening context; and (3) parent-child interactional models and examples that are simple and tailored to each parent's needs (Crittenden, 1983). For example, one center holds a weekly "parents' day" during which parents spend time in group activities. Parents attend a support group and group therapy meeting in the morning, move on to parenting skills groups to discuss and practice parenting skills, followed by a visit with their children in the classroom. With permission, parents, children, and teachers are videotaped during classroom visits. The adults have a hot lunch together once the children are down for a nap, followed by a review of the classroom interactions including viewing videotapes either with an individual therapist or in group (depending upon the parent's comfort level). In addition, many parents are engaged in individual and parent-child interactional therapies; parents are encouraged to use techniques learned during parent day in their individual sessions.

Another key rule surrounding parent interaction at therapeutic day care is that violence, including any form of physical punishment, is not allowed. Any evidence of physical punishment of a child, or physical encounters between adults, are immediately stopped. A center's active role in condemning violence and informing authorities when children are at serious risk should be made clear to parents at the outset. Active, honest discussion with clients is essential, as is the development of institutional steps to aid reporting and build support for parents within the protective services system. Parental involvement in the reporting process is recommended whenever possible. Parental involvement can serve as an important stimulus for a family to acknowledge that there is a problem.

Many families do not change their patterns of violence. Attrition from child abuse and neglect treatment programs ranges from 40% to 60%. However, recent research (Willett, Ayoub, & Robinson, 1991) indicates that families that show signs of violence, physical child maltreatment, and/or parent-child interactional difficulties on program entry can improve their family functioning if they can be persuaded to stay in treatment for at least two years. Families must be prepared for long-term intervention. Children in violent families need outside support and treatment as well as monitoring during this time of change to ameliorate the

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BOOK REVIEWS

– Edited by Mark Chaffin

Children's Rights in America: UN Convention on the Rights of the Child Compared with United States Law.
Edited by Cynthia Price Cohen and Howard A. Davidson. Washington, DC: American Bar Association Center on Children and the Law, Defense for Children International - USA, 1990. 339 pages. Paperback: $25.00.

—reviewed by Sol Gothard

The United Nations Convention on the Rights of the Child was adopted by the General Assembly on November 20, 1989, and went into force on September 2, 1990, with more than the required twenty ratifications. Fifty-six Member States had ratified the treaty when this book went to press, but the United States had neither signed (agreeing to review the treaty with an eye toward future ratification) nor ratified. This collection of essays was compiled in an effort to arouse interest in adopting the Convention among members of the legal profession and other persons working in the field of child advocacy. As stated by the editors, it was felt that "a general overview of the relationship between existing United States law and the standards of the Convention would help to minimize confusion about the treaty's content and that it would provide a basis for facilitating discussion and dialogue among legislators and within the Administration" (p. iv). The editors also state their opinion "that the United States should ratify this new human rights treaty as soon as possible" (p. iv).

The book begins with the reproduction of the Convention's Preamble and its fifty-four articles, forty-one of which are substantive, the last thirteen of which set out procedures for ratification of the treaty. The seventeen chapters of the book are divided into two parts. The four chapters comprising Section I, "General Considerations," discuss the actual drafting of the Convention: guiding principles, problems encountered, compromises made. In Section II, "Substantive Issues," each chapter contains an in-depth examination of one or more articles, under such varied topics as, "The Child, Parents and the State," and "The Child's Access to Diverse Intellectual, Artistic and Recreational Resources." The book ends with an "Afterword" by Sanford N. Katz, a distinguished writer on family law, in which he points out the qualities inherent in our political and legal system which make implementation of the Convention here problematical.

The twenty other authors represent a wide spectrum of expertise in child development and in law. Although attorneys predominate, most of the authors have had direct experience in the area of children's issues in the United States as well as in other countries. Consequently, the essays are readable and carefully documented, explaining the Federal and State statutory law, case law, and social policies and programs dealing with children's rights in America.

In this reviewer's opinion, the book is useful to professionals dealing with children's issues and the law, because the essays succinctly present the big picture. The topic of child abuse, for example, is specifically referred to in articles 9, 10, 19, 34, and 39 and is discussed briefly in portions of several chapters. Of the several articles, number 39, providing for the recovery and social reintegration of child victims of neglect, abuse, or exploitation, is particularly important. It calls attention to a need which has been addressed by state legislation but has been severely underfunded in many states. Whether a child is removed from his home because of parental misconduct or remains with his family, a variety of social services on a regular basis is vital but is often not provided. The same unfortunate situation exists in many areas, such as prenatal care, where services are provided for by law but are not delivered effectively.

Stanford Katz describes the Convention as "a statement of ideals" (p. 335). The child's right to optimum benefits in virtually every area of life is set out in one or more articles. The chapters of this book explore how American social policy does or does not meet the ideals articulated in the Convention. Unfortunately, no matter how closely American ideals match those of the Convention, the American federal system of government presents problems for the implementation of any international treaty in the area of domestic relations. Because state law regulates domestic relations, Convention articles which appear on their face to be self-evident are in reality controversial. As Professor Katz points out, "Article after article refers to words and concepts like 'inherent rights,' 'privacy,' 'freedom,' 'family,' 'family members,' 'best interests of the child,' and so forth, which are not easily defined in American law, nor is there necessarily a national consensus on their meaning" (p. 337). But he also adds that, "In spite of considerable difficulties, sometimes only verbal, which the articles present of the American context, taken as a whole this Convention does point the way to a brighter future for the world's children" (p. 338).

In summary, this volume of commentaries on the United Nations Convention on the Rights of the Child is valuable in acquainting the public with its provisions and the effects its adoption might have upon American law, and in presenting ideals toward which federal and state legislation should be directed.

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The New Child Protection Team Handbook.
Edited by Donald C. Bross, Richard D.Krugman, Marilyn R. Lenherr, Donna Andrea Rosenberg, Barton D. Schmitt. New York: Garland Publishing, Inc., 1988. 636 pages. Hardback: $55.00.

Review #1: by Robert Block

Given the increasing focus on the interdisciplinary approach to child abuse and neglect, a review of *The New Child Protection Team Handbook* is timely. This encyclopedic text can serve as a blueprint as more and more communities learn how best to protect their children.

In addition to the editors, there are 42 contributors to this 36-chapter book. Each brings a unique perspective, often teaching through historical overview. For example, chapter three discusses, "The Child Protection Team in a City." In this chapter, Jeannine Williamson reviews the experience of the Denver Child Protection Team, beginning in 1974. Developers of new teams would do well to review her section on "problems" to anticipate similar situations in their own communities.

The authors of the chapter on "Program and Case Coordination" have done an excellent job providing what I felt was the core of the *Handbook*. This practical chapter alone would save most communities beginning to coordinate community resources from a great deal of inefficiency and frustration.

Once a team has been formed, the chapter on "Guidelines for Team Decisions and Case Management" will be very helpful. And all of us who have been to court, as well as new community professionals and volunteers, will appreciate the chapters on the expert witness and the child witness.

Physicians are criticized all too often for failing to understand the role of others in child abuse protection, intervention and treatment. As a pediatrician, I read the chapters pertaining to medical examination with interest. Physical abuse receives a well prepared, succinct review, although the references suffer from missing the large influx of information in the medical literature which has occurred since 1985. Failure to thrive was also well presented. The chapter on sexual abuse appropriately discusses more than just the physical examination. I was bothered, however, by the emphasis on two references to reports by Cantwell which focus on the size of vaginal openings. More recent data dictate a less rigid interpretation of vaginal opening measurements (Heger & Emans, 1990; McCann et al., 1990). Despite such lapses, however, this book contains crucial information that will allow physicians to appreciate the roles of other team members and help us to function as more effective team players ourselves.

In summary, this text benefits from the wide-ranging experience and expertise of its editors and contributors. Frequent appendices present additional ideas and concrete data applicable to a variety of communities and teams. Although a yearly update of the references would be very helpful, chapters are consistently clear and well presented, with topic headings and paragraph content identification which allow a reader to find sections of particular interest easily. Overall, this book is an excellent roadmap for all

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***BOOK* (continued from page 17)**

practitioners in the field.

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Robert Block, MD, is Professor and Vice-Chair of the Department of Pediatrics at the University of Oklahoma College of Medicine (Tulsa), and Chief Child Abuse Examiner for the state of Oklahoma.

Review #2: by Louanne Lawson

Somewhere there is a teacher who is trying to find a readable, useful textbook for a child abuse course; or a professional, new to the field, who is trying to figure out where to start; or a director of a child protection team who is trying to figure out why it's not working; or a lawyer who is trying to figure out a doctor who's trying to figure out a social worker who's trying to figure out a nurse who's trying to coordinate a system. These people should read this book.

They are unlikely to read it cover-to-cover, although they could: it is information-dense without being pedantic. They are more likely to use it as a reference manual to address particular problems. Bross and his colleagues provide profession-specific role descriptions and discuss dynamics of group process with those roles in mind. They share their expertise in setting up new teams, evaluating existing teams, even fixing dysfunctional teams.

The New Child Protection Team Handbook's most useful characteristic is its specificity. A professional could make setting-related changes to one of the many protocols or checklists presented in the book and apply it to a client who just walked into the room. There is, of course, the risk that a well-meaning but unseasoned worker could use the guidelines as a "cookbook" and make mistakes avoided by those with better clinical judgement. On the other hand, the handbook makes information gathered by experienced practitioners accessible to us all.

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MOVING?

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

RECENT RELEASES

Knudsen, D.D., & Miller, J.L. (1991). *Abused and Battered: Social and Legal Responses to Family Violence*. Hawthorne, N.Y: Aldine de Bruyter. 232 pages. $43.95, $21.95 paperback.

Patton, M.Q. (Ed). (1991). *Family Sexual Abuse: Frontline Research and Evaluation.* Newbury Park, CA: Sage. 248 pages. $36.00, $17.95 paperback.

Holmes, R.M. (1991). *Sex Crimes.* Newbury Park, CA: Sage. 160 pages. $32.00, $16.50 paperback.

Hollin, C.R., & Howells, K. (1991). *Clinical Approaches to Sex Offenders and Their Victims.* Somerset, NJ: John Wiley and Sons. 329 pages. $74.95

ASSOCIATE EDITOR'S NOTE

Would you like to see The Advisor *publish critiques or comparative reviews of materials other than books? We have discussed augmenting our regular book review section to include reviews of such things as videotapes, workbooks, assessment instruments, manuals, prevention materials, board games, play therapy and interview aids, etc. related to child abuse and child abuse treatment. Would this be useful to you in your work? If so, is there any category of material you would recommend we review? Any feedback from the membership on these questions would be greatly appreciated. Please address your response to my address listed in the front of the newsletter. In addition, we are now publishing a list of selected recent book releases, beginning with this issue. (MC)*

***AYOUB* (continued from page 16)**

negative consequences of their home environment. The hope is that through a network of child- and parent-focused supports, children living in violent families can be cared for in positive ways as their parents change their lives.

Endnote: The example and some of the content of this article was published in : Ayoub, C., Grace, P., & Newberger, C. (1990). Working with maltreated children and families in day care settings. In S. Cherazi, M.D., (ed.), *Psychosocial issues in day care.* Washington, D.C.: American Psychiatric Press, Inc.

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APSAC MEMBERSHIP BY STATE

CA	223	VA	50	AZ	32	NM	16	NE	8
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WA	97	MD	39	NH	24	AR	11	UT	7
NC	88	MN	37	CT	23	LA	10	VT	6
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CO	67	ME	36	NV	22	SC	10	ND	3
TX	62	GA	33	OR	22	IA	9	WV	2
OK	52	TN	33	IN	20	MS	9	MT	1
WI	52	AL	32	DC	17	KS	8	SD	1

States with no members: Delaware.

International or Territorial members: Australia (5), Bahamas (1), Belgium (1), Canada (22), England (1), Israel (1), Italy (1), Jamaica (1), New Zealand (1), Puerto Rico (4), Virgin Islands (1). **Total: 1,781**

Child Abuse and Neglect

People of Color Leadership Institute

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

POCLI NEWS

DENVER CONFERENCE ACTIVITIES

—by Cheryl Rust

Denver, Colorado, was the host city for the Ninth National Conference on Child Abuse and Neglect and the site of several activities sponsored by the People of Color Leadership Institute. On September 13, 1991, POCLI held its first project Advisory meeting. This meeting was successful in bringing together POCLI staff, subcontractors, consultants, and Expert Task Force members to review project materials and to develop strategies for implementing the various project components.

POCLI sponsored several workshops at the Ninth National Conference to share resources and highlight information regarding service delivery to children and families of color. On Saturday, September 14, POCLI hosted four roundtables to allow professionals an opportunity to express their concerns, recommendations, and strategies for improving child welfare services to communities of color. The four roundtables highlighted critical child welfare issues in the African American, Latino, Asian, and Native American communities.

Each roundtable focused on identifying gaps, problems, and deficiencies in child welfare service delivery to children and families of color. Participants had an opportunity to verbalize their frustrations and develop policy recommendations to improve child welfare services to communities of color.

The roundtable conversations were rich with ideas and energy, and a myriad of critical issues surfaced during the discussions. Participants expressed the need to include community representatives in decisions regarding service delivery. Concern was raised about how families are currently being defined and how this definition affects decision regarding out-of-home placement of children of color. The roundtables were successful in outlining strategies to address the identified problem areas. Participants provided the following policy recommendations to improve service delivery to communities of color:

1. Expand the definition of "family" to include extended family members that serve as vital support systems in communities of color.
2. Provide financial support to extended family members in order to facilitate placement of children in these settings.
3. Incorporate traditional healing practices in treatment models.
4. Involve tribal leaders in the Native American community in case management decisions.
5. Integrate services and enhance cooperation between social service agencies.
6. Develop policies that ensure that agency staff is culturally competent.
7. Develop strategies to keep children at home and support the strengths within families.
8. Increase intervention efforts and re-evaluate interventions that are punitive in nature.

In summary, the roundtables were successful in providing an abundance of ideas and strategies that will serve as a guide for POCLI's activities and policy agenda. POCLI staff will use the ideas to develop formal policy recommendations and establish project priorities.

For further information regarding POCLI's participation in the Ninth National Conference, please contact staff at 202-544-3144.

FEATURE

PSYCHOSOCIAL STRESS AND CHILD ABUSE: AN HISPANIC CULTURAL PERSPECTIVE

—by Luis H. Zayas

POCLI presents the following article to heighten awareness and stimulate discussion about life experiences that influence case management decisions involving Hispanic immigrants. For additional information to clarify or expand on the issues raised in this article, please contact POCLI staff at 202-544-3144.

There is considerable literature on the influence of social stress and negative life events on parents' tendency to abuse their children. Most of this information, however, assumes comparability of psychosocial stressors across racial-ethnic groups. When we consider recently arrived Hispanic people, however, it is essential to view psychosocial stress as not simply originating in a demanding but stable situation, but rather as a longitudinal process that encompasses conditions associated with the decision to migrate, migration itself, and adjustment to a new culture. By definition, the process is unstable and unpredictable.

In this brief communication, the stresses commonly faced by recently arrived Hispanic immigrants are reviewed, in the effort to help child welfare professionals recognize the presence, multiplicity, and complexity of these stresses. Hopefully, the clinician will integrate this understanding in formulating a comprehensive assessment and treatment plan.

Two caveats are crucial at the outset. One is that Hispanic immigrants represent diverse populations. They differ in race, national origin, and cultural traits. What may be said of one Hispanic group may not apply to another. However, their overarching similarities, such as language, similar family values, and often economically impoverished immigrant status allow some discussion of Hispanic emigres as a group. The other caveat is that not all Hispanic parents who experience the stressors reviewed here abuse their children. Most immigrant families function well and raise happy children. The discussion of psychosocial stressors is intended to offer potential etiological factors to consider in families who do abuse.

The accumulation of psychosocial stress often associated with immigration, poverty, and discrimination can contribute to child abuse. Stressful life events that endure and are intense, whether sequential or concurrent, often dramatically impair a family's capacity to deal with strains, changes, and challenges in survival. For Hispanic immigrants, the stresses are often multiform and chronic, beginning before they leave their country and persisting through their time of adjustment in the United States. As we present the three phases of immigration stress—pre-immigration, immigration, and post-immigration—please bear in mind that they often overlap: the emotional effects of one stage can still play a part in individuals' psychosocial functioning during a subsequent phase.

Pre-immigration stresses

Pre-immigration stress refers to the numerous strains immigrants experience in their country of origin—those strains that motivate the decision to emigrate in the first place. Since emigration, even when desired, is dangerous and distressing, the conditions that motivate it have to be extreme. Dominican, Mexican, Central American, Salvadoran, and other Hispanic immigrants cite a combination of factors as motivation for their often life-threatening journeys. The search for economic opportunities is the reason most often given for emigration. Most immigrants suffered from unrelenting pov-

Continued on next page

ZAYAS *(continued from page 19)*

erty in their country of origin. Many have endured governmental instability or political oppression and persecution, sometimes including torture and other atrocities.

Living in those conditions is extremely difficult, often physically and emotionally damaging. In addition, contemplating a flight from such conditions entails traumatizing decisions about separation and responsibility. Saving oneself may mean leaving family and friends behind; it may feel like abandoning them without protection in a brutalizing country. Deciding to bring them along may mean exposing them to a life-threatening trip. Uncertainties about the future—how the trip will be accomplished, what it will be like, what one's adopted country will be like—cause prospective immigrants anxiety for their own and for their loved ones' safety.

The pre-immigration ordeal may manifest itself in symptoms ranging from depression and hopelessness to symptoms associated with post-traumatic stress disorder. These symptoms include extreme anxiety, hypervigilance, paranoia, sleeping disturbances and nightmares, and impaired interpersonal relations characterized by extreme mistrust and wariness.

Immigration stresses

Immigration stress is the immediate, short-term difficulty involved in moving oneself from one sociocultural system and geography to another. The immigration process can be extremely traumatizing. Many immigrants have to traverse harrowing terrain to complete their journey. Guatemalans must travel through rural Mexico, then find passage across the Mexico-U.S. border; Dominicans have fled to Puerto Rico on rafts and poorly equipped boats over turbulent waters. Many Hispanic immigrants have died in the process of immigrating, and all immigrants know that death is a possibility. Think of it: *vacations* are listed as stressors in most mental health inventories. The dangerous journeys of immigrants can be emotionally exhausting.

Post-immigration stresses

Post-immigration stress begins immediately upon arrival in the host country. Immediately, differences in language, culture, geography, and climate are evident. Within days, discrimination may be felt. The immigrant's difficulties with the language may be exacerbated by the impatience of natives with the foreigner's halting speech.

Non-verbal communication is another source of confusion. In some Latin American cultures, for example, eye contact is seen as a sign of aggression or disrespect. For Americans, in contrast, eye contact is a sign of firmness and directness. Many embarrassing and even dangerous misunderstandings can occur as a result of this difference. Americans and Hispanics tend to view time differently as well. Whereas Americans tend to be very business-oriented and time-conscious, almost to view time as an adversary, Hispanics tend to view time much more calmly, to see it as something they can't standardize or control. These and many other cultural differences can create confusion, disorientation, anger, and fear in the Hispanic immigrant.

These differences can also contribute to the Hispanic immigrant's inability to get or hold a job. Even while immigrants may be feeling great anxiety about making enough money to help bring their loved ones to join them in the States, they may be chronically plagued by unemployment, underemployment, job instability, substandard working conditions, victimization by their employers, and, of course, poverty. Housing is often substandard; homelessness is a palpable threat. The neighborhoods in which immigrants live are often unstable, full of crime, violence, substance abuse, and hopelessness. These economic disadvantages create barriers to health care, education, and recreation. In some cases, lack of legal documentation of immigrant status increases the barriers and the stress.

We cannot cite cultural factors as rationalizations for child maltreatment.

When they need help most, Hispanic immigrants may find it least. The familiar social support systems of their country of origin may be absent or limited. Without these supports, disruption and fragmentation of personal and family life may ensue.

Breakdown of the family may be hastened by particularly divisive factors about the new situation. For example, the wife may be more employable than the husband. If so, that part of the man's sense of worthiness and pride which derives from being the family's principle breadwinner may be diminished or destroyed. In addition, children often acculturate more quickly than their parents. When an adolescent girl wants to dress, use cosmetics, and date like her American peers, but her parents want her to retain the traditional, modest behaviors of women in her culture, powerful parent-child conflicts can ensue.

All of these stressors can lead to cognitive disorientation and low self-esteem. Unfortunately, public and private sector services are seldom adequately prepared to serve disenfranchised populations. Service providers are not always sensitive to or familiar with the language and cultures of their Hispanic clients. Access to the services that are available may be limited due to hours of operation that conflict with daily work schedules. Most Hispanic immigrants' jobs do not offer flexible leave policies: time taken from work to take advantage of available social services may result in the loss of wages, even the loss of a job.

Some Hispanic immigrants respond to these complex multiple stresses by turning to alcohol and other drugs. They may respond to the dissolution of their families by employing culturally acceptable approaches to child and adolescent discipline, which may include corporal punishment. It is all too easy, when drugs are being used, for corporal punishment to escalate into abuse. Whether disciplinary behavior is abusive or not, however, it may be interpreted and reported as such by others. Well-intentioned professionals such as social workers, teachers, and physicians, may act within the guidelines of mandated reporting laws, which lack flexibility in making culturally sensitive assessments of whether abuse actually occurred. The reasons a family may be identified are many, but often it is the individual professional's or the bureaucratic system's failure to understand the values that govern childrearing in the Hispanic cultures. Whether or not abuse has in fact occurred, reports inevitably initiate a labyrinthine process of involvement in the local child welfare system, which is very often culturally insensitive and perpetuates rather than solves the family's problems.

Conclusions and clinical implications

We cannot hide family and parental deficiencies behind descriptions of culture and what the culture prescribes. We cannot cite cultural factors as rationalizations for child maltreatment. Further, it is inaccurate to focus on environmental factors as the only determinants of child abuse; to a certain extent it is also unfair, since the majority of people who experience maximum stress do not abuse their children. There are, after all, aspects of individual psychology and psychopathology that lead to child abuse and neglect.

We do, however, have a responsibility to take into consideration the cultures from which immigrant Hispanic families emerge and the trials they have undergone, both before and after their decision to immigrate to the U.S.

An understanding of the immigration process and the associated social stresses must be combined with our understanding of individual psychology. The clinician must look for the expression of loss and yearning among persons who have migrated, and understand the immigrants' sometimes intense attachment to their language or culture as an attempt to maintain closeness to family and friends they have left behind.

To begin to integrate knowledge of the Hispanic immigrant family, the clinician should approach each family with a desire to elicit from them a narrative history of their family life, including pre-immigration experiences. Asking families about how their specific culture views childrearing and parents' and children's rights will give the clinician a chance to better understand the suspected abuse or neglect situation. It is essential that the service provider respect the family structure and engage immediate and extended family members in the case management decisions.

The clinician must be aware that a family may misreport traditional cultural practices to exonerate excessive physical violence. But frequent inquiries about parenting behaviors and values of the culture of origin will gradually provide the clinician with a broad understanding from which informed and sensitive decisions can emerge.

Luis H. Zayas, PhD, is a psychologist on the Psychosocial Faculty of the Department of Family Medicine, Montefiore Medical Center, and a Research Associate at the Hispanic Research Center at Fordham University, both in the Bronx, New York.

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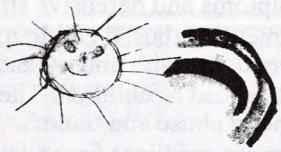

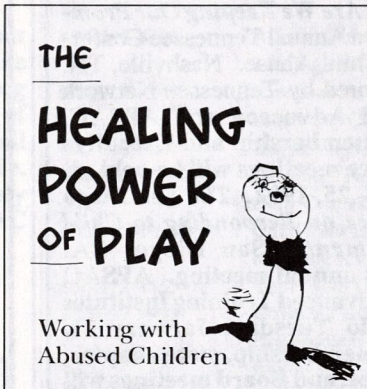

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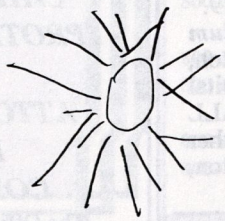

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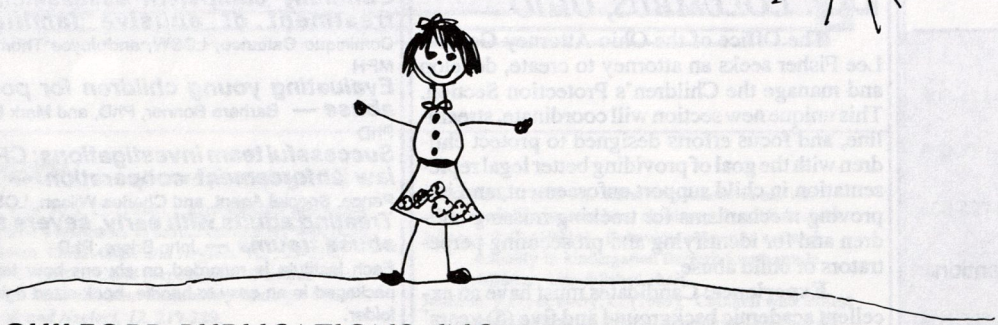

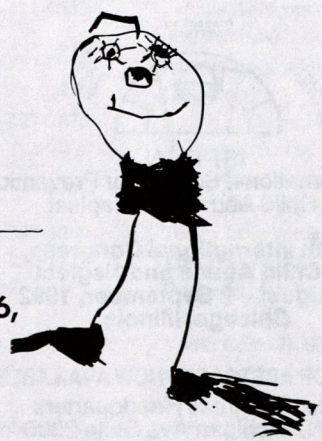

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In conjunction with the Eighth National Symposium on Child Sexual Abuse. For information call Cheryl Rust, 202-544-3144.

NEWS

ENDOWMENT FUND CONTINUES TO GROW

—by Theresa Reid

The list of people contributing to APSAC's Endowment Fund is getting longer. Our initial goal is to raise $25,000 to help APSAC achieve financial stability and meet its long-range goals. Among these goals are to launch our own national conference, to produce *The APSAC Handbook on Child Maltreatment,* and to offer scholarships to professionals who can't afford to pay membership dues. You can help 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 $4,672 to help APSAC toward its $25,000 goal.

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JOHNSON *(continued from page 11)*

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Toni Cavanaugh Johnson, PhD, is a psychotherapist in private practice in South Pasadena, California.

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