APSAC

Volume 5 Number 1 Winter 1992

THE ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

NEWS

APSAC HAS ANOTHER EXCELLENT YEAR

—by Theresa Reid

New Board and Officers Are Elected

In Fall, 1991 ballotting, APSAC's membership elected the following professionals to APSAC's Board of Directors for three-year terms that began on January 1, 1992:

- Antonia Dobrec, MSW
- Harry Elias, JD
- Martha Erickson, PhD
- William N. Friedrich, PhD
- Beverly James, MSW
- Paula Jaudes, MD
- Robert Prentky, PhD
- Robert Reece, MD
- Benjamin Saunders, PhD
- Anthony Urquiza, PhD.

As usual, the slate presented difficult choices among outstanding professionals. Those elected are an energetic and experienced group, whom we warmly welcome to APSAC's Board. Officers (elected during the annual meeting) and Executive Committee members are as follow:

President: Charles Wilson, MSW

First Vice President: Barbara Bonner, PhD (President elect, chair of the Membership Committee)

Second Vice President: Patricia Toth, JD (Chair of the Program Committee)

Treasurer: Thomas Curran, LCSW, JD (Chair of the Finance Committee)

Secretary: Kathleen Coulborn Faller, PhD (Chair of the Nominating Committee)

Executive Committee Members at Large: Linda Canfield Blick, LCSW (chair of the Media Relations Committee); Astrid Heger, MD; Susan Kelley, RN, PhD (chair of the Awards and Publications Committees, Editor-in-Chief, *The Advisor*); Ben Saunders, PhD (co-chair, Research Committee); Paul Stern, JD; Joyce N. Thomas, RN, MPH; Linda Williams, PhD (co-chair, Research Committee).

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FROM THE PRESIDENT

These are, as Dickens wrote, the best of times and the worst of times. The child protection system of this country is under enormous pressure, with over 2.5 million new reports of child maltreatment received last year. Professionals doing the challenging work of preventing, investigating, assessing, prosecuting, treating, and managing child abuse and neglect cases are faced with growing expectations and shrinking resources. The recession caused 38% of the states to reduce funding to children's services last year. The Child Welfare League of America reported recently that 20% of the states have already made additional cuts this fiscal year. This not only means reduction in public agency services but reductions in private treatment services, research, and prevention efforts. State budget crises have postponed the opening of new prisons, meaning convicted child sex offenders are, in some states, released early due to prison overcrowding. Overloaded judges and child protection workers with growing caseloads face the inceased risk of judgment errors which could result in the death of a child. These are tough times indeed.

> ***"Maltreated children need the expertise of all involved and need us to work together."***

But despite these pressures, all is not lost. The quality of services is in many ways getting better. While still in the developmental stages, the volume and quality of research is growing rapidly. The field is beginning to build a strong empirical base. This was demonstrated at the recent Children's Hospital Conference co-sponsored by APSAC in San Diego. Three afternoons were filled with excellent research presentations. Ben Saunders, PhD, of the Medical University of South Carolina, and Linda Williams, PhD, of the Family Research Lab at University of New Hampshire, co-chair APSAC's Research Committee. One of the committee's major goals is to present "APSAC Research in Action" workshops which make the latest data available and useful for practitioners on the front line. APSAC presented its first Research Career Achievement Award in San Diego, to Gail Goodman, PhD, of State University of New York at Buffalo.

The field is also breaking down old and dysfunctional barriers between the disciplines. Maltreated children need the expertise of all involved and need us to work together. APSAC excels at building that rich interdisciplinary environment. A wide variety of disciplines is represented among our members, and we must seek to include even more. We will become stronger as our growing ranks of psychologists, social workers, physicians, and nurses urge their colleagues on the front line in law enforcement, child protection, and prosecution to become involved in APSAC. Our strength will grow as we improve cross-cultural practice and competence, and encourage persons of color to become increasingly active in this important organization.

One highly successful means of building this interdisciplinary and multicultural environment is the APSAC state chapter. We now have nine chartered chapters, and 25 more in progress. I encourage you to join in these efforts. Strong state organizations directly further APSAC's goal of enhancing America's response to child maltreatment. They can aggressively address state and local issues, making a real difference in the services kids and families receive.

We are proud of what APSAC is accomplishing. APSAC is furthering knowledge by fostering and disseminating research, improving professionals' skills by offering a variety of training experiences, and building an effective network for the benefit of children by building interdisciplinary coalitions. While times are tough, APSAC members have demonstrated that, in spite of the budget crisis and public pressures, we can remain focused on quality of services. Our collective efforts hold much promise for children. If you haven't already, begin this year to take an active part in APSAC state chapters, guidelines task forces, and conferences. The year ahead holds as many promises as challenges. Together we are up to the task.

> ***"We will become stronger as our growing ranks of psychologists, social workers, physicians, and nurses urge their colleagues on the front line in law enforcement, child protection, and prosecution to become involved in APSAC."***

—by Charles Wilson, MSW, Director, Child Welfare Services, Tennessee Department of Human Services.

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LEGAL NEWS

U.S. SUPREME COURT DECIDES TWO CHILD ABUSE CASES

—by John E.B. Myers

On December 4, 1991, the U.S. Supreme Court decided *Estelle v. McGuire* (112 S.Ct. 475 [1991]), an important case dealing with battered child syndrome (BCS). The Supreme Court joined ranks with all other American courts in approving expert medical testimony on BCS to prove that a child's injuries were not accidental. In addition to approving BCS evidence to prove nonaccidental injury, the Supreme Court indicated that evidence of BCS can also be used to help the prosecutor establish the identity of the perpetrator of physical abuse.

The Supreme Court wrote that "the proof of battered child syndrome itself narrowed the group of possible perpetrators to McGuire and his wife, because they were the only two people caring for [the victim during] her short life." The Supreme Court then quoted approvingly from the California Court of Appeals' 1971 decision in *People v. Jackson* (95 Ca. Rptr. 919, 921 [Ct. App. 1971]), where the California court observed that "only someone regularly 'caring' for the child has the continuing opportunity to inflict these types of injuries; an isolated contact with a visious stranger would not result in this pattern of successive injuries stretched through several months."

> ***"The impact of the* White *decision is to make it easier for prosecutors to use children's hearsay statements in child abuse litigation."***

Thus, expert testimony on BCS is evidence of (1) abusive injury, and (2) the identity of the abuser. Note, however, that an expert witness may not offer an opinion that a particular person abused a child.

On January 15, 1992, the U.S. Supreme Court decided *White v. Illinois* (112 S.Ct. 736 [1991]). The *White* decision clarifies the law regarding admissibility of hearsay evidence in criminal trials. In *White*, the defendant entered the four-year-old victim's home in the middle of the night, covered her mouth, choked and threatened her, then sexually abused her. In the minutes and hours following the abuse, the child described the abuse to five people: her mother, the baby sitter, a police officer, a nurse, and a physician. The child was unable to testify at defendant's trial, and the five adults to whom the child disclosed the abuse were called as prosecution witnesses and asked to repeat what the child had told them of the assault.

Defendant's attorney made a two-part objection to allowing the adults to repeat what the victim had told them: (1) Defense counsel objected that the child's statements were hearsay, and hearsay cannot be used in court. (2) Defendant's attorney argued that allowing the statements to be used in court would violate the defendant's Sixth Amendment right to confront the witnesses against him.

The trial judge overruled the first part of defense counsel's objection because the child's statements were admissible under excited utterance and medical diagnosis or treatment exceptions to the hearsay rule. The judge also ruled that defendant's constitutional right to face his accuser was not infringed.

Defendant was convicted. His conviction was affirmed on appeal to the Illinois Court of Appeal. The case went to the U.S. Supreme Court, and the Supreme Court again affirmed the conviction.

With its decision in *White*, the U.S. Supreme Court clarified an area of constitutional law that has been unclear since the Court's 1980 decision in *Ohio v. Roberts* (448 U.S. 56 [1980]). In *Roberts*, the Court ruled that under the Confrontation Clause of the Sixth Amendment, when the prosecutor wants to use hearsay against the defendant, the proecutor normally must produce the person who made the hearsay statement as a witness in court, or demonstrate that the person is not available to testify as a witness at defendant's trial. Only after the prosecutor fulfills the responsibility to produce or demonstrate unavailability can the prosecutor offer hearsay.

But then, in 1986, the Supreme Court decided *United States v. Inadi* (475 U.S. 387 [1986]). In *Inadi*, the Court ruled that the prosecutor does not *always* have to produce or demonstrate the unavailability of persons whose hearsay statements the prosecutor wants to use against a defendant.

After the *Inadi* decision, it was unclear when a prosecutor desiring to use a child's hearsay statements had to produce the child as a witness or demonstrate that the child was unavailable to testify. With *White*, the Supreme Court clarified this issue. The Court ruled that the prosecutor's duty to produce or demonstrate the unavailability of individuals who make hearsay statements applies "only when the challenged out-of-court statements were made in the course of a prior judicial proceeding." Thus, the prosecutor in a child abuse case has no duty to produce or establish the child's unavailability before the prosecutor can use the child's hearsay statements that are admissible as excited utterances, present sense impressions, statements of state of mind, or statements for purposes of medical diagnosis or treatment. The impact of the *White* decision is to make it easier for prosecutors to use children's hearsay statements in child abuse litigation.

John E.B. Myers, JD, is Professor of Law at University of the Pacific, McGeorge School of Law, Sacramento, CA, and Executive Editor of The Advisor.

1992 APSAC AWARDS

It is with great pleasure that APSAC's Board of Directors, Awards Committee, and Research Committee announce the following award recipients.

1992 APSAC OUTSTANDING SERVICE AWARD

Jon R. Conte, PhD

Jon Conte has contributed to APSAC's development and growth in countless ways. He was one of APSAC's original founders, whose vision, courage, and determination inspired APSAC's creation. As its first President, Dr. Conte assumed the unenviable responsibility of guiding APSAC as it took its first steps on an uncertain journey. Dr. Conte found APSAC its administrative home and its first and current Executive Director, worked on the development of APSAC task forces, negotiated with Sage Publications to make the *Journal of Interpersonal Violence* a benefit of membership, and guided decision-making on every aspect of APSAC's development. In a field where the work is very difficult, the frustrations many, the successes far too few, and society's misunderstanding a constant obstacle, Dr. Conte's is a voice of reason and support for countless child abuse professionals. We as individual child abuse professionals, and in particular APSAC, owe him our sincere thanks.

1992 APSAC OUTSTANDING PROFESSIONAL AWARD

Ann Wolbert Burgess, DNSc

Ann Burgess's contributions to the field of child maltreatment are legion. She has pioneered in speaking for adult and child victims of sexual abuse and assault. She literally wrote the book on sexual victimization, first about rape trauma syndrome, then about the documentation of children as victims. Dr. Burgess was the first researcher to document empirically the impact of sexual assault, and the first to write a textbook on child victims. Despite her multitude of commitments, Dr. Burgess is never too busy to offer guidance, support, and encouragement to her colleagues. Working closely with mental health and criminal justice professionals, Dr. Burgess has exemplified throughout her professional life APSAC's goal of an interdisciplinary approach to combating child maltreatment.

1992 APSAC RESEARCH CAREER ACHIEVEMENT AWARD

Gail Goodman, PhD

Gail Goodman maintains an unparalleled career as both scientist and advocate. As a scientist, Dr. Goodman argued that previous findings about children's recall were not ecologically valid for generalization to maltreated children. Breaking new ground, Dr. Goodman was the first to apply rigorous scientific standards to the question of children's credibility with ecologically sensitive paradigms. Her elegant studies became prototypes, launching an innovative movement in research and kindling the efforts of many young scientists. Her findings reshaped our conceptualization of the child's journey from trauma to disclosure to recovery. Not content to gain the respect and admiration of other scholars, Dr. Goodman works tirelessly to translate her results into a form that is functional for policy makers, judges, attorneys, physicians, and parents. Her research influences decision-making at every level, from the U.S. Supreme Court to countless trials regarding the safety of individual children.

1992 APSAC PRESIDENT'S HONOR ROLL

The APSAC President's Honor Roll honors fifteen members nationwide who have made exceptional contributions of time, energy, and resources toward the realization of APSAC's primary goal: enhancing America's response to child maltreatment. We are delighted to name the following fifteen exemplary professionals to APSAC's first annual Honor Roll.

Bonnie Beneke, LCSW
Nashville, Tennessee

Mark Chaffin, PhD
Little Rock, Arkansas

Jill Cohen-Kolb, MA
Madison, Wisconsin

David Cory, MSSW
Abilene, Texas

Debbie Doane, MSW
Bellevue, Washington

Marilyn Grundy
Huntsville, Alabama

Elise Katch, LCSW
Denver, Colorado

Louanne Lawson, RNPC, MNSc
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Charlotte, North Carolina

Linda Lewin, RN, MS
Toledo, Ohio

John E.B. Myers, JD
Sacramento, California

L. Dennison Reed, PsyD
Plantation, Florida

Erin Sorenson, MA, ACSW
Hanover Park, Illinois

Suzanne White, MSW
Cambridge, Massachusetts

Michelle Zimmerman, MA, RN
Chesapeake, Virginia

MEDIA RELATIONS

CHILD ABUSE AND THE MEDIA: TWELVE TIPS FOR DEALING WITH THE PRESS

—by Deborah Fisher

You're asked to be on a television talk show to discuss child abuse. Maybe it's a talk show in your town. Maybe it's *Donahue*. You assume the program will include people who disagree with your point of view. You're right. You also assume that the host will know something about child abuse. You're wrong. The show is a disaster. You argue that many children are not protected from child abuse. Others on the show refute your claims by saying they've been falsely accused of abuse. The host seems to think one of you will emerge victorious by the end of the show if he just lets you battle it out. He doesn't guide the discussion or ask the right follow-up questions. When you try to elaborate on an important point, the host takes a commercial break. You end up feeling you could have accomplished a lot more back at the office.

What Watergate did to politics, McMartin did to child abuse. Suddenly, the topic was hot, or what reporters call "sexy." "Sexy" means it has momentum or, in the parlance of convention politics, the "Big Mo." The story the reporter has is bigger than what anyone else has. Preferably, it'll be the first. And the more aberrant, the better.

One problem most reporters have, though, is that they are generalists. When the McMartin story hit the wires, suddenly reporters were trying to understand a highly complex and deeply emotional topic—on deadline. In the rush to be topical, reporters made mistakes, mistakes that were devastating. In the aftermath of coverage about the McMartin case, the Jordan, Minnesota case, and similar cases, the press went through the throes of self-examination, discovering and admitting errors in reporting along the way. But the press has yet to find an effective way of retracting those errors. In fact, the press is still searching for a way to cover these stories adequately at all.

On the whole, reporters are trained to believe that they are on a mission from on high. Whether initiated in the classroom or in the newsroom, every reporter, no matter how small the small-town weekly, has a sense of defending the First Amendment. In the most positive sense, reporters believe they are representing the interests of all the people in their community when they step into a courtroom or city council meeting to get their stories.

But there is sometimes a fine line between a sense of duty and a sense of arrogance in the press. Because reporters are protected by the Constitution, they sometimes feel that they're shielded from being held accountable for their mistakes. And many pressures, both personal and institutional, can lead a reporter to make mistakes.

What shapes the daily news.

Consider reporters' boredom the number one influence on daily news. Journalists are constantly subjected to an intense level of interaction with newsworthy subjects. They know the politics of the city council intimately. They've heard the Governor speak a million times. Eventually, reporters become saturated with facts about topics they cover with any regularity. The boredom of the press led to the extremely poor coverage of the McMartin case in the latter stages of the trial. Reporters rarely cover a trial that lasts two weeks, let alone one that lasts two years.

Consider deadlines the number two influence on daily news. A journalist can only manage so much information in one day. If the press conference occurs at 3 p.m. and the news goes on the air at 5:00, a reporter has very little time to research in depth. And, unless the story has a wrinkle in it that makes it possible to "advance" it the next day with new information, it's dead by 11 p.m. In the rush toward deadlines, reporters are sometimes prone to finesse the facts. Stories are only as good as the sources who fill them, and who is talking makes a big difference in how a story sounds. In her critique of McMartin coverage, entitled "Flip Flop," Mary A. Fischer wrote in the December, 1988 issue of *Los Angeles* magazine that the primary influence in the earliest days of the story's release was that the prosecutor's office was talking and the defense attorneys were not.

> ***"What Watergate did to politics, McMartin did to child abuse. Suddenly, the topic was hot."***

The personality and taste of an individual reporter can have a lot to do with what shapes a story as well. Sometimes, stories get covered because reporters are interested in them. That can lead to good coverage, because an interested reporter often knows his or her material. But it can also make it hard sometimes to separate the reporter from the reporting. An unwritten rule that most reporters live by is to remain free of any conflicts or even the appearance of any conflicts of interest. But interest in a topic can very easily become special interest in one side of a topic, and readers are naturally suspicious when unexpected ties are revealed. Many were concerned, for example, when David Rosenzweig, former Metro editor of the *LA Times* who supervised the McMartin coverage for a time, became engaged to Lael Rubin, who prosecuted the case.

Most consumers of news are aware of the foibles of individual reporters. But many people don't consider that news is very much influenced by which side of the bed a reporter's *editor* got up on. The news can be shaped by the most pedestrian sense of what's important, or by what the local newspaper already covered that morning. Four or five different reporters may be rotated through a single trial, with each one handing off yesterday's summary like a relay race. A reporter prepared to cover a news conference on important changes in the state's juvenile code may be called off by an incompetent editor to do an obituary instead. I covered one civil trial in Federal court involving a man suing his family for having him kidnapped to be "deprogrammed" from a religious cult. One day the editors of a local wire service threw in a sports reporter to cover the day's proceedings.

Each day's stories are further subject to the competitive lineup of news produced by the elements and the unexpected. A story planned for weeks in advance falls without a bang or even a whimper when something urgent or new supersedes it. In the three years I covered the Jordan, Minnesota case, I often argued with my editor over what to cover. Most frequently, he argued on behalf of the people he thought were bored out of their minds with child abuse stories. I argued on behalf of those who weren't.

While you can't control most of the variables that determine what gets covered and how well, you can do some things to ease your relations with the press. First of all, *have* a relationship with the press. This is not something you are *required* to do. I think it's healthy for reporters to be reminded once in awhile that no Constitutional mandate insists that everyone answer their questions. But there are advantages to having good relations with the media. Reporters are much more willing to entertain story ideas from someone with whom they have an ongoing, friendly relationship.

Secondly, accept the media as a wild card. While you may be able to predict some coverage based on positive, working relationships with some reporters, accept the fact that you cannot control the press. You can avoid talking to them if you wish, but then you run the risk of not having your point of view expressed at all.

Tips for Dealing with the Press

1. Know how reporters in your area work. You often ask them to understand your world. Learn a little bit about theirs.
2. Respect a reporter's deadlines. Call with timely information well in advance.
3. Talk simply, not in professional jargon. This doesn't mean talk down to reporters. Give them the basics in plain language, and let them ask questions.
4. Don't push a story. Suggest. Send information. Make yourself available. Argue passionately, but don't shove. The press is suspicious of stories it doesn't find itself.

Continued on page 6

MEDICINE

ASSESSMENT OF SUSPICIOUS BURN INJURIES

—by Seth Asser

Associate Editor's Note:

This couplet of articles by Dr. Seth Asser and Investigator Phylip Peltier provides insight into current practice in the medical evaluation of suspicious burns and articulates the importance of crime scene investigation. The pair highlights the need for a multidisciplinary approach to child maltreatment. — by Martin Finkel, DO

At least 6 to 15 percent of burned children seen as outpatients and one third of those hospitalized were injured as a result of abuse or neglect. It is therefore essential for anyone caring for injured children to be aware of the signs of non-accidental burns.

The biomechanics of burn injury are readily understood. Energy applied to skin causes direct cell damage or cell death. In almost all burns in the high-risk group—children under five years of age—injury is caused by thermal energy, or heat. The severity of thermal burns is a function of the amount of heat applied applied to the skin, the duration of exposure, and the thickness of the skin. At 156 F or above, it takes less than one second to produce a full-thickness burn. At the temperature of an average home water heater, 140 F, 5-10 seconds is required. At 124 F, producing a full-thickness burn takes several minutes. Heated metal objects, open flames, or grease—all of which have very high heat content—are damaging on very brief contact. Thick skin—such as that on the soles of the feet—takes longer to burn than thin skin.

In assessing the cause of burns, the two most important factors are the appearance of the injury and the plausibility of the history.

The injury

The size, shape, depth, and distribution of the injury are telling. Some non-accidental injuries such as forced immersion scalds produce burns with easily recognizable features. Forced immersion injuries produce circumferential injury around the extremities, often in "stocking" or "glove" distribution. Forced immersion burns are also seen on the buttocks, lower back, and perineum. These burns are nearly uniform in depth with sharp lines of demarcation. Occasionally there is an area of sparing of the buttock or sole of the feet, where a child is forcibly held down against the tub or sink. Such patterns suggest restriction of motion and significant exposure time. Adults, who have thicker skin and may wear protective clothing, almost always escape injury during forced immersions. Thus, absence of concurrent burn of the caregiver does not exclude involvement.

> ***"In assessing the cause of burns, the two most important factors are the appearance of the injury and the plausibility of the history."***

Cigarette burns also produce easily recognizable features. They tend to be round, of varying depths, and in clusters, often on the hands or feet. Blistering seen early in cigarette burn injuries is sometimes confused with bullous impetigo, and vice-versa. Cigarette burns can be distinguished by their varying depth and by their characteristic pattern upon healing, namely round craters with hyperpigmented edges.

In burns from hot objects, the injury often closely resembles the object. Very hot objects such as household steam irons may produce a significant injury from a brief accidental touch. Suspicious injuries include very discrete lesions (especially in clusters), and burns in unusual locations such as the antecubital fossa or buttocks.

Some burn patterns are usually accidental. In the pull-down of hot liquid from a stove or table top, burns are predominantly on the head and trunk and have the characteristic "arrow down" pattern where the injury narrows as the liquid trails over the surface.

The history

Determining if the history is plausible requires an understanding of child development, knowledge of burn pathophysiology, and application of common sense. A good history includes a detailed description of events with exact location of people, furniture, appliances, and other features of the room. The story should be assessed with the age and specific abilities of the victim in mind. If the caretaker refers to what could be a trigger event, such as incessant crying or soiling, be alert for signs that the caregiver might have lost control and perpetrated physical abuse.

Assessment of child and caregivers for known risk factors for abuse may serve to identify those at high risk, but cannot alone be relied upon to make a diagnosis of non-accidental trauma. A scene review by an experienced investigator can prove invaluable, providing additional information such as the rate of rise and peak temperature of tap water. Paramedics responding to the scene often can provide details about the events and scene which caregivers might knowingly or inadvertently misreport. In addition, examination for evidence of concurrent and prior injury, including occult trauma, is essential in cases where reasonable suspicion exists. Injuries that appear old, e.g., have old, decomposing eschar or underlying cellulitis, need careful correlation with historical events as they may represent anything from inadequate medical care to attempts to hide abuse or neglect.

By careful assessment of injuries and a critical, reasoned approach to correlation with the history, one can identify injuries that are either non-accidental or at least suspicious enough to warrant further investigation. Children who receive non-accidental burn injuries—many of which are at least partially premeditated—are in a home environment that is seriously psychopathological. It is essential that suspicious injuries be referred for extensive investigation.

Seth Asser, MD, is Cheif of Pediatric Critical Care at University of California, San Diego, Medical Center.

FISHER (continued from page 5)

5. Don't view the press as a vehicle for "public relations." PR is a dirty word to a working journalist. A reporter will accept PR material for background, but all PR is suspect, since it's created for whoever paid for it. When you have a story to suggest, shape it in terms of what's called a "hard news peg." What is important and timely about the story? What is the conflict? What is the resolution to a problem? What are the main elements of who, what, when, where, and how?
6. Never, under any circumstances, lie to a reporter.
7. Avoid the use of "no comment" whenever possible. If you feel you must not comment on a story, give a short explanation why, such as, "Not until the trial is finished," or be honest and say, "I don't trust your reporting."
8. Cultivate good working relationships with reporters over time. This doesn't necessarily mean trumping up excuses to chat with reporters or trying to be buddy-buddy. Be available. Respond to requests for information in a timely fashion. In short, be reliable when called upon.
9. Don't be afraid to ask questions of the reporter asking questions of you. Most reporters don't have a problem with giving you some idea what their story is about so you have a feel for the broader context in which your comments will be displayed.
10. Exercise your rights to object to mistakes or just plain bad coverage.
11. Leap to ask for corrections *immediately*. Do not form a committee to study the problem and then ask for a correction. Your only hope of getting a correction is to be timely and, in the case of letters to the editor, succinct.
12. Have a "fire brigade" formed and standing by. Judges in Washington state have a small committee that is on call to deal with media problems on behalf of their colleagues. They are ready to handle what's recommended in suggestion #11.

Deborah Fisher is a writer and consultant in Issaquah, Washington, and former legal affairs reporter for Minnesota Public Radio.

INVESTIGATION

CRIMINAL INVESTIGATION OF SUSPICIOUS BURN INJURIES

—by Phylip J. Peltier

To determine whether suspicious burns are accidental or non-accidental, the investigator must collect specific physical evidence, and histories from the victim, witnesses, and suspect.

Preliminary investigation

In the first stage of the investigation, review all medical and social service reports and photographs. Interview the medical staff to determine their suspicions regarding the injury. What specific points have aroused their suspicions? This information will help you prepare an evidence collection list and formulate specific questions to ask when you interview suspects, victims, and others.

First responders to the scene are also of great assistance, particularly when trained to recognize abuse factors. Always consult these individuals before your scene investigation and interviews. Fire and paramedic personnel are invaluable in the collection of spontaneous statements and scene observations. For example, fire personnel respond to a hot water scald of a six-month-old baby. The lone caregiver tells them the burn occurred during a routine bath. Entering the bathroom, rescuers find a filthy diaper and bathwater twelve inches deep and too hot to immerse their hands in. Communication tapes verify a six-minute response to the scene. The value of this primary information is obvious: babies are not routinely bathed in twelve-inch-deep scalding water, and the dirty diaper could have been a trigger event. None of this information would be available from hospital personnel. Partly because they have access to primary information others miss, paramedics and fire personnel carry credibility that is rarely disputed during courtroom testimony.

Scene investigation

At the scene, photographs, a sketch, and a verbal description of the physical environment in which the injury took place will provide a permanent record. Prepare a detailed sketch of the room in which the injury occurred, including the location of all objects. Photograph the scene with a 35mm camera. A ruler, yardstick, or tape measure should be used in all photos.

When you have identified a source of contact burn (e.g., a cigarette lighter, steam iron, or barbecue grill), it must be collected and impounded if possible. In the case of a hot water scald, photography and temperature data from first responders will be the collected evidence.

A hot tap water scald requires specific details from the scene. Two people armed with an immersion thermometer, tape measure, camera, and stop watch should investigate. Measurements of the basin, tub, or other container should include width, length, depth, height from the floor, and distance from other nearby objects. Documenting the material used to construct the basin is sometimes helpful when determining cooling factors. To determine the peak temperature, one person should turn on the hot water and call out the temperature reading, while the other times and records. (It is important to use a long immersion thermometer to prevent injury to the worker. Additionally, the worker reading the thermometer should not be wearing glasses, since the hot water will steam them up.) Next, fill the basin with straight hot water to a depth of five inches. Immerse the thermometer in the middle of the basin at mid depth and record the temperature. Record readings at five minute intervals for thirty minutes.

> ***"Proper techniques will keep a case from ending up as one person's word against another's."***

Suspect interview

First, ask the caregiver to recreate the incident. This is often useful in discrediting the initial history. As you interview subsequently, your goal is to obtain truthful statements through legally acceptable techniques from victims, witnesses, and suspects. As you interview, record all information, regardless of how remarkable some may sound. Control your own nonverbal behavior, always appearing interested and empathetic. Carefully note the nonverbal behavior of the person you're interviewing. Eye contact, facial expressions, posture, voice, and attitude are all keys that can assist you in formulating and asking questions.

People want to tell the truth. It is up to the investigator to determine what will trigger their confessions. Confronting suspects with photographs, suspicions, technical data, prior cases, and investigative logic is often beneficial. Late in the interview, after the suspect has been given ample opportunity to relate his version of the incident and has been confronted with your suspicions, an emotional break may be detected. If so, move to within arm's reach. At this stage, the suspect may admit to the act while rationalizing the behavior. Help him or her do that. Offer explanations for his or her behavior that don't cast the suspect as a criminal. Be creative, basing your explanations on the information the suspect has provided through statements and nonverbal behavior. If you have determined that the suspect was abused similarly as a child, you might suggest that they thought it was appropriate discipline for their child. Job stress, finances, relationships gone bad, medical problems, and fatigue are other explanations that make it easier for the suspect to admit what he or she has done.

Proper training, teamwork, evidence collection, and interview techniques will combine to keep a case from ending up as one person's word against another's. The result will much more likely be confessions and successful prosecutions, or full exoneration.

Phylip J. Peltier is a criminal investigator for the San Diego County District Attorney's office.

On January 27, 1992, Dr. Ray E. Helfer—our beloved friend and colleague—passed away after complications from a stroke suffered while abroad. Dr. Helfer was 62. Prolific author, scholar, pediatrician, and teacher, Ray was best known to all of us as the father of the child abuse movement. A co-editor with Dr. C. Henry Kempe of the classic textbook in the field, *The Battered Child*, Ray mapped out a comprehensive approach to prevention years ago which remains the framework for prevention today. His early work on mother-infant bonding has spawned countless support programs for new parents in every kind of community. His innovative idea about creating a permanent funding base for prevention resulted in the creation of Children's Trust Funds all across the country. One of Ray's favorite expressions, which has become a watchword for our prevention work is, "If you want to prevent something bad from happening, you have to enhance something good." Ray was funny, he was cheerful, he was optimisitic. He was sensitive and committed, and he cared deeply about all those he knew and so many millions of children whom he would never know. In speaking at his funeral, Dr. Richard Krugman summarized well what many of us think about Ray:

RAY EUGENE HELFER:
Resourceful Advocate for Youth. Editor. Unbelievably Genuine. Extraordinarily Novel. Exuberant. Honest. Empathetic. Loving Father (and husband and grandfather). Educator. Role model.

Ray was to be awarded the Distinguished Career Award from the International Society for the Prevention of Child Abuse and Neglect at the Congress in Chicago in August of this year. The award will be presented posthumously.

A special fund has been established in lieu of flowers: Ray E. Helfer Children's Fund, PO Box 1781, East Lansing MI 48826.

Ray will be greatly missed. The impact of his work will continue to be felt for decades.

—Written by Anne Cohn Donnelly, DPH

MEDICINE

MEDICAL STANDARDS FOR CHILD ABUSE PHOTOGRAPHIC DOCUMENTATION

—by Lawrence R. Ricci

Photographic documentation of significant findings is an important part of any child abuse evaluation, whether for physical or sexual abuse. The American Medical Association diagnostic and treatment guidelines for the abused child recommend that all visible lesions be photographed. Whether such documentation is relevant to a given case is a judicial decision. Photographs may have evidentiary value yet be deemed prejudicial to the defendant. Whether the probative value outweighs the prejudicial danger remains a decision the trial judge must make with each case. Photographs are generally considered admissible, however, if they shed light on the issue, enable a witness to better describe the objects portrayed, permit the jury to better understand the testimony, or corroborate testimony. Courts generally permit physicians to explain or illustrate their testimony with a photograph. High quality photographs of significant physical findings may be important in influencing courts to adjudicate that child abuse has taken place.

Although some institutions have access to professional photographic staff, either inside the institution via a media department or outside via law enforcement, many do not. It is incumbent upon physicians to ensure adequate photographic documentation of visible lesions either by taking the photographs themselves or by guaranteeing that they are taken by someone else. Pictures that are inadmissible because of technical error (out of focus, distorted, unidentifiable, too dark, etc.) must be avoided. The following discussion outlines critical principles of photographic documentation of child abuse cases. (More detailed reviews are noted in the accompanying bibliography.) These principles include good equipment, adequate lighting, and planned composition.

Equipment

The key equipment concerns are camera, lens, lighting, and film. A quality lens, adequate flash, and proper technique are of far greater importance than the brand of the camera. Decisions about what brand to acquire should be based on the needs of the photographer and the cost of the system.

Camera. 35mm slide and print photography remains the standard for patient documentation. Although new technologies are emerging, including videotape and computer based digital image manipulation, the cost of these systems probably far outweighs their benefits for most physicians. Similarly, while the utility of colposcopy for photographic documentation and for magnified examination of the sexually abused child is clear, such expensive equipment is not always required for adequate photographic documentation.

At the other end of the spectrum, instant processing cameras have the advantage of simple operation and low initial cost. Their disadvantages include poor resolution and poor color rendition when compared to 35mm cameras and film. This is particularly a problem when photgraphing subtle or faded bruises. Additionally, instant processing cameras have minimal close-up capability and require expensive film which is difficult to reproduce and store. The best argument for using an instant processing camera is that the print develops just after the photograph is taken, guaranteeing at least one form of documentation. One compromise, particularly when there is a need for immediate documentation, is to take both instant and 35mm photographs.

> ***"The AMA diagnostic and treatment guidelines for the abused child recommend that all visible lesions be photographed."***

Specific 35mm camera types available include traditional 35mm single lens reflex (SLR) cameras, fixed-focus lens "point and shoot" cameras, and "bridge cameras—a new generation offering the simplicity of fixed focus lens and the versatility of a SLR. A traditional 35mm SLR is adequate for most physicians' needs, and offers requisite versatility not available in fixed-focus lens cameras.

Lens. The most versatile system for the relatively skilled photographer utilizes a traditional 35mm SLR camera body with a series of lenses, e.g., 50mm, 105mm, 35-105mm zoom, and macro lens. Attached to a 35mm camera, a macro lens or a standard lens with close-up adaptors allows photographs of fine anatomic detail otherwise not easily documented. The ideal lens for medical photography should have good optics, medium telephoto focal length to minimize distortion (85-105mm), and macro or close-up capability up to 1x (the image on the negative or transparency is magnified to life-size). A relatively inexpensive alternative to a macro lens for close-up work is a set of close-up or supplementary lenses. These are lens attachments placed over the normal lens to magnify the image. These auxiliary lenses provide magnification up to 0.5x. A colposcope mount may be useful for greater than life-size magnification particularly of the genitalia. The accessories may be used in various combinations depending on the particular clinical circumstances.

Lighting. Additional lighting should always be used when shooting indoors with daylight film. Three sources of studio lighting is the ideal arrangement, but expensive and sometimes difficult to manage. Short of that, an electronic flash offers the best light for indoor, color, medical photography. There are two basic types of electronic flash units, a traditional point source flash mounted to one side or the top of the camera (a "hotshoe"), and a ring flash which encircles the camera lens. A traditional hotshoe mounted flash is easiest to use. However, for close-up work such a flash may provide too much shadow. A ring flash mounted on the end of the lens provides shadowless, uniform illumination particularly useful for close-up photographs of cavities such as the rectum and vagina. Having both types of flash affords the greatest versatility.

Film. 35mm color slide film, sometimes called color transparency or color reversal film, remains the standard for medical use. Color film offers a distinct advantage over black and white in that color film uses the various hues of the subject to separate details much more effectively than shades of gray. Color slides are relatively inexpensive, quickly developed, easy to file, and can be converted into satisfactory color prints if necessary. Color slide film offers a distinct advantage over color print film by providing a first generation image that can be projected. It is important that the first generation image can be projected, because duplicating an image may significantly distort the color and resolution.

Because duplicating slides or prints may result in significant distortion of color and resolution, duplication should be avoided if at all possible. Rather, two or three sets of slides should be shot initially, i.e., each view should be photographed two or three times. One set can be used in court, while the others are retained with the child's record. Likewise, magnification should be accomplished in the original photograph by varying camera distance and/or by changing the lens, not in the print or slide making process. A standardized color bar, though awkward, may be placed in the photographic plane for comparison to the subject color. If color is a significant concern, as when trying to age a bruise, clinicians should always carefully document the coloring in writing, rather than rely on photographs, which may not always turn out.

> ***"High-quality photographs of significant physical findings may be important in influencing courts to adjudicate that child abuse has taken place."***

As a rule, only one patient should be photographed on each roll of film. Even if a roll has only a few exposures it should be developed rather than kept in the camera where a mistake might either expose the film or confuse subjects. The use of a standard commercial processing laboratory for color film assures quality control, standardization, and legal acceptability.

Composition

Composition is the proper arrangement of the elements in a photograph. The compositional goal of medical photography is to accurately document the patient's condition. Artistic composition is not important: consistency of technique and reproducibility of results is important. A technically excellent photograph or series of photographs may not be admissible as evidence if they do not establish both the scale and the anatomic location of the trauma.

Medical photographs must show injuries as realistically as possible and should not be used to enhance or exaggerate trauma. It is useful to photograph burns, abrasions, and children both before and after they have been cleaned. Lesions should be rephotographed as they change over time. photographing injuries from different angles and distances can add a three dimensional quality to photographic representation; photographs of the same child over and over again can add a fourth dimension.

"Medical photographs must show injuries as realistically as possible and should not be used to enhance or exaggerate trauma."

The cooperation of the child is essential, both to minimize trauma to the child and to achieve the best composition. It is important to explain to children what is going to happen, in language they will understand. Allowing children to try out the camera and flash often aids in gaining their trust. Children should be allowed to assume a comfortable position. It is far better to have a cooperative child who is holding still, if somewhat out of optimal photographic position, than an uncooperative, restless child.

In order for photographs to be used as court evidence they must be properly verified and relevant to the issue. Verification requires that the photographer or physician testify that the pictures accurately portray the findings and be able to state how the photograph was taken. One way to help verify that the photographs taken are actually of a particular child is to take one picture of the child's name and another of the child's face. Likewise an identifying sign may be placed in front of the patient for each picture. But including such signs or labels with the patient's name and date in the photograph is time consuming and distracting. An alternative for identification of the film is the use of the camera dateback. Dateback attachments are available for many 35mm cameras which imprint the time, date, and an identifying code in each frame. Another advantage of a dateback is that since the imprint is always located in the bottom right of the transparency or negative right/left, top/bottom orientation is made simpler.

Disposition of photographs

After the film is developed, each image should be reviewed both for technique and content. No photographs, even poor ones, should be discarded. This could be misconstrued as destruction of evidence. Processed slides or prints should be reviewed and labeled. On the rim of each print or slide should be the name of the child, age, date of birth, date and time of photograph, hospital number, name of photographer, and name of physician. If confidentiality is a concern, each print or slide should, at a minimum, be labeled with a medical record number and the date the photographs were taken. The description, dimensions, and coloration of significant findings should be noted on each photo and/or on the original record.

The laws of a number of states address the issue of taking photographs in suspected cases of abuse. Indeed, many states require that reasonable efforts be made by the reporting hospital staff member to take or cause to be taken color photographs of any areas of visible trauma to the child. Many provide for immunity from civil or criminal prosecution for the institution reporting and the person arranging for or taking photographs if done in good faith.

Each institution should have a policy for both the handling and the release of the photographs. Though an unbroken chain of custody may be important in a criminal proceeding, in a civil case, where the photographer's testimony can verify that the photographs are representative of a particular subject, such a chain of custody may be less critical. For an unbroken chain of custody, film should change hands as infrequently as possible. With each transfer, the signature of an authorized recipient should be affixed to a list of the materials and should include date, time, and place. Outside lab processing may be acceptable, even if the lab does not sign for the film, if sending the film out is the normal business procedure for the institution. Courts usually accept films sent via first class mail to a standard commercial processing laboratory as an unbroken chain of custody. These laboratories will, upon request, enclose an affidavit ensuring the receipt, correct processing, and return of the film.

"Many states provide for immunity from civil or criminal prosecution for the institution reporting and the person arranging for or taking photographs if done in good faith."

Since photographs offer the only certain method of preserving often perishable visual findings, they may serve several useful purposes. Photographs can be reviewed after the examination to double check findings or perhaps even to discover previously unnoticed findings. If the magnification is precisely known, measurements can be obtained directly from the photograph. Photographic findings can be discussed among colleagues and consultants or can be compared to recent published data. The development of regional peer review groups to enhance technical and interpretive skills is to be encouraged. Photographs taken during an initial examination can provide a standard for subsequent comparison. Likewise, should a second opinion be required, photographs may save the child from the trauma of a repeat examination. In court, photographs can provide a powerful and convincing statement where a simple verbal description might fail. Even when not directly used in court, photographs serve to enhance testimony by jogging the examiner's memory of specific findings.

As important as corroborative physical evidence can be, many cases present without current physical evidence. Particularly with the sexually abused child, a normal examination does not exclude the possibility of abuse. The need for a sensitive medical legal history continues to be paramount.

Summary

The following principles should be kept in mind when photographing abused children:

1. At least one if not several pictures should contain an anatomic landmark. The inclusion of an elbow or knee allows the viewer to identify the anatomic location of a wound. Anatomic or background material unnecessary to the photograph, however, should be left out.
2. At least two photos should be taken of each finding, one including identifying landmarks and one close-up with the lesion filling the frame. Magnification should be obtained in an original, not from a blowup.
3. To minimize distortion, the subject should be arranged in a manner that allows the surface of interest to be parallel to the film. Likewise, the photographer and the subject should be at the same level.
4. Varying perspective (taking a number of shots form different angles and distances) is quite useful, particularly since electronic flash may produce unpredictable reflections. Since the skin is a curved surface, some lesions may require several photographs to fully reveal the pathology.
5. The picture should be composed the way the examiner would normally look at that anatomic area.
6. Both color and size may be distorted in the photograph. Color should be documented if possible with a color scale within the photograph, and the size of lesions with a measuring device such as a metric ruler. Clearly written and detailed descriptionsof the dimension, shape, color, size, and location of the lesions are essential whether or not photographs are taken.
7. It is desirable but not always possible to have a standard set of views for each area

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of the body photographed. The four cardinal anatomic positions—AP, PA, right and left lateral—should be kept in mind when photographing children. However, young children may not cooperate with such positioning plans, reinforcing the usefulness of multiple views from varying perspectives.

8. Forensic bite mark photography is a specialized branch of medical photography and best left to a forensic dentist or pathologist. The basic objective of photographing bites is the accurate rendering of all aspects of the mark. Size, shape, color, depth of indentations and three-dimensional contours must be preserved. No one medium is suitable for all of these functions. Photographs, both black and white and color, can record the first three whereas dental impressions can show the last two. Ultimately, the photographs may be enlarged to life size and compared with a representation of the suspect's teeth.
9. Recording photographic data (date, time, location, case number, camera, lens, aperture, film, light, source, subject distance) helps reconstruct cases particularly for courtroom verification, aids learning and teaching, and encourages consistent technique if the child requires more photographs later.
10. Background is important. The background wall should be nonreflective, ideally a matte finish neutral gray, green, or blue. Glossy background surfaces can produce a glare. A cluttered room makes a poor background for medical photographs.
11. Before photographing children in clinical settings, it is important to establish both a protocol and a checklist for operation. Clearly identify who will take the photographs and how the film will be handled after picture taking.

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STATE CHAPTER NEWS

CHAPTERS TAKE OFF

Four more state chapters were chartered in December, 1991, and January, 1992. (Pennsylvania, Tennessee, Ohio, and Washington) These four bring the number of official APSAC state chapters to nine. The coordinators and interim officers of these newly-formed chapters are to be commended for their dedication and hard work. Getting a state chapter off the ground while you're working full time is no easy feat. (And Linda Lewin, coordinator and interim President of the Ohio chapter, is not only working full time, she's a mom, and is going to graduate school for a PhD in child development!)

Interim officers of the new chapters are as follow: **Pennsylvania:** Tom Curran, LCSW, JD; Christine Grant, RN, PhD; Carmen Anderson; Arlene Baxter, PhD; Rita Borzillo, JD. **Tennessee:** David Muram, MD; Bonnie Beneke, MSW; Kitty Oliver; Nancy Chandler, MSW; Tempie Dotson, MA. **Ohio:** Linda Lewin, RN, MS; David Gemmill, MD; Robert Reece, MD. **Washington:** Jon R. Conte, PhD; Paul Stern, JD; Mary Gibbons, MD; Florence Wolfe, MSW; Deborah Doane, MSW.

Other chapters are moving quickly to become chartered as well. Texas APSAC members met in Fort Worth in November and December to organize a chapter, and the interim Board will meet again in February to finalize a draft of the charter and begin organizing a slate of candidates for election to the Board. The next meeting of the general membership will be held in conjunction with a multidisciplinary, all-state conference to be held September 28-30 in Amarillo, sponsored by The Bridge.

The North Carolina chapter (one of the first to be chartered) has issued its first newsletter. Mailed to all APSAC members in the state, the newsletter is designed to stimulate statewide coalition building and provide local update information on the field. In addition, NCPSAC has dealt creatively with a problem faced by all chapters in big states (it takes 12 hours to drive east to west across North Carolina): how to be sure all areas of the states are represented and involved in state chapter activities. NCPSAC has organized chapter activities into nine regions which utilize the same boundaries as AHEC. Each region has two coordinators who will promote the development of NCPSAC within their region, and serve as contact people for prospective new members. This is a terrific way to make sure that everyone who wants to get involved at the state level can get involved.

CALL FOR NOMINATIONS

Nominations are being sought for the 1993 APSAC Awards. Awards will be given in the following categories:

Outstanding Service Award

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

Outstanding Professional Award

This award honors a member of APSAC who has made outstanding contributions to the field of child maltreatment and to the advancement of APSAC's goals.

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.

Outstanding Media Coverage Award

This award recognizes a reporter or team of reporters in print or electronic media whose coverage of child abuse encidents or issues shows exceptional knowledge, insight, and sensitivity.

For information on how to nominate a colleague call the APSAC office at 312-554-0166. **Complete nominations must be received no later than May 31, 1992.**

SAVE THIS DATE

Monday, August 31, 1992, 5:30 p.m. In conjunction with the ISPCAN Ninth International Congress on Child Abuse and Neglect, to be held in Chicago, APSAC will hold an International Networking and Social Hour. APSAC members and their colleagues worldwide will have an opportunity to meet and discuss the professional concerns that unite us across oceans. It should be a stimulating couple of hours. We hope to see you there! (See page 23 for Conference information.)

REACH OUT

HELP APSAC STRETCH ITS ADVERTISING BUDGET!

You can be of vital service to APSAC by taking brochures and news about APSAC with you when you meet with other professionals in the field. We are delighted to send you as many brochures as you can use—just give us at least a week's advance notice. Do you know of any relevant newsletters that might publish a news brief about APSAC? For a supply of brochures or sample articles about APSAC, please call 312-554-0166 anytime.

Thanks to all of you who will call, and all who have called and helped spread the word about APSAC and its goals.

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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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608-244-4022

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.*

NEW TASK FORCE SEEKS INPUT

APSAC has formed a new task force to develop guidelines on investigative interviewing of children in cases of suspected sexual abuse. The task force is co-chaired by Mark D. Everson, a child psychologist at the University of North Carolina at Chapel Hill, and Donna Pence, Special Agent, Tennessee Bureau of Investigation. As a part of its work, the task force will be reviewing existing protocols and guidelines on investigative interviewing, and invites you to submit copies of relevant written materials and training videotapes to Mark D. Everson, PhD, UNC at Chapel Hill, Program on Childhood Trauma and Maltreatment, Department of Psychiatry, CB# 7160, Chapel Hill NC 27599-7160.

LAW

IDENTIFYING THE BEST INTERESTS OF THE CHILD IN PROTECTION PROCEEDINGS: NINE GUIDELINES FOR THE CHILD ADVOCATE

—by Donald N. Duquette

Increasingly, judges appoint court appointed special advocates (CASAs) to represent children in child abuse and neglect proceedings. Like lawyers, CASAs are charged with looking out for the "best interests" of the child. Unfortunately, although the phrase "best interests" sounds noble, it provides little practical guidance for the child advocate.

> *"Although the phrase 'best interests' sounds noble, it provides little practical guidance for the child advocate."*

Identifying the best interests of any particular child is difficult because there is no universal standard for "best." A cross-cultural view reveals a variety of parenting practices around the world, and a variety of views about what constitutes good and bad treatment (Korbin, 1987). One of the few universal standards of child rearing is that children should not be harmed. That is, children should be protected from maltreatment considered *in that culture* to be physically or psychologically harmful. But when the focus of attention shifts from the relatively clear goal of preventing harm toward the goal of achieving the best interests of the child, difficulties abound. The difficulties multiply with older children, whose wishes must be given serious consideration.

Rather than strive to realize an abstract goal such as best interests, the advocate should focus on meeting concrete needs shared by most children.

1. Protect the child from harm. This is the goal of the entire child protection system, and must always be at the forefront of the advocate's mind.

2. Assure minimally adequate food, clothing, and shelter. The child's need for food, clothing, and shelter is hardly ambiguous. The advocate should ensure that wherever the child lives, the youngster's basic needs are fulfilled.

3. Preserve the family—if it's safe for the child. Children face a risk of over-intervention when removed unnecessarily from the family home, and of under-intervention when those responsible fail to act decisively when necessary. An advocate can help ensure that all reasonable efforts are taken to protect the child at home. But the child's interests in protection from harm should not be sacrificed for the sake of giving the family a chance. The increasing emphasis on family preservation is appropriate; but the child advocate must be vigilant for the safety and interests of the individual child.

4. Disrupt the daily living pattern of the child as little as possible. The child has an interest in continuity of placement. If the child must be placed out of the family home, disrupt the child's daily living pattern as little as possible. Place the youngster in the most familiar and most family-like setting available. Ordinarily, maintain family, neighborhood, church, and school ties as much as possible.

5. Inform the child and consider the child's views. An independent advocate for the child can play an important counseling role by humanizing the process for the youngster and making court proceedings less mysterious, and therefore less stressful (Oran, 1989; Oran & Oran, 1990). The advocate's "client counseling" role is distinct from that of the psychological counselor, caseworker, or big brother or big sister. The youngster may need assistance of these sorts, and the advocate should secure such services. But the advocate's job is not to be the support system for the child, but to see that one is in place.

The advocate counsels the young client in several ways: first, by explaining the child protection process. The advocate should explain the legal process and the advocate's role in terms the child can understand, inviting and answering questions at every stage.

> *"The advocate's job is not to be the support system for the child, but to see that one is in place."*

The advocate's second counseling responsibility is to listen to the child. The child's wishes are often not clear initially. The advocate can help clarify the child's thinking. What would the youngster like to happen? What are the child's concerns? "What can I tell the judge for you?" "What do you want to tell the judge?" Such consultation is a form of empowerment for the child. When an older child takes an initial position that seems unreasonable, the advocate discusses the consequences of such a position—much as a lawyer does with an adult client. With a young child, the advocate may tell the court the child's preferences and then advocate another position.

Howard Oran's work shows that these steps serve to reduce the child's anxiety about court and foster care experiences (Oran, 1989; Oran & Oran, 1990).

6. Coordinate, coordinate, coordinate. The child has an interest in the coordination of the various social services and courts that may be involved in his or her life. Sometimes criminal proceedings or divorce/child custody actions proceed without coordination with child protection proceedings. Sometimes one agency adopts a strategy inconsistent with that adopted by another. The school system may not be talking with the foster care worker or the mental health agency. The advocate needs to have authority to enter all proceedings on the child's behalf and to discuss the child's needs with all relevant social, educational, law enforcement, and judicial organizations.

7. Attend to the child's sense of time. "Placement decisions should reflect the child's, not the adult's, sense of time" (Goldstein, Freud, and Solnit, 1973, p.40). As well-accepted as this concept is, judges, lawyers, social workers, and others forget it in the pressure of handling many cases. Overburdened caseworkers may not be as sensitive, as careful, or as skilled as they would be under less taxing circumstances.

It is difficult to defeat the "culture of acceptable delay." Do not let such lapses occur to the detriment of a child. Perhaps the most critical decision in the child protection process is whether to place the child outside the home in the first place. If the child is to be removed from the family, removal should usually be for the shortest time possible. If services to the child and the family are necessary before reunification, the services should be identified accurately and provided promptly. Do not let time slip away.

8. Expedite permanency planning decisiveness. The ultimate permanency planning goal is to provide the youngster—*as soon as possible*—with a stable and secure home environment in which to grow to adulthood. If, despite all therapeutic efforts, parents prove unable to establish a suitable home for the child in a reasonable period of time, the advocate should act decisively to seek an alternative permanent placement for the child.

9. Be sure the professionals follow through. The child has an interest in making sure adults keep promises. Busy agency professionals may see periodic calls from advocates as helpful reminders or unrelenting nagging. Whatever the reception, however, the advocate's job is to keep reminding: "Is that psychological exam arranged yet?" "Are the home visits organized?" "Is that petition filed yet?" "Who is going to do what, when?" Ensuring follow-through is often the advocate's most vital role.

Conclusion

Although the interests of any particular child may be subjective and unclear, the nine interests identified above are common to the vast majority of children. The child advocate who operates with these interests in mind serves the child's best interests well.

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Child Abuse and Neglect

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THE YEAR IN REVIEW

A MESSAGE FROM THE DIRECTOR

—by Joyce Thomas

It is hard to believe that only a year has passed since the beginning of the People of Color Leadership Institute. What an exciting year it has been. So much interest has been generated on issues of cultural competency, ethnic diversity, and the need for changes in the field of child abuse and neglect. It is obvious to most of us that there are many gaps in our service delivery system, state program administration, and national policies which affect children of color and their families known to the child welfare system.

As we begin our second year, in order to clarify our future directions, I feel it is important for me to take time to reflect on the many activities and accomplishments of the past several months. As we are striving to achieve our long term goals, we must carve out the dimensions of our short term objectives. We must ask ourselves, "What is it that we really want to see happen for both our clients and professionals in the field of child abuse?" The good news is that we are enthusiastic and energized by the potential for true impact on this field. The significance of this national project on understanding the implication of culture in our day to day practice is very important. The wisdom of the National Center on Child Abuse and Neglect to fund such an innovative project is truly remarkable.

Almost immediately following the notification of the grant award, the staff, consultants, and collaborating organizations began to strategize approaches for the implementation of the many tasks. There was so much positive support and sincere commitment from professionals from all around the country. POCLI is visualized as a vehicle for rapid change in our attitudes, for expanding our knowledge, and for ensuring professional growth and development for persons of color. This is a lot to expect from one federally funded project in such a short span of time.

The first several months have been a tremendous learning experience and a highly productive time for us. We have had many opportunities to share ideas with committed professionals around the country. We are fortunate to have had numerous forums in which to articulate our concerns and to share information. Critical discussions have been held in Atlanta, Huntsville, Washington,D.C., and Denver. We have developed a draft training curriculum for enhancing agency cultural competence. Throughout the coming year, training for trainers workshops will be a major vehicle to expand these concepts into the system. We are beginning to identify successful program models which incorporate issues of culture and diversity into their service efforts. We are planning our mentorship efforts, as well as gathering resources to document our state-of-the-art knowledge. We are quickly approaching the task of conducting agency self assessments. Publication of short articles in *The Advisor* by persons of color has expanded our visibility in the field, and more and more professionals of color are participating in workshops, conferences and other educational seminars. The Ninth National Conference on Child Abuse and Neglect, which was held in Denver, provided an excellent forum to present the vision of this extraordinary project. All of this in one short year, yet there is so much more that most be done.

It is quite obvious to me and others who are involved in this project that the issue of cultural competence is very complex and will not be resolved with a "quick fix" or short term tasks. We must go for the long range integrated impact of establishing a process for improving our overall understanding, attitudes and values for diverse populations. In order for us to move forward, we must have the commitment of many professionals at every level.

During the past several months, I have

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MEET THE LEADERS

AN INTERVIEW WITH DOMINIQUE CATTANEO

—by Joyce Thomas and Cheryl Rust

Joyce Thomas, Director of the People of Color Leadership Institute, interviewed Ms. Dominique Cattaneo about child sexual abuse treatment issues that are significant to the Latino community. The following is an excerpt from that interview.

Ms. Cattaneo is a clinical social worker specializing in child sexual abuse, physical abuse, and neglect. In addition to her private practice, Ms. Cattaneo is the Evidentiary Social Work Supervisor at the Center for Child Protection, Children's Hospital and Health Center, in San Diego, CA.

Ms. Cattaneo's private practice involves working primarily with Latino families. She utilizes her expertise on cultural issues to provide training and workshops on culturally appropriate evaluations and treatment of Latino children and families. Ms. Catteneo's workshops have focused on issues relating to cultural competence and sensitivity; psychosocial issues in child sexual abuse; and family violence issues within communities of color. Ms. Cattaneo is a member of the San Diego Community Child Abuse Coordinating Council and the American Professional Society on the Abuse of Children.

In this interview, Ms. Cattaneo addresses critical child sexual abuse treatment and cultrual issues that impact on Latino children and families.

JT: What are some of the common myths and misconceptions about child sexual abuse in the Mexican American family?

DC: I believe that both Mexican Americans and non-Mexican American communities have misconceptions about child sexual abuse within the Mexican American family. Often, non-Latinos believe that sexual abuse is more prevalent in the Mexican American family than in any other community. To support this misconception, individuals cite examples of large families, inadequate housing and family members sleeping together and therefore they assume that sexual abuse will be more prevalent. Often, Latino family members tell me that they do not believe that sexual abuse is a big problem or a problem at all in their community. Some Latinos believe that it is an "American" problem. However, statistics do indicate that with regard to the incidence of child sexual abuse there is an equal representation in the population across all cultural and ethnic groups.

JT: Can you describe a Mexican American mother's most critical concern, when she finds out her teenage daughter has been a victim of sexual abuse by a member of the family?

DC: I think the most important issue for any mother, and the rest of the family, but more importantly, mothers, is the issue of virginity. This is a very important cultural issue within the Latino community. Women are still raised to be virgins until they are married and when a child has been sexually abused, a mother's first question after the child's exam relates to the status of the child's virginity. This raises the question of how do we deal sensitively with the issue of virginity because of the implication on that family.

> ***"If the family really believes in traditional healing methods – such as herbalism – and we put them down for using these methods, then we are certainly not going to be able to engage the family, nor will they believe we can help them."***

Another issue surrounding the reaction of the family to the sexual abuse relates to if the mother has been a victim of sexual abuse herself. Often, I ask the mother about this without her husband being present because often times if she has been a victim of sexual abuse, she has not even disclosed it to him.

Some of the mothers I have worked with, who have experienced some sexual abuse in their childhood, experience guilt for not being a virgin on the wedding night. In the case of the teenager, if she's not a virgin anymore, her parents may question what will happen—will they be able to control her? We must be concerned about the impact of the incident on the daughter. For example, if she's not feeling that she's worth anything, then she may tend to become sexually active. These are some of the concerns of the parents. Sometimes there is severe emotional trauma surrounding the virginity issue. That's not in all families, but it's important to assess the importance of the virginity issue and this needs to be addressed over and over in treatment.

JT: If there is a situation where she is no longer a virgin and this has been made known to the parent of the victimized child, what are the treatment strategies for assisting in the healing process?

DC: It is important for us to understand that we can not change someone's belief system with just one explanation regarding sexual abuse and virginity. It is an issue that must be addressed over and over again. The emotional aspect of the virginity issue is something else that must be discussed with parents, but often they get so focused on the physical aspects of the virginity that they cannot hear the other piece of it.

We need to be very patient, because this is something they have grown up with. It's part of their beliefs, and we must not be frustrated in dealing with them. We also need to do the same education with the girl, especially the adolescent girl. With the younger girl this may not be so much of an issue. She may not be as aware of it. We need to explore the family's issues regarding virginity because in some families it's not as important as is the welfare of their child.

JT: With regard to the values of the Mexican American family, how do Mexican American cultural values and the whole attitude towards child rearing influence how we go about dealing with sexual abuse?

DC: Well, I think in the traditional Mexican American family sex education is not something that is openly talked about within the family. Again, I have to say traditionally. I think it's good to find out how families talk about sex. It's not as common for families to openly discuss sex, but it's getting more common. There's more information available to families to discuss sex education with their children, but on the whole a lot of families do not talk about normal sex. Therefore sexual abuse is even less talked about.

Often, when a child has been sexually abused, family members do not want to talk about the incident. Family members feel that it is more traumatic for the child to discuss the incident and they want the child to forget about the abuse. This reluctance to talking about the sexual abuse may resemble resistance on the part of the family members. This "resistance" is the family's way of trying to protect their child. They feel that talking about the sexual abuse will serve to only reinforce the trauma. It's important to assess that because it can be labeled as resistance— but resistance to what? Sometimes it's resistance to further traumatizing their child. Education needs to go into that as to why it's important for their child to deal with this.

JT: What are some alternate healing methods? That question comes up a lot — in

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CATTANEO *(continued from page 15)*

terms of specific kinds of techniques or activities that occur within a culture.

DC: Some families will turn to their priest and want people to pray for them. Often, families may go to a spiritualist. It depends again on the level of acculturation — where the family comes from and whether or not the family maintains traditional values. In some parts of the country Mexican people see herbalists and spiritualists who use incense and herbs to take away different spirits. It's really important to find out what the family uses first in order to assess how they feel about the mental health system and alternative healing methods.

JT: Can you combine alternate healing methods with some of the traditional therapeutic methods, and if so, how?

DC: Absolutely. I think a lot has been written on this subject. I've seen some articles by mental health professionals who do combine traditional healing methods and they feel that this is the best way to help some of these families because they are so tied to these healing methods. I believe that if we do not combine some of these methods of healing we will not be effective with the family. For example, if a family is seeing an herbalist, we should not discourage this but talk openly about it, and be able to use this along with the traditional psychotherapy or family therapy. If the family really believes in these healing methods, and we put them down for using them, then we are certainly not going to be able to engage the family nor will they believe we can help them. This is an important part of their belief system, and to use these healing methods] along with what we do is perfectly accurate.

JT: What has been your experience in terms of some of the reactions of Mexican American families to the child protective system or the criminal justice system and how do these issues come out in the therapy setting?

DC: I think that's a very good question. I think it's really important to understand — to get a knowledge of the family's prior experience with law enforcement and protective services. If a family has had a negative experience with the CPS system regarding the sexual abuse of their child, and there has been an adversarial role, this must be dealt with in treatment.

I find that with some families, because of language barriers or an inappropriate assessment, their previous interactions with CPS resulted in the family feeling very angry and very misunderstood. The family may want to help their child but they cannot get past the stage of having to talk about their prior negative experience with the system. So that is an important part. It's not necessarily that the family is being resistant, but they may have had a real negative previous experience with the CPS system.

JT: Can you address some cultural factors regarding treatment issues for Mexican American families involved in sexual abuse situations?

DC: I think it is important to involve the child's family in the treatment. This is extremely important in helping a child through that healing process. Also, it's very important in working with Latino families that we recognize that we need to assess very carefully the family's levels of acculturation. And I say "levels" because we may find different levels within any given family. The importance of that has to do with whether or not a family is more traditional or takes on more of the dominant culture's values. Different levels of acculturation within a family may cause a lot of stressors within that family, because associated with these different levels of acculturation are different values.

> ***"As clinicians, we need to address within ourselves what it is like to work with a different culture. We need to examine how open we are to looking at not only the problems that we see before us but the strengths within the other culture."***

Also, as clinicians, we need to address within ourselves what it is like to work with a different culture. We need to examine how open we are to looking at not only the problems that we see before us but the strengths within the other culture. That's why I say, again, we need to look at ourselves. How do we feel about working with different cultures? If we're not feeling comfortable with it, it's going to come across. We need to do some soul searching on our end. We need to be polite, but also friendly. We need to give the hope to the family that we can understand them and we can help them. Otherwise we will lose them.

JT: I know you are familiar with the People of Color Leadership Institute. If you had to make some strong recommendations, particularly as it relates to Latinos or Mexican Americans — what are some of the things that we should be promoting or encouraging as we are trying to ensure more diverse and more sensitive service providers?

DC: We need more professionals in this field from the Latino culture. The Latino culture is very fast growing. In doing child sexual abuse assessments and treatment, we need people that truly understand the culture and the language. So we need to encourage a lot of young people to look into this field. I see the People of Color Leadership Institute as being able to perhaps motivate or let students know about the field of child abuse and neglect.

THOMAS *(continued from page 14)*

seen a range of responses to this issue, from great enthusiasm to honest uncertainty to strong disagreement. Some professionals are ambivalent, reluctant, and even confused about what is going on. We need to move from this "buzz" word mentality, to some serious strategic planning. Unfortunately, we are behind in our conceptual understanding of how make our system more culturally responsive for a large number of clients. More culturally specific quality research is needed to guide our decision making, help us clarify our fiscal priorities and foster quality program implementation for all clients.

Where do we go from here? Obviously we now need to be more sophisticated on how to integrate this knowledge into our everyday practice and policy formulations. For example, how does culture impact on risk assessment decisions or interviewing techniques, or preparing a case for court, etc.? What are we doing right, and what issues need further development? Where can we reach consensus and what issues are unresolved? I am sure that the next several years of this project will prove to be just as exciting as these first few months. If you have any questions regarding the People of Color Leadership Institute, please call me or Cheryl Rust. We'd love to hear your point of view. We can be reached at (202) 544-3144.

MEET THE LEADERS

Antonia (Toni) Dobrec, MSW, earned her masters degree from the University of Kansas in 1976 and is currently working on a PhD in Public Administration at the University of Oklahoma. Since 1981 she has served as the President and Director of Projects for Three Feathers Associates, Norman, Oklahoma.

Herself a member of the Yurok Tribe, Ms. Dobrec has dedicated 15 years to providing training and technical assistance for Indian tribes and organizations. A Native American representative to the Council of Social Work Education's (CSWE) House of Delegates, she was recently elected to CSWE's Board of Directors. Ms. Dobrec began a three-year term on the Board of Directors of APSAC in January, 1992. Beginning with the Summer, 1992 issue of *The Advisor*, Ms. Dobrec will co-edit the POCLI News with Lula Beatty, PhD, of Howard University.

From 1979 to 1984, Ms. Dobrec was Assistant Director and Assistant Professor at the University of Oklahoma School of Social Work. During that time she was Program Manager for the American Indian Social Work Education Program and Education Program Coordinator for the Indian Child Welfare Project. She was responsible for class scheduling, admission coordination, and administration.

During her tenure with Three Feathers Association, Ms. Dobrec has directed the study of the implementation of the Indian Child Welfare Act of 1978. The goal of the Act is to keep placement and control of Native American children within their own tribe. *Indian Child Welfare: A Status Report*, co-authored by Ms. Dobrec, was the result of this study.

In addition, Ms. Dobrec served as the Project Director for the Child Protection Team Training Project funded by the Bureau of Indian Affairs. She just completed the American Indian Community Awareness Campaign to Combat Child Abuse and Neglect. The campaign produced a community-based curriculum and multimedia support materials, called *Wildfire. Wildfire* has been nominated for a Secretary's Award, conferred by DHHS, OHDS, and NCCAN, and for the prestigious Crystal Star Award, conferred by the American Federation of Television and Radio Artists—Screen Actor's Guild—American Scene Awards.

Currently, Ms. Dobrec's energy is focused on policy analysis and recruitment of Native American minorities into the human service sector. She states, "The working area of child protective services within Indian communities is complex. Native Americans must become committed to meeting the challenge that child maltreatment presents, both within their own communities and in the broader system that affects Indian children. There is an overwhelming need for trained Native Americans to assist their own communities."

Margaret Iwanaga-Penrose, MA, is Executive Director of UPAC, the Union of Pan Asian Communities, in San Diego, California. Ms. Iwanaga-Penrose earned her bachelors degree in Anthropology from Beloit College in Beloit, Wisconsin, and her Master of Arts from the University of Chicago, in Human Development. She has worked in management, supervisory, direct service, and consultant capacities in social service delivery systems for the past 20 years.

Before moving to San Diego, Ms. Iwanaga-Penrose served as Program Manager for the Austin-Travis County Mental Health Mental Retardation Center in Austin, Texas. There, she managed county-wide delivery of mental health services to disturbed children and their families. Services included a child abuse and neglect unit, outpatient clinics, latency-age day treatment, drop-out and drug prevention community outreach programs, and an adolescent wilderness camping program. In addition, she negotiated contracts with inpatient psychiatric units, emergency shelters, residential homes, school districts, and the Department of Human Resources. Under her supervision, the day treatment and wilderness camping programs were recognized as national models by the National Institutes of Mental Health (NIMH).

As Executive Director of UPAC, Ms. Iwanaga-Penrose is responsible for the overall administration of the agency. Her duties include program and resource development, needs identification and assessment, fund raising, program implementation, budget evaluation and administration, and supervision of management staff.

For the past 17 years, UPAC has been the primary provider of human care services to San Diego's Pan Asian communities. Its 80 bilingual and bicultural staff, representing 13 Asian languages and dialects, served over 13,000 Asians and Pacific Islanders in San Diego County. With a budget of approximately two million and a half dollars, UPAC currently manages 24 programs in the areas of child abuse and domestic violence, mental health, health promotion, substance abuse, juvenile delinquency prevention, developmental disabilities, elderly care, child care, employment, parent school involvement, and consumer education.

In addition to UPAC responsibilities, Ms. Iwanaga-Penrose maintains involvement on committees and boards at the city, county, state, and national levels. In her spare moments, she enjoys sailboat racing and mountain bicycling with her husband, a business professor at San Diego State University, as well as Asian art and music.

MENTORSHIP PROGRAM SUMMARY

POCLI is dedicated to promoting leadership development among professionals of color who are working in the field of child abuse and neglect. POCLI is also committed to increasing the number of professionals of color in management, administrative, and policy making positions in order to improve child welfare practices and policies for families of color. Therefore, POCLI has developed an innovative mentorship program that will provide support, assistance, training, and guidance to emergent professionals of color.

Specifically, the mentorship program will bring together senior professionals of color, who have demonstrated expertise in the field of child maltreatment, with emergent professionals of color. POCLI has selected mentors who have demonstrated leadership ability and been involved in promoting the principles of cultural competency within the field of child abuse and neglect. Also, mentors have made a commitment to nurture, support, and share their knowledge with emergent professionals of color (mentorees) and to assist these young professionals in advancing their careers in the field of child maltreatment.

POCLI staff is now in the process of recruiting mentorees for this program. We are seeking dedicated professionals who have expressed an interest in enhancing management, administrative, and research skills in order to further their careers in the field of child maltreatment. This mentorship program will provide an excellent opportunity for professionals to enhance their abilities in problem solving, develop stronger leadership skills and increase confidence while having access to a nurturing support system.

If you are interested in participating in the mentorship program, please contact Joyce Thomas or Cheryl Rust at 202-544-3144.

PROFESSIONAL EXCHANGE

HELPERS AND HEALERS: ARE WE REALLY WHO WE SAY WE ARE?

—by Dan Sexton

I am director of the ChildHelp USA/ IOF Foresters national child abuse hotline and the National Survivors of Child Abuse program in Los Angeles. I have worked with survivors for over 10 years and am myself a survivor of child abuse and an adult child of alcoholics. Years ago, I looked for therapy, but there wasn't much. What was available left me out: it was for women only, for incest survivors only, etc. I was told that my childhood trauma should no longer be a problem. Worse, I heard that telling anyone about it could hurt my credibility as a professional. These messages only reinforced what many of us have felt and still feel as survivors: isolated, alone, ashamed.

Many helpers and healers come from dysfunctional families. Some of us are working out personal issues with clients; some are still in denial about our backgrounds. "Maybe if I get an advanced degree, get more experience, or get elevated to a position of power, nobody will really know who I am and what I'm feeling about myself," we think. We can create an unsafe environment for survivors, keeping the real issues from surfacing, because our own issues are in the way.

"Helpers and healers who are survivors are trying to fit into a world that keeps saying that we are damaged goods, and should keep our problems to ourselves."

One of the areas I struggled with was my personal and professional training. I could diagnose clients, create a treatment plan, do everything I had learned was most appropriate. What I couldn't do was be with survivors, facilitate their healing by giving them a sense of control in their own process. I was the therapist. I was trained always to know what was best for the client. The factor that escaped my control was my own abuse issues. They were blocking the process. Survivors educated me and still do about how my own issues interfere with the resolution of their issues.

This field needs to create a safe environment for helpers who are themselves survivors. Survivor-therapists need to feel affirmed about who we are and what we overcame in our childhoods. We need role models, people who feel a sense of pride in their healing. Our non-abused colleagues' disciplines and level of education are less important than their warmth, openness, and helpfulness in creating a meaningful process through which we can interact as professionals and people with integrity and loving compassion.

We all want to find out more about ourselves and to have a meaningful impact on dysfunctional systems so that people can be healthier, happier, and more productive. But in many ways it is easier to hide our histories behind our initials or position of authority. It is easier to think, "Now I have credibility. No one has to know my past; no one has to know what I really feel about myself." We tell our clients that the only way to heal is to expose the secrets. But—too often—that advice is only for our clients.

Helpers and healers who are survivors are trying to fit into a world that keeps saying

"We must look at how we can facilitate our own healing. Sometimes it helps to remember, 'What we teach is teaching us.'"

that we are damaged goods, and should keep our problems to ourselves. So of course we seek positions of power that can isolate us from our feelings. Look at our present systems: How functional are they? What do they reflect about the people who created them?

This field appears to have little room for the voices of survivors. Just go to our national conferences: How often do you see a keynote about survivors, or from a survivor? Survivors are a vital piece to preventing this horrendous cycle of violence against children. We need to embrace the courage of survivors. We need to create a safe environment for all survivors to share our pain and secrets in order to heal and be healed. The field needs to help survivor-therapists take pride in what we have overcome and begin to reclaim our personal power. If the people in the helping professions still deny their own or their colleagues' abuse, still feel shame or suspicion about it, what do we expect from the rest of society?

In some ways, this field is a snare for healers who are survivors. It is filled with burned out, overworked, and underpaid people. We love to hate all the work, lack of money, lack of self-care, etc. But we're set up to love secretly feeling important and powerful because all these people depend on us. We are indispensable. What would happen if we just said no to another project, or went home after eight hours of work? People might forget about us or realize they don't need us. They might discover what we secretly fear—that we really don't matter that much. We are doubly attracted to the conflicts and the chaos because for many of us this is what we know best. To have something that is nurturing, loving, and has boundaries is too foreign. It doesn't sit well; we don't trust it. Even as we strongly expect risk-taking from our clients, we fear taking risks that will create wellness for ourselves.

We must look at how we can facilitate our own healing. Sometimes it helps to remember, "What we teach is teaching us." We need to move toward being the kind of people we say we are, the kind of people we urge our clients to be. We are in a position of creating change. We have to create a voice, very much like the civil rights movement did. The credibility gap implied in the question, "Are you a healer or are you a survivor?" doesn't have to be as significant as we make it. If we are willing to own our histories, people will begin to see the magnitude of this problem. People will see then that child abuse isn't just "over there" somewhere, among marginal groups, far removed from their own worlds. By owning our histories and organizing, healing ourselves as well as our clients, we can force political and societal changes. We can initiate a response to the problem itself rather than just to the symptoms.

Everyone in this field has a wonderful opportunity to facilitate positive changes for adult survivors and ultimately for all children. Survivor-therapists should not be afraid to look inside at who you are and what you want in ways that are loving and positive. The world will change if we allow it to, and if we commit our collective energies in a healing posture. There is power in numbers, and power in healing, and we are that power. Like healing from abuse, power can be very positve. Be courageous.

Dan Sexton, MA is director of the National Child Abuse hotline for Child Help, USA, and Director of the National Survivor of Child Abuse Program.

INVITED RESPONSE TO DAN SEXTON

—by Christine Courtois

I write this invited response as a professional who is not a survivor of physical or sexual abuse. As someone who entered the helping profession to bolster self-esteem and to achieve personal credibility, however, I understand the dynamics of seeking to help/heal as compensation. Hopefully, careful attention in training, supervision, and personal therapy alert the trainee and practicing professional to the treatment traps inherent in these compensatory dynamics.

A major focus throughout my professional career has been sexual assault and abuse, in particular the aftereffects of incest and other forms of molestation and the treatment of the adult survivor. I have thus been closely connected to the plight and the cause of this long-denied and neglected population, and have advocated for personal healing as well as societal change. I agree with Dan that the needs of today's adult survivors have been ignored for far too long, the needs of sub-populations of survivors even more so. Although such special populations as males, survivors of color, those abused by women, gays, and lesbians, those ritually abused, the differently abled, adoptees, and military dependents have been increasingly identified and services developed, others remain to be acknowledged and served.

The fields of traumatology and child abuse and neglect are relatively young but fast developing. Those of us in the field, survivors, non-survivors, and pro-survivors alike, must commit ourselves to the development of a field that is comprehensive in its awareness of survivor sub-populations and

continued on next page

COURTOIS *(continued from page 17)*

their needs. This includes the acknowledgement of survivor-helpers as a sub-population with special abilities and characteristics.

I have been on the training circuit for approximately five years now, conducting training for thousands of professionals on the treatment of adult survivors of incest and other forms of molestation. In the early years, few survivor-therapists in my audiences identified themselves as such. More recently, however, two trends have become evident: increasing numbers of therapists have been identifying their own repressed, dissociated, or denied histories of childhood abuse, and survivor-therapists are becoming more forthright in revealing themselves in various professional forums, including training workshops. I am often asked to address the special needs and concerns of the survivor-therapist. My philosophy is that survivor-therapists have unique contributions to make, but in providing therapy services, also face some personal and professional pitfalls of which they must remain aware. Many are struggling with dual roles: their own healing process and that of the survivors they serve professionally.

Survivor-therapists are invaluable resources in the sexual abuse recovery movement. But they must be advanced enough in their own healing to be able to go through the process again as healers with their clients. They need acknowledgement, affirmation, and support every step of the way in their personal healing and their professional decision-making from colleagues, family, friends, therapists, and professional supervisors. Because of the rigors of their own healing or the additional transference and countertransference issues they may face, this support might sometimes be that they take a sabbatical from providing direct services or from professional endeavors altogether.

Survivor-therapists have a primary obligation to themselves: self-care comes before and undergirds the capacity to provide care appropriately to others. Healers

"Survivor-therapists have a primary obligation to themselves: self-care comes before and undergirds the capacity to provide care appropriately to others."

must pay attention to their own deepest wounds, to quote Kathy Steele (1987), but must not be in the most excruciating stage of their personal recovery as they counsel others. This does not automatically mean that they cannot practice. I agree with the guidelines of Kluft (1990) regarding supervision and consultation for therapist-survivors who are able to continue professionally during their own therapy. The decision should be made with consideration of the needs of the survivor-clinician and his or her ethics, and professional obligations of practice.

Finally, I do not believe that being out of denial about one's personal abuse history necessarily means making private or public disclosure. The degree of disclosure is the survivor's prerogative whether s/he is a therapist or not. Personal safety and security can be seriously compromised with open public disclosure, as many survivors and survivor-therapists have discovered. I agree with Dan that a safe environment must be created and that survivors and survivor-therapists alike should not be labelled as damaged goods or second-best. Attitudes such as this reinforce the stigma and shame that are the purview of child abuse.

Many survivors and survivor-therapists have come forward and bonded together. Unlike Dan, I have attended many conferences where survivors have been key speakers. I only hope this trend continues and that leadership comes from those who know best the cost of abuse. To provide such leadership is a choice which only individuals can make. Hopefully, the field will honor survivors and provide enough validation and sustenance both for the lessening of stigma and for societal change.

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Christine Courtois, PhD, is a psychotherapist in private practice in Washington, DC, and author of Healing the Incest Wound: Adult Survivors in Therapy.

REID *(continued from page 1)*

New Board members got their first taste of the amount of work that's expected of them during APSAC's annual Board meeting. They met for a two-hour orientation prior to the full Board meeting, which ran from 1 - 7:30 p.m. on Monday, January 20, in San Diego. Proceedings of the meeting are summarized below. Among the most important topics addressed were APSAC's financial health, membership growth, and future conference plans.

Finances

APSAC more than doubled its assets in 1991, beginning with a balance of nearly $29,000 and ending with a balance of nearly $60,000.

Actual expenses in budgeted categories were less than 1% over budget. An additional $11,000 (9%) in expenses were approved later in the year for audiotaping the Advanced Training Institutes, paying travel expenses for speakers, and sending information about APSAC to major media.

Actual income was 47% higher than budgeted income. In major categories: dues were 28% over budget (+$24,737); sales were 35% over budget (+$5,558), primarily due to the sale of Institute audiotapes; and conference income was 297% over budget (+$19,690) because of unbudgeted income from the conference we co-sponsored with the Tennessee Network for Child Advocacy, and from Advanced Training Institutes offered in San Diego.

A bank balance of $60,000 frees APSAC to take on projects it couldn't have considered undertaking before.

Membership

APSAC's strength lies in its membership, which is exceptionally intelligent and committed, and growing by leaps and bounds. Net membership growth in 1991 was a robust 41%. Renewals were up 5% from the year before, from 66% to 71%. In addition, 23% more new members joined in 1991 than in 1990. APSAC began 1991 with 1,374 members, and ended the year with 1,943. Now, at the end of January, 1992, we can boast over 2,000 members.

APSAC's Fifth Birthday Party

On January 23 in San Diego, APSAC celebrated its fifth year of life. Incorporated in 1987, APSAC has a great deal to celebrate: over 2,000 members; members in every state of the union and in several territories and foreign countries; nine chartered state chapters, and chapters forming in 25 more states; a powerful *amicus* brief and set of best practice guidelines in print; popular Advanced Training Institutes on audiotape; *The APSAC Study Guides* and *The APSAC Handbook on Child Maltreatment*, on the front burner; and money in the bank.

A brief business meeting was held during the festivities, to let the 150 or so members who attended know everything we have to celebrate. Revelers were treated to lemonade, coffee, and a wickedly rich chocolate cake, and many treated themselves at the cash bar in the corner. Entertainment was provided by a motley crew of traveling musicians. Although many of the troupe of 20 or so were virtually unrecognizable under fright wigs, pig noses, and toucan-bedecked hats, some thought they spotted John Stirling, Mary Ellen Shields, Paul Stern, and Lucy Berliner from Washington State; Roland Summit, Kee MacFarlane, and Harry Elias from California; Barbara Bonner from Oklahoma, and Mark Chaffin from Arkansas; Donna Pence and Charles Wilson from Tennessee; Patti Toth and Joyce Thomas from Washington, DC. Other identifications were too tentative to be repeated here. The entertainers danced a can-can while they serenaded the crowd with old APSAC favorites, "Hello, APSAC" (to the tune best known as "Hello, Dolly"), and "I'm an Expert" (to another popular show tune).

Awards were presented too, to the members of APSAC's first annual President's Honor Roll. These APSAC members, listed on p. 4, have all extended themselves far beyond the call of duty in furthering APSAC's major goal: enhancing America's response to child maltreatment. APSAC is blessed with many, many members who do more for APSAC and for the children we serve than anyone has a right to expect. I look forward to working with all of you to make APSAC's next five years as astonishingly productive as its first five.

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BOOK REVIEWS

—Edited by Mark Chaffin

The healing power of play: Working with abused children. By Eliana Gil. NY: Guilford Press, 1991. 210 pages. $35.00 hardbound, $16.95 paperback.

—Reviewed by Jamshid A. Marvasti, MD

This very interesting book about play therapy with abused children could be divided into three sections. The first deals with the impact of child abuse and trauma, child therapies, and treatment issues such as directive versus non-directive play therapy. The second section deals with clinical examples of play therapy with neglected and abused children. The third section, although very brief (a mere 4 pages) is devoted to such important issues as countertransference, clinical self-care, and clinical safety. Writing in very simple language, the author skillfully explains difficult theoretical issues regarding child treatment and the impact of the trauma on the child's psychological development.

"This book is a valuable addition to both the child abuse and play therapy fields, and a pioneer book in regard to using the healing power of play in treating abused children."

In the second section the author aptly explains her technique and the outcome of therapy in seven cases. The only weak point here is that the author, like many other therapists, prefers to publish her successful cases and not those cases where play therapy did not contribute to improvement, or the child deteriorated during therapy. All seven cases of play therapy that the author describes have "happily ever after" endings. However, there are many unfortunate cases in which play therapy may not be very successful, such as when the ego has been damaged in early life, or the source of stress is still present, such as a child who is repeatedly moved from one foster home to another.

The book might also be enhanced by adding a chapter about the use of play for diagnostic purposes or validation of psychodynamic formulations (Marvasti, 1989) and multidisciplinary evaluations. Another point needing more elaboration is the interpretation of children's drawings. Different clinicians see different ideas in children's drawings. For example, on page 98, the author writes, "the lack of body is probably symbolic of his lack of body image, due to his being severely malnourished, so developmentally delayed, and now so physically uncomfortable with his interpreted weight gain. The family picture reflects his sense of isolation. None of the family members has a mouth and the mother's small size indicates Leroy's view of himself as the caretaker." One wishes for more explanation about how the author arrives at this particular interpretation.

In the third section, the author very briefly discusses countertransference. She explains that these children can elicit a multitude of responses from the therapist, "including hostilities, sadness, protective impulses and/or feelings of helplessness." It would be useful to include potential sexual issues in the therapist which might be precipitated by a child's description of sexual activity or sexualized behavior, especially when one is working with sexually abused children or the children from incestuous families (Marvasti, in press). The author gives a few examples of therapists who develop positive countertransference toward children; however, she does not elaborate about the negative countertransference or feelings of anger and resentment therapists may feel toward abused children or their families. She might also elaborate in regard to therapists who themselves have a history of physical or sexual abuse. Potential effects of working with abused children include the development of post traumatic stress disorder, or the related "vicarious traumatization" as described by McCann and Pearlman (1990). Both of these effects can be more severe for therapists who are survivors, as the child's trauma reawakens the therapist's old trauma. Addressing the child's transference toward the therapist is also important. Negative feelings generally develop toward children who show extreme negative transference or who are destructive, oppositional, or defiant in the play room. It would be interesting to have one case history where there was a tendency to re-enact the abusive home situation or where the therapist began to feel and act as the child's parents did by restraining or getting angry with the child.

Overall, this valuable book, although short (210 pages), is very rich in clinical material. I wish the author would add a few more pages, further explanation, and attention to countertransference issues. Nonetheless, it is a valuable addition to both the child abuse and play therapy fields, and a pioneer book in regard to using the healing power of play in treating abused children. I strongly recommend that play therapists, whether they work with traumatized children or not, have this book in their library.

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McCann, I.L., Pearlman, L.A. (1990). *Psychological trauma and the adult survivor.* New York: Brunner/Mazel.

Jamshid A. Marvasti, M.D. is a child and adult psychiatrist, Director of the Sexual Trauma Center in Manchester, CT and a fellow of the American College of Forensic Psychiatry.

Child sexual abuse: The initial effects. By Beverly Gomes-Schwartz, Jonathan Horwitz, and Albert P. Cardelli. Newbury Park, CA: Sage Publications. 205 pages. $45.00, $19.95 paperback.

—Reviewed by Sheri Katz-Plotkin

Child sexual abuse: The initial effects is a summary of research conducted at the Family Crisis Program for sexually victimized children of Tufts New England Medical Center in the early 1980's. Initially glancing over the outline of the book, I worried that the contents would replicate previously published findings, particularly because the bulk of the research was conducted some time ago. However, I was pleasantly surprised to find a concise and well thought through synthesis of past and current research as a guide to the author's current findings and conclusions. The book is divided into eight chapters, many co-authored by noted authorities in the field. There is also a lengthy appendix with tables summarizing research findings.

Chapter One provides a brief initial overview addressing the causes of child sexual abuse from the psychiatric, social-psychological and sociological models. Chapter Two provides an overview and outline of the research framework, its limitations and methodological considerations. Of particular note is the author's concern with the impact of system interventions, such as those of protective service and judicial agencies, on the child and family.

"Child sexual abuse: The initial effects ***is a particularly good book for beginning researchers and clinicians because it details and summarizes the literature related to many abuse variables and articulates the avenues and pitfalls of research."***

Chapter Three describes selection of the treatment sample and the specific characteristics used to describe the sample. Chapter Four details abuse related variables such as age and duration, etc. which will be familiar to most readers. Chapter Five presents the project's findings. Of importance is the authors' discussion of emotional harm and the impact of development on this issue. Emotional harm was measured by assessing four different areas of psychological functioning: overt behavior, somaticized reactions, internal emotional states and self-esteem. The variables affecting abuse effects are addressed, including maternal response to the child's disclosure. Sexually abused children were found to demonstrate more

Continued on page 23

JOURNAL HIGHLIGHTS

—edited by Thomas Curran

The purpose of Journal Highlights *is to alert readers to current literature and research on child maltreatment. Selected articles from journals representing APSAC's multidisciplinary membership are presented in the form of an annotated bibliography. All APSAC members are encouraged to send copies of current articles they believe would benefit* Advisor *readers, accompanied by a two to three - sentence summary of the article, to: Thomas F. Curran, LCSW, JD, 1405 72nd Av., Philadelphia, PA 19126.*

LEGAL ISSUES IN CHILD MALTREATMENT

Berlin, F.S., Malin, H.M. and Dean, S. (1991). Effect of statutes requiring psychiatrists to report suspected sexual abuse of children. *American Journal of Psychiatry, 148* (4), 449-453.

Data collected from 1979 through 1990 at the Johns Hopkins Sexual Disorder Clinic raise questions regarding the efficacy of laws requiring mandatory reporting by psychiatrists of sexual abuse disclosures. Self-referrals by perpetrators dropped from a ten year average of seven per year to zero after reporting of abuse that occurred prior to treatment became mandatory in 1989. Also, in 1988, when laws went into effect that mandated reporting of abuse that occurred during treatment, the rate of patients' disclosures fell from approximately 21 per year to zero. The authors conclude that options other than reporting may enhance the chances that children will be protected. (JH)

Pipe, M.E. and Goodman, G.S. (1991). Elements of secrecy: Implications for children's testimony. *Behavioral Sciences and the Law, 9,* 33-41.

Several studies dealing with children's secrets are reviewed in this article. The significance of social and motivational factors on children's willingness to report information is discussed in detail. The studies examined provide strong evidence that asking children to conceal information or to keep it secret may have marked effects on their subsequent reports or disclosures, including in-court testimony. (TFC)

PERPETRATORS OF ABUSE

Milner, J.S. and Chilamkurti, C. (1991). Physical child abuse perpetrator characteristics: A review of the literature. *Journal of Interpersonal Violence, 6* (3), 345-366.

A thorough review of physical abuse perpetrator characteristics is presented. Four categories of perpetrator variables are discussed in detail: social, biological, cognitive-affective, and behavioral factors. Very practical assessment implications are also discussed. (TFC)

Rice, M.E., Quinsey, V.L. and Harris, G.T. (1991). Sexual recidivism among child molesters released from a maximum security psychiatric institution. *Journal of Consulting and Clinical Psychology, 59,* 381-386.

This article reports on correlates of recidivism among 136 extrafamilial molesters, 50 of whom received 20-session treatments, primarily with aversion therapy. Recidivism was associated with no marital history, prior convictions/incarcerations, presence of a personality disorder, and deviant pre-treatment phallometric assessment. However, neither aversion therapy nor associated changes in arousal patterns were associated with reduced recidivism rates, suggesting that this treatment approach was not sufficient for this admittedly severe population, and supporting previous findings that phallometric measures of treatment success have limited validity. (MC)

Whipple, E.E. and Webster-Stratton, C. (1991). The role of parental stress in physically abusive families. *Child Abuse and Neglect, 15* (3), 279-291.

This study utilized parent interviews, self-report questionnaires, and home observations to explore differences between 29 physically abusive and 94 nonabusive families seen in a parenting clinic for conduct-problem children. Physically abusive parents, especially mothers, reported more psychosocial stressors and less social support than nonabusive families: lower social position, history of abuse as a child, alcohol or drug abuse, maternal depression and anxiety, marital dissatisfaction, and more subjectively-reported behavior problems among their children, emerged as significant contributory factors to the complex relationship between stress and abuse. (JKC)

PHYSICAL ABUSE, NEGLECT AND EMOTIONAL ABUSE

Haskett, M.E. (1990). Social problem-solving skills of young physically abused children. *Child Psychiatry and Human Development, 21* (2), 109-118.

This study examines the social problem-solving ability of a group of physically abused children (between the ages of 4 and 6 years) and a matched comparison sample of nonabused children. In response to hypothetical social problems, abused children generated a more restricted range of types of solutions and were more likely to perseverate on negative solutions. Implications for direct intervention with young abused children and recommendations for future research are made. (MEH)

Kaufman, J. (1991). Depressive disorders in maltreated children. *Journal of the American Academy of Child and Adolescent Psychiatry, 30* (2), 257-265.

This article reports a finding that the rate of depressive disorders in a sample of fifty-six 7-12-year-old maltreated children was much greater than the base rate in the general population, especially for children with histories of out-of-home placements, physical abuse, or emotional maltreatment. The author highlights the importance of the quality of parent-child relationships in predicting which maltreated children will develop depressive disorders, but notes the impact of such environmental stressors may be mediated by cognitive and neurophysiological abnormalities. (JKC)

Nightingale, N.N. and Walker, E.F. (1991). The impact of a social class and parental maltreatment on the cognitive functioning of children. *Journal of Family Violence, 6* (2), 115-130.

This study compared the cognitive functioning of (50) maltreated children with that of (20) nonmaltreated children. The maltreated children were deficient in cognitive functioning but no more so than children from low SES backgrounds. These findings suggest that it may be deprived family circumstances common in abusing families, and not the abuse per se, that is responsible for the cognitive deficits often found in abused children. (KKT)

Singer, L.T., Song, L.Y., Hill, B.P. and Jaffe, A.C. (1990). Stress and depression in mothers of failure-to-thrive children. *Journal of Pediatric Psychology, 15,* 711-720.

This article reviews a study in which 30 mothers whose children were hospitalized for failure-to-thrive (FTT) were compared to a normative group. Mothers of the FTT children perceived their children as more stressful, less adaptable, more inconsolable, and more unhappy than did mothers of healthy children. (KKT)

Vissing, Y.M., Straus, M.A., Gelles, R.J. and Harrop, J.W. (1991). Verbal aggression by parents and psychosocial problems of children. *Child Abuse and Neglect, 15* (3), 223-238.

Analyses of a representative sample of 3,346 families found that 63% of parents reported one or more instances of verbal aggression, such as swearing at and insulting the child. Children of all ages who experienced frequent verbal aggression from parents exhibited higher rates of physical aggression, delinquency, and interpersonal problems than other children. (KKT)

SEXUAL ABUSE

Friedrich, W.N., Grambsch, P., Broughton, D., Kuiper, J. and Beilke, R.L. (1991). Normative sexual behavior in children. *Pediatrics, 88* (3), 456-464.

A sample of 880 normal 2- to 12-year-old children whose mothers completed the Child Sexual Behavior Inventory (CSBI) in this study to assess the frequency of a wide range of sexual behaviors and to measure the relationship of these behaviors to age, gender, socioeconomic and family variables. Significant findings for both sexes included a decline in overt sexual behavior with age. In addition, some sexual behaviors were found to be normal, but others were clearly quite unusual for this age group. (TFC)

Hazzard, A., Webb, C., Kleemeier, C., Angert, L. and Pohl, J. (1991). Child sexual abuse prevention: Evaluation and one-year follow-up. *Child Abuse and Neglect, 15* (1/2), 123-138.

Implementing the Feeling Yes, Feeling No prevention curriculum, which incorporates an affective component as well as concrete rules and behavioral rehearsal, was effective among mid-elementary aged children in increasing prevention-related knowledge and the ability to differentiate, in videotape vignettes, between safe and unsafe situations. Gains were maintained at 6-week and 1-year follow-ups, and enhanced slightly by an interim "booster" shot intervention. Negative emotional/behavioral consequences from program participation in a school setting were reportedly minimal. (JKC)

Johnson, B.K. and Kenkel, M.B. (1991). Stress, coping, and adjustment in female adolescent incest victims. *Child Abuse and Neglect, 15* (3), 293-305.

This article assessed the association between coping styles and distress in 45 adolescents in treatment for intrafamilial sexual abuse. Maternal disbelief and lack of support, appraisal of self as unable to control one's environment, and coping by detachment/distancing, wishful thinking, or similar mechanisms were associated with increased distress. These factors appeared more important than abuse characteristics. (MC)

Wurtele, S.K., Currier, L.L., Gillispie, E.I. and Franklin, C.F. (1991). The efficacy of a parent-implemented program for teaching preschoolers personal safety skills. *Behavior Therapy, 22* (1), 69-83.

This study demonstrated that children as young as 3 1/2 years of age can achieve greater knowledge about sexual abuse and can increase levels of personal safety skills through a one-week in-home Behavioral Skills Training Program taught by their parents. Gains were noted in comparison to a delayed-treatment control group and were maintained at a two-month follow-up. Although no negative side effects of the program were reported, the sample was restricted primarily to upper income, well-educated, two-parent families. (JKC)

PROFESSIONAL ISSUES

Craft, J.L. and Stuart, M.M. (1991). Reporting and founding of child neglect in urban and rural communities. *Child Welfare, 70,* 359-370.

Forty subjects from a rural community and 36 from an urban community were surveyed regarding their inclination to report child neglect as represented in a number of vignettes. There was considerable agreement among residents of both communities as to what should be reported, and overall inclination to report was high, supporting previous findings that there are common minimal standards of child care across communities. (MC)

Conte, J.R., Fogarty, L. and Collins, M.E. (1991). National survey of professional practice in child sexual abuse. *Journal of Family Violence, 6* (2), 149-166.

This article reviews a survey exploring how 276 professionals spend their professional time, how much they know and what they think about etiology and treatment of sexual abuse. The findings, particularly related to knowledge of sexual abuse, are somewhat distressing. In some areas of practice current knowledge of child sexual abuse apparently has not been widely disseminated. (TFC)

Conte, J.R., Sorenson, E., Fogarty, L. and Dalla Rosa, J. (1991). Evaluating children's reports of sexual abuse: Results from a survey of professionals. *American Journal of Orthopsychiatry, 61* (3), 428-437.

This study of 212 experienced professionals surveyed the assessment and validation procedures they use in child sexual abuse cases. An excellent analysis of the current knowledge supporting such validation procedures and tools is provided. (TFC)

Contributing editors for this issue included Mark Chaffin, PhD, Janice K. Church, PhD and Jim Harper, MSW, all of the University of Arkansas, Arkansas Children's Hospital, Little Rock, AR; Mary E. Haskett, PhD, North Carolina State University, Raleigh, NC; Kathleen Kendall-Tackett, PhD, Family Research Laboratory, University of New Hampshire, Durham, NH, and Thomas F. Curran, LCSW, JD.

REVIEW ***(continued from page 20)***

behavioral disturbances and stressful reactions than non-abused children, but not all child victims evidenced symptoms, and the range of symptoms exhibited was wide.

Chapter Six provides a thorough and sensitive look at the mother's role after disclosure and the impact of maternal variables such as psychological development, personality characteristics, and relationship to the child and offender, on the mother's response to her child's abuse. It is clear that the authors were determined to explain the often difficult position mothers occupy in the chapter title: The Myth of the Mother as "Accomplice" to Child Sexual Abuse.

Chapter Seven describes the emotional and behavioral functioning of the children at an 18-month follow-up period, stressing whether sexual abuse led to the breakup of the family unit and the extent of therapeutic services the child received. It would have been helpful for the authors to describe the type of treatment services the children and families received. This information is not discussed until the final chapter of the book, and then only briefly. For clinicians reading the research findings, a description of the therapy, plus case examples, would have proved helpful.

The final chapter provides a summary and conclusions to the project as well as directions for further research. Limitations of the study and their implications are given.

Overall, *Child sexual abuse: The initial effects* is a good piece of research which I recommend as a reference book. It is a particularly good book for beginning researchers and clinicians because it details and summarizes the literature related to many abuse variables and articulates the avenues and pitfalls of research. Finally, it is a book that addresses the complex issues, unique to this field, of conducting research with sensitivity and concern.

Sheri Katz-Plotkin, PhD, is a Psychologist and Coordinator of the Child Sexual Abuse Treatment Team at Franklin Medical Center in Greenfield, MA.

ISPCAN
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CLASSIFIEDS

PROJECT DIRECTOR

National Resource Center on Child Sexual Abuse. Considerable experience in and/or knowledge of the field of child abuse, excellent administrative capabilities, and strong interpersonal skills required. For more information, contact Susan Riise or Karen Hall, National Children's Advocacy Center, 106 Lincoln St., Huntsville, AL 35801; 205-533-5437.

CHILD ABUSE INTERVENTION CENTER MANAGER.

Clark County, WA. $37,860 - $53,496 DOQ. Clark County is looking for an experienced manager, reporting directly to the Child Abuse Intervention Board, to supervise an interdisciplinary team of law enforcement and human service professionals involved in expediting successful prosecution through the investigation, evaluation, and development of case plans. Responsibilities focus on supervising and motivating law enforcement, professional, and clerical staff members, developing and monitoring the Center budget, and producing a cooperative environment between agencies. The Board is seeking an individual with *considerable experience in managing and coordinating criminal investigatory activities in the area of child abuse.* Interested applicants may submit a detailed resume together with a narrative describing experiences in management and supervision in a criminal justice environment and other professional experiences and education relevant to the position.

Clark County Human Resources Dept.
P.O. Box 5000
Vancouver WA 98668-5000
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Applications must be received by March 12, 1992. **An Equal Opportunity Employer.**

SURVEY ON SELF-MUTILATION

For preliminary work toward guidelines on assessing and treating self-mutilating behavior in survivors of childhood abuse, I would like to survey clinicians who have experience assessing and treating clients with self-injurious behavior. Clinicians do not have to be specialists in child abuse, and do not have to have a current caseload of self-injurious clients. **For more information please write Eliana Gil, PhD, PO Box 5629, Rockville MD 20855.**

CRIMINAL JUSTICE DOCTORAL

STUDENT familiar with child sexual abuse literature seeks research, writing, and/or publishing opportunities. Specific interests are nonfamily offenders and criminal justice/law enforcement issues. All suggestions and proposals welcome. Contact Edward Ross Maguire, 13 Dorlyn Rd., Colonie, NY 12205. 518-482-5890.

CONFERENCES

APSAC DISCOUNTS

October 12 - 15, 1992. ***Midwest Conference on Child Sexual Abuse and Incest.*** Madison, WI. Call Jill Cohen Kolb, 608-244-4022.

November 21 - 24. ***Networking in the Nineties.*** Nashville, TN. Sponsored by the Tennessee Network on Child Advocacy. Call Judith Brown, 901-327-0893.

January 20 - 23, 1993. ***The San Diego Conference on Responding to Child Maltreatment.***

March 10 - 13, 1993. ***Ninth National Symposium on Childhood Sexual Abuse.*** Huntsville, AL.

March 13 - 14. ***Incest: The Family Reconstruction Dilemma.*** Arlington, MA. Sponsored by New England Forensic Associates, with Henry Giarretto. Contact Carol Ball, PhD, 617-643-0610.

April 22 - 24. ***Mothers: Victimization, Stigma, and Survival. The Eighth Annual Conference on Abuse and Victimization in Life-Span Perspective.*** Sponsored by Harvard Medical School Department of Continuing Education. Call 617-432-1525.

May 13 - 16. ***Children at Risk: An International Interdisciplinary Conference.*** Bergen, Norway. The Norwegian Center for Child Research, The University of Trondheim, 7055 DRAGVOLL, NORWAY. Phone +47 7 59 65 00.

May 16 - 19. ***I Dream a World: National CASA Conference.*** Nashville, TN. Contact Mercedes Lawry, 206-328-8488.

May 18 - 22. ***20th Annual Child Abuse and Neglect Symposium.*** Keystone, CO. Presented by the C. Henry Kempe Center. Call Marilyn Lenherr, 303-861-6919.

May 19 - 22. ***National Symposium on Child Victimization.*** Washington, DC. Sponsored by Children's Hospital National Medical Center. Call Yvette Washington, 202-939-4950.

July 9 - 12. ***Turning Trauma into Triumph.*** Chicago, IL. Sponsored by VOICES in Action, for survivors, pro survivors, and professionals. Contact Nina Corwin, 30 N. Michigan, Suite 1611, Chicago 60602.

August 30 - September 2. ***ISPCAN Ninth International Congress.*** See display ad.

October 22 - 25. ***Trauma and Development: The Shattering and Rebuilding of Human Expectations.*** Sponsored by the International Society for Traumatic Stress Studies. For information call 312-644-0828.

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I would like to make a contribution to APSAC's Endowment Fund over and above my membership dues. I understand that, after making this donation, I will be acknowledged as a "Friend of APSAC" in four consecutive issues of APSAC's newsletter, *The Advisor.*

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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 information on the cultural diversity of its membership. Your participation is strictly voluntary.

I consider my cultural group identification to be: ______________________ (please specify)

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