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THE ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

NEWS

APSAC FILES SECOND AMICUS BRIEF BEFORE U.S. SUPREME COURT; PLANS FOR APSAC'S FIRST NATIONAL COLLOQUIUM UNDERWAY; NOMINATIONS SOUGHT FOR BOARD ELECTIONS

—by Theresa Reid

New Amicus Brief

APSAC has filed its second *amicus* brief before the U.S. Supreme Court. The case is *Montana v. Imlay*. At issue is whether completion of an offender treatment program can be required as a condition of probation.

Donald Imlay was found guilty in Montana of molesting a little girl. He was given probation on the condition that he complete a sex offender treatment program. Like most such programs, the one to which Imlay was sentenced required that he overcome denial about his offense. Having maintained his innocence throughout his trial, Imlay continued denying the offense during treatment. The therapist told the court that Imlay's persistent denial made him unsuitable for outpatient treatment, and recommended that Imlay receive inpatient treatment. But the only inpatient sex offender treatment facility in Montana is in the state prison. When Imlay appealed, the Montana Supreme Court found that mandated offender treatment which requires the offender to overcome denial violates the probationer's Fifth Amendment rights against self-incrimination.

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RESEARCH AND PRACTICE

A PRACTITIONER'S GUIDE TO INTERPRETING RESEARCH RESULTS

—by Kathleen Kendall-Tackett, Linda Meyer Williams, and Paul Stern

APSAC encourages research and discussion of research findings in the area of child abuse and neglect. We understand that sometimes research is difficult to understand, and in fact can be downright incomprehensible. As a service to our members, ***The Advisor*** *thought it might be helpful to share the following exchange of letters between prosecutor Paul Stern and researchers Linda Meyer Williams and Kathy Kendall-Tackett.*

Dear Linda and Kathy,

Help! I am a trial lawyer, and I am the first to admit that we talk funny, with all those Latin phrases (for years I thought *Lis Pendens* was a woman in my first-year law class). But at least there are law dictionaries out there. I read a lot of research articles, and you folks have a language all your own, and I can't find a research guide anywhere.

What the heck is a "cohort"? Why is *p* always less than something, never more than, and what kind of expression is that, anyway? I prosecute deviants, but after seven years at it, the only thing I know for sure is that there is no such thing as a standard deviation—yet you guys talk about them all the time. If a deviation was standard, it wouldn't be a deviation, but a societal norm. But norms are something else again.

Please tell me what this stuff means. De-mystify your vocabulary. And how in the world am I supposed to figure out if what I am reading is good research or bad research? Can I really rely upon a study that draws wide-ranging conclusions based on a sample (I know, an "n") of 100 people?

Is a study which is of 500 subjects ten times better than one of 50? How do I tell if this is really new information — information I should ask a judge, a jury, and an expert witness to rely upon? Help.

48% sincerely, 38% cordially,
and 19% very truly yours,
Paul

Response

Dear Paul,

We admire your desire to use and not abuse research results, and to discern which research is worthy of your attention. As you have discovered, research terminology can be confusing. Many people attribute this to a lack of socialization on the part of researchers. Some have even been so unkind as to refer to researchers as "nerds," likening us to trekkies (without tape on our glasses, polyester clothing, or plastic pocket protectors). But we assure you, research terminology is not meant to exclude or confuse others.

As with professionals in any field, researchers have an "insiders' language" of agreed-upon terminology that helps us communicate clearly and concisely with each other. Imagine how much longer journal articles would be if we had to say "number of subjects" or "probability that these results could have occurred by chance" instead of "n" and "p". As you can see, these types of abbreviations save lots of time and paper, and make really good sense. We hope we can clear up some of your questions about them.

> ***What the heck is a "cohort"? Why is p always less than something, never more than? I prosecute deviants, but after seven years at it, the only thing I know for sure is that there is no such thing as a standard deviation.***

First off, it is important for you to understand that one study (or one journal article) is *never* the final word. Journal articles are essential to the scientific process in that they communicate findings to other scientists, and add to the body of research literature. Each published paper is a piece of the puzzle that enables other scientists to build on work that has already been done, thus advancing knowledge in the field.

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NEW RESEARCH

THE IMPACT OF TESTIFYING ON CHILD SEXUAL ABUSE VICTIMS

—by Debra Whitcomb, Desmond K. Runyan, Edward De Vos, Wanda M. Hunter, Theodore P. Cross, Mark D. Everson, Nancy A. Peeler, Carol Q. Porter, Patricia A. Toth, and Cabell Cropper

How can child sexual abuse cases be prosecuted most effectively without imposing additional trauma on the child victims? The Child Victim as Witness Research and Development Program was designed to answer this question.

This three-year study, funded by the Office of Juvenile Justice and Delinquency Prevention, involved a collaboration of Education Development Center, Inc., the University of North Carolina at Chapel Hill, and the American Prosecutors Research Institute. Four jurisdictions participated: Erie County (Buffalo), New York; Polk County (Des Moines), Iowa; Ramsey County (St. Paul), Minnesota; and San Diego, California.

Factors related to acceptance for prosecution

A first question asked was what determined whether a sexual abuse case would be accepted for prosecution. Preliminary findings from the review of case records reveal that in these communities most cases referred for prosecution involved more severe abuse, as measured by the type of abusive acts, number of incidents, and duration of abuse.

Prosecutors were less likely to accept cases involving victims of pre-school age than school-aged or teenaged victims. Cases involving white perpetrators were more likely to be prosecuted than cases involving black or Hispanic perpetrators, and cases involving biological fathers and mothers' boyfriends were less likely to be prosecuted than cases involving perpetrators in any other relationship to the child victim.

Alleged oral-genital contact was significantly related to greater odds of acceptance, but alleged penetration was not. This finding may reflect prosecutors' expectation that juries would not believe allegations of penetration without medical evidence, which is usually lacking. Juries may not have such expectations about allegations of oral-genital contact.

The existence of a perpetrator confession, physical evidence, and "fresh complaints" made by the victims were highly related to acceptance for prosecution. Perpetrators' reports of alcohol use during incidents were also related to significantly greater odds of acceptance for prosecution. Furthermore, a history of alcohol abuse by the perpetrator is reported in a large proportion of prosecuted cases. It is unclear, however, whether alcohol abuse is a factor that is considered in the decision to prosecute, or whether it is detected after a case has been accepted, either as a result of more intensive investigation or as a possible defense tactic.

Effects of the adjudication process on child psychological status

In order to evaluate the impact of case processing on the psychological well-being of child victims, two interviews were conducted with children in a prospective sample. The first interview occurred shortly after the case was referred for prosecution; the second occurred between seven and nine months later. A battery of instruments was selected to capture the four dimensions of the traumagenic dynamics of child sexual abuse (Finkelhor and Browne, 1984): traumatic sexualization, betrayal, powerlessness, and stigmatization. At the follow-up interview, in addition to the administration of psychological tests, data were obtained about all court-related experiences, therapy, and residence changes that had occurred since the child was first interviewed. In general, all sexually abused children (aged 4 to 17 years) reported to the prosecutors' offices in the four study counties over a 16- to 18-month period ending on December 15, 1989, were eligible for inclusion. Ultimately, 256 children completed both interviews.

Although the act of testifying itself was not found to have a significant effect on children's mental health, analyses revealed a significant adverse effect among older children who testified more than once or who experienced lengthy or harsh cross-examination.

Preliminary findings from analyses of child interview data suggest that sexually abused children were highly distressed at the time of the initial interview, regardless of whether the perpetrators were intrafamilial or extrafamilial. Intrafamilial victims tended to experience abuse for a longer period of time by someone in a close relationship, whereas extrafamilial victims tended to experience more threats and use of force. Despite these differences, study findings suggest that the child victims were equally traumatized.

Older children and children with more educated mothers (a proxy for higher socioeconomic status) were more likely to testify. Older children were also more likely to experience harsh cross-examination.

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MEDICINE

THE HEALTH AND CARE OF FOSTER CHILDREN

—by David L. Chadwick

Introduction

The purpose of this article is to summarize current knowledge about the health of children in foster care, and to present some approaches to improving foster children's health. The care of foster children is clearly a child abuse issue. For at least ten years, most children in foster care have been there for protection from very serious abuse or neglect. Infants of drug addicted mothers are making up a larger and larger proportion of children entering foster care. Few states place these infants just because of perinatal maternal drug use, however. Most also require that they be neglected or abused to a degree which would require out-of-home care in the absence of maternal addiction.

The care of foster children has received insufficient attention in the child abuse literature. For many years, health professionals in child abuse work have concentrated their efforts on assessment, diagnosis, and verification. More recently, mental health professionals have concentrated efforts on care of the problems of sexually abused children. It is time that child abuse professionals turned greater attention to children in foster care, who are among the country's neediest.

The Health Status of Foster Children

The physical and mental health status of foster children have been the subject of a number of studies during the last decade. Schor (1982) compared the health status of foster children in the Baltimore area with that reported in other surveys of foster children and with general pediatric populations. Psychological, behavioral, and chronic physical health problems were much more frequently found in foster children than would be expected in general pediatric populations. Schor concluded that foster children have "a high rate of chronic medical problems, educational handicaps and severe emotional impairment." Hochstadt, et al. (1987) directly examined 149 abused and neglected children entering foster care in Chicago and found problems strikingly similar to those revealed by Schor's chart reviews. Foster children are shorter, lighter, and much more likely to have chronic physical conditions and emotional and developmental problems than are their peers. Moffat, et al. (1985) reviewed 257 random records of 900 foster children in Montreal and concluded that, although serious handicapping conditions were often well cared for, growth problems, less serious chronic problems, and behavioral problems were generally unaddressed. Moffat et al. pointed out that this neglect persisted despite the enactment of universal health insurance in Canada, and they pointed to the absence of a planned, systematic approach to health care for this population.

Schor (1982) pointed out the changes in the foster care population during recent decades, indicating that in the 1970's abuse and neglect replaced loss of parents as the chief reason for out-of-home care and that, as a result, emotional problems in foster children have become more common. In addition, during the last decade, the passage and implementation of Public Law 96-272, the Adoption Assistance and Child Welfare Act of 1980, placed great pressure on social service agencies to keep abused and neglected children out of foster care. A dramatic increase in child abuse reports may have canceled out the reduction in the numbers of foster children in care intended by that law, but as more children were seen by social services, and a smaller percentage placed or kept out of their homes, the severity of the problems of the children in care increased.

For at least ten years, most children in foster care have been there for protection from very serious abuse or neglect.

Another and even more marked worsening in the health status of foster children is now being seen as large numbers of infants affected by perinatal drug use enter care. This trend has not yet seen its peak. These infants seem even less likely than children of past years to leave foster care by return to their natural parents or by adoption.

It is now probably safe to say that foster children are the unhealthiest subset of U.S. children. The visibility of this problem is reduced by geographic and custodial transience and miserable health record-keeping.

The Health Care of Foster Children

Foster children enter care with health problems of many kinds. Moreover, foster children still have significant problems after some period in care. Foster care does not appear to cause the problems, but neither does it ameliorate them. In this connection it is interesting to note that the study by Wald, et al. (1988) showed that the problems of school performance and emotional adjustment seen in a population of foster children were only slightly less severe than in a population of comparably abused and neglected children who were kept in their homes with intensive family services.

Chadwick (1985) argued that foster care should be a therapeutic experience. Although foster care interrupts gross abuse and neglect in most cases, and allows some resilient children to heal themselves, systematic diagnosis and treatment are generally not provided to foster children.

Many dependent children in out-of-home care are moved frequently from one home to another. In many jurisdictions, "emergency homes" are available to take new children at all times, then move them quickly to other settings. Reabuse and replacement after reunification with natural parents accounts for mobility as well, as do failed placements, in which foster parents eventually turn a child away. Goldstein, Freud, and Solnit (1973) called attention to the profoundly disturbing developmental consequences of transience and absence of attachment in the lives of young children, and proposed a policy of legal decision-making which would take children's attachment needs into account. Unfortunately, however, policymakers in child welfare and social services have generally been unable to provide for the developmental imperatives of children.

The American Academy of Pediatrics (AAP) (1987) has noted that "the foster care system has not been successful in addressing the health needs of children." Halfon and Klee (1987) surveyed foster parents and social workers in 14 California counties by telephone, and found—for the most part—poorly organized and limited health care services being provided to foster children. Foster parents and social workers frequently pointed out that few private physicians now accept Medicaid-supported patients, and that public clinics are increasingly difficult to access.

The transience of placement exacerbates the problem. Medicine has traditionally regarded the patient's personal history as the most important component of knowledge for understanding health or disease. Even the most technologically sophisticated tests reflect the patient's status at a single point in time; change in many of these measurements is the rule. These measurements are best recorded and made a part of the person's health history, along with all of the information which the person knows from his or her own experience. Yet in most cases, persons providing health services to foster children are expected to do so without a complete personal health history, because of difficulties in obtaining such histories and in insuring that they follow the children across placement changes.

Mental health care is very limited for foster children, and when it is provided, it is usually because the child's behavior presents serious problems to the foster parent, rather than because the child's history or an assessment suggests the need for mental health care. Some foster parents "doctor-shop" for physicians who will prescribe psychoactive drugs for foster children as a means of behavior control. Although some medication of this sort may be justified, the general disarray in the foster care system means that medications are being used without clear indications and careful medical control.

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Legal and Policy Implications

The problems in the health of foster children have not gone unnoticed. The articles cited above themselves cite others that address the issue, and the Child Welfare League of America (CWLA, 1989) has reviewed the problem and published standards for the health care of children in out-of-home care. The standards call for excellent health assessments, case planning, therapy, and continuous case management for all foster children. Few if any foster children currently receive care at a level of quality approaching that recommended by the CWLA.

In the early 1980's the American Civil Liberties Union (ACLU) (Lowry, 1989) began to instigate litigation aimed at forcing responsible states and counties to provide adequate health services for foster children. Weinstein and LaFleur (1990) have written a detailed review of the status of legislation and case law as they affect the responsibilities of governmental entities with respect to foster children's health. States and counties are increasingly being held responsible for the provision of good care to foster children, and the risks to both the governmental entities and to individuals who fail to insure this care are rising. Nevertheless, and despite universal agreement that good care should be provided, no state that has been carefully examined has been found to provide good health care to its foster children.

Insuring Health for Foster Children

A project based at the Center for Child Protection at the Children's Hospital in San Diego, and the Children's Services Bureau of the San Diego County Department of Social Services, and funded by the David and Lucile Packard Foundation, has begun to address the problem of foster children's health. The project is intended to create a complete and accessible health care record for every child in out-of-home care, and an accompanying health care plan for each child. To keep costs within reach of the government that must pay them, the San Diego model creates new functions and educates providers and administrators within existing systems. The model has a number of elements which may be essential for reliably improving foster children's health.

1. A consortium has been developed of public agencies and private practitioners knowledgable about and determined to provide good health care for children in out-of-home care. This consortium now includes the San Diego County Department of Social Services, the Department of Health Services, the Children's Hospital, private physicians, private and public mental health specialists, and a growing set of foster parents.

2. A health history for each child going into medium or long-term foster care is developed.

3. The health history is recorded both in an electronic data base and in portable paper form (The Health Passport).

4. Physical and mental health care is provided within the community by private physicians, community clinics, hospitals and hospital clinics, and public and private providers of mental health services.

5. New health information from all encounters is recorded in the centralized data base.

6. Record maintenance, record review, and quality assurance are centralized. The standards for the quality assurance program are those established by CWLA for the health care of foster children.

7. The health record is continuously available to foster parents, supervising social workers, and all health providers during the period of dependency.

8. The health record is provided and explained to natural parents or other guardians whenever these individuals become either the physical or legal custodians of the child.

9. The health record is provided and explained to children who are attaining majority and preparing to exit dependency.

Five years after the project's inception, a number of these elements are more or less in place; but almost all require further developmental work. In practice, each of the listed components is a project unto itself, requiring the investment of considerable time and energy and the continuing support of the entire coalition of interested persons. Acceptance of the goals by top management, middle management, and service delivery personnel is essential, but by no means automatic or instantanteous.

Foster children arguably constitute the least healthy subset of children in the U.S.

We have yet to determine that the health of children is being improved as a result of their being in care; the next major step in the project is to examine this question in a sample of children entering care during the next three years.

Summary and Conclusions

Foster children arguably constitute the least healthy subset of children in the U.S. Despite obvious need, they do not receive adequate health care. As awareness of this situation grows, legislation and litigation put increasing pressure on the governmental entities which have custody of foster children to provide them with the treatments which will benefit them.

The obstacles to provision of good care for foster children are daunting. The children have major needs which would be hard to meet if they were in capable natural families. The absence of the natural parent (who is the health advocate and health case manager for children in most homes), and the division of parental responsibility between an agency social worker and a foster parent, neither of whom is likely to have a long term relationship to the child, weakens efforts to provide good care. Frequent moves and an absence of health records increase the odds that providers who see foster children are limited to dealing with acute issues, and that the chronic, debilitating mental and physical health problems will go unaddressed.

A health system which intends to provide good care for foster children must deal with all of these issues. In addition, if persons abused during childhood are prone to repeat the maltreatment they experienced, then foster children represent a population which should receive whatever interventions may help interrupt the intergenerational transmission of abuse.

Despite the difficulties, providing good health care to foster children is a critical responsibility. For one thing, as the lawsuits have shown, if the State removes children from the natural parents because of abuse or neglect, and then continues to neglect them, the State is guilty of the worst kind of hypocrisy, and the courts will not tolerate the situation. For another, if the long-term detrimental effects of abuse and neglect are to be overcome by children, they must have the help from adults that allows them to accomplish that task. If we fail to provide that help, we are not only guilty of a gross moral failure, we may ensure that society has to continue to care for them as adults, in the penal system, the mental health system, or both.

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PROFESSIONAL EXCHANGE: VIDEOTAPING FORENSIC INTERVIEWS: PRO OR CON?

PRO: THE EXPERIENCE IN SAN DIEGO

—by Catherine Stephenson

A multi-agency approach to videotaping evidentiary interviews of suspected child abuse victims enhances prosecution efforts and serves the best interests of the child by reducing the number of interviews and the number of interviewers to which a child is subjected.

Anyone, anytime, can position a videocamera in an interview room and call that videotaping. This article describes a much more sophisticated process that has evolved over many years and which is employed successfully in several jurisdictions in this country.

Videotaping gives tremendous advantages to the prosecutor in a child molestation case.

The San Diego Experience

Videotaping evidentiary interviews of child abuse victims in San Diego has the support of law enforcement, prosecution, and social services. Without this broad-based multi-agency support, videotaping would simply be another means by which to preserve an interview. It can be so much more than that if those involved will allow it. In San Diego County there are approximately ten law enforcement agencies which investigate allegations of child physical and sexual abuse. Each of these agencies has agreed to cooperate in sending victims to the Center for Child Protection (hereafter referred to as "Center") at Children's Hospital for a law-enforcement-financed evidentiary interview. The mechanics of this process are relatively simple. Law enforcement, and sometimes social services, will call the Center and schedule an interview for the earliest convenient time (usually within one to two days). The detective assigned to the case, the social worker from the Department of Social Services and, if given advance notice, the prosecutor will all observe the interview.

At the Center are a number of specially trained and experienced masters level or licensed clinical social workers who will conduct the interview after a briefing from the detective. The interview is conducted in a playroom with toys, and lasts on average 35 minutes. The video equipment is concealed behind a one way mirror; it is not fixed and can swivel to follow the child's movements. The camera is concealed to make it less obtrusive; however, the children are always told they are being taped and if they ask they can tour the observation room and see the equipment. The children are told that the video will not be seen on television or sold in video stores. In fact, in San Diego, a protective order must be signed by a judge before a copy of the videotape may be released to an attorney representing the perpetrator or family members.

When the interview is completed, the original tape is kept at the hospital as part of the child's medical record. A copy of the tape, which has been made simultaneously with the original, is given to law enforcement and becomes part of their investigative packet.

The San Diego approach, like those in other parts of the country, is successful because it focuses on the needs of the child. In

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CON: VIDEOTAPING INTERFERES WITH THE ACCURATE DETERMINATION OF GUILT

—by Paul Stern

Routinely videotaping investigative interviews with children suspected of being victims of sexual abuse does not promote an accurate determinaion of guilt, is not in the best interests of the child, is counter-productive to prosecution, and is unncessary.

That is the reality.

In theory, videotaping is a fine idea. In theory, it best preserves the integrity of the interview process and has the potential of reducing the number of interviews a child must endure. Videotaping can increase the possibility of obtaining a guilty plea. But these potential advantages do not justify a blanket policy of routinely videotaping investigative interviews with children. The claimed advantages of videotaping are more theoretical than real. The cited reasons to videotape do not comport with the way videotapes are actually used in criminal prosecutions.

In reality, videotaping can be detrimental to a true and fair determinaion of guilt. Whatever advantages might exist to support a policy to videotape, they are substantially outweighed by the disadvantages.

This article discusses why the routine videotaping of investigative interviews of suspected child sexual abuse victims is inappropriate and dangerous. This article is intended to examine only the routine use of videotaping as a part of the law enforcement investigation. While this article specifically discusses videotaping of interviews, the same concerns are equally applicable to audiotaping interviews. The author is equally opposed to the routine audiotaping of investigative interviews with children.

Whatever advantages might exist to support a policy to videotape, they are substantially outweighed by the disadvantages.

Why videotaping is detrimental to an accurate determination of guilt.

The in-court use of a single videotaped interview is exceptionally misleading. For many children, disclosure of sexual abuse is a gradual process that can take weeks or months or years. Many children disclose a little bit at a time, in a process that has been described by experts as "rolling" or "progressive."

The investigative interview with the child is merely one point along this continuum of disclosure. As such, it represents just a single snapshot in time. It is what the child told one particular person on one particular day in one particular setting. The investigative interview is, usually, neither the first nor the last disclosure.

No matter how skilled the interviewer, there is no reason to believe that this one session will consistently provide the most complete or accurate disclosure of abuse the child will offer. In fact, the very "official" nature of the interview can seem intimidating, making the child more cautious, resulting in incomplete or minimal disclosure.

Yet if this interview is the only disclosure on tape and the only one physically reproducible before a jury, it will be given greater weight than any other out-of-court statement made by the child.

We live in a video age. Our media culture has replaced news analysis with the 15-second soundbite. A presidential address or campaign speech is reduced to a few quotables, a football game to replays. A war is visualized by strapping video cameras to missiles, which we ride to the strike on Iraqi targets. We forget, of course, about all those missiles that missed their intended targets, all those aspects of the speech or the game that didn't make the videotaped clip on the

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PRO, continued

1991 the San Diego Regional Child Victim-Witness Task Force developed a protocol for the investigation of child abuse crimes. Central to the protocol was the use of videotaped evidentiary interviews as a means by which we could reduce the number of times a child is interviewed. In order to achieve this goal someone had to give up his or her "turf" in the investigation. Detectives, social workers, and prosecutors all want to interview the child and the same questions are asked over and over again by different people in different settings.

Most professionals in the area of child abuse recognize that repetitive interviews often further traumatize a child victim of abuse. Younger children in particular sometimes respond to redundant interviews by thinking to themselves—"If they believed me the first time, why are they asking me again? Maybe they didn't like what I said the first time and they want a different answer now." It is difficult for children to understand why so many people need to hear this information.

Law enforcement and prosecutors in San Diego are able to avoid redundant interviewing when the nature and scope of the previous interview has been well documented on videotape. It is also much easier to curtail defense requests for victim interviews when the defendant has had an opportunity to see and hear the victim on tape.

We can't pretend that bad interviews don't exist just because we don't videotape them.

Law enforcement, social workers, and prosecutors in San Diego have been willing to coordinate the interviewing process because of the trust they have in the skills of the interviewers at the Center. Each interviewer there has conducted hundreds of interviews according to a written protocol. The interviewers engage in peer review of their work and are very open to suggestions from other agencies.

Videotaping gives tremendous advantages to the prosecutor in a child molest case. Generally, before prosecutors in the Child Abuse Unit meet with victims, they watch the videotape from the Center. This not only gives prosecutors a wealth of information, it also gives a sense of the child's developmental ability, demeanor, and vocabulary. Children are very relieved to hear that the prosecutor will not have to ask all those same questions over again; it may be that just some follow-up questions are necessary.

Critics of videotaping suggest that the tape provides yet another piece of evidence that will be scrutinized by a defense"expert". Every question, every gesture will be taken apart before the jury's eyes, and when it is all over and done with, the prosecutor will wish she had never seen the videotape.

This criticism seems to have as its premise that without videotaping, the interviewer will be free from attack. Of course that is not true. Imagine that you are the interviewer on the witness stand months after the interview. You have only some hand scribbled notes or a summary report to aid you. You are asked these questions on cross-examination: "What was the very first

CON, continued

evening news. Generally, if it is not on tape, it never happened. Child sexual abuse trials should not be presented in any way that encourages this "Film at 11" mindset.

To have one isolated interview reproducible before a jury is to encourage the jury to place exaggerated and unwarranted importance on that one piece of evidence. All other disclosures, no matter how compelling and how carefully documented, will take a less prominent place in the jury's consideration. The freshness of the child's first disclosure, the anguish of a later, more complete disclosure to a loved one, the pain evident in the history provided by the child to an examining therapist after months of supportive counseling, all are deserving of thorough consideration by the jury. Such testimony is generally the most complete, most accurate, and most probative evidence a jury will hear. But such evidence can only be presented by the traditional, relatively sterile question and answer method of direct examination. Compare that to the active and visual reproduction of a select videotaped interview. The impact of the videotaped presentation is apt to cause it to receive disproporionate attention by the jury. When that occurs, the interests of the child and of the justice system to have a fair and accurate determination of guilt are not properly served.

Videotaping interviews does not solve any of the existing problems of poor interviewing. Perhaps the most significant disadvantage to videotaping is that it doesn't fix any of the problems of bad interviewing. Too often, videotaping is proclaimed to be a "solution." It is not. It may highlight bad interviewing skills which need to be addressed. But far too often it highlights what an attorney can isolate and label "bad," when in reality, in the proper context, no deficiency exists.

Poor, unprofessional interviewing of children needs to be corrected. If all the money that is poured into the purchase of videocameras, tapes, storage facilities, security, etc. were used instead to hire and train professional interviewers of children, we would accomplish much more to enhance the quality of interviews.

Videotaped interviews presented to a jury allow the defense to change the focus of the trial away from the child's answers and onto the interviewers' questions. Prosecutors need to focus on trying child abuse cases based upon what the child says. When children testify compellingly in court, the defense attorney's obligation is either to defuse the evidence or confuse the jury.

Research supports the concern that damage can be done by inappropriate leading or suggestive questions asked by an interviewer. Prosecutors need constantly to examine that possibility. However, research also supports the conclusion that the responses elicited by leading questions are not always unreliable. There is a big gap between unartful interviews and interviews so poor they taint all future disclosures.

A defense attorney is going to use these videotapes to identify every unartful question asked, each "inappropriate" facial gesture made by the interviewer. If defense counsel miraculously finds none, the attorney will point out all the questions that were not asked. There is no perfect interview, no agreement on a specific protocol for investigative interviews. Anyone can look at a videotape and find fault with some questions asked. A defense attorney, however, will seek to make counsel's own protocol the jury's protocol, and will measure the videotaped interview against it.

By replaying a videotape to a jury, the defendant has the adversarial advantage to concentrate the jury's attention on the questions asked instead of on the answers given. When that occurs, the entire focus of the trial has been skewed away from the defendant's guilt and onto the interviewer's skill. This does not serve the interests of justice.

The knowledge that a particular interview is being videotaped can increase the pressure on the child and decrease the fluidity of disclosure. If a child is to be videotaped, ethical standards (and in some states, law) dictate that the child must be so advised. Such knowledge can act as an inhibitor, adding to the child's pressure and discomfort. Aware that a camera is rolling, an adolescent is likely to feel intimidated. Place a microphone in front of an adult and ask a non-personal question, and the adult is likely to lose some of his or her composure, become stiff, and speak with more caution and hesitancy. Then ask the adult to describe, in detail, his or her last sexual encounter. Envision the open response you are likely to obtain. Yet videotape advocates seek a relaxed, fluid, and complete disclosure by a child being asked invasive and traumatic questions by a stranger before a microphone and camera.

question you asked the child? What were the exact words the child used to describe the act? Did the child demonstrate with any hand motions? What was the child's facial expression? What was the second question you asked? Did you hug the child? Did the child cry? And so on. The videotape can speak for itself, in essence, and is the best evidence of the non-suggestive nature of the interview. At the very least, it allows the interviewer to refresh his or her recollection without having to rely on incomplete notes.

Additionally, the videotape of the evidentiary interview is a legitimate means by which to refresh the child's recollection before trial. Children will be asked on the stand about what they have said to others in the past. Prosecutors routinely show adult witnesses transcripts of prior testimony or police reports to refresh their recollection prior to trial. In San Diego, prosecutors tell children that they may be asked about their interview at the Center and that they may watch the video if they need help remembering what questions were asked. This is no different from offering a witness the chance to review transcripts, and is very helpful with children too young to read. Finally, the prosecutor certainly doesn't want to be put in the extremely vulnerable position of refreshing the child's recollection with the prosecutor's interpretation of what was or was not said in the interview.

Experienced child abuse investigators and prosecutors know that children have their own unique vocabulary when describing incidents of molestation. The metaphors and analogies of children are unlike those of adults, and it is imperative that they be reported accurately. Further, in the several months or years between initial disclosure and trial, tremendous developmental changes can occur with the child. It is extremely helpful for the jury to see and hear the child, through videotape, closer in time to the disclosure—closer in time to the abuse. Also, a well-documented evidentiary interview can compliment other statements made by the child that were not captured on videotape. Spontaneous declarations to a teacher, parent or friend can be extremely powerful evidence, as is the disclosure to the physician during the medical examination.

During seminars and conferences throughout the country, I am privately told, "I'd be scared to death to videotape the interviews we do back home—they're just so bad." My response: "That is not a problem with videotaping, that is a problem with the interviewer."

If in your jurisdiction you have interviewers who are inarticulate, overbearing, intimidating, manipulative or insensitive, I suggest you have the courage to do something about that. Retrain them or stop using them. We can't pretend that bad interviews don't exist just because we don't videotape them. Videotaping can be your best tool in maintaining quality control of interviews.

I suggest that in evaluating when to use videotaping in your community, you do not save videotaping for the *big* case—the multi-victim, multi-perpetrator media attraction. That is a little like saying you'll start practicing the piano after you get invited to Carnegie Hall. Those jurisdictions which are successful with videotaping are successful because its done every day—on little cases, on big cases, and on cases that eventually go nowhere. It is experience and consistency that will give credibility to your program.

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A technical or administrative error can have devastating results. In some states, destruction of evidence, even if unintentional, can require dismissal of a charge (see, e.g., *State v. Wright*, 87 Wn.2d 783, 557 P.2d 1 [1976]). Surely a videocamera sometimes malfunctions. Sometimes voices are too soft to be audible on tape; sometimes the camera is out of focus or shoots blackness; sometimes a tape will be accidentally erased or lost. The risk of dismissal of charges if any of these accidents occurs is too great to warrant routine videotaping.

In addition, the responsibility of maintaining the integrity and confidentiality of the videotapes is an enormous administrative burden to the State. Where are the tapes stored? For how long? Where does the money come from for cameras, tapes, storage, etc.? Who gets access to the tapes? Are defendants entitled to review them as evidence against them? If so, is it appropriate to endorse a procedure whereby pedophiles can watch (and savor?) their victims recounting their abuse? How do we justify invading the child's right of privacy when we make these videotapes available to her abuser, her abuser's attorney, her abuser's attorney's experts? What remedy is there if they are not returned, or are given to unauthorized persons? Videotapes of child disclosures have ended up in the hands of the media. These problems are too great to support a system of dubious merit. The advantages of videotaping are based in theory, not in reality.

Theory: Having the interview on videotape will most accurately record what is said.

No competent prosecutor would take a child victim into court without first personally interviewing the child. Is a defense attorney going to concede that viewing the videotape is sufficient preparation and not seek to interview the child?

Reality: That is true of any interview. Why record only interviews with children? Why not videotape all forensic interviews, with adult victims as well as children? The argument that we should videotape only child interviews implies that children, or their interviewers, are less credible and trustworthy than are adults and their interviewers. Much current research contradicts the preconception that children are less credible witnesses than adults. There is certainly no reason to believe that those who conduct forensic interivews with children will mislead a court about what is said. Are police trustworthy when they talk with adults, but liars when reporting what children say? By mandating videotaping, don't we create that impression? It is inappropriate to create a separate class of citizens law enforcement can talk with only if a video camera is on.

Theory: Videotaping investigative interviews may reduce the need for additional interviews.

Reality: It would seem so, but experience shows it does not. Several prosecutors' offices that utilize videotaping anticipated a reduction in the number of interviews. What many have found, however, is that in cases that go to trial, there have been virtually no reduction in the number of interviews with the child.

Common sense dictates that in those cases a videotape is not going to eliminate additional interviews. No competent prosecutor would take a child victim into court without first personally interviewing the child. Is a defense attorney going to concede that viewing the videotape is sufficient preparation and not seek to interview the child?

Theory: A videotape may assist the child in preparing for court.

Reality: Children can be and are successfully prepared for court by prosecutors. Prosecutors do not need to have children view themselves on tape to recall what occurred. If the child needs to look at a prior tape, that should raise a huge red flag for the prosecution. Trial preparation means knowing what to expect in court: What the prosecutor will ask, how the defense attorney might try to confuse or attack the child. It does not mean cueing up a tape to encourage repetition. An appropriate court school program is a more beneficial way to prepare a child for court.

Theory: Videotaping is an important form of ongoing training for the interviewer.

Reality: Videotaping selected interviews for training may be an appropriate educational tool. Having an experienced professional review the interviewer's work

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is fine, but setting a blanket protocol around such a concern is inappropriate.

Theory: An expert witness could use the videotape to help form an opinion about whether the child was abused.

Reality: No ethical expert would. Yet, the defendant will find his hired gun to so opine. Some self-proclaimed experts claim they can look at a videotape and determine whether the child is truthful or not. As a prosecutor, one would never hire someone who claims this expertise. Such an opinion should not ordinarily be admissible at trial. Why would a prosecutor want to encourage such a practice and help create that cottage industry?

Theory: Videotaping may be used as a therapeutic tool, or be used to confront potential parental disbelief or denial.

Reality: Videotaping disclosures may have an important therapeutic role. If so, the therapist should decide whether to videotape clinical interviews. Investigative interviews have a distinctly different purpose. An investigative interview should not be treated as a clinical or therapeutic device.

Theory: A good videotaped interview may convince the defendant that the child will be a powerful witness and that, therefore, he should plead.

Reality: I believe this is the greatest advantage to videotaping. However, a confession or guilty plea is also likely to be obtained when a child's statements are clear, well-documented, and made to a professional child interviewer. There are an insufficient number of cases in which a guilty plea has been obtained only through a videotaped statement to justify routine videotaping of investigative interviews. Besides, this is a sword that can cut both ways: If the videotaped interview is poor, a defendant who might otherwise plead guilty might decide to go to trial.

Conclusion

In theory, there are many advantages to routinely videotaping investigative interviews with children. Experience to date suggests, however, that in reality those advantages have not been realized. The disadvantages are substantial. Videotapes give too much power to the defendant to dictate the focus of the trial and to mislead and confuse the fact-finder.

Child abuse prosecution should be based on a system that promotes full and fair review of all the evidence available. The videotaping of selected interviews with children presents instead a piece of evidence which can too easily be distorted and misused. When that occurs, the interests of proecution, of justice, and of the child, are ill-served.

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An extended version of this exchange is published in the Journal of Interpersonal Violence 7, 2 (June, 1992).

LAW

ADMISSIBILITY OF CHILDREN'S STATEMENTS OF ABUSE UNDER THE CONFRONTATION CLAUSE AND RECENT SUPREME COURT CASES

—by Josephine Bulkley and Debra Whitcomb

Introduction

Child victims of sexual abuse often make convincing disclosures to parents, doctors, teachers, or other people they trust. When, for example, a seven-year-old girl casually asks her father, "Daddy, does milk come out of your wiener? It comes out of Uncle Bob's, and it tastes yukky" (Berliner and Barbieri, 1984), there can be little doubt that the child has been sexually abused. Similarly, during the course of an investigation, children frequently offer detailed descriptions of abusive acts to social workers, law enforcement officers, or mental health professionals. Statements like these are extremely valuable to investigators as they seek to complete the puzzle of what happened to the child. Moreover, these statements may be the most compelling evidence available to the prosecution—save for the child's testimony in court. Indeed, a child's statements may be the only evidence available, since other witnesses or physical trauma to the child are rarely found, and the child may be ruled incompetent or otherwise unavailable as a witness.

When the prosecution offers such "out-of-court" statements at trial as evidence that a child was abused, however, such statements are considered "hearsay," and under the hearsay rule cannot be admitted to prove the truth of the statement. Hearsay statements are not admissible because it is difficult to determine whether they are trustworthy: they are not made under oath, there is no opportunity to cross-examine the child, and the jury is unable to observe the child's demeanor. Numerous exceptions to the hearsay rule have been adopted, however, to allow certain statements into evidence because the declarant (the person who made the statement) is considered likely to have been telling the truth at the time.

Thus, when the prosecution wants a witness to testify about what an alleged child sexual abuse victim told him or her, the witness's testimony may only be admitted if the child's statement satisifes an exception to the hearsay rule. Hearsay exceptions commonly used for children's statements of abuse include excited utterances (also called spontaneous declarations) statements made for purposes of medical diagnosis or treatment, residual (or "catch-all") exceptions, and special child abuse exceptions.

Hearsay exceptions for children's statements of abuse

Excited utterances. The excited utterances exception to the hearsay rule often applies in child sexual abuse cases. The three essential requirements of an excited utterance are: (1) a sufficiently startling experience suspending reflective thought; (2) a spontaneous reaction, not one resulting from reflection or fabrication; and (3) a statement relating to the startling experience. Traditionally, the statement must have been made contemporaneously with the event, but the modern trend is to consider whether any delay between the event and the statement provided an opportunity to fabricate the statement.

Under the excited utterances exception, some courts have allowed in a child victim's spontaneous statements made days, weeks, or even months after the abusive incident, provided there is a plausible explanation for the delay. Reasons for a child's reticence to disclose may include threats made by the defendant, fears of not being believed, feelings of confusion and guilt, and efforts to forget. Many courts have admitted as excited utterances statements made in response to limited questioning (Commonwealth v. Fuller, State v. Mateer, State v. Wagner).

From a practical standpoint, the primary effect of* White *will be to relieve the state from proving that a child who is unable to testify is "unavailable."

Statements made for purposes of medical diagnosis or treatment. Under this exception, statements to doctors relating to bodily feelings, conditions, pains or symptoms are admissible if made in order to obtain treatment. The underlying assumption is that people do not lie when seeking medical attention because they believe the effectiveness of treatment depends largely on what they tell the examining clinician. Courts have even allowed in statements identifying the perpetrator under this exception, reasoning that the perpetrator's identity is important to the child's treatment, particularly if the child is diagnosed with a sexually transmitted disease or if the perpetrator shares the child's household (State v. Robinson; State v. Olesen).

Some courts have also applied this exception to statements made by children to nonmedical personnel, such as psychologists or social workers regarding psychological feelings, although others have excluded such statements where the child does not clearly or subjectively appreciate the need to provide accurate information for

treatment (Mosteller, 1989).

Residual exceptions. Many states' rules of evidence include a residual or "catch-all" category to allow certain out-of-court statements that do not fall within any of the existing categories, but possess "equivalent circumstantial guarantees of trustworthiness."

Special child abuse exceptions. At least 29 states have statutorily created a special hearsay exception to allow into evidence certain out-of-court statements made by child abuse victims (Whitcomb, 1992). These special exceptions were passed to provide a means of admitting children's statements of abuse, if shown to be reliable, that do not fit the strict requirements of traditional exceptions (Bulkley, 1985; Bulkley, in press; Whitcomb, 1992).

Hearsay and the confrontation clause

Although many children's statements of abuse fall within the above exceptions to the hearsay rule, such statements also must satisfy the requirements of the sixth amendment's confrontation clause, which provides: "In all criminal prosecutions, the accused shall enjoy the right to be confronted with the witnesses against him." When a child testifies and prosecutors offer into evidence the child's out-of-court statement, there is no confrontation problem because the defendant can physically confront and cross-examine the child in court. A problem arises, however, when the prosecution seeks to admit out-of-court statements made by a child who does not testify. Under these circumstances, hearsay exceptions may collide with the confrontation clause, and the child's out-of-court statements may be excluded from evidence.

In 1980, the U.S. Supreme Court set forth a two-pronged test for determining whether an out-of-court statement can be admitted without violating the confrontation clause when the declarant does not testify. In Ohio v. Roberts, which involved the preliminary hearing testimony of an absent witness at trial, the Court stated:

When a hearsay declarant is not present for cross-examination at trial, the confrontation clause normally requires a showing that he is unavailable. Even then his statement is admissible only if it bears adequate indicia of reliability (Ohio v. Roberts; emphasis added).

Subsequent Court opinions have clarified both the "unavailability" and "reliability" prongs of the test in Roberts. The Supreme Court repeatedly has indicated that it would not equate the confrontation clause with the hearsay rule, holding that some hearsay admissible under a hearsay exception is not admissible under the confrontation clause. However, recent opinions appear to signal the end of this principle, indicating that, if a statement falls within a "firmly rooted" hearsay exception, it also satisfies the confrontation clause and should be admissible into evidence (White v. Illinois; Idaho v. Wright; Bourjaily v. United States; United States v. Inadi; Bulkley, in press; Bulkley, 1985; Graham, 1988).

Unavailability requirement. Many believed that the two requirements in *Ohio v. Roberts* (involving the hearsay exception for prior testimony) applied to all hearsay exceptions. In *Inadi v. United States*, however, the Supreme Court in 1986 held that the confrontation clause did not require a showing of unavailability when the prosecution offers a non-testifying co-conspirator's statement under the co-conspirator exception to the hearsay rule. Although *Inadi* made it clear that the unavailability rule, applicable to prior testimony, did not apply to all other hearsay exceptions, it did not specifically state that unavailability would never be required. After *Inadi*, therefore, courts were not sure whether unavailability applied to exceptions commonly used in child abuse cases.

In February, 1992, in *White v. Illinois*, the Supreme Court decided that the confrontation clause also does *not* require the state to produce a child as a witness or prove his or her unavailability before admitting the child's statement under the excited utterance and medical diagnosis exceptions. In *White*, a four-year-old child made a series of statements to her babysitter, her mother, a law enforcement officer, a nurse, and a physician—all describing a recent incident of sexual abuse. The trial court allowed these persons to testify, despite the fact that the child was present in the courtroom during the trial but did not testify, and the prosecutor made no showing of her unavailability to testify. The defendant was convicted solely on the basis of the child's out-of-court statements.

The Court in *White* not only expanded its holding in *Inadi* from the co-conspirator exception to the excited utterances and medical diagnosis exceptions, it also explicitly eliminated the "unavailability rule" for *all* firmly rooted hearsay exceptions. *White* did not address, however, the unavailability requirement for non-firmly rooted exceptions, and thus whether this opinion will apply to the residual or special child abuse exceptions remains to be seen.

From a practical standpoint, the primary effect of White will be to relieve the state from proving a child who is unable to testify is "unavailable." *White* does not mean the state can prevent a child from being a witness if he or she is truly available to testify, since both *Inadi* and *White* clearly indicate that the defendant has a right to call the child for cross-examination. Indeed, a major reason the Court in these decisions held that an unavailability rule was of little benefit was because the defendant may call any witnesses the state has not called.

There are, however, situations in which an unavailability rule would exclude a child's out-of-court statements from evidence and probably force the state to abandon prosecution altogether. For example, parents might not allow their child to testify, fearing emotional distress. At the same time, the state might not be able to show emotional trauma sufficient to prove "unavailability." A recent California case allowed a child's hearsay statements to be admitted into evidence under this scenario (People v. Lusk).

In another situation, a prosecutor may have excellent testimony from several adults regarding statements made by the child (as in *White*), but the child witness is not likely to be a credible or sympathetic witness. In yet another scenario, the state may not be able to meet the very high thresholds required by the courts for demonstrating emotional distress (Bulkley, 1985; Bulkley, in press). If the state nevertheless does not call the child because she in fact would be traumatized, an unavailability rule would preclude use of the child's out-of-court statements.

In sum, the Supreme Court's ruling in *White v. Illinois* may permit some prosecutions that otherwise could not go forward. It should not, however, encourage prosecutors to refrain from calling child witnesses who are available to testify. In those few cases where the state does not produce a child who is in fact available to testify, defendants should exercise their right to call the child.

Reliability requirement. Several recent Supreme Court decisions have confirmed the principle (set forth in *Roberts*) that the reliability of an out-of-court statement may be assumed if the statement falls within a firmly rooted hearsay exception. And, in *Idaho v. Wright*, the Court reaffirmed *Roberts*'s holding that statements not falling within a firmly rooted exception must be excluded, unless the state demonstrates they possess "particularized guarantees of trustworthiness." *Idaho v. Wright* was a child sexual abuse case in which the prosecution sought to admit a 2½ year old's statements to a physician under a residual hearsay exception.

In sum, the Supreme Court's ruling in White v. Illinois may permit some prosecutions that otherwise could not go forward. It should not, however, encourage prosecutors to refrain from calling child witnesses who are able to testify.

After finding that the residual exception was not firmly rooted, the Court held

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BOOK REVIEWS

—edited by Mark Chaffin

With the best of intentions: The child sexual abuse prevention movement. By Jill Duerr Berrick and Neil Gilbert. New York: Guilford Press. 210 pages. Hardback $25.00.

—Reviewed by Sandy K. Wurtele

In recent years, child sexual abuse (CSA) has gained increasing attention as a serious problem for children of all ages. The prevailing model for preventing sexual abuse involves programs delivered to children in the classroom setting. The objective of this book is to illuminate the purpose, design, and consequences of these CSA prevention training programs. Berrick and Gilbert acknowledge that these programs are begun with the best of intentions; but the authors question whether the programs are appropriate for young children, specifically those in preschool through the third grade.

The book begins with an historical perspective. In Chapter 1, the authors trace the history of the sexual exploitation of children along with recent efforts to prevent CSA. Their thesis is that feminist theory is at the ideological core of the CSA prevention movement, as reflected in programs' emphases on empowering children and teaching them self-defense. The ideology of empowerment, as applied to young children, is called into question throughout the text.

In Chapter 2, Berrick and Gilbert describe the development of legislation in California which made publicly funded training available to children in every preschool program in the state. Their concern about this legislation (and about the entire CSA prevention movement) is that it was supported without empirical evidence of program effectiveness. Reviewing findings from their own evaluation of preschool programs, they note that overall gains made by young children were quite low.

The book is well written and informative, and its developmental emphasis is clearly a strength.

The middle section contains a review of what's taught in prevention programs and how well children learn this information. In Chapter 3 they compare 15 CSA prevention curricula in terms of structural features (e.g.,

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that indicators of a statement's reliability must be found in the circumstances surrounding the making of the statement itself, and not from extrinsic or corroborating evidence. In other words, evidence that tends to corroborate the child's allegations of abuse, such as medical findings or testimony of other witnesses, may not be used to support the reliability of the child's out-of-court statements. Examples of "circumstances surrounding the making of the statement" (cited by a Washington state court decision) relevant in assessing a statement's trustworthiness under *Wright* include the following:

1. whether there is a motive to lie
2. the general character of the declarant/child
3. whether more than one person heard the statement
4. whether the statement was spontaneous
5. the timing of the statement and the relationship between the declarant/child and witness
6. the statement contains no express assertions about past fact
7. cross-examination could not show the declarant/child's lack of knowledge
8. the possibility of the declarant/child's faulty recollection is remote
9. the circumstances surrounding the statement are such that there is no reason to suppose the declarant/child misrepresented the defendant's involvement (State v. Ryan).

The Court in *Wright*, however, found that, "Given the presumption of inadmissibility accorded accusatory hearsay statements not admitted pursuant to a firmly rooted hearsay exception, we agree with the court below that the state failed to show that the younger daughter's incriminating statements to the pediatrician possessed sufficient 'particularized guarantees of trustworthiness' under the confrontation clause to overcome that presumption" *(Idaho v. Wright).*

Conclusion

After *White v. Illinois* and *Idaho v. Wright*, for firmly-rooted exceptions commonly used in child abuse cases, such as the excited utterances and medical diagnosis exceptions, the prosecution must only show that a child's statement satisfies a particular hearsay exception, and has no other proof requirements even if the state does not put the child on the witness stand. For non-firmly rooted exceptions, such as the child abuse and residual exceptions, however, when the state does not put the child on the witness stand, the confrontation clause requires the state to prove a child's statement is trustworthy. *White* left open whether the state must produce the child to testify or demonstrate her unavailability when offering the child's statement under these exceptions.

Because *Roberts* and *Wright* emphasized the presumptive inadmissibility of statements falling within non-firmly rooted exceptions, the Court may well require an unavailability showing for the special child abuse and residual exceptions when the prosecution does not produce the child to testify. Most statutory child abuse exceptions contain an unavailability requirement, because they were adopted to confrom with *Ohio v. Roberts*. About seven statutes do not require unavailability, however, and if the Court were to require unavailability for non-firmly rooted exceptions, such statutes would violate the confrontation clause (Whitcomb, 1992).

On the other hand, the Supreme Court's recent decisions appear to focus on the trustworthiness requirement, and if the state has met its burden of proving a statement has "particularized guarantees of trustworthiness" to satisfy even a non-firmly rooted exception, the Court may eliminate the unavailability rule for these exceptions, too. This result also is supported by the reasoning in *Inadi* and *White* for eliminating the unavailability requirement, where the Court indicated that the rule was of little benefit because the defendant could call witnesses not called by the prosecution—equally applicable to non-firmly rooted exceptions.

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mode of presentation; program length) and content. They observe that the concepts taught to preschoolers, first graders, and third graders are strikingly similar. In Chapter 4, the authors review developmental and learning theories to determine if CSA prevention programs are developmentally appropriate, and conclude that they are not. This conclusion is bolstered by results (presented in Chapter 5) from a study of first- and third-grade participants in CSA prevention programs, in which subjects learned and retained a small amount of prevention knowledge. These results are then compared to findings from a handful of other studies, and the authors conclude that students in the early elementary school grades register relatively small gains in knowledge from CSA prevention programs. There is also a lack of evidence that this limited learning translates into behavior that can prevent abuse.

In general, the book is long on criticisms and short on suggestions.

The remainder of the book describes the roles parents and teachers play in preventing CSA. In Chapter 6 the concern is raised that parents are not being informed about the content of CSA prevention programs, nor are they made aware of possible negative effects related to training. The authors assert that these omissions make it difficult, if not impossible, for parents to exercise informed consent for CSA prevention training. In Chapter 7 the authors review potential prevention roles for teachers, including reporting suspected abuse and enhancing children's communication skills and help-seeking behaviors.

In the final chapter, additional concerns are raised about making 3- to 9-year-old children targets for CSA prevention interventions. Should young children be responsible for their own protection? Should children be told that they could be sexually molested by parents? Based on these concerns and their own research, the authors recommend that the current empowerment model be replaced by a protection model, which relies more heavily on teachers and parents to protect children. Rather than teaching young children about sexual abuse per se, they recommend that general communication skills and help-seeking behaviors be taught, along with lessons about body awareness and secret touching.

The book is well written and informative, and its developmental emphasis is clearly a strength. Although reviewing developmental theory helps to illuminate the programs' theoretical inadequacies, the authors could have usefully offered suggestions for how to better incorporate child development knowledge into prevention programs. In general, the book is long on criticisms and short on suggestions. Another strength of the book is its analysis of the concepts taught in CSA prevention programs. The authors provide a good framework for determining what concepts children are developmentally able to learn. For the most part, the authors' claims regarding program effects are well grounded in theory and research, although their conclusion that there are negative effects related to prevention training is based more on anecdotal reports and methodologically weak surveys. My own reading of the literature suggests that prevention programs are associated with no or minimal short-term negative effects (no study has documented any long-term negative effects), and there is a strong possibility that they may even produce positive indirect effects (e.g., increased discussion at home). Although some readers may not agree with Berrick and Gilbert's conclusion that CSA prevention programs are inappropriate for young children, they will most certainly benefit form reading this thought-provoking book.

Sandy K. Wurtele, PhD, is a Professor of Psychology at University of Colorado, Boulder.

RECENT RELEASES

Ammerman, R.T., & Hersen, M. (1991). Case studies in family violence. *New York: Plenum. $59.50 (h), $29.50 (p)*

Cirillo, S., & DeBlasio, P. (1992). Families that abuse: Diagnosis and therapy. *New York: Norton. $22.95.*

Dolan, Y. (1991). Resolving sexual abuse: Solution-focused therapy and Ericksonian hypnosis for adult survivors. *New York: Norton. $29.95.*

Horowitz, A.R. (1992). The clinical detective: Techniques in the evaluation of sexual abuse. *New York: Norton. $34.95.*

Starr, R.H., & Wolfe, D.A., (Eds.) (1991). The effects of child abuse and neglect. *New York: Guilford Press. $34.95.*

Wolfe, D.A. (1991). Preventing physical and emotional abuse of children. *New York: Guilford Press. $45.00 (h), $15.95 (p).*

NEWS

DNA EVIDENCE APPROVED BY NATIONAL STUDY

—by Paul Stern

The use of DNA typing evidence in criminal cases received a substantial endorsement by the release of a report by the National Academy of Sciences.

The report recommended that courts "accept the reliability of DNA typing and recognize that current laboratory techniques are fundamentally sound."

In confirming the general reliability of using DNA typing evidence, the report came with specific recommendations to resolve a number of issues, such as establishing detailed quality assurance programs, mandatory accreditation of laboratories, and a restrictive approach to the use of statistical probabilities.

A full copy of the report, *DNA Technology in Forensic Science,* is available from the National Academy Press, 1-800-624-6242.

NEWS – *HEALTHY FAMILIES AMERICA*

—by Anne Cohn Donnelly

The National Committee for Prevention of Child Abuse (NCPCA), in conjunction with the Ronald McDonald Children's Charities, has begun a new national effort to prevent child abuse. Entitled Healthy Families America, the effort focuses on helping parents get off to a good start.

The U.S. Advisory Board on Child Abuse and Neglect recently recommended that we as a nation begin to develop a voluntary home visiting program for all new parents. The Healthy Start program in the state of Hawaii provides a model for this initiative.

NCPCA is now working to replicate the Hawaii model and establish a voluntary neonatal home visiting program across the United States. The Healthy Families America program will work with the Hawaii Family Stress Center, local NCPCA chapters, Children's Trust Funds, the states' Maternal and Child Health Units and any other interested national, state or local groups in this effort.

The goals over the next three years include the following:

1. More than 25 states will have initiated state-wide home visiting services for all parents; numerous community agencies will have done the same.

2. At least twice as many at risk parents will be receiving intensive home visitor services than were at the onset of the effort.

3. Child abuse will be reduced by at least 75% in the population receiving intensive home visitor services.

Extensive evaluation of these goals will be conducted. For more information, contact Anne Cohn Donnelly, c/o National Committee for Prevention of Child Abuse (NCPCA), 332 S. Michigan Avenue, Suite 1600, Chicago, Illinois 60604

KENDALL-TACKETT,

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A key component of the scientific process is the replication of results. When several researchers find the same type of result, it is more likely that the result is genuine and not caused by some peculiarity in the research design or by chance error. That is why you cannot place too great an importance on the results of one study—even an excellent one. That is also why "reviews of the literature" are especially helpful. "Literature" or research reviews survey many articles on the same topic, noting aspects of study design, data analysis, and conclusions that help readers put the findings of particular studies in perspective.

However, we understand that there are times when one study is all you have. Therefore, we have attempted to define what makes a good study. Defining "good research" is about as easy as nailing jelly to the wall. As anyone who has ever submitted an article to a journal will tell you, one person's good research is another person's trash. But do not despair! Some rules of thumb will help you make that judgment.

Research Basics

First, it helps to have a bird's eye view of the function and purpose of research. The most basic question of research is, "How does X affect Y?" X might be sexual abuse, and Y a child's emotional health; X a particular treatment method, and Y a perpetrator's subsequent behavior; X a prevention program, and Y a child's knowledge. X is called the *independent variable*: we can manipulate it—eliminate sexual abuse as a consideration, change a treatment program, refine a prevention curriculum. Y is called the *dependent variable*: we don't directly manipulate it; rather, if it varies, it varies (hypothetically) with changes in the independent variable.

As with professionals in any field, researchers have an "insiders' language." ... We hope we can clear up some of your questions.

A study may have more than one variable (that is, independent variable: when people use shorthand and talk about a study's "variables," typically they are talking about the independent variable). For instance, a study might ask whether either socioeconomic status or child abuse has measurable effects on a child's emotional health.

If we're trying to find out the effect of X on Y (or, to turn it around, what factors cause a change in Y), we want to rule out—*control for*—the effects of other possible variables. For instance, if we're testing the effects of a particular treatment program on incarcerated offenders, we want to control for the possibility that something besides the treatment program—say, visits from family members—affects offending behavior. Variables that we have not adequately controlled for are aptly called *confounding variables*.

The results of research are reported in scientific articles, which are generally divided into four major sections: Introduction, Methods, Results, and Discussion. Here are some things to look for in each section.

The Introduction

The Introduction states the research questions for the present study and briefly reviews relevant previous research. A good introduction describes the major studies on the topic at hand, clearly articulates the goals of the present study, and explains reasonably why past study results justify the present study. The authors should make a case for doing this particular study, stressing how it will advance the frontier of the question being asked, or clarify a major muddle. In the introduction, also, the researcher states the *hypothesis*. As you probably know from high school science, the hypothesis is the statement of expectation: "I think X is going to affect Y in these ways." The *null hypothesis* is the statement that X will have no effect on Y. A null hypothesis sounds like a silly thing to spend time proving, but it's important when someone claims, for instance, that a certain treatment program is highly effective, and others want to prove the person wrong.

Methods

The Methods section is where the researcher describes what he or she did in the study. Several aspects of the methods need to be considered.

Sample

The sample is the group of people studied. Sampling is a key issue, and can be a major source of discrepancies between studies. When you evaluate a study, you must consider whether the sample is appropriate to the question being asked. For example, is the sample from a clinical practice or from the larger, nonclinical community? Is it comprised of people who underwent a traumatic experience in the distant past, or more recently? At what developmental stage are people in the sample? Are race, sex, socioeconomic status, education level, etc., important to the question being asked? If so, is the sample appropriately chosen? Whom does the sample represent, and can conclusions drawn from a study of this sample be generalized to a larger group? When authors attempt to apply their results to all sexual abuse victims, for example, but have sampled only a clinical population, their conclusions are likely to be inappropriate, because sexual abuse victims who seek and receive treatment may differ from those who do not. (For more information, see the introduction of Kendall-Tackett and Simon [1987], where this issue is discussed in agonizing detail.)

Cohort, to answer your question, is often simply used as another name for sample. It is more specifically used in longitudinal research (discussed below) to describe the groups the researcher will follow at point 1, point 2, and beyond. It is not the group the researcher hangs out with after work.

The main benefit of correlational research is that you can study the effects of harmful influences without having to introduce them in an experiment. The main disadvantage is that you cannot say variable X causes Y.

Sample size, to answer another of your questions, requires a judgment call. The answer to the question, "How big is big enough?" is, "It depends." If you have a carefully controlled experiment with only one or two variables, even 20 subjects might be enough (although a larger sample would be preferable). On the other hand, if you are trying to consider many variables, and you want your results to be applicable to a broad population, your sample size may need to be in the hundreds or thousands. As a rough guideline, many researchers recommend a minimum of 10 subjects for every variable included in the design.

Research Design

Researchers choose from a variety of design elements depending upon the question they're asking. One of the first questions is whether a study will be *longitudinal* or *cross-sectional*. Most studies on child abuse collect data only once, which means they're *cross-sectional*. Studies which collect data more than once (e.g., 6 months, 12 months, 24 months, and 36 months post-abuse) are *longitudinal*. Longitudinal studies are more difficult and costly than cross-sectional studies (just keeping track of subjects can be very difficult), but they give researchers a chance to address questions about the effects of various interventions over a period of months or years.

Another major distinction is between *experiments* and *correlational studies*. (Researchers can use either longitudinal or cross-sectional data collection with either type of study.) The key distinction is whether the researcher places subjects into groups, then tries out different variables on each group, or whether the researcher studies already-existing groups (or conditions), such as abused vs. nonabused children.

In an *experiment*, subjects are randomly assigned to groups, and different variables are introduced (or there may be treatment for one group and no treatment for the other).

Experiments have the advantage of maximum control of potential biases, and allow the researcher to claim that X *causes* Y. The major drawback of experiments is that they are often artificial because the number of variables that can be explained and controlled for within the design is limited. In addition, experimental designs have recently come under fire for ethical reasons, because they mean withholding potentially beneficial treatment (such as medications and early intervention programs) from subjects in the non-treatment or "control" group. Further, experiments cannot be used to address issues where the "treatment" involves potentially serious harm to subjects. You can't randomly assign one group of children to be abused, and another to be treated well. Although experimental designs have been used very effectively in research on children as witnesses and similar topics, some questions must be examined in groups that occur naturally. That brings us to the other major type of design—the correlational study.

In *correlational research*, there is no random assignment to groups, and therefore less control of potentially confounding variables. You do not attempt to change subjects, but simply collect data from them by asking questions or using other measures to evaluate them.

The main benefit of *correlational research* is that you can study the effects of harmful influences without having to introduce them in an experiment. The main disadvantage is that you cannot say variable X *causes* Y. Predictably, cigarette manufacturers love this type of data. Because we can't ethically conduct an experiment in which one group is subjected to cigarette smoke on a daily basis for 20 years, and another is free of it, cigarette manufacturers are forever claiming that no one has ever proven that smoking *causes* lung cancer.

If cigarette manufacturers' claim is valid, how can we make any definitive statements about the effects of abuse? Aren't we caught in the same type of dilemma?

The answer is "yes and no." Although we cannot claim that child abuse causes the negative outcomes we see (e.g., aggression, depression, sexual acting out, etc.), we can describe the effects of abuse by statistically controlling for other factors that may cause the negative outcomes (the dependent variables). That is, if someone suggests that socioeconomic status, not abuse, accounts for the negative outcome, we can be sure to take the socioeconomic status of subjects into account when analyzing the data. If the effect occurs independent of variations in SES, we can be more confident that abuse, not SES, is causing it.

By controlling for several potential intervening or confounding variables, we can find out the strength of the relationship of child abuse (the independent variable) to the negative outcome we're studying (the dependent variable). This is where you are likely to encounter terms such as "percentage of variance accounted for" or "independent contribution." For example, "Child abuse accounts for 45% of this negative outcome," or "Child abuse clearly makes an independent contribution to this outcome."

Although we cannot say that child abuse causes depression, we can say that child abuse is related to or increases the likelihood of depression. For further information on the subject of research design, see Philips (1971) and Rosenthal and Rosnow (1984).

Data Collection

Another critical issue reported in the Methods section is how the data were collected. Did researchers review case records searching for specific sorts of information? Did they interview subjects? If so, did they use a written protocol? Did researchers administer tests to measure personality traits or the potential to commit child abuse? The measures used are very important. Standardized measures are those that have gone through an often rigorous process of being used and tested by others before being published. Standardized measures are tested for *validity* (it measures what it's supposed to) and *reliability* (it is consistent). When standardized measures are used, we know more about what the results mean.

But in our field, we cannot be afraid of research which uses new measures. In the past, many standardized measures were developed with no sensitivity to or consideration of childhood abuse or trauma. Just as clinical assessments often neglected to ask individuals about experiences with child abuse or family violence, many standard measures of child behavior or human psychological functioning have ignored the widespread human experience of child abuse and other maltreatment. Measures still need to be developed and standardized which take these phenomena into account.

If the journal is reputable, then the chances of the researcher using inappropriate statistics are far fewer. In our experience, reviewers are only too happy to spot inappropriate statistics.

Results

The results section is where the researcher describes the results of statistical analysis. Many books have been written discussing the rigors of appropriate analysis; it is impossible to summarize them briefly enough for this already long letter. But we would like to assure you that, although there is some variation of opinion about appropriate statistical analysis, there are certain well-established standards, and it is highly unlikely that someone just "cooked" the data to get it to say what he or she wanted. Even in the case of out-and-out fraud, the results of the "cooked" study would fail to hold up under replication, and the fraud would be quickly exposed.

When you are considering whether to trust the analysis, consider where the article was published. If the journal is reputable, then the chances of the researcher using inappropriate statistics are far fewer. In our experience, reviewers are only too happy to spot inappropriate statistics (it shows they were paying attention in their stat classes), and will jump on faulty analysis like ducks on June bugs.

But to answer some of your specific questions. . . . As we indicated earlier, p refers to the "probability that these results occurred by chance." By convention, something is statistically significant if $p < .05$ (translation: it has less than a 5% chance of occurring by chance). In this case, the smaller the number, the better. If $p < .01$, then the result is considered "highly or very significant." Statistically significant does not necessarily mean "good," nor does it mean "socially significant." It merely means that the change (variance) in the dependent variable accounted for by the variables you are interested in is greater than the amount of error.

Which brings us to *standard deviations*. These numbers reflect the degree of heterogeneity within each group. A large standard deviation means that many individual responses varied widely from the group mean. A small standard deviation means that there were few "outliers"—that individual responses tended to cluster around the mean. Results can be significant even with a large standard deviation (especially when the sample size is large): the test of statistical significance takes the standard deviation and sample size into account.

Discussion

The final section of a scientific article is the *discussion*.In this section, the author summarizes the results of the study in words (rather than statistical symbols), and attempts to draw conclusions. The author may also describe how this study is similar to or different from previous studies. This section is generally considered one of the "softer" sections because it is open to the author's interpretation. On the other hand, it is often the most interesting to read, and may be the most important, because readers can benefit from the full experience of the author. It also provides a ready-made interpretation of the statistical results. The major danger in this section is that the author (and therefore you) will overstate his or her case and make conclusions that go beyond the study.

continued on next page

KENDALL-TACKETT,

continued from previous page

When articles appear in journals such as *Journal of Interpersonal Violence* or *Child Abuse and Neglect*, they have survived a peer-review process. This means that they have been sent to two or more reviewers (sometimes also called referees, although they rarely wear black-and-white shirts) for comments and suggestions about whether the journal should publish the paper. The author is typically required to revise the article one or more times before it appears in print.

Although the peer-review process is not perfect, it is a check for the scientific value of the article. If the article is published in a reputable journal, there is some assurance that the methods, data analysis, and conclusions are at least reasonable.

However, we would like to caution you that publication of a peer-reviewed journal is no guarantee of good science. That is where replication of findings comes in (have we mentioned this before?). If a study was poorly done, and it somehow slipped through the peer-review process, chances are the findings will not be replicated in future studies. That is why it's important to base practice or policy decisions on the results of more than one study (to find reviews of the relevant literature).

We hope we have been able to answer some of your questions and make the findings from research more accessible. Thank you for your interest, and good luck in your work.

Sincerely,
Kathy and Linda.
P.S. Just who precisely is this *Lis Pendens*?

Response

Dear Kathy and Linda,

Thanks for your reply. I understand research better now. I write a three-paragraph letter, and a researcher needs eight pages to answer.

Lis Pendens hasn't meant a thing to me since I met *Viva Voce*. I'm enclosing the plastic pocket protector you left at the APSAC conference in San Diego.

Sincerely,
Paul

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Rosenthal, R., and Rosnow, R.L. (1984). *The essentials of behavioral research: Methods and data analysis.* New York: McGraw Hill.

Kathleen Kendall-Tackett, PhD, is a Developmental Psychologist and Research Fellow at the Family Research Laboratory at the University of New Hampshire. She is also on the Board of Directors of the Massachusetts chapter of APSAC, and chairs MAPSAC's Research Committee.

Linda Meyer Williams, PhD, is a Sociologist and Research Associate Professor at the Family Research Laboratory at the University of New Hampshire. She is a member of APSAC's Executive Committee, and is co-chair of its Research Committee. She is a founding member of the Northern New England chapter of APSAC.

Paul Stern, JD, is Deputy Prosecuting Attorney for Snohomish County, Washington. He is also a member of APSAC's Executive Committee, and is Secretary of the Washington state chapter of APSAC.

REID, *continued from page 1*

The State of Montana's Attorney General's office was joined by 20 other states in asking the U.S. Supreme Court to hear the case. They argued that the Montana Supreme Court decision went against several precedents. When the U.S. Supreme Court agreed to hear the case, the Montana Attorney General's office approached APSAC for an *amicus* brief explaining the expectations of offender treatment. APSAC's Legal Committee strongly recommended to the Executive Committee that the brief be undertaken, and the Executive Committee agreed. The primary concern from APSAC's point of view was that, if the Montana decision stood, judges would have to give probation *without* treatment if probation were the choice.

Primary authors of the brief were offender treatment expert William Murphy, PhD, of the University of Tennessee, and legal scholar John E.B. Myers, JD, of University of the Pacific's McGeorge School of Law. Josephine Bulkley, JD, provided substantial written commentary on the case before the brief was undertaken. Treatment experts William Pithers, PhD, Robert Prentky, PhD, and Lucy Berliner, MSW, contributed to the writing of the brief.

The brief focuses on three aspects of offender treatment: the necessity that the offender admit the crimes he or she has committed, the importance of the court order in securing participation in a treatment program, and the effectiveness of offender treatment programs.

The Supreme Court's decision is expected this Spring, and will be reported in *The Advisor*. APSAC owes major thanks to those professionals who responded so quickly to the request for this brief. By contributing unstintingly of their time and expertise, they have enabled APSAC to weigh in at the highest level on the critical issue of offender treatment.

Copies of the brief are available by writing to APSAC's office. Please send $5.00 to cover costs.

APSAC's First National Colloquium

APSAC's Program Committee has been hard at work designing APSAC's First National Colloquium. It will be held in June 24 - 26, 1993, in Chicago. The committee decided "colloquium" was the best word to convey the intention of having small, highly interactive, intensive, day-long sessions.

Since many other national conferences do an excellent job offering 1-1/2 hour workshops, APSAC has decided to fill a different need. The first day of the colloquium will be devoted to intensive, day-long *within*-discipline institutes, the second day to intensive, day-long *across*-discipline institutes. The focus of the colloquium will be professional interaction. Participants of many institutes will be asked to send in case examples in advance, so institute leaders can incorporate participants' immediate concerns into the day's colloquium. The idea is to replace the "me lecturer, you student" format with one that stresses the energetic interaction of peers.

In addition, program designers are committed to putting into practice at this colloquium one of the major goals of APSAC's Board: to foster new leadership in the field of child abuse and neglect. Many institute faculty teams will pair a well-established, well-known expert in the field with a less well-known expert who has a great deal to contribute. APSAC's goal in recognizing emerging expertise is to maximize the talent brought to bear on the formidable challenges confronting this field.

Please contribute your talent by submitting your ideas for topics of both within-discipline and cross-discipline colloquia. Attention your suggestions to Lucy Berliner, Chair, Program Subcommittee, at APSAC's office address.

Nominations sought for Board election

It's time to start thinking of outstanding professionals to nominate to stand for election to APSAC's Board of Directors. The election will be held this Fall, and nominations are due in by July 15th. You can either suggest a nominee to the Nominating Committee, or nominate someone directly. APSAC seeks nominees from all relevant disciplines, all regions of the country, and all ethnic, religious, and racial groups. For a copy of the nominating procedures, call or write the office.

Thanks!

Many members have called in asking for brochures to distribute at conferences, seminars, and training sessions around the country. More than 10,000 APSAC brochures have been sent to members just this Spring. By telling your colleagues about APSAC, you help build a national network of professionals that can profoundly affect the way America responds to the pervasive maltreatment of its children. Thank you for your dedication and support!

PRACTICE

INTERDISCIPLINARY TEAMS: DO THEY HELP VICTIMS OF CHILD ABUSE?

—by Robert M. Reece

There are no good data to support the view that interdisciplinary teams have a positive impact on the prevention, treatment, or outcome of child abuse cases. Outcome measures relying on crude measures of success for clients are fraught with imprecision owing to the enormous complexities of such families, confounding variables, and effect modifiers. Case-control studies are lacking, leaving us with experience alone to assess the efficacy of particular models of service delivery.

Outcomes of interdisciplinary team functioning can and should be measured, to give us more accurate guidance on the value of such teams. They have strong advocates throughout the child protection world, however, because when such teams are functioning optimally, the positive effects experienced by both professionals and clients are numerous: better coordination of the diagnostic process, a stable working relationship promoting better communication among team members, richer case-specific information, a broader, deeper fund of knowledge because of the sharing of information across the disciplines, and the security of group support helping to prevent burnout.

How have interdisciplinary teams evolved? The interdisciplinary team model was utilized formally and informally in a variety of settings long before child protection teams began to make use of it. Within the health care field, interdisciplinary teams were used to organize services for the large numbers of multiply handicapped children resulting from the polio epidemics of the 1930's and '40's. This model was then used within hospitals to serve children handicapped from many other congenital and acquired diseases.

It was natural to follow this proven success within hospitals to deal with equally complex problems of child abuse. In 1958, C. Henry Kempe organized one of the first hospital-based child abuse teams, at the University of Colorado Hospital. Since then, such teams have been forged in cities, counties, regions, states, and on a national scale.

Within some smaller units of government—cities and towns—the interdisciplinary model has been organized with the legally mandated child protection service agency (Department of Social Service, Department of Human Services, etc.) as the convening body. The elements of these teams are usually the governmental social service agency, the prosecutor's office, law enforcement representatives, medical personnel, and members of the judiciary. Depending upon local conditions, mental health professionals, nurses, guardian-ad-litem groups, and victim witness advocates may also be members.

The functions of the team vary, with case review being the sole focus in some, while others see direct service delivery and case review as their goals. The commitment to education, research, and evaluation of outcome depends on the orientation, resources, and level of sophistication of the team.

The next level of evolutionary development of community-based interdisciplinary teams is best exemplified by the child advocacy center. In this model, the same agency representatives described above are participants, but the important difference is that the agency is governed by a non-profit advisory board whose members include leaders in the political and private sector and representatives from all the component agencies.

The Child Advocacy Centers's "one-stop shopping" streamlines the process for everyone, most importantly for the child and family. For child protection workers—who are generally undervalued, and get attention only when they make mistakes— cooperating in such a model enhances professional identity and self-esteem.

By lifting the mission of the child advocacy center above the vested interests of the individual components, no particular discipline dominates the group process, and all disciplines have equal status within the Center. Operating as a non-profit child protection agency in a child-friendly neutral facility, the CAC's goal is to deliver, under one roof, comprehensive interdisciplinary evaluation and treatment to the children and families involved in child abuse. One-way mirrors or closed circuit television allow all disciplines to cooperate simultaneously in forensic interviews with the child and family. Medical professionals can complete their examination during the same visit. Immediately following the evaluation, the child evaluators, case workers, attorneys, and law enforcement representatives sit down to make case management decisions.

The CAC's "one-stop shopping" streamlines the process for everyone, most importantly for the child and family. It promotes cohesion among the participating personnel, and expedites the initiation of therapy. For child protection workers—who are generally undervalued, and get attention only when they make mistakes— cooperating in such a model enhances professional identity and self-esteem.

The Children's Advocacy Center paradigm is a solution for a defined and circumscribed population, but it should be recognized as having limitations. The major limitation is that the service area is defined by the unit of government sponsoring it. For this reason, interdisciplinary services should be provided at a regional level. Newborn care services and poison control centers are successful examples of regionalization of specialized, universally-needed services. Similar centers of excellence could be developed to provide services to the ever-increasing numbers of families enmeshed in the child abuse epidemic sweeping the country. Such centers could, in fact, be more economical in both human and fiscal terms, by offering tertiary care interdisciplinary specialized child protective resource services for those complex cases not solved at the local level. Consultative "hot lines" in all of the relevant areas of psychosocial, legal, and medical domains could provide the most current information to community professionals working in the field.

This area of practice has made giant strides since Caffey and Kempe's pioneering work. But even the best service model can only reflect available knowledge; therefore, continuing relevant and creative interdisciplinary research must be supported and strengthened. New generations of highly motivated and well-educated professionals will be available only if we continue and expand educational initiatives in all disciplines. Educational programs that focus on interdisciplinary cooperation will smooth the transition from school to practice.

Those of us who have chosen this "road less travelled" may recall another line by Robert Frost: "But I have promises to keep, and miles to go before I sleep, And miles to go before I sleep." We have come far, but have much further to go to make interdisciplinary team cooperation function to the optimal benefit of children and families.

Robert M. Reece, MD, is Director of the Child Protection Program at Rainbow Babies and Children's Hospital, Case Western Reserve University, Cleveland, Ohio.

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. We hope to see you there!

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FEATURE

AN INTERVIEW WITH AMY OKAMURA

—by Joyce Thomas

Amy Okamura is originally from Honolulu, Hawaii. Ms. Okamura attended the University of Minnesota, where she received a Master's degree in psychiatric social work. She has been a therapist in San Diego since 1971, working primarily with Asians and Pacific Islanders. Ms. Okamura is Network Manager for the Health and Human Resource Center in San Diego, and was Program manager for the Union of Pan Asian Communities for 18 years. Ms. Okamura has written several articles about child abuse in Asian communities, and is author of the book, ***Women in Shadows.***

JT: What are some of the major ethnic groups which are considered to be Asian-Americans?

AO: The U.S. census identifies something like 66 Asian groups. I can't list them all! Major ones include Chinese, Japanese, Filipinos, and Koreans (these four were among the first to arrive), and East Asian, Vietnamese, Laotians, Thai, East Indians, Pakistani, Cambodians, Malaysians, Indonesians, Burmese, and Okinawans. Major groups that are considered Pacific Islanders include Samoans, Hawaiians, Tongans, Guamanians, and Marshall Islanders.

JT: Often, Asian American and Pacific Islanders are viewed as one community within the U.S. and sometimes a distinction is made between the two ethnic groups. Can you explain why?

AO: This question needs to be examined from a historical perspective. Coalitions have been developed between the Asian Americans and Pacific Islanders which often cause them to be viewed as one community. The coalitions are developed in order for these groups to obtain a stronger political base within the United States. This political affiliation has allowed these communities to lobby more effectively for government-supported health and social services. This is evidenced by the earlier development of these coalitions in order to leverage for public funding of mental health services to the Asian community.

Many of these coalitions or political affiliations remain in existence today, and continue to be developed around different social and political issues affecting the Asian and Pacific Islander community. However, the lifespan of these political coalitions is dependent upon how advantageous it is for each of the participating communities to remain aligned and be identified as one community. For example, in San Diego county the Filipinos are such a large group that they decided they wanted the county to pull them out as a separate identifier. The large Filipino representation in and of itself elicit recognition from the political systems within San Diego County. So, Filipinos are not automatically identified as Asians in San Diego County. An individual has the choice of identifying himself/herself as Filipino or Asian.

Within the Asian community, there is tremendous value in children, value in caring for them, value in protecting them, value in teaching them, value in raising them in the right way. But traditional methods of discipline may be pretty severe, strict, or physical.

JT: What are some of the critical issues which bring Asian families into the child protection system?

AO: With respect to the Asian community, I think one of the most critical issues is that we have a larger percentage of foreign born persons in this country than we have ever had before. These individuals have been socialized in a cultural orientation and value system that differs from that of the United States. Therefore, these families bring with them different cultural norms and values.

JT: How do these differences in cultural norms and values impact on parental roles and child rearing practices within the Asian community?

AO: Within the Asian community, there is tremendous value in children, value in caring for them, value in protecting them, value in teaching them, value in raising them in the right way. But traditional methods of discipline may be pretty severe, strict, or physical. Traditionally within the Asian com-

munity it is believed that physical discipline of children is the ultimate responsibility of the parent. Therefore, there is not a well-defined concept of child abuse by parents. In some belief systems, a parent has the right to do anything to the child, even to kill the child, if it is felt that the child deserves it. So, the role of the child within these cultures is definitely different from that of the United States where in this country we have developed laws that protect a child's human rights. So one of the big problems that exists is that children are really not viewed as human beings. Children are not viewed as having feelings or being able to contribute to the family system until they reach a certain age.

Often, when professionals are exposed to these traditional beliefs about child rearing in the Asian community they begin to crack down a little harder because they view these beliefs as terrible. Further language barriers and cultural gaps tend to complicate the interaction between the family and the service provider. For example, there are cases where Filipino women are "penalized" by service providers because the women do not behave in a way that is expected. So I think the difference in cultural perspective regarding the child's role and position in the family may be a reason why we're seeing more Asian families being reported for physical abuse and/or neglect.

JT: What are the critical child protection issues within traditional Asian countries? And are they similar to the issues present in the United States?

AO: First of all, the issue of child protection definitely was never a government or community responsibility within the traditional Asian community because it was assumed that families would take care of their own children.

Also, I think the issue of child abuse and child protection are judged or perceived as a matter of degree within the Asian community. I'm conducting a survey within my agency to determine the individual's perceptions about child abuse. What I've discovered is that most people grew up having never experienced being hurt or witnessed anyone being hurt intentionally by their parents. Overall, it is believed that Asian parents never intentionally hurt their children. However, there are cases of children being hurt because parents believed they were teaching the child to be good. I think that some parents still believe that they must cause children pain in order for them to remember what is being taught.

Another critical child protection issue involves what might be termed medical neglect. Sometimes, parents may be reported for neglect because they refuse to permit their children to have any invasive medical procedures. Also, many folk practices are still being reported as physical abuse. In "Coin and Oil," for example, an ancient Chinese folk remedy, oil is rubbed into various areas of the body using a coin. If strong pressure is used during the process, it causes abrasions and skin discolorations, which are sometimes interpreted as signs of abuse. Another common folk remedy is called "Cupping." The idea is to draw evil essences out through the skin. A candle is lit inside the cup to eliminate the oxygen, then the hot cup is pressed against the skin, often on the forehead, until the area turns dark red. This practice, intended to cure, often leaves noticeable marks that are reported as evidence of child abuse. These are practices we may well want to discourage, but it's inappropriate to handle them as child abuse — hurting the child was the furthest thing from the parent's mind.

We are seeing more cases involving sibling abuse, probably because of the traditional value placed on elder children being given authority to discipline younger siblings in the absence of their parents.

Another thing that is happening is that young runaway teenage girls are being "rescued" by adults within the community, and sexual abuse is occurring because of the naivete on the part of the teenage girls.

JT: As a therapist, what do you feel are some important cultural aspects one should know in order to deliver culturally competent services to the Asian-American child who is a victim of child sexual abuse?

AO: First, the therapist needs to have a basic understanding of the history and culture of Asian Americans. Second, the therapist must determine what specific ethnic group the child belongs to and to what degree the child identifies with that ethnic group. The therapist needs to assess the acculturation level of the child as well as the family members. It is important for the therapist to assess what the family's experiences have been in the U.S. as well as those prior to the family coming to the U.S. For example, was the family subjected to any political persecution while in their country of origin?

Unfortunately, the therapist who is working with the child is not always able to assess the entire family system because he/she may not have immediate access to other family members. Too often, different therapists are assigned to different families members and there is little or no opportunity for dialogue among these professionals. Overall, there are a lot of basic issues that must be examined when dealing with the Asian-American family. The therapist will be at a loss if he/she is unable or unwilling to retrieve background information on the entire family.

JT: How common is the problem of child sexual abuse in the Asian community?

AO: I think that even though child sexual abuse cases are being reported there remains a hidden problem. I have found that the abuse is almost never reported by a family member, but it is often disclosed by someone outside of the family. Most often children will tell their friends or teachers about the sexual abuse. Also, many children are still naive about sexual issues even though there are sexual abuse prevention and education programs in the schools.

The issue of child protection definitely was never a government or community responsibility within the traditional Asian community because it was assumed that families would take care of their own children.

JT: Can you describe the cultural factors that influence the Asian American family's reaction to the sexual abuse?

AO: The disclosure of the sexual abuse causes a great deal of stress in children especially if they are identified as victims or they are removed from the home and separated from family members for any period of time. Many times the reactions of the other family members to the disclosure of the sexual abuse is that of shock and horror. There is a lot of shame involved and therefore a tremendous amount of denial and anger surrounding the incident. There is tremendous shame on the part of the perpetrator especially if he/she is a family member.

Often, the shame turns into anger and frustration which results in the child being blamed for the incident. Then it becomes the child's responsibility to make sure the family is reunited.

As long as the child continues to be placed outside the home there is continued shame in that community because the family is no longer intact. So, the child becomes tremendously isolated. Many times it will be the responsibility of the therapist to uncover these issues because the child will not and can not articulate these feelings or expectations.

JT: How do the cultural values and attitudes within the Asian community toward child rearing practices influence the healing process in situations of intra-familial sexual abuse?

AO: As I have stated before, traditional Asian family values and child rearing practices sanction physical discipline and put a child in a very low power position in the family. Traditionally children are not permitted to express what they feel. Children are expected to sacrifice their feelings or wishes for the family—everything is family

continued on next page

oriented. It's very tough to try to change a family's system in order to create the more positive parenting styles that we would like to develop. For example, we would like parents to recognize that children are human beings and that they have equal rights—that they should be able to express how they feel, especially about the sexual abuse.

I think the family can move towards more positive ways of functioning if the therapist builds on the strengths that are present within Asian American families. For example, there are extended family members who can offer the child an environment that is very similar in culture and value to the child's family of origin. However, in order to guarantee protection of the child in whatever setting, the therapist must obtain, on some level, agreement from parents, siblings and other family members to function in a more positive way. The professional who is working with the family will find that the less acculturated the family is, the harder this might be to achieve.

JT: What are some components of an effective child abuse prevention program for the Asian community that takes into account traditional cultural values?

AO: I think developing an effective child abuse prevention program for the Asian community must be approached in a different way to meet the needs of the community. Child abuse prevention must be taught so that parents don't feel like they are having to give up their parental responsibilities. Often, Asian parents who are attempting to adjust to the U.S. culture react to the child abuse laws by abdicating their parental responsibilities. For example, our agency has observed over the years that the parents give up at an early stage saying, "I cannot even spank my child so how else am I going to be a parent?" or, "The government says we can't be parents the way we know how, so we don't care anymore." As a result, we see teenagers taking over total control of the family, and becoming "terrorists" in their own home. Then we see parents who are totally depressed and ready to commit suicide because they feel they have lost control over their children. And that's what's happening because these parents have abdicated their responsibility as parents. So it is important that the parents learn, at an early stage, alternative ways of disciplining their children in order to keep the parents actively involved and to prevent them from giving up their parental role.

JT: Specifically, how does the therapist address these cultural factors?

AO: First, the therapist must focus on the entire family system. You cannot expect to do the kind of family therapy that you learned in school, where you begin addressing the various parts of the system before you get the whole system together. Of course the child definitely needs to be worked with individually. The non-offending parent needs to be worked with individually and with the child victim as well. The perpetrator also needs to be seeing somebody.

Eventually, once individual members understand child abuse laws, the family work can begin. Acculturative experiences in therapy would focus on the family learning things about themselves, their bodies and their feelings in a way that is culturally appropriate for each particular family. If this acculturative process does not occur, the family work will not progress and the family may revert back to discipline methods that are traditional to their country of origin.

Second, the therapist must also act as a clinical case manager by articulating some things for the family, and educating and encouraging the family through the treatment process. Also, the therapist may need to act as a mediator between the child protective system worker and the client in order to come up with more creative solutions or other ideas for the client. This will allow the family to see the possibility of the family "making it" rather than feeling defeated before they start. Often, community-based providers are most effective. I believe that Asian American and Pacific Islander families who are involved in the Child Protective System deserve access to providers who are supportive and have an understanding of differences in culture and communication styles. In my opinion, these supportive child protective services can be delivered most effectively by community-based providers.

MEET THE LEADERS

DOROTHY HARRIS, LCSW

A member of POCLI's Expert Task Force, Dorothy Harris is currently Project Director of the National Head Start Training Assistance Resource Center (NRC) at Research Assessment Management, Inc. in Silver Spring, Maryland. The NRC provides training and technical assistance services to support the development and implementation of national Head Start program improvement initiatives.

As Project Director, Ms. Harris manages and supervises all tasks performed by the NRC, including publication of the Head Start Bulletin and other reports and manuals, logistical planning for cluster meetings, and provision of training and technical assistance to Head Start programs as requested by the Head Start Bureau. Last August, Ms. Harris managed the logistical arrangements and technical programming aspects for the 1991 Head Start Management Institute, which was attended by approximately 2000 Head Start Directors and Administrators.

Ms. Harris has over 20 years' experience working in health and human service agencies and advocating for quality services for children and families of color. She has been active in promoting strategies, policies and programs that strengthen social work practice with vulnerable children and families. As president of the 140,000-member National Association of Social Workers during 1985-1987, Ms. Harris began an initiative to enhance collaboration and coordination between schools of social work and public human service agencies in order to better prepare social work students for careers in the child welfare field. Ms. Harris was also responsible for developing a partnership between the National Association of Social Workers and the Council on Social Work Education to attract students to careers in the public service arena.

During 1987-1990, Ms. Harris served on the Executive Board of the National Committee for Prevention of Child Abuse, Chicago, Illinois. She is currently participating on the Advisory Committee for the National Resource Center on Child Sexual Abuse, Huntsville, Alabama.

Through her affiliation with POCLI, Ms. Harris continues to demonstrate her commitment to enhancing services to children and families of color within the child abuse and neglect system. As a member of POCLI's Expert Task Force, Ms. Harris has provided assistance in promoting POCLI's goals and objectives, developing POCLI's policy agenda, and formulating recommendations and strategies to improve child welfare service delivery. Ms. Harris is especially committed to encouraging, stimulating and facilitating participation of professionals of color in administrative, policy making and research areas within the field of child abuse and neglect.

Ms. Harris is extremely excited about POCLI's innovative Mentorship Program for professionals of color. She believes that this initiative will support the recognition of the outstanding professionals of color who are available to make a contribution to the field of child abuse and neglect. She is also convinced that this initiative will serve to foster the development of new leadership capabilities among people of color.

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.*

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NEW MEMBERSHIP CATEGORY APPROVED

A new $35 membership has been approved by APSAC's Board of Directors for professionals making *under $25,000 per year.* The new membership includes all benefits except the *Journal of Interpersonal Violence.* The goal is to bring APSAC's critical information within the reach of as many child abuse professionals as possible. *Only people meeting the income requirements are eligible.* For further information, call the office at 312-554-0166

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. Phone: 919-966-1760.

STATE CHAPTER NEWS

State chapters continue to blossom. The Northern New England Professional Society on the Abuse of Children (NNEPSAC) was recognized as a state chapter in March. NNEPSAC unites APSAC members in Vermont, New Hampshire, and Maine. Officers are Ann Bastille, President (NH), Ramona Belanger, Vice President (NH), Sally McIntyre, Treasurer (ME), and Alan Rosenfeld, JD, Secretary (VT).

NNEPSAC, Oklahoma (OPSAC) and Texas (TPSAC) are among the state chapters planning Fall conferences. Washington (WPSAC) has taken off, in one of its early sessions meeting with six of the state's key lawmakers to discuss children's issues. Among WPSAC's committees is the Public /Professional Education and Media Relations committee, which is developing a statewide media plan which will include training for members on working with the media.

The Illinois (IPSAC) and Massachusetts chapters (MAPSAC) have several dynamic committees and task forces as well. One of the most innovative is Massachusetts's working group on child sexual abuse victims who have contracted AIDS as a result of abuse. MAPSAC has received a small grant from the Massachusetts AIDS Action Committee to explore this issue and to develop guidelines for professionals, parents, and victims. MAPSAC would like to hear from APSAC members who are working on this issue. Please call Sue White or Janet Fine at 617-666-2101.

NEW RESEARCH, continued from page 2

Although the act of testifying itself was not found to have a significant effect on children's mental health, as measured before and after the adjudication process, *analyses revealed a significant adverse effect among older children who testified more than once or who experienced lengthy or harsh cross-examination.* At the same time, parental reports for younger children suggest that testifying was far less stressful for them and may, in fact, have been helpful.

In sum, preliminary results suggest that it may not be testifying itself, but the harshness of the testifying experience, that is harmful to children.

Capacity for systematic change

Another component of the study involved working with multidisciplinary teams in the participating communities to identify and implement new policies or practices designed to remedy perceived problems in the response to child sexual abuse cases. Not surprisingly, the four communities employed very different approaches.

In sum, preliminary results suggest that it may not be testifying itself, but the harshness of the testifying experience, that is harmful to children.

To determine whether variations in practice have any impact on children's experience of the adjudication process, the Intervention Stressors Inventory (ISI) was developed. A national, interdisciplinary sample of child abuse experts was asked to assign relative weightings of perceived stress to specific elements of the process (here summarized as interviews, adjudication, testimony, and social services intervention), and moderating factors that may exacerbate or lessen that stress. These expert weights were then applied to parents' and children's self-reports of their actual experiences in the system at the time of the follow-up interview.

Mean ISI stress scores for children who entered the study during its first six months were compared to the scores for children who entered during the latter half of the study period. This comparison revealed significant reductions in the stress associated with the interview and adjudication components of the scale, a non-significant reduction for the testimony component, and no difference for the social services intervention component. This finding suggests that the four communities did, in fact, implement changes in policy or practice meant to alleviate stress during investigative interviews and the adjudication process. Additional analyses will determine whether these observed changes had the intended beneficial effects on the children's psychological well-being.

The Final Report on the Child Victim as Witness Research and Development Program will be available from the Juvenile Justice Clearinghouse at 1-800-638-8736. For more information, please contact Debra Whitcomb, Project Director, Education Development Center, Inc., 55 Chapel St., Newton MA 02160. 617-969-7100 x451. FAX: 617-244-3436.

Debra Whitcomb, Edward De Vos, Theodore P. Cross, and Nancy A. Peeler work at Education Development Center, Inc., in Newton, MA.

Desmond K. Runyan, Wanda M. Hunter, Mark D. Everson, and Carol Q. Porter work at the University of North Carolina at Chapel Hill, Departments of Medicine and Psychology.

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JOURNAL HIGHLIGHTS

—edited by Thomas F. Curran

The purpose of Journal Highlights is to inform Advisor readers of current literature and research on various aspects of child maltreatment. Selected articles from journals representing APSAC's multidisciplinary membership are presented in the form of an annotated bibliography. APSAC members are encouraged to send copies of current articles they believe would benefit Advisor readers to: Thomas F. Curran, MSW, JD, 1405 72nd Avenue, Philadelphia, PA 19126.

PHYSICAL ABUSE, NEGLECT AND EMOTIONAL ABUSE

Ammerman, R.T. (1991). The role of the child in physical abuse: A reappraisal. *Violence and Victims, 6 (2), 87-101.*

This article presents a comprehensive examination of the role played by the child in physical abuse. Particular attention is devoted to the role of handicapping or developmentally disabling conditions in child abuse. Research studies over the past fifteen years that have addressed these questions are reviewed in detail, along with an analysis of the leading theoretical models for explaining child abuse.

Kelley, S.J., Walsh, J.H. and Thompson, K. (1991). Birth outcomes, health problems, and neglect with prenatal exposure to cocaine. *Pediatric Nursing, 17 (2), 130-136.*

This article discusses a study of 30 children exposed prenatally to maternal cocaine use compared to 30 nonexposed children on maternal variables, birth outcomes, health problems and issues related to child maltreatment. The cocaine-exposed infants were much more likely to have mothers who received either inadequate or no prenatal care, to be born prematurely and have more health problems beyond the newborn period. In addition, significantly more cocaine-exposed children were the subject of subsequent child abuse or neglect reports and placed in foster care. Very important policy issues concerning the management of exposed newborns and their cocaine-using mothers are discussed.

Kiser, L.J., Heston, J., Millsap, P.A. and Pruitt, D.B. (1991). Physical and sexual abuse in childhood: Relationship with post-traumatic stress disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 30 (5), 776-783.*

This study describes the clinical symptoms found 89 children and adolescents (with a control group of 74 non-abused children and adolescents) who experienced physical and/or sexual abuse, and examines the relationship between abuse and post-traumatic stress disorder (PTSD). The findings indicated that 55% of the children who experienced abuse developed symptoms characteristic of PTSD, whereas abused children who did not develop such symptoms exhibited more anxiety, depression and externalizing behaviors, such as delinquency and aggression. Significant differences were also found between victims reacting to single event abuse, who displayed more behavior disorders, and victims of on-going abuse, who were more disturbed. Contrary to previous research on PTSD in victims of child sexual abuse, this study found no relationship between many aspects of sexual abuse (e.g., relationship of perpetrator to victim, use of force) and the development of PTSD in victims.

Murphy, J.M., Jellinek, M., Quinn, D., Smith, G., Poitrast, F.G. and Goshko, M. (1991). Substance abuse and serious child maltreatment: Prevalence, risk and outcome in a court sample. *Child Abuse and Neglect, 15 (3), 197-211.*

The prevalence and specific types of substance abuse in a sample of 209 cases of serious physical abuse and neglect brought before the Boston Juvenile Court during a two-year period are examined. Because of its correlational design, the study could not establish a causal relationship between substance abuse and child abuse. Nonetheless, results did reveal that parents who were documented substance abusers were significantly more likely to have been previously charged with child maltreatment, to be considered as presenting risks of danger to their children, to reject court-ordered services, and to have their children permanently removed than were non-substance abusing parents. Very difficult intervention policy questions are also discussed.

SEXUAL ABUSE

Awad, G.A. and Saunders, E.B. (1991). Male adolescent sexual assaulters: Clinical observations. *Journal of Interpersonal Violence, 6(4), 446-460.*

This study examined various characteristics of 49 male adolescent sexual offenders referred to the Toronto Family Court Clinic between 1980 and 1988 for assaulting females their age or older. This sample was compared to 24 male juvenile delinquents matched for social class and age, and 45 child molesters. Most of the adolescent sexual offenders were recidivists with histories of antisocial behaviors which predated or coincided with their sexual offenses, and most came from disturbed families, with a known sexual pathology in 25% of the parents. Finally, although 33% of the adolescent non-sexual offenders reported a history of physical abuse in childhood, only two reported being sexually abused.

Becker, J.V. and Stein, R.M. (1991). Is sexual erotica associated with sexual deviance in adolescent males? *International Journal of Law and Psychiatry, 14 (1/2), 85-95.*

Four factors that can possibly play a role in the commission of a sexual offense by an adolescent male were examined in this study: sexually explicit material, substance abuse, past sexual victimization, and past physical victimization. Study results could not demonstrate a relationship between use of sexually explicit material and number of victims. In fact, the majority of the subjects questioned felt sexually explicit material played no part in the commission of a sexual offense. Alcohol consumption and being physically or sexually abused were related to increased number of victims. Major problems with research on the effects of pornography are discussed.

Faller, K.C., Froning, M.L. and Lipovsky, J. (1991). The parent-child interview: Use in evaluating child allegations of sexual abuse by the parent. *American Journal of Orthopsychiatry, 61 (4), 552-557.*

This article reviews the practice of conjointly interviewing parents who have been named as alleged sexual abuse perpetrators with their victims to determine whether children have actually been abused. A very useful review of the relevant literature is provided, with an analysis of practical and ethical reasons why such interviews should not be conducted.

Kahn, T.J. and Chambers, H.J. (1991). Assessing reoffense risk with juvenile sexual offenders. *Child Welfare, 70 (3), 333-345.*

A retrospective evaluation of case data from a two-year study of 221 juvenile sexual offenders who entered one of ten treatment programs in Washington was conducted to assess reoffense risk. Very few of the variables identified as likely to affect recidivism were found to have a significant relationship to sexual reoffending. Only 14% of the juveniles thought to be "at risk" for reoffending actually recidivated during the follow-up period. Factors suggested for consideration in assessing reoffense risk include a juvenile's previous nonsexual criminal history and any possible nonsexual criminal reoffense risks.

Kendall-Tackett, K.A. and Watson, M.W. (1991). Factors that influence professionals' perceptions of behavioral indicators of child sexual abuse. *Journal of Interpersonal Violence, 6 (3), 385-395.*

Factors that might influence interviewers' perceptions of the convincingness of certain behavioral indicators of child sexual abuse are examined in this study. A sample of 201 professionals was interviewed and, as predicted, those who believed that children do not lie about sexual abuse were more convinced by various behavioral indicators that sexual abuse occurred than were professionals who approached cases neutrally. Contrary to prediction, interview purpose (investigative v. therapeutic) had no effect on professionals' perceptions of indicators. Age of the child, however, significantly affected perception of abuse indicators.

Long, P.J. and Jackson, J.L. (1991). Children sexually abused by multiple perpetrators: Familial risk factors and abuse characteristics. *Journal of Interpersonal Violence, 6 (2), 147-159.*

Utilizing the Family Environmental Scale, this study of 324 college women examined family characteristics and characteristics of the initial abuse experience that might differentiate children abused by a single perpetrator from those victimized by more than one person. Multiple-perpetrator victims characterized their families as displaying less cohesion, less expressiveness and more conflict than did the single-perpetrator victims or the non-victims. Also, certain initial abuse characteristics, such as victim age and family deviance, appeared directly related to characteristics of later victimization. The findings suggest that family dysfunction and initial abuse characteristics may serve as risk factors for multiple victimization.

Ray, K.C., Jackson, J.L. and Townsley, R.M. (1991). Family environments of victims of intrafamilial and extrafamilial child sexual abuse. *Journal of Family Violence, 6 (4), 365-374.*

This study examined the family environments of intrafamilial and extrafamilial child sexual abuse victims to determine whether characteristics of incestuous families that appear to place children at risk for abuse can also be viewed as risk factors for extrafamilial abuse. As predicted, family characteristics associated with intrafamilial abuse were also found to be associated with extrafamilial sexual abuse. These characteristics included a lack of involvement of family members with each other, in terms of emotional support, closeness and activities that generally promote children's healthy growth and development. Families of intrafamilial victims were not found to be significantly less well-functioning than families of extrafamilial victims.

OTHER ISSUES IN CHILD MALTREATMENT

Kahan, B. and Yorker, B.C. (1991). Munchausen Syndrome by Proxy: Clinical review and legal issues, *Behavioral Sciences and the Law, 9, 73-83.*

An overview of Munchausen Syndrome by Proxy is presented, including a discussion of important clinical and diagnostic features, etiology and detection, and legal issues relevant to intervention and treatment. A comprehensive case example is used to illustrate some of the unique characteristics and problems commonly found in Munchausen Syndrome by Proxy cases.

Kelley, S.J. (1991). Methodological issues in child sexual abuse research. *Journal of Pediatric Nursing, 6 (1), 21-29.*

Factors such as measuring a child's response to sexual abuse, sample selection, use of comparison subjects, and ethical considerations are examined in detail. Suggestions are made for strengthening sexual abuse research designs, with a review of several studies that have incorporated these suggestions.

Sivan, A.B. (1991). Preschool child development: Implications for investigation of child abuse allegations. *Child Abuse and Neglect, 15 (4), 485-493.*

This article summarizes those aspects of normal child development research which are particularly significant in evaluating the question of veracity in child abuse allegations by preschoolers. The author's examination of current research on young children's fears, fantasy, and play, as well as research on the influence of television on children of this age, led to the conclusion that preschoolers base their play on the reality of their experiences, not made-up stories or fantasy. Abuse investigators and attorneys should find this article especially useful.

CALL FOR PAPERS

SAN DIEGO CONFERENCE ON RESPONDING TO CHILD MALTREATMENT

January 26–30, 1993

Research papers in the field of child maltreatment are solicited for presentation at the Conference. Original research papers on all issues in this field are welcome, and presentations in the areas of medical assessment and foster care are particularly encouraged. Research may be from any discipline and may have been previously presented, but not previously published. Graduate students are encouraged to submit. Three afternoon sessions have been arranged for presentation of 20 minute papers, followed by a discussion period. Selection of presentations will be made by November 15, 1992. Four hundred word abstracts should be submitted by November 1, 1992 to:

John Landsverk, Ph.D.
Director of Research
Center for Child Protection
Children's Hospital
8001 Frost Street
San Diego, CA 92124
Phone: 691-5670-6950

CLASSIFIEDS

EXECUTIVE DIRECTOR

Lake County Parents Anonymous, Inc., a child abuse prevention organization, seeks highly motivated individual with knowledge and experience in fund raising, direct service, training, program development, and community outreach. Master's degree in social work, psychology, or related field required. Experience directing a non-profit agency important. Must have basic knowledge of child abuse issues and their prevention. Group therapy and facilitation skills as well as excellent communication and presentation skills are necessary. Send resume to Lake County Parents Anonymous, Inc., 641 Lorraine Av., Waukegan, IL 60085. EEOP.

PHYSICIAN CHILD PROTECTION PROGRAM

Children's Hospital and Medical Center, Seattle, WA. The Children's Protection Program at Children's Hospital and Medical Center seeks a half-time pediatrician to participate in the clinical, academic, and organizational activities of the program. This dynamic position offers the physician an opportunity to work with a multidisciplinary team of professionals who coordinate all the child abuse and neglect services at the medical center. These services include medical consultation, participation in review of the most complex cases with the Children's Protection Team, advocacy in the court system and with community groups, teaching, and research. Children's Hospital and Medical Center is affiliated with the University of Washington School of Medicine. Additional time withing the General Pediatric Division of the University of Washington is negotiable. Please send resume to Dr. Ken Feldman, Children's Protection Program, Children's Hospital and Medical Center, PO Box C5371, Seattle, WA 98105.

PEDIATRICIAN, CENTER FOR CHILDREN'S SUPPORT.

The Center for Children's Support at the University of Medicine and Dentistry of New Jersey seeks a Board-eligible or Board-certified pediatrician with experience in the evaluation of sexually and physically abused children to join our expanding regional diagnostic center. Located in the Philadelphia metropolitan area, the Center is the primary provider of forensic medical and mental health services for southern New Jersey. Be part of our multidisciplinary team's development and outreach services. The available position combines patient care, teaching, and clinical research. This position is full-time, with an academic rank commensurate with qualifications. Send resume to Martin A. Finkel, DO, Acting Chair, Associate Professor of Clinical Pediatrics, Department of Pediatrics, University of Medicine and Dentistry of New Jersey, School of Osteopathic Medicine, Ambulatory Health Care Center, Suite 2100, 301 South Central Plaza, Laurel Road, Stratford NY 08084. UMDNJ is an Affirmative Action/Equal Opportunity Employer M/F/H/V.

FORENSIC INTERVIEWER

St. Joseph's Hospital and Medical Center in Phoenix, AZ, seeks clinical/forensic interviewer for established child sexual abuse assessment program. Salary flexible depending on qualifications. Contact Thom Stuart, RN, at 602-285-2076.

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 26 - 30, 1993. ***The San Diego Conference on Responding to Child Maltreatment.*** See display ad, this page.

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

June, 1993. ***First National APSAC Colloquium.*** Chicago

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 7 - 9. ***Drug-Exposed Children: Their Development and Education.*** Orlando, FL. A conference for teachers, school administrators, counselors, and other school personnel. Sponsored by NAPARE. Call 312-329-2512.

September 17- 19. ***Beginner's Training for Interviewers and Examiners: A Clinical Response to Child Sexual Abuse.*** Portland, OR. Sponsored by Emanuel Children's Hospital and Healthcare Center. Call 503-280-4179

September 25 - 26. ***New England Regional Conference of NAPARE.*** Boston area. Call 312-329-2512.

October 1 - 3. ***Bridging the Gap for Children: A Multidisciplinary Conference on Child Abuse.*** Tulsa, OK. Call DeLynn Fudge, 405-271-4477.

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.

December 12 - 15. ***NAPARE National Training Forum on Drugs, Alcohol, Pregnancy, and Parenting.*** Chicago, IL. Call 312-349-2512.

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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.

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