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AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

RESEARCH AND PRACTICE

The Question of Objectivity in the Survivor Therapist

—by Diana M. Elliott

APSAC's *Advisor* recently featured two articles on survivors of child abuse in the helping professions (Courtois, 1992; Sexton, 1992). Sexton noted that mental health professionals who are survivors of childhood abuse often feel compelled to hide their history in order to maintain professional credibility. It is clear that such concerns are well founded, at least in terms of society's current response to abuse and survivors.

In the County of Los Angeles, for example, child evaluators and expert witnesses in the area of childhood sexual abuse have been questioned about their personal abuse history while testifying in the case of an abused minor. There is an assumption that acknowledging such a history will damage the expert's objective credibility and thus hurt the legal case. This can cause significant distress for the would-be witness who is a survivor, and who may fear not only that s/he will hinder the minor's chances for justice, but that s/he may be publicly humiliated in the process.

The appropriateness of what appears to be a violation of the therapist's right to privacy protected by the constitution is a battle that will be fought primarily not by clinicians but by attorneys in the legal arena. While this issue awaits resolution, there are, as of yet, insufficient data available from which to address the court's legitimate concerns that objectivity be maintained in legal matters or to refute attorneys' discrediting questions posed to the clinician while on the witness stand. This silence is somewhat surprising, since sexual abuse researchers are in a unique position to examine issues related to the impact of childhood abuse on professional practice. Perhaps this reticence is motivated by a fear of giving "the other side" information that will make advocacy for children more difficult. Such reluctance, however, will not make the problem go away—instead, the absence of clear data may allow unduly negative or pejorative arguments by opposing counsel to continue unchallenged. Ultimately, we will do better as a profession if *we* examine these issues ourselves, and interpret them in the context of our understanding of clinical practice and practitioners.

As a preliminary step toward obtaining accurate information on therapists, the author examined the abuse histories and psychological symptoms of nearly 3,000 professional women across the United States. This sample included 340 mental health workers and more than 2,500 women from 11 other professions (including attorneys, CPAs, engineers, etc.). In a forthcoming article in *Professional Psychology: Theory and Practice,* Elliott and Guy (in press) report a higher rate of childhood abuse among psychotherapists compared to individuals working in other professions. Compared to non-therapists, mental health professionals reported a significantly higher rate of both

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MEDICINE

Failure to Thrive

—by Randell Alexander

Failure to thrive (FTT) is a life-threatening condition, whose diagnosis generates considerable confusion among professionals. Estimates of its frequency range up to 1% of all pediatric hospitalizations and 10% of children followed in rural outpatient clinics (Mitchell et al., 1980). When FTT is classified as neglect, foster care often is recommended. Yet standards vary, lower socio-economic groups probably are more likely to be reported for this type of child abuse, and community opinions differ as to whether specific cases should be labelled neglect and how they should be treated. How has FTT become such an acceptable and relatively common diagnostic entity given the murkiness surrounding the subject?

History

Feeding and malnutrition problems have always been present for a certain proportion of the population. With very high mortality rates in the 1800's, efforts were directed towards more humane institutional living conditions. Pediatrics developed as a medical discipline around the turn of the century, in large part in response to feeding specialization. Holt described children who "ceased to thrive" in his textbook *Diseases of Infancy and Childhood* (Holt, 1899). By 1933, a later edition referred to "failure to thrive" (Holt and McIntosh, 1933). Henry Dwight Chapin spoke of "atrophic infants" in describing children wasting away in poor home environments (Chapin, 1908). Psychological factors were blamed for both malnutrition and developmental deficits in institutionalized children, in pioneering work by R. A. Spitz (Spitz, 1945). His concept of "hospitalism" included the combination of "anaclitic depression," malnutrition, and growth failure. In effect, he blamed FTT on emotional deprivation, the idea being that one could waste away from lack of love (Stevenson, 1992). The concept of "maternal deprivation syndrome" also arose from this viewpoint. In 1969, strong evidence emerged

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NEWS

First National Colloquium Planning Going Strong; Second Annual APSAC Awards Announced

—by Theresa Reid

Colloquium Plans

Thanks are due to many members who sent in suggestions for programming for APSAC's First National Colloquium. Program Committee members have tried hard to incorporate the suggestions of members as they designed the two-day Colloquium.

As reported in the Spring, 1992, issue of *The Advisor*, the Colloquium will be held June 24-26, 1993, in Chicago. With so many outstanding conferences already offering 1-1/2 or 3-hour sessions, the purpose of APSAC's First National Colloquium is to bring together advanced professionals for intensive, interactive, day-long sessions dedicated to exploring the most difficult issues facing the field.

The first day of the Colloquium will be devoted to six-hour *within*-discipline sessions; the second day to six-hour *cross*-discipline sessions. A list of confirmed sessions and faculty is printed on page 17.

On June 24, time will be scheduled for task force meetings, meetings of state chapter coordinators, and a general membership meeting. Members will be asked for feedback on several important issues, including what sort of conference APSAC should have in the future (the Program Committee has discussed combining a field-generated research colloquium with day-long sessions such as those being offered this first year), whether Chicago should become the colloquium's permanent home, and what goals should receive top priority in APSAC's long-range plan.

June 24 will be especially fruitful as well because the People of Color Leadership Institute (POCLI) will hold meetings and workshops in conjunction with the Colloquium. Professionals on the POCLI Expert Task Force will be invited to sit in on every Colloquium session to offer feedback from different cultural points of view.

APSAC's First National Colloquium should be an exciting three days. Tuition has been tentatively set at $285 for members, $350 for non-members. Please keep your suggestions about the committees' plans coming, so the program reflects your needs and wishes. We look forward to seeing you in Chicago!

APSAC Awards Announced

1993 APSAC Awards recipients have been named by the Awards Committee and the Media Relations Committee.

From the Awards Committee:

1993 Outstanding Professional Award
Lucy Berliner, MSW

1993 Outstanding Service Award
David Corwin, MD

From the Media Relations Committee:

1993 Outstanding Media Coverage Award recipients are Jay Grelen, Valarie Honeycutt, Frank Langfitt, Kevin Nance, David Green, and Harry Merritt of the **Lexington *Herald-Leader*** for their series "Twice Abused," which details the inadequate handling of child sexual abuse cases by Kentucky's criminal justice system.

The Research Committee will announce its awards recipients in November.

Our warmest congratulations to all of these distinguished professionals. We look forward to honoring them at APSAC's Annual Membership Meeting, to be held at the Hyatt Regency La Jolla on Wednesday, January 27, 1993, in conjunction with the San Diego Conference on Responding to Child Maltreatment (see display ad, page 23).

APSAC T-shirt and mugs available!

For the first time in APSAC's history, we are making it possible for members to blazon their support for APSAC across their chests, and wave it around the office on coffee mugs. T-Shirts and mugs are available immediately from APSAC's office. See page 18 for ordering information.

Thanks again . . .

So many members call and offer to take brochures to their professional meetings, it would be impossible to name them all. Thanks in large part to their efforts, this year APSAC is matching last year's remarkable net growth rate of 41%. Thank you to all who have helped. If you know of professional meetings where APSAC should have a presence, please let us know. Word of mouth is the best advertising of all.

Member Input Requested on Offender Treatment Statement Approved by Board

This summer, a story broke in the national media about a hospital in Arizona that has used penile plethysmography and olfactory aversive conditioning with pre-adolescent sexual offenders and sexually reactive children. In response to the heated controversy that resulted, the Association for the Treatment of Sexual Abusers (ATSA) released the following statement:

The Association for the Treatment of Sexual Abusers does not endorse the use of plethysmography or olfactory aversive conditioning with pre-pubescent children who have engaged in sexually abusive behaviors. No scientific basis exists for the use of these procedures with pre-pubescent children. Any use of these procedures with pre-pubescent children must be considered experimental and, therefore, subjected to scrutiny by institutional review boards or other professional review groups which serve to ensure that the safety and rights of experimental subjects or clients are protected fully.

ATSA asked APSAC to lend its weight to the statement by endorsing it, and at its August 29, 1992, meeting, APSAC's Executive Committee agreed to do so. APSAC policy requires that members have an opportunity to comment on any statement before it is officially approved by the organization.

If you are concerned about APSAC's endorsing ATSA's statement as written, please write to APSAC by January 1, 1993 (write "ATSA Statement" on your envelope). Unless strong opposition is voiced, APSAC will officially endorse the ATSA statement in January.

PRACTICE

The Victim Sensitive Interviewing Program: Outline and Data

—by Mary Martone and Paula Jaudes

Child sexual abuse in the United States is a problem of overwhelming proportions. At least 250,000 new cases of sexual abuse of children are reported each year. Anywhere from one in ten to one in three children will have experienced at least one episode of sexual abuse before age 18 (Russell, 1983). The dramatic number of child sexual abuse reports has raised crucial questions about how to conduct investigations of the reported cases:

* Who should be involved in the investigation and at what point?

* Who should conduct the interview of the child?

* Should there be a medical exam?

The following paper is a description of a project, The Victim Sensitive Interviewing Program (VSIP), started in 1986 at La Rabida Children's Hospital and Research Center, to minimize multiple interviewing of alleged child sexual abuse victims. The paper begins with a study that we conducted evaluating the efficacy of this model when compared to child sexual abuse cases not investigated using this model. Next is a description of the project and an overview of our expert interviewing protocol.

Most investigations of alleged sexual abuse cases involve an array of professionals, all with their own focused interest on what they need to know from the child. These professionals include at a minimum: state child protective workers, police (detective, youth, and/or patrol), nurses, doctors, social workers, and state's attorneys representing both criminal and juvenile courts. Moreover, some investigations result in several professionals from the same field talking with the child. It is not uncommon for the child to go through 5 to 10 interviews in the investigative phase alone, with further interactions during the prosecution phase. Often with no coordination or communication among any of the investigative agencies, inconsistencies occur among the professionals' accounts of the alleged incident so that confused, often disbelieving parents, and traumatized children, result from an investigative system designed to protect the victims.

Like child advocacy centers across the country, VSIP is designed to improve coordination among professionals and decrease the number of interviews the child has to endure. It has three main components: interagency coordination, expert interviewing and medical examinations of victims, and case follow-up after the forensic investigation. An interagency agreement between the police, state child protective agency, and state's attorney's office establishes a protocol of one investigative interview conducted by an expert interviewer and observed through a one-way mirror by professionals from the police, state's attorney's office, and child protection system.

As pointed out by Reece (Reece, 1992), while it is obvious to most professionals in the field that the team approach has clear benefits, we have very little empirical outcome data to back up those observations. We decided to test these observations against recorded fact.

After the VSIP program was in operation for two years, we conducted a study to assess the program's efficacy. A retrospective chart review was performed on all children seen in the VSIP program between June 1986 and June 1988. Retrospective chart reviews were then conducted on all children seen at La Rabida for evaluation of sexual abuse prior to VSIP (1984 - 1986) to ascertain if VSIP was minimizing the number of interviews and interviewers. We then looked at the results of police investigations of child sexual abuse in another area of the city of Chicago without a multidisciplinary model (Police area V) during the same time period as VSIP to determine if the outcomes of the investigations were the same.

In comparing pre-VSIP cases at La Rabida to VSIP cases, significant differences were found in the number of interviews and interviewers. Fifty percent of the children pre-VSIP were interviewed three or more times, while almost 80% of the children in VSIP received only one investigatory interview ($p<.001$). In addition, significantly more children in pre-VSIP were interviewed by two or more professionals, while those in VSIP had only one interviewer.

Outcomes of the alleged sexual abuse cases were compared between the two groups. The VSIP cases when compared with pre-VSIP cases showed significant increases in (1) identification of perpetrator (71% of pre-VSIP cases and 85% of VSIP cases, $p<.035$); (2) charges pressed if identification of the perpetrator occurred (33% of pre-VSIP cases and 60% of VSIP cases, $p< .01$); and (3) indicated cases of sexual abuse by the state child welfare agency (68% of pre-VSIP cases and 88% of VSIP cases, $p<.006$).

We compared investigative outcomes between VSIP and alleged sexually abused children whose cases were investigated by Chicago Police Department on the Northwest side of the city (Area V). VSIP identified more perpetrators and had more indicated cases of sexual abuse by the state child welfare agency than Police Area V.

In conclusion, the VSIP model did significantly decrease the number of interviews and interviewers the child had to face during the course of a child sexual abuse investigation. In addition, the VSIP model increased the likelihood of identification of the perpetrator and the indicated cases by the state child protective agency.

VSIP Program Description

Background

Because child sexual abuse cases are so complex, coordination of mandated investigators (child protection, police, medical, and prosecution) is critical. Often there are no physical findings, or the physi-

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cal findings (e.g., hymenal tear) can only be seen by the physician and not by the other investigators. Investigators used to seeing concrete evidence must depend on the physician's assessment for critical information on physical findings. In addition, in child sexual abuse cases there are rarely eye witnesses or other forms of corroboration (torn clothes, scratches, semen in underwear, etc.) The investigator, accustomed to requiring corroborative evidence, must often rely completely upon the word of the child in order to complete an investigation. Investigative interviews with children call for communication skills not in most investigators' arsenals. These factors—the lack of physical evidence, the lack of corroborative evidence, and the special demands of child interviews—mark child sexual abuse investigations for most investigators as difficult, if not impossible, from the start. To provide the best possible environment for forensic evidence to be collected, interagency coordination and planning is crucial.

A single collaborative forensic investigation is an effective way to prevent "system abuse" of the child and an efficient way to communicate important details and get professionals working together. This process encourages cooperation, prevents early denial of the abuse by the family members, and is reassuring for children and their parents (non-offending).

Interagency Coordination

The first step in developing the VSIP program was to create a Task Force made up of all of the professionals (police, state's attorney, state child protection, medical, and psychosocial) involved in the investigation of child sexual abuse allegations. Establishing rapport, understanding, and respect for each professional's role was critical as a foundation for interagency coordination.

The second step was agreeing on a protocol for notification and referral of the cases. The protocol was a simple and concise document that spelled out the goal of one forensic interview, established criteria for referrals, and listed the procedures for notification. Each agency represented had a clearly identified role in the interagency agreement.

Once the interagency protocol was established and each agency representative had obtained a letter of support from his or her agency, an interview protocol was established that incorporated all of the questions from each agency that needed to be answered in the course of the expert forensic interview. The protocol was modified to accommodate the needs of children at different developmental levels. When the letters of support were received and the interview protocol approved, the VSIP program began accepting referrals.

Referral Procedure

Any child between the ages of three and 13 can be referred to VSIP if there is an allegation of child sexual abuse reported to the Illinois Department of Children and Family Services hot line. The age parameter of three was selected because that is generally the youngest age at which a child can verbalize information in a manner that can be used for forensic purposes. The age of 13 was selected because the Illinois Criminal code guidelines specify that sex crimes against children under 13 can be considered a felony (therefore the presence of an assistant state's attorney is necessary at each interview).

Cases can be referred by the police, child protection, hospitals, parents, schools etc., but in general they are referred by the police officer making an initial contact on the case. Detailed case information is taken from the referring officer by the hospital social worker on call for the VSIP, and a tentative interview time is established. Risk is also assessed by the officer. If the child is felt to be at risk, an inpatient hospital admission can be considered. The VSIP social worker is responsible for contacting the other mandated professionals to confirm the interview time.

Forensic interviewing and medical examination

The VSIP philosophy is to hold one expert medical examination and conduct one in depth forensic interview of the child victim. Every effort is made to perform the medical examination prior to the forensic interview so that as much information as possible is available to the interviewer.

The medical examination is performed by a trained pediatrician who follows an established protocol consisting of a general physical examination and then a genital examination. Appropriate laboratory tests and cultures are conducted as indicated. If the sexual incident occurred within 72 hours, forensic specimens are obtained. The results of the physical and genital examination are documented according to protocol. A diagnosis of sexual abuse is generally given only in conjunction with the information gathered during the forensic interview.

The goal of the forensic interview is to gather all of the relevant information needed to complete DCFS, police, and state's attorney's investigations. Identification of a crime, a perpetrator, a victim, a place where the crime occurred, and a time of occurrence are critical. When the child gives information related to any of these areas, the interviewer asks simple clarifying questions to elicit as much detail as possible. What is different about these interviews from more clinically focused interviews is that the goal of the questioning is completion of an investigation rather than assessment of psychological functioning or trauma.

Many of the children interviewed in the La Rabida VSIP program are very young (average age is 7.5 years). For this reason developmental consid-

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erations are essential for our forensic interviewing program. Our environment immediately lets children know that the room is a space meant for children. We use child sized furniture, a small room, and always have available items familiar to children such as crayons, paper, markers, telephone and stuffed toys.

A very simple orientation to the room and program is given to the child before the child is actually brought to the room for the start of the interview. The child's parent is asked to sit in a waiting area near the interview room so the child knows the parent is nearby and available.

As pointed out by Reece, while it is obvious to most professionals in the field that the team approach has clear benefits, we have very little empirical outcome data to back up those observations. We decided to test these observations against recorded fact.

With very young children (under 6) the timing and the length of the interview are very important. The interview should be at a time when the child is not tired or hungry and the length should not exceed the child's attention span (perhaps 20 minutes for 3-year-old and somewhat longer for older children). The interviewer must prepare to talk with the child in a way that is not confusing or overwhelming. Compound questions and statements are avoided. Questions that expect a child to abstract a concept (i.e., "Do you like to eat?" versus, "Do you like hot dogs?") are also avoided. Questions must be simple, with one thought or concept. The techniques that are used in this style of interviewing are not leading, and are designed to communicate with the child in a way that brings about spontaneous statements.

Making the transition from the beginning of the interview, which generally deals with descriptions about home, school, family etc., to questions about an alleged incident of sexual abuse is very important. An example of a transition question that is commonly asked is, "Could you tell me why you are here today?" If the child responds with a statement about an abusive incident, the interviewer assists the child in re-creating the experience in the interview situation. The interviewer uses simple questioning to elicit details about the incident. Contextual details, such as what it felt like, looked like, etc., are very important. The interviewer is always careful to follow the child's lead rather than suggest a response.

The VSIP cases when compared with pre-VSIP cases showed significant increases in (1) identification of perpetrator, (2) charges pressed if identification of the perpetrator occurred, and (3) indicated cases of sexual abuse by the state child welfare agency .

After the interviewer talks with the child and gathers as much information as possible, he/she generally takes a break to confer with the other professionals behind the one-way mirror. Any additional questions are then asked prior to concluding the interview. When ending, the interviewer often ascertains what the child thinks or would like to have happen next. This is also is an opportunity for the child to ask questions of the interviewer. If appropriate, the interviewer may give the child some corrective information such as, "What happened to you is against the law," or "Adults are not supposed to do that." The child is given information about whom to contact if he or she wishes to talk further about what happened. At this point the interview is ended with a statement to the child about what may happen next, e.g., "Now you can play while the grown ups talk about this problem." Promises that may not be kept—that the perpetrator will go to jail, or the child will never have to relate this information again—are never made.

The multidisciplinary team then meets to discuss the case. After there is a consensus about the case thus far and a plan for what to do next, a conference with the parent is initiated. When the police and state's attorney complete their discussion with the parent regarding prosecution stages and requirements, planning and intervention for the victim and/or parent ensues. Generally, the hospital social worker and the child protection worker meet with the parent to discuss immediate concerns such as housing, safety, questions from family members, and communication and/or contact with the perpetrator. Many families request and receive immediate treatment, while other families, where cases may be unfounded, do not request services and the case is closed.

Conclusion

The VSIP program is similar to many coordinated investigation efforts across the country. As Dr. Reece stated in his earlier article, we all believe coordinated team efforts are much better for children. The data we have generated about the relative efficacy of the VSIP program supports such intuitive knowledge. When the VSIP protocol was used, children were subjected to fewer interviews and interviewers, more perpetrators were identified, more charges were pressed, and more cases were indicated. Such data are satisfying insofar as they verify what we thought we knew, and crucial in the search for continued program funding. We urge others to seek to verify their own observations, and in so doing help build the empirical knowledge base Dr. Reece rightly calls for.

References

Russell, D.E. (1983). The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children, *Child Abuse & Neglect, 7*, p.133-146.

Reece, R.M. (1992). Interdisciplinary Teams: Do they help victims of child abuse, *The Advisor, 5*, 2, p.15.

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LAW

Pre-Trial Preparation: At the Prosecutor's Desk

—by Sue Marx

The key to winning most cases is good preparation. The following tasks will help you organize your trial file and focus on the issue and potential problems in your case.

1. Review of Statements.

Read any pre-trial statements or testimony given by the victim and witnesses to be called at trial. Chart the testimony, looking for inconsistencies, cross-corroboration, and impeachment material. Some prosecutors make skeletal outlines of prior statements with page notations for easy reference. Others use plastic tabs to signal crucial portions. Whatever system you develop, make sure the content of prior statements is easily accessible during trial.

2. Period of Abuse.

Make a chart for yourself of the victim's ages, school grades, or other identifying factors (prior addresses, prior teachers) during which the abuse occurred. This will help you to present that information clearly to the jury.

3. Applicable Case Law.

Try to predict the legal issues that may arise during the trial and gather all the case law you need. If you have time, prepare written memoranda of law regarding the issues most crucial to your case. Consider presenting the memoranda to the court and the defense attorney prior to trial. The judge will appreciate your preparedness and fairness. If the issues are particularly complicated, consider filing motions *in limine* well in advance of trial. Pre-trial resolution of some issues will avoid delay during the trial. If you are unable to locate case law in your state, the National Center for Prosecution of Child Abuse will be happy to do legal research on any issue in your case.

4. Notice to Defense.

Do a last check to ensure you have given all required notices to the defense: notice of any charges for which you will seek mandatory minimum prison sentences, notice of experts to be presented, notice of intent to proceed under any statutes allowing the use of hearsay evidence, notice of intent to present prior bad acts of defendant in your case-in-chief, notice of any physical evidence to be presented, etc. Obviously, notice requirements will differ greatly from state to state; check your jurisdiction's statutes.

5. Subpoenas.

Make sure that you have subpoenaed all necessary witnesses and all documentary material that you will need at trial. Include here a subpoena *duces tecum* for the files of any prior convictions of the defendant for possible impeachment use.

6. Work Records of the Defendant.

Get the defendant's work records. These can be surprisingly useful. If the defendant testifies and presents an alibi defense by claiming he was always at work and therefore could not have abused the victim at home, impeachment becomes easy when his work records show numerous instances of vacation and sick time. Also, work records can lead you to "bad character" witnesses from the defendant's workplace—witnesses who can then rebut the defendant's good character witnesses at trial.

7. Discovery.

Make sure discovery is complete. The last thing you want is the granting of a continuance due to the prosecutor's failure to provide all the documentation to the defense.

8. Witness List.

Organize your case-in-chief. This may include jotting down a list (that is subject to change) of your witness line-up. Some prosecutors write brief outlines of what areas they will cover with each witness so that, during the heat of trial, they will not miss covering an important issue with a witness. Your list should include the schedules of the witnesses who are fitting their testimony into a day of other duties, including any medical, social service, or police witnesses. Having schedules and phone numbers in a central place will allow you to juggle their appearances with more ease.

9. Elements of the Offenses.

Read the definitions of the charges in your case. You may want to make a concise list of the elements of each crime and the evidence you will use to prove each element.

10. Cross-Examination Checklists.

Before trial is also a good time to outline areas that you want to cover on cross-examination of defense witnesses and the defendant. It is important that you don't forget to cover certain basic areas, particularly those small details which the victim mentions that can then be corroborated by the defense witnesses.

11. Closing Argument Outline.

As you investigate the case and long before you enter the courtroom, it is a good idea to form your closing argument. Some prosecutors write the argument, some outline, and some merely jot down thoughts. Whatever your style, you should have the points you will be making in your closing argument firmly in mind as you begin the trial. This will help you identify strengths and weaknesses in your case before you begin and formulate appropriate *voir dire* questions and your opening statement.

12. Defendant's Statements.

Make sure that defense counsel has written notice of each statement of the defendant. At first assessment, you may not feel those statements will be important at trial. Often, as the trial develops and particularly if the defendant takes the stand, seemingly inconsequential statements made pre-trial become excellent impeachment material. For example,

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the defendant says at trial that the victim fabricated the abuse because she hates him; pre-trial, however, the defendant told the child protective services worker that he and the victim had a wonderful relationship. That pre-trial statement then may be used to impeach the defendant at trial. If the defendant gave a multitude of statements, consider indexing them as you did the victim's statements.

13. Investigation of Defense Witnesses.

Depending upon your state's discovery statutes, you may have notice from the defense of potential experts, eyewitnesses, or alibi witnesses. Make sure that you investigate these witnesses. In some situations, you may want to have a detective take a statement from the defense witness. Should the witness then change his story at trial, your detective will be available to take the stand and testify concerning the prior inconsistent statement of that witness. Check with the Center to see if they have a file on the expert(s).

14. Preparation of Prosecution Witnesses.

Make sure that you have prepared all of your witnesses for trial. Often in a child abuse trial, prosecutors are caught up in preparing the victim for court and unwittingly forget that their other witnesses may need preparation and reassurance as well. This is particularly true for doctors and social service personnel who often have never testified in a criminal trial. Go through their direct testimony and possible cross-examination questions. Review any documents that may be presented or used by the defense at trial.

15. Inspection of Physical Evidence.

Before trial, look at any physical evidence taken by the police or any other investigators. If your paperwork indicates that the police confiscated the victim's diary, for example, make sure you have read it prior to trial. You need to know both helpful and damaging material contained in potential exhibits before you get to the courtroom. Of course, defense counsel must be given the opportunity to review physical evidence as well.

16. Demonstrative Evidence.

Create charts, graphs, or visual exhibits as needed. Such exhibits can illustrate simply something that is difficult to describe. In a complicated multi-victim multi-defendant case, a chart can be particularly useful in helping a jury follow your closing argument.

17. List of Exhibits.

List all of the exhibits you plan to introduce at trial. Jot down any objections you anticipate to their admission and your responses to those objections.

18. Scientific Testing.

If there are bodily fluids (semen, blood, etc.) found on the victim's clothing, bed sheets or other relevant location, make sure to have the appropriate laboratory tests ordered, results in your file, results forwarded to defense counsel, and your expert lined up to testify concerning the meaning of the test results.

19. Victim-Witness Support.

Well in advance of trial, contact the person or people who will be the victim's support at trial. You do not want to get to the day of trial and find that you have no one available to be with the victim during her testimony. Should your jurisdiction lack a victim advocate assigned to accompany the victim, evaluate which family members or friends will have a calming and nurturing influence on the victim and not be subject to a sequestration order.

20. Therapy Referral.

Double check to make sure that the victim is in therapy. Depending upon the child, the interruption of supportive counselling can be devastating to her ability to testify, particularly if she is not getting support at home.

21. Record Checks.

Be aware of any prior arrests and convictions of the defendant and each witness. Also find out pre-trial if any of your witnesses is on probation or parole. Subpoena the court files and obtain the prosecuting attorney's files for any of your witnesses' prior arrests and convictions. You will need to prepare the witness should you decide to bring out a prior conviction during your direct examination or should the defense cross-examine about it. Results of record checks should be disclosed to the defense.

22. Investigate Other Victims.

You may become aware, pre-trial, that the defendant has abused other children than your victim. Make sure you locate them, interview them, and file appropriate motions to consolidate their testimony at trial.

23. Defendant's Other Bad Acts.

During your trial preparation, carefully note any harassment or threats made by the defendant to the victim or her family. After ensuring the safety of the family by a motion to revoke bail or through a new arrest on intimidation of witness charges, notify the defense of your intention, when permissible under the case law, to present evidence of the threatening behavior in your case-in-chief.

24. Photograph of Victim.

Ask the victim's family for a picture of the victim showing her appearance at the time of the abuse. The picture will allow the jury to see how much younger the victim was then, if there has been a long delay between the time of the abuse and trial.

25. Prior Record of the Defendant.

When you find the defendant has prior arrests or convictions, get as much information as you can about them. This includes obtaining files of the prosecutor who handled prior cases and the court files of convic-

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Law

–Sue Marx

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tions. Should the defendant have an out-of-state conviction, particularly for child abuse, call the prosecutor's office to find out about the case. Make sure to get a certified copy of the conviction. Investigation of this kind can uncover other bad acts (which you may then argue to present at trial), bad character witnesses (should the defendant be foolish enough to present good character), and may well induce a plea.

26. Family Court Records/Transcripts.

If your criminal case is intertwined with a custody matter that is being litigated in Family Court, obtain the records and court transcripts. You may need those materials to combat the "mom-made-it-up-to-get-custody" defense. Check for any existing restraining orders issued by the Family Court judge that were violated by the defendant when he gained access to the victim.

27. List of Pre-Trial Motions.

Make a checklist of any pre-trial motions you need to present to the court. The list may include motions to amend the dates contained in the charging documents, Rape Shield motions, etc.

28. Plea Offer.

As you prepare you case, consider whether plea negotiations are appropriate. If so, formulate an offer. Whether you or the defense attorney initiates plea negotiations, it is important to know what type of sentence you seek if plea negotiations begin.

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THANK YOU!

Sharon Ahart, MD, and **Howard Levy, MD,** who run the Pediatric Ecology Program at Chicago's Grant Hospital, donated $1,000 to make APSAC's International Networking and Social Hour possible. Held on August 31 at the Hyatt Regency in Chicago during the Ninth International Congress on Child Abuse and Neglect, APSAC's International Social Hour was a great success. Several hundred people from all over the world came and enjoyed a sumptuous array of cheeses, fruit, and crackers, while they compared notes about the trials and satisfactions of work in this field. **Richard Adie,** General Manager of the Hyatt Regency Chicago, ensured the success of the evening by underwriting half the cost of the food. Many thanks to Drs. Ahart and Levy, and to Mr. Adie, for their generous contributions to APSAC.

Thanks also to all of the APSAC volunteers who staffed the continuing education table and APSAC's booth at the Ninth International Congress in Chicago. **Susan Liuzzo** and **Greg Dezulskis** in particular gave time and cheer well beyond the call of duty. Also indispensable were Spanish-speakers **Sylvia Balderas, Carmen Calderone, Nilda Claudio, Yolanda Fuentes, Maria Nanos, Enrique Perez,** and **Daliah Ramirez,** and other volunteers **Karen Brown, Richard Cozzola Kathe Dempster, Mike Dolan, Jennifer Hayes, Cindy Hickman, Lisa Keyes, Ann Koranda, Jennifer Lea, Jolene McCann, Dawn McLaughlin, Julie McLean, Willie Moore, Laura Notson, Tom Ryan, Lee Shell, Linda Singleton, Abigail Sivan, Judy Sommers, Lisa Stone, Ernestine Watts,** and **Jeanne Wren.**

Research

–Diana M. Elliott

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sexual abuse (42.8% compared to 31.0%) and physical abuse (13.8% compared to 5.9%). Other types of childhood trauma or loss, including death of a parent, death of a sibling, parental alcoholism, and mental illness of a parent were also higher for therapists than for individuals working in other professions. Additionally, therapists were more likely to experience more than one of the aforementioned traumas or losses in their childhood than were non-therapists. Finally, therapists reported more dysfunctional dynamics in their family of origin than did women from other professions.

The finding that therapists experience a higher rate of child abuse than non-therapists raises the specter of the wounded healer whose needs may be as salient as those of the client.

The finding that therapists experience a higher rate of child abuse than non-therapists raises the specter of the wounded healer whose needs may be as salient as those of the client. However, as noted in Elliott and Guy (in press), the data do not support such an image. Despite the higher rate of abuse, therapists reported fewer symptoms of psychological distress on the Trauma Symptom Checklist-40 (TSC-40; Briere and Runtz, 1989) than did women in other professions. Further, therapists reported less disruption in their interpersonal relationships compared to non-therapists.

Additional analyses focusing specifically on survivor therapists—not reported in the aforementioned paper—suggest that survivor therapists have fewer interpersonal difficulties than either abused or nonabused non-therapists and that they have equivalent levels of psychological distress. On the other hand, this relative advantage did not pertain when survivor therapists were compared to nonabused therapists. Mental health professionals with no reported history of abuse recounted fewer interpersonal difficulties and fewer psychological symptoms than did their survivor cohorts. Finally, survivor therapists were more likely to have received psychotherapy as an adult (83%) than were nonabused therapists (71%), survivor non-therapists (52%) and nonabuse non-therapists (37%).

Despite the higher rate of abuse, therapists reported fewer symptoms of psychological distress on the Trauma Symptom Checklist-40 than did women in other professions. Further, therapists reported less disruption in their interpersonal relationships compared to non-therapists.

There are obvious limitations to these data. For example, the sample is comprised entirely of women. Additionally, the therapist subsample was composed primarily of LCSWs (63%), with psychologists, psychiatrists, and psychiatric nurse practitioners with a certification to provide individual psychotherapy comprising the remainder of the sample (37%). Thus, these data should be considered preliminary and used as a starting point from which other researchers generate and examine appropriate empirical questions.

Given the limitations, however, these data have important implications. First, the good news: As a group, survivor therapists report healthier interpersonal relationships than either survivor non-therapists or nonabused non-therapists. Their symptomatology on the TSC-40 (including anxiety, depression, dissociation, post sexual abuse trauma, sexual problems, and sleep disturbance) is essentially equivalent with the symptom picture of survivors in other professions, despite a greater likelihood among survivor therapists to have experienced multiple traumas and loss. Thus, for instance, the survivor therapist testifying before a challenging attorney has a lower probability of interpersonal difficulties than the attorney facing her (regardless of the attorney's abuse history), and approximately the same likelihood of abuse-related psychological distress.

The "bad" news is that therapists are, indeed, more likely than other professionals to have been abused as children. Finding a higher rate of abuse among therapists may be disconcerting for some people, particularly if there is a vested interest in maintaining an idyllic image of the therapist's childhood.

Given the above, an interesting question arises: Why are mental health professionals more likely to have an abuse history than non-therapists? Two hypotheses were examined in Elliott and Guy (in press). First, therapists may be better able to label their maltreatment as abuse than non-therapists. Thus, the data may reflect, not a higher incidence of abuse among therapists, but rather, a better reporting rate of the abuse by individuals in the helping professions. This hypothesis was not supported by the data, however. Given behavioral definitions of sexual abuse, therapists were no better at labeling that which is sexually abusive than were non-therapists.

A second hypothesis examined by Elliott and Guy (in press) suggests that abuse survivors are drawn to the mental health profession not because of their experience as victims, but because of their experience in treatment. Thus, the strength of the relationship between child abuse and professional choice may actually be a function of having been in treatment and not uniquely related to the individual's profession. The finding that 83% of the survivor therapists had sought treatment as adults seems to lend credence to this hypothesis. However, as with the first, this hypothesis was not supported by the data. The strength of the relationship between child abuse and professional choice remained highly significant when statistically controlling for the impact of a treatment history.

A third hypothesis, offered by some in the addictions field, is that the therapist's abuse history leads him or her to be "co-dependent" and, as a result, to become a psychotherapist—presumably for the con-

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tact with psychologically disabled individuals. Although this question is not easily addressed, especially given the problems associated with the concept of co-dependence (Briere, 1992), there is another possibility that is worthy of equal consideration: By virtue of their direct experience with family violence and psychological distress early in life, the therapist-to-be may have been made aware of the reality of suffering and trauma in the world, and thus may have developed a mission early in life to help others similarly afflicted. Supporting this hypothesis is an equivalent finding reported among medical professionals: as children, they were more likely to have had physically ill members of their immediate family than nonmedical personnel, perhaps causing them to be more aware of physical suffering and, thus, influencing their decision to enter the medical profession.

To the extent that this sample is a true representation of the mental health field in general, it would suggest that therapists who are survivors of child abuse are a substantial subset rather than a small minority within the mental health profession, with approximately 46% of this sample experiencing physical and/or sexual abuse prior to the age of 16. Survivor therapists as a group experience more psychological pain than do nonabused therapists. This is not a particularly surprising finding. It would have been the anticipated finding if the comparison being considered were abused versus nonabused non-therapists. Successful treatment of a survivor does not equate to the elimination of psychological pain.

The survivor therapist testifying before a challenging attorney has a lower probability of interpersonal difficulties than the attorney facing her (regardless of the attorney's abuse history), and approximately the same likelihood of abuse-related psychological distress.

As a clinician, I have heard clients who were reaching the end of their treatment report a heightened awareness of that which is painful and/or unjust in everyday life. This awareness, while causing some internal pain, also resulted in these particular survivors feeling more alive (or "awake" as one survivor phrased her experience). These same survivors also reported an increased ability to experience delight in the very simple pleasures of life. Thus, at least part of what is accomplished in treatment is not the surcease of pain, but an incorporation of the experience of joy while acknowledging the depth of pain that life has held for many survivors.

When the issue of a clinician's abuse history is raised in the legal arena, there is the implication that a history of child abuse and the experience of abuse-related symptomatology equate to a lack of objectivity. This is, however, an issue that is most appropriately addressed through empiricism rather than intuition. The data reported in Elliott and Guy (in press) neither support nor refute this assumption; they suggest only that survivor therapists, like others abused as children, suffer post-abuse effects. The assumption that psychic pain experienced by therapists has an adverse impact on their ability to provide treatment relatively free from countertransferencial issues has yet to be tested. It may be that survivor therapists who endure greater emotional pain (based on their personal experience of that which is truly tragic), but who are able to contain and use their pain are at least as capable as the non-survivor therapists of understanding the client's pain in a therapeutically helpful manner.

One final implication of these data is a compassionate one, although it may appear stigmatizing to some: The fact that some therapists suffer significant abuse-related distress suggests that the child abuse field should provide active outreach for therapists who are especially affected by their abuse history. The field should be cognizant that not all therapists may be able to provide optimal psychological services to their clients, at least prior to their own successful psychotherapy. Whether such therapists are particularly affected in working with other abuse survivors is unknown at present, since the Elliott and Guy study neither directly studied therapists in the child abuse field, nor evaluated the clinical skills of therapists as they relate to different client populations. As was noted by Courtois (1992), the survivor therapist's decision of whether or not to provide direct services to others is ultimately based on both personal and professional ethics—the same criteria by which nonabused therapists assess their capacity to provide services.

It seems clear, and is reasonable, that survivor therapists have some unique needs that are important for the therapeutic community to address. There are, however, no empirical data to substantiate the assumption that a child abuse history significantly impairs a clinician's ability to make objective evaluations of others. Indeed, being a survivor may equip a therapist to be especially helpful and insightful in certain clinical circumstances. Thus, assumptions related to the potential bias of the survivor therapist should be critically examined through further research on and by professionals in the child abuse field.

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Medicine

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that emotionally deprived children actually consumed or were offered fewer calories than needed, indicating a physical basis for growth failures (Whitten, Pettit, and Fischhoff, 1969). As a consequence of the debate between physical and psychological causes for FTT, a distinction was made about organic and non-organic FTT. As discussed below, this distinction has gained wide currency even as it has become obsolete.

Definition

There is no commonly accepted definition of FTT. In part, this is because FTT is a symptom resulting from many causes and not a condition in itself. Operational definitions have included (1) any child below the third percentile for weight when plotted on a standard growth chart, (2) any child whose weight when corrected for height is below the third percentile, and/or (3) any child whose weight curve crosses two or more major "percentiles" on the standard growth curves. None of these definitions prove satisfactory in practice. For example, an infant about 9 months of age usually begins some self-feeding. It is not uncommon to find a child who tracked along the 75th percentile for weight up to that time drop to the 25th percentile over the next 4 - 6 months. If the parent was "overfeeding" at the earlier age because the child was crying and it seemed to help, a pattern of relative "growth failure" now that the child is in more control of its own hunger may represent a return to the growth pattern the child was originally destined to have.

As a consequence of the debate between physical and psychological causes for FTT, a distinction was made about organic and non-organic FTT. This distinction has gained wide currency even as it has become obsolete.

A more accurate, if less precise, definition of FTT is a relative growth pattern determined by a physician to be subnormal for a child given the underlying medical status. If a child gains weight slowly, this may be FTT if she is not keeping pace with growth percentiles. Weight loss or weight gain are usually of more acute concern. However, children with certain genetic syndromes or medical conditions may have growth impairments based upon an underlying condition.

Put most simply, FTT is one of three problems: not enough calories are going into the child, too many calories are being excreted by the child, and/or too many calories are being lost internally.

For a relatively common condition such as moderate to severe cerebral palsy, FTT may reflect major neurological damage limiting possible growth, a neuromotor feeding disorder requiring special feeding techniques, the need to insert tubes for adequate sustenance, and/or neglect by a parent. Occasionally both limiting physiological factors and neglect co-exist: a child who needs small volumes spread out for 60 minute feedings five times a day, and a parent who tries for 10 minutes and quits.

FTT nearly always is equated with a dangerous failure to grow. Most children with FTT are under 2 years of age (before they can get food independently or ask for it more effectively), a critical period during which most brain growth occurs and the fundamentals of language are being learned. Although some professionals still advise that a child is better managed if left small, this attitude is not supported by medical ethics or law, and threatens to deny some children of adequate nutrition to support optimal health and neurological growth. One advantage of a multi-disciplinary approach to FTT is greater attention to other aspects of what it means to *thrive* ("One does not live by bread alone . . . .").

Development

The basic job of a child is to develop (grow). Imagine if an adult had the task of a newborn: to double his weight in five months and triple it in one year! (This explains why a newborn eats 6 to 7 times a day and gets up at night to eat again. It does not explain why a parent sees that as a problem.) Failure of a newborn to gain weight over three to four months can be fatal. To accomplish the explosive growth required, all physiologic and environmental systems must be operating satisfactorily. FTT is a non-specific indicator that something is wrong, but does not pinpoint which domains may be affected.

Etiologies

Although clinical circumstances may seem complex, certain basic features always apply. Matter and energy will be conserved: calories that go into the system will show up somewhere. Put most simply, FTT is one of three problems: not enough calories are going into the child, too many calories are being excreted by the child, and/or too many calories are being lost internally. The child may not get enough calories because of failure to feed, neuromotor feeding problems, or refusal of food by the child fail to provide enough caloric input. Too many calories may be excreted because of vomiting, sugar lost in the urine (diabetes), and diarrhea. Internal calorie losses are fairly rare and may be due to fluid accumulations and hypermetabolic states (e.g., hyperthyroidism, dyskinetic cerebral palsy, and possibly extreme hyperactivity). Combinations of these causes of calorie deficiencies are possible.

Physiological problems leading to growth failure were described by Dr. Ray Helfer (personal communication) as usually consisting of five P's: peeing (e.g., calories lost in urine, metabolic problems leading to altered calorie input), pooping (e.g., cystic fibrosis, lactose intolerance), pumping (e.g., cardiac or perfusion problems), pulmonary (e.g., bronchopulmonary dysplasia), or psychiatric (i.e., neurological).

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Psychosocial dwarfism is a particularly difficult form of FTT for the clinician, requiring longer treatment with less immediate success. Many define 24 months of age as a cutoff between environmentally-caused FTT and psychosocial dwarfism. Before that age children may be denied food. After, the child probably has developed maladaptive interactions whereby they refuse food or fail to seek food. When developmental disabilities are considered, the situation can be confusing.

Conceptual models

Medicine may have inadvertently mislead the legal profession and others in adopting an approach that divides FTT into "organic" and "non-organic" categories. Although a recent national survey of pediatricians showed that nearly 90% rejected such a distinction, either explicitly or in solving case scenarios, this dichotomy persists in some of the literature and many child abuse cases (Stevenson and Alexander, 1990, unpublished study; Stevenson, 1992). On its face, it is difficult to persuade the non-professional that any given FTT case does not involve both an "organic" component (i.e. the child is not growing normally) or a "non-organic" component (at least someone is upset about it). By the time a diagnosis is made, organic and non-organic issues are inevitably intertwined, making the question of which came first difficult and often pointless. The more important question is what can be done to correct the situation.

Consider the child with a severe congenital heart defect. If she fails to grow normally is it a case of organic FTT? What if the parents are not giving medication as prescribed? Then it may be a question of neglect (non-organic FTT), a child who would not grow well anyway (organic FTT), or both. Breast feeding is another example of the failure of the organic vs. non-organic distinction. If the child does not grow, it may be that the mother's milk supply is insufficient (organic FTT), that she is supposed to feed six to eight times a day (non-organic FTT), and/or she does not make adequate attempts to feed (non-organic FTT). Few pediatricians would report the mother for neglect, at least without making substantial efforts to correct the situation. Nevertheless, the distinction between organic and non-organic FTT is still being taught at many medical schools.

By the time a diagnosis is made, organic and non-organic issues are inevitably intertwined, making the question of which came first difficult and often pointless. The more important question is what can be done to correct the situation.

A number of authors have offered alternative models for FTT (e.g. Goldson, 1978; Casey, 1983; Goldson, Milla, and Bentovim, 1985; Stevenson, 1992). A transactional model assumes that the parent brings certain factors to the feeding situation, the child has inherent physical and temperamental characteristics, and the interaction of the two coupled with environmental forces may work over time to produce malnutrition. Other models (e.g. Engel, 1977) examine the interactions of social, psychological, and physical systems both to explain current circumstances and to suggest methods of treatment. A simple two-dimensional model could consist of a child dimension ranging from no known physiological deficits to severe deficits, and a parent dimension ranging from supportive to failure to attend to the child's needs. The advantage of such a model would be to unlink the child's physical state from the parent's care obligations.

The complexities of the many clinical situations in which FTT is seen demand a simple model. The distinction between "organic" and "non-organic" FTT is obsolete, misleading, and should be abandoned. It confuses "non-organic" with neglect, cause with intervention. Any model assuming two or more dimensions is more helpful and should not confuse neglect with the absence of major underlying physical problems.

Diagnosis

History and physical examination are the most important methods to elucidate FTT. Recording a child's weight, height, and head circumference should be routine at all physician visits. Short stature or microcephaly typically are not considered to be FTT. Weight alone should not be the defining characteristic, but considered as weight for height. Growth velocity charts exist to help determine whether weight gains over time are appropriate. Parental heights and their childhood growth patterns, and the growth of siblings may yield important information as to cause, treatment, and prognosis.

Laboratory testing is rarely useful unless it is to specify what is generally suspected by history and physical examination. In one study an average of 40 laboratory tests and x-rays were performed for each child with FTT, but only 0.8% yielded causes not previously suspected (Berwick, Levy, and Kleinerman, 1982). More recently, when 150 pediatricians were asked which screening tests they routinely perform, a median of 8 were named (Stevenson and Alexander, 1990, unpublished study). A complete blood count, urinalysis, electrolytes, BUN/creatine, and urine culture were the only tests endorsed by more than 50% of the pediatricians.

X-rays are useful when certain genetic conditions are suspected (e.g., dwarfism). Children with FTT often have "growth arrest lines." These are seen at fast-growing areas of the skeleton such as the knees, and indicate starts and stops in bone growth caused by significant illness, periods of inadequate caloric intake, or other non-specific stressors. For any form of suspected abuse of a child under 2 years of age, a skeletal survey should be obtained.

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Once pediatricians obtain a history, physical, and perhaps a few screening lab tests, nearly all aggressively pursue psychosocial and interactional work-ups concomitant with further physical testing (Stevenson and Alexander, 1990, unpublished study). In reality, pediatricians approach the diagnosis as a multi-dimensional problem with inter-related concerns.

Treatment

The treatment of FTT depends upon which diagnosis is made, or whether a primary cause is found. Most cases can be managed in an outpatient setting. Only a few observations about cases of FTT primarily caused by neglect will be made here.

The goal of treatment for FTT primarily caused by neglect is to permanently alter the environment to be conducive to growth.

Calorie counts are important. If the parents' reports are suspect, admitting the child to a controlled setting can be valuable. A very young infant may need 110 to 120 calories (technically: kcal) per kilogram per day to sustain normal growth. The FTT infant may not grow at this rate and may need in excess of 150 calories/kg/day. This is particularly true if catch-up growth is desired. For a child of any age, the failure to grow at a certain number of calories necessitates increasing input beyond calculations applicable to normal children, until growth or an adverse response such as diarrhea results. Failure of the professional to be sufficiently aggressive prolongs resolution of FTT and may lead to unnecessary testing. As a general rule, children in a hospital setting should quickly have all testing out of the way and be allowed to eat and grow in as positive an environment as possible.

Psychosocial dwarfism, by definition, has taken longer to develop and therefore takes longer to turn around. If inpatient or foster care is necessary, it may take months before regular weight gain is assured.

The goal of treatment for FTT primarily caused by neglect is to permanently alter the environment to be conducive to growth. Sometimes an undemanding infant will gain energy after a period of growth and thereafter more effectively cry for food. However, caregivers often have many needs that must be met before they are able adequately to feed their children and provide other nurturing care.

Prognosis

Most FTT children eventually reach normal weights for their height, although some have residual growth problems (Strum and Drotar, 1989). Of the many studies exploring the question of residual cognitive and psychological effects, nearly all are confounded by other influences of the home environment. As is true for other forms of neglect, language development and microcephaly (but not necessarily I.Q.) may be long-term residuals. Cognitive impairments clearly exist for severe cases, but a positive environment coupled with adequate nutrition can help overcome much of the physical, social, and cognitive delays (Winick, Meyer, and Harris, 1975; Grantham-McGregor, Schofield, and Powell, 1987).

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Have you seen good media coverage of child abuse issues lately? If so, APSAC's Media Relations Committee wants to know. APSAC's Outstanding Media Award recognizes sensitive, balanced, well-informed coverage of the complex issues that challenge the field of child abuse and neglect. The award can be given to professionals in print, radio, or television journalism. If you hear, see, or read excellent coverage, alert the Media Relations Committee by writing to APSAC headquarters.

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STATE CHAPTER NEWS

Chapters Spur APSAC Growth, Member Involvement

—by Cathy Crino

Two new chapters formed

The momentum to form state chapters is growing. Two more chapters have been chartered in the last few months, bringing the total number of official chapters to 12. Minnesota and Arkansas earned their charters over the summer, and Texas and Arizona will do the same by the end of the year.

Officers in the **Minnesota** chapter are Ann Ahlquist, MSW (President), Carolyn Levitt, MD (1st Vice President), Sandra Hewitt, PhD and Susan Phipps-Yonas, PhD (2nd Vice Presidents), Mary Kenning, PhD (Secretary), and Thomas Dybvik and Dean Vereide (Treasurers). The original chapter meeting was in May, with Dr. Bill Friedrich of the Mayo Clinic (and a member of APSAC's Board of Directors) discussing research on treatment effectiveness and the assessment of different clients' needs. The chapter met again formally in October, when Minnesota Attorney General Skip Humphrey and Barbara Boat of UNC Chapel Hill spoke to members' concerns.

Officers in the **Arkansas** chapter are Louanne Lawson, RNPC (President), Mark Chaffin, PhD (1st Vice President), Janice Church, PhD (2nd Vice President), Kaarin Salisbury (Secretary), and Jerry Jones, MD (Treasurer). Their next general membership meeting will be at a statewide training for multidisciplinary teams in early December. This will be an agenda-setting meeting with the membership, to determine future directions.

Chapters attract members

The news that chapters are forming is especially good for APSAC, because chapters attract members. By June, 1992, 42% of APSAC's members resided in a dozen states with chartered chapters. Chapters attract members for a number of reasons: they're a great opportunity to meet colleagues statewide to form a treatment, referral, and support network; many chapters offer stimulating educational programs and working groups; and chapters allow members to do hands-on work at the state and local level to meet the APSAC goals they hold dear.

One example of an active chapter's impact on the local professional community is MAPSAC in **Massachusetts** (170 members). During the fall, MAPSAC sponsored or co-sponsored three meetings. These included "Assessing Children for Sexual Abuse: APSAC Practice Guidelines" in September, "Court Investigations in Care and Protections," a two-day seminar in cooperation with Massachusetts Continuing Legal Education in early October, and the general MAPSAC membership meeting on October 27. The topic of the membership meeting was "Domestic Violence and Child Abuse." There are eight special interest working groups within the organization, including ones dealing with abuse allegations in custody and visitation disputes, children's advocacy, developing an integrated intervention model for incestuous families, clinical issues, research, working in the courts, juvenile offenders, public communication and education, and ritualistic abuse.

The Clinical Issues Group organized the fall conference on the APSAC Practice Guidelines. The response was so enthusiastic that people had to be turned away due to lack of space. As a result, the Clinical Issues Group is sponsoring several more meetings on the same topic throughout the state.

The fall Court Investigations conference came out of the Working in the Courts Group. They are also in the process of developing guidelines for clinicians and courts to use in determining the placement of children in custody and divorce cases.

The Children's Advocacy Group is trying to influence the redesign of the Department of Social Services. Members of the group are developing a position paper and meeting with representatives of DSS to make sure MAPSAC's input is heard. They are also considering promoting legislation to address the quality of children's services through the educational system.

MAPSAC is working to keep its members informed about these and other developments through their newsletter, the first copy of which has recently been published. The newsletter is four pages long and full of information for the membership about these and other working groups, and about conferences, meetings and networking opportunities throughout the state. The newsletter looks professional, with crisp layout and typesetting on glossy paper.

Another example of a chapter that has galvanized the professional community is WPSAC in **Washington** (165 members). WPSAC's first newsletter appeared in June, with information that will keep membership aware of state legislation and judicial developments. They are targeting two priorities in public and professional education—a statewide multidisciplinary conference, and training for the state's judiciary.

WPSAC has a number of task forces and committees as well. The members feel particularly strongly about the committee whose task is to educate the media. The committee's goal is to ensure that the media has access to the best information possible on the complex issues in child maltreatment. During the summer, several media representatives were invited to a forum at the general membership meeting. Aspects discussed included the negative coverage of Child Protective Services, how children and families are approached by the media, and how the media corrects erroneous information, should it occur. This meeting was the first step in WPSAC's plan to make this an ongoing dialogue.

Finally, IPSAC, **Illinois's** state chapter (137 members) has brought together professionals from all

continued on next page

State Chapter News

–Cathy Crino

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over the state to work on diverse issues. IPSAC is about to launch their newsletter, the goal of which is to keep members informed about topics of concern on the state level. They are concentrating their efforts right now to affect the reorganization of the Department of Children and Family Services. The first step they are undertaking is developing a coherent voice to articulate a child welfare philosophy. They have also made a commitment to try to have adequate IPSAC representation on DCFS task forces and committees.

IPSAC's Public Education and Training Committee is currently planning the next general membership meeting, where the topic will be sexually reactive children. They are also committed to providing local support for APSAC's 1993 Colloquium.

Professionals in Colorado, Oklahoma, Ohio, Pennsylvania, Tennessee, and Northern New England are actively working in the chapter network as well to enrich their professional lives. The **North Carolina** chapter is co-sponsoring a conference on March 22-23 in Greensboro, NC along with North Carolina Child Medical Evaluation Program, and the North Carolina Committee for Prevention of Child Abuse. APSAC will hold its spring Executive Committee meeting in conjunction with this conference. Plans are for Executive Committee meetings to be held regularly in conjunction with conferences sponsored or co-sponsored by APSAC chapters, to lend national support and exposure to state-based conferences.

If you would like to begin a chapter in your state, call APSAC for information. If you'd like to stimulate an existing chapter effort, call the organizers listed on page 14.

Cathy Crino, MDiv, is a new part-time APSAC staff member with responsibility for state chapter development.

ENDOWMENT FUND CONTINUES TO GROW

APSAC is nearly halfway toward its goal of establishing a $25,000 Endowment Fund through individual donations. The purpose of APSAC's Endowment Fund is to help ensure APSAC's financial future. The Endowment Fund principal will not be spent: it will be allowed to grow, hopefully to become part of the financial bedrock on which APSAC can comfortably depend. Ultimately, interest from the Endowment Fund will be used in ways determined by the Board to further APSAC's goals.

Since it was established in 1990, dozens of supporters have contributed amounts ranging from $5 to $500. Won't you join the "Friends of APSAC" listed below, and contribute whatever you can to help realize our dreams? All gifts to APSAC are tax-deductible; donors will be listed in four consecutive issues of APSAC's Advisor, unless they request anonymity.

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THE FIRST NATIONAL COLLOQUIUM OF THE AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

JUNE 24-26, 1993

CHICAGO, ILLINOIS

FRIDAY, JUNE 25, 8:30 AM - 5:00 PM: WITHIN-DISCIPLINE SESSIONS.

MENTAL HEALTH

Therapy with children who have been physically and/or sexually abused.
Esther Deblinger, PhD, and Eliana Gil, PhD

Special issues in the therapy relationship in child abuse cases.
Jon R. Conte, PhD, and Kee MacFarlane, MSW

Working with families who deny and minimize.
Lucy Berliner, MSW, and Ben Saunders, PhD

Therapy with adult survivors of severe child abuse.
Veronica Abney, MSW, and John Briere, PhD

Evaluation and treatment of sex offenders: males and females, adults and teens.
Barbara Bonner, PhD, and Tim Smith, MSW

Treatment of physically, sexually, and/or emotionally abused boys and men.
Bill Friedrich, PhD, and John Hunter, PhD

LAW

Preparing and prosecuting child fatality and head injury cases, including cases in which children were killed long ago.
Paul DerOhannesian, JD, and Harry Elias, JD

Special issues in child sexual abuse prosecution, including recantation, STDs, and adolescent and male victims.
Sue Marx, JD, and Patti Toth, JD

MEDICINE

Advanced issues in differential diagnosis of physical child abuse, including bone and head abnormalities and failure to thrive.
Randell Alexander, MD, and Carole Jenny, MD

Advanced issues in medical assessment of sexual abuse, including interpreting ambiguous evidence, standardizing terminology, and providing fact and expert testimony.
Carolyn Levitt, MD, and David Muram, MD

INVESTIGATION

Advanced issues in the investigation of child abuse, including equivocal death investigations, interviewing alleged offenders, and uses of DNA typing.
Rick Cage; Bill Hammond; and Ken Lanning, MS

Complete session descriptions will be published in the Winter, 1993 issue of *The Advisor*.

Enrollment is limited.
PLEASE REGISTER EARLY!

SATURDAY, JUNE 26, 8:30 AM - 5:00 PM CROSS-DISCIPLINE SESSIONS.

Civil suits for damages: evaluation, treatment, case preparation, and professional issues. **For mental health and legal professionals.**
Jay Howell, MD; and Ben Saunders, PhD

Relationship of drug abuse and child abuse: identification, intervention, and case management. **For health care, CPS, and legal professionals.**
Jan Bays, MD, and John Myers, JD

Reunifying families: deciding when it is time and safe. **For mental health, CPS, and legal professionals.**
Diane DiPanfilis, PhD; Robert Pierce, PhD; and Charles Wilson, MSW

Critical analysis of "syndromes" and validation methods and their use in court: Child Sexual Abuse Accommodation Syndrome, False Memory Syndrome, Parental Alienation Syndrome. **For legal and mental health professionals.**
Jon R. Conte, PhD; Patricia Toth, JD; and Steven Komie, JD

Evaluating your program: assessing its effectiveness, communicating with grantmakers. **For program administrators in all disciplines.**
Deborah Daro, DSW, and David Lloyd, JD

Culturally competent child abuse intervention. Assessing the cultural identification of clients, improving the cultural competence of staff. **For medical, legal, mental health, CPS, and investigative professionals.**
Veronica Abney, MSW; Jill Korbin, PhD; and Diane Willis, PhD

Survivors' memories and long-term consequences of child abuse. Ramifications for prosecution, clinical intervention, investigation, research.
Lucy Berliner, MSW; John Briere, PhD; and Linda Williams, PhD

State of the art of forensic interviewing of children. **For investigative, legal, and mental health professionals.**
Sue Marx, JD, and Karen Saywitz, PhD

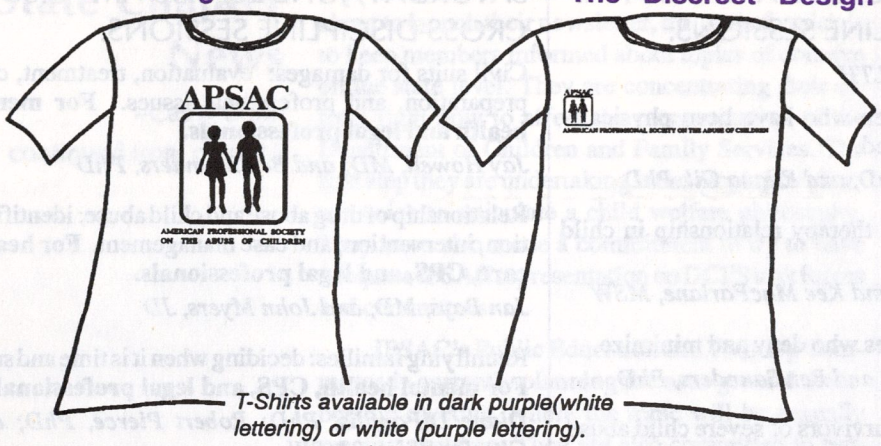
Preparation and presentation of expert medical testimony. **For legal and medical professionals.**
Randell Alexander, MD; Paul DerOhannesian, JD; Harry Elias, JD; and Carolyn Levitt, MD

Issues in investigation and litigation of multi-victim, multi-perpetrator cases. **For legal, investigative, and CPS professionals.**
Larry Hardoon, JD; Ken Lanning, MS; and Donna Pence

Investigating, assessing, and arguing sexual molestation cases when domestic charges are pending. **For investigative, mental health, and legal professionals.**
Ann Haralambie, JD, and Kee MacFarlane, MSW

The "Bold" Design

The "Discreet" Design



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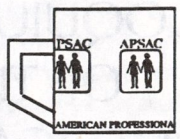

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People of Color Leadership Institute

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FEATURE

Moving from Talk to Action: Toward Cultural Competence in the Field of Child Abuse and Neglect

—by Joyce N. Thomas and Jacqueline Booth

So much has been said about the importance of the issue of "cultural competence", but the real challenge for the People of the Color Leadership Institute is to determine what specifically we are doing and what future actions must be taken to enhance services to children and families from diverse cultural backgrounds. Hardly a day goes by that we don't hear these questions. We know it's a fact that most child abuse professionals who are concerned about being sensitive or even competent are seeking *practical, concrete,* and *specific* information in order to improve the quality of their services. In spite of this demand for knowledge, the realities are that there are still more questions than there are answers. The good news is that some of the forums, workshops, and meetings which are being held throughout the country today are rich with ideas and information. On September 16-17, 1992, the People of Color Leadership Institute's Expert Task Force held its second annual meeting in Washington, D.C. to continue to seek solutions to these pressing concerns. The event was a welcome opportunity to review the project's accomplishments to date and to chart new directions in our planning for programs and services for abused and neglected children.

We were so pleased with the outcome that the group felt it would be important to share our early findings with the APSAC membership and reading audience. Theresa Reid, the Executive Director of APSAC, the original twelve-member task force, and the other child welfare professionals came together to discuss divergent perspectives on the issues of research, policy, programming, and legislation as they confront ethnic minority clients and professionals of color. David Lloyd, Director of NCCAN was present during the initial part of the meeting. The intent of this gathering was to begin to develop some concrete frameworks for addressing these complex issues. More specifically, the objectives of the meeting were:

(1) to begin to develop a national agenda centered around issues of cultural competence in the field of child maltreatment;

(2) to discuss the implications of the recent amendment to the Child Abuse Prevention and Treatment Act (CAPTA) that specifically relate to issues of cultural diversity;

(3) to identify appropriate criteria for selecting culturally competent child abuse treatment and prevention programs;

(4) to delineate current and impending child welfare policy issues affecting persons of color, and;

(5) to review two POCLI products, the Cultural Competence Self Assessment and the Training Curriculum on Cultural Competence.

As we focused on each of the objectives that we set for ourselves, we realized that each one could in fact be a full scale project. It was a hard hitting group that expressed many concerns about problems in the system, inadequate services, and limited information for victimized children and their families who come from ethnically diverse communities. The group expressed a sense of urgency about addressing the overrepresentation of ethnic minorities in the system. It was recognized that as people of color, we are witnessing and participating in a multiracial and transcultural upheaval of social anger about our disenfranchisement.

The significance of this meeting was not just the coming together to rehash "unfixable" problems, but to formulate strategies for action within the field of child abuse and neglect. Many insightful suggestions, recommendations, and ideas were advanced during the meeting, in particular by small working groups focused on specific problems.

Lula Beatty, Ph.D., was the resource person for the working group on research priorities. Participants were expected first to identify the ten most critical research questions confronting people of color in this field, then to rank order these issues in terms of their need for attention. The top three needs identified were (1) to examine the participation of professionals of color in the research arena, (2) to develop programs of research which focus on prevention in communities of color, and (3) to identify effective service delivery models which are used within various ethnic populations. The full scope of ideas will be presented by the POCLI project director to the next Research Committee meeting. Review and refinement of these goals will be an ongoing effort of the POCLI project.

Fe'lecia Holley, MSW, JD, Director of Program Services of the Center for Child Protection and Family Support, led the discussion for the legislative working group. In May of 1992, Congress finally passed legislation to reauthorize CAPTA (the Child Abuse Prevention and Treatment Act). This legislation authorized spending by the National Center on Child Abuse and Neglect through fiscal year 1996. There are lots of components to this law, including funds for discretionary research and demonstration grants, support to the U.S. Advisory Committee, and data collection through the National Incidence Study to name only a few. For the first time, the language within the law

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Feature

-Joyce N. Thomas and Jacqueline Booth

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specifies issues of "cultural diversity," "cultural distinctions" and cultural sensitivity." The group strongly suggested that within the CAPTA legislation, in addition to research projects, the focus on cultural issues should extend to demonstration projects and technical assistance contracts. The terms referring to "cultural diversity," "culture specific," "cultural distinctions," and "cultural sensitivity," which are written in the language of the bill, were discussed at length. The group was charged with the responsibility to provide greater clarification of the meaning of these terms.

Another compelling question which often gets presented to the POCLI staff is, "How many child abuse and neglect programs focus on issues of culture and ethnicity?" and, "What criteria should be used to identify such programs?" Our goal is to assist the Clearinghouse on Child Abuse and Neglect in the development of a directory of such programs. Building on her extensive experience with technical assistance projects, Mareasa Issacs, Ph.D., was charged with leading this important working group. In terms of identifying "culturally competent" child abuse and neglect treatment and prevention programs, the group suggested that one should look at the factors determining "community-based" status; the ethnicity of the staff; and active efforts to promote cultural awareness. These were only a few of the suggestions that were cited as criteria that are useful to consider. The group felt that site visits, surveys of the mission statement, a review of the philosophy of the program, and conducting more in-depth interviews with clients would certainly contribute to more quality selection of programs.

The final small group focused on identifying critical policy issues in the field of child abuse which have implications to the children and families of color. Under the leadership of Terry Cross, MSW, the policy group's key recommendations included that local, state, and federal agencies should be thoroughly coordinated to form a fine-webbed, strong safety net for families in trouble; that all agencies should shift their focus from punishment to empowerment; that we should ensure parity in services for all communities; that risk assessment in populations of color should be culturally specific, and that child placements should be culturally congruent.

In addition to the group discussion, the task force provided critical feedback on the progress of the POCLI products under development. Terry Cross, Executive Director of the Northwest Indian Child Welfare Association, has been instrumental in developing and refining two major POCLI products, the Cultural Competence Agency Self Assessment and the Training Curriculum in Cultural Competency. Using a self-study model, the POCLI Agency Self-Assessment is a diagnostic tool that examines the cultural relevance of the policies, practices, administration, and community relations of child welfare agencies serving populations of color. Pilot testing of the instrument was completed at each of POCLI's four collaborating subcontracting agencies, whose feedback will be crucial in revising the tool. All of these national child abuse agencies indicated that the POCLI Agency Self Assessment instrument is a concrete and useful tool to assist agencies in exploring organizational components of cultural competency. It is expected that during the third year of the POCLI project this Agency Self-Assessment Instrument will be pilot tested in three state CPS systems. Following the final modifications of this instrument, we hope that *all agencies* which serve maltreated children and their families will volunteer to examine their levels of cultural competence.

A second product reviewed by the Task Force was the Training Curriculum on Cultural Competence. The goal of this curriculum is to assist child welfare workers in developing cultural competence. During the Task Force meeting, the curriculum underwent a thorough review of its content and structure. Although they recommended substantial revisions, Task Force members also expressed enthusiasm about the potential of the curriculum to create cultural competence among CPS line staff—the critical point of entry for most families entering the system.

The Task Force Meeting had a particularly memorable moment in bringing together a mentor and a new mentoree. Carmen Fernandez, a mentoree, is a social worker who has worked in the area of child abuse and neglect for many years. Ms. Fernandez wishes to be mentored to enhance her skills in the areas of research, proposal writing, and public policy. Her mentor, Dr. Eduardo Diaz, is Director of the Department of Justice Assistance in Miami, Florida. The Task Force Meeting provided an opportunity for them to meet face-to-face for the first time and converse about their intended projects within the Mentorship Program. Contact such as this is crucial to a productive mentoring relationship. POCLI hopes to provide other occasions in which mentorship dyads will be able to meet. To date, there are over 100 nationally-recognized persons of color available to serve as mentors in the program. Requests for mentoree applications are steadily coming in to the POCLI office.

There was a strong sense that the Expert Task Force meeting was a tremendous success. A multitude of insightful findings and recommendations were generated from the event, and efforts are currently underway to incorporate these suggestions into the POCLI framework. As part of its attempt to propel issues of cultural relevance into the national arena, POCLI continues to share this information with members of APSAC and other local, state and national child abuse organizations. For more information on POCLI activities, contact Jackie Booth, POCLI Coordinator, at (202) 544-3144.

Joyce N. Thomas, RN, MPH, is President and co-founder of the Center for Child Protection and Family Support in Washington, D.C., POCLI Project Director, and past president of APSAC. Jacqueline Booth, MS, is POCLI Project Coordinator.

JOURNAL HIGHLIGHTS

-edited by
Thomas F. Curran

The purpose of Journal Highlights is to inform Advisor readers of current research on various aspects of child maltreatment. Selected articles from journals representing APSAC's multidisciplinary membership are presented in annotated bibliography form. APSAC members are invited to contribute to Journal Highlights by sending a copy of current articles, along with a two to three sentence review, to Thomas F. Curran, MSW, JD, 1405 72nd Avenue, Philadelphia, PA 19126-1645.

SEXUAL ABUSE

Conte, J.R. (1992). Has this child been sexually abused? Dilemmas for the mental health professional who seeks the answer. *Criminal Justice and Behavior, 19* (1), 54-73.

This article presents a review and analysis of some of the most important and contrversial issues involved in the forensic mental health practice of determining if a child has been sexually abused. it includes a discussion of issues which affect how useful a professional evaluation will be to the legal system.

Dawson , B., Vaugh an, A.R. and Wagner, W.G. (1992). Normal responses to sexually anatomically detailed dolls. *Journal of Family Violence, 7* (2), 135-152.

The purpose of this study was to examine the responses of 20 normal, non-sexually abused children to sexually anatomically detailed dolls. Consistent with previous research in this area, there were no instances in which a child acted out sexually or described sexual intercourse, oral sex or fondling with the dolls. In contrast to this low incidence of sexual aggression, however, a rather high incidence of sexual exploratory play was found. Also, the dolls elicited more behavioral affection and exploratory play from girls than boys, and were of little interest to either gender during free-play periods.

Elliott, D.M. and Briere, J. (1992). The sexually abused boy: Problems in manhood. *Medical Aspects of Human Sexuality, 26* (2), 68-71.

Common clinical and psychological disorders experienced by many men who were sexually abused as children are reviewed. A concise overview of research findings on the immediate after effects and long-term sequelae of sexual victimization of boys is presented. Includes useful suggestions for physicians who encounter adult men with possible childhood abuse-related symptoms.

Lanktree, C. Briere, J. and Zaidi, L. (1991). The incidence and impact of sexual abuse in a child outpatient sample: The role of direct inquiry. *Child Abuse and Neglect, 15* (4), 447-453.

The impact of direct inquiry about sexual abuse in a sample of child psychiatric outpatients was examined. Rates of sexual abuse were calculated from two groups of 64 total patient charts: 29 randomly selected from outpatient files without abuse inquiry, and 35 examined after clinicians directly asked about sexual abuse. Reports of sexual abuse increased four-fold, from 7% to 31%, when patients were directly asked whether they had been molested. Considering these findings, the devastating and potentially life-threatening consequences of not routinely questioning child and adult patients about abuse are discussed.

Murphy, W.D. and Peters, J.M. (1992). Profiling child sexual abusers: Psychological considerations. *Criminal Justice and Behavior, 19* (1), 24-37.

By reviewing the scientific literature on the use of psychological procedures to develop profiles of sexual offenders, this article indicates that there is currently very limited empirical data available to support any clear profiling of child sexual abusers. Offender profiling research using the MMPI and penile plethysmography is examined in detail.

Roane, T.H. (1992). Male victims of sexual abuse: A case review with a child protective team. *Child Welfare, 71* (3), 231-239.

This article presents descriptive study of 77 cases of sexual abuse of boys seen for assessment by a multidisciplinary child protection team in Florida. An examination of the alleged offenders relationship to their victims revealed that 56% of the boys reported abuse by someone other than a parent or step-parent. Other findings of this study appear to confirm those of earlier research on the sexual victimization of boys.

LEGAL ISSUES

Davies, G. (1992). Protecting the child witness in the courtroom. *Child Abuse Review, 1* (1), 33-41.

Legal obstacles which, until recently, faced child witnesses testifying in British criminal courts are examined. The article reviews the major changes in the admissibility of children's evidence which have resulted from the 1988 and 1991 Criminal Justice Acts in England and Wales. Both pieces of legislation made it easier for children to offer evidence in court through the use of a video-link or closed-circuit television system. This procedure satisfies the confrontation clause requirements of British law and, according to British research to date, provides for better, more reliable testimony by children. Particularly noteworthy is the overwhelmingly positive response the video-link has received from all levels of the British legal system.

Peters , J. M. and Murphy, W.D. (1992). Profiling child sexual abusers: Legal considerations. *Criminal Justice and Behavior, 19* (1), 38-53.

The leading case law dealing with the admissibility of sexual offender profile evidence is reviewed. Citing very persuasive psychological and legal support for their position, the authors conclude that such evidence has absolutely no place in the court room. A brief analysis of the minority view of California courts, which admit offender profile testimony, is also presented.

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JOURNAL HIGHLIGHTS

-edited by
Thomas F. Curran
continued from page 17

OTHER ISSUES IN CHILD MALTREATMENT

Briere, J. (1992). Methodological issues in the study of sexual abuse effects. *Journal of Consulting and Clinical Psychology, 60* (2), 196-203.

Several ways in which the methodology of sexual abuse research might be improved are outlined. Methodological issues examined in detail include cross-sectional vs. longitudinal designs, reporter biases, nonequivalent comparison groups, effects of abuse definitions, conclusions regarding causality, and constraints on generalization. While noting the considerable value of the existing studies on abuse sequelae, the author advocates a "second-wave" of abuse research consisting of more tightly controlled and methodologically sophisticated studies aimed at disentangling the antecedents, correlates, and effects of sexual abuse.

Farrar, M.J., and Goodman, G.S. (1992). Developmental changes in event memory. *Child Development, 63,* 173-187.

This study examined developmental differences in children's (age 4 and 7 years) recall of repeated standard events (i.e., a normal routine), and events that deviated from the normal routine. The event was an unfamiliar laboratory event that subjects experienced one or three times. Following the final visit, deviations from the standard routine were introduced. The researchers found that younger subjects had more difficulty distinguishing between the standard routine and deviations, whereas older subjects remembered features of the standard and deviation visits.

Grasmick, H.G., Bursik, R.J. and Kimpel, M. (1991). Protestant fundamentalism and attitudes toward corporal punishment of children. *Violence and Victims, 6* (4), 283-298.

This thought-provoking research article examines the effect of religion and religious orientation, specifically Protestant fundamentalism, on attitudes toward corporal punishment in the home and in the schools. Extensive and sophisticated data analysis from a random sample of 368 adults revealed that Protestant fundamentalism is very closely linked to favorable attitudes regarding corporal punishment of children, with a belief in biblical literalism acting as the major reason for this view.

Kalichman, S.C. and Brosig, C.L. (1992). The effects of statutory requirements on child maltreatment reporting: A comparison of two state laws. *American Journal of Orthopsychiatry, 62* (2), 284-296.

This article reports on two studies that utilized case vignettes to investigate the effects of different abuse indicators and different state reporting laws on the reporting of suspected child abuse by psychologists. Results of both studies showed an increased tendency to report when more evidence of abuse is available.

Kelley, S. J. (1992). Parental stress and child maltreatment in drug-exposed children. *Child Abuse and Neglect, 16* (3), 317-328.

This study examined the relationship between prenatal exposure to drugs and parenting stress and child maltreatment. Although no attempt was made to establish a cause and effect relationship, the results of this study empirically demonstrated that prenatal drug exposure is strongly associated with increased levels of parenting stress and child maltreatment. The discussion of certain characteristics of drug-exposed infants which make them difficult to care for has very important policy implications for intervention with drug-exposed families.

Poole, D.A., and White, L.T. (1991). Effects of question repetition on the eyewitness testimony of children and adults. *Developmental Psychology, 27,* 975-986.

This study examined the effects of repeated questions about a novel and ambiguous event on the accuracy of memory. The subjects were 4-, 6-, 8-year olds, and adults. Children were as accurate as adults when responding to open-ended questions, but 4 year olds were more likely to change responses to yes-no questions, and adults speculated more about specific answers to which they had no information. When open-ended questions were used, a moderate amount of repetition primarily influenced presentation style rather than accuracy.

Rudy, L., and Goodman, G. (1991). Effects of participation on children's reports: Implications for children's testimony. *Developmental Psychology, 27,* 527-538.

This study examined the effects of children's participation in a set of games with a man on their later recall of these games. Did participating, as opposed to only watching, make their memory more accurate? The researchers found that free recall and specific answers were related to age (ages 4 and 7), but not related to participation. However, participation lowered the children's susceptibility to suggestion. Children in both age groups showed few commission errors to false suggestions about actions relevant to child abuse allegations.

Journal reviewers for this issue included Thomas H. Roane, M.A., Child Protection Team, University of Florida Department of Pediatrics, Gainesville, FL, Kathleen Kendell-Tackett, Ph.D., Family Research Laboratory, University of New Hampshire, Durham, NH, and Thomas F. Curran. The Journal Highlights editor wishes to express special thanks to John Briere, Ph.D. for his help and contributions to this issue.

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RESOURCES

The **Education Development Center** is offering five highly readable Research Briefs on critical issues regarding child witnesses. Developed through a grant from NCCAN, the briefs are available in monograph form for a nominal fee. Write Education Development Center, Inc., 55 Chapel St., Newton, MA 02160. Phone: 617-969-7100

Division 37 of the American Psychological Association (APA) is concerned with child and family policy with special attention to service delivery, child advocacy, and social/legal policy issues. For further information, contact Karen J. Saywitz, PhD, Department of Child and Adolescent Psychiatry, Harbor-UCLA Medical Center, 1000 W. Carson St., Torrance, CA 90509. APA members only eligible to join.

CONFERENCES

APSAC DISCOUNTS

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.

March 22 - 23 1993. ***North Carolina Conference on Child Abuse and Neglect.*** Greensboro, NC. Sponsored by North Carolina Child Medical Evaluation Program, North Carolina Professional Society on the Abuse of Children, and North Carolina Committee for Prevention of Child Abuse. Call Mark Everson, 919-966-1760.

June 24–26 1993. ***First National APSAC Colloquium.*** Chicago. Call 312-554-0166.

December 9–12. ***Investigation and Prosecution of Child Deaths and Physical Abuse.*** Corpus Christi, TX. Sponsored by National Center for Prosecution of Child Abuse. Call Beth Payne, 708-739-0321.

February 28–March 3 1993. ***20th National Conference on Juvenile Justice.*** Seattle, WA. Sponsored by the National Council of Juvenile & Family Court Judges & National District Attorneys Association. Call 703-549-9222.

May 17–21 1993. ***Keystone Conference on Child Abuse and Neglect.*** Keystone, Colorado. Call Marilyn Lenherr, 303-321-3963.

July 8–11 1993. ***Celebration of Diversity: Many Paths, Many Journeys, Many Goals.*** Springfield, Illinois. 11th Annual VOICES Conference. **Workshop proposals due January 15, 1993.** Send to Karen Spolyar, 370 Cherryfield Dr., Valparaiso, IN 46383. 219-759-5283.

NOTICE

The National Council of Juvenile and Family Court Judges seeks nominations for awards in 15 categories. Nominations are due May 31, 1993. For information, call Marie Mildon, 702-784-6686.

NEW MEMBERSHIP CATEGORY APPROVED

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