APSAC

Volume 6 Number 1 Spring 1993

THE ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

MEDICINE AND PSYCHOTHERAPY

Neurodevelopment and the Neurophysiology of Trauma I: Conceptual Considerations for Clinical Work with Maltreated Children

—by Bruce D. Perry

Editor's Note: This is the first of two articles about emerging medical research into the neurological effects of trauma. The aim of the series is to inform practitioners from all disciplines about this new body of research and about the possible behavioral effects of neurophysiological changes. This article presents what is known about the neurological effects of trauma. The second article, addressing clinical implications of a neurodevelopmental conceptualization of childhood trauma, will appear in the next issue of The Advisor *(V.6, n.2).*

Introduction

A terrified three-year-old child huddles, sobbing, in a dark corner of his room after being beaten by a drunk parent for spilling milk; a colicky infant cries for eight hours, left alone, soiled and hungry, by an immature, impaired mother; a four-year-old boy watches his father beat his mother—only the most recent of many terrorizing assaults this child has witnessed in his chaotic, violent household.

Many studies, wise parents and experienced clinicians tell us that these experiences will influence dramatically how these children grow up—but how? How do experiences change development? What is going on in these children's heads, literally; what are they sensing, perceiving, thinking and feeling? What are the neurobiological correlates of the perceptions, thoughts, feelings and actions of a child's response to a traumatic event? How does the neurochemical milieu associated with fear influence the developing brain? How does repeated exposure to a traumatizing experience alter development? What are the mechanisms by which experience, any experience, influences development?

The impact of traumatic life experiences on children and formulations regarding how traumatic experiences affect development have been discussed from many perspectives, primarily using descriptive, clinical, or psychological formulations (e.g., Terr, 1983: 1991; Finkelhor, 1984; ; Conte, 1985; Eth and Pynoos, 1985; Browne and Finkelhor, 1986; Alter-Reid et al., 1985; McLeer, 1988). In contrast, the purpose of this paper is to discuss the impact of traumatic life experiences on the development of the brain and, specifically, on those portions of the brain involved in mediating the stress response. Knowledge of the core neurobiology of the stress response can lead to important insights regarding the etiology and treatment of the adverse physiological, emotional, behavioral and cognitive sequelae of childhood trauma.

Traumatized children: The scope of the problem

The significance of understanding the neurodevelopmental effects of traumatic stress cannot be overstated. Each year in the United States at least four million children are traumatized by physical abuse, sexual abuse, domestic violence, community violence, natural disasters or man-made disasters. The potential devastation from traumatic stress can be illustrated by examining the effects of combat on adult populations.

continued on page 14

NEWS

New Board Elected; By-Laws Amended; Annual Meeting a Great Success

—by Theresa Reid

APSAC's membership elected 10 outstanding new Board members in the Fall, 1992, election. New Board members are:

Catherine Ayoub, RN, EdD
Jan Bays, MD
John Briere, PhD
Jon Conte, PhD
David Corwin, MD
Dana Gassaway
Eliana Gil, PhD
Carolyn Levitt, MD
Patricia Toth, JD
Bill Walsh

Two other Board members were appointed by the Board during the year to replace elected members who resigned. When Antonia Dobrec, MSW, resigned, the Board invited Holly Echo Hawk Middleton, MS, Regional Vice President of the Children's Home Society in Vancouver, Washington, to join the Board for the remainder of Toni's term (through 1994). Veronica Abney, MSW, agreed to serve the remainder of the term of Richard Krugman, MD, who resigned near the end of 1992. Veronica, the coordinator of the Suspected Child Abuse and Neglect Team at UCLA's Neuropsychiatric Hospital, will serve on the Board through 1993. Also appointed at the end of 1992 were five new members of APSAC's Advisory Board. They are Ann Burgess, DNSc; Gail Goodman, PhD; Ken Lanning, MS; John E.B. Myers, JD; and Joyce Thomas, RN, MPH.

The Board elected its officers at the annual meeting. Those elected were:

- Patricia Toth, JD, First Vice President (President Elect and Chair of the Membership Committee)
- Linda Meyer Williams, PhD, Second Vice President (Chair of the Program Committee)
- Paul Stern, JD, Treasurer (Chair of the Finance Committee)
- Kathleen Coulborn Faller, MSW, PhD, Secretary (Chair of the Nominating Committee).

continued on next page

FROM THE EDITOR

Transitions and Thanks

—by Susan Kelley

This first issue of 1993 is accompanied by several changes in the Editorial Board of *The Advisor*. I would like to take this opportunity to express my appreciation to John E.B. Myers, JD, who has recently completed his tenure as Executive Editor. John's contributions to *The Advisor* over the last four years have been outstanding. Much of *The Advisor*'s success is due to his enthusiasm and dedication.

Special thanks also goes to Martin Finkel, DO, and Robert Prentky, PhD, who have recently completed terms as Associate Editors for Medicine and Offender Treatment, respectively. Their contributions over the years have been much appreciated.

I am pleased to announce the following changes and additions to the Editorial Board:

Mark Chaffin, PhD, has agreed to serve as Executive Editor;

Robert Reece, MD, is the new Associate Editor for Medical Issues;

Benjamin Saunders, PhD, is the new Associate Editor for Offender Evaluation and Treatment;

and Kathleen Kendall-Tackett, PhD, is the new Associate Editor for Book and Media Reviews.

We'd like to hear more from you!

Please write or call us with your feedback on *The Advisor*. We'd love to start a "Letters to the Editor" section: write us with your thoughts. Also, please let us know what articles you would like to see. Or consider writing an article yourself. Guidelines for Authors are available from the national office.

News

–Theresa Reid

continued from page 1

The full Board list is printed on p. 31. APSAC's 1993 annual meeting, held on January 25 in conjunction with the San Diego Conference on Responding to Child Maltreatment, provided lively evidence of the great talent and strength of this outstanding Board of Directors. APSAC's members have consistently chosen exceptional professionals to represent their concerns on the Board.

By-laws amended to ensure diversity on the Board

APSAC's by-laws and policies state a clear commitment to achieving and maintaining diversity in the membership and on the Board along professional, geographic, and ethnic lines. From APSAC's inception, the Board has worked to find the best way to achieve this diversity.

After extensive discussion, the Board concluded at its 1993 annual meeting that the best way to address the issue is to amend the by-laws to allow the Board to appoint up to 20% of the professionals to fill new Board slots each year, if such appointment is necessary to achieve the desired professional, geographic, or ethnic diversity. Those appointed would be chosen from among candidates on the ballot who received the most votes but were not elected in the general election.

The Board sees the change as highly positive, and is delighted that it has finally been accomplished. We seek your comments and questions about the change, which should be addressed to Barbara Bonner, APSAC's new President, at the national office.

First National Colloquium brochures out

The First National Colloquium is coming fast! All signs are that it will be a huge success. Several hundred people have asked for more information in response to advance notice flyers sent out by Sage Publications. And in mid-January—weeks before the first brochures were mailed—we received our first paid registration. You should have received a brochure by now. If you haven't—or if you want more to distribute to your colleagues—please call the office at 312-554-0166. To ensure that you get a spot in the Colloquium, please register early. We expect sessions to fill up quickly. Audiotapes and program books will be available for those who aren't able to attend.

Annual meeting a great success

APSAC's annual meeting was never more fun. This year, everyone who registered for the San Diego Conference on Responding to Child Maltreatment became an APSAC member when they paid their registration fee (unless they said they didn't want to join). What a pleasure to welcome everyone into membership and explain all the benefits members receive! Two hundred fifty people—nearly half those attending the conference—spent the extra time and money to attend the APSAC Advanced Training Institutes held the day before the conference proper began. Perhaps because of the general good feeling about APSAC, over one hundred people skipped supper on Wednesday night after a reception for all conference participants and attended APSAC's annual membership meeting.

The meeting began with a "State of the Society" message. Those attending learned that APSAC grew another 40% in 1992—the same remarkable rate of growth as in 1991. Member recruitment was substantially over budget projections, to a year-end high of 2,700 members. With those joining through the San Diego conference and in the early months of 1993, membership will quickly top 3,000.

APSAC's cash assets grew $10,000 in 1992, from $60,000 to $70,000. Of $70,000 in current cash assets, $10,000 is in the Endowment Fund and $60,000 in the general operating account. Largely because of the First National Colloquium, APSAC's budget grew 60% from 1992 to 1993, from under $200,000 to over $300,000.

People attending the membership meeting heard about the status of some of APSAC's current projects including the Long Range planning task force report, APSAC's long-awaited *Handbook on Child Maltreatment* (to be published at the end of this year), and early plans for APSAC's 1994 National Colloquium.

continued on page 21

CONTENTS

OUTSTANDING PROFESSIONAL AWARD

American Professional Society on the Abuse of Children

LUCY BERLINER, MSW

Every academic discipline or field of professional practice has its giants, people whose scholarship and leadership consistently educate and inspire their colleagues and fellow practitioners never to stop searching for answers to the complex and at times overwhelming problems which they confront every day. These rare individuals have a far-reaching impact on research and contemporary practice in their particular area of specialization or study. This year's recipient of APSAC's award for Outstanding Professional in the field of child maltreatment, Lucy Berliner, is clearly such a person.

Few individuals who have worked in the field of child maltreatment during the past 20 years have contributed to the advancement of its knowledge base, policy development, and professional practice as significantly as Lucy Berliner has. In particular, Lucy's impact in the field of child sexual abuse has been profound. She is one of those exceptional people who can be called a modern day pioneer in the study, intervention, and treatment of child sexual abuse; she has remained at the very forefront of sexual abuse research, practice, and policy development year after year.

Child abuse professionals from all disciplines and, indeed, much of American society know more today than ever before about the sexual abuse of children and how most effectively to help victims largely because of the vision and indefatigable commitment of Lucy Berliner.

As one of APSAC's founders and original Board members, Lucy Berliner has helped guide APSAC from its infancy into the strong and rapidly growing organization it is today. There is a bond between Lucy Berliner and APSAC which will never be broken. It is, therefore, a special pleasure name Lucy Berliner the recipient of APSAC's Outstanding Professional Award 1993

OUTSTANDING SERVICE AWARD

American Professional Society on the Abuse of Children

DAVID CORWIN, MD

The purpose of the Outstanding Service Award is to recognize individuals who have made outstanding contributions to APSAC through leadership and service to the organization. While many individuals have contributed to APSAC's success, one individual who had a particularly significant impact on APSAC is Dr. David Corwin.

Dr. Corwin has worked with endless energy and personal sacrifice to create the professional climate out of which APSAC grew. A review of David Corwin's contributions to APSAC is a brief history of the Society's founding and development. In October of 1985, Dr. Corwin organized and chaired the National Summit Conference on Diagnosing Child Sexual Abuse. From that gathering of 100 professionals from around the country, Dr. Corwin carried forth a mandate to form a new multidisciplinary professional society focused on child abuse and neglect.

In July, 1986, Dr. Corwin convened the meeting in Los Angeles that formed the first Board of Directors for APSAC. After the founding of APSAC, Dr. Corwin championed the development of APSAC's professional guidelines effort, served as the first Editor-in-Chief of *The Advisor,* and pioneered the development of state chapters. Dr. Corwin has served on APSAC's Advisory Board and Long Range Planning Task Force, and last Fall was elected to serve his second term on the Board of Directors.

A student of first generation child abuse leader, Dr. Roland Summit, David Corwin carries on his mentor's tradition of scholarship, advocacy, service, and the vision that child abuse can be ended. It is most fitting that Dr. Corwin be honored as the 1993 recipient of APSAC's Outstanding Service Award.

THE ADVISOR

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

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

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

ASSOCIATE EDITORS

Adult Survivors
John Briere, PhD
USC Medical Center
Department of Psychiatry, Box 106
1934 Hospital Place
Los Angeles CA 90033
213-226-5697

Book Reviews
Kathleen Kendall-Tackett, PhD
Wellesley College
Stone Center
Wellesley MA 02181
508-872-1593

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

Journal Highlights
Thomas F. Curran, LCSW, JD
Private Practice
1405 72nd Avenue
Philadelphia PA 19126

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

Medical Issues
Robert Reece, MD
Case Western Reserve University
2074 Abington Rd.
Cleveland OH 44106
216-844-3761

Offender Evaluation & Treatment
Ben Saunders, PhD
Medical University of South Carolina
171 Ashley Ave.
Charleston SC 29425-0742
803-792-2945

Prevention
Deborah Daro, DSW
National Committee for the Prevention of Child Abuse
332 S. Michigan Av., #1600
Chicago IL 60604-4357
312-663-3520

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

Opinions expressed in *The Advisor* do not reflect APSAC's official position unless otherwise stated.

1993 RESEARCH CAREER ACHIEVEMENT AWARD

American Professional Society on the Abuse of Children

NORMAN POLANSKY, PHD

APSAC is delighted to present its first Research Career Achievement Award to Norman Polansky, PhD. Dr. Polansky is a pioneer in research in the field of child abuse and neglect. He edited and co-authored the first textbook on social work research, which was published in 1960. In 1965, with a grant from the Children's Bureau, he began his own research in child neglect. In addition to hundreds of articles, Dr. Polansky has written two seminal monographs and two of the best-known books on child neglect, *The roots of futility* (1972) and *Damaged parents: An anatomy of child neglect* (1981). Dr. Polansky also developed two widely used scales: the Childhood Level of Living Scale, designed to assess child neglect, and the Maternal Characteristics Scale, designed to help evaluate neglectful mothers.

Now Emeritus Professor in the School of Social Work at the University of Georgia, Dr. Polansky's research and writing have dramatically advanced our knowledge of child neglect. His work and commitment have immeasurably enriched both his colleagues in the field, and the thousands of lives those colleagues touch.

1993 OUTSTANDING MEDIA COVERAGE AWARD

American Professional Society on the Abuse of Children

LEXINGTON HERALD-LEADER REPORTERS

DAVID GREEN, JAY GRELEN, VALARIE HONEYCUTT, FRANK LANGFITT, KEVIN NANCE, AND HARRY MERRITT

For several weeks in 1992, Kentucky's *Lexington Herald-Leader* went out on a limb. It published a series of articles—twenty-four in all—collectively entitled "Twice Abused." The articles addressed the ways in which child victims and adult survivors of abuse can be routinely abused for a second time by judges, investigators, physicians, attorneys, and others acting in an official capacity who know little about child abuse and often react with hostility to victims' and survivors' claims.

The reporters and editors of the *Lexington Herald* are commended for the accuracy, fairness, and courage with which they examined these difficult problems.

1993 APSAC PRESIDENT'S HONOR ROLL

Every year, a number of APSAC members distinguish themselves by making an extraordinary contribution of time, energy, and talent to further APSAC's goals. Each year, fifteen of these members are named to the APSAC President's Honor Roll in recognition of their exemplary service to abused children and their families, and to APSAC. We are delighted to present the members of the 1993 APSAC President's Honor Roll.

Janet Adams-Westcott, PhD (Oklahoma)
Ann Ahlquist, MSW (Minnesota)
Gerard Balsley, Jr., MD (Texas)
Ann Bastille, MA (New Hampshire)
Renee Brant, MD (Massachusetts)
Diane Burks, LCSW (Indiana)
Lynn Copen, MSW (Wisconsin)
Paul Davey, MS, and Debrynda Davey, RN, EdD (Mississippi)
Janet Fine, MA (Massachusetts)
DeLynn Fudge, MEd (Oklahoma)
Karen Gray, MSW (Arizona)
David Muram, MD (Tennessee)
Robert Sewell, MD (Oregon)
Ana Sierra, PhD (Illinois)
Muriel Sugarman, MD (Massachusetts)

PRACTICE

Developmental Considerations in Forensic Interviews with Adolescents

—by Wendy Susan Deaton and Michael Hertica

Introduction

In the past eight to ten years, many articles and books have been written regarding the special developmental considerations for interviews with children who are suspected victims of child sexual abuse (Saywitz and Damon, 1988; Freeman and Estrada-Mullaney, 1987; Faller, 1988; Goodman and Reed, 1986). At the same time, little information has become available regarding the special considerations required for effective interviewing of adolescents who are suspected victims of sexual abuse. A successful forensic interviewer of adolescents must not only know and use good interview techniques, but must have an understanding of adolescent development and how it may affect the interview process. The information in this article is intended to improve investigative interviews where the information obtained may be used in the criminal justice system. It is critical to remember that the focus of attention in any case proceeding into the court system will likely be on the interview and the interviewer.

Normal adolescent development: An overview

According to Jean Piaget, the developmental psychologist who described the concept of cognitive stages of development, the capacity for "formal operational thought" begins in adolescence and characterizes adult cognition. Formal operational thinking involves the ability to reason hypothetically, to take into account a wide range of alternatives, and to reason "contrary to fact." Developmental psychologists have come to believe this capability exists in only 30%-40% of adolescents and adults in America (Gardner, 1982). Thus, many adolescents (and many adults) who appear to be mature may not yet be cognitively equipped to fully participate as effective adults in society (Keniston, 1971). Uncertainty, lack of education and experience, confusion about identity, and the emotional turmoil that accompanies rapid growth further limit the adolescent's ability to appear as a competent witness in an investigative interview.

The adolescent's interview requires the same skill and understanding on the part of the interviewer as the child's interview. It is essential to a successful interview that the interviewer be able to understand the adolescent's perspective and appeal to his or her needs and concerns.

Adolescents may appear physically mature and have some cognitive ability to understand how the world works, but psychologically still be dominated by egocentric thinking. Egocentric individuals have difficulty accepting the perspectives of others and tend to take more responsibility for events than is realistic. Excessive self blame or internal attribution of responsibility may result in the adolescent's accepting responsibility for acts that are beyond his or her control, including incidents of molestation or abuse. The adolescent's sense of responsibility or egocentric view of life differs from childhood egocentrism in a very specific way. While the child thinks "everything happened because of me," the adolescent believes that, "While everything did not happen because of me, I should have been able to control or stop it" (Celano, 1992).

All of these developmental issues can have a dramatic impact on the investigative interview of an adolescent. It is important to remember that the adolescent's interview requires the same skill and understanding on the part of the interviewer as the child's interview. It is essential to a successful interview that the interviewer be able to understand the adolescent's perspective and appeal to his or her needs and concerns (Barker, 1990).

Physical development

As with younger children, adolescent physical development is rapid and wide ranging. Development is uneven across the population, with some youngsters maturing early in terms of height, weight, and secondary sexual characteristics, and others still appearing very young and immature even until age sixteen.

Early physical maturity can present a serious social handicap for girls, while boys appear primarily to reap social benefits from being ahead of the growth norm (Steinberg and Hill, 1978). Early maturation, however, can put both boys and girls at great risk, making them appear more erotic and more sexual than they really are. Because adolescent physical growth is erratic, not gradual, the teenager seldom has the opportunity to adjust to new levels of physical maturity before demands to "live up to your appearance" surface. Early maturation can cause adolescents to be brought into sexual situations which they cannot emotionally handle.

Girls who mature early may find themselves outgrowing boys their own age and may become the subject of unwanted attention from older and adult males. Boys who mature early are prized socially and athletically, but may also be the target of unwanted or confusing sexual attention from adults. Adolescents who are abused after developing secondary sex characteristics may feel, guiltily, that their appearance triggered the abuse. Offenders may manipulate the mature-looking victim by playing on this sense of guilt and by suggesting that the child's physical development is a sign that he or she is ready in every sense for sex (Celano, 1992).

The adult appearance of the early maturing adolescent poses a challenge for the interviewer, who must maintain his or her focus on the emotional and cognitive levels of maturity in the subject of the interview, which are often at great disparity with his or her looks.

Intellectual development

As mentioned above, Jean Piaget theorized that adolescents have the capacity to conduct formal operational thought, just as adults do. That is, he suggested that adolescents are able to fully mentally conceptualize, do long-range thinking, and consider all options. Formal operational thinking includes the

continued on next page

-Wendy Susan Deaton
and Michael Hertica

continued from page 5

ability to talk about things using language where words represent objects and actions. Formal thinkers can understand similes, allegories, metaphors, and irony; they can think about their own thinking (metacognition) and about other people's thinking; hypothesize about other people's motives and perspectives; and conceptualize and construct theories apart from concrete reality (Gardner, 1982). In reality, however, many adolescents have not reached this level of thinking, and some never will. For much of the American population, concrete thinking is the dominant perspective. Concrete thinking, according to Piaget, involves black and white perspectives, concentration on short range fixes, immediacy, and restricted perspectives.

David Elkind, a gestalt and transpersonal psychologist who has worked extensively with adolescents, describes some of the perspectives of adolescents which reflect their psychological egocentrism and concrete thinking. Elkind describes how adolescent psychological egocentrism results in the adolescent projecting his or her private thoughts onto others and interpreting these thoughts as public information, creating what Elkind calls an "imaginary audience" which thinks, fears, and judges the adolescent in the same way the adolescent judges him- or herself. Adolescents, according to Elkind, are particularly sensitive to a great number of issues because they truly believe that they are under constant scrutiny and judgment (Elkind, 1979). The individual who is fully cognitively mature, with formal thinking processes intact, can challenge his irrational fears about what others think. But most adolescents cannot comprehend that their projected beliefs are not really what others are thinking. For adolescent victims, any sense of self-blame (internal attributions) is particularly painful because the victims believe that others may know about the abuse simply by looking at them (Celano, 1992).

The adult appearance of the early maturing adolescent poses a challenge for the interviewer, who must maintain his or her focus on the emotional and cognitive levels of maturity in the subject of the interview, which are often at great disparity with his or her looks.

Elkind also talks of adolescents' "personal fables," in which they project themselves, their parents, and their friends onto an ideal standard that results in an unrealistic belief in their own invulnerability and uniqueness (Elkind, 1979). This limitation in evaluating reality can result in enormous risk taking. Adolescents will take on situations clearly beyond their abilities, such as sexual situations, which they fully believe they are capable of handling but in which, in fact, they are unable to control crucial variables. The authors refer to this "personal fable" as adolescents' "As If Thinking," or "Magical Thinking," in which adolescents make decisions and act as if what they wish and believe are reality.

The predominance of concrete thinking, combined with the power of the imaginary audience and the personal fable, make reasoning and confrontation ineffective ways to communicate with adolescents. Empathic, emotional appeals that reflect the interviewer's understanding of the unique perspectives of the adolescent are more likely to be productive.

In professional interviews about victimization, the adolescent is very often an "unwilling subject." The unwilling subject displays the following characteristics:

- Fear of not being believed.
- Embarrassment and humiliation.
- Feeling unduly responsible and accountable.
- Wanting to protect the abuser or the family.
- Believing that he or she alone can cope with the existing situation.
- Fear of what his or her own pleasure, passivity, enjoyment or response might mean in the context of disclosure.
- Fear of reprisal.
- Fear of exposure to others.

In other words, the unwilling subject has a powerful stake in *not* disclosing about events of victimization.

Language

While adolescents technically have sophisticated language—that is, they use all parts of speech—their "in" language predominates and has much more meaning for them than formal communication. Many adolescents have limited vocabularies, and the interviewer's language must be congruent with the adolescent's level of understanding. Adolescents' concern about the "imaginary audience's" perspective may lead them to be reluctant to ask for clarification or to acknowledge when they do not understand what is being discussed.

Adolescents, particularly those with emotional problems, chaotic lifestyles, trauma histories, or learning disabilities may have particular difficulties with language and cognition. These difficulties can include:

1. Difficulty in sequencing events and main ideas.
2. Fragmented understanding of questions.
3. Fragmented responses which do not adequately convey their message.
4. Poor listening skills.
5. Abrasive conversational speech.

When language and communication problems exist, the interview is much more complicated. It is more difficult with an adolescent than with a child to sort out whether the problem is one of language, cognitive development, or emotional barriers. However, the effective interviewer must be able to identify the source of the communication problem and utilize appropriate strategies to overcome it. This would include an assessment of language ability during the rapport-building session.

continued on next page

Practice

-Wendy Susan Deaton
and Michael Hertica

continued from page 6

Social development

Adolescents' primary developmental task is establishing an independent sense of identity and finding their place among their peers (Erikson, 1968). Therefore, adolescents are very concerned with peer group approval and may appear to have little or no concern about the approval of adults. They are striving for emotional emancipation from their family and hence may be very reactive to any interactions with adults that smack of parental discretion or authority.

It is more difficult with an adolescent than with a child to sort out whether the problem is one of language, cognitive development, or emotional barriers.

Victimization dramatically undermines adolescents' nascent sense of identity and independence. They are typically very reluctant to disclose this loss of control to anyone. Forensic interviewers often are identified with parents and other authority figures, and may find adolescents very evasive and hesitant to disclose.

Emotional development

Adolescents tend to be self-centered, volatile, shame-filled, guilty, easily humiliated, awkward, and unrealistic in their self-assessments. Adolescents are more confident than competent, and often refuse to admit that they do not know what they do not know.

Sexual development

Sexual abuse interferes with the normal developmental unfolding of natural sexual feelings, desires, and identity. Because adolescents clearly recognize they have their own sexual thoughts and feelings, they readily take responsibility for anything that may happen to them sexually. They may not be able to differentiate, because of emotional immaturity and cognitive limitations, between purposeful sexual activity and sexual activity in which they have been coerced, seduced or manipulated.

Because adolescents clearly recognize they have their own sexual thoughts and feelings, they readily take responsibility for anything that may happen to them sexually. They may not be able to differentiate, because of emotional immaturity and cognitive limitations, between purposeful sexual activity and sexual activity in which they have been coerced, seduced or manipulated.

Sexual abuse victims also are at risk for developing serious body image problems, thinking of themselves as tarnished or believing that anyone who looks at them can see their sexual victimization. Their shame and humiliation at being victimized accentuates the normal complement of discomfort and embarrassment that accompanies having a body which is changing faster than they can accommodate to it. This condition leads to serious limitations in adolescents ability to sort out sexual abuse from chosen sexual interaction (Celano, 1992).

Reasons for disclosure

If adolescents are unwilling or reluctant disclosers of abuse, what will motivate them to discuss details of sexual abuse? Typical reasons for disclosure by an adolescent include:

1. The family is being disrupted as a result of other stresses.
2. The offender has left the home.
3. The adolescent develops the insight that the abuse is not okay or that there are more serious implications than he or she had realized earlier.
4. The adolescent is directly asked about abuse and given assurances of a safe environment.
5. The adolescent finds a safe relationship; i.e., a love relationship or a therapeutic alliance.
6. The offender or another significant other dies.
7. The adolescent becomes aware that other children or siblings are at risk.
8. The abuse becomes intolerable.

Many adolescents disclose abuse when they have become angry enough at the offender to overcome their humiliation and their reluctance to disclose. Anger is a "red flag" for some interviewers, suggesting a motivation for false allegations. From the authors' perspective and experience, false allegations of sexual abuse from adolescents are rare. While anger may play a role in false allegations, anger is one of the most common motivators for true disclosures of abuse among adolescents (Sorensen and Snow, 1991). When false allegations of abuse are suspected, investigators should be aware that such allegations most frequently signal other serious difficulties in the family life of the adolescent.

Setting up the interview

Adolescents, more than children, may have a gender preference regarding the interviewer. They may also want a support person with them during the interview. Asking about both these issues demonstrates your concern.

The interview itself involves much the same format as an interview with a suspected child victim. The interview involves three phases: (1) Rapport building, which includes a developmental assessment; (2) Information gathering, which includes asking open-ended questions that cue the adolescent to what you need to know, eliciting significant and telling details of the abuse, and exploring the adolescent's perspective on who is accountable; (3) and finally, Closure, in which fears, concerns and a summary of the interview are reviewed.

Credibility guidelines

Corroborating disclosures of sexual abuse by suspected adolescent victims include the following areas for exploration (not necessarily during the interview process):

1. Have there been previous allegations and if so, how were the disclosures made? Statistically, children who are victimized by sexual and physical abuse are at greater risk for future victimization. Conversely, if an adolescent has been victimized in the

continued on next page

continued from page 7

past and experienced secondary gain during or after the disclosure (e.g., attention, material rewards, relief from responsibility, excessive power in the family), there may be a greater risk for a false disclosure.

2. What is the sexual history? How did the adolescent learn about sex? Is there a history of sexual activity? This is necessary history for evidentiary reasons. (Interviewers should be careful to explain the reasons that this information is necessary, so that the process of inquiry not unnecessarily traumatize the adolescent).

3. Is there a history of chronic running away, truancy, or substance abuse on their own or within the family? Is there self-mutilation or other behavior injurious to the adolescent?

4. Is there a history of acting out physically or sexually? Any history of firesetting?

5. Have there been recent changes in the family constellation that may account for disclosure? What has been the history of family relationships?

Anger is a "red flag" for some interviewers, suggesting a motivation for false allegations. From the authors' perspective and experience, false allegations of sexual abuse from adolescents are rare. While anger may play a role in false allegations, anger is one of the most common motivators for true disclosures of abuse among adolescents (Sorensen and Snow, 1991). When false allegations of abuse are suspected, investigators should be aware that such allegations most frequently signal other serious difficulties in the family life of the adolescent.

Parts or all of this information may not be relevant to the case being investigated. These are areas, however, that the interviewer should consider as they may become issues in the criminal justice process.

Cautions for the interviewer

Interviewing the adolescent victim can present a major challenge to the professional interviewer. This individual looks, and in many ways acts, like an adult who is capable of a spontaneous disclosure of victimization. Special developmental issues do exist, however, and must be considered if success in the interview process is to be achieved.

Throughout this article, the authors have provided practical considerations in the various areas discussed. Additionally, interviewers may benefit from the following tips:

1. Remember, the independence-identity issues of adolescents are very powerful. Control is a very important issue for them. Allowing the suspected victim to feel in control of the pace and structure of the interview can be of great benefit.

2. While realizing that the interview has a serious purpose, it may be beneficial to try to lighten up the atmosphere using appropriate humor to make the adolescent feel more at ease.

3. Recognize that the fear that disclosure may mean things will get worse is real and valid.

4. Recognize that adolescents do not, and do not want to, see themselves as powerless. Rather than emphasizing "It's not your fault" as you might do with a child, allow them to accept some accountability and help them find a way to forgive themselves. Also, try to help them plan a way to protect themselves from future decisions which might lead to victimization.

5. Recognize that the adolescent's consensual sexual history confuses the issue for them; they have great difficulty differentiating their own sexual feelings and desires from what has been imposed upon them.

6. Remember that even though adolescents may be capable of formal operational thinking and a sociocentric perspective on world events, when it comes to their own victimization they may be interpreting things from a much younger level of emotional and psychological maturity. They require the same compassionate considerations in the interview process as do young children if they are to participate in a meaningful way.

References

Barker, Phillip, *Clinical interviews with children and adolescents,* New York: W.W. Norton & Co, 1990.

Celano, Marianne, "A developmental model of victims' internal attributions of responsibility for sexual abuse, " *Journal of Interpersonal Violence, 7,* 1, 57-69, Sage Publications, March, 1992.

Elkind, David (Ed.), *The child and society,* New York: Oxford University Press, 1979.

Erikson, E., *Identity, youth and crisis,* New York: W.W. Norton, 1968.

Gardner, Howard, *Developmental psychology,* 2nd Ed., Toronto: Little, Brown & Co, 1982.

Gardner, Howard, *Youth and dissent: The rise of a new opposition,* New York: Harcourt, Brace, Jovanovich, 1971.

Peterson, Anne and Taylor, Brandon, "The biological approach to adolescence: Biological change and psychological adaptation," *Handbook of adolescent psychology,* Toronto: John Wiley and Co., 1980.

Steinberg, Lawrence and Hill, John, "Patterns of family interaction as a function of age, the onset of puberty and formal thinking," *Developmental Psychology, 14,* 6, 683-684, American Psychological Association, 1978.

Sorensen, Teena and Snow, Barbara, "How children tell: The process of disclosure in child sexual abuse," *Child Welfare, LXX, 1,* 3-15, Jan-Feb 1991.

Wendy Susan Deaton, MA, MFCC, is a therapist in private practice in San Luis Obispo, California. Michael Hertica is a Lieutenant in the Torrance Police Department in Torrance, California.

REACH OUT

Help APSAC Stretch Its Advertising Budget!

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

RESEARCH AND PRACTICE

Psychometric Issues for Practitioners in Child Maltreatment

—by Mark Chaffin and Joel Milner

Child protective services workers, prosecutors, and judges are sometimes called on to make far reaching decisions about children on the basis of incomplete or contradictory information. Following a report, for example, a worker must render a judgment regarding the occurrence of maltreatment in situations where the report of abuse *is* adamantly denied by the alleged abuser(s). When maltreatment by a parent is officially confirmed, different but equally difficult questions arise. What interventions are needed? Should the child be placed in foster care? How high is the risk of reabuse? Can the case be safely closed? Although substantial case data are hopefully available to assist in these determinations, the decision making process can sometimes be uncomfortably vague. In the search for clarity, decision-makers may turn to psychological testing for help.

Psychological tests can be seductive. The test score may bear the imprimatur of science, objectivity, and certainty, distinguishing it from the more subjective processes involved in clinical judgment. Although this appeal is not altogether baseless, it is critical to be aware of the very real limits of testing in order to assure its appropriate use. For standardized tests and psychological assessments to provide a real help, both testers and consumers of testing evaluations such as judges and CPS staff need to have a basic knowledge of testing. The first step is knowing how to ask the right questions.

Psychological tests can be seductive. The test score may bear the imprimatur of science, objectivity, and certainty, distinguishing it from the more subjective processes involved in clinical judgment. Although this appeal is not altogether baseless, it is critical to be aware of the very real limits of testing in order to assure its appropriate use.

What is the Question?

One of the most frustrating experiences for a consumer of psychological evaluations is receiving a vague or indecipherable report with little clear relevance to the case at hand and no clear conclusions or recommendations. Often, the problem can be traced to an equally vague referral containing no clear or answerable referral question. When referring a client or conducting testing, it is critical to have a clear and answerable referral question. Often there is no *question* at all. "Mrs. Smith was ordered by the court to receive a mental evaluation," or "Sandra was sexually abused by her father," for example, are not questions. Neither, for that matter, are they problems to be evaluated. They are events in a client's history. The computer science maxim, "garbage in—garbage out," holds for consumers of psychological testing evaluations as well as for computer programmers. If there is no clear and well focused question, the results will most likely be inapplicable or unhelpful.

Don't assume that the evaluator will intuit what sorts of information or target areas will be helpful to you. Ask specific and focused questions. Examples might include: "Does Mr. Smith need inpatient or outpatient chemical dependency treatment?" "Are there mental health factors which might increase Mrs. Smith's risk of re-abusing and what sort of services would best impact these?" or, "Have Mr. and Mrs. Smith made progress from their previous evaluation in their knowledge of non-violent discipline strategies and appropriate expectations for their children?"

Clearly, it is critical for consumers of psychological evaluations in child maltreatment to formulate a clear idea about what questions are important. But what sorts of questions can psychological tests answer? And how can we determine the helpfulness of a particular instrument in answering a question? In order to address these issues, it is important to understand a few "psychometric" principles—principles related to test development and use.

Measurement Issues: Reliability and Validity

Before an assessment device is used, the adequacy of its "reliability" and "validity" must be considered. "Validity," in the psychometric sense, refers to whether or not an instrument hits its intended target. If a test has high validity, then it measures what it purports to measure (e.g. anxiety, coping styles, depression). "Reliability" refers to the consistency of an instrument's performance. If a test is reliable, then it will hit the same target consistently. Clearly the two concepts are related. Although an instrument cannot be valid without also being reliable (it can't be said to hit its intended target if it doesn't do so consistently), it can be reliable without being valid (it can hit the wrong target, but do so consistently).

Reliability

There are two major types of test reliability: "internal consistency" and "temporal stability." Estimates of internal consistency indicate the degree to which test items measure the same factor. One way of determining internal consistency is to divide the scale in half, and correlate the scores on each half. A more sophisticated and now more commonly used way is to use the "alpha coefficient." The alpha coefficient measures the correlation of scores on all possible halves of the test with their corresponding halves. Perfect internal consistency is reflected in an alpha coefficient of one (1.0). A random assortment of unrelated items would be expected to have an alpha of around zero (0.0).

It is worth noting that estimates of internal consistency set the upper limits of the test's validity. A test can only measure what it purports to measure (i.e., be valid) to the degree that it is measuring consistently. The validity of a test cannot exceed the level of internal consistency and is usually somewhat below the internal consistency value.

The other major type of reliability is "temporal stability," which indicates the degree to which a score will vary across time. A high degree of temporal stability is expected if the test purports to measure a personality characteristic which is believed to be stable

continued on next page

Research and Practice

-Mark Chaffin
and Joel Milner

continued from page 9

(e.g., rigid expectations for children). However, a low to moderate temporal stability may be acceptable if the test measures a characteristic whose natural course might be expected to show change across time (e.g., mood).

Test developers measure temporal stability by giving the test repeatedly at varying intervals, such as one month or six months. Then they correlate test-retest scores. Test-retest correlation can range from zero (no correlation) to one (perfect correlation). The degree to which the same characteristic is being measured across time is determined by taking the square of the test-retest correlation. If, for example, the correlation is .70, then only 49% of what was measured initially is measured at the retest. In using a test with a temporal stability of 0.49, changes in a score across time might need to be interpreted cautiously because the change may only reflect the nature of the test, not *bona fide* changes in the client.

Validity

Validity data tell whether a test actually measures what it purports to measure. Despite statements that may appear in advertising copy, no test can ever be said to be "valid" or "fully validated." Test validation is a matter of degree for any given population. Frequently, data suggest that a test is valid for use with one population (e.g., adult parents), while no data are available for the same application with another population (e.g., adolescent parents), or another application with the same population (e.g., screening vs. diagnosis). Thus, an instrument developed and validated to screen adult parents for physical abuse potential would not necessarily be valid for screening adolescents or diagnosing abusiveness in either population.

You cannot rely upon the test title as an indication of an instrument's validity. For example, "sex abuse legitimacy or validity" scales have been marketed without any data to support the validity of their classifications.

You *cannot* rely upon the test title as an indication of an instrument's validity. For example, "sex abuse legitimacy or validity" scales have been marketed without any data to support the validity of their classifications.

Group Differences and Individual Classification

One method of supporting a test's validity is to present data which show group differences: for example, demonstrating that a criterion group (e.g., sexual abusers) has a different average score from that of a comparison group (e.g., non-abusers or normals). Although differences between the criterion and control groups must exist if a test is valid, this finding alone is insufficient to demonstrate that the test is valid in differentiating *individual* sexual abusers from non-abusers. For example, although the average MMPI profile for sexual abusers as a group is elevated over that of a non-abusive group, abusers typically have a wide variety of individual scores and profiles, none of which is unique to sexual abusers. One study found that the most common individual profile type was present in only 7% of offenders tested (Hall, Maiuro, Vitaliano, & Proctor, 1986) and another study found that the most common individual profile showed no significant elevations (Chaffin, 1992). Consequently, despite evidence of group differences, there is no "profile" which could validly assist in classifying any individual as an abuser or non-abuser (Murphy & Peters, 1992).

In examining a test's validity and relevance for your application, it is important to have information on *individual* classification rates. Four rates are typically reported: selectivity, specificity, false positive classifications, and false negative classifications. Selectivity is reported in terms of the percent of individuals correctly classified in the criterion group (e.g., abusers correctly identified as abusers). Specificity is reported in terms of the percent of individuals correctly classified in the comparison group (e.g., non-abusers correctly classified as non-abusers). False positives and false negatives are reported in terms of the percent of misclassifications of non-abusers as abusers, and abusers as non-abusers, respectively.

Classification rates should be determined by using a separate sample from the one on which the test was normed or developed. This procedure is sometimes known as "cross-validation," and is an important step: when the same procedures and scoring are used across samples, there will be an inevitable and potentially substantial decrease or "shrinkage" in the correct classification rates.

Base Rates

However, even when a test has acceptable individual classification rates (say 80%), it still may not be appropriate in certain settings. This is because the usefulness of a test can vary depending on the frequency of its target in a particular population. A test is only useful if it produces a meaningful increase in classification accuracy beyond random guessing. For example, let's assume that 40% of APSAC members are psychologists. In this case, 40% would be the "base rate" of psychologists among APSAC members. We would then expect to be correct in classifying someone as a psychologist 40% of the time on the basis of a blind guess. A test designed to determine whether or not a member was a psychologist would only be useful if it meaningfully increased the accuracy of our classifications beyond the base rate.

The base rate of a particular characteristic in a population critically influences a test's accuracy. Optimal increases in prediction occur when the base rates are 50%, or, in other words, when 50% of the sample are criterion cases. For example, at least one study has found a roughly 50% rate of Post-Traumatic Stress Disorder among sexually abused children referred for treatment (McLeer, Deblinger, Atkins, Foa, & Ralphe, 1988), suggesting that use of valid PTSD scales with this population might be very appropriate.

continued on next page

Research and Practice

-Mark Chaffin and Joel Milner

continued from page 10

If the PTSD scale had an 80% correct classification rate and was administered to 100 children (50 with PTSD and 50 without), then 40 (80% of 50) in each group would be correctly classified. Remember, if we just guessed that all abused children had or didn't have PTSD, the accuracy rate would be 50%. Using the test would increase accuracy to 80%, and we could say that the test improves our classification rates.

When base rates are markedly lower than 50%, however, the usefulness of the test decreases to the point where serious errors can occur and the test should not be used. For example, what if a PTSD scale with an 80% correct classification rate is used in a sample where only 5% of the subjects actually had PTSD? If 100 children were tested (5 with PTSD and 95 without), then 4 PTSD children (80% of 5) would be correctly classified. However, only 77 of the non-PTSD children would be correctly classified (80% of 95), with 19 false positives. Thus, for the 23 children classified as having PTSD (4 correctly and 19 falsely), there would be only a 17% correct classification rate (4/23). Of course, the number of false negative classifications would be very small (one missed child with PTSD).

The computer science maxim, "garbage in—garbage out," holds for consumers of psychological testing evaluations as well as for computer programmers. If there is no clear and well focused question, the results will most likely be inapplicable or unhelpful.

The direction and implication of error rates in cases with very small or very large base rates needs to be carefully considered. In some instances, one might be willing to risk a high number of false positives in order to obtain a low risk of false negatives. In other situations, this would be disastrous.

For example, one particular instance where low base rates could lead to serious problems concerns scales intended to detect false allegations of sexual abuse by children, a phenomenon which several studies suggest accounts for only a small percentage of all allegations (Everson & Boat, 1989; Jones & McGraw, 1987). Assume that a valid scale to detect false allegations could be developed, say with an 80% correct classification rate. If the base rate for false allegations is 5%, the vast majority of children labeled by the test as "false accusers" could actually be *bona fide* abuse victims. The overall error rate in field use would be 20% (with 19 *bona fide* victims labeled as false accusers + one false accuser labeled as a *bona fide* victim), which is four times greater than the 5% error rate which would be obtained by simply assuming that all allegations were *bona fide* (five false accusers labeled as *bona fide* victims). In this example, use of the test would lead to greater error. More importantly, the direction of error would seriously place children at risk.

Response Distortions

Many psychological tests are self-report measures. They count on the person being tested to tell us accurately about himself or herself. A major issue when assessments use self-reports to evaluate parents in child maltreatment cases is the possibility that respondents will distort their responses to the test items. Response distortions include "faking good," "faking bad," and "random responding."

"Faking good" refers to an attempt to distort responses in a socially desirable manner, and is often a major problem in child maltreatment assessments. "Faking bad" refers to the respondent's attempt to present himself or herself in a socially undesirable manner, perhaps as a cry for help or a form of malingering. "Random responding" may be due to a variety of factors, such as a deliberate desire to avoid revealing personal data or difficulty understanding the items. A more comprehensive discussion of potential causes of these three types of distortions is available elsewhere (Milner, 1990).

Clearly, response distortions may be far more endemic in some groups than in others because some groups have more motivation to conceal or mislead. For example, response patterns would be expected to be far different among alleged sexual abusers "in denial" than among admitted sexual abusers. Yet most instruments used to assess sexual offenders only have data available for *admitted* offenders, severely compromising their utility with *alleged* offenders. Indeed, the validity of sex offender assessment instruments to assist fact finders in differentiating denial from innocence among alleged offenders has been seriously questioned (Murphy & Peters, 1992; Myers, Bays, Becker, Berliner, Corwin & Saywitz, 1989). Response distortions and other psychometric issues can also be an issue in phallometric assessments (Hall, Proctor, & Nelson, 1988) which, along with the low rates of clearly deviant response patterns among some groups of offenders (e.g., incest offenders, Marshall & Barbaree, 1988), has led many observers to conclude that phallometry offers no assistance in determining guilt vs. innocence (Simon & Schouten, 1992).

Because response distortions can render test data meaningless, testers should attempt to assess response bias and random responding. While some family violence instruments have built-in measures of response distortion (e.g., Child Abuse Potential Inventory; Milner, 1986a, 1990), most do not. When the instrument does not have its own built-in measure of response distortion, it is critical for the tester to estimate the accuracy of responding using separate dedicated scales designed to measure response sets or clinical assessment of response tendencies. In any case, the question of response distortions or bias, along with any cautions or concerns involving reliability, validity or potential error induced by very low or high base rates, should be addressed in the text of the report.

Standards

As the standards of test use have been revised

continued on next page

Research and Practice

-Mark Chaffin
and Joel Milner

continued from page 11

over the years, there has been a trend toward increasing the responsibilities of the tester to assure that a test application is appropriate. The test user must be aware that if data are not available to support a particular test application, then the user is responsible for providing adequate documentation (i.e., research evidence) to support the new application. Documentation is also necessary when the test application is not new, but the population under investigation has not been previously studied. These responsibilities are spelled out in detail in the *Standards for Educational and Psychological Testing* (APA, 1985).

In addition, it is critical that testing be conducted by a qualified and specifically trained person (e.g., a psychologist or appropriately licensed professional). Decision-makers and other consumers of psychological testing evaluations should feel free to inquire about the limits, appropriateness and supporting data associated with a particular instrument or interpretation, as well as the evaluator's training and experience with testing and child maltreatment populations.

Resources

There are a number of resources available for familiarizing yourself with available psychological instruments and their potential usefulness in child maltreatment cases.

- For reviews of instruments and measures assessing personality characteristics, see, e.g., Mitchell (1983), or Sweetland & Keyser (1986).
- For specific reviews of instruments and measures for use with families, including child abuse perpetrator and child abuse victim measures, see, e.g., Grotevant & Carlson (1989), or Touliatos, Perlmutter, & Straus (1990).
- For discussions of assessment, legal and professional issues related to physical abuse perpetrators, see, e.g., Caldwell, Bogat, & Davidson (1988), Melton & Limber (1989), or Milner (1986b, 1989, 1991a, 1991b).
- For discussions of assessment, legal and professional issues relating to sexual abuse perpetrators, see, e.g., Murphy & Peters (1992), Peters & Murphy (1992), or O'Donohue & Letourneau (1992).
- For suggestions concerning a range of target areas and instruments for use with all types of maltreated children, see e.g., Bonner, Kaufman, Harbeck, & Brassard (1992).

Where Is Testing Most Useful?

In general, psychometric applications would currently appear to have extremely limited utility in investigative or abuse substantiation settings. This pertains not only to assessment of alleged abusers, but also to psychosocial assessments of children where no particular diagnostic profiles or syndromes are available which would meaningfully assist the process of determining the presence of abuse (APSAC, 1990). Testing data might be useful in some cases in order to provide a more comprehensive picture of a child's overall cognitive and expressive abilities, psychological functioning, etc. Although limited for investigative purposes, testing applications can provide a wide range of highly valuable information in treatment, prevention, or service settings.

Prevention

Primary prevention programs are generally targeted to the general community, and discriminating among individuals is not an issue. Consequently, primary prevention workers are not usually concerned with client assessment, except to evaluate programmatic outcomes or goal attainment. In secondary prevention settings, however, the focus is on preventing the occurrence of abuse among high risk parents. It is assumed that some parents are more at risk for child maltreatment than others, and consequently some sort of screening procedure must be instituted in order to triage clients into secondary prevention programs. A number of risk assessment and abuse potential screening scales are available which can assist in screening (e.g., Child Abuse Potential; Milner, 1986a). Given that most secondary prevention services (e.g., parenting classes, perinatal home visiting, etc.) are fairly benign and relatively non-stigmatizing, we might be willing to accept a significant number of false positives from screening instruments in order to reach a large percentage of truly at-risk parents.

Treatment

In treatment settings, formal assessment can play a number of roles. Testing can be useful in providing a broad range of information about how a child or parent copes, the extent of current symptoms or distress, what resources are present, and what problems may lie ahead. They can also assist in deriving recommendations concerning treatment needs, modalities, and settings as well as providing a baseline against which treatment progress can be assessed and documented.

Only recently have researchers begun to develop measures to assess abuse-specific issues in abused children. Examples include the Children's Impact of Traumatic Events Scale—Revised (CITES-R; Wolfe & Gentile, 1991) and the Trauma Symptom Checklist for Children (TSC-C; Briere, 1990). Naturally, abuse-specific instruments share many similarities in target areas with abuse-focused therapy, making them particularly well suited to assessing progress and documenting treatment outcome.

Conclusion

Psychological testing instruments can play a valuable role in making sure that abused children and their families receive appropriate and effective interventions. They can be an important tools. However, it is important to realize their limitations, and to recognize that they supplement, rather than replace, clinical or professional judgment. Also, it is important to realize that in some settings, the most appropriate test may be no test at all. Decision-makers and other consumers of evaluations should consult with a qualified psychologist who is familiar with child maltreatment issues in determining whether or not testing is appropriate and, if so, what instruments would be best suited to answering the specific questions posed by the referral.

References

American Professional Society on the Abuse of Children. (1990). *Guidelines for psychosocial evaluation of suspected sexual abuse in young children.* Chicago, IL: Author.

American Psychological Association. (1985). *Standards for educational and psychological testing.* Washington, DC: Author.

Bonner, B., Kaufman, K., Harbeck, C., & Brassard, M. (1992). Child maltreatment. In C.E. Walker & M.E. Roberts (Eds.), *Handbook of clinical child psychology* (2nd ed., pp. 967-1008). New York: Wiley.

continued on next page

Research and Practice

–Mark Chaffin and Joel Milner

continued from page 12

Briere, J. (1990, August). Early data on the Trauma Symptom Checklist for Children (TSC-C). Paper presented at the annual meeting of the American Psychological Association, Boston, MA.

Caldwell, R.A., Bogat, A.G., & Davidson, W.S. (1988). The assessment of child abuse potential and the prevention of child abuse and neglect: A policy analysis. *American Journal of Community Psychology, 16,* 609-624.

Chaffin, M. (1992). Factors associated with treatment completion and progress among intrafamilial sexual abusers. *Child Abuse & Neglect, 16,* 251-264.

Everson, M., & Boat, B. (1989). False allegations of sexual abuse by children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 28,* 230-235.

Grotevant, H.D., & Carlson, C.I. (Eds.). (1989). *Family assessment: A guide to methods and measures.* New York: Guilford Publications

Hall, G.C., Maiuro, R.D., Vitaliano, P.P., & Proctor, W.C. (1986). The utility of the MMPI with men who have sexually assaulted children. *Journal of Consulting and Clinical Psychology, 54,* 493-496.

Hall, G. C., Proctor, W. C., & Nelson, G. M. (1988). Validity of physiological measures of pedophilic sexual arousal in a sexual offender population. *Journal of Consulting and Clinical Psychology, 56,* 118-122.

Jones, D.P.H., & McGraw, J.M. (1987). Reliable and fictitious accounts of sexual abuse to children. *Journal of Interpersonal Violence, 2,* 27-45.

Marshall, W., & Barbaree, H. (1988). The long-term evaluation of a behavioral treatment program for child molesters. *Behavior Research and Therapy, 26,* 499-511.

McLeer, S.V., Deblinger, E., Atkins, M., Foa, E., & Ralphe, D. (1988). Post-traumatic stress disorder in sexually abused children: A prospective study. *Journal of the American Academy of Child and Adolescent Psychiatry, 27,* 650-654.

Melton, G.B., & Limber, S. (1989). Psychologists' involvement in cases of child maltreatment: Limits of role and expertise. *American psychologist, 44,* 400-411.

Milner, J.S. (1986a). *The Child Abuse Potential Inventory: Manual (2nd ed.).* Webster, NC: Psytec Corporation.

Milner, J.S. (1986b). Assessing child maltreatment: The role of testing. *Journal of Sociology and Social Welfare, 13,* 64-76.

Milner, J.S. (1989). Applications of the Child Abuse Potential Inventory. *Journal of Clinical Psychology, 45,* 450-454.

Milner, J.S. (1990). *An interpretative manual for the Child Abuse Potential Inventory.* Webster, NC: Psytec Corporation.

Milner, J.S. (1991a). Measuring parental personality characteristics and psychopathology in child maltreatment research. In R.H. Starr, Jr. & D.A. Wolfe (Eds.), *The effects of child abuse and neglect: Issues and research* (pp. 164-185). New York: Guilford Publications.

Milner, J.S. (1991b). Physical child abuse perpetrator screening and evaluation. *Criminal Justice and Behavior, 18,* 47-63.

Mitchell, J.V. (1983). *Tests in print III.* Buros Institute of Mental Measurement. Lincoln: University of Nebraska Press.

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

Myers, J.E.B., Bays, J., Becker, J., Berliner, L., Corwin, D., & Saywitz, K. (1989). Expert testimony in child sexual abuse litigation. *Nebraska Law Review, 68,* 1-145.

O'Donohue, W., & Letourneau, E. (1992). The psychometric properties of penile tumescence assessment of child molesters. *Journal of Psychopathology and Behavioral Assessment, 16,* 123-174.

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

Simon, W.T., & Schouten, P.G.W. (1992). Problems in sexual preference testing in child sexual abuse cases: A legal and community perspective. *Journal of Interpersonal Violence, 7,* 503-516.

Sweetland, R.C., & Keyser, D.J. (1986). *Tests: A comprehensive reference for assessments in psychology, education, and business.* Kansas City: Test Corporation of America.

Touliatos, J., Perlmutter, B.F., & Straus, M.A. (Eds.). (1990). *Handbook of family measurement techniques.* Newbury Park, CA: Sage.

Wolfe, V., & Gentile, C. (1991). The children's impact of traumatic events scale—revised (CITES-R). Available from the authors at the Department of Psychology, Children's Hospital of Western Ontario, 800 Commissioners Rd. East, London, Ontario, Canada.

Mark Chaffin, PhD, Executive Editor of The Advisor, *is a clinical psychologist and Assistant Professor at University of Arkansas Medical Center, Department of Pediatrics. Joel Milner, PhD, is Professor of Psychology and Director of the Family Violence Research Program at Northern Illinois University.*

APSAC FRIENDS

These members and supporters have made generous contributions within the last year to APSAC's Endowment Fund to help ensure APSAC's future.

Veronica Abney, MSW
Margaret Beekman, PhD
Carol Berkowitz, MD
Lucy Berliner, MSW
Linda Blick, LCSW
Barbara Bonner, PhD
Marla Brassard, PhD
John Briere, PhD
Susan Brooks, MSSW
Marian Budzynski-Moldan, ACSW
Ann Burgess, DNS
Caryn L. Burke, MSW
Diane Burks, MS
Dominique Cattaneo, MSW
Mark Chaffin, PhD
Susan Charkoudian, LCSW
Saul Cohen, JD
Don Condie, MD
Jon R. Conte, PhD
Thomas Cornwall, MD
David Corwin, MD
Angie Cotie
Christine Courtois, P hD
Ray Coxe, PhD
Patricia Crittenden, PhD
Thomas Curran, LCSW, JD
Kathleen Dully, MD
Yolanda Duralde, MD
Harry Elias, JD
Suzanne Lizabeth Ellis, MA
Kenneth Feldman, MD
Jamie Ferrell, RN
Martin Finkel, DO
Stuart Fishelman, MSW
Agnes Franz, MD
Colleen Friend, LCSW
Det. Dana Gassaway
Charlie Gentry, MSW
William Gideon, MD
Sol Gothard, MSW, JD
Carol Griffith, MA
Laura Gutman, MD
Kathryn Hall, PhD
Cynthia Harbeck, PhD
Jesse Harris, DSW
Kathleen Hatlelid
Astrid Heger, MD
Mary Hogan, MD
Susan Howard, PhD
Judith Hyde, MA
Rita Jaeger, MD
Paula Jaudes, MD
Carole Jenny, MBA, MD
Maureen Jordan
Marilyn Kaufhold, MA
Keith Kaufman, PhD
G. Richard Kishur, PhD
Kyle Knipe, BSW
Sheldon Krems, PhD
Nancy Lamb, JD
Elizabeth L. Landrum, PhD
Aracely Llanos, PhD
David Lloyd, JD
Mindy Loiselle, MSW
Cassandra Lowe, MA
Kee MacFarlane, MSW
Jamshid Marvasti, MD
Lois Maschmeyer, MA
Anita Mason, MA
Ronald D. Matthews, PhD
Candace McCaffrey, PhD
Patricia McFadyen
Catherine Meeks, PhD
Karen Melikian, MSW
Irene L. Mellick, LCSW
Ann Milgroom, PhD
Madelyn Miller
Simon B. Miranda, PhD
Frances L. Morris, MA
Janet Murphy, MSN
Kathleen Murray, MA
Vladimir Nacev, PhD
Kitty Newbern, RN
Linda J. O'Brien
Catherine O'Leary, JD
Dawn Clarke Palchikoff, MA
Faith Phillips, PhD
Linda Marrinaccio Pucci, PhD
Claire Purcell, PhD
Robert Raymond
L. Dennison Reed, PhD
Katharine Redmond
Theresa Reid, MA
& Marc B. Hershenson, MD
Benjamin E. Saunders, PhD
Judith Schechtman, MSW
Sarah Schuh, MD
Ruth Segaloff, MSW
Claudette Selph, MA
Robin Semas, MSW
Robert Sewell, MD
Celina Pina Shemo, MA
Mary Ellen Shields, MD
William Southwell, MA
Patricia Speck, MSN
& Ron Speck
Catherine Stephenson, JD
Herbert & Ina Stern
Richard Sternlof, PhD
Jemme Stewart, RN, LPC
Barbara M. Stock, PhD
John Stuemky, MD
James W. Sullivan, EdD
Roland Summit, MD
Patricia Toth, JD
Deborah Daro Tuggle,
& Coleman Tuggle
G. Christopher Turner, MSW
Gemma Voss, MSW
Moira Woods, MA
Eileen Warren, Zion Township
Kenneth Zike, MD

Medicine

-Bruce D. Perry

continued from page 1

The neuropsychiatric sequelae of combat have been best characterized in veterans of the war in Vietnam. In the 12-year period of the Vietnam Era, three million Americans served in the Vietnam theater. Over the next twenty years, fully thirty percent of these young adults developed Post-Traumatic Stress Disorder (PTSD, DSM III-R) following combat-related traumatic experiences (Kulka et al., 1990). The debilitating symptoms of PTSD fall into three clusters; 1) recurring intrusive recollection of the traumatic event such as dreams, flashbacks and intrusive thoughts, 2) persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness, and 3) persistent symptoms of increased arousal characterized by hypervigilance, increased startle response, sleep difficulties, irritability, anxiety, and physiological hyperreactivity, reflective of a hyper-reactive autonomic nervous system (see DaCosta, 1871; Bury, 1918; Dobbs and Wilson,1960; Horowitz et al., 1980).

Knowledge of the core neurobiology of the stress response can lead to important insights regarding the etiology and treatment of the adverse physiological, emotional, behavioral and cognitive sequelae of childhood trauma.

How much more pervasive and disruptive traumatic stress may be on young children exposed to chronic violence or abuse during the most vulnerable years of their lives, during the time in which they are developing physically, cognitively, emotionally and socially. If a similar percentage of children exposed to the 'battles of childhood' develop stress-related neuropsychiatric problems, over one million American children each year will join the ranks of other childhood 'veterans' in need of special mental health, educational, and medical services. Furthermore, these childhood problems persist; the great majority of traumatized children carry their scars into adolescence and adulthood.

Despite the scope of this serious public health problem, relatively little research has been dedicated to neurodevelopmental trauma or childhood PTSD. In contrast, studies on the neurobiology of the stress response (e.g., Stone, 1975; Sapolsky et al., 1986; Murberg et al., 1990), 'sensitizing' pharmacological (Kleven et al., 1990; Farfel et al., 1992) or stress paradigms (e.g., Kalivas and Duffy, 1989; Post, 1992), and the basic neurochemical and neurophysiology of PTSD in adults (e.g., Perry, 1988; Krystal et al, 1989; Giller et al., 1990; Perry et al., 1990a) have led to important clinical formulations and interventions. Similar progress in understanding disorders related to childhood trauma will depend upon research advances in neurodevelopment and the impact of traumatic stress upon this process.

The development of a human being from a single cell is an amazingly complex miracle of biology. By adulthood, a single set of genetic material has been differentially expressed in a billion different ways—each resulting in a different cell with unique structural and chemical composition and, therefore, unique functional capabilities. The most complex of all organs, the human brain contains 100 billion neurons and 10 times as many glial cells, each of them unique. The neurons and glial cells of the human brain connect and organize into functional units with specific roles to sense, perceive, process and act on information from outside and inside the individual in a fashion that promotes, first and foremost, survival, and then other actions and transactions of being human.

Understanding the traumatized child requires recognition of a key principle of developmental neurobiology: *the brain develops and organizes as a reflection of developmental experience,* organizing in response to the pattern, intensity and nature of sensory and perceptual experience. The experience of the traumatized child is fear, threat, unpredictability, frustration, chaos, hunger, and pain. Therefore, the traumatized child's template for brain organization is the stress response.

The Neurobiology of Survival

When an infant, child or adult is threatened there is a set of critical, ingrained responses which the body uses to perceive, process and act to defend itself from the threat. In 1914 Walter B. Cannon first coined the phrase "fight or flight" reaction (Cannon, 1914). This well-characterized set of adaptive physiological responses to real or perceived danger involves a series of complex, interactive neurophysiological reactions in the brain, the autonomic nervous system, the hypothalamic-pituitary adrenocortical (HPA) axis, and the immune system (see Loewy and Spyer, 1990).

Some of the systems involved in the stress response are termed "adrenergic" or "noradrenergic." These terms refer to systems using adrenaline (also known as ephinephrine) and noradrenaline (also known as norephinephrine), as their chemical messengers. Most people are familiar with adrenaline as the hormone responsible for causing some of the well-known features of the stress response: dilation of the pupils, rapid heartbeat, high blood pressure, and sweating.

The neurophysiology of the alarm reaction has been studied extensively in human and animal models (see Selye, 1936; Stone, 1975; Stone, 1988; Murberg et al., 1990). Acute stress is associated with a variety of physiological responses including the activation of the HPA axis with a concomitant peripheral release of hormones, including ACTH, epinephrine (adrenaline) and cortisol; a significant increase in centrally-controlled peripheral sympathetic nervous system tone; and the activation of a variety of neurochemical systems in the central nervous systems (CNS). The major method of communication in this process is neurochemical transmission. A chemical neurotransmitter is released from one neuron and interacts with specific neurotransmitter receptors on other neurons, communicating some form of chemical message to these

continued on next page

neurons and, thereby, altering their activity and functioning.

One of the most critical neurotransmitter systems involved in the stress response is the noradrenergic nucleus called the locus coeruleus (LC: Korf, 1976). This bilateral grouping of norepinephrine-containing neurons originates in the pons, a more primitive, regulatory part of the brain, and sends branching projections (axons) throughout brain, connecting directly or indirectly with virtually all major brain regions (Moore and Bloom, 1975; Fillenz, 1990). This diverse set of connections facilitates the orchestrating role of the LC, which acts as a general regulator and monitor of many important brain activities, controlling noradrenergic tone and activity throughout brainstem, midbrain, limbic and cortical areas (Foote et al., 1983). The LC plays a critical role in arousal, vigilance, regulation of affect, behavioral irritability, locomotion, attention, the response to stress, sleep regulation and the startle response (Korf, 1976; Redmond and Huang, 1979; Foote et al., 1983; Aston-Jones and Bloom, 1981; Svensson, 1987; Waterhouse et al., 1988; Fillenz, 1990). Another key adrenergic/noradrenergic system in the brain is the ventral tegmental nucleus (VTN) which is involved in regulation of the sympathetic nuclei in the pons/medulla (Moore and Bloom, 1975). Acute stress results in an increase in LC and VTN activity. This increases the release of norepinephrine from these neurons and influences various functions throughout the brain and the rest of the body.

Understanding the traumatized child requires recognition of a key principle of developmental neurobiology: the brain develops and organizes as a reflection of developmental experience, organizing in response to the pattern, intensity and nature of sensory and perceptual experience. . . . The traumatized child's template for brain organization is the stress response.

The neurophysiological activation seen during acute stress is usually rapid and reversible. When the stressful event is of a sufficient duration, intensity, or frequency, however, the brain is altered. Stress-induced sensitization may occur—the neurochemical systems mediating the stress response (e.g., LC noradrenergic systems) change, becoming more sensitive to future stressors related to the original experience. The molecular mechanisms underlying this phenomenon are not well understood but are related to the same cascade of molecular processes involved in learning and memory.

The stressful experience, via a cascade of neurochemical events, alters the microenvironmental milieu of the central nervous system (CNS), resulting in altered gene expression. The portion of the genome that is expressed in a given neuron is dependent upon the local microenvironment in the nucleus of the neuron. This microenvironment, in turn, is a direct reflection of a biochemical cascade which begins with experience. Experience activates the neurosensory apparatus and alters the pattern and quantity of neurotransmitter release throughout the neuronal networks responsible for sensation, perception, and processing of information. This change in neurotransmitter activity influences, initially, the extracellular milieu of the neurons in the system and then, by neurotransmitter receptor/effector activation, changes important intracellular chemical constituents (i.e., second and third messengers) in all of the neurons synaptically connected to these systems. It is the changes in these second (e.g., cAMP, phosphatidyl inositol) and third messengers which alter the microenvironmental milieu of the nucleus, resulting in changes in gene transcription. These new gene products may then result in permanent or structural changes which are associated with sensitization, learning, memory and, in the developing brain, differentiation (see Kandel and Schwartz, 1982; Goelet and Kandel, 1986).

Stressful experiences or certain drugs, then, when they result in a certain pattern of catecholamine (norepinephrine, dopamine, epinephrine) activity trigger a neurochemical cascade which results in altered expression of proteins (including receptors) involved in catecholamine responsivity (Kalivas and Duffy, 1989; Kleven et al., 1990; Farfel et al., 1992). This altered catecholamine responsivity (sensitization) likely underlies the hypervigilance, increased startle, affective lability, anxiety, dysphoria, and increased autonomic nervous system hyper-reactivity seen in adult PTSD (see Krystal et al., 1989; Perry et al., 1990a). In the adult, mature brain, increases in, or unusual patterns of, catecholamine activity may result in sensitization. In the developing brain, however, neurotransmitters, in addition to their roles in cellular communication, play an important role in the basic neurodevelopmental process (Lauder, 1988). Trauma related alterations in catecholamine activity during childhood, therefore, may alter brain development, resulting in altered functional capabilities of the traumatized brain (Perry, in press).

The Developing Brain

Brain development requires that a small number of cells with similar properties divide, migrate and differentiate to result in billions of cells with different physical and chemical properties. Each of these cells has the same genetic material (genotype) but they have different portions of this genetic material being actively utilized, resulting in the different expressed properties (phenotype) of each individual neuron. The expressed properties of a neuron—the size, shape, protein makeup, chemical constituents—confer the functional properties of the neuron. By differentially expressing portions of the genome, the remarkable structural and functional diversity of neuronal components of the human brain is possible.

Differentiation is the process by which cells become specialized, expressing those components of the genome which confer special properties associated with the functions of the neuron in the mature brain. This process takes place throughout development. While the majority of neurons have been born

continued on next page

continued from page 15

(neurogenesis) by birth (i.e., the final number of cells in the newborn brain is roughly the same as in the mature brain), the majority of individual cell growth and specialization has not taken place. Over the three years following birth, the important processes of neuronal migration, axo-dendritic projection, myelinization, synaptogenesis, and neurochemical differentiation continue to take place. As the brain develops, neurons divide, migrate, and differentiate in response to chemical, microenvironmental cues (morphogens) which confer information to, and direct specific differentiation of, the cell. Each neuron's unique structural, biochemical and functional character, then, is a function of its unique environmental history—the specific pattern, timing and quantity of these microenvironmental cues.

Some of the most important of these microenvironmental cues are receptor-mediated signals from neurotransmitters and hormones. Hormones, neurotransmitters and direct cell to cell contacts act as morphogens. The quantity, pattern of exposure and timing of morphogenic cues orchestrate and guide neuronal development. Indeed, catecholamine cues during development are important in determining critical functional properties of mature neurons, including the density of neurotransmitter receptors (e.g., Miller and Friedhoff, 1988; Perry et al., 1990b). Alterations in the pattern, timing, and quantity of catecholamine (or any critical neurotransmitter system) activity during development might be expected to result in altered development of catecholamine receptor/effector systems and the functions mediated, in part, by these systems.

Despite the scope of this serious public health problem, relatively little research has been dedicated to neurodevelopmental trauma or childhood PTSD. In contrast, studies on the neurobiology of the stress response, 'sensitizing' pharmacological or stress paradigms, and the basic neurochemical and neurophysiology of PTSD in adults have led to important clinical formulations and interventions.

A trauma-induced prolonged stress response will result in an abnormal pattern, timing and intensity of catecholamine activity in the developing brain. The time during development that this prolonged or abnormal catecholamine activity is present determines, to some degree, the nature and severity of the disrupted development. In general, the earlier and the more pervasive the trauma, the more neurodevelopment will be disrupted. The intrauterine environment is not necessarily protective. There is some evidence to suggest that prenatal or maternal traumatic stress has significant impact on neurodevelopment—battering the pregnant mother may also be battering the developing fetus (Amaro et al., 1980). The majority of child abuse or neglect takes place after birth, however. The development of the human brain continues beyond birth and its development remains vulnerable to the abnormal patterns of neurotransmitter and hormone activity associated with traumatic stress. Young children victimized by trauma are at risk for developing permanent vulnerabilities—changes in neuronal differentiation and organization—alterations in brain development which persist into adolescence and adulthood, with potential impact on all aspects of emotional, cognitive and behavioral functioning.

The relationships between the age of the traumatized child, vulnerability, and subsequent adverse sequelae are predicted by another key principle of neurodevelopment—critical and sensitive periods.

Critical and sensitive periods

As important in neurodevelopment as the pattern, quantity, and quality of the neurochemical signals which neurons receive is the timing of signals. There are times in development during which a set of signals must be present for the neurons to differentiate normally. These are called critical periods. In addition, there are times when an undifferentiated neuron is specially receptive or sensitive to a set of signals. At these times, termed sensitive periods, the neuron will use this set of signals to facilitate further specialization as part of a larger functional subsystem in the brain. As neurons develop, they organize into larger functional units, co-developing to specialize in a given set of brain functions. Neurons that transduce light, for example, connect with neurons that perceive light, neurons that localize the perception of light in space, neurons that process this information, others that allow responding to this information and so forth. During this process of co-development, the strength of the connections in this network is dependent, first, upon the presence of the signal (e.g., the light), and then upon the pattern and intensity of this signal (see Jacobson, 1991). The times in development during which these connections are being made and these patterns of activation are taking place are critical to the development of normal functional capabilities in the mature brain (see Meaney et al., 1988). Without certain patterns of activation and certain microenvironmental signals which determine differentiation and facilitate the co-development of these networks, there will be disorganized development and diminished functional capabilities in the mature system.

There are many examples of disrupted neurodevelopment and function in animals following deprivation of sensory cues, primarily visual, tactile, and auditory (Jacobson, 1991). For humans, some extreme illustrations of these principles have been provided by cruel experiments of nature. Children raised with little or no exposure to verbal language never develop the neural apparatus needed for optimal speech or language development (Mason, 1942; Freedman, 1981); children raised in sensory-deprived settings have major deficits in developing integrated neurosensory processing (e.g., Davis, 1940; Freedman and Brown, 1968); children with various visual deficits (e.g., strabismus) develop abnormal visual perceptual and association capabilities (e.g., Lipton, 1970; Bishop, 1987; Freedman, 1992). The length of

continued on next page

Medicine

-Bruce D. Perry

continued from page 16

critical and sensitive periods in animals has been documented for a variety of situations. In humans, however, there is very little information regarding these windows of vulnerability; the majority of the irreversible sensory processing deficits have resulted from deprivations during the first three years of life.

The development of networks of neurons mediating a given set of important brain functions is, therefore, dependent upon the quantity, quality, and pattern of activation during key time periods during development. Understanding the principles of this use-dependent development is critically important for understanding the neurodevelopmental effects of childhood trauma. There are, of course, critical and sensitive periods for the development of important brain systems and functions other than neurosensory processing. There is overwhelming evidence suggesting sensitive, if not critical, periods for brain functions associated with mental health, including attachment, affect modulation, anxiety regulation, and behavioral impulsivity (Spitz, 1945; Spitz and Wolf, 1946; Patton and Gardner, 1963; Provence, 1983), all of which utilize to varying degrees the same neurobiological subsystems which mediate the stress response. The best examples of this in humans, again, is from cruel experiments of nature. The orphans described by Spitz (1945) and the more recent Rumanian orphans illustrate the potential neurodevelopmental devastation resulting from affective, tactile, and emotional undernourishment.

The brains of traumatized children develop as if the entire world is chaotic, unpredictable, violent, frightening and devoid of nurturance—and unfortunately, the systems that our society has developed to help these children often continue to fill their lives with neglect, unpredictabililty, fear, chaos and, most disturbing, more violence.

The sensitive periods for the stress response apparatus in the brain—developmental phases during which an individual is most vulnerable to traumatic stressors—occur when the stress-mediating catecholamine systems are undergoing neurogenesis, migration, synaptogenesis and neurochemical differentiation. The functional capabilities of the CNS systems mediating stress in the adult are determined by the nature of the stress experiences during the development of these systems, i.e., in utero, during infancy, and during childhood (Perry, 1988: in press; Perry et al., 1990). A number of fascinating studies in animals demonstrate the exquisite sensitivity of the developing CNS to stress (see Suoumi, 1986).

In rats exposed to perinatal-handling stress, major alterations in the ability of the rat to learn and to mobilize a stress response are seen later in life (Weinstock et al., 1988). The most interesting aspect of these studies is that exposure to unpredictable stress resulted in deficits while exposure to consistent, daily stress resulted in improved or superior behavior—these animals were resilient. The pattern of stress and the predictability are important in determining how traumatic a stressor is. Elements of predictability and some elements of control make the stress much less destructive. One can speculate on equivalent controlled or daily stress and uncontrollable, non-scheduled stressors in the development of a human. An infant who is allowed to have an optimal degree of frustration, one who can control, during rapprochement, his own optimal degree of tension and anxiety (i.e., stress) and return to mother for comfort, is one whose developing CNS is establishing an appropriate neurochemical milieu for the development of a flexible, maximally-adaptive physiological apparatus for responding to future stressors. A child who is reared in an unpredictable, abusive or neglectful environment (see Spitz and Wolfe, 1946) will likely have evoked in his developing CNS a milieu which will result in a poorly organized, dysregulated CNS catecholamine system. One would hypothesize that such an individual would be susceptible to the development of more severe signs and symptoms when exposed to psychosocial stressors through the course of his or her life.

Studies in humans suggest that this is the case. Increased psychiatric symptoms and disorders are observed in adults who have severe, unpredictable early life stressors (Brown and Harris, 1977; Lloyd, 1980; Rutter, 1984). A provocative study by Breier and co-workers (1988) reported the effects of parental loss during childhood on the development of psychopathology in adulthood. They examined a number of adults who had suffered a parental loss during childhood and found that the subjects with psychiatric disorders and symptoms had significant biological and immunological changes related to early parental loss relative to control groups. The authors concluded that early parental loss (a traumatic event) accompanied by the lack of a supportive relationship subsequent to the loss (an external stress-reducing factor) is related to the development of adult psychopathology.

Other studies have documented relationships between developmental trauma and borderline personality disorders (Ogata et al., 1988; Herman et al., 1989), depressive disorders (Kaufman, 1991), dissociative disorders (Putnam, 1991; Peterson, 1991) and a variety of other medical and psychiatric conditions (Coddington, 1972a: 1972b; Garmezy, 1978; Beautris et al., 1982; Boyce, 1990; Greenwood et al., 1990; Davidson et al., 1991). Clearly, these studies provide correlative data indicating that developmental stress is a major expressor of any underlying constitutional or genetic vulnerability and, in some cases, may be the primary etiological factor in the development of certain neuropsychiatric disorders.

The abnormal pattern of stress-mediating neurotransmitter and hormone activations during development alters the brains of traumatized children. The specific nature of these functional alterations is seen in all of the brain functions which are directly or tangentially related to CNS catecholamine systems. Unfortunately, the CNS catecholamines (and likely other important neurotransmitter systems altered by these experiences) are involved in almost all core regulatory activities of the brain. The brainstem and midbrain catecholamines are involved in regulation of affect,

continued on next page

Medicine

–Bruce D. Perry

continued from page 17

anxiety, arousal/concentration, impulse control, sleep, startle, autonomic nervous system regulation, memory, and cognition. Clearly the physical signs and symptoms seen in traumatized children include dysfunction and dysregulation in these domains. Indeed, the core symptoms seen in severely traumatized children may be traced back to dysregulation of these root neurophysiological regulatory functions.

Clinical implications

The human brain and all of the functions that this amazing organ mediate develop as a reflection of developmental experiences. This mirroring quality of the developing human brain has evolved as an extension of the primary mandate of the brain to perceive, process, and act on information from the environment in order to maximize survival potential. If the child is raised in an unpredictable, chaotic, violent environment, it is highly adaptive to have a hypervigilant, hyper-reactive arousal system; if primary relationships are characterized by violence, neglect and unreliability, intimacy becomes maladaptive; if a young child is frequently assaulted, it becomes adaptive to overinterpret non-verbal cues, to quickly act on impulses, and to strike out before being struck. The symptoms of hypervigilance, cognitive distortion, physiological and behavioral hyperreactivity, intimacy avoidance and dissociation commonly seen in traumatized children were all, at some time in the lives of these children, necessary, adaptive and appropriate responses to traumatic stress.

The same remarkable qualities of the developing brain which allow the growing child to internalize and rapidly learn about the world ultimately betray the traumatized child. Their brains develop as if the entire world is chaotic, unpredictable, violent, frightening and devoid of nurturance—and unfortunately, the systems that our society has developed to help these children (the juvenile justice, foster care and mental health systems) often continue to fill their lives with neglect, unpredictabililty, fear, chaos and, most disturbing, more violence. Neurodevelopmental principles and the basic neurophysiology of the stress response would predict that the primary, baseline neurophysiological state of the traumatized child is a persisting state of alarm, most similar to a state of fear. Much more research in the basic neurobiology of development and the neurophysiology of traumatized children is required. Only then can the relationships between neurodevelopment and trauma-related neuropsychiatric problems be understood well enough to guide innovative therapeutic approaches and initiate social policy changes to bring an end to the war on children.

Due to space limitations, complete references for this series will be published with the second article in the next issue of The Advisor, *V.6, n.2, 1993. To receive a copy of references for this article immediately, write or call APSAC, 332 S. Michigan Ave., Suite 1600, Chicago, IL 60604. Phone: 312-554-0166.*

Bruce Perry, MD, PhD, is Associate Professor in the Laboratory of Developmental Neurosciences in the Departments of Psychiatry, Pediatrics, and Pharmacology at Baylor College of Medicine in Houston, Texas.

NEW RESOURCE

Development of a Database for Child Protection Teams

—by Marcia Herman-Giddens

The Child Protection Team (CPT) at Duke University Medical Center is a multidisciplinary group that evaluates children from Durham and surrounding areas of North Carolina referred for concerns of abuse or neglect. Since its establishment in 1978, the Team has evaluated almost 5,000 children. The Team is also responsible for teaching physicians, nurses, pediatric residents, physician assistants, and medical students about child abuse and neglect as well as conducting training sessions around the state for other professionals. Research has always been a component of the Team's work.

As our program grew, we began to seek a database that would suit our needs for reporting and research. After talking with colleagues we were not able to identify an existing database that met our purposes. Since we did not have the funds to have the software written by a firm, we submitted our proposal to a software development competition and were fortunate to be chosen.

The system that was developed met our requirements. It is a user-friendly database that records patient demographics, including the protection of confidentiality, the ability to link children with their mothers when the last names were different, and a safeguard against entering duplicate history numbers. It tracks the referral source, with easy access to numbers and sources of referrals along with their addresses. The outcome of each evaluation is recorded, including the diagnosis, final determination of the case, hospital admissions and mortality. We also record necessary follow-ups, and referrals to social service or police agencies. A record of whether or not physical findings were present is also important to us given our ultimate goal of developing a more detailed database of physical and sexual abuse for research and epidemiological purposes. Finally, we are able to transfer data to other databases or to ASCII in order to generate graphics for our reports.

We now use this flexible program for generating the data requirements detailed above as well as for creating weekly listings for meetings and review.

We think other child protection teams might benefit from this database. Droege Computing Services, Inc., has made the database available as Shareware, which gives users a chance to try software before buying it. Systems requirements are as follow:

- IBM compatible (AT, 80286, or later CPU recommended)
- Hard disk
- MS-DOS 3.1 or later
- 640K or more RAM
- LAN compatibility.

Readers who are interested in more information may write Droege Computing Services, 1816 Front Street, Suite 130, Durham, NC 27705. For $5.00, Droege will send a floppy diskette and a description of the program for trial.

Marcia Herman-Giddens, PA, MPh, is an Assistant Clinical Professor in the Department of Pediatrics at Duke University Medical Center.

MEDIA REVIEWS

***Preventing child sexual abuse: Sharing the responsibility,* by Sandy K. Wurtele and Cindy L. Miller-Perrin. University of Nebraska, 1992, 285 pp., $30.00 cloth.**

—Reviewed by Jennifer Dziuba-Leatherman

This well-researched and thoughtfully-organized book emphasizes the need for redirecting current child sexual abuse (CSA) prevention efforts. The authors, skeptical of the idea that prevention can be accomplished through child-focused programs alone, advocate instead a multi-level plan which assigns much greater responsibility to parents, child professionals, and other adults. They also incorporate detection of ongoing abuse as a fundamental goal of prevention.

Chapter One begins with a comprehensive overview of the CSA problem, including continued on next page current incidence/prevalence estimates, recent findings on characteristics of victims and offenders, and a review of the consequences of CSA. Little novel information is revealed in this review, but it does provide an excellent summary of the current state of knowledge in the field.

Following a review of risk factors associated with CSA, the authors critique the notion of a unidimensional explanation of the problem, and introduce what they term a "multifactor" model. Loosely based on Finkelhor's (1984) Four Preconditions Model, it conceptualizes CSA as arising not from some measurable "cause" but from a context which may include a variety of characteristics of individuals, families, and cultures. The model highlights the need for targeting prevention efforts at levels beyond the individual child.

Each of the remaining four chapters addresses a particular target group: children, parents, professionals, and policymakers, researchers, and the general public. Each chapter begins with an explanation of the rationale behind current prevention efforts aimed at a particular group, and identifies the goals of such efforts. Next, evaluation studies of these strategies are reviewed, and the authors contemplate possible effects and side effects of currently-used techniques. Finally, each chapter ends with recommendations for future prevention efforts within the target group.

A theme of interest in these chapters is that of understanding child sexual development. The authors acknowledge that little is known about children's sexual knowledge at any given age, and that even less is known about their sexual behavior. While inappropriate verbalizations or behaviors can provide important clues about past or ongoing abuse, lack of information about developmentally normative sexuality may hamper detection by adults. To this end, the authors provide a very useful table summarizing what is known about the sexual behavior and knowledge characteristics of children at various ages.

One omission, however, is the book's failure to address the discomfort many adults feel about the topic of sexuality, particularly as it relates to children. The relative lack of knowledge about child sexuality is probably both a symptom and a cause of this uneasiness. Suggestions for facilitating discussions of the topic with children, and for demystifying childhood sexual expression, are sorely needed.

This book makes many outstanding contributions to the field of prevention, including thorough reviews of current research on many CSA-related topics, and some important new roles for parents. Its real value, however, is in its synthesis of a wide range of diverse prevention efforts. This feature makes *Preventing child sexual abuse: Sharing the responsibility* a must-read for prevention programmers and program evaluators at every level.

Jennifer Dziuba-Leatherman is a doctoral student in sociology at University of New Hampshire and Research Assistant at the Family Research Laboratory.

▼ ▲ ▼

Cases of Concern, a videotape by the Sexual Assault Center, Harborview Medical Center, Seattle, Washington. Produced by Pinnacle Productions International, Spokane, Washington. 1991, 73 minutes, $150.00.

—Reviewed by Allan R. DeJong

Cases of Concern is a technically well-prepared videotape focusing on the physician's role in cases of child sexual abuse. The introduction suggests that the purpose of the tape is to train community physicians so they can appropriately assess child sexual abuse, stating:

Every child and parent has a right to expect that a physician in their community be capable of assessing cases of child sexual abuse. Yet in reality few physicians are well prepared to deal with this issue. This program will address the problem in two ways: first with specific medical information and secondly by attempting to present a clear understanding of the physician's role in cases of sexual abuse.

The videotape is divided into three parts: 1) "Cases of Concern" (55 minutes), 2) "Prepubertal Female Genital Anatomy" (2 minutes) and 3) "Review of Clinical Slides" (15 minutes). "Cases of Concern" covers topics including the role of the physician, physical and behavioral indicators of abuse, prepubertal anatomy, sexual abuse history (interview), sexual abuse physical examination, documentation, sexually transmitted diseases, forensic evidence, treatment and follow-up, and legal aspects for the physician. Many pertinent "pearls" are shared by a group of recognized medical, social work and legal experts using a format which integrates brief statements by experts with graphics. Because of its broad scope, the tape moves rapidly from topic to topic. Therefore,

continued on next page

Media Reviews

continued from page 21

some topics are briefly outlined. For example, the prepubertal anatomy is shown in a labeled drawing while the voice-over suggests that physicians need to get training in evaluation of prepubertal genital anatomy, and should routinely examine children's genitalia to gain familiarity with normal variations. Likewise, the description of genial and anal examinations is provided via a series of charts listing the parts to be examined and described, without picturing these structures.

The second part of the tape is entitled "Prepubertal Female Genital Anatomy". This two minute segment uses a diagram of the prepubertal female genitalia, and through a progressive disclosure technique, serially adds labels to specific anatomical structures. The only audio is an inoffensive musical background, with no dialogue to describe the labeled parts. The final segment of the tape, titled "Review of Clinical Slides," provides a series of colposcopic photographs with voice-over dialogue describing specific aspects of the pictures. A number of photographs are used to show the variations of the hymenal tissues, while others demonstrate specific genital and anal lesions, scars and infections. Superimposed arrows are used on some of the photographs to point out specific findings and provide orientation, while others are described only in general terms.

No one should suggest this tape, by itself, can train the community physician to assess cases of child sexual abuse. We can't expect adequate training to occur in 73 minutes. However, Cases of Concern does provide a solid introduction to the physician's role in the identification, evaluation and management of child sexual abuse. This videotape could serve as an overview in a training program supported by additional training materials and experiences.

Allan R. De Jong, MD, is Clinical Professor of Pediatrics and Director of the Pediatric Sexual Abuse Program at Jefferson Medical College in Philadelphia.

NEWS

Data Collection for Third National Incidence Study to Begin this Fall

Federal, state, and local human services officials, together with professionals from a variety of fields, have worked in collaboration for many years to establish effective programs to protect and treat abused and neglected children and their families. While great progress has been made over the last two decades, child maltreatment remains a major social problem in our country.

Since its creation in 1974, the National Center on Child Abuse and Neglect (NCCAN) has supported state and local agencies in developing programs to prevent, identify, and treat child abuse and neglect. On the national level, NCCAN's work has included the conduct of two Congressionally-mandated national studies of child abuse and neglect. The first of these, the National Study of the Incidence and Severity of Child Abuse and Neglect (NIS-1), was conducted in 1979-80. It provided first-time national estimates of the incidence, severity, and demographic and geographic distribution of recognized child maltreatment in the United States. The second study, the National Study of the Incidence and Prevalence of Child Abuse and Neglect (NIS-2), provided 1986 estimates of the national incidence of child abuse and neglect and determined the extent to which the incidence of child maltreatment had increased or decreased since NIS-1.

Now, NCCAN is about to undertake the third National Study of the Incidence of Child Abuse and Neglect (NIS-3). NIS-3 will obtain current national estimates of the incidence, distribution, and severity of child abuse and neglect and will study child abuse and neglect cases that are referred to the court system. Like its predecessors, NIS-3 is a Congressionally-mandated study. It was authorized by Congress under the Child Abuse Prevention, Adoption, and Family Services Act of 1988 (Public Law 100-294). NCCAN has contracted with Westat, Inc. to conduct the study. Westat, a national social sciences research firm, was NCCAN's contractor for NIS-1 and NIS-2.

The objectives of NIS-3 are threefold:

1. To estimate the current national incidence, severity, and geographic and demographic distribution of child maltreatment, based on standardized research definitions.
2. To estimate, to the extent possible, changes in the severity, frequency, and character of child maltreatment since the NIS-1 and NIS-2 data were collected.
3. To estimate the incidence of substantiated child abuse cases that are referred to the court system and characterize these cases.

Data collection will be implemented simultaneously in 40 counties across the country. These counties have been selected according to scientific sampling procedures which ensure the necessary mix of geeographic regions, urban and rural areas, and other major population characteristics. In each study county, the local child protective agency and approximately 20 other community agencies and institutions will be asked to participate in NIS-3 data collection. Data collection will occur during a three-month refernce period in the Fall of 1993.

APSAC wholly supports this effort to secure reliable, useful information about child maltreatment nationally. For more information about the Westat study design, contact Andrea Sedlak, Project Director, or Diane Broadhurst, Senior Researcher, at Westat, Inc., 1650 Research Boulevard, Rockville MD 20850. Phone: 1-800-288-NIS3.

CALL FOR NOMINATIONS

Nominations are being sought for the 1994 APSAC Awards. Awards will be given in the following categories:

Outstanding Service Award

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

Outstanding Professional Award

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

Research Career Achievement Award

This award recognizes an APSAC member who has made repeated, significant, and outstanding contributions to research on child maltreatment over his or her career.

Outstanding Media Coverage Award

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

For information on how to nominate a colleague call the APSAC office at 312-554-0166. Complete nominations must be received by than May 1, 1993.

News

-Theresa Reid

continued from page 2

Your opinions about all of these key projects will be solicited in *Advisor* issues to come.

A moving awards ceremony followed the business report. Lucy Berliner and David Corwin accepted their awards in person (see p. 3), as did several members of the 1993 President's Honor Roll. Then, the raucous fun began.

The uninhibited members of APSAC's Board, Advisory Board, and general membership treated (or subjected) the rest of the crowd to the APSAC Variety Show. John Stirling, MD, a member from Vancouver, Washington, composed a song for the occasion for the second year in a row. Called "Prosecutor's Blues," it features original words set to original music. An overwhelming hit, "Prosecutor's Blues" will be reprised at the membership meeting at APSAC's First National Colloquium, and included in *The APSAC Song Book* (to be published in the unforseable future).

In all, the evening was very enjoyable, and we look forward to meeting with as many APSAC members as possible on Thursday, June 24, 1993, 5:30 p.m. at the Hotel Nikko in Chicago.

TOLL-FREE HELP:

Nationwide Numbers for Child Abuse and Neglect Services

800-227-5242	American Association for Protecting Children
800-448-3000	Boystown National Hotline
800-I-AM-LOST	Child Find Hotline
800-422-4453	Child Help USA
800-999-9999	Covenant House Hotline
800-221-2681	Family Services of America
800-A-WAY-OUT	Hotline for parents considering abducting their children
800-272-0012	Kevin Collins' Foundation for Missing Children
800-872-5437	Missing Children Help Center
800-843-5678	National Center for Missing and Exploited Children
800-222-1464	National Child Safety Council
800-222-2000	National Council on Child Abuse
800-333-SAFE	National Domestic Violence Hotline
800-999-5599	National Information Center for Children and Youth with Handicaps
800-KIDS-006	National Resource Center on Child Sexual Abuse
800-231-6946	National Runaway Hotline
800-621-4000	National Runaway Switchboard
800-442-HOPE	National Youth Crisis Hotline
800-782-SEEK	Operation Lookout, National Center for Missing Youth
800-421-0353	Parents Anonymous (except in California)
800-352-0386	Parents Anonymous (in California)
800-627-3675	Red Flag/Green Flag Resources (sexual abuse prevention materials for children and young women)
800-333-1069	Tough Love (problem teens)
800-236-1222	Tri-County Council on Domestic Violence and Sexual Assault
800-HIT-HOME	Youth Crisis Hotline (child abuse, runaways)

STATE CHAPTER CONTACTS

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

States with approved charters:

AR - Louanne Lawson, RNPC, MNSc
Arkansas Children's House
800 Marshall
Little Rock AR 72207
501-320-1013

AZ - Karen Gray, MSW
Maricopa Medical Center
Pediatric Social Work
P.O. Box 5099
Phoenix AZ 85010
602-267-5321

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

Philip Madonna, MSW
U. Colorado Health Science Ctr.
4200 E. 9th Av., Box C-259
Denver CO 80262
303-270-5016

IL - Erin Sorenson
Children's Advocacy Center
640 Illinois Blvd.
Hoffman Estates IL 60194
708-855-0100

MA - Suzanne White, MSW
Simmons College,
School of Social Work
51 Commonwealth Ave.
Boston MA 02115
617-728-2930

MN - Ann Ahlquist, MSW
Corner House Child Abuse Center
2502 10th Ave. South
Minneapolis MN 55404
612-872-6225

Carolyn Levitt, MD
Children's Hospital
345 Smith Av. North
St. Paul MN 55102
612-298-8478

NC - Carolyn Cole, MSW
Duke U. Medical Center
Box 2906
Durham, NC 27710
919-286-4456

Timothy Lemmond, MSW
2012 E. Ninth Ave.
Charlotte NC 28204
704-333-2751

OH - Linda Lewin, RN and David Gemmill, MD
Medical College of Ohio
Unit 6B (Child & Family Assessment)
P.O. Box 10008
Toledo, OH 43699
419-381-3493

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

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

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

OR - Robert Sewell, MD
Lincoln City Medical Center
2870 W. Devils Lake Road
Lincoln City OR 97367
503-994-9191

Paul Thomas, MD
Emanuel Hospital
Children's Health Care Center
2801 N. Gantenbein
Portland OR 97227
503-280-3042

PA - Thomas F. Curran, LCSW, JD
Defenders Association
of Philadelphia
Child Advocacy Unit
121 N. Broad St.
Philadelphia PA 19107
215-568-3190

Christine Grant, RN, PhD
U. Penn. School of Nursing
420 Guardian Dr.
Philadelphia PA 19104-6096
215-898-5660

TN - David Muram, MD
UTMG Dept. OB/GYN
853 Jefferson Av. #E102
Memphis TN 38103
901-528-5819

Bonnie Beneke, MSW
Old Harding Road Mental Health Consultants
4819 Old Harding Road, Suite 206
Nashville TN 37205
615-352-4439

TX - David Cory, MSSW
Texas Dept. Human Services
P.O.Box 6635
Abilene TX 79608
915-672-6814 x224

WA - Debbie Doane, MSW
Eastside Sexual Assault Center
925 116th St. NE, Suite 211
Bellevue WA 98004
206-462-5130

Paul Stern, JD
Snohomish Co. Prosecutor's Office
Mission Building
3000 Rockefeller Ave.
Everett WA 98201
206-388-3671

NNEPSAC (Northern New England)

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

Ann Bastille, MA
Community Council
7 Prospect St.
Nashua NH 83060
603-889-6147

AL - Michael Taylor, MD
CAPstone Medical Center
700 University Blvd. East
Tuscaloosa AL 35401
205-348-1309

Patrick F. Guyton
Child Advocacy Center
1351 Springhill Ave.
Mobile AL 36604
205-432-1101

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

Cheryl Burack-Lynch, MS
Coordinating Council for Children in Crisis
900 Grand Ave.
New Haven CT 06511
203-624-2600

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

DE - Robert Hall, MDiv
Delawareans United to Prevent Child Abuse
124CD Senatorial Drive
Wilmington DE 19807
302-654-1102

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

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

GA - Paul Cardozo
1270 Prince Ave., Suite 105
Athens GA 30606
404-546-9880

HI - Beverly James
James Associates
P.O. Box 148
Honaunau HI 96726
808-328-2073

IA - Rizwan Shah, MD, FAAP
Family Ecology Center
1111 Ninth St., #230
Des Moines IA 50314
515-208-1808

Randy Alexander, MD
University of Iowa
209 Hospital School
Iowa City IA 52242
319-353-6136

ID - Paul Vogel, JD
Deputy Prosecuting Attorney
Box 1486
Sandpoint ID 83864
208-263-6714

IN - Diane Burks, MS
Indianapolis Institute for Marital and Family Relations
652 N. Girls School Road #135
Indianapolis IN 46214
317-271-3500

KS - Lynn Sheets, MD and Patricia Phillips, MN
U. of Kansas Medical Center
Department of Pediatrics
39th and Rainbow Blvd.
Kansas City MO 66103
913-941-2236

KY - Katie Bright, MD
Department of Pediatrics
University of Kentucky
Medical Center
Lexington KY 40536
606-233-6426

LA - John Jennette, LPC
Counseling & Education Resources
11941 Justice Ave., Suite E
Baton Rouge LA 70816
504-291-9960

MD - Gail Bethea-Jackson, LCSW
Psychological Assoc. of Oxon Hill
6178 Oxon Hill Road
Oxon Hill MD 20745
301-567-9297

MI - Charles Baker-Clark, MS
Battle Creek Adventist Hospital
165 N. Washington
Battle Creek MI 49016
616-964-7121

MO - David Corwin, MD
Wash. Univ. Med. Schl.
Dept. of Psychiatry
4625 Lindell Ave.
St. Louis MO 63108
314-454-2605

MS - Paul Davey, MS
Children's Advocacy Center
753 N. President
Jackson MS 39202
601-627-7267

MT - Sandra Rahrer
405 W. Central
Missoula MT 59801
406-721-1455

NE - Mary Paine, PhD
U. Nebraska-Lincoln, Dept. Psychol.
209 Burnett Hall
Lincoln NE 68588
402-472-3721

NJ - Karen Obssuth, MSW
364 Henley Ave.
New Milford NJ 07646
201-599-6235

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

RI - Eileen Ovadje
155 Orms St.
Providence RI 02908

UT - Marilyn Sandberg
Executive Director
Child Abuse Prevention Council
457 26th Street (rear)
Ogden UT 84401
801-399-8012

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

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

Michelle Zimmerman, MA, RN
Avery-Finney Associates
11 Koger Center, Suite 141
Norfork VA 23502
804-461-8697

WI - Lynn Copen
Office of the District Attorney
912 56th St., Room 312
Kenosha WI 53140
414-656-6480

Mark Lyday, ACSW
P.O. Box 1997
Milwaukee WI 53201
414-258-1494

Sue Seitz, PhD
Madison Mental Health
Marshall Court, Suite 1
Madison WI 52705
608-238-4595

People of Color Leadership Institute

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

A MESSAGE FROM THE PROJECT DIRECTOR: We Are Also in Transition

—by Joyce N. Thomas, RN, MPH

Racial conflict and ethnic injustice is this nation's most serious disease. Unfortunately it impacts the lives of millions of people from all ethnic groups. We know this problem has affected the child protection system, and perhaps accounts for much of the over-representation of children of color in our system. The POCLI project has provided all of us with a wonderful opportunity to gain greater knowledge, share our concerns, and identify useful strategies for working with ethnic populations. As the project has expanded, we have observed, first hand, the changes in attitudes and behavior. As the country has demonstrated the desire to change political administrations, so has the field of child abuse demonstrated the desire to change in the right direction. In fact there is a very strong message from our colleagues in this field about the documented need for all services and interventions for abused children and their families to be "culturally appropriate."

The problems in delivering services to ethnic-minority populations have been cited by several writers (Billingsley, 1978; Williams, 1986; Walker, 1990). While the source of the problems does not follow strict racial lines, it is quite clear that there are disproportionately fewer professionals of color in leadership and decision making roles. We hear this point stated over and over again in workshops, speeches, seminars, conferences and similar forums. Such language as "cultural diversity," "culturally sensitive," and "cultural distinctions," even appears in the 1992 Child Abuse and Neglect Prevention and Treatment Act. Naturally, it will take a long time to see any radical changes, but the issues of diversity are more openly addressed. This is an extremely positive sign.

Recently the issue of cultural competence was highlighted on a grand scale at the U.S. Advisory Board on Child Abuse and Neglect Symposium. This forum, which was held in Bethesda, Maryland in the Fall of 1992, focused on "Creating and Maintaining Caring and Inclusive Communities." We heard about the critical elements necessary to maintaining well-functioning ethnic-minority neighborhoods. We heard about the numerous problems and barriers in our ethnic communities. Many promising approaches and strategies for improved client outcome were also discussed. Complex elements of the issue were raised by Dr. John Holton, Amy Okamura, Carmen Fernandez, Delores Bigfoot and others, including myself. Hard-hitting questions from members of the U.S. Advisory Board demonstrated an intense desire to gain greater insight, and thus improve the quality of care for all

continued on next page

A College-Wide Prevention Program on Child Abuse and Neglect

—by Jacqueline Booth

In response to the growing problem of child abuse and neglect, Spelman College, a historically Black institution, launched an innovative child abuse prevention program which targets its student population. Implemented in 1990, the College-Wide Prevention Program on Child Abuse and Neglect is designed to increase awareness and knowledge of child abuse and neglect issues among Spelman's all-female student body and to enhance students' understanding of how this information can contribute to their family living, volunteer experiences, and professional growth and development. Program activities are specifically aimed at providing information about (1) the nature of child abuse and neglect as a social issue; (2) characteristics and antecedents of abusive and neglectful situations; (3) social, moral and legal obligations to report suspected cases of child maltreatment; and (4) local and national agencies that provide services in cases of abuse and neglect.

Dr. Sandra Sims Patterson, Project Director and faculty member in Spelman's Department of Education, oversees the program. Recognizing that prevention efforts have primarily focused on children, parents and professional groups, Dr. Patterson perceives the need to reach a college-aged audience of young adults who have received little attention in the fight against child maltreatment. With this focus in mind, the project was conceived as a vehicle through which undergraduate students as well as other members of the campus community could become immersed in issues and concerns pertinent to this escalating social problem. As future parents, professionals, and public service providers, program participants will hopefully be able to use this experience in rearing their families, selecting career options, and strengthening their communities.

As a College-Wide Program, the project is a multi-faceted endeavor that pursues a vast Spelman audience and utilizes several approaches to achieving its goals. Students are targeted at the freshmen through senior levels; their areas of study represent virtually every discipline within the institution. In addition to their involvement as recipients of program efforts, the young women of Spelman College also take an active

continued on page 25

A Message

-Joyce N. Thomas

continued from page 25

children. The Board should be commended for this informative symposium.

It is important to point out that professionals from all ethnic backgrounds are invested in developing more effective approaches for meeting the needs of clients of color. Diane English and her colleagues from the Department of Social and Health Services, State of Washington, are looking at the issues of CPS risk assessment in families of color. This effort is still in the preliminary stage, but it promises to be a useful tool for consideration for the states. POCLI staff are reviewing materials and will provide comments for change as appropriate.

Throughout the country, there is strong evidence that many ethnic communities are working hard on their own behalf to reduce the incidence of child abuse and improve parenting in their respective communities. For example, historically black colleges have initiated programs and held conferences to address child maltreatment in African-American communities. The College-Wide Prevention Program on Child Abuse and Neglect sponsored by Spelman College, a historic black college in Atlanta, is an excellent example of how universities and community groups are working together to address child abuse needs in the local community.

Given all the talk, a major question is, "Are we really becoming more aware and more sensitive to the needs of persons from diverse populations in ways that will improve client outcome?" In general, my response to the former question is YES! Without a doubt, some of us are much more aware, and we welcome the opportunity to obtain diverse points of view on various issues. The real challenge is for each of us to invest greater amounts of time in the process of self examination, knowledge enhancement and clarification of our own beliefs about people who are different from ourselves. This is not easy.

Frequently we get calls from agency directors and others in leadership positions, who wish to conduct the POCLI self-assessment within their system. There seems to be a real interest on the part of many state and local child protective service systems to begin to examine their operations and plan for organizational changes in policy, practice and community relationship. We know what a major commitment of time and resources this is. It certainly provides us with concrete evidence of our change in attitude. Such systems should be commended and supported in their efforts. We are delighted that the POCLI agency self-assessment will soon be available to all who are interested. It is strongly recommended that agency training precede implementation of the self assessment. The agency self assessment is one of several products of the People of Color Leadership Institute project. For additional information, contact Jackie Booth, project coordinator, at (202) 544-3144.

Another product which the APSAC reading audience should be familiar with is the annotated bibliography of resources on cultural competency and cultural diversity in child welfare/child protection services. This is a listing of resources contained in the POCLI database, located at the American Humane Association- Children's Division, in Englewood, Colorado. The comprehensive materials in this bibliography are organized in categories such as Asians/ Pacific Islanders; Blacks/African-Americans; Hispanics/Latin Americans and Native Americans/Alaskan Natives. In addition, this excellent resource book has listings from conference proceedings, program summaries, bibliographies and general information on cultural competence. This project will continue to be updated throughout the life of the project. It is a must for every professional library. For additional information, contact Clyde Freeman, American Humane Association at (303) 792-9900.

Yes, we are making progress in our efforts to create a more culturally competent system, but this progress has not been without its growing pains and personal stresses. Tension and frustration are still in the air, but we must be patient and understand the realities of the slowness of change. During a recent training effort, workers shared with me that they felt like they were "walking on egg shells" and afraid to open their mouths for fear of saying the "wrong thing." It is important to emphasize that we all have feelings. Recalling and facing one's own experiences with racial prejudices, stereotypes, and biases can release feelings of fear, anxiety, and in some cases guilt or shame. It is for this reason that training in the area of cultural competency cannot be done in a "quick" workshop. Time is needed to gradually address topics and issues which are sensitive to us all. Training is essential for every person in this field. We can't point the finger that others must be "culturally competent" unless we seriously embrace this issue for our selves.

During this third year of the project, POCLI will provide several opportunities for training. First, there will be a three- day training-for-trainers workshop on March 30 to April 3, 1993 in Portland, Oregon. Terry Cross of the Northwest Indian Child Welfare Association will lead this training effort based on the POCLI curriculum that he and colleagues have developed. This curriculum provides the participants with an understanding of the cultural competence model and the components and strategies to enhance content knowledge in working with ethnic-minority communities. In addition, POCLI will sponsor a one day mini-conference on June 24, 1993, in Chicago, just prior to the APSAC conference. The National Committee on the Prevention of Child Abuse will assist the POCLI staff in planning and implementing one forum for the field. For additional information on either activity, please contact the POCLI coordinator. Further, the POCLI staff will also be active at the Tenth National Conference on Child Abuse and Neglect which will be held in Pittsburgh in November, 1993. We welcome your ideas and suggestions. Call me if we can be of assistance to you or your organization.

Preventing Child Sexual Abuse in the African American Community Without Reinventing the Wheel

—by John K. Holton

Meharry Medical College, the oldest historically black medical college in the United States, held its 3rd Annual Lloyd C. Elam Mental Health Symposium in Fall, 1992. The symposium provides a forum for state-of-the-art discussions on current issues of mental health among leading child sexual abuse authorities, researchers, medical students and faculty representing the diverse African American community. Specifically, the objectives of this year's symposium were:

- To offer professionals working in the field of child sexual abuse the opportunity to share approaches for intervention and treatment of sexual abuse.
- To explore the impact of alcohol and other drug addiction on child sexual abuse and make implications for successful prevention and treatment strategies.
- To highlight the status and magnitude of the problem of sexual abuse and incest in the African-American community and determine strategies for health recovery.
- To promote creative audio-visual productions on prevention to be sponsored by community youth groups.

I was given the honor of being this year's invited symposium speaker. Selecting as my theme, "Preventing Child Sexual Abuse in the African American Community Without Reinventing the Wheel," I outlined the issues and future directions needed to be taken by blacks desiring to prevent child sexual abuse. In summary, I stated that we need to begin with what we know about this insidious form of child maltreatment and determine if the methods we're using are preventing the problem. I happen to think that the field's approach isn't working well when it comes to the African American community; further, I happen to believe that our collective inventiveness is needed and not a reliance on what has been used.

New avenues of approach must be developed, and it is the responsibility of African American professionals to develop a descriptive and conceptual knowledge base for understanding the problem. This knowledge base should:

1. Recognize the failure of current research findings in clarifying the problem of child sexual abuse in black communities;
2. Address the need for a holistic and comprehensive analytical framework that attends to the cultural body of black people and incorporates the diverse socioeconomic realities of that community;
3. Examine underlying issues such as race, gender, and age discrimination which tend to be overlooked in prevention and treatment efforts for African Americans families; and
4. Elucidate our understanding of black culture.

These efforts will help illuminate many critical issues surrounding child sexual abuse in the black community and hopefully will lead to more effective prevention activities in the future.

Editor's Note: The full text of Dr. Holton's inspiring and insightful message is scheduled to be printed in the Journal of Health Care for the Poor and Underserved.

John K. Holton, PhD, is Executive Director of the Greater Chicago Council for Prevention of Child Abuse and Neglect, and a member of POCLI's Expert Task Force.

College-Wide

–Jacqueline Booth

continued from page 23

role in sponsoring program activities. Student-centered organizations such as honor societies, sororities, and social clubs co-sponsor many events related to the child abuse program. (Faculty and staff members also lend their support.) Involvement at this level serves to reinforce students' understanding of the issues and helps to nurture their commitment to preventing child abuse. To facilitate this "developmental" process, the program engages several methods of information dissemination which include a series of convocations and forums, a speaker's bureau, and a newsletter. These varied activities will help ensure that a broad base of students receives child abuse and neglect information.

During convocations and forums, students are introduced to an array of topical issues in the field of child maltreatment and are exposed to guest speakers from diverse professional backgrounds such as mental health, child advocacy, law enforcement, and medicine. Convocational events consist of large assemblies of the Spelman community at which senior level professionals in child welfare or related areas speak on their area of expertise. Some speeches and presentations have included, for example, a social worker's account of her experiences in dealing with abused children and their families; a Juvenile Court judge's discussion of legal issues in abuse and neglect; and a pediatrician's overview of situations encountered in identifying and reporting suspected abuse and neglect cases. In comparison to the more sizeable gatherings, forums comprise smaller informational sessions in which students are able to dialogue with experts around issues such as psychological consequences of child maltreatment, treatment strategies in child abuse and neglect, and identification of leading agencies and organizations in the field. Representatives of national organizations such as the Child Welfare League of America and the Washington, D.C.-based Center for Child Protection and Family Support have been invited to appear before the audience of program participants. Throughout the duration of the College-Wide Program, the forums and convocations have provided an enriching experience for students and other individuals who attend.

In another knowledge-building venue, the College-Wide Program on Child Abuse and Neglect instituted a speaker's bureau to disseminate information about child abuse and neglect prevention. Spear-headed during the second year of the program, the bureau

continued on next page

College-Wide

-Jacqueline Booth

continued from page 25

incorporates a two-tier approach in educating the student body. Students across the campus are trained as speakers on the subject in an attempt to increase their knowledge of the issue and provide spokespersons to other audiences. A resource center housing books and other materials in the area of abuse and neglect has been established to aid these avid learners. After the training process is completed, student speakers are then dispatched to "spread the word" among their fellow Spelman peers, their families and friends, and the community at-large. It is hoped that by becoming "experts" on the issue, students will mature into life-long advocates for the prevention of child abuse and neglect.

To further stimulate interest and garner campus-wide support, the program publishes an insightful newsletter which provides numerous updates, summaries, announcements, letters and poems, all addressing child abuse and neglect. The publication offers the opportunity to share important information on this problem and provides an outlet for highlighting program activities and events. One such venture was an essay contest entitled "Child Abuse Prevention: Ways to Promote Community Awareness and Education Among College Students." The winning composition suggested several creative approaches to achieving this worthwhile goal. The newsletter is circulated throughout the Spelman community and has received overwhelming acclaim for its enlightening contents.

Generally, the response to Spelman's College-Wide Program has been very positive. Believed to be one of the rare programs of its type in the country, the project has been successful in several respects. In a pre-posttest survey, students rated the program very favorably. Most young women felt that, as a result of project activities, they had acquired a better understanding of abuse and neglect and were able to recognize symptoms of maltreatment. Moreover, they were relatively confident about their ability to help someone who may be confronted with an abusive or neglectful situation. As future parents and professionals, students also believed that information contained in the forums, convocations and newsletter would help them become better mothers and would assist them in choosing a career. These findings suggest that program participants become more knowledgable of maltreatment and experience an increased awareness and sensitivity to the problem. Additionally, it would appear that professional options in the child welfare arena may be a consideration for a substantial proportion of the Spelman student-body. Amidst calls for increased ethnic sensitivity and cultural proficiency in the child welfare system, their entry into the field would be timely.

The College-Wide Prevention Program on Child Abuse and Neglect is located in Atlanta, Georgia and is sponsored, in part, by a grant from the Children's Trust Fund Commission of Georgia and Spelman College. For further information, contact Dr. Sandra Sims Patterson at (404) 223-1493.

DON'T MISS THE POCLI MINI-CONFERENCE

June 24, 1993

POCLI will hold a one-day mini-conference on June 24, 1993, immediately preceding APSAC's First National Colloquium. To be held at Malcolm X College in Chicago, the POCLI mini-conference will focus on critical issues in child maltreatment affecting minority children. A schedule for the conference is below. For further information, contact Joyce Thomas, RN, MPH, POCLI, c/o Center for Child Protection and Family Support, 714 G St. SE, Washington DC 20003. 202-544-3144.

Morning Plenary: An Overview of the Issues (9:00 a.m.–12:00 p.m.)

Moderator: John Holton, PhD

Panelists: Eliana Gil, PhD
Margaret Iwanaga-Penrose, MA
Anthony Urquiza, PhD
Gail Wyatt, PhD
Cecilia Fire-Thunder

Afternoon Concurrent Workshops (1:30–3:30 p.m.)

I. CULTURALLY COMPETENT TRAINING CURRICULUM
Terry Cross, MSW, and Margaret Iwanaga-Penrose, MA

II. AGENCY SELF-ASSESSMENT INSTRUMENT
Fe'lecia Holly, MSW, JD, and John Holton, PhD

III. RESEARCH METHODOLOGY
Gail Wyatt, PhD, and Anthony Urquiza, PhD

IV. THERAPY ISSUES WITH CLIENTS OF COLOR
Eliana Gil, PhD, and Cecilia Fire-Thunder

Closing Plenary: Keynote Address (4:00–5:00 p.m.)
Joyce Thomas, RN, MPH, Director, POCLI

JOURNAL HIGHLIGHTS

—edited by Thomas F. Curran

The purpose of Journal Highlights is to inform readers of current literature 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, Defenders Association of Philadelphia, Child Advocacy Unit, 121 N. Broad St. Philadelphia PA 19107.

PHYSICAL ABUSE AND NEGLECT

Connelly, C.D. and Straus, M.A. (1992). Mother's age and risk for physical abuse. *Child Abuse and Neglect,* 16 (5), 709-718.

This study investigated the relationship between the age of mothers and the physical abuse of their children from a nationally representative sample of 1,997 mothers. The results showed that the younger the mother, the greater the risk of physical abuse, provided mother's age is measured as age at time of birth of the abused child. A significant relationship was not found when mother's age was measured as age at time of abuse. Possible implications which these findings have for prevention and intervention policies are discussed. (TFC)

Sabotta, E.E. and Davis, R.L. (1992). Fatality after report to a child abuse registry in Washington state, 1973-1986. *Child Abuse and Neglect,* 16 (5), 627-635.

This study analyzed the mortality rate for children reported to the Washington state child abuse registry between 1973 and 1986, compared to a cohort of children with no abuse reported. Children reported to the state registry had an almost threefold greater risk of death than children not reported as abused, and a report of physical abuse carried the greatest risk of subsequent death. (TFC)

SEXUAL ABUSE

Becker, J.V. and Hunter, J.A. (1992). Evaluation of treatment outcome for adult perpetrators of child sexual abuse. *Criminal Justice and Behavior,* 19 (1), 74-92.

Therapy outcome studies on adult sexual offenders of child victims are reviewed. Current theories of child sexual abuse are reviewed, along with various biological treatments for offenders and traditional therapies. Following a selected evaluation of treatment outcome studies, the authors conclude that sex offenders can be treated and effective programs are available with demonstrated low recidivism rates. The question requiring further empirical study is which therapeutic approach will be most effective given various client characteristics and conditions of treatment, not whether treatment for child molesters works. (TFC)

Hanson, R.F., Saunders, B.E., and Lipovsky, J.A. (1992). The relationship between self-reported levels of distress of parents and victims in incest families. *Journal of Child Sexual Abuse,* 1 (2), 49-60.

The purpose of this study of 32 incest families was to test empirical indicants that father perpetrators of incest and child victims are involved in close, enmeshed relationships, specifically concerning symptoms of emotional distress. The study failed to find evidence of a unique emotional enmeshment or special intimate relationship between the victim and perpetrator in incest families. Results did suggest, however, the existence of a familial, rather than dyadic, bond concerning symptoms of emotional distress, implying that overall family dysfunction may contribute significantly to levels of individual stress. Important research and clinical implications are discussed. (TFC)

Kendall-Tackett, K.A. (1992). Professionals' standards of "normal" behavior with anatomical dolls and factors that influence these standards. *Child Abuse and Neglect,* 16 (5), 727-733.

In this study, a multidisciplinary sample of 201 professionals experienced in working with sexually abused children was asked to rate the normalcy of certain behaviors in non-abused children ages 2 to 5.9 years while using anatomical dolls. The majority of respondents agreed that engaging in highly sexualized behaviors with the dolls is abnormal for non-abused children, but could not agree about less-overtly sexual behaviors such as touching the dolls' breasts or genitals. The researchers examine how respondents' answers were influenced by their experience working with children, their profession, and their gender. (TFC)

McCormack, A., Rokous, F.E., Hazlewood, R.R., and Burgess, A.W., (1992). An exploration of incest in the childhood development of serial rapists. *Journal of Family Violence,* 7 (3), 219-228.

Sexual abuse in the childhood development of 41 incarcerated serial rapists is explored in this study to examine the early experiences of male incest victims. Just over half of the men who reported being sexually abused (N=31) recalled an incestuous experience as their first sexual experience. Among the several recommendations made is a call for renewed attention to the significance of childhood sibling incest, which, according to this study, should serve as a "red flag" that other incestuous activity has taken place. (TFC)

Watkins, W. and Bentovim, A. (1992). The sexual abuse of male children and adolescents: A review of current research. *Journal of Child Psychology and Psychiatry & Allied Disciplines,* 33 (1), 197-248.

This lengthy article reviews the current research on many aspects of the sexual abuse of males, with commentary on what is still not known about this victim population and suggestions for future research. The underreporting and underdetection of male victims is discussed in detail along with some initial and long-term effects which sexual abuse appears to have on male victims. (SF)

LEGAL ISSUES

Bulkley, J.A. (1992). The prosecution's use of social science expert testimony in child sexual abuse cases: national trends and recommendations. *Journal of Child Sexual Abuse,* 1 (2), 73-93.

continued on next page

Journal Highlights

-edited by
Thomas F. Curran
continued from page 31

This thought-provoking article examines six categories of social science expert testimony presented by the prosecution regarding behaviors of child sexual abuse victims. The author argues that such testimony fails to meet basic evidence admissibility requirements of relevance and reliability and, except for rehabilitative testimony, should be excluded. Finally, the author recommends convening a multidisciplinary symposium of experts to address and debate the complex legal, psychological and ethical issues surrounding the admission of behavioral science expert testimony in child sexual abuse prosecutions. (TFC)

Bulkley, J.A. (1992). Recent Supreme Court decisions ease child abuse prosecutions: Use of closed-circuit television and children's statements of abuse under the confrontation clause. *Nova Law Review,* 16 (2), 687-709.

Recent U.S. Supreme Court decisions addressing the constitutionality of admitting children's hearsay statements of abuse and permitting closed-circuit television transmission of a child's testimony under the confrontation clause are discussed. Although attorneys will find it most useful, this article presents the very complex issues surrounding the testimony of child abuse victims and the confrontation clause in a manner which will also appeal to non-attorneys. (TFC)

OTHER ISSUES IN CHILD MALTREATMENT

Crouse, K.A. (1992). Munchausen Syndrome by Proxy: Recognizing the victim. *Pediatric Nursing,* 18 (3), 249-252.

Detection and management skills particularly important to nurses and other health care professionals are stressed in this article, which also provides an overview of Munchausen Syndrome by Proxy characteristics which will be helpful to all child maltreatment professionals. (TFC)

Daro, D. and Gelles, R.J. (1992). Public attitudes and behaviors with respect to child abuse prevention. *Journal of Interpersonal Violence,* 7 (4), 517-531.

Utilizing data collected from a nationally representative sample of 1,250 respondents, this informative study examined public attitudes toward specific parental discipline practices, the incidence of specific practices, the public's support and involvement in child abuse prevention efforts, and the public's perception of the causes of child abuse. The results indicate a general public quite well educated about the nature and consequences of child abuse and willing to take personal action to prevent it. The discussion of whether public education and increased prevention efforts lead to changes in abusive parenting practices is enlightening. (TFC)

Gelles, R.J. (1992). Child protection needs to replace family reunification as the goal of child welfare agencies. *The Brown University Family Therapy Letter,* 4 (6), 1-2.

In a radical reversal of position, a nationally recognized authority on domestic violence outlines his reasons for abandoning his support of family reunification as a goal for child protective service agencies. Gelles argues that while family reunification policies help some children, social science and crime data clearly indicate that such policies place other children at unacceptable risk. According to Gelles, child protection and child advocacy should replace family reunification as the guiding policy of child welfare agencies. (TFC)

Harbeck, C., Peterson, L. and Starr, L. (1992). Previously abused child victims' response to a sexual abuse prevention program: A matter of measurers. *Behavior Therapy,* 23, 375-387.

The effects of the prevention program, "The Touch Continuum," with twenty children who all had histories of child sexual victimization were examined. Generally, children's demonstrated knowledge about sexual abuse prevention varied greatly, depending on the outcome measure utilized, with each measure tapping into a slightly different sexual abuse knowledge domain. Most significantly, children had difficulty recalling abuse prevention concepts when asked open-ended questions and in responding to role-play, where they could identify prevention information but had problems actually using that information. Methodological and ethical concerns important to abuse prevention research are discussed at length. (TFC)

Kalichman, S.C. (1992). Clinicians' attributions of responsibility for sexual and physical child abuse: An investigation of case-specific influences. *Journal of Child Sexual Abuse,* 1 (2), 33-47.

This study examined the influence of case-specific characteristics on patterns of child abuse responsibility attribution among a sample of 328 licensed psychologists from two states. Particularly significant among the findings was that fathers suspected of sexual abuse were held more responsible for their actions than those suspected of physical abuse. The results provide evidence that child sexual abuse allegations may be viewed and responded to by clinicians more seriously than physical abuse cases. Considering these results, it appears that professional expectations and actions may vary for fathers and mothers in abusive families depending on the type of child abuse perpetrated. (TFC)

Weissman Wind, T. and Silvern, L. (1992). Type and extent of child abuse as predictors of adult functioning. *Journal of Family Violence,* 7 (4), 261-281.

Information regarding child abuse histories as well as current functioning was gathered from a community sample of 259 working women. Contrary to speculation that types of child abuse have unique consequences, the results of this study indicate that physical and sexual abuse have common long-term correlates in terms of internalizing symptoms. Incest and severe physical abuse were each associated with similar symptoms, with women who were more severely abused showing worse outcomes. (TFC)

Journal reviewers for this issue included Sandra Foti of the Massachusetts Professional Society on the Abuse of Children and Thomas F. Curran. The Journal Highlights editor wishes to express special thanks to Kathleen Kendall-Tackett, PhD, Ingrid Raab, and Josephine Bulkley, JD, for their contributions to this issue.

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

1993 Board of Directors

EXECUTIVE COMMITTEE

Barbara Bonner, PhD, President (94)
Affiliation: University of Oklahoma
Department of Pediatrics
Mailing address: 1107 Hemstead
Oklahoma City OK 73116
405-271-8858 FAX: 405-271-2931

Patricia Toth, JD, First Vice President (95)
National Center for Prosecution of Child Abuse
99 Canal Center, Suite 510
Alexandria VA 22314
703-519-1669 FAX: 703-836-3195

Linda Williams, PhD, Second Vice President (94)
University of New Hampshire
Family Research Laboratory
126 Horton Social Science Center
Durham NH 03824
603-862-2342 FAX: 603-862-1122

Paul Stern, JD, Treasurer (93)
Snohomish County Prosecuting Attorney's Office
Mission Building, 3000 Rockefeller Ave.
Everett WA 98201
206-388-3671 FAX: 206-388-3572

Kathleen Coulborn-Faller, MSW, PhD Secretary (93)
University of Michigan School of Social Work
1015 E. Huron
Ann Arbor MI 48104-1689
313-763-3785/6572 FAX: 313-936-1961

John Briere, PhD (95)
University of Southern California
School of Medicine, Department of Psychiatry
1934 Hospital Place, Box 106
Los Angeles CA 90033
213-226-5697 FAX: 213-226-4094

Jon Conte, PhD (95)
University of Washington, School of Social Work
4101 15th Ave. NE, JH-30
Seattle WA 98195
206-543-1001 FAX: 206-543-1228

Harry Elias, JD (94)
North County Municipal Court
325 S. Melrose Dr. Suite 120
Vista CA 92083
619-940-4728 FAX: 619-940-4988

Carole Jenny, MD, MBA (93)
Children's Hospital, B-138
1056 E. 19th St.
Denver CO 80218
303-861-6919 FAX: 303-837-2791

Susan Kelley, RN, PhD (93)
Boston College School of Nursing
140 Commonwealth Ave., Cushing Hall, Room 201
Chestnut Hill MA 02167
617-552-4272 FAX: 617-552-0745

Ben Saunders, PhD (94)
Medical University of South Carolina
Crime Victims Research and Treatment Center
171 Ashley Ave.
Charleston SC 29425-0742
803-792-2945 FAX: 803-792-3388

Charles Wilson, MSW (93)
Tennessee Department of Human Services
400 Deaderick Street
Nashville TN 37219
615-741-3443 FAX: 615-741-4165

DIRECTORS AT LARGE

Veronica Abney, MSW (93)
UCLA Neuropsychiatric Hospital & Institute
300 UCLA Medical Plaza
Los Angeles CA 90024
310-825-0457 FAX: 310-206-4447

Catherine Ayoub, RN, EdD (95)
Harvard Graduate School of Education
Larsen Hall, Appian Way
Cambridge MA 02138
617-495-3614; 508-470-0906 FAX: 617-495-3626

Jan Bays, MD (95)
Emanuel Hospital, CARES Unit
2801 N. Gantenbein
Portland OR 97227
503-280-4943 FAX: 503-280-4326

David Corwin, MD (95)
Hawthorn Children's Psychiatric Hospital
1901 Pennsylvania Ave.
St. Louis MO 63133
314-862-7227 FAX: 314-862-1812

Patricia Crittenden, PhD (93)
c\o Family Research Lab, University of New Hampshire
128 Horton Social Science Ctr.
Durham NH 03824
603-862-1888 FAX: 603-862-1122

Thomas Curran, MSW, JD (93)
Defenders Association of Philadelphia
Child Advocacy Unit
121 N. Broad St.
Philadelphia PA 19107
215-568-3190 FAX: 215-557-4910

Deborah Daro, DSW (93)
National Center for Child Abuse Prevention Research
332 S. Michigan Ave., Suite 1600
Chicago IL 60604
312-663-3520 FAX: 312-939-8960

Martha Erickson, PhD (94)
University of Minnesota
Children, Youth & Family Consortium
4420 Fremont Av. South
Minneapolis MN 55409
612-626-9582 FAX: 612-624-0879

Mark Everson, PhD (93)
University of North Carolina, Chapel Hill
Program on Childhood Trauma and Maltreatment
Department of Psychiatry, CB 7160
Chapel Hill NC 27599-7160
919-966-1760 FAX: 919-966-6342

Martin Finkel, DO (93)
University of Medicine and Dentistry of New Jersey
301 S. Central Plaza
3400 Laurel Rd.
Stratford NJ 08084
609-346-7036 FAX: 609-435-8246

William N. Friedrich, PhD (94)
Mayo Clinic
Department of Psychiatry (Psychology)
200 First St. SW
Rochester MN 55905
507-284-2511 FAX: 507-284-0727

Dana Gassaway (95)
San Diego County District Attorney's Office
101 W. Broadway, Suite 800
San Diego CA 92101
619-531-4300 FAX: 619-531-3759

Eliana Gil, PhD (95)
Private Practice
17812 October Court
Rockville MD 20855-1643
301-258-9361 FAX: 301-869-0621

Hon. Sol Gothard, ACSW, JD (93)
Fifth Circuit Court of Appeals
State of Louisiana Courthouse Building
Gretna LA 70053
504-361-6625 FAX: 504-361-6638

Beverly James, MSW (94)
James Associates
Post Office Box 148
Honaunau HI 96726
808-328-2073 FAX: 808-328-2073

Paula Jaudes, MD (94)
University of Chicago
La Rabida Children's Hospital and Research Center
East 65th St. at Lake Michigan
Chicago IL 60649
312-753-8633 FAX: 312-363-6527

Carolyn Levitt, MD (95)
Children's Hospital
345 Smith Ave. North
St. Paul MN 55102
612-220-6750 FAX: 612-220-6770

Holly Echo-Hawk Middleton, MS (94)
Children's Home Society of Washington
P.O. Box 605
Vancouver WA 98666
206-695-1325 FAX: 206-695-9803

Robert Prentky, PhD (93)
35 Howland Lane
Hingham MA 02043
617-727-6013 FAX: 617-727-6013, x1720

Robert Reece, MD (94)
Case Western Reserve University
Rainbow Babies and Children's Hospital
2074 Abington Rd.
Cleveland OH 44106
216-844-3761 FAX: 216-844-8444

Anthony Urquiza, PhD (94)
Child Protection Center, Dept. of Pediatrics
University of California-Davis Medical Center
2516 Stockton Blvd.
Sacramento CA 95817
916-734-7614 FAX: 916-456-2236

Bill Walsh (95)
Dallas Police Department
106 S. Harwood St.
Dallas TX 75201
214-670-5936 FAX: 214-670-5099

CALL FOR NOMINATIONS

Nominations for Election to Board of Directors Solicited

The ballot for the 1993 Board of Directors' election will be included in the Fall, 1993 *Advisor*. Due to publications deadlines, nominations will have to be received earlier than usual this year. APSAC's Nominating Committee urges all APSAC members to submit their suggestions for nominees by **June 1.** To recommend a candidate for nomination, you must submit a Candidate Nomination Form, a copy of the nominee's vita, and a letter 200-400 words in length formally nominating the candidate and outlining his or her qualifications. For a copy of the full policy regarding Board Election Procedures and the Candidate Nomination Form, write or call the national office at 312-554-0166.

NEW MEMBERSHIP CATEGORY APPROVED

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

RESOURCES

The Texas Legal Resource Center for Child Abuse and Neglect (TLRCCAN) serves professionals inquiring about child abuse and neglect by providing timely, cost-free reference services. In addition to legal materials, the center has developed an extensive collection of child abuse and neglect books, journals, videos and other materials. Mail and phone requests for information and reference assistance are answered. Books and videos in the collection can be checked out to patrons in any location. In addition, over seventy bibliographies of books and articles on specific child abuse and neglect issues are available upon request for a small charge. The toll-free number is 800-543-8398. (Local telephone in Austin is 471-6543.)

CALL FOR PAPERS

NCCAN and the co-sponsors of the *Tenth National Conference on Child Abuse and Neglect — Building Bridges to the Future* — invite abstracts for 1-1/2 hour workshop presentations. Submissions from culturally and ethnically diverse communities are strongly encouraged. Workshops should focus on prevention, intervention, treatment, or evaluation, in the areas of policy, research, program, and practice. Workshops should combine theoretical and experiential approaches. The conference will be held in Pittsburgh on December 1-4, 1993. **Abstract proposals are due April 30, 1993.** For further information, contact Zena Rudo at 301-589-8242.

DON'T MISS APSAC'S FIRST NATIONAL COLLOQUIUM

June 24-26, 1993
Chicago, Illinois

FRIDAY, JUNE 25, DAY-LONG WITHIN-DISCIPLINE SESSIONS.

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.
Barbara Bonner, PhD, and Tim Smith, MEd

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

Preparing and prosecuting child fatality and head injury cases.
Paul DerOhannesian, JD, and Harry Elias, JD

Special issues in child sexual abuse prosecution.
Sue Marx, JD, and Patti Toth, JD

Advanced issues in differential diagnosis of physical child abuse.
Randell Alexander, MD, and Carole Jenny, MD

Advanced issues in medical assessment of sexual abuse.
Carolyn Levitt, MD, and David Muram, MD

Advanced issues in the investigation of child sexual abuse.
Rick Cage and Ken Lanning, MS

Advanced issues in the investigation of physical child abuse.
Bill Hammond and Bill Walsh

SATURDAY, JUNE 26, DAY-LONG CROSS-DISCIPLINE SESSIONS.

Civil suits for damages.
Larry Hardoon, JD; and Ben Saunders, PhD

Relationship of drug abuse and child abuse.
Jan Bays, MD, and John Myers, JD

Reunifying families: deciding when it is time and safe.
Diane DiPanfilis, PhD; Robert Pierce, PhD; and Charles Wilson, MSSW

Critical analysis of "syndromes" and validation methods and their use in court.
Jon R. Conte, PhD; Patricia Toth, JD; and Steven M. Komie, JD

Evaluating your program: assessing its effectiveness, communicating with grantmakers.
Deborah Daro, DSW, and David Lloyd, JD

Culturally competent child abuse intervention.
Veronica Abney, MSW; Jill Korbin, PhD; and Diane Willis, PhD

Professional responses to the phenomenon of repressed memory.
Lucy Berliner, MSW; John Briere, PhD; and Linda Williams, PhD

State of the art of forensic interviewing of children.
Sue Marx, JD, and Karen Saywitz, PhD

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

Issues in investigation and litigation of multi-victim, multi-perpetrator cases.
Dan Casey, JD; Ken Lanning, MS; and Donna Pence

Investigating, assessing, and arguing sexual molestation cases when domestic charges are pending.
Ann Haralambie, JD, and Kee MacFarlane, MSW

CONFERENCES

APSAC DISCOUNTS

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.

April 16–18, 1993. ***Psychological and Psychiatric Testimony in Court.*** Miami Beach, FL. Sponsored by the University of Miami School of Law and Forensic and Clinical Psychology Associates. Call Bruce Frumkin, 305-666-0068.

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

November 21 - 24, 1993. ***Networking in the Nineties.*** Nashville, TN. Sponsored by the Tennessee Network on Child Advocacy. Call Judith Brown, 901-327-0893.

January 26 - 30, 1994. ***The San Diego Conference on Responding to Child Maltreatment.*** Co-sponsored by San Diego Children's Hospital Center for Child Protection and APSAC. Call Robbie or Diane at 619-576-5814.

April 4–7, 1993. ***Focus on Children: Protecting our Future.*** Sponsored by the Canadian Organization for Victim Assistance and Child Find Alberta. Calgary, Alberta. Contact Victim Programs Consultants, Ltd. (VPC), Conference Coordinator, 256 Ranchridge Court, NW, Calgary, Alberta, Canada T3G 1W5.

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

June 10–12, 1993. ***Fifth Annual Conference on Child Abuse and Neglect.*** Sponsored by the Children's Hospital of Philadelphia. They are seeking abstracts dealing with any aspect of child abuse as well as care reports of unusual manifestations of abuse or neglect. Submit typewritten copy to Stephen Ludwig, MD, Director, Division of General Pediatrics, The Children's Hospital of Philadelphia, 34th Street and Civic Center Blvd., Philadelphia PA 19104. Or call 1-800-TRY-CHOP.

July 8–11 1993. ***Celebration of Diversity: Many Paths, Many Journeys, Many Goals.*** Springfield, Illinois. 11th Annual VOICES Conference. Call 1-800-7-VOICE-8.

August 3–8, 1993. ***"Building Alliances to Stop Sexual Assault."*** Chicago. Sponsored by National Coalition Against Sexual Assault. Women of Color Institute, "Defining Our Power" will begin on Tuesday, August 3 at 1:00 p.m. Call Jane Fee at 217-753-4117.

August 13–15, 1993. ***Parents United International Conference.*** Louisville, KY. Call 408-453-7611.

September 1–3, 1993. ***Crimes Against Children.*** Sponsored by Dallas Police Dept. & Dallas Children's Advocacy Center. Dallas, TX. Call Leighann Lozano, 214-670-4982.

September 6–11, 1993. ***Fifth Biennial Conference, South African Society for the Prevention of Child Abuse and Neglect (SASPCAN).*** Cape Town. Call SASPCAN Conference, 1993, Children's Centre, 46 Sawkins Rd., Rondebosch 7700 South Africa. FAX number: 021-6895403.

September 30 – October 3, 1993. ***Fifth Annual National Conference on Male Survivors, Advancing National Awareness of Male Victimization.*** Bethesda, MD. Call Ann Dodelin or Liz Nelson at 301-251-4610.

October 15–16, 1993. ***Third International Research Symposium on Child Abuse and Neglect.*** Philadelphia. Sponsored by the Temple University Center for Sound Policy and Community Development. Call John Trudeau at 215-787-7491.

December 1–4, 1993. ***Building Bridges to the Future: 10th National Conference on Child Abuse and Neglect.*** Pittsburgh. Sponsored by National Center on Child Abuse and Neglect, cosponsored by APSAC and many other child abuse organizations. Call Zena Rudo, 310-589-8242.

NEW SERVICE

Researcher-Clinician Information Exchange

APSAC's Research Committee is offering a new service to facilitate members' research efforts. The Researcher-Clinician Information Exchange will help clinicians who wish to answer questions about their methods or their clients team up with researchers who need access to clinical populations. Clinicians and researchers seeking to establish mutually beneficial research partnerships should write to Linda Williams, PhD, and Ben Saunders, PhD, Co-chairs, APSAC Research Committee, 332 S. Michigan Ave., Suite 1600, Chicago, 60604. Listings will be published in *The Advisor* and will be available by mail from APSAC's office.

MOVING?

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

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.

Announcing!

First National Colloquium

The American Professional Society on The Abuse of Children

June, 1993—Chicago, Illinois

In-depth, interdisciplinary, intensive training on current issues in child maltreatment.

All institutes are:
- ✔ Day long
- ✔ Designed for advanced professionals
- ✔ Based on cutting edge research and theory
- ✔ Highly interactive

First day: Within-Discipline Institutes
Second day: Cross-Discipline Institutes

MARK YOUR CALENDAR!

To be placed on the mailing list for further information, return this form to
APSAC, 332 S. Michigan Ave., Suite 1600
Chicago, IL 60604

Please Mail Today!

APSAC

Name _____

Street Address _____

City _____

State _____ Zip _____

Daytime Phone # _____

JUNE 24–26, 1993

Membership Plans

❑ New Membership ❑ Renewal

Regular Membership
One year membership
- $50,000 annual income and above. $85
- $25,000–$50,000 annual income. $55
- Under $25,000 annual income. (Does not include *Journal of Interpersonal Violence*) $35

Two year membership
- Over $50,000 annual income $160
- Under $50,000 annual income $100

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

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

Group Membership
Discounts are available for five or more individuals from a single institution. Call 312-544-0166 for details.

Applicants outside North America add $10 per year to annual dues.
In order to be enrolled as a member, please enclose your check with this form.

Application for Membership

(Please print or type all information clearly)

Name _____ Degree _____

Title _____

Please indicate (✔ or ✕) your preferred mailing address.

❑ Office Address (Agency name) _____

Street _____ City _____ State ____ Zip ____

❑ Home Address (Optional) _____ City _____ State____ Zip____

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

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

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

Enclosed is check number _____, to cover $ _____ Membership Dues

Please also accept this voluntary tax-free gift of $ _____ for APSAC's Endowment Fund

Total amount enclosed: $ _____

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

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

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