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MEDICINE AND PSYCHO-THERAPY

Neuro-development and the Neurophysiology of Trauma II: Clinical Work Along the Alarm–Fear–Terror Continuum

—by Bruce D. Perry

INTRODUCTION

This is the second of two articles by Dr. Bruce Perry about emerging medical research into the neurological effects of trauma and their clinical implications for both physicians and psychotherapists. The first article was published in The Advisor, V.6, n.1 *(Spring, 1993). References for both parts are published with this article.*

This article describes some of the important therapeutic principles which may prove of use to clinicians working with traumatized children. These principles arise from understanding the underlying core pathophysiology and psychology of the acute, immediate and persisting 'alarm' reaction in the developing child (see Part I). The key neurodevelopmental issues discussed are that 1) traumatized children function along an alarm-fear-terror continuum involving developmental equivalents of the 'freeze, flight and fight' response, 2) traumatic experiences during development can shift this continuum by altering brain regions involved in the fear response, 3) therapeutic approaches must appreciate that traumatized children are in a persisting fear state and, finally, 4) these therapeutic approaches must be directed at specific brain areas which mediate this alarm-fear-terror continuum.

The following discussions are intended to illuminate, organize and focus clinical work with traumatized children. They are not intended be comprehensive or to exclude other clinical perspectives.

The Lingering Fear State: Persistence of the "Freeze, Flight or Fight" Response

1. The sensitized fear response: When a child experiences a traumatic event, the immediate reaction is a primitive and deeply ingrained 'freeze, flight or fight' reaction. This total body response to threat has been described in detail in Part I of this series. During the 'freeze, flight, or fight' response, key areas of the human brain are activated. Following the acute fear response, these parts of the brain will be *reactivated* when the child is exposed to a reminder of the traumatic event. Furthermore, these parts of the brain can be reactivated when the child simply thinks or dreams about the event. In other words, despite being away from threat and the original trauma, these key parts of the child's brain are reactivated again and again as the child re-experiences the trauma.

The 'freeze, flight or fight' response is a primitive adaptive response and is, therefore, mediated in large part by primitive parts of the human brain. The brain stem, midbrain, limbic areas and, to a lesser degree, the cortex are involved in modulating the hypervigilance, startle response, anxiety, mood dysregulation, behavioral impulsivity, and physiological hyper-reactivity seen in the acute post-traumatic syndrome. Frequent reactivations of the fear response can result in altered sensitivity of these parts of the

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NEWS

Future Colloquium Planning Begun; APSAC SWAT Team Swings Into Gear; Board Election Ballot to Be Enclosed in Next Issue

—by Theresa Reid

Future Colloquium Planning Begun

At the time of this writing, all indications are that we will have a sell-out crowd for APSAC's First National Colloquium, to be held in Chicago June 24-26, 1993. If you will be attending the Colloquium, we look forward to seeing you there. If you can't make it this year, we hope you will be able to attend in future years, and will continue to give APSAC's Program Committee your feedback on such crucial issues as program content, location, speakers, and size. APSAC's Second National Colloquium has been scheduled for **May 4-7, 1994, at the Hyatt Regency in Cambridge, Massachusetts.** The Committee's goal is to schedule all future Colloquia for one of the first two weekends in May.

Among the questions the Program Committee is currently discussing are these:

- The Colloquium is unique in featuring all-day, intensive seminars instead of 1.5- or 3-hour workshops. Is this the format we want to keep for the annual APSAC Colloquium?
- Do we want to continue to gear the Colloquium to advanced professionals, and keep it relatively small, or do we want to try to meet the needs of a greater number of APSAC members, and sponsor one of the larger annual conferences in the field?
- What are the topics of most concern to APSAC members now, which need to be addressed at the APSAC Colloquium?
- Should we add a day for field-initiated research presentations?

The Program Committee seeks your input on these questions, and on other aspects of program planning that occur to you. Please write your responses to Linda Williams, PhD, Chair, APSAC Program Committee, University of New Hampshire, Family Research Laboratory, 126 Horton Social Science Center, Durham NH 03824. APSAC's Program Committee is determined to design a Colloquium that is responsive to members' concerns.

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News

–Theresa Reid

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APSAC SWAT Team Mobilizes

"SWAT Team" is the nickname for APSAC's new Urgent Issues Analysis Committee, created by the Board of Directors at its annual meeting last January. The purpose of the SWAT Team is to enable APSAC to respond quickly to emerging issues affecting professionals in the field of child maltreatment. The SWAT Team might respond to new research or legal decisions, professional practice disagreements, and public perceptions of child maltreatment and of professional intervention in it.

The role of the committee will be to assess the need for APSAC to take action to educate or influence its members, other professionals, policymakers, lawmakers, or the general public. The committee will determine what action APSAC should take, see that the appropriate materials are developed (e.g., Fact Sheets, press releases, articles for local publication and for publication in the popular media, articles for professional publications), and release the material appropriately.

Members' help could be instrumental in achieving broad dissemination of the material developed by the SWAT Team. Availability of articles and press releases will be posted in *The Advisor* and communicated to state chapter coordinators and officers. Members can call APSAC's office for copies of the material for submission to local newspapers and other publications. The SWAT Team thinks that child advocacy centers, treatment agencies, prosecutors' offices, CPS agencies, pediatric associations, and our state chapters may all be allies in this effort to distribute accurate, unbiased information about issues in child maltreatment.

A press release and Fact Sheet on child sexual abuse allegations in custody and visitation disputes was sent to news media in late April. These are reprinted on p. 23-24. Several other topics have been raised for immediate attention: ritualistic abuse, recovered memories, the effects of mandatory reporting, and alleged excesses of child protective services.

If you have ideas about other issues to cover or other avenues for dissemination, please contact Theresa Reid at 312-554-0166, or Charles Wilson, MSSW, Chair, Urgent Issues Analysis Committee, Tennessee Department of Human Services, 400 Deaderick St., Nashville TN 37219.

Ballot for Board Election to be Included in Next *Advisor*

Thanks to all of you who have suggested names for the ballot or the 1993 Board election, we expect an outstanding slate to be presented again this year. To save time and money, a change in election procedure will be instituted this year: the Board election ballot will be enclosed in the next issue of *The Advisor*. Please be alert for the ballot, and exercise your very real influence on the leadership of your professional organization.

MEMBERSHIP COMMITTEE SETS GOALS

You have a critical role to play in strengthening your professional society: tell your colleagues about it! Fully 50% percent of APSAC members learn about APSAC through word of mouth, according to new members' responses to the question on the membership application form. Another 33% learn about APSAC at conferences, 12% through advertisements, and 5% through publications, guidelines, and other outlets.

APSAC continues to buy advertising in various professional publications. The numbers show, however, that your enthusiasm is far more effective than paid advertising in bringing in new members. Here's what you can do:

- Tell your colleagues about APSAC. Tell them what the benefits of membership are, and what APSAC does for you and for the field. Emphasize that the more members we have, the more we are seen as a force to be reckoned with. If you need brochures to hand out, call the office and we will be happy to send them.
- Take APSAC brochures to conferences you're attending, and hand them to people there, or put them on the take-one table. See if you can get an announcement about APSAC made from the podium during a plenary session (or make one yourself), so people know what they're looking at when they see the brochure.
- If you are involved with professional newsletters in the field, see if you can get information about APSAC printed in the newsletter. Prewritten stories are available from APSAC's central office.

You may have additional ideas of your own for recruiting members. If so, let us know. **For brochures, pre-written articles, and other information, contact APSAC at 332 S. Michigan Ave., Chicago, Illinois 60604, Tel: 312/554-0166.** Every member plays an important role in this organization. APSAC's Membership Committee hopes you will make telling your colleagues about APSAC a major part of your role.

PRACTICE

Enhancing Children's Resistance to Misleading Questions During Forensic Interviews

—by L. Dennison Reed

In recent years, there has been a growing trend in cases of child sexual abuse to fault those who perform forensic interviews of children for their use of improper interview techniques and questions (Myers, 1992). A major front of this "attack on the interviewer" includes the premise that children are highly suggestible and are therefore easily led or, more accurately, "misled" by the use of improper questions to initiate or affirm false allegations of sexual abuse. More specifically, it is argued that false accusations of sexual abuse are easily elicited from non-abused children when they are asked misleading questions which erroneously imply that they were sexually abused.

Although there is some debate over which types of questions truly qualify as being "leading", it is generally agreed that questions which suggest certain information and tempt or pressure the child to agree with the suggested information are clearly leading. The question "Your daddy touched your pee-pee, didn't he?" is an example of a clearly leading question. When the suggested information is erroneous, such questions are more accurately labeled "misleading" questions.

Some have purported that because children are so suggestible, even "focused" and "direct" questions (i.e., questions which contain information about possible sexual abuse but which do not blatantly tempt or pressure the child to agree), are likely to mislead non-abused children to falsely claim abuse. Thus, focused and direct questions such as, "Did anybody ever touch your pee-pee?" have been targeted for attack as well. Consequently, children's affirmative statements of sexual abuse made in response to clearly leading questions as well as to direct and focused questions are arguably "highly suspect," and interviewers who utilize such questions can anticipate being criticized and challenged for this practice.

What Do We Know About Children's Suggestibility and Their Ability to Resist Misleading Questions?

Research indicates that suggestibility is not a "trait" that remains constant for an individual regardless of the circumstances (Saywitz & Snyder, 1993.) Children as well as adults are sometimes suggestible and susceptible to misleading questions. Suggestibility is an extremely complex, multiply-determined phenomenon. Situational factors relating to the interview context as well as memory factors influence the suggestibility of adults and children alike.

Overall, studies have not converged on a simple or linear relationship between age and suggestibility. Research has consistently shown that, by the time children reach 10 or 11 years of age, they are no more suggestible than adults (Cole & Loftus, 1987). However, studies of non-abused children as young as 4 to 7 years old have demonstrated that children in this age-range were no more easily misled than older children to make false reports of abuse when asked misleading questions about a staged event such as, "He took your clothes off, didn't he?" (Goodman, et al., 1991). Also, a study of 72 non-abused 5 and 7 year old girls questioned about genital contact occurring during a medical exam revealed that such children were highly resistant to misleading abuse questions (Saywitz, et al., 1991). This study also revealed that "direct" questions focusing on genital touch (e.g., "Did the doctor touch you there?" pointing to the anatomical doll's vagina or anus) elicited few false reports of genital contact, i.e., 2.86% false reports of vaginal touch and 5.56% false reports of anal touch. Moreover, of the three children who erroneously responded "yes" to one of the direct questions concerning genital touch, two were unable to provide any elaboration whatsoever about the alleged genital touching when questioned further. Skilled forensic interviewers recognize that it would be entirely inappropriate to conclude that child sexual abuse had occurred based solely on an unelaborated singular "yes" response of this sort.

Thus, empirical studies which have investigated the effects of various types of abuse-focused questions have found that, while there is the "potential" for leading and direct questions relating to genital contact to elicit false reports from some non-abused children under certain circumstances, the proportion of children actually misled in this fashion was relatively small. Furthermore, the nature of the false reports of genital contact elicited in these studies generally would not lead prudent investigators to conclude that abuse had occurred, in the absence of other supporting evidence.

Although children are not necessarily more suggestible than adults in all situations, there do appear to be some age-related considerations concerning suggestibility. For example, very young children (particularly those under 4 years old) tend to be more vulnerable than older children and adults to "going along" with the interviewer's misleading questions and suggestions—even when such children realize the suggestions contained in the question are incorrect (King & Yuille, 1987; Saywitz, et al., 1991; Zaragoza, 1987). In such cases, the child's agreement with the false information proposed by the questioner is not attributable to the child's lack of memory for the event in question, but rather reflects a tendency on the part of some younger children to acquiesce to the "social demand features" of the interview context (King & Yuille, 1987). That is, a greater "status differential" exists between younger children and adults than exists between individuals who are more similar in regards to age, autonomy, authority, experience, and sophistication. And this "status differential" can contribute to the likelihood of lower status individuals (i.e., children) deferring to the authority and presumably greater wisdom of higher status individuals (i.e., adults). This

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was demonstrated in a recent study investigating the effects of misleading questions on pre-schoolers which revealed that 3-year-olds were more likely to acquiesce to misleading information when it was presented by an adult interviewer than when the same information was presented by a 7-year-old child (Ceci, Ross & Toglia, 1987).

Young children tend to view most adults as authoritative and as the controllers of rewards and punishments (Kohlberg, 1969). Consequently, children may sometimes agree with the erroneous suggestions contained in the adult's misleading question in order to please the adult or to avoid displeasing the adult—even when the child recognizes the adult's information is erroneous. Some children may be too fearful or intimidated to challenge or disagree with an adult, especially if the adult is authoritarian and unfriendly (Goodman, et al., 1991). Many children simply believe they are "not allowed" to challenge or correct an adult. One 7-year-old girl explained in a recent study on children's suggestibility, "I wouldn't tell the principal he's wrong!" (Moan, 1991). Indeed, children learn early in life that adults are smarter, more powerful, and the dispensers of rewards and punishments, and accommodating to the suggestions and authority of adults under normal circumstances is often entirely appropriate and adaptive—even when the adult's suggestions may be erroneous.

Suggestibility is an extremely complex, multiply-determined phenomenon. Situational factors relating to the interview context as well as memory factors influence the suggestibility of adults and children alike.

Furthermore, children who are uncertain of the accuracy of the information contained in the adult's question may acquiesce to the adult's suggestions based on the mistaken belief that adults are inherently more knowledgeable than children. Children may sometimes feel that any question by an adult requires a definitive answer and that an "I don't know" response is not an option (Raskin & Yuille, 1989). Children may also refrain from providing an "I don't know" or an "I don't remember" response because they consider 'not knowing' to be a sign of failure (Moan, 1991). Consequently, such children may 'guess' the correct answer based on information contained in the question.

General Guidelines for Using Direct, Focused, and Clearly Leading Questions.

While it may be true that some individuals greatly exaggerate the degree to which children are susceptible to agreeing with the suggestions contained in misleading or direct questions regarding sexual abuse, it is entirely proper for critics of interviewing techniques to raise reality-based concerns about the potential for "contamination" (e.g., the elicitation of erroneous information) when such questions are used with children.

The use of clearly leading questions which blatantly coerce children to agree with the suggested information is not justifiable in forensic interviews. Although interviewers are also often cautioned about using "focused" and "direct" questions because of the potential for influencing and distorting children's accounts, banning their use altogether is not realistic or advisable (Saywitz, et al., 1991). Even the most skilled interviewers will sometimes ask direct and focused questions which may be construed as leading or misleading. Moreover, research relating to the disclosure process among sexually abused children as well as among non-abused 5 and 7 year olds questioned about genital contact occurring during a medical exam offers a compelling argument for the judicious use of direct and focused questions.

For years, experienced clinicians have recognized that sexually abused children are frequently quite reluctant to disclose their abuse. In his seminal article published a decade ago, Roland Summit eloquently articulated the plight of many sexually abused children who feel compelled to tolerate their abuse in silence due to their intense fears associated with its disclosure (Summit, 1983). The findings of recent empirical studies support what clinicians have been observing all along. For example, Sorenson and Snow's (1991) study of 116 confirmed cases of child sexual abuse revealed that 72% of the child-victims denied being abused when initially questioned. Although nearly all of the children (most of whom were in therapy) eventually disclosed their abuse, 70% first provided a minimized account of their abuse, and 22% later recanted their valid allegations of abuse. Similarly, Lawson and Chaffin (1993) found that the majority (57%) of a sample of pre-pubertal children diagnosed as having sexually transmitted diseases (which were, at the very least, extremely suggestive of sexual contact) denied any sexual contact when initially interviewed. The willingness of the children's caretakers to consider that sexual contact was a possibility was correlated with the children's willingness to reveal abuse.

Research has also shown that focused and direct questions are often necessary in eliciting accurate accounts of genital touching due to developmental factors as well as the reluctance of most children to spontaneously offer such information. For example, in Saywitz, et al.'s study (1991), only 22% of children who were touched vaginally and 11% of those touched anally as part of a medical exam admitted the genital touching when asked open-ended questions. In marked contrast, when the same children were asked direct, focused questions (i.e., "Did the doctor touch you there?", pointing to the anatomical doll's vagina/anus), 86% admitted vaginal touching and 69% admitted anal touching. Consequently, exclusive reliance on "open-ended" questions is highly likely to result in a gross underreporting of genital contact/sexual abuse. Such a stance is clearly not justified by the existing

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relevant empirical research and would most likely result in the failure to identify and protect a large proportion of sexually abused children.

APSAC's Guidelines for Psychosocial Evaluation of Suspected Sexual Abuse in Young Children (1991) recommend that initial questioning should be as non-directive as possible to elicit spontaneous responses and, if open-ended questions are not productive, more directive questions should follow. Furthermore, APSAC's "Guidelines" state that highly specific questioning should only be used when other methods of questioning have failed, when previous information warrants substantial concern, or when the child's developmental level precludes more non-directive approaches. However, responses to these questions should be carefully evaluated and weighed accordingly. Thus, although direct and focused questions may be potentially misleading in some situations, their use is often justifiable and necessary.

Forensic interviewers should be mindful that children can be misled in either direction — i.e., to make false accusations of abuse or to falsely deny or minimize abuse — and should attempt to structure their questions accordingly.

Although it is conceivable that non-abused children may occasionally be misled to falsely claim abuse, it is probably much more likely that sexually abused children can be misled to minimize, deny, or recant their abuse. Given that sexually abused children are often predisposed to deny and minimize their abuse (Sorenson & Snow, 1991; Lawson & Chaffin, 1993), it is probable that misleading questions which erroneously imply the absence of abuse or a minimized version of abuse may be particularly influential in eliciting false denials, minimizations, and recantations from sexually abused children. Therefore, forensic interviewers should be mindful that children can be misled in either direction — i.e., to make false accusations of abuse, or to falsely deny or minimize abuse — and should attempt to structure their questions accordingly.

Strategies for Enhancing Children's Resistance to Misleading Questions.

For the most part, procedures aimed at reducing children's susceptibility to misleading questions focus on reducing the "status differential" between the child and the adult interviewer and providing the child with a clear understanding of what is expected and desired of the child during the interview task. By making the child as comfortable as possible and encouraging the child to be assertive with the adult interviewer, the child is empowered and is better able to resist misleading by the interviewer. Furthermore, once the child understands that providing reliable testimony is what the interviewer desires, the child's tendency to say things to "please" the interviewer becomes an asset rather than a liability.

For several years, highly skilled and innovative forensic interviewers, such as Detective Rick Cage of Wheaton, Maryland, have been working on the front lines at developing practical procedures for enhancing the reliability of children's statements in child sexual abuse cases (personal communications, 1991-1993). Several of the strategies pioneered by Detective Cage and others appear to be quite promising and useful in enhancing children's resistance to misleading questions during forensic interviews. Recently, distinguished researchers in the fields of child development and child sexual abuse, (e.g., Karen Saywitz, Gail Goodman) have been empirically studying the effectiveness of various methods aimed at enhancing the reliability of children's statements and reducing their susceptibility to misleading questions.

The strategies that are described below have been utilized experimentally by experienced forensic interviewers and represent those which appear to have practical utility and "face" validity. As a psychologist, I have found these strategies to be useful in enhancing children's resistance to misleading questions during psychosocial evaluations in cases of suspected sexual abuse. One of these strategies in particular (i.e., #7) has also been effective in rehabilitating children's credibility when it has been attacked on the grounds that the child's allegations were a product of leading questions and are, therefore, unreliable. As noted below, several of the suggested strategies have been empirically studied and validated in situations which more or less mimic the forensic interview. The reader should be cautioned, however, that research in this area is extremely complex and is still incomplete in many respects. Therefore, some of the suggested strategies, while appearing useful, will require further empirical study and validation before we can be confident in their efficacy in this regard. In addition, the suggested strategies require varying degrees of interviewing skill and clinical judgement and should be perfected before being attempted in actual forensic interviews. Strategies of this sort are potentially dangerous in the hands of those who are not skilled and knowledgeable in the performance of forensic interviews in cases of suspected child sexual abuse, and they are not intended for individuals who lack expertise in this area.

1. Be friendly rather than authoritarian with the child. Research by Goodman, et al. (1991) has shown that 3 and 4 year-olds who were interviewed by an adult who acted "friendly" (i.e., smiled, complimented the child, gave the child cookies) were more resistant to misleading abuse-related questions than same-aged children who were interviewed by an "unfriendly" adult (i.e., who rarely smiled, did not compliment the child or give the child a snack). When the interviewer develops rapport with the child by being friendly and empathic, the child is less likely to feel too intimidated by the status differential to resist the adult interviewer's misleading questions. Of course, caution should be exercised so that certain responses

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by the child are not being selectively reinforced, i.e., smiling only when the child provides responses affirming abuse.

2. Explain to the child that you are naive, especially regarding the facts of the case. Because children sometimes mistakenly presume that adults inherently know more than children, there is a risk that a child may acquiesce to the adult's misleading questions even though the adult's suggestions directly contradict the child's memory of the event in question. In a series of studies of children's suggestibility, Saywitz and Snyder (1993) found that 7 year olds were more likely to resist misleading questions when they were told to trust their own memories because the interviewer was not knowledgeable about the event in question as he wasn't present when it occurred. Therefore, interviewers can minimize children's resistance to misleading by stating to the child something like:

By making the child as comfortable as possible and encouraging the child to be assertive with the adult interviewer, the child is empowered and is better able to resist misleading by the interviewer.

"I wasn't there, so I don't know what happened. I need your help to learn about what happened."

Detective Cage often uses what he refers to as the "Colombo approach" when interviewing children wherein he portrays himself as being generally uninformed, quite puzzled, and needing the child's help. This approach encourages the child to 'educate' the apparently naive interviewer.

3. Advise the child that if questions are repeated, this does not mean the child's previous response was incorrect. Sometimes forensic interviewers ask children the same question more than once. This may be unintentional, as when the interviewer forgets that the question was previously asked and answered, or it may be deliberate, as when the interviewer is attempting to assess the child's consistency in responding. In either case, children may be misled by repetitive questions, especially when the questions are repeated verbatim.

When questions are repeated, children may infer that their initial response was incorrect or displeasing to the interviewer. As a result, children's confidence in their earlier response may be undermined, and they may then provide an alternate response. Or, some children who remain confident in the accuracy of their earlier response may still feel pressured to alter their subsequent response to avoid displeasing the interviewer — particularly if the interviewer is intimidating.

In order to minimize the likelihood of children being misled by repetitive questions, the interviewer is advised to rephrase questions which are repeated and to explain that questions will not be repeated because the child's initial response was wrong or undesirable. Empirical research has shown that when children understand that the interviewer is not repeating questions because the child's earlier answers were incorrect, children are less likely to change an answer they know to be correct in order to appease the interviewer. I use instructions similar to the following to reduce the potentially misleading effects of repeated questions:

"Sometimes I might forget what I already asked you. So I might ask you the same question again and again. If I ask you the same question more than one time, it's not because you gave me the wrong answer the first time. It's just because I forget sometimes. So you just keep giving me the answer you know is right even if I ask the same question again and again, okay?"

4. Give the child permission to decline answering questions that are too difficult to discuss at the moment. For a child who has been sexually abused, certain aspects of the abuse may be too embarrassing or frightening for the child to discuss at a particular moment. Consequently, the child may be unwilling to volunteer this information and may take refuge in denying or minimizing the abuse - especially when asked misleading questions which imply the absence of abuse or which minimize the abuse. Thus, when misleading questions of this sort are asked, the embarrassed or frightened child may avoid the topic of abuse and the concomitant distress it provokes by agreeing with the interviewer's suggestion that "nothing" or "nothing else" happened. Therefore, it is important to enable the child to avoid discussing aspects of the abuse that are too frightening, embarrassing, or painful to talk about at the time, while still attempting to elicit as much factual information as possible. Instructions such as the following can be helpful in this regard:

"If you do not want to answer some of the questions right now, you don't have to. Just tell me 'I don't want to answer that question right now' if it is too hard to talk about at the moment."

It can be counterproductive to overemphasize the point that the child need not tell you everything at the moment because a child may opt to avoid talking about the abuse altogether. As always, the interviewer's sensitivity to the child's predicament and the interviewer's judgement about the child's ability to tolerate a discussion about certain topics related to abuse are the key determinants in how and whether this strategy is used. When a child is given permission "not to talk" about aspects of the abuse that are too distressing this can, paradoxically, result in the child being more willing and able to disclose such abuse. By giving such permission, the interviewer is communicating a sensitivity to the child's predicament and empowering the child with choices about the direction of the interview. Consequently, the child may then feel a sense of control and may feel "safe enough" to

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discuss material that would otherwise be too threatening or embarrassing to discuss.

5. Encourage the child to admit lack of memory or knowledge rather than guessing. Sometimes children presume that any question asked by an adult requires a 'definitive' answer. (Raskin & Yuille, 1989). Children may also have been encouraged to 'guess' answers to questions in certain situations rather than admit ignorance, i.e., games, school, etc. Consequently, when they do not know or remember the correct answer, children will sometimes 'guess' the answer. If a question is leading, the child may answer by affirming the information suggested by the question. When such questions are misleading, the child may answer by affirming the erroneous suggestion contained in the question.

Dr. Karen Saywitz recently described a strategy which has been incorporated into the "modified cognitive interview" which appears to reduce the likelihood that children will guess answers to questions (Saywitz, 1992). I use similar instructions to discourage children from guessing answers to questions, such as the following:

"Nobody knows everything, do they? I'll be asking you lots of questions today. Some will be easy and some will be hard. Sometimes you may not know for sure what the right answer is. Maybe you forgot or you just don't know. If you don't know what the right answer is for sure, please don't guess an answer. Only tell me what you really know for sure and what you really remember. If you don't know the answer or if you forget, just say 'I don't know,' or 'I forget,' because that's the right answer".

If the child continues to agree with the interviewer's misstated information despite concerted efforts to get the child to correct the interviewer's "mistakes," the interviewer should be concerned about the child's attentiveness and vulnerability to suggestion.

Research and clinical experience have shown that mere instructions of this sort have a limited effect unless they are accompanied by practice or role-playing with the child (Saywitz & Snyder, 1993). Therefore, it is critical that this concept is role-played with the child and that the child is praised for admitting "I don't know" at the appropriate times. The child should also be given corrective feedback if she/he 'guesses' answers. The interviewer may role-play this concept by asking the child about things the child has no knowledge or memory of, such as:

"How old am I?"

"What is my wife's name?"

"How many hairs are on your head?"

"What did the doctor say to your mommy the day you were born?"

While it is important to discourage guessing by the child, research and clinical experience have shown that there is a risk that the child may overgeneralize the "I don't know" response if the interviewer overemphasizes this response set (Saywitz & Snyder, 1993). Therefore, the interviewer should take care to encourage the child to be selective in using the "I don't know" response and to provide definitive answers when the child knows what the correct answer is.

6. Encourage the child to admit confusion rather than guessing. Sometimes children do not understand the interviewer's question and may 'guess' what the question means and respond accordingly. When the confusing question is a misleading question, the child is likely to respond based on the erroneous suggestion that is contained in the question. Studies by Saywitz and Snyder (1993) have shown that sensitizing children to the possibility that the interviewer may ask confusing questions, and role-playing appropriate assertive responses to be used by the child when he/she is confused can reduce the risk of guessing. Instructions similar to the following, when accompanied by role-playing, can discourage guessing when the child is confused:

"Some of the questions I'll be asking you will be tricky and they might get you mixed up because they get lots of people mixed up. I need your help so I don't get you mixed up. If I ask you something that makes you get mixed up, please just say, 'Huh?' or 'I don't know what you mean'. Then I'll say the question with new words to help you understand."

This strategy should be role-played with the child and the child should be praised for appropriately admitting confusion and for not guessing. Also, corrective feedback should be given to the child if the child guesses or fails to admit confusion. Questions such as the following can be used to assess and facilitate the child's willingness to admit confusion:

"If in is around, what is out?"

"When Mickey Mouse was little and Donald Duck was big, what did the Ninja Turtles see in the swimming pool on top of the car?"

"How many gazintas are there in a babalooza?"

7. Encourage the child to disagree with you and to correct you when you misstate the facts. Disagreement and correction demonstrate that the child has a clear grasp of the facts, is not responding unthinkingly, and is willing to be assertive with the interviewer when the interviewer makes mistakes (Myers, 1992 pp.49-50). Of the various strategies described in this article, encouraging children to disagree with the interviewer's incorrect statements requires the highest level of clinical judgement and sophistication. Therefore, this strategy in particular is not recommended for interviewers lacking in experience or training. The following instructions and role-playing exercises should occur prior to and separate from abuse-specific questioning:

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"Sometimes I get mixed up and say the wrong thing. I need your help so I don't say the wrong thing. If I do say the wrong thing, will you please tell me? Just say 'That's not right,' or, 'You made a mistake'. Okay?"

Again, research has shown that mere instructions of this sort have a limited effect unless they are accompanied by practice or role-playing with the child. Therefore, prior to abuse-specific questioning, the interviewer should deliberately misstate information which the child knows for certain to be incorrect. Such deliberately misleading questions should be relatively innocuous and should not be specific to the alleged abuse as this may contaminate the child's statements. For example, the interviewer might ask the deliberately misleading question, "Is your sister's name Mary?" to a child who has no sister and has already told the interviewer of this. Or, the interviewer may point to a picture of Mickey Mouse and say to a child who has already correctly identified Mickey Mouse, "No, that's Donald Duck, isn't it?" Several deliberately misleading questions of this sort should be asked and the child should be praised for "catching" the interviewer's mistakes and for "correcting" the interviewer.

Since the defense often argues that children are inherently highly suggestible, it can be invaluable to demonstrate that the child whose testimony is in question was able to resist non-abuse-related misleading questions during the same forensic interview in which abuse was alleged.

If the child initially "goes along" with the erroneous information contained in the interviewer's deliberately misleading questions, it may be helpful to bring this to the child's attention and to further encourage the child to "listen very carefully" for the interviewer's mistakes and to correct the interviewer when such mistakes are made. If, in fact, the child continues to agree with the interviewer's misstated information despite concerted efforts to get the child to correct the interviewer's "mistakes," the interviewer should be concerned about the child's attentiveness and vulnerability to suggestion. The interviewer should then take steps to heighten the child's attention and should be extremely cautious about using potentially misleading questions with such a child.

Since the defense often argues that children are inherently highly suggestible, it can be invaluable to demonstrate that the child whose testimony is in question was able to resist non-abuse-related misleading questions during the same forensic interview in which abuse was alleged. While the child's demonstrated resistance to non-abuse-related misleading questions does not "prove" that the child was also resistant to abuse-related misleading questions, it can go a long way in countering the argument that the child in question yielded to the interviewer's questions suggesting abuse because "children as a class" are so easily misled by interviewers. Such evidence can also be quite helpful in establishing indicia of reliability in the context of exceptions for hearsay statements.

Conclusion

There is little empirical support for the notion that children are easlily misled to falsely claim sexual abuse. Nevertheless, forensic interviewers are strongly encouraged to take reasonable steps to minimize the risk of misleading children *either* to falsely claim abuse, *or* to minimize, falsely deny, or recant their abuse. The strategies for enhancing children's resistance to misleading questions discussed in this article have been used in forensic practice and appear to be promising. Although empirical study of the suggested strategies is not complete, findings thus far are encouraging. Significantly, such strategies may serve not only to enhance children's resistance to misleading questions, but to enhance the perception of children's credibility by the triers of fact. When the interview is attacked on the grounds that the child was misled by the interviewer to falsely claim abuse, the use of these strategies may make the forensic interview more defensible.

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OPINION

The Doctrine of Family Reunification: Child Protection or Risk?

—by Richard J. Gelles

The prevailing child welfare doctrine in cases of child abuse and neglect is to provide short-term protection for maltreated children but to work toward long-term reunification for children with their families. The doctrine of family reunification draws its support from the Federal Adoption Assistance and Child Welfare Act of 1980, which requires state agencies to make "reasonable efforts" to reunify children with maltreating parents. If "reasonable efforts" fail to produce a change in the caretaking abilities of the parents, then the state child welfare agency can move toward terminating parental rights and finding a "permanent placement" for the children. Family reunification is also often mandated as part of state child abuse laws. Even in states where reunification is not a legal requirement, it is the implicit goal of child protective service agencies.

Assumptions that support the doctrine of reunification

1. A Continuum of Maltreatment

A number of key assumptions support the family reunification policy. The first is that abusive, neglectful, or maltreating behavior exists as a linear continuum. The assumption begins with the notion that "anyone can be a child abuser, given certain circumstances." The assumption is supported by empirical data that show that abuse and neglect cross all social and demographic boundaries. Following from the assumption of a continuum is the notion that without appropriate intervention, maltreatment will inevitably escalate in families until children are severely injured or even killed.

Although the compassionate approach to child maltreatment is attractive to those of us in the helping professions, I believe that the data fail to support the model. While there are indeed many child maltreators who can be helped to be competent parents with timely and effective social services, other parents cannot be assisted to be caring and nurturing parents.

The continuum assumption generally rejects a "kind of person" explanation for maltreatment. Abusers and neglectors are not conceptualized as defective, deviant, or sick individuals. Rather, the continuum assumption rests on a "tipping point" or a "deficit" model of parental behavior. In the "tipping point" model, stresses or problems pile up until a "tipping point" is reached that pushes parents from being caring parents to maltreating parents. Over-stressed parents either actively lash out and physically abuse their children, or passively neglect their children. An alternative but compatible model is the "deficit model" that assumes that some parents lack personal, social, or economic resources to be effective parents. Adding resources, such as psychological counseling, parent education, home visitors, or other resources is believed to help parents to meet their own needs and the needs of their children.

Thus, the mandate for child welfare interventions is to: (1) add resources, (2) remove stresses, or (3) both, and make the home safe again so that children can be reunified with their parents. Both models assume that children need only be removed from their parents when they are at risk of harm and should be returned when the parents are able to adequately care for their children.

2. Children Do Better With Their Parents

The second assumption that supports family reunification as the overarching doctrine for child welfare is the assumption that children do best when cared for by their birth parents. A corollary to this assumption is that children do best when they can interact with both birth parents. Thus, judges tend to assign joint custody or allow visitation even in the face of strong clinical evidence that one of the parents physically abused, sexually abused, emotionally abused, or neglected the child or children.

3. Children Are Harmed In Foster Placements

Following the second assumption that children do better when cared for by their birth parents is the assumption that children are harmed when they are placed in foster families. Foster parents are often viewed as the "necessary evil" of child welfare. Although there are scant reputable scientific data to support the claim that children are at risk in foster families, the assumption that children are harmed in foster families is often propped up with anecdotal evidence and stories that detail the horrors and harms that befall children in foster homes. The journalist Richard Wexler, in his book, *Wounded Innocents* (1991), and the legal scholar Douglas Besharov in his book *Recognizing Child Abuse* (1990) both provide anecdotal evidence about the harm done to children in foster families.

The shortcomings of the assumptions and the policy of family reunification

Family reunification, family preservation, and many of the permanency placement doctrines are all forms of a compassionate approach to child maltreatment and child maltreators. Child welfare professionals who employ the compassionate approach believe in an abundance of human kindness and a non-punitive outlook on intervention. The compassionate philosophy views the abusive parents as victims themselves. The cause of the abuse may be seen in social and developmental origins, and not in the abuse. Abusive parents, rather than being seen as cold, cruel monsters, are seen as sad, deprived, and needy human beings.

Although the compassionate approach to child maltreatment is attractive to those of us in the helping professions, I believe that the data fail to support the model. While there are indeed many child maltreators who can be helped to be competent parents with timely and effective social services, other parents cannot be assisted to be caring and nurturing parents. The "tipping scale" and "deficit" models apply to only a

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portion of child abusers. My guess is that this model might apply to between two-thirds and seventy percent of all the cases of abuse and neglect — a substantial proportion of cases, but not all.

An additional problem with the family reunification doctrine is the lack of empirical support for its assumptions. My own research clearly indicates that there is not a "continuum of abuse" with severe abuse occurring because of increased stress and disadvantage (Gelles, 1991; Wolfner and Gelles, 1993). Instead, there seem to be distinct categories of maltreatment. Thus, parents who inflict severe harm on their children or kill offspring are categorically different from those parents whose maltreatment does not involve life-threatening harm to children. There is little rigorous scientific empirical support for the notions that children do better when raised by their birth parents or that children must have regular contact with both birth parents, even if one parent is an abuser or neglector. The idea that children do better with their birth parents is indeed a cherished value and belief in our society, but it is not a belief that rests on much scientific evidence.

I believe that we have collected sufficient knowledge about the effectiveness of family reunification programs, the nature and causes of abuse and neglect, and the developmental needs of children to base our policies on this evidence, not horror stories.

The arguments about harm done to children in foster care are merely anecdotes and stories. Here again, there is little scientific data behind the stories told by those who feel that so-called "child savers" are overly aggressive in removing children form their parents.

Lastly, the arguments for the effectiveness and cost effectiveness of some family reunification/family preservation programs, such as "Home Builders", are also largely anecdotal or else are based on data that are not scientifically rigorous enough on which to build a national policy.

Toward a new child-centered policy of child protection

I believe that the all-encompassing family reunification model needs to be abandoned as an official and unofficial child welfare policy. What data we have on child abuse, children, and child welfare interventions support a child-centered policy that aims at reducing the risk for children and matching interventions to the needs of children. More importantly, the interventions must be applied with sufficient efficiency that children do not have to languish in administrative limbo while court cases drag on and on.

The most compelling argument for abandoning the uniform policy of family reunification and family preservation are the data on child homicide. Research on child homicide clearly reveals the damage done by rigidly following the family reunification model. Thirty to fifty percent of the children killed by parents or caretakers are killed *after* they have been identified by child welfare agencies and have been involved in interventions, and were either left in their homes or returned home after a short-term removal (Anderson, Ambrosino, Valentine, and Lauderdale, 1983; Besharov, 1991; Daro, 1987; Mitchel, 1989; Mayor's Task Force on Child Abuse and Neglect, 1983; Texas Department of Human Resources, 1981).

A second argument in favor of a child centered policy is the data that children's optimal development is not dependent on living with their birth parents, but on developing a nurturing relationship with a caring adult (Egeland and Erickson, 1991; Sroufe, 1983). More importantly, children need to develop this attachment during a finite developmental period, somewhere between ages four and ten. The failure of permanency planning policies is that they often leave children in limbo during this developmental stage while child welfare agencies are providing so-called "reasonable efforts" to rehabilitate and support parents with the goal of reunification.

I could easily provide a long list of anecdotes to support these arguments. Over the past few months I have been contacted by foster parents, child welfare workers, child welfare administrators, and others concerned with the welfare of children. Each has voiced support for my position and each has provided me with one, two, or more stories about the harm done by "tunnel visioned" family reunification policies. As powerful as these stories are, they should not be the basis of a change in child welfare policies any more than other anecdotes should be the basis of supporting "Home Builders" or other family reunification programs. I will leave the anecdotes to the journalists. I believe that we have collected sufficient knowledge about the effectiveness of family reunification programs, the nature and causes of abuse and neglect, and the developmental needs of children to base our policies on this evidence, not horror stories.

Summary

Child protection and child advocacy need to replace family reunification as the guiding policy of child welfare agencies. Child welfare workers need to "listen" to the actions of maltreating parents. Parents who fracture the skulls or bones of 6-month-old children, who have sexual intercourse with twelve-month-old daughters, and whose drug abuse patterns compromise their ability to care for their children are simply not entitled to "three strikes" before they lose their rights as parents. With some kinds of child maltreatment, "one strike" is sufficient to warrant terminal parental rights.

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MEDICINE

Classification of Anogenital Findings in Children with Suspected Sexual Abuse: An Evolving Process

—by Joyce A. Adams

Medical professionals who evaluate children for suspected sexual abuse are usually asked to render an opinion as to whether the child's examination is normal or abnormal, and whether the findings are consistent with the child's description of the abuse (when available).

In an attempt to develop some internal consistency in how we rate findings with respect to abuse, my colleagues and I at the Child Sexual Abuse Evaluation Program in Fresno, California developed and published a classification scale (Adams, Harper, & Knudson, 1992) Since the publication of the scale in April of 1992, we have made a few changes, taking new data into account. This paper will present our revised scale, with references to the studies of abused and non-abused children which were used to develop the classification scale, as well as subsequent research findings.

The definitions of the classifications of physical findings are as follows:

It is important to keep in mind that most children with documented sexual abuse will have no specific abnormalities on medical examination. We find it necessary to remind our colleagues in law enforcement, social services, and the judiciary that even in cases of legally-proven sexual abuse, 74-77% of children will have normal/non-specific examinations.

Class 1: Normal - Variations in the appearance of the hymen, perihymenal tissues, and peri-anal tissues which have been documented in more that 10% of the subjects in studies of non-abused children. The studies we used were McCann, et. al, 1989; McCann, et. al, 1990; Berenson, Heger, & Andrews, 1991; and Berenson, et. al, 1992. All variations in the appearance of the hymen in newborns (Berenson, Heger, & Andrews, 1991) are listed as normal.

Class 2: Non-specific - Findings which may be the result of sexual abuse, but may also be due to other non-abusive causes.

Class 3: Suspicious - Findings which are rarely seen in non-abused children and have been noted in children with documented abuse, but have not been clearly proven to occur **only** as a result of abuse.

Class 4: Suggestive of abuse or penetration - Findings, or a combination of findings which can only reasonably be explained by postulating that sexual abuse or penetrating injury has occurred. This type of finding would mandate a report to a law enforcement and child protective services, even if the child is unable to give a clear history of molestation, assuming there is no clear and consistent history of accidental penetrating injury.

Class 5: Clear evidence of penetrating injury - Findings which can have no explanation other than penetrating trauma to the hymen or peri-anal tissues.

We have carried out two research studies using this classification scale, and found that when medical professionals viewed colposcopic photographs, in the absence of a history (Adams & Wells, 1993, in press), or were asked to rate findings by name in a mail survey (Adams, Harper, & Wells, 1993, in press), it was necessary to combine Class 1 and Class 2 as "normal/non-specific", and Class 4 and Class 5 findings as "abnormal" in order to be able to analyze the results, because of the wide spread of responses using a 5-point scale. However, we still feel it may be useful, for research purposes, to continue with the 5-point system, and present the revised system here, in Table 1 and Table 2.

In a study of examiner agreement in which participants viewed and rated colposcopic photographs as to the significance of findings with respect to abuse (Adams & Wells, 1993, in press), there was more than 80% overall agreement on 2 cases showing a smooth, crescentic hymen as being normal/non-specific, 2 cases showing a hymenal transection as being abnormal, and one case showing anal dilation without stool and irregular anal folds as being abnormal. More experienced examiners, who examine more that ten cases of suspected abuse per month, also had 95% agreement in rating a posterior fourchette scar as abnormal, and a hymenal tag as normal/non-specific.

In a written survey of 141 physicians who examine sexually abused children (Adams, Harper, & Wells, 1993, in press), over 80% agreed on a rating of normal/non-specific for the following findings: hymenal tag; labial adhesion; increased erythema in the genital area; anal skin tags; and increased peri-anal dilation with stool present. 90% of the most experienced group also rated hymenal bumps as normal/non-specific. Findings rated by over 80% of respondents as abnormal were: hymenal transections; hymenal lacerations; worn away hymen; laceration of posterior fourchette or peri-anal tissues; granulation of tissue or scarring

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Opinion

–Richard J. Gelles

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on vaginal wall; positive cultures for Gonorrhea and Chlamydia; and the presence of Trichomonas. The presence of sperm was rated by 99% of respondents as clear evidence of sexual contact, Class 4 overall.

The results of these two studies indicate that medical professionals in the field of sexual abuse evaluation are reaching agreement, in some cases, as to which findings are normal in children, and which are specific for sexual abuse. Committees in the American Professional Society on the Abuse of Children are currently working to develop guidelines for terminology, as well as a consensus statement addressing the interpretation of findings in children with suspected sexual abuse.

It is important to keep in mind, however, that most children with documented sexual abuse will have no specific abnormalities on medical examination. We find it necessary to remind our colleagues in law enforcement, social services, and the judiciary that even in cases of legally-proven sexual abuse, 74-77% of children will have normal/non-specific examinations (Muram, 1989; DeJong & Rose, 1991).

We would welcome input from other professionals in the field on this classification scale.

The absence of physical "evidence" should never be used to screen out cases for prosecution, when the child's verbal evidence is strong and convincing. A large part of the medical professional's role in evaluating suspected sexual abuse is to document the appearance of his or her genitalia, and to emphasize that normal examinations, or non-specific findings, are consistent with most, if not all, types of molestation. Table 2 lists the "Overall Assessment of the Likelihood of Abuse" system that we use in formulating our opinion, after a comprehensive evaluation of the child.

An initial review of data on 426 children referred to our program during a 1 year period, only 6% of girls and 1% boys had clearly abnormal findings on examination, yet the overall assessment was "Probable Abuse" in 67%, and "Definite Abuse" in 5% of the cases, using the classification system we have presented here.

We would welcome input from other professionals in the field on this classification scale, and encourage others to use the scale in their centers, if it is found useful. Remember, though, that as more studies of abused and non-abused children appear, it may be necessary to make further revisions. Assessment of suspected sexual abuse is indeed an evolving field.

TABLE 1
Proposed Classification of Ano-Genital Findings in Children

Normal (Class 1)

1. Peri-urethral (or vestibular) bands (McCann, et al., 1990; Berenson, Heger & Andrews, 1991; Berenson, Heger, & Hayes, 1992).
2. Longitudinal intravaginal ridges (McCann, et al., 1990; Berenson, Heger & Andrews, 1991; Berenson, Heger, & Hayes, 1992).
3. Hymenal tags (McCann, et al., 1990; Berenson, Heger & Andrews, 1991; Berenson, Heger, & Hayes, 1992).
4. Posterior (inferior) hymenal rim measuring at least 1 millimeter wide (McCann, et al., 1990; Berenson, Heger, & Hayes, 1992).
5. Estrogen changes (uniformly thickened, redundant hymen) (McCann, et al., 1990).
6. Hymenal clefts in the anterior (superior) half of the hymenal rim: on or above the 3 o'clock - 9 o'clock line, patient supine (Berenson, Heger & Andrews, 1991).
7. Hymenal bumps or mounds (McCann, et al., 1990; Berenson, Heger & Andrews, 1991; Berenson, Heger, & Hayes, 1992).
8. Diastasis ani (smooth area) at 6 or 12 o'clock in peri-anal area (McCann, et al., 1989).
9. Anal tag/thickened fold in midline (McCann, et al., 1989).
10. Increased peri-anal pigmentation (McCann, et al., 1989).

Non-specific findings (Class 2)

11. Erythema of vestibule or peri-anal tissues (McCann, et al., 1989; McCann, et al., 1990; Muram, 1989).
12. Increased vascularity of vestibule or hymen (McCann, et al., 1989; McCann, et al., 1990; Muram, 1989).
13. Labial adhesions (McCann, et al., 1989; McCann, et al., 1990; Muram, 1989).
14. Vaginal discharge (McCann, et al., 1990; Berenson, Heger, & Hayes, 1992).
15. Lesions of condyloma acuminata in a child less than 2 years of age (American Academy of Pediatrics, 1991).
16. Anal fissures (McCann, et al., 1989; Muram, 1989).
17. Flattened anal folds (McCann, et al., 1989; Hobbs & Wynne, 1989).
18. Anal dilation with stool present (McCann, et al., 1989; Hobbs & Wynne, 1989).
19. Venous congestion of perianal tissues (McCann, et al., 1989; Hobbs & Wynne, 1989; Hammerschlag, 1988).

Suspicious for Abuse (Class 3)

20. Enlarged hymenal opening—greater than 2 SDs above mean, for age and position (McCann, et al., 1990; Berenson, Heger, & Hayes, 1992).
21. Immediate venous congestion of perianal tissues, with edema, and/or distorted anal folds (McCann, et al., 1989; Hobbs & Wynne, 1989; Hammerschlag, 1988).
22. Anal dilation of at least 20 mm with stool not visible in rectal vault (McCann, et al., 1989; Hobbs & Wynne, 1989).
23. Posterior hymenal rim less than 1 millimeter in all views (McCann, et al., 1990; Berenson, Heger,

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& Hayes, 1992; McCann, Voris, & Simon, 1992; Kerns, Ritter, & Thomas, 1992).

24. Condyloma acuminata in a child over 2 years of age (Hammerschlag, 1988).
25. Acute abrasions or lacerations in the vestibule or on the labia (not involving the hymen), or peri-anal lacerations (Muram, 1989; McCann & Voris, 1993; McCann, Voris, & Simon, 1992; Kerns, Ritter, & Thomas, 1992).

Suggestive of Abuse/Penetration (Class 4)

26. Combination of 2 or more suspicious anal findings or 20 or more suspicious genital findings.
27. Scar or fresh laceration of the posterior fourchette (Muram, 1989; McCann, Voris, & Simon, 1992).
28. Peri-anal scar (McCann & Voris, 1993).

Clear Evidence of Penetrating Injury (Class 5)

29. Areas in the posterior (inferior) half of the hymenal rim with an absence of hymenal tissue, confirmed in knee-chest position (Muram, 1989; McCann, Voris, & Simon, 1992; Kerns, Ritter, & Thomas, 1992).
30. Obvious hymenal transections (Muram, 1989; McCann, Voris, & Simon, 1992; Kerns, Ritter, & Thomas, 1992).
31. Peri-anal lacerations extending beyond (deep to) the external anal sphincter (McCann & Voris, 1993).
33. Recent hymenal-vaginal lacerations (Muram, 1989; McCann, Voris, & Simon, 1992).
34. Lacerations through the hymen and posterior fourchette, or perinuem (Muram, 1989; McCann, Voris, & Simon, 1992).

TABLE 2
Overall Assessment of the Likelihood of Sexual Abuse

Class 1: No evidence of Abuse

1.1 Normal exam, no history, no behavioral changes, no witnessed abuse.

1.2 Non-specific findings with another known etiology, and no history or behavioral changes.

1.3 Child considered at risk for sexual abuse, but gives no history and has non-specific behavior changes.

1.4 Physical findings of injury consistent with accidental trauma, with history given.

Class 2: Possible Abuse

2.1 Class 1, 2 or 3 findings in combination with significant behavioral changes, especially sexualized behaviors, but child unable to give history of abuse.

2.2 Presence of condyloma or Herpes I (genital) in the absence of a history of abuse, and with otherwise normal exam (Hammerschlag, 1988).

2.3 Child has made a statement, but no detailed or consistent history.

2.4 Class 3 findings with no disclosure of abuse.

Class 3: Probable Abuse

3.1 Child gives a clear, consistent, detailed description of molestation, with or without other findings present (American Academy of Pediatrics, 1991).

3.2 Class 4 or 5 findings in a child, with or without a history of abuse, in the absence of any convincing history of accidental penetrating injury (American Academy of Pediatrics, 1991).

3.3 Culture proven infection with Chlamydia trachomatis (child over 2 years of age) in a prepubertal child. Also culture proven Herpes Type 2 infection in a child, or documented Trichomonas infection (Hammerschlag, 1988; American Academy of Pediatrics, 1991).

Class 4: Definite Evidence of Abuse or Sexual Contact

4.1 The finding of sperm or seminal fluid in or on a child's body (Muram, 1989; American Academy of Pediatrics, 1991).

4.2 A witnessed episode of sexual molestation. This also applies to cases where pornographic photographs or videotapes are acquired as evidence

4.3 Non-accidental, blunt penetrating injury to the vaginal or anal orifice (McCann & Voris, 1993; McCann, Voris, & Simon, 1992).

4.4 Positive, confirmed cultures for Neisseria gonorrhea in a prepubertal child, or serologic confirmation of acquired syphilis (Hammerschlag, 1988; American Academy of Pediatrics, 1991).

4.5 Pregnancy (Muram, 1989; American Academy of Pediatrics, 1991).

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brain: that is, the same emotional and behavioral response can be elicited from a much smaller provocative stimulus. After sensitization, a full-blown fear response maybe evoked with a minor stressor. This, of course, is very often observed in traumatized children.

The same brain areas involved in the acute stress response also mediate motor behavior, affect regulation, anxiety, arousal, sleep, the startle response, cardiovascular and respiratory function and so forth. Sensitization of these systems by repetitive re-experiencing of a traumatic event leads to dysregulation in these various functions. It is not surprising then, that a traumatized child may, over time, exhibit motor hyperactivity, anxiety, mood 'swings', behavioral impulsivity, sleep problems, tachycardia and hypertension, among other dysfunctions (see Part I).

The traumatized child is walking around in a persisting fear state. Everyday stressors which previously may not have elicited any response are now able to elicit an exaggerated reactivity—these children are hyperreactive and overly 'sensitive'. Furthermore, the child will very easily be moved along the alarm/fear continuum—from being mildly anxious to feeling threatened to being terrorized. What we are observing in these children is a set of *maladaptive* emotional, behavioral and cognitive problems which are rooted in the original *adaptive* response to a traumatic event.

2. Freezing and "oppositional-defiant" behaviors: One of the first responses in the initial stages of the alarm reaction initiated by a potential threat is freezing. The adaptive advantage of this is clear. Freezing allows one to hear more clearly and observe more keenly, scanning your environment for a potential threat. In addition, lack of movement makes one harder to 'find' (camouflage, of a kind) and a less likely target for a predator. The psychological equivalent of freezing is indecision or ambivalence.

Each of us has had times when we have too much 'going on': we are swimming in information yet cannot organize it and make a decision. This makes us anxious, and the anxiety makes it harder to think clearly, making it more difficult to organize and decide. "When I have too much to do, I do nothing," is a complaint familiar to many busy people. Typically, we will "freeze." This temporary freezing allows us to slowly begin to process and re-evaluate the available information to us in order to make an appropriate decision. The more anxious we get, the less likely we are to be decisive or make a wise decision.

Children who have been traumatized often use this freezing mechanism when they feel anxious. This is often labeled "oppositional-defiant" behavior. Typically, what will happen is that the child will feel anxious due to an evocative stimulus to which their sensitized fear response is reacting (e.g., a family visit). They are often not aware of the evocative nature of a given event, but what they do perceive is anxiety. At this point, they tend to feel somewhat out of control and will psychologically and often, physically, freeze. When adults around them ask them to comply with some directive, they are 'frozen' and refuse. This forces the adult— a teacher, a parent, a counselor—to give the child another set of directives. Typically, these directives involve more threat. The adult will

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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)

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say, "If you don't do this, I will . . .". The nonverbal and verbal character of this 'threat' make the child feel more anxious, threatened and out of control.

The more anxious children feel, the more quickly they will move from being wary to being threatened and, ultimately, to being terrorized. Typically, as the child feels more threatened and terrorized, the 'freezing' adaptation no longer works and the primitive adaptations to threat are enlisted—moving along the alarm-fear-terror continuum, the child utilizes 'flight or fight' responses.

3. Dissociation: The child's 'flight' reaction: The reaction to threat was coined the 'fight or flight' reaction following clinical research and observations in adults under threat. The adaptive responses to the threat involved fighting or running away. For a child, running away is not a realistic adaptive response in most cases. There are, however, childhood equivalents of running away. The most common childhood equivalent of running away is dissociation. When a newborn infant or a toddler is under threat, rather than using physical means to flee the threat, the infant or child can psychologically disengage. Dissociation mechanisms are well described and commonly observed in young children and adults.

Each of us has had times when we have too much "going on": we are swimming in information yet cannot organize it and make a decision. This makes us anxious, and the anxiety makes it harder to think clearly, making it more difficult to organize and decide. . . . Typically, we will "freeze." This temporary freezing allows us to slowly begin to process and re-evaluate the available information in order to make an appropriate decision . . . . Children who have been traumatized often use this freezing mechanism when they feel anxious. This is often labeled "oppositional-defiant" behavior.

Situations which result in evoking an alarm reaction in children may result in the child using any variety of dissociative techniques. The clinical approach to working with children who dissociate is to try to keep them in the here and now. A dissociated child is not capable of utilizing the therapeutic milieu or therapeutic interactions which are taking place—he or she is in a different place. Therefore, it is very important that, when traumatized children are observed "daydreaming," staring off with a glazed look, or seeming to be absent, the therapists, families, teachers and others understand that these children are frequently dissociating—utilizing the psychological equivalent of flight. The pain or anxiety has become so great that they disengage. The therapeutic approach whether individual, group, or milieu, must acknowledge that the child may be using a dissociative adaptation and make every attempt to minimize anxiety-provoking content or techniques which will make the child unavailable for therapeutic work.

If the child continues to feel threatened and dissociative adaptations are not completely successful in reducing the pain or anxiety of this threat, the child will be forced to utilize other mechanisms to minimize the pain.

4. Vocalization, resistance and aggressive behaviors: The child's 'fight' reaction: Children, of course, are not particularly well equipped to fight. Children, rather than fighting, have evolved the use of vocalization, i.e., crying, to get an adult caretaker to know that the child is under threat. Crying, therefore, is the developmentally appropriate response to a threat which the child is unable to avoid and which is causing the child to require a possible fight reaction. The child is unable to fight for himself, so the cry should bring attention to the adults to come and defend the child.

Unfortunately, crying only infrequently brings an adult to defend a traumatized child. The child is then forced to utilize the child's fight reaction—tantrums. Tantrums, particularly those that have a real regressive feel to them are very typically seen in traumatized children after they have moved along the alarm-fear-terror continuum. When a traumatized child has a tantrum, they are often terrorized. These tantrums often result in physical restraint until the child is able to feel contained, held, calmed and, ultimately, reintegrated. Aggressive behaviors, rather than a deteriorated tantrum, may be the fight equivalent for a terrorized child. This if often seen in children who themselves were victims of physical assault or violence.

It is important to distinguish between physically assaultive re-enactment behaviors and a regressed, terrorized psychological disintegration seen in tantrums. One can see the differences in these two classes of behavior: children re-enacting tend to be more integrated, they appear to have some "willful" quality to the aggressive behaviors, and they are often aware of the consequences of their behaviors, although frequently they do not show much remorse. In contrast, terror-related behaviors are regressed, defensive, often appearing purposeless. In many cases, both types of behaviors may be observed, sometimes in the same episode, making it difficult to distinguish between them. It is important, however, to try to understand the difference between aggressive reenactment behaviors (often predatory) and aggressive behaviors related to a child feeling anxious, fighting and afraid. The cornered animal is terrorized and will fight very violently. This very same animal when not terrorized, however, will very infrequently fight. Stalking behavior, in contrast, is practiced, planned, calculated and predatory. Understanding antecedent behavioral and emotional functioning prior to an aggressive or violent act is critical in developing appropriate treatment interventions.

Clinical Considerations: Risk and Protective Factors

1. Age and developmental stage: One of the most important clinical considerations in working with traumatized children is recognizing that children of different ages think differently, act differently and

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have different emotional functioning. Children of different ages will experience a traumatic event in different ways. Frequently, experiences which are traumatic to an adult may not be to a child. On the other hand, experiences that are extremely traumatic to a young child may be perceived by an adult as something that is not that frightening. A child of three or four will experience separation from a parent and family as profoundly traumatic. The traumatic nature of this may be easily observed when looking at the behavior and functioning of the child over time. Initially, of course, there will be lots of crying and weeping, but the child very quickly will 'adapt' and will become withdrawn, quiet, possibly using dissociative adaptations, and will be observed by others to be a "normal, good little child." This is observed frequently in young children (three to four years old) removed from parental custody. Adults frequently minimize for the child experiences which they themselves would not have found traumatic, such as a two-week separation from family. Although their adaptations mask their distress from most adults, the children are being traumatized. Our work with children in these situations has demonstrated that traumatized children, even when they are "behaving" and acting like "good kids," will have profound physiological hyperactivity, such as heart rates above 120 even while asleep.

Once someone learns how to ride a bicycle the parts of the brain involved in that action are indelibly altered—that person will always know how to ride a bicycle. . . . In a similar fashion, children (and adults) who have been traumatized have affective or emotional memories indelibly burned into their brainstem and midbrain: these are alterations in basic physiological functioning, persisting emotional memories related to the original trauma. No matter how much you talk, you will not be able to take those away.

On the other hand, a child who is with his parent when the parent is held up in a parking lot may not be nearly as traumatized as the adult. The three-year-old child may not understand the significance of a gun being held to his parent's head if the context in which the child has seen guns has been in play. The fear that the child feels will more frequently be a reflection of that of the adult rather than generated by the child's own perception of the event. A two-year-old child in this situation will not be likely to be traumatized, whereas a seven-year-old child who understood that this was a life threatening experience will be very traumatized. Again, the individual experience of the trauma is age dependent.

2. Threat to life and limb: One of the most important factors in determining whether or not a traumatic event will be carried forward in a malignant way is the degree to which this event is a threat to the life and limb of the child. Children and adults who perceive that they are potentially in a life-threatening situation will be much more traumatized and much more likely to have long-term sequelae than children who are not.

3. Disruption of social and family supports: Following a traumatic event, the ability of family, friends and community to comfort the child and make sense of the event is directly related to the ability of the child to cope. When the traumatic event disrupts a previous social structure and results in loss of previously utilized social and familial mechanisms for comfort, the event is more likely to be carried forward and have long-term adverse effects.

4. Number, nature and pattern of traumatic events: The number, nature and pattern of the traumatic event all make a difference in whether or not the trauma will be carried forward in a malignant way. The more frequently someone is traumatized, the more likely they are to have symptoms. Children who are chronically physically abused, for example, have much more pervasive and malignant symptoms than children who are traumatized a single time (e.g., a car accident) and are able to return to a supportive emotional and social situation.

Unfortunately, most children victimized by physical or sexual abuse have been experiencing some elements of low level traumatic experience over much of their lives. The acute threat to life and limb may be infrequent, yet these children continue to feel quite threatened at times. These children are affected both by re-experiencing phenomena and through actual new stressful events. Frequent changes in the adult caretakers, mental health professionals, contact with law enforcement and contact with family members may all result in ongoing stress. It is likely that these children, therefore, have some degree of alarm reaction sensitization and are at great risk for developing Post-Traumatic Stress Disorders (PTSD).

5. Early intervention and 'sensitization': There is some evidence to suggest that early intervention including psychoeducational and critical incident debriefing techniques can minimize the sensitization of the alarm reaction and, therefore, to fewer long-term symptoms. This has been one principle guiding the early involvement of the Trauma Assessment Team with traumatized children. We have been carrying out assessment, initial brief treatment and crisis intervention to help acutely traumatized children, hoping to minimize the long term adverse effects of their experiences. Although a variety of critical incident debriefing and early intervention models have been developed for adults, much less work has been done with children. As part of our work with traumatized children, we have developed novel psychoeducational and debriefing techniques and games for traumatized children, and are hoping to minimize the long-term adverse effects of their experiences. Work of our group and others demonstrate the need for, and the potential promise of, these early, aggressive therapeutic activities with traumatized children. Unfortunately,

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the majority of traumatized children experience ongoing and persisting traumatic life events.

6. Loss of control: A key element in making someone feel more comfortable and safe is giving them a sense of control. One of the major clinical observations in traumatized children is that they feel much more vulnerable and much more anxious when they don't feel in control. A major therapeutic guideline for working with traumatized children, then, is to help them understand that they do have control over many things and help them learn how to transform and alter their sense of being victimized and helpless. This is an ambitious but useful goal.

Children, of course, are not particularly well equipped to fight. Children, rather than fighting, have evolved the use of vocalization, i.e., crying, to get an adult caretaker to know that the child is under threat. . . .Unfortunately, crying only infrequently brings an adult to defend a traumatized child.

When traumatized children feel that they are not in control, they will very predictably exhibit signs and symptoms of the sensitized fear response. That is, again, they will start by psychologically freezing—which can return a sense of control to them. They have control over what they do even if it is to do nothing. If the adults around them are not able to give them some sense of control, the children get more anxious, oppositional, fearful, and ultimately terrorized. This can easily escalate into the primitive, regressed tantrum state described above. It is extremely important in the early interventions with these children that they are given choices. The adult can give them choices which are equally acceptable for the adult, and which are framed in such a way as to make the children understand that they are in control and making the choice.

When traumatized children feel that they are not in control, they will very predictably exhibit signs and symptoms of the sensitized fear response. That is, again, they will start by psychologically freezing—which can return a sense of control to them. They have control over what they do even if it is to do nothing.

Specific Clinical Interventions

1. Re-conceptualizing psychotherapies as being 'brain-region directed': The overriding clinical principle in working with traumatized children is understanding what part of the brain is mediating and generating the emotional and behavioral symptoms. The stress response is a primitive ingrained part of the human central nervous system. The cortex, where we think, is obviously involved but the key parts of the central nervous system involved in post-traumatic stress disorders are the primitive brain stem and the midbrain. These brain areas mediate the physiological, hyper-reactivity, hypervigilance, anxiety, emotional, lability, behavioral impulsivity and sleep problems of PTSD.

No matter how much you talk to someone, the words will not easily get translated into changes in the midbrain or the brainstem. Once someone learns how to ride a bicycle the parts of the brain involved in that action are indelibly altered—that person will always know how to ride a bicycle. No matter how often someone talks to you (cortical activity), the parts of the brain involved in motor memory will not change. No amount of talking can unlearn and change the part of the brain that is controlling the simple motor memories involved in riding a bicycle. You may learn to not get on bicycles or if you do get on bicycles to not put your feet on the pedals, but you cannot unlearn the motor behavior.

In a similar fashion, children (and adults) who have been traumatized have affective or emotional memories indelibly burned into their brainstem and midbrain: these are alterations in basic physiological functioning, persisting emotional memories related to the original trauma. No matter how much you talk, you will not be able to take those away. You may teach someone to understand what has happened to them, you can help them learn to avoid situations that might evoke that trauma, but you cannot take away the fact that part of their brain (and mind) has been altered.

Simply using cognitive and verbal interventions will not alter the parts of the brain mediating PTSD symptoms. What is needed to change those portions of the brain is interventions and therapeutic modalities which affect and alter the activities of those parts of the central nervous system.

The major way to affect those primitive parts of the brain is to provide predictability, nurturance, support, and cognitive or insight-oriented interventions which make a child feel safe, comfortable and loved. As noted in all psychotherapies, the mutative or changing element of the therapy is the 'relationship' (i.e., the affective elements) not the 'words' of the therapy. Therapists familiar with conceptualizations of transference will recognize this conceptualization. The less anxious a child feels, the more likely you are able to have access to replacing and re-routing painful affective memories.

2. Early intervention and crisis management: The key to minimizing the sensitizing potential of an experience is early intervention. Early interventions should focus on providing stability, predictability, and information. Children in the midst of a crisis are very often confused and bewildered with little idea about what is going to happen next. It is critically important that mental health professionals and other caretakers working with children in the midst of an acute crisis provide information for the children which is age appropriate, and helps the children develop some sort of cognitive understanding of what has happened and what will happen next. Withholding information or attempting "smooth over" what has happened to a child will not help. Children are extremely sensitive to nonverbal cues. Rather than let the child's mind build the experience into something more terrorizing, provide simple, clear and factual information to help the

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child build more realistic mental images of the event.

3. Milieu therapy: A key to all therapeutic approaches which are focused on minimizing stress or trauma is, of course, providing a stable, predictable and nurturing milieu. Whether this is in the context of a hospital, residential or family setting, the child needs to have a predictable schedule. The schedule needs to include a variety of activities, some of which are quiet and contained and others which allow the children to have control over their own activities. This includes free play with games, art materials, and so forth.

4. Psychoeducational and cognitive interventions: Children need to have factual information about what they have experienced and about the way the mind and the body respond to a trauma. Therefore, psychoeducational and cognitive interventions are very important and useful. It is not helpful to hide information from children, nor is it helpful to gloss over traumatic events. ***The ability of the adults to adequately identify and cope with their own emotions regarding the traumatic event is critical.*** The adults who work with these children need to be able to tolerate the intense emotional nature of the acute traumatic situation.

5. Family psychotherapy: Family psychotherapies are important in working with traumatized children. This is particularly important when the family constellation has been affected by the traumatic event. In cases of familial abuse, family members are variably available for therapeutic work. In our experience, unfortunately, we often have little or no family participation. In other cases, we have extremely complex transgenerational issues related to power, sexuality and atypical 'boundaries' which must be addressed for any long term healing to take place. Family psychotherapy can be helpful for children as they reorganize and restructure their sense of relatedness.

Whether individual psychotherapy involves a therapist with a dynamic, cognitive or behavioral approach or any combination thereof, the key element will be the relationship. It is the relationship which will allow access to parts of the brain involved in social affiliation, attachment, arousal, affect, anxiety regulation and physiological hyper-reactivity. Therefore, the element of therapy which induces positive change will be the ability to re-experience events in the context of this reparative, psychologically-informed relationship.

6. Individual psychotherapy: Individual psychotherapy will be important for all of these children. The key to the individual psychotherapy is, of course, the ability to have a special relationship with an adult who has the capability of being nurturing, supportive, and predictable. These qualities in the relationship are required before children can re-experience elements of their traumatic experience in a safe and reparative fashion.

A key to individual psychotherapy with traumatized children is an initial neutral, nonintrusive stand. These children do not need to have any therapist remind them of, or search for, "material." Due to the profound nature of their experience, traumatized children will be bubbling over with re-experiencing material in their therapies. Whether individual psychotherapy involves a therapist with a dynamic, cognitive or behavioral approach or any combination thereof, the key element will be the relationship. It is the relationship which will allow access to parts of the brain involved in social affiliation, attachment, arousal, affect, anxiety regulation and physiological hyper-reactivity. Therefore, the element of therapy which induces positive change will be the ability to re-experience events in context of this reparative, psychologically-informed relationship.

7. Group therapy: Group psychotherapy for traumatized children can be useful. Chronically abused children tend to be asocialized, very frequently exhibiting difficulties with socialization and peer-relations. Groups focused on specific developmental tasks or social skills can be very useful. In addition, groups with children similarly traumatized children can be an excellent forum for psychoeducational approaches.

8. Pharmacotherapy: It is highly probable that many traumatized children will have persisting symptoms which require adjunctive pharmacotherapy. Useful medications include: clonidine, tricyclic or atypical anti-depressants and sometimes benzodiazepines. These medications help buffer the dysregulation and sensitization seen in the brain stem and midbrain neurotransmitter systems involved in mediating PTSD symptoms. Adjunctive pharmacotherapy can be very useful, particularly in context of evolving and intrusive individual and milieu treatment.

Devloping a Treatment Plan

1. Multidisciplinary evaluation: The key to developing appropriate treatment planning is having a good multidisciplinary assessment to provide the baseline from which treatment decisions can arise. Understanding the family, social, psychiatric, psychological and cognitive characteristics of a child is essential to optimal treatment planning. This means that extensive psychological, social, family, psychiatric and developmental evaluations are required. In addition, communication between the various evaluators needs to take place. A single coordinating group or case monitor is very helpful. Traumatized children tend to come from very chaotic situations, where they tend to fall between the cracks. Only by having an assigned case monitor can these long-term problems be minimized.

2. Ongoing monitoring of clinical status: Monitoring the ongoing problems that any individual child will have is very important. There should be periodic re-evaluation of the cognitive, emotional, behavioral and physiological state of the child, and a refocusing of the treatment plan originally developed. When new problems arise, specific interventions should be implemented.

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The key in providing useful longitudinal care for traumatized children is to be proactive rather then reactive. A child's history will frequently predict which sets of problems will re-emerge at what point of their development. Children who have been abused or experienced traumatic losses during childhood will likely have re-emergence of profound anxiety and impulsivity during adolescence. This leaves them at great risk for the developing anxiety, affective, and substance abuse problems. Close monitoring of a child's ongoing progress by well-informed caretakers, family members, teachers, case-workers and therapists can provide the mechanism by which proactive treatment planning can take place.

It is very frequently the case that children will have submerged a set of symptoms, only to have them re-emerge when a new developmental phase begins. Because the developmental tasks of adolescence echo those of childhood, this reemergence is very frequently seen during adolescence.

3. Submergence and re-emergence of clinical problems during development: Developmental plateaus: One important clinical phenomenon that occurs in traumatized children is that symptoms and problems become submerged, altered or even disappear during certain stages of development. During these developmental plateaus, a child's functioning may appear age appropriate and they may no longer need special services. That does not mean, however, that the child should not be monitored in an ongoing fashion.

It is very frequently the case that children will have submerged a set of symptoms, only to have them re-emerge when a new developmental phase begins. Because the developmental tasks of adolescence echo those of childhood, this reemergence is very frequently seen during adolescence. Many children traumatized as young children seem to make good progress until they become 12 or 13 years old, when symptoms of hypersexuality, aggressive or assaultive behaviors, and impulse and anxiety problems may re-emerge. This underscores the critical element of ongoing monitoring of clinical status regardless of current treatment status.

Summary

Each year in the United States over 2 million children are traumatized by physical or sexual abuse or by exposure to domestic or community violence. The relatively small community of professionals working with these children have noted this increasing number of traumatized children with alarm. Available clinical resources are overwhelmed by the increase in numbers and in the severity of the presenting problems plaguing these children. This set of articles has presented one conceptual framework for evaluating and working with traumatized children. The ultimate utility of these conceptualizations can only be demonstrated with time. Basic research and clinical research in this area must increase. As we are able to bring more federal, foundation and individual resources to bear on these problems, I anticipate, and welcome, the day when reviews of this nature can be based upon data from numerous studies which have addressed the complex problems—ranging from neurobiological to sociocultural—related to the mistreatment of children in our culture.

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Medicine & Psychotherapy

–Bruce D. Perry

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MEDIA REVIEWS

Child Abuse Trauma: Theory and Treatment of the Lasting Effects by John N. Briere. Sage Publications, 1992, 203 pp., $35.00 hard cover, $16.95 soft cover.

—Reviewed by Holly Ramsey-Klawsnik.

This reviewer found *Child Abuse Trauma* to be an informed and useful guide to understanding and treating child abuse survivors. A unique aspect of the book is its focus on the broad spectrum of child abuse trauma and the interrelationships among the various forms of abuse and their consequences.

The book is logically divided into three parts. Part I presents the incidence of child maltreatment, and discusses sexual, physical and psychological abuse, emotional neglect and other types of abuse including exposure to parental substance abuse. Part II is a well-documented presentation of the long-term negative effects of childhood maltreatment as discerned by clinical and research efforts. The impact of childhood abuse on later psychological functioning and on behaviors and relationships is described. The final section addresses psychotherapeutic treatment of adolescent and adult abuse survivors. Briere presents his philosophy of treating the long-term effects of early trauma, discusses the process of therapy, and provides intervention techniques. This section and the book conclude with attention to "special issues" of abuse-focused therapy, including abuse-related countertransference. Illustrative case examples are utilized throughout the book.

A major strength of the book is that Briere manages to be theoretical and scholarly, yet also practical. Clinicians will find enormously valuable his focus on issues and dilemmas which inevitably arise during trauma therapy

The work is indeed a welcome and helpful pioneering effort in the fledgling field of child abuse-focused treatment. The significant value of the book makes constructive criticism difficult. Some may view the lack of guidance in the provision of group, couples or family therapy with abuse survivors as a minor weakness, in that this volume addresses only individual treatment.

A major strength of the book is that Briere manages to be theoretical and scholarly, yet also practical. Clinicians will find enormously valuable his focus on issues and dilemmas which inevitably arise during trauma therapy (and supervision of therapy). For example, the book includes an excellent discussion on when and how to explore abuse-related memories, versus when and how to prepare clients for this work and support them in it. The section on dealing with self issues (for example, "Building Affect-Regulation Skills") is also particularly elucidating and helpful.

It is Briere's view that the survivor's symptoms are natural and logical consequences of and attempts to cope with a toxic childhood environment and dangerous early intimate relationships. The book is direct in pointing out the lack of usefulness (and in some instances harmful effects) of certain traditional psychotherapeutic labels, orientations and interventions for abuse survivors. The author bravely addresses notions such a "codependence," "resistance," and "borderline personality" and their limited usefulness in abuse-focused treatment. Briere states:

It seems clear that untreated trauma arising from abuse during childhood constitutes a major risk factor for a variety of mental health and social problems later in life. The implications of this relationship are substantial. They suggest that some significant proportion of the psychological and psychosocial difficulties of adolescents and adults are directly attributable to childhood maltreatment, despite the fact that most theories of psychopathology make no reference to child abuse in their analysis of etiology or their prescriptions regarding therapy (page 77).

The major contribution of the book is addressing this rather profound oversight. It provides therapists struggling to help survivors lead more satisfying, less dysfunctional lives with guidance and insight, as well as a theoretical basis for interventions which make sense. Generalist clinicians occasionally serving abuse survivors will find that it illuminates and informs trauma treatment. Clinicians specializing in abuse-focused therapy will discover much of value in this volume and, I would anticipate, find themselves recommending it to supervisees as well as to seasoned colleagues.

Holly Ramsey-Klawsnik, PhD, is a psychotherapist in private practice in Canton, Massachusetts, and a Board member of the Massachusetts APSAC chapter and Coordinator of MAPSAC's Clinical Issues Group.

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A Practical Guide to the Evaluation of Sexual Abuse in the Prepubertal Child, by Angelo P. Giardino, MD, MSEd; Martin A. Finkel, DO, FACOP; Eileen R. Giardino, PhD, RN, MSN; Toni Seidl, MSW, ACSW; and Stephen Ludwig, MD, FAAP. Sage Publications, 1992, 152 pages, with b/w illustrations.

—Reviewed by Andrea Vandeven.

This book is intended to serve as a guide for health care professionals who are asked to see prepubertal children suspected of having been sexually abused. The emphasis is on the practical application of current medical and psychological knowledge that has appeared in the field in the last decade. The book is organized by chapters that explore each aspect of the evaluation in the sequence a clinician would actually encounter: history, physical, laboratory evaluation, etc.

The volume begins with a concise but thorough consideration of the epidemiology of sexual abuse, and includes a brief overview of the psychological construct of child sexual victimization. The next chapter includes a summary of the complete evaluation as

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Media Reviews

–Holly Ramsey-Klawsnik

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an introduction to the chapters that follow. The authors are careful to stress throughout that most sexual abuse victims have normal or non-specific physical examination findings, and place the physical examination in its proper place within a comprehensive evaluation. Chapter 3 presents a strategy for obtaining the relevant history and interviewing the child, with clear guidelines for the clinician on how to question the child in a non-leading manner. In the next chapter the elements of the physical examination and laboratory evaluation are presented, beginning with a comprehensive overview of the normal anatomy of prepubertal boys and girls. The text, which includes specific definitions of the various anatomic structures (which is vital if one is to avoid sloppy documentation), is supplemented by carefully labeled drawings. There follows a discussion of the various abnormalities one might see, arranged by the type of abuse (penile penetration, oral-genital contact, etc.) A small atlas of normal and abnormal findings is included. The method of the examination is described in a step by step manner, with suggestions for improving the experience for the child. To close the chapter, typical laboratory studies are suggested, and a brief overview of forensic specimen collection is provided.

This volume clearly meets its stated goal. It is a clear and easy-to-use guide for the clinician.

Especially useful information is provided in Chapter 5 which deals with the differential diagnosis of anogenital findings. The clinician is provided with examples of physical findings seen in other diseases and conditions which may be confused with those seen in sexual abuse. Illustrations and easy to use summary tables supplement the text. Chapter 6 presents the various sexually transmitted diseases, discusses their implications with regard to the diagnosis of sexual abuse, and provides standard treatment recommendations. The next chapter provides a description of the role of the mental health professional in the evaluation and treatment of sexual abuse victims, detailing aspects of the validation of the disclosure and the potential long term impact of sexual abuse on the child. The discussion in the final chapter of proper documentation of the child interview and physical examination findings is a very helpful contribution. Guidelines for what should (and more importantly, what should not) be written in the chart are provided, with several excellent examples of careful and accurate documentation. An ample reference list is included at the end of the book.

This volume clearly meets its stated goal. It is not encyclopedic, and therefore glosses over some current controversies. But it provides something very useful: a clear and easy-to-use guide for the clinician.

Andrea Vandeven, MD, MPH, is Medical Consultant to the Sexual Abuse Treatment Team at the Children's Hospital, Boston.

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Hear their cries: Religious responses to child abuse. **Video produced by the Center for the Prevention of Sexual and Domestic Assault, 1914 N. 34th St., Suite 105, Seattle WA 98103. Running time: 48 minutes. $129.00 purchase, $60.00 rental.**

–Review by Robert A. Fulton.

Hear their cries is a video that describes the role of clergy and lay leaders in preventing child abuse. It is produced by the Center for the Prevention of Sexual and Domestic Violence, an interfaith organization that works on issues of family violence. In this video are interviews with Jewish and Christian clergy as well as secular professionals. Adult survivors of physical and sexual abuse also tell their stories, which include stories of response (or non-response) of clergy members once the abuse was disclosed.

The video is intended to be used for training clergy and lay leaders to respond more effectively to child abuse allegations. It summarizes four types of abuse: physical abuse, neglect, emotional abuse, and sexual abuse. It cites the incidence of each of these types of abuse, as well as indicators of each. Finally, it describes steps that should be taken if child abuse is suspected. Also included with the video is a 22-page discussion guide that offers suggestions for how to set up a training session for clergy using the video, and lists discussion questions for after the video is shown.

Hear their cries is very well done. It is unfortunate that this deep problem touches all walks of life, including the clergy. Ignoring the problem clearly produces great harm. The video shows us that there is hope if the abuse is dealt with firmly yet sensitively. Clergy of all faiths would do well to view this video and benefit from its message.

Robert A. Fulton is an Elder in the Village Bible Chapel, Framingham, Massachusetts.

The Advisor's Book Review Editor is Kathleen Kendall-Tackett, PhD. If you would like to suggest books or videos for review, or to volunteer as a reviewer, contact Kathleen at Wellesley College, The Stone Center, Wellesley MA 02181.

NEW APSAC TASK FORCE FORMING

APSAC has established a National Child Abuse Fatality Task Force. The goal of the task force is to provide an interdisciplinary approach to the issues surrounding abuse related deaths and child death review teams. The first organizational meeting will be June 24, 1993, at the First Annual Colloquium in Chicago. If you would like more information, contact Sheila Thigpen, 405-271-8858.

CORRECTION

A mistake was made in the listing of Eliana Gil's address in the last issue of *The Advisor* (V.6, n.1). The correct address is P.O. Box 5629, Rockville MD 20855. Phone: 301-869-0469. FAX: 301-869-0621.

We're sorry for the error.

The following press release and Fact Sheet on child sexual abuse allegations in custody and visitation disputes were prepared by APSAC's Urgent Issues Analysis Committee and sent to over 500 major media outlets nationwide. You can help with their dissemination by providing copies to your local radio and television stations and newspapers. Send the release to the attention of the News Editor or Program Director.

APSAC

Press Release

When public attention is focused on select celebrity custody battles, such as the Woody Allen-Mia Farrow case currently ongoing in New York, facts about child sexual abuse allegations can get distorted, according to the nation's only interdisciplinary society for professionals working in the field of child maltreatment.

"There is no scientific support for the claim that an epidemic number of mothers are falsely accusing fathers of sexual abuse during custody and visitation disputes," said Theresa Reid, Executive Director of the American Professional Society on the Abuse of Children (APSAC). "Some claim that these charges are rampant, fueled by 'hysteria' about child sexual abuse. But to the best of our knowledge allegations of sexual abuse still occur in a small proportion of custody and visitation disputes," Reid added.

A two-year study published in 1990 examined 9,000 divorces in 12 states and found that child sexual abuse allegations were made in less than 2% of contested divorces involving child custody, Reid noted. Mothers accused fathers in 48% of these cases, and accused stepfathers or others in 19%. Fathers accused mothers in 6% of these cases, and stepfathers and others in 16%. In 11% of these cases, third parties made the reports against mothers, fathers, boyfriends, and others.

"This study is from data collected in the late 1980's, so the incidence may have increased in recent years," Reid noted. "But there is no reliable evidence that the incidence of these charges has skyrocketed."

Some have claimed that a high percentage of these allegations are intentionally false. But, Reid states, "In the most rigorous study to date on the topic, the researchers estimate that 86% of the allegations they could evaluate were motivated by sincere concern. On investigation, many of these allegations were not supported by available evidence. But researchers estimated that only 14% were were intentionally false."

"Claims that most allegations made in the context divorce are intentionally false are very misleading, and are not based upon any reliable data," Reid stated.

The most reliable research suggests that the incidence of intentionally false reports of child sexual abuse generally is 5% to 8% of all cases. Authors of the 1990 study, researchers Nancy Thoennes and Patricia Tjaden, concluded that false allegations of sexual abuse made in the context of a custody dispute are "relatively rare . . . and no less likely to be 'unfounded' than are other reports of child sexual abuse made to protective service agencies."

"'Unfounded' does not mean 'false,'" Reid explained. "Still less does it mean 'intentionally false.' 'Unfounded' means, 'Not enough evidence to make a determination.'"

APSAC actively supports the careful, thorough, unbiased evaluation of all child sexual abuse allegations, to ensure that the innocent on both sides of allegations are protected.

APSAC is the nation's only interdisciplinary society for professionals working in the field of child maltreatment. Founded in 1987, APSAC has over 3,000 members. Among APSAC's members are many of the nation's leading experts in psychology, law, medicine, research, law enforcement, and social work.

FOR FURTHER INFORMATION CONTACT APSAC EXECUTIVE DIRECTOR THERESA REID, 312-554-0166.

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APSAC

Fact Sheet

CHILD SEXUAL ABUSE ALLEGATIONS IN CUSTODY AND VISITATION DISPUTES

How frequent are child sexual abuse (CSA) allegations in divorce custody disputes?

In a 1990 study of 9,000 divorces in 12 states, CSA allegations were made in less than 2% of contested divorces involving child custody. This study was commissioned by the Association of Family and Conciliation Courts.

No reliable national study documents either an increase or decrease in CSA allegations in custody disputes since 1990.

Who makes these allegations?

In the 1990 study cited above,

- Mothers accused fathers in 48% of cases.
- Mothers accused stepfathers or others in 19% of cases.
- Fathers accused mothers in 6% of cases.
- Fathers accused stepfathers or others in 16% of cases.
- Third parties accused fathers, mothers, or others in 11% of cases.

How often are these allegations intentionally false?

Determining which allegations are false is often extremely difficult, and few reliable studies on this topic are available. The incidence of intentionally false reports generally appears to be 5% to 8% of all cases.

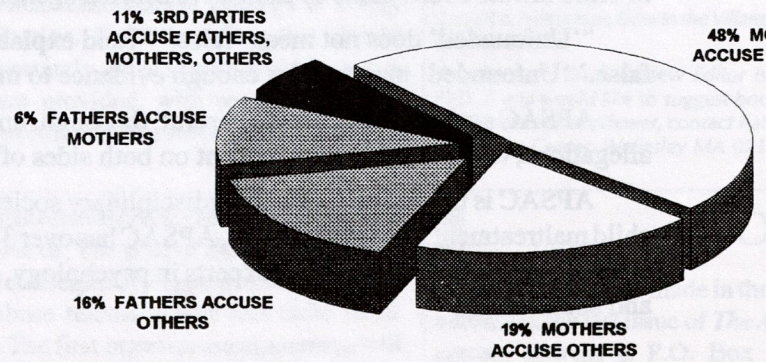
How often are these allegations "unfounded"?

The large-sample study cited above found that CSA allegations in custody disputes were substantiated about as frequently as all other CSA allegations.

What does "unsubstantiated" or "unfounded" mean?

"Unsubstantiated" and "unfounded" do not mean "false." They mean, "Not enough evidence to make a determination." Cases may be "unfounded" because

- the caseworker has no time to investigate.
- the alleged victim is too young to testify.
- the suspicion has been reported previously and determined to be unfounded, and is not reinvestigated.



Data taken from Nancy Thoennes and Patricia G. Tjaden, (1990). The extent, nature, and validity of sexual abuse allegations in custody/visitation disputes, *Child Abuse and Neglect, 14,* 151–163.

JOURNAL HIGHLIGHTS

—edited by Thomas F. Curran

The purpose of Journal Highlights is to inform readers of current research on various aspects of child maltreatment. Selected articles from journals representing APSAC's multidisciplinary membership are presented in annotated bibliography form. APSAC members are invited to contribute to Journal Highlights by sending a copy of current articles (preferably published within the past 6 months), along with a two to three sentence review, to Thomas F. Curran, MSW, JD, Child Advocacy Unit, Defender Association of Philadelphia, 121 N. Broad Street, Philadelphia, PA 19107-1913.

PHYSICAL ABUSE AND NEGLECT

Herzog, E.P., Gara, M.A., and Rosenberg, S. (1992). The abused child as parent: Perception of self and other. *Infant Mental Health Journal, 13,* 83-98.

The impact of abuse on mother's self- and interpersonal perception, and the interrelationship among abused mothers' social and self-perception, the quality of her interactions with her child, and the child's development were assessed. (KK-T)

Silber, S., Bermann, E., Henderson, M., and Lehman, A. (1993). Patterns of influence and response in abusing and nonabusing families. *Journal of Family Violence, 8(1),* 27-38.

Behaviors of influence and response during a conflict negotiation task were examined in eight physically child abusing, substance abusing families in which the father was the primary abuser, and eight matched non-abusing families. Abusing fathers displayed more coercive patterns of influencing behavior and more negative patterns of response to other family members. The findings are discussed in terms of their implication for understanding interaction in child abusing families. (TFC)

Toth, S.L., Manly, J.T., and Cicchetti, D. (1992). Child maltreatment and vulnerability to depression. *Development and Psychopathology, 4,* 97-112.

Children from abusive homes showed significantly higher levels of depressive symptomatology than children from either neglectful or nonmaltreating families. Children from physically abusive homes exhibited lower self-esteem than did nonmaltreated children. All groups of children, who were low SES, evidenced higher levels of acting out behaviors than would be expected in a nonclinical group of children. (KK-T)

Zuravin, S.J. and DiBlasio, F.A. (1992). Child-neglecting adolescent mothers: How do they differ from their nonmaltreating counterparts? *Journal of Interpersonal Violence, 7* (4), 471-489.

Among the objectives of this study of 102 low-income single parents who gave birth to their first child before age 18 was the identification of predictors of neglect. The findings suggest that the neglectful teen mothers differed from their nonmaltreating counterparts in five ways. Independent of race, they were more likely to have been sexually abused as children, to have had their first child at a younger age, to have completed fewer years of school, to have had a premature and/or low-birth-weight child first, and to have had more than one child during teen years. Educational achievement and number of children were moderately successful in predicting neglect. (TFC)

SEXUAL ABUSE

Berliner, L. and Conte, J. (1993). Sexual abuse evaluations: Conceptual and empirical obstacles. *Child Abuse and Neglect, 17* (1), 111-126.

Current clinical approaches to child sexual abuse evaluations are critically examined for their empirical support and conceptual integrity. The two general approaches to recent sexual abuse clinical validation efforts, the indicators approach and the standards approach, are analyzed in detail. (TFC)

Berson, N.L., Herman-Giddens, M.E., and Forthingtham, T.E. (1993). Children's perceptions of genital examinations during sexual abuse evaluations. *Child Welfare, 72 (1),* 41-49.

Based on the experiences of over 500 children evaluated for sexual abuse over a two-year period, this article examines the potential added stress and sense of violation which the medical examination can inflict on sexually abused children. Various techniques found useful in reducing children's anxiety levels are discussed, along with some very important suggestions for future research on children's reactions to medical examination for child sexual abuse. (TFC)

Gellert, G.A., Durfee, M.J., Berkowitz, C.D., Higgins, K.V. and Tubiolo, V.C. (1993). Situational and sociodemographic characteristics of children infected with Human Immunodeficiency Virus from pediatric sexual abuse. *Pediatrics, 91* (1), 39-44.

A report on an effort to estimate the number of children in the U.S. and Canada infected with HIV as a result of child sexual abuse, and to describe the situational and sociodemographic characteristics of sexual abuse that resulted in HIV infection. Of the 28 HIV - infected victims of sexual abuse identified, 22 had no other risk-factors reported for HIV infection. These children were mostly female, African American, prepubescent, and from low socioeconomic status families. Important prevention and policy considerations are discussed. (TFC)

Grayston, A.D., deLuca, R.V., and Boyes, D.A. (1992). Self-esteem, anxiety, and loneliness in preadolescent girls who have experienced sexual abuse. *Child Psychiatry and Human Development, 22,* 277-286.

In this study, the levels of self-esteem, anxiety, and loneliness were compared for 35 sexually abused girls (ages 7-12) and 35 controls. Sexually abused girls had lower levels of self-esteem than nonabused children, but levels of anxiety and loneliness did not differ between the groups. (KK-T)

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Journal Highlights

-Thomas F. Curran

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Newberger, C.M., Gremy, I.M., Waternaux, C.M., and Newberger, E.H. (1993). Mothers of sexually abused children: Trauma and repair in longitudinal perspective. *American Journal of Orthopsychiatry, 63 (1),* 92-102.

The course of mothers' psychological symptomology over the year following disclosure of their children's sexual abuse was examined in this study, along with the relationship between mothers' emotional well-being and their children's emotional states. Strong relationships between mothers' reports of their own and their children's symptoms were accompanied by persistent discrepancies between maternal and direct assessments of the children's emotional states. Possible explanations for such discrepancies are discussed, along with treatment implications. (TFC)

Priest, R.(1992). Child sexual abuse histories among African-American college students: A preliminary study. *American Journal of Orthopsychiatry, 62,* 475-476.

This study collected self-report questionnaire data from 684 female and 356 male African-American college students (aged 18-56 years) regarding their experiences of child sexual abuse. Twenty-five percent of females and 12% of males had been sexually abused before age 17 years. However, only 3 females and none of the males indicated they had received mental health counseling directly related to their sexual victimization. (KK-T)

Springs, F.E. and Friedrich, W.N. (1992). Health risk behaviors and medical sequelae of childhood sexual abuse. *Mayo Clinic Proceedings, 67,* 527-532.

The relationship between childhood sexual abuse and subsequent health risk behaviors and medical problems was examined in 511 women who had used a family practice clinic in a rural midwestern community during a two-year period. The results indicated that sexually abused women reported significantly more medical problems, greater levels of somatization, and more health risk behaviors than did the nonabused women. More severe abuse correlated with more severe problems. (KK-T)

LEGAL ISSUES

Tjaden, P. and Thoennes, N. (1992). Predictors of legal intervention in child maltreatment cases. *Child Abuse and Neglect, 16 (6),* 807-821.

This study examined the extent and nature of dependency and criminal filings in 833 substantiated intrafamilial child maltreatment cases reported in Denver, Los Angles, and New Castle (DE) counties during 1985-1986. Factors and case characteristics associated with filings in both court systems are examined in detail. Overall, legal intervention was found to be very rare: only 21% had dependency court filings and 4% had criminal filings. In each jurisdiction, sexual abuse was the type of maltreatment most likely to result in a filing in both courts. (TFC)

OTHER ISSUES IN CHILD MALTREATMENT

Cicchetti, D. and Barnett, D. (1991). Attachment organization in maltreated preschoolers. *Development and Psychopathology, 3,* 397-411.

The attachment patterns of maltreated and nonmaltreated preschoolers from the low socioeconomic strata were examined. Results revealed that maltreated children were significantly more likely to exhibit insecure patterns of attachment to their caregivers. Longitudinally, the high percentage of nonmaltreated children who were classified as securely attached were likely to remain securely attached at subsequent assessments. (KK-T)

Haskett, M.E. and Kistner, J.A. (1991). Social interactions and peer perceptions of young physically abused children. *Child Development, 62,* 979-990.

Behavior observations, teacher reports, and peer sociometric ratings were used in this study. Abused children initiated fewer positive interactions with peers and exhibited more negative behavior than nonabused children. Peers viewed abused children as less well liked and were also less likely to reciprocate the initiations of abused children. In addition, teachers viewed abused children as more disturbed. (KK-T)

Gutman, L.T., Herman-Giddens, M.E., and Phelps, W.C. (1993). Transmission of human genital papillomavirus disease: Comparison of data from adults and children. *Pediatrics, 91* (1), 31-38.

This article reviews the evaluation of the data on the means of transmission of human papillomavirus (HPV) disease of the genital tract in adults and compares those data with that available on the transmission of anal-genital HPV disease in children. Considerable evidence is presented supporting the proposition that anal-genital HPV diseases of children appearing after infancy are usually acquired through abusive sexual contact. (MEH-G)

Steward, M.S., Bussey, K., Goodman, G.S., and Saywitz, K.J. (1993). Implications of developmental research for interviewing children. *Child Abuse and Neglect, 17* (1), 25-38.

A brief and practical review of recent research on children's development of cognition, memory and language is provided, along with an analysis of studies on children's knowledge about the legal system. The literature on young children's experiences in pediatric settings is also reviewed, with a discussion of how these studies can assist in understanding children's abuse reports and in preparing children for court. Investigative interviewers and attorneys will find this article particularly valuable. (TFC)

Journal reviewers for this issue included: Thomas F. Curran, MSW, JD; Kathleen A. Kendall-Tackett, Ph.D., Wellesley College, Wellesley, MA; Nancy L. Berson, B.A., Clinical Fellow, Department of Psychiatry, University of North Carolina, Chapel Hill, NC; and Marcia E. Herman-Giddens, P.A., M.P.H., Department of Pediatrics, Duke University Medical Center, Durham, NC.

TAPE ORDERS

First National Colloquium of the American Professional Society on the Abuse of Children

SESSIONS - FRIDAY, JUNE 25

Quantity | Title | Price

Mental Health

____ Therapy with physical and sexual child abuse victims. ____
Esther Deblinger, PhD and Eliana Gil, PhD

____ The therapy relationship in child abuse cases. ____
Jon Conte, PhD and Kee McFarlane, MSW

____ Working with families who deny and minimize. ____
Lucy Berliner, MSW and Benjamin 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, MSW

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

Law

____ Proving serious physical abuse and child fatalities. ____
Harry Elias, JD and Paul DerOhannessian, JD

____ Targeting special issues in child sexual abuse prosecution. ____
Mark Ells, JD and Patricia Toth, JD

Investigation

____ 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

Medicine

Medical seminars presented on Friday will not be audiotaped.

SESSIONS - SATURDAY, JUNE 26

Quantity | Title | Price

____ Civil suits for damages ____
Laurence Hardoon, JD and Benjamin Saunders, PhD

____ Relationship of substance abuse and child maltreatment. ____
Jan Bays, MD and John E.B. Myers, JD

____ Reunifying families: when is it time, when is it safe? ____
Diane DePanfilis, MSW, Robert Pierce, PhD, and Charles Wilson, MSSW

____ The use of mental health "syndromes" in the prosecution and defense of child abuse related crimes. ____
Jon R. Conte, PhD, Stephen M. Komie, JD, and Patricia Toth, JD

____ Proving your worth. ____
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 forensic interviewing of children. ____
Mark Ells, JD and Karen Saywitz, PhD

____ Preparing and presenting expert medical testimony. ____
Randell Alexander, MD, PhD, Paul DerOhannesian, JD, Harry Elias, JD, Bill Hammond, and Carolyn Levitt, MD

____ Investigating and litigating multi-victim, multi-perpetrator cases. ____
Dan Casey, JD, Kenneth Lanning, MS, and Donna Pence

____ Assessing and arguing sexual molestation cases when domestic charges are pending. ____
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STATE CHAPTER NEWS

—by Cathy Crino

CHAPTERS PLAN TRAININGS AND CONFERENCES

As APSAC state chapters grow in strength and numbers, they are becoming more and more visible all over the country. Chapters have sponsored a series of local meetings and conferences, as well as making connections with state legislative and judicial bodies. Here is a short list of chapter activities nationwide:

- On February 13, 1993 the Northern New England chapter (NNEPSAC) held its first annual meeting. The featured speakers were Lucy Berliner, MSW and Linda Meyer Williams, PhD. They included in their meeting small group brainstorming sessions on "When the System Fails" to collectively generate strategies to employ when abuse is strongly suspected, but cannot be proven in court.
- On February 19, 1992, the Ohio chapter (OHPSAC) held its first general membership meeting in conjunction with a continuing education program conducted by Bill Pithers, PhD, on "Assessing Adolescent Offenders." About 250 people attended the program, providing OHPSAC with fertile ground from which to recruit new members.

The MAPSAC training program for court investigators is an excellent example of the direct impact that a local chapter can have on the process and structures that deal with child maltreatment at the state level.

- The North Carolina chapter (NCAPSAC) co-sponsored the North Carolina Conference on Child Abuse and Neglect on March 22-23, 1993 in Greensboro, North Carolina. Co-sponsoring organizations were the North Carolina Child Medical Evaluation Program and the North Carolina Committee for the Prevention of Child Abuse. The organizers invited several members of APSAC's Executive Committee to speak at the conference and sponsored a beautiful, well-attended cocktail reception so members of the Executive Committee could meet the sponsors. The Executive Committee held its spring business meeting the day before the conference.
- In an effort to spark interest in APSAC in the southwest, the newly formed Arizona chapter (AZPSAC) sponsored a multidisciplinary conference in May in conjunction with the Maricopa County Task Force Against Domestic Abuse. One of their goals was to have as many APSAC members from Arizona as possible speak, so the roster included Judith Becker, PhD, Ann Haralambie, JD, Carol Ainley, PhD, Linda Gray, BA, and Larry Morris, PhD. They also wanted to address local issues, so they invited FBI Special Agent Blaine McIlwaine to speak about the investigation of child sexual abuse in the Native American community.
- The Texas chapter (TPSAC) joined with the Children, Abused, Rejected, Empowered (CARE) Coalition to lobby the Texas legislature at Austin. About 1000 professionals from APSAC and CARE gathered there in conjunction with the Governor's Conference on the Prevention of Child Abuse, where David Lloyd, JD, was the keynote speaker. Members of the coalition then met with individual legislators to lobby on a variety of children's issues.

MAPSAC Training on Court Investigations in Care and Protection Petitions

(With information supplied by Suzanne M. Bolduc, LICSW, and Ruth Segaloff, LICSW.)

Another successful training program has been organized in Massachusetts as a result of a chapter task force focusing on a problem and proposing a solution. In April, 1991, the APSAC Massachusetts' Chapter's Task Force on Working in the Courts began meeting monthly to discuss legal, clinical and social policy issues related to the juvenile and district courts. They learned that there was a need for training for court investigators for Care and Protection Petitions in juvenile courts. "Care and Protection Petitions" are filed in district or juvenile court on behalf of a child who is at continued risk for abuse and neglect. These are often referred to in other states as "abuse and neglect" or "dependency" petitions. These petitions can be filed by any concerned person, although most come from the Department of Social Services. Their purpose is to bring to the attention of the court any situation in which abuse or neglect continues to be a danger.

State law requires that every care and protection petition be independently investigated by a court-appointed professional, usually either a social worker or an attorney. In the process of designing a curriculum for newly-appointed court investigators, the Task Force members concentrated on the need to provide information on the relevant psychiatric, domestic, and protective issues as well as information regarding the investigative process. There are a wide variety of expectations of investigators in Massachusetts, but no existing official standards for them. Because of this, Task Force members agreed that enriching the knowledge base and disseminating information regarding general guidelines could be useful.

The task force designed a two-day training session. The first day comprised of a series of six presentations covering a review of legal statutes, mental illness, parental substance abuse, sexual and physical abuse and domestic violence, including their functional impact on parenting and on child and family development. Day two focused on techniques of gathering collateral data, investigative interviewing, and report writing, with an emphasis on documenting data in a concise and objective fashion. The seminar is supplemented by two volumes of published articles, sample reports, and a bibliography.

continued on next page

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

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State Chapter News

-Cathy Crino

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Once the seminar was developed, the task force teamed up with the MCLE (Massachusetts Continuing Legal Education) to sponsor the presentation. They also received the endorsement of the Chief Justices of both the juvenile and district courts. The first training, in October, 1992, was made mandatory for all juvenile court investigators. One hundred and fifty attended. Among the presenters were Catherine Ayoub, PhD, Robert Kinscherff, PhD, JD, Richard Barnum, MD, Ruth Segaloff, LICSW, Thomas Carr, LCSW, Renee Brant, MD, Angela Brown, PhD, Sarah Buell, JD and Jeremy Stahlin, JD. Suzanne Bolduc, LICSW, moderated the seminar. Because this was such a successful program, based upon the evaluations of both the investigators and the judges, a second training, in April, 1993, was held for district court investigators.

The goal of the Task Force is to work with the courts to have a system in place whereby each investigator will attend the basic training course, and will then be required to attend an annual seminar which will provide advanced training in these areas.

This training program is an excellent example of the direct impact that a local chapter can have on the process and structures that deal with child maltreatment at the state level. The effectiveness of this program is due to the combination of an organized task force, with a clearly defined purpose, working in conjunction with other organizations and agencies. The potential to effect change in other states with this kind of teamwork is exciting.

New Chapters Chartered

In the past few months, three new chapters have been chartered by APSAC. The Oregon chapter (OREPSAC) officers are Robert Sewell, MD, President; Paul Thomas, MD, Vice-President; and Maxine Hoggan, PsyD, Secretary-Treasurer. The Texas chapter (TPSAC) has gotten off to an energetic start under the leadership of David Cory, MSSW, President; Gary Buchanan, First Vice-President; Donna Massey, Second Vice-President; Debbie Frick, MS, Secretary; Colleen McCall, MSSW, Treasurer. The most recent chapter to join is Arizona (AZPSAC). Their officers are Karen Gray, President; Cheryl Karp, Vice-President; and Caryl Ainley, Treasurer. All of these officers are to be congratulated for the persistence and dedication to get their chapters moving ahead.

Cathy Crino, MDiv, is the APSAC staff member working with state chapters.

CONFERENCES

APSAC DISCOUNTS

October 4-7, 1993. ***Midwest Conference on Child Sexual Abuse and Incest.*** Madison, WI. Sponsored by Health and Human Issues of the University of Wisconsin at Madison, and Family Sexual Abuse Treatment, Inc. For information call Jim Campbell, 608-262-2352. **See display ad this page.**

November 15-17, 1993. ***Networking in the Nineties.*** Nashville, TN. Sponsored by the Tennessee Network on Child Advocacy. Call Judith Brown, 901-525-2377.

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.

May 4-7, 1994. ***APSAC's Second National Colloquium.*** Boston, MA.

July 8-11, 1993. ***Celebration of Diversity: Many Paths, Many Journeys, Many Goals.*** Springfield, IL. 11th Annual VOICES Conference. Call Karen Spolyar, 219-759-5283.

August 3-8, 1993. ***Building Alliances to Stop Sexual Assault.*** Chicago, IL. Sponsored by the Illinois Coalition Against Sexual Assault. Call Jane Fee at 217-753-4117.

August 13-15, 1993. ***Healing the Child, Hope for the Future.*** Louisville, KY. Parents United 1993 International Conference. Call Rosey Stronck, 712-277-4031.

September 1-3, 1993. ***Crimes Against Children.*** Sponsored by Dallas Police Dept. and 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 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 1-3, 1993. ***Fourth Annual Southwest Regional Conference on Abuse and Dissociative Disorders.*** Tyler, TX. Sponsored by the Family Violence and Sexual Assault Institute. For more information, call 903-595-6600.

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

October 20-22, 1993. ***Building Bridges for Our Children: Keeping the Spirit of Excellence Alive.*** New York, NY. Sponsored by the National Black Child Development Institute. Call 202-387-1281.

October 24-27, 1993. ***Trauma, Coping and Adaptation.*** San Antonio, TX. Ninth Annual Meeting of the International Society for Traumatic Stress Studies. Call ISTSS, 312-644-0828.

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

COMMENTS

Do you have comments on the draft guidelines on the use of anatomical dolls, published in the last issue of *The Advisor*? If so, please submit them to APSAC by Friday, July 16, 1993.

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The American Professional Society on The Abuse of Children

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

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American Professional Society on the Abuse of Children
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