APSAC

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LITERATURE REVIEW

Research on False Allegations of Sexual Abuse in Divorce

—by Kathleen Coulborn Faller, David L. Corwin, and Erna Olafson

The statement, "There is an epidemic of false allegations of sexual abuse in divorce cases," is regarded by some as a truism. The argument is that women seeking to win custody of their children, to cut off the father's visitation, or to wreak vengeance on former spouses, falsely accuse them of child sexual abuse (Mantell, 1988; Renshaw, 1985; 1986). Such is the assertion of accused fathers, their attorneys (Gordon, 1985), and their expert witnesses (Blush & Ross, 1986; Gardner, 1989). Moreover, the media have supported and broadcast these views, and many professionals with mandated responsibility for these cases, including child protection workers, law enforcement personnel, and, most importantly, judges, have come to believe that abuse allegations during divorce are likely to be false.

Are there any empirical findings that lend credibility to the view that most allegations of child abuse in divorce are false? In this article, literature addressing this issue will be critically reviewed, looking specifically at data cited, sample size, any sample biases, and the criteria employed to determine the veracity of the allegation.

Studies providing no data

Writers holding the most extreme positions and promulgating new "syndromes" provide no data to support their statements (Blush & Ross, 1986; Gardner, 1987).

Blush and Ross have propounded the Sexual Allegations in Divorce (SAID) Syndrome, the overwhelming majority of which they assert are false. These false allegations are fostered by mothers, whom Blush and Ross label psychotic or hysterical (dominated, dominating, or "justified vindicators"). They advise that almost no weight should be given to any statement made by the child, and in practice they may not even interview the child. However, Blush and Ross maintain, great weight should be given to the fact that these allegations are made by mothers who wish to restrict their ex-partners' access to their children (Ross, 1988). Blush and Ross find fathers much less likely to make false allegations, and describe those who do as rigid and hypercritical of their estranged wives. Falsely accused men are also described as inadequate, dependent, and passive, descriptors the authors also apply to incest perpetrators.

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NEWS

First National Colloquium a Major Success

—by Theresa Reid

Colloquium report

Early in 1992, APSAC's Board of Directors decided to risk the little capital APSAC had accumulated and put on a small national conference for advanced professionals in the field of child maltreatment. The plan was to start with a 200-300 person conference—to be called a "Colloquium" because of its small size and unique design. We were surprised and delighted when, from June 24-26, 1993, more than 650 professionals converged on Chicago to attend APSAC's First National Colloquium.

Who attended?

Professionals came from 48 states, the District of Columbia, and several U.S. territories and foreign countries (including Belgium) to attend the Colloquium.The interdisciplinary mix was strong, with 21% from the field of social work, 18% from law, 17% from psychology, 9% from children's services, 7% from medicine, 6% each from nursing and licensed counseling, 5% each from law enforcement and administration, and the remaining 6% from the judiciary, education, offender treatment, psychiatry, and research. More than half of those attending were new APSAC members.

In addition to welcoming these participants, APSAC was happy to be able to offer more than 25 full tuition scholarships to lower-income professionals and students who provided much hard work during the Colloquium.

Why did they come?

Surveying the many outstanding training opportunitites already offered in the field, APSAC's Program Committee concluded that what was missing was in-depth training for advanced professionals on the most difficult issues in the field. The committee accordingly designed a two-day training comprised of all-day, six-hour seminars. The first day was devoted to within-discipline training (physicians with physicians, attorneys with attorneys, etc.) the second day was devoted to cross-discipline training on the many issues that must be dealt with across disciplinary lines.

This unique design had much broader appeal than the Program Committee had anticipated. In addition, most Colloquium participants were attracted by the very strong faculty APSAC offered. Many of the nation's leaders in the field of child maltreatment served as faculty for the Colloquium, all of them waiving their speaking fees to benefit APSAC.

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News

-Theresa Reid

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In addition to the faculty and the program design, program content drew many participants. Those attending felt that APSAC's Program Committee had successfully identified the topics that most concerned them.

Were they satisfied?

The mood at the First National Colloquium was exuberant. Everyone was delighted with the strong turnout, and happy to be at what felt very much like the heart of the field of child maltreatment. The Hotel Nikko in downtown Chicago, where the Colloquium was held, supplied very beautiful surroundings, delicious food, and accomodating staff, all of which combined to make participants feel pampered and welcome. But more objective data about participant satisfaction are available as well, from evaluation forms filled out by many attendees.

Asked whether the session should be offered again, 100% of the respondents in eleven (of 23) sessions said yes. In the other sessions, 88-98% of respondents replied affirmatively. Across all sessions, participants thought faculty were very knowledgable (4.7 on a scale of 1 to 5), and very proficient at explaining material and answering questions (4.6 on a scale of 1 to 5). A large majority of respondents said they were "likely" or "very likely" to attend the 1994 Colloquium.

What will change for next year?

Participants in the First National Colloquium, and members of APSAC's Program Committee, Board of Directors, and Advisory Board have made several excellent suggestions for improving on success. The following changes will be made for 1994:

- One day will be added to showcase field-initiated research presentations, skills sessions, special issues caucuses, and posters. Abstracts for these presentations will be rigorously reviewed to ensure that they represent the most advanced work being done in the field.

- Some of the intensive seminars will be three hours in length instead of six hours, to better reflect the knowledge base and skills available on some topics.

- Several of the intensive seminars will be repeated, so that people have more than one chance to attend their first choices.

- At least one plenary session will be held, to provide a focus for the Colloquium as a whole.

- A casual dinner will be held for all Colloquium participants to provide a lengthier opportunity for informal networking.

In addition to the advanced training seminars offered by APSAC, three other important meetings were held during the Colloquium. The People of Color Leadership Institute (POCLI), headed by Joyce N. Thomas, RN, MPH, held an all-day mini-conference on cultural issues in child maltreatment on Thursday, June 24. The U.S. Advisory Board on Child Abuse and Neglect (see article, p. 27), held a hearing on child abuse fatalities on Friday evening, June 25, in preparation for its 1994 report on the topic. And the National Center on Child Abuse and Neglect (NCCAN) held a two-day "Chronic Neglect Symposium" on Sunday, June 27 and Monday, June 28. We were honored to co-host all of these meetings. One of the changes organizers would like to make for next year is somehow to adjust the schedule so participants don't have to make so many hard choices between important task force, committee, state chapter, and adjunct meetings. This may, however, require adding more hours to the day.

Who's to thank?

Speakers. All Colloquium speakers waived their fees to benefit APSAC and to further APSAC's goal of providing outstanding professional education. We cannot thank them enough for their invaluable gift of time and expertise.

Program Committee. Members of APSAC's Program Committee—particularly Linda Williams, PhD, 1993 Chair—have given countless hours over the last several months to make sure this Colloquium is a success. Program Committee chair for 1992 was *Patricia Toth, JD*; the 1993 co-chair was *Charles Wilson, MSSW*. *Lucy Berliner, MSW*, was chair of the sub-committee for program content. *Mark Chaffin, PhD*, and *Ben Saunders, PhD*, co-chaired the sub-committee on financial support. *Deborah Daro, DSW*, and *Nancy Slater, PhD*, designed and will administer the long-term evaluation component. Other Program Committee members who have given critical advice and time on a broad range of questions are *Veronica Abney, MSW; Pat Crittenden, PhD; Martin Finkel, DO; Mary Kenning, PhD; Holly Echo Hawk Middleton, MS; Robert Prentky, PhD; Joyce Thomas, RN, MPH; and Anthony Urquiza, PhD.*

Federal Financial Partners. The financial support of three federal agencies was indispensable. We would not have taken the financial risk associated with a national conference had we not been assured of support from the following agencies:

- ***The National Center on Child Abuse and Neglect (NCCAN)***, U.S. Department of Health and Human Services, *David Lloyd, Director,* provided financial support for speaker travel, speaker board and lodging, materials reproduction, and audiotaping for several sessions.

- ***The Office of Juvenile Justice and Delinquency Prevention (OJJDP)***, U.S. Department of Justice, *John Wilson, Acting Director,* provided financial support for speaker travel, speaker board and lodging, and materials reproduction, for several sessions.

- ***The Office for Victims of Crime (OVC)***, U.S. Department of Justice, *Brenda Meister, Former Director,* provided financial support for the production of our program book and other printed materials.

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INVESTIGATION

The Telephone: Tool or Tort?

—by Ray Rawlins and Dana Gassaway

Allegations of sexual abuse of children are extremely difficult to prove in criminal proceedings. Sometimes the only evidence is the statement of the child victim. Often there is no corroborating evidence. In many of these cases, the offender is not prosecuted because of the lack of evidence and the belief that the offense cannot be proven beyond a reasonable doubt. Often the police charged with investigating the allegations do not submit the case to the prosecuting attorney because a successful prosecution is doubtful. If the police find no corroborating evidence such as eye witnesses, medical evidence, or photographs, they may simply give up.

Investigators know that if they obtain a confession from the perpetrator the likelihood of a conviction increases ten fold. In fact, in most cases, if police have a legally obtained confession the defendant will plead guilty, thus eliminating the need for a trial and testimony by the victim. Unfortunately, a confession is not always obtained. The perpetrator may deny the allegations or invoke his right to remain silent and make no statement.

Administered properly, the recording of a conversation between the victim and the perpetrator can benefit both law enforcement and the victim. To law enforcement there isn't a better piece of evidence than having the perpetrator admitting what he did, why he did it, or that he is sorry for what he has done. For the victim, these admissions assure that people will believe his or her word.

Although the perpetrator may not talk to the police, he* will almost always speak to the victim. He will speak to the victim about things that he would never discuss with anyone else. The investigator should consider the possibility that the child victim can elicit incriminating statements from the suspect over the telephone, while the investigator records the conversation. This article will address the technical, legal, and ethical considerations in utilizing this technique.

Decision-making

In the past the idea of using the telephone to record confrontations between the victim and the perpetrator of sexual abuse was very controversial. Today, however, the value this piece of evidence plays during the prosecution has made the practice of recording conversations between the victim and the perpetrator commonplace in some jurisdictions. The risk of potential trauma to the victim must be weighed against the impact this piece of evidence can have on the outcome of the case. The possible trauma associated with this procedure must also be weighed against the potential trauma the victim could suffer trying to prosecute an offender successfully without a confession.

Administered properly, the recording of a conversation between the victim and the perpetrator can benefit both law enforcement and the victim. To law enforcement there isn't a better piece of evidence than having the perpetrator admitting what he did, why he did it, or that he is sorry for what he has done. For the victim, these admissions assure that people will believe his or her word. Many times the confrontation with the offender can be therapeutic. Victims often feel that they have had no control over what has happened to them. With the investigator's support and guidance, the victim can say no to the offender and take control of the situation.

Consideration should also be given to the relationship between the victim and the perpetrator. In an incest case, the potential trauma to the victim may outweigh what is gained, and it may not be wise to have the victim make the call. The investigator must always consider the victim's welfare in making the decision to go forward.

Procedure

Preparation

Know who and what you are dealing with. Interview the victim and witnesses, and if possible profile the offender. Know what his basic characteristics are, how he manipulated the victim, and his relationship with the victim. How did they talk about what was occurring between them? Did the suspect ever tell the victim that he felt guilty for what he was doing? Are there any more victims? Was the victim ever threatened? Did the suspect threaten suicide if he was reported? What was their routine? Has the victim ever run away from home or threatened to run away, and did the offender know? Does the perpetrator know that the molestation has been reported? Is there any evidence such as letters, diaries, or pictures? Did the perpetrator give the victim gifts or did they go places together? Would the perpetrator think it unusual to receive a phone call from the victim? If so, what excuse can be used so the call does not raise suspicion?

If the child is in counseling, the investigator should contact the child's therapist. This can give insight to the investigator as to the victim's well being and his or her ability to make the call. If the primary caregiver is not the perpetrator, obtain his or her permission as well before making the call.

After obtaining the above information, let the victim know that you have some understanding of what has happened to her. Discuss with her some of the feelings she may be having at the moment. Explain to the child how many offenders use denial as a means to avoid prosecution. Talk about guilt reversal—how the perpetrator sometimes shifts the guilt for what has happened from himself to the victim. Tell the victim what some offenders have said when confronted with the possibility of disclosure. Basically, let the victim know that you know what has happened and that it isn't the victim's fault.

Based upon what you have learned from the victim, the victim's therapist, and the victim's caregivers, decide whether or not you feel the victim is capable of making a phone call to the offender.

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* *We use the masculine pronoun throughout the article to refer to offenders, and the feminine pronoun occasionally to refer to victims. We understand, however, that some offenders are female and many victims are male.*

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Discuss the subject with the victim and see how he or she feels about making the call. If the victim is not sure, consider playing tapes of other victims making calls. Sometimes this gives victims ideas as to how to act in dealing with the perpetrator. Ask the victim if he or she wants to make the call. If victims say no, **do not force them to make the call.** If the victim agrees to make the call, discuss what approach you feel would best elicit a favorable reaction on the part of the suspect. Rehearse with the victim what is going to be said and what the responses might be. Make sure that the victim is prepared for the following questions the suspect may ask:

Where are you?
Are you alone?
Can I meet with you and discuss this in person?
Can I call back?
Can someone (sister, friend, etc.) pick you up and talk with you?

Always give the victim a way to terminate the call. Tell the victim that he or she can end the call by saying, "I have to go, someone is here," "I can't talk anymore, I'll call you back," or some other statement that allows the victim to hang up. This allows the victim to be in control of the call.

Execution

To properly conduct this procedure the following equipment is suggested:

An in-line telephone recording device.

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News

-Theresa Reid

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Private Financial Partners. The exhibitors listed below also made a significant financial contribution to the Colloquium, and we thank them for joining us in this exciting first year.

• ***Sage Publications***, publishers of professional social science books, Newbury Park, California.

• ***KidsPeace***, a national program based in Philadelphia which offers comprehensive services for children in crisis.

• ***Charter Barclay Hospital in Chicago***, a mental health and addictions treatment facility for inpatient and outpatient adolescents and adults.

• ***Mt. Sinai Medical Center's Under the Rainbow: Program for Assessment, Treatment, and Prevention of Child Abuse and Neglect***, based in Chicago.

• ***The Center for Trauma and Dissociation*** in Denver, Colorado, which specializes in the treatment of adults, adolescents, and children who have suffered severe trauma.

• ***Wallach Surgical Devices*** in Milford, Connecticut, which combines innovation in colposcopic examination with advanced digital image technology for a new detection and documentation system aimed specifically at the problem of child abuse.

• ***Cabot Medical Corporation*** of Langhorn, Pennsylvania, which develops, manufactures, and markets medical devices and systems for minimally invasive surgical and diagnostic procedures.

We are all delighted and relieved that APSAC's First National Colloquium was an unqualified success. We look forward to future years of Colloquia which—with your input—we hope will distinguish APSAC as the source of the most rigorous professional training in the field.

APSAC Staff. APSAC did not have sufficient staff to put on a major national conference, but the staff we have did it anyway, giving extraordinary amounts of time and effort, and smiling almost all of the time. I am proud to thank for their exceptional work APSAC staff members *Betty Johnson, Latrice Woods*, and *Catherine Crino, MDiv*.

Colloquium Overview

APSAC's major goal is to improve interdisciplinary professional practice and communication in the field of child maltreatment. A national conference is one natural means of achieving that goal. Vigilant of APSAC's fiscal health, APSAC's Board of Directors was cautious about taking the risk before we were ready. We are all delighted and relieved that APSAC's First National Colloquium was an unqualified success. We look forward to future years of Colloquia which—with your input—we hope will distinguish APSAC as the source of the most rigorous professional training in the field.

Welcome to New APSAC Staff Members

The success of APSAC's First National Colloquium was instrumental in creating both the need and the means to hire new staff.

Claudia Soldano, MSW, MBA, joined us on September 13 as Director of State Chapter Development, a new full-time position which will be a boon to all of those dedicated members who are working to begin or maintain viable APSAC state chapters. Claudia received her joint master's degree in business administration and social work from Washington University. During the last three years, Claudia established and directed an award-winning program of more than 100 volunteers for a Chicago-based hospice for AIDS patients.

Jennifer Martin joined APSAC on September 13 as Secretary and Office Manager. Jennifer has just completed her bachelor's degree from Universtiy of Illinois in political science and women's studies, and is interested in domestic violence, rape, and child abuse law.

I hope you will join me in welcoming Claudia and Jennifer to APSAC's staff. Henceforth, *Betty Johnson* will serve as APSAC's Membership Services Manager and Editorial Assistant for *The APSAC Advisor*. *Latrice Woods*, who joined us last February as secretary, has been promoted to Conference Manager. I am confident that APSAC's remarkable growth is in very capable hands.

Investigation

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Cassette tape recorder with external microphone jack.

Any telephone with a modular phone jack.

Earphones to overhear both sides of the conversation.

It is best to chose equipment that is adaptable to most telephones so as to allow some flexibility in choosing the location from which to make the call. Care should be given that whatever location you choose, it is free from distractions and outside interruptions. If made from the police station, make sure the business phones and intercom speaker cannot be overheard. If the victim is pretending to call from home, ask if he or she normally has music playing in the background. In case the suspect suggests calling the victim back at a later time, have a telephone available whose number is not traceable to the police station. Remember, it is your job to set the scene for whatever role the victim is assuming during the call. If you are having the victim call from a pay phone make sure there is appropriate background noise. Decide who will be present during the call. Ask the victim privately if he or she wants a parent present. Many times children may not want their parents present because they haven't told them about everything that has occurred.

The victim may become frightened when speaking to the suspect. It is important to be present to support the victim and help her overcome her fears. The investigator should always monitor both sides of the conversation. This allows you control over the call and enables the you write out additional questions for the victim to ask the suspect.

The tape recording of the conversation should be identified for evidentiary reasons. An announcement at the beginning of the recording providing the date and time along with the names of the persons to be recorded usually is sufficient to meet this requirement. Treat the recording and any notes taken during the call as evidence.

It is best not to write a script for the victim. If you do, the child most likely will read from it. The call then might not sound natural to the suspect. It is acceptable to write out important points that you want the child to talk about to the suspect. You should also have a list of statements or questions that the victim can use to help in eliciting incriminating statements. It is extremely important for the investigator to be present when the phone call is made. This allows the investigator to control the direction of the call. The victim may become frightened when speaking to the suspect. It is important to be present to support the victim and help her overcome her fears. The investigator should always monitor both sides of the conversation. This allows you control over the call and enables the you write out additional questions for the victim to ask the suspect.

Be alert to the fact that the suspect may make incriminating statements without issuing a full confession. It is not always necessary for the perpetrator to be specific about the acts that occurred. Statements such as, "It won't happen anymore," or, "I could go to jail," can be just incriminating as a confession.

Follow-up

Upon conclusion of the call, discuss with the victim how he or she feels. Counter any negative comments the perpetrator made that might have hurt the victim. Ask if the victim wants to hear the recording of the call. If so, play it and clear up any further questions you or the victim have.

There is always the possibility that victims will have second thoughts about having made the call. Assure them that they made the right decision. Tell them they were instrumental in "solving" the case. Let them know how they can reach you if they start having fears at a later date.

The investigator should also consider leaving the tape recorder attached to the victim's phone. Many times the suspect will call the victim back. If the suspect has been arrested, he may attempt to contact the victim from the jail. The suspect could make additional incriminating statements or threats toward the victim.

Once the recording is obtained, the investigator should consider whether or not to use it when interviewing the perpetrator. Letting the suspect listen to the recording can be very helpful in obtaining a confession.

Legal issues

Laws vary from state to state and investigators should research the laws that pertain to their jurisdiction before attempting to use this technique. Some states prohibit the tape recording of any phone conversation. Others allow one party consent recording of the conversation. Some of the most common questions that investigators and lay people ask about the recording of the call are:

Is the victim a police agent?

Yes. The victim is making the call at the investigator's direction and thus becomes the investigator's agent.

Does the suspect need to be advised of his rights?

No. Even though the perpetrator is a suspect and he is being asked questions by the investigator's agent, he is not in custody nor is his movement restricted by the police. No Miranda warning is necessary unless the perpetrator has been indicted or arraigned.

Isn't this entrapment?

No. The suspect has already committed the crime. In order to constitute entrapment, the police must encourage someone to commit a crime who would not normally do so.

Can the recording be used in court?

The investigator should check the laws that pertain to their jurisdiction. In most states, if the recording is obtained legally, then it can be used as evidence in court.

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Can someone else make the phone call?

Yes. Anyone can call the offender and attempt to elicit incriminating statements. This technique has proven to be successful when the victim's mother or protective parent makes the call or the investigator has called the suspect acting as the child's counselor.

Be alert to the fact that the suspect may make incriminating statements without issuing a full confession. It is not always necessary for the perpetrator to be specific about the acts that occurred. Statements such as, "It won't happen anymore," or, "I could go to jail," can be just incriminating as a confession.

The call should always be done at the direction of law enforcement, however. In many states, it is illegal for non-law enforcement personnel to record telephone conversations.

Is it legal to lie to the suspect?

You may deceive the suspect, just don't fabricate evidence.

With adequate preparation on the part of the investigator and the victim, this technique can go a long way in helping to prove a defendant's guilt or innocence. When used properly, the evidence obtained can greatly enhance criminal cases and reduce the possibility of the victim having to testify in court.

PRETEXT CONVERSATION RECORDINGS AND FEDERAL LAW

(Oral, telephonic or electronic communications)

Below is a list of federal law pertaining to the recording of pretext conversations.

Title 18 U.S. Code 2510 through 2520. describes Federal restrictions on recording, monitoring, etc. of oral, telephonic and electronic communications.

Title 18 U.S. Code 2511(2)(c). It shall not be unlawful under this chapter for a person acting under color of law to intercept a wire, oral or electronic communication, where such person is a party to the communication or one of the parties to the communication has given prior consent to such interception.

CASE LAW re 18 U.S.C. 2511(2)(c)

White 401 US 745 (1971). Monitoring body transmitter (with consent of wearer).

Caceres 440 US 741 (1979). IRS agent recorded bribe offer (legal even though department regulations required superior's authorization which was not obtained).

Jernigan 582 F2 1211 (9th Circuit)(1971). DEA agent recorded telephone conversation between informer, the agent and defendant.

Puchi 441 F2 697 (9th Circuit)(1972). Customs agent recorded telephone conversation with one party consent.

Howell 470 F2 1064 (9th Circuit) (1972). Defendant tried to set up the recording by agents in an effort to establish a phony story. Conversation admitted—court held that the defendant had consented.

Holmes 486 F2 55 (9th Circuit) (1973). Attorney suspected of crime is called by client and call is recorded with client's consent by state agents.

Little 753 F2 1420 (9th Circuit) (1983). IRS agent's recorded conversations with defendants admissible.

Ray Rawlins is a detective with the San Diego County Sheriff's Department. Dana Gassaway is an investigator in the San Diego District Attorney's Office, and a member of APSAC's Board of Directors.

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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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Literature Review

-Kathleen Coulborn Faller, David L. Corwin, and Erna Olafson

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Since no data are provided, there is no way to evaluate the SAID Syndrome, other than to note that the admonition to put little weight on children's accounts is contrary to general practice (see Conte et al., 1991).

Perhaps even stronger views are held by Gardner (1987; 1989; 1991; 1992), who has defined the Parental Alienation Syndrome (PAS), which is manifest in children who "view one parent as all good and the other as all bad." These children have been "programmed by their mothers to hate their father and to subject him to a campaign of denigration" (Gardner, 1992, p. 160). Among the material the mother sometimes also programs the child to believe is that the father has sexually abused him/her. When an allegation arises after a dispute over custody, Gardner believes it possesses a "high likelihood of being false" (Gardner, 1991, p. 4).

There is no way to evaluate authors' opinions not supported by data. Thus all that can be said about the SAID Syndrome and the Parental Alienation Syndrome is that they express the authors' opinions.

A companion to the PAS is the Sexual Abuse Legitimacy Scale (SALS, Gardner, 1987). The present version (1992) contains 84 differentiating criteria, 24 of which apply to the alleged offender, 30 to the child, and 30 to the mother. Many of these criteria relate specifically to allegations of abuse in divorce. For example, if one finds, in examining the mother, "the presence of a child custody dispute and/or litigation," "enlistment of the services of a 'hired gun' attorney or mental health professional," or "history of attempts to destroy, humiliate, or wreak vengeance on the accused," her allegations are less likely to be true, according to Gardner.

Gardner presents no data to validate either the PAS or the SALS. Therefore, the utility of the scales cannot be evaluated. Most of Gardner's writing on these topics is not peer reviewed and is published through his own press.

Studies involving small samples

The first and oft-cited clinical study of false allegations of sexual abuse in divorce involved a single case and reference to a second one (Kaplan & Kaplan, 1981). In the case, described in detail, an 11-year-old boy and his 5-year-old sister made allegations against their father and paternal grandparents. Both children had testified numerous times in court about the abuse and persisted in their accusations when challenged. Indeed, the Kaplans describe one particularly stormy session in which the boy is confronted simultaneously by the paternal grandparents and one of the Drs. Kaplan. Because, during this session, the boy partially recanted and said he had only been anally penetrated once instead of numerous times, the Kaplans conclude that his allegation is false. His partial recantation also led them to doubt the sister's account even though, in addition to her statements, she had a number of behavioral and emotional symptoms of sexual victimization. The Kaplans propose the possible dynamic of folie á deux as an explanation for the children's allegations, despite the fact there was no delusional thinking diagnosed in either child, the mother, or the maternal grandparents, who were supportive of the allegations, and despite the fact that the allegations originated with the children rather than a dominant adult.

Another frequently quoted study is that of Schuman (1986), who cites seven cases determined to be false on the basis of "psychodynamic formulation" and court determinations, out of an unknown number seen in his practice of probate and family court cases. Six of these were sexual abuse allegations against a father or stepfather; the seventh was a physical abuse case. The psychodynamic explanation for the false allegations was regression by the child and the accusing adult; in addition, in some instances (Schuman does not say how many) this adult retracted the allegation. This study is limited by its small sample size and by the lack of an empirical basis for the criteria Schuman uses to determine that allegations are false.

A study that has excited quite a lot of controversy is one reported by Green (1986) involving 11 cases from his practice, four of which (36%) he believed to be false. From these four cases, he generates criteria indicative of a false allegation, including easy disclosure, no evidence of negative affect, use of adult sexual terminology, checking with the accusing parent (mother) during the interview, and an ability to confront the father with the accusation. Falsely accusing mothers are described as hysterical and paranoid.

Green's conclusions were challenged because of the size and bias of his sample, and because one of his "false" cases was deemed possibly valid by two other experts in child sexual abuse (which would reduce his rate of false cases to 27%). His paper occasioned a rebuttal article (Corwin, Berliner, Goodman, Goodwin, & White, 1987) as well as a letter to the editor of the journal that published the original article, challenging its findings (Hanson et al., 1988). Among other things, Corwin and colleagues point out that there is a difference between a false (no abuse) and an unsubstantiated case (a null finding). In addition, they note that marital dissolution may increase the risk of sexual abuse and increase the likelihood of disclosure of pre-existing incest.

Benedek and Schetky (1985) also present findings from their private practices. They were interested in studying the characteristics of false allegations in divorce, and Benedek (1987) reports screening at intake to include suspected false cases and to exclude ones that appeared to be true. Fourteen of the 18 cases they assessed involved custody or visitation disputes in the context of divorce (four involved other issues related to custody). The authors thought that 10 of their cases were false (71% of 14 and 56% of 18). Not surprisingly, since they screened for false cases, this is

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the highest false allegation rate reported by any author presenting case data. All but one of the allegedly false allegations were made by mothers. It is not clear what criteria Benedek and Schetky used to determine that allegations were false; among the explanatory factors they cited were that the mother suffered from psychiatric disturbance ("paranoia" was the diagnosis most frequently mentioned by the authors), or wished to exclude their ex-spouses from their lives, were being vindictive, or were "crying wolf."

A much larger study (576 cases) of sexual abuse cases referred to child protective services provided findings relevant to the issue of sexual abuse and divorce (Jones & McGraw, 1987). Criteria employed in classifying the cases as likely true or likely false consisted of source of report, vindictiveness of parties, emotional disturbance in the accuser or the accused, abnormal parent/child relationships, timing of report, child's emotional state, physical evidence, confessions, polygraph results, and court role. Of the 5% of cases which a team of sexual abuse experts determined were "fictitious" allegations by adults, a large proportion involved contested custody or visitation. These findings suggest that false accusations are very rare generally, but may be more common in the context of custody disputes.

In a subsequent study by Jones and Seig (1988), 20 divorce cases involving accusations of sexual abuse from the Kempe Center were evaluated using the Jones and McGraw (1987) criteria to ascertain the rate of fictitious allegations. Four cases (20%) were determined to be fictitious, 14 (70%) reliable, and 2 (10%) uncertain. In this study, the authors observed that factors thought to be characteristic of false allegations were noted in the reliable cases, and characteristics expected in reliable cases were noted in the fictitious ones.

There is a fair amount of disagreement among writers about characteristics of false allegations. Indeed, one professional's indicator of a false allegation may be another's indicator of a true one. In addition, some criteria lend themselves to a variety of interpretations, either in the context of a single case, or depending upon the case.

Using the criteria developed by Jones and McGraw (1987) and used by Jones and Seig (1988), McGraw and Smith (1992) re-examined 18 cases referred to Boulder County Protective Services involving sexual abuse allegations in the context of divorce, all but one of which had been unfounded after CPS investigation. The results of this re-examination were that eight cases (44.4%) were founded, seven cases (39%) had insufficient information or unsubstantiated suspicion, and three (16.5%) were fictitious (one from a child and two from adults). The authors admonish investigators and clinicians to keep an open mind when investigating such cases, rather than assuming that they will be false.

Studies comparing divorce cases to other sexual abuse cases

Two studies compare results from divorce and non divorce cases. Paradise, Rostain, and Nathanson (1988) examined 31 cases, (25 from Children's Hospital of Philadelphia and six from the first author's private practice), 12 of which involved divorce. Those cases involving divorce were significantly less likely to be substantiated: 67% substantiation rate in divorce cases vs. 95% substantiation rate in cases not involving divorce. In addition, children in the divorce group were significantly younger (5.4 years vs. 7.8); this age difference may have affected substantiation rates, since cases involving younger children may be generally more difficult to substantiate (Thoennes & Tjaden, 1990).

Hlady and Gunter (1990) examined the records of 370 children seen at the Child Protection Service Unit at British Columbia Children's Hospital. One hundred seventeen children were primarily referred for alleged physical abuse, and 253 for alleged sexual abuse. Forty-one children were the objects of custody disputes. Surprisingly, children involved in custody disputes were more likely to exhibit physical findings (71% had findings of physical abuse, 17.6% had findings of sexual abuse) than were children not involved in custody disputes (43.6% showing findings of physical abuse, 15% of sexual abuse). Generalizations from these data must be cautious, since the number of custody cases with allegations of physical abuse was small, and the difference on sexual abuse cases was not significant. However, these data suggest that sexual abuse allegations made in the context of divorce are at least as likely to have the corroboration of medical findings.

More studies comparing commonly evaluated characteristics of sexual abuse cases in divorce and other contexts would be very useful.

Studies involving larger samples

To date, there are two pieces of research with samples larger than 100 cases. Faller (1990) studied 136 cases involving divorce that were referred to the University of Michigan Interdisciplinary Project on Child Abuse and Neglect, which includes a tertiary care program for evaluation of child maltreatment cases. Using criteria derived from a study of confessed cases, Faller determined the likelihood of sexual abuse in her sample. These criteria included (1) description of the sexual abuse; (2) details about the context; and (3) affect congruent with allegations and circumstance. Faller categorized these cases into six groups: cases in which disclosure of apparently true abuse leads to divorce (N=11; 8.1%); cases in which divorce leads to disclosure of apparently true abuse by the child or belief by the parent (N=26; 19.1%); cases in which divorce leads to sexual abuse (N=52; 38.2%); cases in which apparently false allegations arise in an atmosphere of acrimony surrounding the divorce

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(N=19; 14%); cases in which false allegations may have been made (N=12; 8.8%); and cases in which other dynamics were at work (N=16; 11.8%). Of the 19 cases involving apparently false allegations, three appeared to be consciously made; two of these three intentionally false allegations were made by fathers.

By far the most important study to date is that conducted by the Association of Family and Conciliation Courts Research Unit (Thoennes, Pearson, & Tjaden, 1988; Thoennes & Tjaden, 1990). The researchers surveyed 9,000 divorce cases involving custody/visitation disputes from 12 domestic relations courts to determine how many such disputes involve allegations of sexual abuse. The researchers found allegations of child sexual abuse in less than two percent (169) of these cases. In 129 cases, the question of sexual abuse was addressed by the domestic relations court. Accusations were made by mothers (67%), fathers (28%), and third parties (11%). Fewer than half of cases involved mothers making accusations against the fathers of children.

On the basis of the research that has been conducted so far, it is difficult to support an assertion that there are high rates of false allegations of sexual abuse consciously made by mothers in divorce situations.

Using the Child Protective Services determination and/or the report of a court-appointed mental health evaluator as the criteria for substantiation, the researchers found that 50% of cases were likely, 33% were unlikely, and 17% were uncertain (which included cases in which two evaluators held different opinions). They also attempted to discern the motivation for unlikely reports and found 58 cases in which the case material addressed that issue. In eight cases, child protective service workers thought the allegation was maliciously made. Factors associated with cases being classified as unlikely or uncertain were younger age of the child, a single incident alleged, non-intrusive sexual behavior, a single report, a report less than two years since the filing for divorce, and animosity between the parents.

Conclusions

On the basis of the research that has been conducted so far, it is difficult to support an assertion that there are high rates of false allegations of sexual abuse consciously made by mothers in divorce situations.

There is no way to evaluate authors' opinions not supported by data. Thus all that can be said about the SAID Syndrome and the Parental Alienation Syndrome is that they express the authors' opinions. Moreover, the language used in both suggests a bias against mothers concerned about sexual abuse of their children.

The remainder of the research can be evaluated regarding possible sample biases, sample size, and criteria used to determine that the allegation is false.

With the exception of the research supported by the Association of Family and Conciliation Courts (Thoennes & Tjaden, 1988; Thoennes & Tjaden, 1990) and that by Paradise and colleagues (1988), all of the studies cited rely on cases from a single source. A single site or source may introduce biases based upon geography, the authors' selection criteria, and the reputation of the clinician or the site. Selection criteria include such factors as Benedek's screening for cases she thought might be false, or Faller's taking cases referred by another agency. Payment source for the service may also determine the sorts of cases seen at a particular site. In addition, cases seen in private practices are likely to differ from those seen at an agency or at a hospital.

Sample size is also very important in weighing the utility and potential validity of findings. It is very difficult to draw any conclusions from samples smaller than 20 cases. Particularly problematic is the situation in which the writer draws conclusions about characteristics of false allegations from a subset of a small sample, as does Green (1986).

The most difficult problem in evaluating research on allegations of child sexual abuse is evaluating the criteria researchers use to assess the veracity of allegations. To test these criteria, researchers need to see if they are in fact reflected in a sample of cases proven false or true by some independent measure (for example, that the offender never had access to the victim, or, alternatively, that the offender gave a complete, detailed confession). Since such samples are hard to find and indeed may be unrepresentative, research on the veracity of child sexual abuse allegations cannot draw upon them. Most writers use their clinical judgment, the consensus of several clinicians or experts, or a legally supported decision, such as the disposition of the child protection agency, the conclusion of a court-appointed expert, or a judge's opinion. All of these have limitations. Jones' and Seig's (1988) determination that cases thought to be reliable had characteristics of false reports and vice versa is illustrative. So is the Association of Family and Conciliation Courts' classification of cases as "uncertain" when two opinions disagreed.

Moreover, there is a fair amount of disagreement among writers about characteristics of false allegations. Indeed, one professional's indicator of a false allegation may be another's indicator of a true one. In addition, some criteria lend themselves to a variety of interpretations, either in the context of a single case, or depending upon the case.

When the research is examined critically, the strongest study is that conducted by the Association of Family and Conciliation Courts, because of its large sample, its use of multiple sites, and the fact that cases are fairly representative of the total population of divorce cases with disputes over custody and visitation. Its findings indicate that sexual abuse allegations do occur in the context of divorce, but the overwhelm-

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ing majority (98%) of disputed custody cases do not involve sexual abuse accusations. Moreover, although the majority of charges are brought by mothers, by no means all are. The predominance of women as accusers and men as accused is consistent with the finding that the majority of offenders are men. This study and that of Faller contradict the assertion by others that most adults who make false reports do so knowingly (e.g. Benedek & Schetky, 1985; Blush & Ross, 1986; Gardner, 1987; Renshaw, 1986).

Where the Association of Family and Conciliation Courts may be weaker than other studies is in the criteria it used to judge the veracity of an allegation: the child protective services determination or a court- appointed mental health professional's opinion. Perhaps criteria such as those based on a consensus of experts or a collaborative decision (Jones & McGraw, 1987; Jones & Seig, 1988; McGraw & Smith, 1992) or derived indirectly from cases substantiated by confession (Faller, 1990) are more accurate. Interestingly, substantiation rates tend to be higher in such studies and uncertainty rates lower.

Perhaps the likelihood of a parent making a false allegation in a divorce has increased because of greater awareness of sexual abuse and of the potential power of an allegation. Conversely, adults cognizant of the recent outcomes in such cases...may be less likely to raise a legitimate concern about sexual abuse because the legal consequences may further traumatize a child and family without stopping the abuse.

Altogether 11 data-based articles about sexual abuse allegations in divorce are cited here. This number is too small to draw more than tentative conclusions. Moreover, characteristics of allegations in divorce may be influenced by increased public education and experience regarding sexual abuse, so that samples that are just five years old may not reflect current caseloads. Perhaps the likelihood of a parent making a false allegation in a divorce has increased because of greater awareness of sexual abuse and of the potential power of an allegation. Conversely, adults may be cognizant of the recent outcomes in such cases. These include disbelief by the court or refusal to hear evidence of sexual abuse, incarceration of the parent who refuses visitation, loss of custody by the parent alleging sexual abuse, and negative experiences of parents, who with their children may go so far as to enter the "underground" to avoid court decisions. This knowledge may result in parents becoming less likely to raise a legitimate concern about sexual abuse because the legal consequences may further traumatize a child and family without stopping the abuse.

References

Benedek, E. (1987). Court testimony. *E. Morgan v. E. Foretich, V. Foretich, & D. Foretich.* Alexandria, VA: United States District Court, February 18.

Blush, G., & Ross, K. (1986). Sexual allegations in divorce: The SAID syndrome. Unpublished manuscript available from the Psychodiagnostic Clinic, Macomb County Circuit Court, Mt. Clemens, MI.

Conte, J., Sorenson, E., Fogarty, L., & Dalla Rosa, J. (1991). Evaluating children's reports of sexual abuse: Results from a survey of professionals. *American Journal of Orthopsychiatry, 61,* 2.

Corwin, D., et. al. (1987). Child sexual abuse and custody disputes: No easy answers. *Journal of Interpersonal Violence, 2,* 1, 91-105.

Faller, K. (1988). Criteria for judging the credibility of children's statements about their sexual abuse. *Child Welfare, 67,* 5, 389-401.

Faller, K. (1991). Possible explanations for child sexual abuse allegations in divorce. *American Journal of Orthopsychiatry, 61,* 1, 86-91.

Gardner, R. (1989). Differentiating between bona fide and fabricated allegations of sexual abuse of children. *Journal of the American Academy of Matrimonial Lawyers, 5,* 1-25.

Gardner, R. (1987). *The parental alienation syndrome and the differentiation between fabricated and genuine child sexual abuse.* Cresskill, NJ: Creative Therapeutics.

Gardner, R. (1991). *Sex abuse hysteria: Salem witch trials revisited.* Cresskill, NJ: Creative Therapeutics.

Gardner, R. (1992). *True and false allegations of child sex abuse.* Cresskill, NJ: Creative Therapeutics.

Gordon, C. (1985). False allegations of abuse in child custody disputes. *Minnesota Family Law Journal, 2,* 14, 225-228.

Green, A. (1986). True and false allegations of sexual abuse in child custody disputes. *Journalof the American Academy of Child Psychiatry, 25,* 449-455.

Hanson, G. (1988). The sex abuse controversy: Letter to the Editor. *Journal of the American Academy of Child and Adolescent Psychiatry, 27,* 258.

Hlady, L., & Gunter, E. (1990). Alleged child abuse in custody access disputes. *Child Abuse and Neglect, 14,* 4, 591-594.

Jones, D., & McGraw, M. (1987). Reliable and fictitious accounts of sexual abuse to children. *Journal of Interpersonal Violence, 2,* 1, 27-45.

Jones, D., & Seig, A. (1988). Child sexual abuse allegations in custody or visitation cases: A report of 20 cases. In B. Nicholson & J. Bulkley (Eds.), *Sexual abuse allegations in custody and visitation cases.* Washington, DC: American Bar Association.

Kaplan, S., & Kaplan, S. (1981). The child's accusation of sexual abuse during a divorce and custody struggle. *Hillside Journal of Clinical Psychiatry, 3,* 1, 81-95.

McGraw, J., & Smith, H. (1992). Child sexual abuse allegations amidst divorce and custody proceedings: Refining the validation process. *Journal of Child Sexual Abuse, 1,* 1, 49-62.

Mantell, D. (1988). Clarifying erroneous child sexual abuse allegations. *American Journal of Orthopsychiatry, 58,* 4, 618-621.

Paradise, J., Rostain, A., & Nathanson, M. (1988). Substantiation of sexual abuse charges when parents dispute custody or visitation. *Pediatrics, 81,* 6, 835-839.

Renshaw, D. (1987). Child sexual abuse: When wrongly charged. *Encyclopedia Britannica Medical and Health Annual,* 301-303.

Renshaw, D. (1985). When sexual abuse is wrongly charged. *Medical Aspects of Human Sexuality, 19,*7, 116-121.

Ross, K. (1988). SAID syndrome: Fact or fallacy. Workshop at Grand Valley State University, Grand Rapids, MI, May.

Schetky, D. (1985). Allegations of sexual abuse in child custody cases. In E. Benedek & D. Schetky (Eds.), *Emerging issues in child psychiatry and the law.* New York, NY: Brunner/Mazel, 145-156.

Schuman, D. (1986). False allegations of physical and sexual abuse. *Bulletin of the American Academy of Psychiatry and the Law, 14,* 1, 5-21.

Thoennes, N., Pearson, J., & Tjaden, P. (1988). *Allegations of sexual abuse in custody and visitation cases.* Denver, CO: Association of Family and Conciliation Courts.

Thoennes, N., & Tjaden, P. (1990). The extent, nature, and validity of sexual abuse allegations in custody/visitation disputes. *Child Abuse and Neglect, 14,* 151-163.

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MEDICINE

Fatal Child Abuse and Sudden Infant Death Syndrome (SIDS): Can We Tell the Difference?

—by Robert M. Reece

National statistics during 1991 indicated that 1,241 child homicides occurred in the United States. Some contend that this figure is inaccurate and is based on incomplete information, since child fatality investigations are so variable in the many jurisdictions of the country. Others have estimated as many as 5,000 annual cases, but this statistic is likewise subject to questions of validity. There is little question that better data on this subject are needed. Also needed are better means to distinguish between child homicide, medical conditions leading to sudden death, and the entity known as sudden infant death syndrome (SIDS).

SIDS is high on the list for possible confusion with child homicide since the diagnosis of SIDS depends on a postmortem examination and a death scene investigation, two activities that occur regularly in only a small proportion of infant deaths. The significance is self-evident: coroners and medical examiners are responsible for determining and reporting the cause and manner of death; pediatricians and family physicians are mandated to report child abuse to child protection agencies; child protection agencies, in turn, must insure that other children in the same home are protected, and that police and prosecutor's offices are informed if child abuse is suspected. Conversely, if the death is due to SIDS or another medical condition, innocent parents must be protected in their time of tragedy from wrongful accusations. They should be given the available necessary information about why their baby died and counseling to avoid compounding their grief.

SIDS is high on the list for possible confusion with child homicide since the diagnosis of SIDS depends on a postmortem examination and a death scene investigation, two activities that occur regularly in only a small proportion of infant deaths.

An almost simultaneous evolution of knowledge has occurred in child abuse and SIDS during the last forty years. Werne and Garrow (1953) and Adelson and Kinney (1956) were pathologists seeking the cause of infant deaths in the middle of this century. Other pathologists (Beckwith, 1973; Beckwith, 1988; Krous, 1984; Krous, 1989; Smialek, 1988, and Norman, 1984) as well as a wide array of scientists from diverse fields of interest, have become intrigued with the mysterious nature of sudden infant death syndrome. The pediatric pathologist most familiar to her colleagues and the lay public alike for her efforts in clarifying the medical complexities of SIDS has been Dr. Marie Valdes-Dapena (1982; 1992) who has persistently sought answers to parents' questions in cases of SIDS. Determining the cause of this phenomenon has been elusive, but as new information has developed, the broad scope of theories about what is responsible for "crib death" has been narrowed and real progress has been achieved to focus attention on the more plausible and scientifically credible hypotheses.

The definition of SIDS as promulgated by the National Institute of Child Health and Human Development in 1989 is: "The sudden death of an infant under one year of age which remains unexplained after the performance of a complete postmortem investigation, including an autopsy, and examination of the scene of death and review of the case history." The overall SIDS incidence rate in the United States is currently 1.4 deaths per thousand live births. In 1988 there were 5,476 deaths attributed to SIDS. There are differences in incidence rates in this country among various racial groups: among African-Americans the rate is 2.26/1000; among the Northern Plains Indians, the rate is 10/1000, but the role of race is confounded by socioeconomic factors. One group of researchers has concluded that there is a consistent inverse relationship between SIDS and socioeconomic status (SES). Whether the SES effect acts as a confounder, effect modifier, or intermediate variable is still unclear.

Clinical presentation of SIDS

When SIDS occurs, typically a parent or other caretaker puts an apparently healthy infant to bed as usual and later discovers that she/he is lifeless in the crib. In a panic the caregiver calls for medical assistance, and, despite efforts at resuscitation, the baby is ultimately pronounced dead. Most victims of SIDS are between two and four months of age but SIDS can occur anytime through the twelfth month of age. Very few cases occur in the first week of life and approximately 90% of cases have occurred by six months of age. Often the baby has recently been declared healthy by a physician during a routine "well baby" visit. The death is completely unexpected. There is a preponderance of male victims over female (60-70% male:female ratio). Deaths are more common in the winter months but occur at all times during the year. SIDS occurs more commonly in infants of lower socioeconomic status mothers, in babies with lower than average birth weights and in multiple births (twins, triplets, etc.) Mothers of future SIDS babies are more likely to have smoked cigarettes during pregnancy. Certain other so-called risk factors — illnesses before the death, subtle neurological abnormalities during the neonatal period, more frequent reports of rapid breathing or heart action, blue spells and vomiting — have been described in a variety of populations, but no one factor or combination of factors has been sufficiently powerful to predict future SIDS babies. Moreover, most of the infants succumbing to SIDS have none of these characteristics.

In Peterson's (1986) study of risk reoccurrence within families, there was no statistically significant difference in SIDS rate or in total infant mortality rates in families with a history of SIDS compared with families with no SIDS. This dispelled the previously held notion that having one SIDS baby raised the risk of SIDS in subsequent pregnancies.

Clinical presentation of fatal child abuse

Caffey's early paper on subdural hematoma and

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fractures of long bones appeared in 1946, six years before Werne and Garrow (1953) and nine years before Adelson and Kinney (1956) had reported on infant death. In 1953, Silverman postulated that these injuries were the result of unrecognized trauma and Adelson, in 1961, reported on 46 child homicides, of whom 10 were less than one year of age. Of the ten, five had died of drowning, three of starvation, and in two the cause of death was not reported. Thirty years later, Adelson (1991) described 194 child homicides, of which only 28 occurred before one year of age and sixteen of whom were under six months of age. All of these were obviously fatally battered and not confused with SIDS. Emery and Taylor (1986) reported on a 24-year period in England (1960-1984), during which deaths under 24 months of age were reviewed. They concluded that suffocation accounted for 10% of these deaths. The possibility of active intervention on the part of one or both parents was raised in another 10%, but specific data on infants between one month and twelve months were not reported. The manifestations of fatal child abuse are too numerous to recount here, but have been described in a plethora of publications over the last 50 years, summarized in recent periodicals and books.

If the death is due to SIDS or another medical condition, innocent parents must be protected in their time of tragedy from wrongful accusations.

The parallel development of interest in the medical community about child abuse and SIDS is probably in part due to the advent of antibiotics and immunizations, innovations that reduced the mortality rate in children making infant death a much rarer event than ever before. Since it became increasingly uncommon for babies to die, when it did happen, curiosity was aroused. The inevitable question when an infant died suddenly and unexpectedly was raised: Was this child a victim of homicide? To the many parents of SIDS infants, the question became anathema. Parent groups formed to raise money for research into the reasons for their baby's death as well as to defend themselves against those who would accuse them of harming their children. Ultimately the various groups merged into the SIDS Alliance. This organization's mission is to raise public awareness about SIDS, provide information to parents, and to encourage research into the cases of SIDS.

The autopsy

Postmortem examination in cases of unexpected infant death in the sine qua non in diagnosis. The findings typical of SIDS have been summarized by Valdes-Dapena (1982; 1992) and Huff (1986). Postmortem examinations in fatal child abuse demonstrate that the causes of death are injuries to the head or abdominal viscera, burns, drowning, gunshot wounds, exposure, suffocation, poisoning, or a combination of these. Radiographic imaging has gradually been introduced into these postmortem examinations with the use of the "skeletal survey", an examination employing numerous high detail projections of the skeleton (Kleinman, 1989), adding immeasurably to the information derived from the autopsy.

Scene investigation and child death review

Prompt investigation by protocol of the scene of death should be the standard in all infant and childhood deaths. Delay of this important activity risks losing important documentation of the possibility of environmental risk factors as well as risk factors associated with the sleeping conditions of the infant. Prompt interviewing of the caretakers is needed to ascertain details of the infant's situation when first discovered. Assembling information from medical providers, family members, relatives, neighbors, and the local child protection agencies helps complete the diagnostic process. This investigation, if conducted sensitively and with concern for the feelings of the family, can be useful in the later counseling of innocent parents who have lost their baby because of a medical condition or SIDS. The investigation is critical if child abuse is to be established. Review of all information by a child death review team, consisting of at least the medical examiner or coroner, a pediatrician knowledgeable about both child abuse and other medical conditions responsible for child fatalities, representatives from local child protection agencies, law enforcement and the prosecutor's offices. The approach, composition, and function of such teams has been outlined superbly in a series of manuals published jointly by the Child Maltreatment Fatalities Project of the American Bar Association Center on Children and the Law and the American Academy of Pediatrics (Granik; Kaplan).

Since child abuse is a contributory factor in a substantial portion of infant deaths, the following recommendations are offered for death ascertainment:

1. Accurate history-taking by emergency responders and medical personnel at the time of death and made available to the medical examiner or coroner
2. Examination of the dead infant at a hospital emergency department (Often such infants are taken directly to the morgue, depriving the case of clinical appraisal prior to autopsy.)
3. Protocol postmortem examinations within 24 hours of death, including toxicology and metabolic screening when deemed appropriate in the context of the complete evaluation of the infant's death
4. Prompt death-scene investigation by knowledgeable individuals including careful interviews of the household members
5. Collection of previous medical records from all sources of medical care and personal interviews of key medical providers
6. Detailed collection of medical history from care-

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takers, using a standardized medical history questionnaire

7. Locally based infant death review teams to review the collected data with participation of the medical examiner or coroner in the review
8. Use of accepted diagnostic categories on death certificates as soon as possible after review
9. Prompt informing sessions with parents when the results indicate SIDS as causation of death (High-quality medical examiners' offices inform parents of SIDS cases as soon as the results of the gross autopsy findings are available.)
10. Recognition of all the diagnostic elements comprising the decision about infant deaths (Table)
11. Maintenance of a supportive approach to parents during the death review process
12. Adequate funding of this critical process, both for death ascertainment and for the protection of all infants and children
13. Stimulation and support of more research into the etiology of both SIDS and child abuse.

An almost simultaneous evolution of knowledge has occurred in child abuse and SIDS during the last forty years.

References

Adelson, L. (1961). Slaughter of the innocents: a study of forty-six homicides in which the victims were children. ***New England Journal of Medicine, 264,*** **1345-1349.**

Adelson, L. (1991). Pedicide revisited: The slaughter continues. ***American***

TABLE. Criteria for Distinguishing SIDS from Fatal Child Abuse and Other Medical Conditions

	Consistent With SIDS	Less Consistent With SIDS	Highly Suggestive or Diagnostic of Child Abuse
History surrounding death	Apparently healthy infant fed, put to bed. Found lifeless. Silent death. EMS resuscitation unsuccessful.	Infant found apneic. EMS transports to hospital. Infant lives hours to days. Substance abuse, family illness.	History atypical for SIDS. Discrepant history. Unclear history. Prolonged interval between bedtime and death.
Age at death	Peak 2–4 mo. 90% <7 mo. Range 1–12 mo.	8–12 mo.	>12 mo.
PE and laboratory studies at time of death	Serosanguinous watery, frothy, or mucoid nasal discharge. PM lividity in dependent areas. Possible marks on pressure points of body. No skin trauma. Well-cared-for baby.	Organomegaly of viscera. Stigmata of disease process (PE, laboratory, x-ray).	Cutaneous injuries. Traumatic lesions of body parts (conjunctiva, fundi, scalp, intraoral, ears, neck, trunk, anogenital extremities, malnutrition, neglect. Fractures.
History of pregnancy, delivery, and infancy	Prenatal care—minimal to maximal. Frequent history of cigarette use during pregnancy. Some future SIDS victims are premature or LBW. Subtle defects in state, feeding, cry, neurological status (hypotonia, lethargy, irritability). Less postneonatal height and weight gain. Twins, triplets. Spitting, GE reflux. Thrush, pneumonia, illnesses requiring hospitalization, tachypnea, tachycardia, cyanosis. Usually: No signs of antecedent difficulty.	Prenatal care—minimal to maximal. History of recurrent illnesses and/or multiple hospitalizations. "Sickly" or "weak" baby. Specific diagnosis of organ system disease.	Unwanted pregnancy. Little or no prenatal care. Late arrival for delivery. Birth outside of hospital. Few or no well baby care. No immunizations. Use of cigarettes, drugs/alcohol during and after pregnancy. Baby described as hard to care for or to "discipline." Deviant feeding practices.
Death scene investigation	Crib, bed in good repair. No dangerous bedclothes, toys, plastic sheets, pacifier strings, pellet pillows. No cords, bands for possible entanglement. Accurate description of position with attention to possible head/neck entrapment. Normal room temperature. No toxins, insecticides. Good ventilation, furnace equipment.	Defective crib/bed. Use of inappropriate sheets, pillows, sleeping clothes. Presence of dangerous toys, plastic sheets, pacifier cords, pellet pillows. Cosleeping. Poor ventilation, heat control. Presence of toxins, insecticides. Unsanitary conditions.	Chaotic unsanitary crowded living conditions. Evidence of drugs/alcohol. Signs of terminal struggle in crib, bed, bedclothes or other equipment. Discovery of blood-stained bedclothes. Evidence of hostility by caretakers. Discord between caretakers. Display of violence between caretakers. Admission of harm. Accusations.
Previous infant deaths in family	First unexplained and unexpected infant death.	One previous unexpected or unexplained infant death.	More than one previous unexplained or unexpected infant death.
Autopsy findings	No adequate cause of death at PM. Normal: skeletal survey, toxicology, chemistry studies (blood sugar may be high, normal, or low), microscopic examination, metabolic screen. Presence of: large numbers of intrathoracic petechiae; dysmorphic, dysplastic, or anomalous lesions; gliosis of brainstem; sphincter dilation. Occasionally subtle changes in liver, including fatty change and extramedullary hematopoiesis.	Subtle changes in liver, adrenal, myocardium. Few or no intrathoracic petechiae.	Traumatic cause of death (IC or visceral bleeding). External bruises, abrasions, or burns. No intrathoracic petechiae. Malnutrition. Fractures. Subgaleal hematoma. Abnormal body chemistry values (Na, Cl, K, BUN, sugar; liver, pancreatic enzymes; CPK). Abnormal toxicology.
Previous CPS or LE involvement	None.	One.	Two or more. One or more family member arrested for violent behavior.

* Abbreviations: SIDS, sudden infant death syndrome; EMS, emergency medical services; PM, postmortem; PE, physical examination; LBW, low birth weight; GE, gastroesophageal; WBC, well baby care; IC, intracranial; BUN, blood urea nitrogen; CPK, creatine phosphokinase; CPS, children's protective services; LE, law enforcement.

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Journal of Forensic Medical Pathology, 12, 16-26.

Adelson, L., & Kinney, C. (1956). Sudden and unexpected death in infancy and childhood. *Pediatrics, 17,* 663-699.

Anderson, T., & Wells, S. *Data collection for child fatalities: Existing efforts and proposal guidelines.* American Bar Association Order Fulfillment Center, 750 N. Lake Shore Drive, Chicago, IL 60611.

Bass, M. (1977). Asphyxial crib death. *New England Journal of Medicine, 296,* 555-556.

Bauchner, H., Zuckerman, B., (1990). Cocaine, sudden infant death syndrome and home monitoring. *Journal of Pediatrics, 117,* 904-906.

Bauchner, H., Zuckerman, B., & McClain, M., et. al. (1988). Risk of sudden infant death syndrome among infants with in-utero exposure to cocaine. *Journal of Pediatrics, 113,* 831-834.

Beckwith, J. (1973). Sudden infant death syndrome: A new theory. *Pediatrics, 55,* 583.

Beckwith, J. (1988). Intrathoracic petechial hemorrhages: A clue to the mechanism of sudden infant death syndrome? *Annals of the New York Academy of Sciences, 533,* 37-47.

Bergman, A. (1972). Unexplained sudden infant death. *New England Journal of Medicine, 287,* 254-255.

Bergman, A. (1973). The management of sudden infant death syndrome (SIDS) in the United States. Testimony offered in Sudden Infant Death Syndrome Hearings, Committee on Labor and Public Welfare, Subcommittee on Health and on Children and Youth, 93rd Congress, 1st Session, Sept. 20, 1973. Washington, DC: US Government Printing Office, 324-762.

Black, L. David, R., & Brouilette, R., et. al. (1986). Effects of birth weight and ethnicity on incidence of sudden infant death syndrome. *Journal of Pediatrics, 108,* 209-214.

Brown, R. (1976). The battered child syndrome. *Journal of Forensic Science,* 21-65.

Caffey, J. (1946). Multiple fractures in the long bones of infants suffering from chronic subdural hematoma. *American Journal of Roentgenology, 56,* 163.

Chasnoff, I., Burns, W., Schnoll, S., & Burns, K. (1985). Sudden infant death syndrome in infants of substance-abusing mothers. *New England Journal of Medicine, 313,* 666-669.

Christoffel, K., Zieserl, E., & Chiaramonte, J. (1985). Should child abuse and neglect be considered when a child dies unexpectedly? *American Journal of Diseases of Children, 139,* 876-880.

Davies, D. (1985). Cot death in Hong Kong: A rare problem? *Lancet, 2,* 1346-1348.

Emery, J., & Taylor, E. (1986). Investigation of SIDS. *New England Journal of Medicine, 315,* 1676.

Famularo, R., Stone, K., Barnum, R., & Wharton, R. (1986). Alcoholism and severe child maltreatment. *American Journal of Orthopsychiatry, 82,* 888-895.

Granik, L., Durfee, M., & Wells, S. Child death review teams: A manual for design and implementation. American Bar Association Order Fulfillment Center, 750 N. Lake Shore Drive, Chicago 60611.

Griffin, M., Ray, W., Livengood, J., & Schaffner, W. (1988). Risk of sudden infant death syndrome after immunization with the diphtheria-tetanus-pertussis vaccine. *New England Journal of Medicine, 319,* 618-622.

Griffith, J., & Slovik, L. (1989). Munchausen Syndrome by Proxy and sleep disorders medicine. *Sleep, 12,* 178-183.

Groothius, J., Altemeier, W., & Robarge, J., et. al. (1982). Increased child abuse in families with twins. *Pediatrics, 70,* 769-773.

Guntheroth, W. (1983). The pathophysiology of petechiae. In J. Tildon, L. Roeder, & A. Steinschneider (Eds.), *Sudden Infant Death Syndrome.* New York: Academic Press, 271-278.

Hagland, B., & Cnattingius, S. (1990). Cigarette-smoking as a risk factor for sudden infant death syndrome: A population-based study. *American Journal of Public Health, 80,* 29-32.

Handforth, C. (1939). Sudden unexpected death in infants. *Canadian Medical Association Journal, 80,* 872-873.

Harpey, J., Charpentier, C., & Paturneau-Jonas, M. (1990). Sudden infant death syndrome and inherited disorders of fatty acid B-oxidation. *Biology of the Neonate, 58 (suppl.: Metabolic Problems of the Newborn),* 70-80.

Hoffman, H., Damus, K, & Hillman, L., et. al. (1988). Risk factors for SIDS: Results of the National Institute of Child Health and Human Development SIDS Cooperative Study. *Annals of the New York Academy of Sciences, 533,* 13-30.

Hoffman, H., Hunter, J., & Damus, P., et. al. (1987). Diphtheria-tetanus-pertussis immunization and sudden infant death: results of the National Institute of Child Health and Human Development Cooperative Epidemiological Study of sudden infant death syndrome risk factors. *Pediatrics, 79,* 598-611.

Howat, A., Bennett, M., & Variend, S., et. al. (1985). Defects of metabolism of fatty acids in the sudden infant death syndrome. *British Journal of Medicine, 290,* 1771-1773.

Huff, D. (1986). Cytomegalovirus inclusions in 401 consecutive autopsies on infants aged 2 weeks to 2 years: A high incidence in patients with sudden infant death syndrome. Presented at a meeting of the Society for Pediatric Pathology, Dallas, TX.

Irgens, L., Skjaerven, R., Peterson, D. (1984). Prospective assessment of recurrence risk in sudden infant death syndrome siblings. *Journal of Pediatrics, 104,* 349-351.

Kaplan, S. Child fatality legislation in the United States. American Bar Association Order Fulfillment Center, 750 N. Lake Shore Drive, Chicago 60611.

Kaplan, S., & Granik, L. (Eds.). Child fatality investigative procedures manual. American Bar Association Order Fulfillment Center, 750 N. Lake Shore Drive, Chicago 60611.

Kempe, C., Silverman, F., & Steele, B., et. al. (1962). The battered child syndrome. *Journal of the American Medical Association, 181,* 17.

Kirschner, R., Stein, R. (1985). The mistaken diagnosis of child abuse: A form of medical abuse? *American Journal of Diseases of Children, 139,* 873-875.

Kleigman, R. Unpublished data.

Kleinman, P. (1987). *Diagnostic Imaging in Child Abuse.* Baltimore, MD: Williams & Wilkins.

Kleinman, P., Blackbourne, B., & Marks, S., et. al. (1989). Radiologic contributions to the investigation and prosecution of cases of fatal infant abuse. *New England Journal of Medicine, 320,* 507-511.

Korbin, J. (1986). Childhood histories of women imprisoned for fatal child maltreatment. *Child Abuse and Neglect, 10,* 331-338.

Korbin, J. (1987). Incarcerated mothers' perceptions and interpretations of their fatally maltreated children. *Child Abuse and Neglect, 11,* 397-407.

Kraus, J., & Bultreys, M. (1991). The epidemiology of sudden infant death syndrome. In M. Kiely, (Ed.), *Reproductive and Perinatal Epidemiology.* Boca Raton, FL: CRC Press.

Krous, H. (1984). The microscopic distribution of intrathoracic petechiae in sudden infant death syndrome. *Archives of Pathology and Laboratory Medicines, 108,* 77-79.

Krous, H., & Jordan, J. (1989). A necropsy study of distribution of petechiae in non-sudden infant death syndrome. *Archives of Pathology and Laboratory Medicines, 108,* 75-76.

Lauer, B., Ten Brock, E., Grossman, M. (1974). Battered child syndrome: Review of 130 patients with controls. *Pediatrics, 54,* 67.

Little, R., & Peterson, D. (1990). Sudden infant death syndrome epidemiology: a review and update. *Epidemiology Review, 12,* 241-246.

Meadow R. (1990). Suffocation, recurrent apnea, and sudden infant death. *Journal of Pediatrics, 117,* 351-357.

Meadow, R. (1977). Munchausen Syndrome by Proxy: the hinterland of child abuse. *Lancet, 2,* 343-345.

Molz, G., & Hartman, H. (1984). Dysmorphism, dysplasia, and anomaly in sudden infant death syndrome. *New England Journal of Medicine,* 311-259.

Nelson, E., Williams, S., & Taylor, B., et. al. (1989). Postneonatal mortality in south New Zealand: Necropsy data review. *Paediatric Perinatal Epidemiology, 3,* 375-385.

Newman, N. (1986). Sudden infant death syndrome in Tasmania, 1975-1981. *Australian Paediatric Journal, 22 (suppl.),* 17-19.

Norman, M., Newman, D., & Smialek, J., et. al. (1984). The postmortem examination of the abused child. *Perspectives in Pediatric Pathology, 8,* 313-343.

Peterson, D. (1988). Clinical implications of sudden infant death syndrome epidemiology. *Pediatrician, 15,* 198-203.

Peterson, D., Sabotta, E., & Daling, J. (1986). Infant mortality among subsequent siblings of infants who died of sudden infant death syndrome. *Journal of Pediatrics, 108,* 911-914.

Scott, P. (1973). Fatal battered baby cases. *Medical Science and the Law, 13,* 197.

Silverman, R. (1953). The roentgen manifestations of unrecognized skeletal trauma in infants. *American Journal of Roentgenology, 69,* 413.

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MENTAL HEALTH

Individual Treatment of the Sexually Abused Child

—by Julie A. Lipovsky and Ann N. Elliott

The current state of knowledge regarding treatment of sexually abused children is simultaneously vast and limited. The knowledge is vast as a result of the many excellent resources published by clinicians who have shared their perspectives on treatment (e.g., Berliner & Wheeler, 1987; Friedrich, 1990; Gil, 1991; James, 1989). However, the state of knowledge is limited by the lack of an empirical foundation informing the field about the effectiveness of treatment approaches for reducing behavioral, emotional, and cognitive difficulties associated with sexual abuse experiences. The discussion that follows will highlight various aspects of abuse-focused treatment that are commonly recommended by clinicians. Several controlled treatment outcome studies currently are in progress and are designed to examine empirically the efficacy of such approaches.

Assessment

Child Functioning

The list of symptoms and psychiatric difficulties found among child victims of sexual abuse is long and varied (see Beitchman, Zucker, Hood, DaCosta, & Ackman, 1991; Kendall-Tackett, Williams, & Finkelhor, 1993 for reviews). Furthermore, sexual abuse experiences are themselves quite diverse. Therefore, it is essential that specific treatment approaches be informed by a comprehensive evaluation of the child's current presenting problems, the nature of the abuse, the context in which abuse occurred, and the consequences of disclosure or discovery. The goal of the clinical assessment is not to determine whether or not the child has actually been abused. Rather, the goal is to develop a framework for understanding the behavioral, emotional, and cognitive functioning of the child within his or her current environment in order to guide the process of treatment. The assessment process is designed to identify targets for intervention as well as factors which may mediate the child's response to the abuse and which may affect the progress of treatment.

It is essential that specific treatment approaches be informed by a comprehensive evaluation of the child's current presenting problems, the nature of the abuse, the context in which abuse occurred, and the consequences of disclosure or discovery.

The effects of sexual abuse tend to occur on a continuum from neutral to negative (Friedrich, 1990), and no single syndrome has been identified as common for the majority of child victims (e.g., Beitchman et al., 1991). Therefore, a significant portion of the assessment process will be directed towards determining the impact that the abuse has had on the particular child presenting for treatment. The most commonly noted psychosocial problems among children who have been sexually abused are sexualized behaviors, anxiety, depression, poor self-esteem, general behavior problems, and Post-Traumatic Stress Disorder (PTSD; e.g., Kendall-Tackett et al., 1993). Suicidal ideation/behavior, substance abuse problems, dissociation, and faulty or maladaptive cognitions also may be present and are worthy of assessment (Berliner, 1991).

Features of the abuse experience

In addition to evaluating the child's current behavioral, emotional, and cognitive functioning, assessment focuses on the particular features of the child's sexual abuse experience. Important factors to be addressed include the nature of the relationship between child and offender, frequency and duration of abuse, level of force or threat used by the offender, and whether or not sexual penetration occurred. These factors tend to be associated with the impact of abuse (Kendall-Tackett et al., 1993). Assessment should also address whether or not the child has been exposed to other types of traumatic events or maltreatment (e.g., physical abuse, neglect, witnessing violence within the family or the community) which may affect his or her response to the sexual abuse. The context of disclosure, including familial and community responses, also potentially influences the child's adjustment. Assessment of the child's family environment and support (i.e., attitudes towards the child and the abuse) is important since research has demonstrated that maternal support mediates the effects of child sexual abuse (e.g., Everson, Hunter, Runyan, Edelsohn, & Coulter, 1989). The cultural context in which the child lives also is influential and should be examined within the assessment process.

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Sinclair-Smith, C., Dinsdale, E., & Emery, J. (1976). Evidence of duration and type of illness in children found unexpectedly dead. *Archives of Disease in Childhood, 51*, 424-428.

Smialek, J., & Lambros, Z. (1988). Investigation of sudden infant deaths. *Pediatrician, 15*, 191-197.

Stanton, A., Oakley, J. (1983). Pattern of illnesses before cot death. *Archives of Disease in Childhood, 58*, 878-881.

Steele, B. (1980). Psychodynamic factors in child abuse. In C. Kempe & R. Helfer (Eds.), *The battered child (3rd ed.)*, Chicago, University of Chicago Press, 49-83.

Taylor, E., & Emery, J. (1982). Two year study of the causes of postperinatal deaths classified in terms of preventability. *Archives of Disease in Childhood, 57*, 668-673.

Valdes-Dapena, M. (1982). The pathologist and sudden infant death syndrome. *American Journal of Pathology, 106*, 118-131.

Valdes-Dapena, M. (1992). A pathologist's perspective on the sudden infant death syndrome - 1991. *Pathology Annual, 27*, 133-164.

Variend, S., & Pearse, R. (1986). Sudden infant death and cytomegalovirus inclusion disease. *Journal of Clinical Pathology, 39*, 383-390.

Vawter, G., & Kozakewich, H. (1983). Aspects of morphologic variation amongst SIDS victims. In J. Tildon, L. Roeder, & A. Steinschneider (Eds.), *Sudden Infant Death Syndrome*. NewYork: Academic Press, 133-134.

Vawter, G., McGraw, C., & Hug, G., et. al. (1986). An hepatic metabolic profile in sudden infant death (SIDS). *Forensic Science International, 30*, 93-98.

Wallace, B. (1991). Crack cocaine: A practical treatment approach for the chemically dependent. New York: Brunner/Mazel.

Wecht, C., & Larkin, G. (1981). The battered child syndrome: A forensic pathologist's viewpoint. *Medical Trial Technical Quarterly, 28*, 1-24.

Werne, J., Garrow, I. (1953). Sudden apparently unexplained death during infancy *I: pathologic findings in infants found dead*. American Journal of Pathology, 29, 633-652.

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Information gathered during the assessment process should aid in the formulation of a treatment plan. Targets for intervention are prioritized, and strategies for intervention can then be selected.

Treatment

Common goals

While unique factors relevant to each case will provide direction and priorities for intervention, several common goals guide individual treatment with sexually abused children. First, abuse-focused treatment is designed to help the child understand the nature of the trauma and the effects that this experience has had on him or her. Second, treatment facilitates the child's ability to talk and think about the abuse without embarrassment or significant anxiety. Third, treatment addresses presenting symptoms in order to reduce the frequency and intensity of behavioral and emotional distress. Fourth, treatment fosters healthy expression of feelings about the abuse as well as about consequences of disclosure. Finally, distorted, faulty, or unhealthy cognitions are examined and modified to promote more adaptive ways of thinking about the abuse, self, and relationships. It is important to note that we view these broadly defined goals as central to individual abuse-focused treatment with children. However, additional goals are also established based upon the child's individual experience (Friedrich, 1990). For example, modification of family interactions may be warranted in order to ensure an environment that facilitates the child's healing process (e.g., Gil, 1991).

Most experts would agree that the cornerstone of treatment with child victims is the direct focus on the victimization experiences themselves....Direct approaches communicate the therapist's ability to tolerate uncomfortable issues. This may counteract the child's feelings of shame and embarrassment by modeling acceptance of the experience.

Focus on victimization

Most experts would agree that the cornerstone of treatment with child victims is the inclusion of direct focus on the victimization experiences themselves (e.g., Friedrich, 1990; Salter, 1988; Berliner, 1991; James, 1989; Gil, 1991). The therapist is active in directing the child to examine abuse-related issues, while at the same time maintaining a supportive relationship with the child. Strategies involving exploration of the abuse are expected to facilitate attainment of the treatment goals described above. Further, direct approaches communicate the therapist's ability to tolerate uncomfortable issues. This may counteract the child's feelings of shame and embarrassment by modeling acceptance of the experience (e.g., James, 1989). Treatment may utilize various modalities (e.g., traditional "talk" therapy; play therapy; drawings; puppets) to facilitate exposure to actual abuse experiences and issues associated with those experiences. It is essential that the selection of specific intervention strategies take into account the child's developmental capabilities (e.g., Lipovsky, 1992).

Direct exposure to abuse-related memories, thoughts, and feelings has most frequently been described as it relates to reducing fear, anxiety, and PTSD symptoms (e.g., Berliner & Wheeler, 1987; Deblinger, McLeer, & Henry, 1990). Both the literature on adult rape (e.g., Kilpatrick, Veronen, & Best, 1985) and child sexual abuse (e.g., Berliner & Wheeler, 1987) contain conceptualizations of assault-related fear and anxiety arising through the process of classical conditioning. Such conceptualizations posit that previously neutral cues become associated with fear and anxiety as a result of being paired with these emotions during the abuse. Thus, the presence of specific cues, including thoughts and memories of the abuse, can elicit anxiety or fear responses. Children then frequently avoid abuse-related thoughts and memories in order to reduce their experience of emotional discomfort (Deblinger et al., 1990).

Direct focus on abuse experiences encourages the child to approach uncomfortable memories, thoughts, discussions, and feelings in the absence of objective threat (Deblinger et al., 1990). This strategy is intended to enable the child to disconnect the association between specific abuse-related cues and emotional discomfort and with a subsequent reduction of distressing symptoms. This in turn diminishes the child's need to avoid thoughts and feelings related to abuse experiences and allows for an integration of the experience(s). Discussion of the sexual abuse can also reveal important cues present during the abuse itself that may trigger anxiety or other emotional responses (Berliner & Wheeler, 1987). Finally, focusing on the victimization assists the child in accepting the reality that abuse has occurred (e.g., James, 1989).

Cognitive interventions with abused children also support the use of approaches which focus directly on victimization. A long list of cognitive issues and themes has been identified as theoretically important to the functioning of children who have been sexually abused. Among these are the traumagenic dynamics of betrayal, powerlessness, stigmatization, traumatic sexualization (Finkelhor & Browne, 1985), guilt, self-esteem (e.g., Porter, Blick, & Sgroi, 1982), and attributions of responsibility and blame (e.g., Wolfe, Gentile, & Wolfe, 1989).

Direct focus on the victimization allows the therapist to determine whether particular abuse-related themes are relevant to the child and the context in which faulty beliefs developed. Therapist inquiry also clarifies children's understanding of the abuse and their reactions to it, about the offender and his or her behaviors, and about the abuse itself. Furthermore, talking about the abuse can reveal inaccurate or maladaptive cognitions, particularly those related to self-blame and responsibility. Accurate information regarding the process of victimization (Berliner & Conte, 1990), sexuality, and the development of symptoms can be provided to challenge incorrect beliefs. However, cognitive processing involves more than mere challenges to faulty thinking. The bases for beliefs should be examined and cognitive processing occurs by exploring alternatives to unhealthy assump-

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tions (Berliner, 1991).

Abuse-focused treatment also is ideally suited to promote emotional processing of the child's experiences. In addition to fear and anxiety, sexually abused children may experience anger, sadness, shame (Porter et al., 1982), and sexual feelings (Berliner, 1991) related to their abuse. Exposure not only stimulates feelings and permits emotional expression and processing, it also provides important information regarding the particular experiences which influence such reactions. The child can be directed to describe feelings experienced at the time of the abuse as well as current emotional reactions. This should facilitate identification, labeling, and ventilation of painful affect. Appropriate means for expressing discomforting feelings can be explored and practiced within the therapeutic process.

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Assessing the child's readiness

Thus far, we have discussed reasons for utilizing interventions which focus directly on abuse experiences rather than techniques which expose children to abuse-related stimuli. Direct focus on victimization can evoke strong emotional reactions in children. Therefore, children and caregivers may be reluctant to participate in treatment due to a belief that it would be best for children simply to "put the abuse experiences behind them." However, because exposure to abuse-related material is a central part of treatment, it is essential to provide a rationale to both children and caregivers for incorporating such approaches (Friedrich, 1990). Much of the above discussion can be tailored to children and caregivers using nontechnical language.

It is essential that the therapist assess the child's ability to tolerate exposure to abuse-related material and be sensitive to issues of psychological safety....Children may communicate their distress verbally or behaviorally and the clinician should respect the child's need to distance him or herself from abuse-related issues if the process of therapy becomes emotionally overwhelming.

In addition to providing the child with information about the process of therapy, it is essential that the therapist assess the child's ability to tolerate exposure to abuse-related material (Friedrich, 1990) and be sensitive to issues of psychological safety (e.g., MacFarlane & Krebs, 1986). Thus, exposure generally progresses at a gradual pace (Deblinger et al., 1990), with the therapist continually monitoring the child's emotional reactions. Children may communicate their distress verbally or behaviorally and the clinician should respect the child's need to distance him or herself from abuse-related issues if the process of therapy becomes emotionally overwhelming. With highly anxious or avoidant children the exposure process can begin with indirect discussion of abuse issues, including using books about sexual abuse, asking the child how other abused children might feel, or talking about peripheral issues rather than central ones. Other approaches may involve setting time limits on abuse-focused work (eg., Friedrich, 1990) or beginning with minimally distressing topics and gradually increasing the time or intensity of involvement. Reasons for avoidance should be identified and addressed directly when they interfere with the child's ability to process abuse-related materials (e.g., Lipovsky, 1992).

Specific anxiety reduction strategies can be taught and implemented to facilitate abuse-focused therapy and to empower the child (e.g., Berliner, 1991). Skills such as relaxation, deep breathing, and guided imagery (e.g., Berliner & Wheeler, 1987) are important tools for children to employ in managing their emotional distress. Cognitive strategies, including mediated self-talk (e.g., Deblinger et al., 1990), thought stopping, and covert rehearsal (e.g., Berliner, 1991) also can facilitate the child's ability to cope with uncomfortable feelings.

Other treatment approaches

While direct exposure to victimization experiences will comprise the bulk of abuse-focused treatment, it generally is not, in and of itself, sufficient to meet all goals of intervention with sexually abused children. For example, many of the behavioral problems that sexually abused children display are best understood from a social learning perspective, and may require behavior management strategies for amelioration (Berliner & Wheeler, 1987). Such strategies identify contingencies within the child's environment which may serve to reinforce undesirable behaviors, or punish desirable ones. Careful monitoring of the conditions under which behaviors occur and subsequent alteration of the environmental contingencies may be required to intervene. It is important to stress the importance of maintaining a broad perspective when working with sexually abused children, and of recognizing that abuse-focused work may be only one component of treatment. Further, there may be situations within which exposure to the victimization itself may not be a priority for intervention. First, circumstances surrounding disclosure must be managed and the child's living situation stabilized prior to initiating abuse-focused work. If the child does not have the support of a nonoffending parent and/or is in out-of-home placement, it may be necessary to focus initially on those issues rather than on the sexual abuse itself. Second, if the child's physical safety needs are not currently being met, abuse-focused treatment may be difficult or contraindicated. Children require an environment in which they are protected from the perpetrator and are receiving emotional support to be able to tolerate abuse-focused treatment. Third, it is important to recognize the possibility that sexual abuse is not the most disruptive experience in the child's life. Therefore, assessment should determine how to prioritize issues to target within the overall treatment.

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Conclusion

This article described the rationale and conduct of abuse-focused treatment. Many issues were not addressed explicitly, including the importance of involving caregivers in treatment (see Cohen & Mannarino, 1993; Deblinger, 1992), attending to developmental issues, incorporating instruction in prevention skills (e.g., Deblinger et al., 1990), and interventions directed towards the family (e.g., Berliner, 1991). Many of the references cited in this article will serve as useful resources for the interested reader.

It is important to stress the importance of maintaining a broad perspective when working with sexually abused children, and of recognizing that abuse-focused work may be only one component of treatment. Further, there may be situations within which exposure to the victimization itself may not be a priority for intervention.... Assessment should determine how to prioritize issues to target within the overall treatment.

In conclusion, most clinical descriptions of therapeutic intervention with sexually abused children emphasize the importance of direct focus on the victimization itself. There are several theoretical rationales to support this type of intervention. Currently, several controlled outcome studies are examining the efficacy of treatment approaches that incorporate exposure techniques, instruction in the use of stress management skills, and cognitive processing (e.g., Berliner & Saunders, 1992). The challenge for the field will be to continue to design and implement research studies such as these to evaluate the effectiveness of treatment approaches for sexually abused children.

References

Beitchman, J.H., Zucker, K.J., Hood, J.E., DaCosta, G.A., & Ackman, D. (1991). A review of the short- term effects of child sexual abuse. *Child Abuse and Neglect, 15*, 537-556.

Berliner, L. (1991). Clinical work with sexually abused children. In C.R. Hollin & K. Howells (Eds.). *Clinical Approaches to Sex Offenders and Their Victims*. New York: Wiley.

Berliner, L., & Saunders, B.E. (1992, January). Treating fear and anxiety in sexually abused children: Preliminary results. Presentation at the San Diego Conference on Responding to Child Maltreatment, San Diego, CA.

Berliner, L., & Conte, J.R. (1990). The process of victimization: The victims' perspective. *Child Abuse and Neglect, 14*, 29-40.

Berliner, L., & Wheeler, J.R. (1987). Treating the effects of sexual abuse on children. *Journal of Interpersonal Violence, 2*, 415-434.

Cohen, J.A., & Mannarino, A.P. (1993). A treatment model for sexually abused preschoolers. *Journal of Interpersonal Violence, 8*, 115-131.

Deblinger, E. (1992). Child sexual abuse. In A. Freeman & F.M. Dattilio (Eds.). *Comprehensive Casebook of Cognitive Therapy*, New York: Plenum Press, pp. 159-167.

Deblinger, E., McLeer, S.V., & Henry, D. (1990). Cognitive behavioral treatment for sexually abused children suffering post-traumatic stress: Preliminary findings. *Journal of the American Academy of Child and Adolescent Psychiatry, 29*, 747-752.

Everson, M.D., Hunter, W.M., Runyan, D.K., Edelsohn, G.A., & Coulter, M.L. (1989). Maternal support following disclosure of incest. *American Journal of Orthopsychiatry, 59*, 197-206.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry, 55*, 530-541.

Friedrich, W.N. (1990). *Psychotherapy for Sexually Abused Children and their Families*. New York: W.W. Norton.

Gil, E. (1991). *The Healing Power of Play: Working with Abused Children*. New York: Guilford.

James, B. (1989). *Treating Traumatized Children: New Insights and Creative Interventions*. Lexington, MA: Lexington Books.

Kendall-Tackett, K.A., Williams, L.M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychology Bulletin, 113*, 164-180.

Kilpatrick, D.G., Veronen, L.J., & Best, C.L. (1985). Factors predicting psychological distress among rape victims. In C.R., Figley (Eds.), *Trauma and Its Wake*. New York: Brunner/Mazel, pp. 113-141.

Lipovsky, J.A. (1992). Assessment and treatment of post-traumatic stress disorder in child survivors of sexual assault. In D. Foy (Ed.). *Treating PTSD*. New York: Guilford Press, pp. 127-164.

MacFarlane, K., & Krebs, S. (1986). Techniques for interviewing and evidence gathering. In K. MacFarlane & J. Waterman (Eds.). *Sexual Abuse of Young Children: Evaluation and Treatment*, pp. 67-100.

Porter, F., Blick, L., & Sgroi, S. (1982). Treatment of the sexually abused child. In S. Sgroi (Ed.). *Handbook of Clinical Intervention in Child Sexual Abuse*. Lexington, MA: D.C. Heath, pp,. 109-146.

Salter, A.C. (1988). *Treating Child Sex Offenders and Victims: A Practical Guide*. Newbury Park, CA: Sage.

Wolfe, V.V., Gentile, D., & Wolfe, D.A. (1989). The impact of sexual abuse on children: A PTSD formulation. *Behavior Therapy, 20*, 215-228.

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New Series of Articles to Begin

Editors of *The APSAC Advisor* are pleased to announce that a new series of articles on cultural issues in child maltreatment begins in this issue. The series will address such topics as the rationale for cultural competence, a research agenda for improving our knowledge base on the effects of cultural variables, and techniques for enhancing one's own cultural awareness. Veronica Abney, MSW, a member of APSAC's Board of Directors and SCAN Team Coordinator at UCLA's Neuropsychiatric Institute, will serve as Associate Editor for the series.

To date, cultural issues in child maltreatment have been addressed in *The APSAC Advisor* primarily through the work of the People of Color Leadership Institute (POCLI), headed by Joyce Thomas, RN, MPH. We have been very happy to be the "home" for the POCLI section thus far. POCLI will continue to publish its own work periodically, in tandem with the new series.

We are delighted to be able to offer a wealth of resources on this important topic. Please let us know how this or any other aspect of *The APSAC Advisor* can be most helpful to you.

CULTURE
A Rationale for Cultural Competency

—by Veronica D. Abney and Karen Gunn

Introduction

Within many segments of human services, cultural competency has been acknowledged as a critical element of professional expertise. Many professionals remain confused, however, about some of the basic assumptions underlying thequest for cultural competence and terms used to address the issues. In this first article in an ongoing series on the topic of cultural competence to be published in *The APSAC Advisor*, we will take a brief historical look at various cultural perspectives in the social sciences, define the meaning and usefulness of terms such as "race," "ethnicity," and "culture," address the rationale for cultural competency, and offer a description of cultural competency at both the clinical and organizational level.

Historical overview

Historically, the role of culture has been viewed from various perspectives. Early theories based in the biological sciences focused on the purported genetic inferiority of non-white peoples. This "scientific racism" (Thomas and Sillen, 1972) has been widely espoused: the distinguished American psychologist, G. Stanley Hall (1904), contended that Africans, Indians, and Chinese were members of "adolescent races" and not fully mature; Lewis Terman, adapter of the Stanford-Binet Intelligence Test, claimed in 1916 that Spanish-Indians and Mexicans were ineducable; recently, Arthur Jensen (1969) and William Shockley (1966) have argued that African Americans have genetically lower IQs.

"Culture" is a set of beliefs, attitudes, values and standards of behavior which are passed from one generation to the next. It is what everybody knows that everybody else (like you) knows.

The "cultural deviance" model takes as normative the patterns and values of white middle-class culture and sees any digression from those norms as pathological (Gibbs, 1991). In the 1960's, this model evolved into the "cultural deprivation" model, in which cultural differences are ascribed to the effects of oppression, poverty, and discrimination. A well-meaning effort to reject these deficit models and to focus more on human similarities than on cultural differences is seen in the argument that we should be "color blind" (Thomas and Sillen, 1972). Unfortunately, this "cultural equivalence" model is insensitive as well (Karno, 1966), insofar as it blinds people to important cultural features related to historical, social, and political experiences—features which are essential to seeing the world from another's point of view.

The "cultural variant" model (Allen, 1978) helps us approach the worldview of a particular culture from within a broader cross-cultural base (Korbin, 1981). It avoids ethnocentrism by not taking any one culture as the standard against which others are judged: it sees different cultural practices as belonging to a unique context which is best understood from within. Yet it avoids cultural relativism as well (the perspective that *any* value judgement about cultural practices is ethnocentric) by acknowledging that some cultural practices—such as infibulation, foot binding, and coining—are destructive. Cultures legitimately vary in their means of meeting universal human needs, such as those for food, clothing, shelter, affiliation, safety, order, procreation, and attachment. Yet value judgements can be made based upon how well or poorly certain practices address these universal human needs. In addition to cultural variations, individuals within any culture may deviate from cultural norms and behave in ways which are clearly harmful to children. By combining an appreciation of legitimate cross-cultural variations in nurturing child-care practices with a theoretical basis for making value judgements that protect children from harm, the cultural variant model is the core of cultural competence.

"Race," "ethnicity," "culture": What's what?

The terms "race," "ethnicity," and "culture" are often used interchangeably, and are defined in various ways by anthropologists, ethnologists, psychologists, sociologists, and the people the terms are meant to describe. This confusion impairs communication, and needs to be addressed directly. Racial classifications (i.e., negroid, caucasoid, and mongoloid) refer to common ancestry and genetic physical characteristics (e.g., skin color, hair type, eye shape and color, lip shape). These three categories, while broadly useful, may "ignore or obscure considerable internal diversity within each group" (Yetman, 1991, p. 9) which arises from interracial breeding.

"Ethnicity" is a term that has gained more frequency in recent years. The common definition of "ethnic group" is a sociological one, "a group of people of the same race or nationality who share a common and distinctive culture" (Random House, 1968). However, in common usage "ethnicity" is frequently used to refer only to race, nationality, and land of origin, ignoring the important variable of culture. The U.S. Census Report classifies the population by both race and ethnicity using the following categories: African American, Asian/Pacific Islander, Hispanic, Alaskan/Aleutian and White. These classifications mute the cultural "subgroups" with various religious, linguistic, and historical backgrounds. For example, the category of Asian-Pacific Islander includes Filipinos who, as a result of colonization by Spain, may have Spanish surnames and practice Catholicism. Some argue that although this group resides in the Pacific Islands, they require a separate category which better distinguishes their unique language and lineage. Such important distinctions are what bring us to considerations of "culture."

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guage, worldview, dress, food, styles of communication, notions of wellness, healing techniques, child rearing patterns, and self-identity. Racial and ethnic classifications *might* tell us what someone looks like and where they are from, but tell us nothing about the important cultural factors we need to consider when trying to diagnose and treat child abuse and neglect.

A final term that must be addressed is "people of color." This term has largely political significance, and is meant to unite all non-white people. It focuses on color as a significant social factor in the U.S. because most people of color have experienced oppression throughout the history of this nation. This fact has an impact on virtually all of our cross-cultural interactions, and the term "people of color" highlights this political and social reality.

Rationale for cultural competency

In brief, cultural competence is the ability to share the worldview of your clients (or peers) and adapt your practice accordingly. If that sounds familiar, it should: cultural competence is, at base, the ideal of good social work practice. In order best to help people, professionals must understand the world from their clients' point of view, provide the help that is really needed, and provide it in a form in which it can be used. The contemporary urgency about cultural competence is a response to three major factors now at work in the U.S.: (1) the increasing cultural diversity of the U.S. population, (2) the underrepresentation of professionals from diverse backgrounds in the helping professions, and (3) inadequate delivery of social and mental health services to maltreated children of color. Before more specifics about these factors are offered, an important caveat must be aired: cultural competence is not just for those from the majority culture. Few professionals of *any* color are adequately trained to work cross-culturally.

In brief, cultural competence is the ability to share the worldview of your clients (or peers) and adapt your practice accordingly. If that sounds familiar, it should: cultural competence is, at base, the ideal of good social work practice. In order best to help people, professionals must understand the world from their clients' point of view, provide the help that is really needed, and provide it in a form in which it can be used.

The increasing cultural diversity in the U.S.

The United States has experienced a tremendous increase in diversity over the last decade, as immigration from Asia, Europe, and Central and South America has increased and birthrates among some groups have risen rapidly. The 1990 U.S. Census reveals that nearly one in four Americans are people of color, reflecting the largest change in racial and ethnic composition in any one decade during the 20th century. By some estimates, between now and the year 2000 the Latino population will increase by 21 percent, the Asian-Pacific Islander population by about 22 percent, the Black population by almost 12 percent, and Whites by a little more than two percent (Henry, 1990). Given this rate of growth in U.S. diversity, if our policies and clinical practices are not culturally sensitive, the needs of maltreated children will not be well served.

Underrepresentation of professionals from diverse backgrounds

While people of color are overrepresented in the criminal justice and child protective service populations (see below), professionals of color appear to be underrepresented in those workforces. Statistics on this matter are unavailable, but professional consensus based on observation and experience is that professionals of color in these systems are scarce, particularly at upper levels. This shortage may reflect a number of factors: undergraduate and graduate programs in relevant areas may not adequately recruit and retain students of color; hiring and promotion practices are still discriminatory in some areas; and qualified candidates of color may be being lured away by increased opportunities, since the 1960s, to enter a wider range of professions.

The relative scarcity of professionals of color in these fields is not a problem that can be solved easily or quickly. It is also, however, not the whole solution. Although there will always be clients who desire an ethnic match, this is not always feasible nor is it always a client's choice. The idea that being a member of a particular ethnic group makes one automatically cognizant of and sensitive to cultural issues is a myth. Within each cultural group, there is much heterogeneity resulting from varying levels of assimilation, acculturation, and socio-economic status. The match or fit which we must aim for is one that derives from expanding our worldview and increasing our empathy for those who are different from us. The bottom line is that, as increasing numbers of people of color enter the social service system, an increasing percentage of professionals serving them must be able to respond to their needs in a culturally informed and sensitive manner.

Inadequate delivery of social and mental health services

The failure of professionals to be culturally competent is reflected in a number of ways in the delivery of social and mental health services. One consequence of this failure may be the overrepresentation of children of color in the child protection system. The American Humane Association (AHA) national data for 1990 on substantiated reports of child maltreatment indicate that the ethnic diversity of children in the system is far greater than that found in the nation (Working Paper Number 1, 1990) (see Table 1). For instance, African-Americans and Native Americans represent 12% and 0.8% of the American population, respectively, yet represent 24% and 1.7% of substantiated child abuse reports—double their representa-

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tion in the general population. In sharp contrast, Whites and Asian/Pacific Islanders represent 80% and 3% of the population, respectively, but only 56% and 0.8% of substantiated child maltreatment reports. Hispanic children are about equally represented in substantiated reports and in the general population. These substantiation rates may be affected by many factors, including sampling biases and other research limitations, and the behavior of those being reported, as well as professionals' perceptions. Racial and ethnic stereotypes, poverty, drugs, and social factors such as the use of physical discipline may leave African Americans and Native Americans more vulnerable to reporting and subsequent substantiation. In contrast, lower rates of substantiated reports for Asian American children may not be due just to a lower incidence of child abuse in these communities but to professionals' stereotypes regarding Asian "passivity" and the view of Asians as the "model minority" (Sue & Sue, 1990, 192).

The idea that being a member of a particular ethnic group makes one automatically cognizant of and sensitive to cultural issues is a myth. Within each cultural group, there is much heterogeneity resulting from varying levels of assimilation, acculturation, and socio-economic status. The match or fit which we must aim for is one that derives from expanding our worldview and increasing our empathy for those who are different from us.

While not definitive evidence by any means of cultural stereotyping, this disproportionate substantiation rate raises concerns about the cultural competence of professionals in the field of child protection. This concern is only reinforced by data on the delivery of social and mental health services.

As child abuse professionals, we are all concerned that social and mental health services be delivered in the most efficacious manner. Unfortunately, there is much evidence indicating that services for clients of color are inadequate.

Table 1

Comparative rates of substantiated child abuse reports and US population by ethnicity, 1990

Percentage	African American	Asian Pac. Islander	Nat. American	Hisp.	White	Unknown Other
US Census Report *	12.10	2.9	.80	9.00	80.3	4.00
Substantiated Reports AHA	24.44	.81	1.65	8.45	55.91	8.74

* Total exceeds 100% due to an individual's possible inclusion in multiple categories.

In a series of research studies done by Sue and associates in 1974 and 1975, it was revealed that 50% of people of color terminate treatment after just one contact with the mental health system as compared to a rate of 30% for whites (Sue & Sue, 1990). The primary reasons cited were the lack of non-white staff, the traditional way in which services were delivered, poor response to education and vocational needs of clients, and an antagonistic response to culture, class, and language variables (Sue & Sue, 1990).

Reviewing the evidence on the fate of families of color in public social service systems, one researcher concluded, "Once children and families of color enter child welfare systems, there is evidence which indicates differential treatment with regard to what services are provided, both in terms of quantity and quality" (Harris, 1990). A 1980 study indicates that assessment and intervention is "harsher" for families of color (Close, 1980). Another study cites higher rates of out-of home placements for children of color than for Anglo children, different and more restrictive referral and diagnostic patterns for African American children, and a disproportionate number of these children in less desirable placements (Stehno, 1982). In Los Angeles County the rate of African American children going into the system is four times higher than that for whites (Swinger, 1993). Nationally, 50% of children in out-of-home care are children of color, although they comprise only 20% of the population (Keys, 1991).

Poverty may play as great a role as child maltreatment in affecting these disproportionate numbers, for people of color are also disproportionately poor. Impoverished people are more dependent upon publicly funded social and mental health systems which, when not culturally competent, can result in their being over-scrutinized and misunderstood. Additionally, poor people are often powerless to deal with these massive governmental systems.

Aspects of cultural competency

To be fair to their clients, the systems meant to protect American children should be culturally competent. Systematic cultural competence means that culture and its influence are respected, understood and taken into account at all levels of service delivery, from the individual practitioner to the program, agency, organizational, and legislative levels. At each level, three aspects of cultural competency to be attained are **value base, knowledge,** and **methods.**

A sensitive **value base** regards cultural

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compentency as a critical focal point for professional development. It respects the following:

- That difference is not synonymous with pathology or deviance.
- That cultural difference creates dynamics that can, handled well, produce entirely positive learning experiences for all parties involved.
- That individual and institutional biases systematically affect perceptions, and that myths and stereotypes may control our interactions with others.
- That empowerment for the disenfranchised is a goal.

Knowledge is the second key aspect of cultural competency. Culturally competent professionals and systems must have a phenomenological understanding of the following factors:

- The influence of culture on perceptions, behaviors, interactions, expectations and modes of communication.
- The history of racism and oppression and the individual's response and adaptation to it.
- The client's culture (e.g., child rearing practices, sex roles, family structure, religious beliefs), community characteristics, and level of acculturation or assimilation.
- The impact of social class on the client's experience.

The contemporary urgency about cultural competence is a response to three major factors now at work in the U.S.: (1) the increasing cultural diversity of the U.S. population; (2) the underrepresentation of professionals from diverse backgrounds in the helping professions, and (3) inadequate delivery of social and mental health services to maltreated children of color.

In addition, professionals must have access to unbiased theories and data sets pertaining to child maltreatment in communities of color, and must be familiar with universal criteria of child abuse that take into account the physical and emotional harm done to a child, the parent's intentions, and socialization goals of the culture (Korbin, 1981).

The **methods** used in professional practice, research, and the development of human resources comprise the third aspect of cultural competency.

- Professionals must develop the ability to diagnose, determine and adapt clinically to culturally based values, viewpoints, attitudes and behavior patterns.
- Researchers must push to improve and expand current research practices and data bases.
- Professionals must work together toward the development of resources at all levels for clients of color and the practitioners, administrators, and private and federal funders who work with them.
- Professionals should work with communities to create and build on indigenous systems of support.
- Professionals should insist that cultural competence be an integral part of professional training programs and practice standards.
- Professionals need to develop tools to assess cultural competence at all levels.

Conclusion

Social service delivery for children and families of color has suffered from a lack of cultural awareness, acceptance, and competence. The increasing diversity of the U.S. population is a challenge and an opportunity for every American. The challenge is to incorporate so many dramatic demographic changes in so short a period of time. The opportunity is to derive maximum benefit from the richness of perspectives and experience that diversity provides. If we seize the opportunity presented, we can create positive, essential change in our effectiveness as individuals and systems. Cultural competence must be regarded as a standard professional skill, supported by valid theoryand knowledge base. By embracing the need for cultural competence in our workplace, professionals in the field of child maltreatment can be in the vanguard for the nation as a whole as we strive to make our increasing diversity a gift to all.

References

Allen, W. R. (1978). The search for applicable theories of Black family life. *Journal of Marriage and the Family, 40,* 117-129.

Close, Mary M. (1980). *Child welfare and people of color: Denial of equal access.* Quoted in, Harris, N. (1990). Dealing with diverse cultures in child welfare. *Protecting Children, 7* (3), 6-7.

Gibbs, J. T. (1991). Developing intervention models for Black families: Linking theory and research. In H. E. Cheatham & J. B. Stewart (Eds.), *Black families: Interdisciplinary perspectives* (New Brunswick, NJ: Transaction Publishers).

Hall, G. S. (1904). *Adolescence.* New York: Appleton.

Harris, N. (1990). Dealing with diverse cultures in child welfare. *Protecting Children, 7,* 6-7.

Henry, W.A. III (1990). Beyond the melting pot. *Time.* April 9.

Jensen, A. R. (1969). How much can we boost IQ and scholastic achievement? *Harvard Educational Review, 39,* 1-123.

Kamo, M. (1966). The enigma of ethnicity in a psychiatric clinic. *Archives of General Psychiatry, 14,* 516-520.

Keys, H. (1991). "The CWLA cultural responsiveness initiative: A status report, *The Advisor, 4,* 3, 12-13.

Korbin, J. (1981). *Child abuse and neglect: Cross-cultural perspectives.* Berkeley: University of California Press.

Random House Dictionary (1968). *Random House Dictionary of the English Language: College Edition.* New York: Random House.

Shockley, W. (1966). Possible transfer of metallurgical and astronomical approaches to the problem of environment versus ethnic heredity. Quoted by Birch, H.G. in Mead et al., (Eds.) 1968. *Science and the concept of race* New York, NY Columbia University Press.

Stehno, S.M. (1982). Differential treatment of minority children in service systems. *Social Work, 27* (1):39-46.

Sue, D. W. & Sue, D. (1990). *Counselling the culturally different: Theory and practice.* New York: John Wiley and Sons, Inc.

Swinger, H. (1993). Cross cultural considerations in working with African American families. Presentation at the San Diego Conference on Responding to Child Maltreatment. La Jolla.

Terman, L. M. (1916). *The measurement of intelligence.* Boston: Houghton, Mifflin.

Thomas, A. & Sillen, S. (1972). *Racism and psychiatry.* New York: Brunner-Mazel.

Working Paper Number 1 (1990). *Summary data component.* Washington, D. C.: National Center on Child Abuse and Neglect-NCANDS Project April 1992.

Yetman, N. R. (1991). Introduction: Definitions and perspectives. In N.R. Yetman (Ed.), *Majority and minority: The dynamics of race and ethnicity in american life.* Needam Heights, MA: Allyn and Bac

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CULTURE
Cultural Diversity and Child Maltreatment

—by Jill Korbin

The cultural component of child maltreatment is experiencing a resurgence of interest and attention, largely stimulated by increasing recognition of the necessity of cultural competence for successful and equitable child protection. The worldwide record informs us that all cultures have standards for acceptable and unacceptable treatment of children, and that some individuals in all cultures either violate these standards or are at risk of violating them.

The challenge of cultural competence in child protection is to encompass cultural diversity while also ensuring equitable standards of care for all children. The issue of cultural competence evokes strong and deeply-held beliefs about how best to serve a multicultural population. Much of the literature that has informed policy and practice concerning culture and child maltreatment is problematic and contradictory. The purpose of this brief review is to summarize some of the major issues.

The challenge of cultural competence in child protection is to encompass cultural diversity while also ensuring equitable standards of care for all children.

"Ethnic competence" is a term first used by anthropologist James Green (1978; 1982). Ethnic or cultural competence demands more than cultural awareness and sensitivity, even though these qualities are the necessary starting point for competence. Competence requires a set of skills and knowledge that must be learned and that can be applied across cultural contexts. Cultural competence also has become associated with the idea of empowering ethnically diverse populations.

Culturally-informed definitions of maltreatment:

Definitional issues are the linchpin around which other issues in child protection revolve. The lack of clear and precise definitions has hampered research and practice efforts in child maltreatment, and is all the more complex with the addition of culture. While all cultures have parameters and standards for child care, all cultures do not define optimal or deficient care in precisely the same way. Attempts to establish universal definitions of child abuse and neglect have again and again hit the brick wall of cultural differences.

While all cultures have parameters and standards for child care, all cultures do not define optimal or deficient care in precisely the same way. Attempts to establish universal definitions of child abuse and neglect have again and again hit the brick wall of cultural differences.

The literature on culturally-informed definitions of child abuse and neglect has been of three major types. First, theoretical constructions have been offered that stress the importance of distinguishing between cultural beliefs and practices and individual deviant behavior (e.g., Korbin, 1987a). Second, studies of cultural groups have stressed the diversity of conceptions of abusive behavior and the potential for misunderstanding (Gray & Cosgrove, 1985). And third, vignette research (Giovannoni & Becerra, 1979; Hong & Hong, 1991), has examined cultural (and professional) judgements of the seriousness of hypothetical incidents.

The practical import of culturally-informed definitions is to ensure that cases of maltreatment are identified without bias. Poor and non-white families in impoverished neighborhoods are at greater risk of being reported for child maltreatment than are white families in more affluent neighborhoods (Hampton & Newberger, 1985; Wolock, 1982). When some children are in danger of being overidentified and others of being underidentified, neither population is well-served. Cultural or ethnic competence can help to ensure that maltreatment is not misidentified as culture and that culture is not misidentified as maltreatment.

Culturally-informed definitions of culture and ethnicity

A major difficulty in sorting out what is abusive within a cultural context is the fact that cultures are not homogeneous and are constantly changing. Ethnic and racial categories are not one and the same. Within each of the commonly-used categories of "Hispanic-Latino," "African-American," "Euro-American," and "Asian/Pacific Islander" are a multitude of cultures with distinctive characteristics. These populations may have different profiles of maltreatment (Ima & Hohn, 1993) and distinctive therapeutic needs (McGoldrick et al., 1982). Further, within any ethnic group, there is substantial variability by age, gender, education, socioeconomic status, and immigration and acculturative history.

Incidence and prevalence

There is little empirical basis to indicate that any cultural, ethnic, or racial group in the United States has greater rates of child maltreatment than any other. Contradictory results of studies reflect methodological inadequacies in study design, bias in reporting, and entanglement of culture with poverty and socioeconomic status.

Neither of the national incidence studies (NCCAN, 1981, 1988) has found a significant relationship between race and the type or severity of maltreatment. While some studies have found African-Americans and other ethnic populations to be overrepresented in official reports of abuse (Jason et al., 1982; Lauderdale et al., 1980), others have found that ethnically diverse populations are represented in equal proportions to their representation on AFDC (Horowitz & Wolock, 1981), suggesting a stronger link to poverty than to race. An important early study by Giovannoni and Billingsley (1970) found that across ethnic groups it is the poorest of the poor who neglect. Further, self-reports of violent behaviors towards children also found low socioeconomic status to be a risk factor (Straus, Gelles, & Steinmetz, 1980; Gelles & Straus, 1988).

Incidence and prevalence studies have not disaggregated socioeconomic status and cultural, ethnic or racial identity in rates of reported child maltreatment. A critical problem is that the search has nevertheless

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ensued for cultural factors that are related to maltreatment. This search has been largely speculative. With rare exception, studies do not link specific cultural beliefs or practices to higher rates of maltreatment.

Cultural differences in the incidence and prevalence of child sexual abuse also have not been demonstrated (Finkelhor, 1984; Russell, 1986; Wyatt, 1985). Nevertheless, clinically-relevant ethnic differences have been identified (Ahn & Gilbert, 1992; Rao et al., 1992).

Ethnic or cultural competence demands more than cultural awareness and sensitivity, even though these qualities are the necessary starting point for competence. Competence requires a set of skills and knowledge that must be learned and that can be applied across cultural contexts.

Is culture causal?

Nowhere is child maltreatment normative, by that culture's definitions. Culture cannot be causal of child maltreatment in and of itself or, logically, all members of a culture would maltreat. Rather, the field would benefit from a more focused and careful analysis of the balance of cultural risk and protective factors and an analysis of which individuals in which cultures maltreat their children (Korbin, 1987a, 1987b). However, it is worth noting that anthropologists are critically examining cultural relativism and whether all cultures are truly adaptive for all of their members (Edgerton, 1992).

Implications for practice

What, then, are some implications for culturally competent work?

Approach culture as an interested learner. Considering the multitude of cultures in the U.S., it is not feasible to demand that every worker or agency have complete knowledge of all populations. Further, cultures are in a near- constant state of change, and there is a substantial intracultural variability. Regardless of how much one knows about a culture in general, each individual should be treated as potentially unique and not by a formula that may be based in stereotypes. The helping professions, then, need to approach their clients as teachers about their cultures.

Understand culturally appropriate communication strategies. In the role of a learner, attention must be directed towards culturally appropriate verbal and nonverbal communication styles. Aversion of eye contact, for example, does not mean lack of attention in many groups. Language barriers do not necessarily lend themselves to simple solutions. The use of an interpreter, for example, in a small, closely-knit community may increase clients' distress by violating privacy and making their shame public.

Promote a difference rather than a deficiency model of culture. Cultures legitimately vary in their childrearing beliefs and practices. Rather than an ethnocentric stance that one pattern of child care (middle-class white) is the standard towards which all other cultures should aspire, practices of other cultures should be viewed as different rather than deficient as long as they do not harm children.

Do not assume that behavior harmful to children can be explained away by culture. Understand each culture's acceptable continuum of behavior and differentiate culturally acceptable practices from individual deviance in those practices.

Understand each culture's history of and current relations with the dominant culture of service provision. Suspicion and distrust of "the system" may preclude reports of maltreatment or cooperation with the child protection agencies even if by cultural standards the child has been treated poorly (Long, 1986).

Selected References

Ahn, H., and Gilbert, N. (1992). Cultural diversity and sexual abuse prevention. *Social Service Review*, September, 410-427.

Edgerton, R. (1992). *Sick societies: Challenging the myth of primitive harmony*. New York, NY: Free Press.

Finkelhor, D. (1984). *Child sexual abuse: New theory and research*. New York, NY: Free Press.

Garbarino, J., and Ebata, A. (1983). The significance of cultural and ethnic factors in child maltreatment. *Journal of Marriage and the Family, 45*, 4, 773-783.

Gelles, R., and Straus, M. (1988). *Intimate violence*. New York, NY: Simon and Schuster.

Giovannoni, J., & Becerra, R. (1979). *Defining child abuse*. New York, NY: Free Press.

Giovannoni, J., & Billingsley, A. (1970). Child neglect among the poor: A study of parental adequacy in families of three ethnic groups. *Child Welfare, 49*, 4, 196-204.

Gray, E., & Cosgrove, J. (1985). Ethnocentric perception of childrearing practices in protective services. *Child Abuse and Neglect: The International Journal, 9*, 3, 389-396.

Green, J. (1978). The role of cultural anthropology in the education of social service personnel. *Journal of Sociology and Social Welfare, 5*, 214-229.

Green, J. (1982). *Cultural awareness in the human services*. Englewood Cliffs, NJ: Prentice-Hall.

Hampton, R., and Newberger, E. (1985). Child abuse incidence and reporting by hospitals: Significance of severity, class, and race. *American Journal of Public Health, 75*, 1, 45-48.

Hong, G., and Hong, L. (1991). Comparative perspectives on child abuse and neglect: Chinese versus hispanics and whites. *Child Welfare, 70*, 4, 463-475.

Horowitz, B., and Wolock, I. (1981). Material deprivation, child maltreatment, and agency interventions among poor families. In L. Pelton, (Ed.), *The social context of child abuse and neglect*. New York, NY: Human Sciences Press.

Ima, K., and Hohm, C. (1991). Child maltreatment among Asian and Pacific Islander refugees and immigrants: The San Diego case. *Journal of Interpersonal Violence, 6*, 3, 267-285.

Korbin, J. (Ed.) (1981). *Child abuse and neglect: Cross-cultural perspectives*. Los Angeles, CA: University of California Press.

Korbin, J. (Ed.) (1981). *Child abuse and neglect: Cross-cultural perspectives*. Berkeley, CA: University of California Press.

Korbin, J. (Ed.) (1987). Child abuse and neglect: The cultural context. In R. Helfer and R. Kempe (Eds.), *The battered child, fourth edition*. Chicago, IL: University of Chicago Press, 23-41.

Korbin, J. (1987). Child maltreatment in cross-cultural perspective: Vulnerable children and circumstances. In R. Gelles and J. Lancaster (Eds.), *Child abuse and neglect: Biosocial dimensions*. Chicago, IL: Aldine, 31-55.

Long, K. (1986). Cultural considerations in the assessment and treatment of intrafamilial abuse. *American Journal of Orthopsychiatry, 56*, 1, 131-136.

McGoldrick, M., Pearce, J., and Giordano, J. (1982). *Ethnicity and family therapy*. New York, NY: Guilford Press.

National Center on Child Abuse and Neglect (1981). *Study findings: National study of the incidence and severity of child abuse and neglect*. Washington, DC: U.S. Department of Health and Human Services.

National Center on Child Abuse and Neglect (1988). *Study findings: Study of national incidence and prevalence of child abuse and neglect*. Washington, DC: U.S. Department of Health and Human Services.

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MEDIA RELATIONS

APSAC Responds to Frontline Documentary

On July 20 and 21, 1993, PBS's "Frontline" ran a two-part, four-hour documentary on the Edenton, North Carolina case involving allegations of sexual abuse in day care. Entitled "Innocence Lost: The Verdict," the documentary took a strong pro-defense perspective on two trials which have resulted in guilty verdicts, one of Robert Kelly, lasting eight months, and one of Dawn Wilson, lasting two and one-half months. APSAC's Board of Directors felt that the powerful documentary was one-sided. Below is the text of the letter sent on APSAC's behalf to the Executive Producer of "Frontline," David Fanning.

July 23, 1993

David Fanning, Executive Producer
Frontline
125 Western Av.
Boston MA 02134

Dear Mr. Fanning,

We wish to commend Ofra Bikel on her two-part documentary, "Innocence Lost: The Verdict." Ms. Bikel is to be praised for her remarkable command of the documentary medium, and for raising serious questions about how well American justice is served when allegations of child sexual abuse are made. Ms. Bikel poses legitimate questions about the manner in which allegations of child sexual abuse arise; the professional response of investigators, protective service workers, therapists, and prosecutors to such allegations; and the standards of evidence on which convictions for child sexual abuse may be based. A community's response to allegations of child sexual abuse is an absorbing topic for a documentary, and Ms. Bikel revealed some very disturbing facts about Edenton's response, including the community's ostracism of the defendants' families and the excessive bail imposed by the judge.

Those of us not present throughout the trial and in the jury room are not able to state with confidence whether or not justice was served in this case. We can say that a selective presentation of the issue by "Frontline" does not serve justice or the interests of American children.

Given the gravity of the issues Ms. Bikel addresses, we are dismayed that she omitted so much critical information about the Edenton case. On Friday, July 16, APSAC's Executive Director, Theresa Reid, contacted a "Frontline" producer after seeing advance material on "Innocence Lost" to discuss the possibility of airing a panel discussion after the program to provide a more balanced view. Ms. Reid was assured that "Frontline" stood by Ms. Bikel's documentary as a balanced presentation of the facts.

Yet in Bob Kelly's trial, eight months' worth of children's testimony, testimony about the children's behavior, and testimony about the defendant's behavior and character convinced twelve jurors. Ms. Bikel showed the nation a few unrepresentative minutes of that testimony. Having not heard all of the testimony, we do not know that the defendants are guilty; but we are convinced that Ms. Bikel's decision to present a highly selective version of the facts as an unbiased account does not serve justice as she intended. Here are some of Ms. Bikel's omissions, all of which were entered into evidence in Mr. Kelly's criminal trial:

- During intensive cross-examination that lasted, on average, five times longer than direct examination, not one of twelve children recanted his or her allegations about the core events. Cross examination focused on peripheral details, about which adults as well as children are easily confused.
- The documentary leaves the strong impression that the children were abused for months or years before any of them disclosed, a sustained silence many people find incredible. In fact, the initial allegations, made in January, 1989, stem from incidents occurring between September and December, 1988.
- The documentary strongly implies that charges of sexual abuse arose as the personal vendetta of a mother, Jane Mabry, whose son was slapped by Betsy Kelly. In fact, the record shows that police and social service investigators had no knowledge of that incident when they first questioned the Kellys about allegations of sexual abuse at the day care. According to court testimony, in September, 1988, the happy, outgoing three-year-old son of Mr. and Mrs. Stever began attending Little Rascals on a regular basis. Shortly after he began attending, he became more withdrawn, quiet, and somewhat sad. At Thanksgiving time, preparing for a bath, the little boy bent over, naked, and asked his mother to stick her finger in his "butt." When Mrs. Stever said that isn't something they did, the boy said, "Just do it, Mommy, just do it." Not knowing what to make of this behavior, his mother tried to dismiss it. The boy became increasingly withdrawn and sad, and increasingly vehement about not being taken to day care. Around Christmas, Mrs. Stever consulted a police investigator she knew, who advised her to ask him why he didn't want to go to day care. According to court testimony, the investigator cautioned Mrs. Stever not to ask leading questions, advising her to ask only "W" questions:

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Culture

–Jill Korbin

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Rao, K., DiClemente, R., and Ponton, L. (1992). Child sexual abuse of Asians compared with other populations. *Journal of the American Academy of Child and Adolescent Psychiatry, 31*, 5, 880-886.

Russell, D. (1986). *The secret trauma: Incest in the lives of girls and women*. New York, NY: Basic Books.

Straus, M., Gelles, R., & Steinmetz, S. (1980). *Behind closed doors: Violence in the American family*. New York: Anchor Press.

Wolock, I. (1982). Community characteristics and staff judgements in child abuse and neglect cases. *Social Work Research and Abstracts, 18*, 9-15.

Wyatt, G. (1985). The sexual abuse of Afro-American and white American women in childhood. *Child Abuse and Neglect: The International Journal, 9*, 507-519.

Jill Korbin, PhD, is Professor of Anthropology at Case Western Reserve University in Cleveland, Ohio.

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Media Relations

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Who, What, When, Where, Why. When asked why he didn't want to go to day care, the boy said he didn't like Mr. Bob. When asked why he didn't like Mr. Bob, the boy said because he played doctor during nap time—not with him, the boy hastened to add, but with other little boys. He named the other little boys. When Mrs. Stever informed the police investigator of her son's statements, in January, 1989, the investigator contacted the department of social services, and the investigation began. Court records make clear that the Kellys' explanation to parents—that the investigation was a vendetta by Mrs. Mabry, whose child had been slapped—was false.

It is time for the American media to engage the American public in a serious discussion of the issues Ms. Bikel raises. We call upon "Frontline" producers and other representatives of the media to exercise journalistic integrity and wield their considerable power truly for the public good by addressing these topics with balance.

- Many people find it hard to understand how so much sexual abuse could occur in a setting that afforded so little privacy. In fact, the record shows that the new building into which the Kellys moved their center in September, 1988, had many separate classrooms. These classrooms had doors which, according to three teachers who were never indicted, were kept closed all day. The new center also had several rooms upstairs; at the bottom of the stairs was a door that locked from the inside. Several children testified to being abused upstairs.
- According to their testimony in court, the children's parents—most of whom knew each other little, if at all, at the time—were all told individually not to visit the center during nap time. Parents were also told not to drop in. If they wanted to pick up their children at unscheduled times, they were to call ahead. One grandfather whose granddaughter had begged to be picked up from day care before nap time could not resist her pleas. He testified that he tiptoed in on one occasion, and when his eyes adjusted to the dim light, he witnessed Bob Kelly kneeling on the floor straddling a little boy, Mr. Kelly's hands not visible. When the grandfather cleared his throat to announce his presence, Mr. Kelly glanced around, then turned back to the boy and said sharply, "You better go to sleep now." Mr. Kelly then stood, but would not turn around or speak to the grandfather, even after the grandfather announced that he was there to pick up his granddaughter. In addition to that incident, several parents, another grandparent, a real estate agent, and an unindicted child care worker testified to arriving at the center during nap time on separate occasions, finding the outside doors locked, and waiting some moments before the doors were unlocked from within by one of the Kellys.
- The documentary implies that there was no medical evidence of abuse. A team of experienced medical examiners at the University of North Carolina testified that, although child sexual abuse often leaves no physical evidence, in fact four of the girls had anal and vaginal scarring, anal dilation, and asymmetrical attenuation of the hymen that were very unusual and strongly suggestive of sexual abuse. The defense experts testified that there was no evidence of abuse after viewing 35mm slides of Polaroid photographs produced by the UNC team's diagnostic equipment.
- The documentary focuses much attention on jurors who now question their decision to convict Mr. Kelly. It does not point out, however, that, because the charges against Bob Kelly were grave and confusingly numerous, the judge took unusual measures to allow the jurors to recant. He required each juror to sign each verdict sheet, a process which extended over twelve days, from April 10 through April 22, 1991. After signing the first verdict sheets on April 10, jurors had an unexpected week off, during which they had time to rest and reconsider their verdicts. On April 22, when the verdicts were delivered, each juror was asked, under oath, in open court, to answer three questions put by the judge: "Are these your verdicts?" "Are these still your verdicts?" "Do you still assent thereto?" Each juror answered affirmatively to each question. It is not uncommon for jurors to express doubts after making weighty decisions.

The crime of child sexual abuse presents unique problems for professionals charged with protecting children and administering justice because it rarely involves strong corroborative evidence or innocent adult eyewitnesses. In cases of child sexual abuse, a child's word and circumstantial evidence are weighed against the word and reputation of an adult. Ms. Bikel rightly points out that the practice of professionals is of the utmost importance in these cases. But her argument that the investigators, therapists, and prosecutors in the Edenton case were instrumental in perpetrating a gross miscarriage of American justice is marred by distortions and omissions.

Those of us not present throughout the trial and in the jury room are not able to state with confidence whether or not justice was served in this case. We can say that a selective presentation of the issue by "Frontline" does not serve justice or the interests of American children.

It is time for the American media to engage the American public in a serious discussion of the issues Ms. Bikel raises. We call upon "Frontline" producers and other representatives of the media to exercise journalistic integrity and wield their considerable power truly for the public good by addressing these topics with balance.

Sincerely,

Barbara Bonner, PhD
President

Theresa Reid, MA
Executive Director

Representating the Board of Directors of the American Professional Society on the Abuse of Children

cc: Ofra Bikel

COMMENT

Reflections on the U.S. Advisory Board on Child Abuse and Neglect

—by Howard Davidson

Upon my completion of a four-year term on the U.S. Advisory Board on Child Abuse and Neglect (twenty-one months of which I served as Chair), I thought APSAC members might be interested in what I look upon as our accomplishments, and our failures, to date. I hope that the new Clinton/Shalala Board will build upon the work we began.

In an amendment to the 1974 federal Child Abuse Prevention and Treatment Act (CAPTA) created a new federal body, the U.S. Advisory Board on Child Abuse and Neglect ("the Board"). The law stipulated that, of the Board's 15 members, two were to be federal officials, and the remaining 13 were to come from outside the federal government. These 13 were to be knowledgable about child abuse policy, prevention, intervention, treatment, and research, and to have specific expertise in law, medicine, mental health, state and local government, or another discipline relating to child maltreatment. The 1988 statute charged the Board with evaluating the nation's progress in achieving the purposes of CAPTA, and with making recommendations to the Secretary of Health and Human Services (HHS), to Congress, and to the Director of the National Center on Child Abuse and Neglect (NCCAN) about how better to achieve those purposes.

Two of the twelve questions for elected officials and candidates are these:

- ***Will you help make child abuse and neglect treatment programs available to all children and families that need them, and how will you do this?***
- ***Will you work to ensure that family preservation services are made available to all families that merit them?***

When the new Board was first addressed by HHS Secretary Louis Sullivan in 1989, he charged us to be his "working partners." He asked for "not only recommendations and suggestions...but criticism as well." He challenged us to look at how HHS money was being spent, whether Federal inter-departmental gears were "meshing smoothly," and how HHS could help states perform their child protection responsibilities more effectively. He told us that *nothing* was "off limits" to our examination.

Our first action as a Board was a wise one. We elected as our first chair Dr. Richard Krugman, MD, then director of the Kempe Center in Denver. Dr. Krugman's leadership during our formative years of work was a critical factor in the positive recognition we received from the child protection community. While likening the American child protection system to a patient with "chronic and critical multiple organ failure," Dr. Krugman wisely encouraged the Board's "no fault" approach to the crisis, pointing out that there is enough blame to be shared by all. Dr. Krugman is also to be credited with authoring and guiding the Board's single most important recommendation to date: a call for universal, voluntary home visitation.

The Board was also lucky to have, as Executive Director, a seasoned federal civil servant whose dedication to the Board has known no bounds: Byron Metrikin-Gold. In his distinguished career in the federal government, Byron developed an understanding of how advisory boards should function which, coupled with his dedication, has served to put this Board "on the map."

This Board is now completing its fourth major report. The first report, published in 1990, was entitled, *Child Abuse and Neglect: Critical First Steps in Responding to a National Emergency*. This report gained the nation's ear by declaring that child abuse and neglect was actually "a threat to national survival." It highlighted the brutal fact that, each year, hundreds of thousands of American children are "starved and abandoned, burned and severely beaten, raped and sodomized, berated and belittled." The report stressed the economic as well as human costs of this "moral disaster," noting that we annually spend "billions of dollars on programs that deal with the results of the nation's failure to prevent and treat child abuse and neglect." Having sounded this alarm, the report sets forth "31 critical first steps" to avert the collapse of America's child protection system.

Because the Board in 1990 had found "an absence of coherent Federal policy" in national child protection efforts, it decided to address its second (1991) report to that glaring lapse. Entitled *Creating Caring Communities: A Blueprint for An Effective Federal Policy on Child Abuse and Neglect*, the 1991 report called for a National Child Protection Policy that, as part of the U.S. Code, would be a beacon in the Federal law to guide the child protection-related activities of all Federal agencies. Among the specific recommendations were these:

- that there be a flat statutory prohibition on the use of Federal funds for any "activities, programs, institutions, and facilities" that permit the use of corporal punishment of children.
- that Congress commission a study on the costs of an enhanced Federal effort to prevent and treat child abuse and neglect, and on the human and economic consequences of not addressing the problem adequately.
- that the Federal government enhance volunteer involvement in child protection.
- that the nation's religious community become more involved in the prevention of child maltreatment.

In April, 1993, the Board issued its third annual report, entitled *The Continuing Child Protection Emergency: A Challenge to the Nation*. In it, we said that three years after the Board first described the "national emergency," the emergency had clearly deepened in all parts of the nation and that it continued to threaten "to disintegrate the nation's social fabric." The report stated that an effective and adequately funded child maltreatment prevention program must

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Comment

–Howard Davidson

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be at the heart of all crime prevention programs.

Because, as the report stated, "hundreds of thousands of children are having their childhoods destroyed," it provided a list of things Americans can do about the crisis, as well as a list of child abuse-related questions everyone should ask of elected officials and candidates for public office.

Two of the twelve questions for elected officials and candidates are these:

- Will you help make child abuse and neglect treatment programs available to all children and families that need them, and how will you do this?
- Will you work to ensure that family preservation services are made available to all families that merit them? (p.73)

Two of the twenty-six steps the Board recommended for all Americans include these:

- Pledge, if you are able to give some of your free time, to become a mentor for a child in a residential group home.
- Be an advocate for better staffing in local child protection services agencies. (p. 74-75)

Two of the twenty-six steps the Board recommended for all Americans include these:

- ***Pledge, if you are able to give some of your free time, to become a mentor for a child in a residential group home.***
- ***Be an advocate for better staffing in local child protection services agencies.***

The Board hopes to release its fourth annual report in late October, 1993. Tenatively entitled, *Neighbors Helping Neighbors: A New National Strategy for the Protection of Children*, the 1993 report is grounded in a much-quoted passage in the 1990 report: "It has become far easier to pick up the telephone to report one's neighbor for child abuse than it is for that neighbor to pick up the telephone to request and receive help before the abuse happens." The 1993 report will offer a new strategy for child protection which we hope will be a useful guide for policymakers along the following lines:

- fashioning neighborhood improvement strategies;
- helping change societal values related to violence against children;
- changing the focus of child protection from post hoc investigation and coercive intervention to prevention and family empowerment;
- making government child protection programs more comprehensive, child-centered, neighborhood-based, and family- focused.

The Board is also deep into work on its 1994 report. This report focuses on child maltreatment fatalities, a focus mandated by Congress when it last amended CAPTA. The Board has already held several hearings on this subject, including one at APSAC's First National Colloquium in June. It will convene a number more hearings throughout the country before it begins drafting the 1994 report.

A constant theme of the Board's reports over four years has been that child protection cannot be addressed within government as solely (or even primarily) a social service agency responsibility. The Board has pointed out that child abuse has been dealt with by Congress' committee structure in an inappropriate manner, under which the subject has been assigned to subcommittees that do not have comprehensive jurisdiction over the mental health, health, education, and justice aspects of child protection, or even over major child welfare services programs. We have consistently argued that CAPTA should be fully funded (it never has been), and that NCCAN must be given an increased level of financial support so it can strengthen professionalism at state and county child protective services agencies. From the beginning, our Board has decried the inadequate Federal investment in research related to child abuse and neglect.

So what has been the outcome of our efforts? Unfortunately, we have yet to see Congress or any administration embrace many of our most important recommendations. No legislative proposal prohibiting the use of federal funds for programs permitting corporal punishment has been introduced in Congress. No study of the costs of addressing vs. not addressing the problem of child maltreatment has been commissioned. Likewise, our recommendation that the President of the United States sign and ask the Senate to ratify the U.N. Convention on the Rights of the Child has not yet been implemented.

Yet I am optimistic. In partial response to the Board's criticism of the low federal investment in research, HHS—through the leadership of David Lloyd and Wade Horn—commissioned the National Research Council of the National Academy of Sciences to identify critical gaps and needs in the field of child maltreatment research. Their report, entitled *Understanding Child Abuse and Neglect*, was published in July, 1993.

Further, as I have traveled the country and spoken of the Board's work, people have expressed appreciation for our insight, candor, toughness, and leadership. With a new administration, a new Board chair—Deanne Tilton Durfee—and a mostly new Advisory Board appointed by that administration, we have new hope for an increased commitment to implementing some of the Board's suggestions. With you, I will eagerly await the new Board's ideas. I hope that APSAC's leadership and members will keep channels of communication with the Advisory Board wide open.

(U.S. Advisory Board Reports can be obtained from either the U.S. Government Printing Office or by writing or calling the Board's office, 200 Independence Ave., S.W., Washington, DC 20201 [Tel. 202/690-8137])

Howard Davidson, JD, is Director of the American Bar Association Center on Children and the Law in Washington, D.C.

BOOK REVIEWS

—Edited by Kathleen Kendall-Tackett, PhD

Testifying in Criminal Court, by Gail S. Goodman, Elizabeth Pyle Taub, David P.H. Jones, Patricia England, Linda K. Port, Leslie Rudy and Lydia Prado. Monographs of the Society for Research in Child Development, vol. 57, No. 5, 1992. 163 pp. $7.75 paper.

—Reviewed by Thomas F. Curran

What emotional effect does testifying in court have on child sexual assault victims? Few issues in child maltreatment have generated as much scholarly debate or received as much multidisciplinary attention during the past several years. In *Testifying in Criminal Court*, Goodman and her colleagues present what is perhaps the most comprehensive and meticulously documented research study ever to examine this question.

Testifying in Criminal Court is an unparalleled scientific study of child abuse victims as criminal court witnesses.

This monograph describes a two year study of 218 child sexual abuse victims. From this sample the behavioral disturbance of a group of "testifiers" was compared to that of a matched group of "non-testifiers" at three points following courtroom testimony: 3 months, 7 months, and after prosecution ended. The sample was taken from cases active in three district attorneys' offices in the Denver area. In ten short chapters Goodman and colleagues present extremely important research for child abuse litigation in general, and, more specifically, the best available answer to the questions of whether and under what conditions criminal courtroom testimony is associated with emotional distress for child sexual abuse victims.

The introductory chapter presents a very thorough overview of previous research on children's emotional reaction to the legal system. The discussion of studies on children's reactions to other stressful events is especially interesting.

Chapter two, the longest chapter, is a painstaking description of the study design and population. The reader who is not a researcher will find this chapter difficult if not boring. The experienced researcher, on the other hand, will appreciate Goodman's scrupulous attention to sound research methods.

The behavioral assessments made and measures used are reviewed in chapter three.

Chapter four presents initial findings on the emotional effects of courtroom testimony. Three months after testifying the "testifiers" and "control" group did not differ in behavioral adjustment. Seven months after testifying, however, the control group should behavioral improvement, but the tesifiers did not. At final follow-up, testifiers still should less improvement than the control group.

In addition, contrary to study predictions and commonly held belief, the children showed greater behavioral and emotional improvement with a greater number of continuances. Also, parents and caretaker of children who testified were much more likely to rate court involvement as adversely affecting their children's behavior than were caretakers of non-testifies.

Possible protective and vulnerability factors that would predict children's improvement or lack of improvement are discussed in chapter five. Consistent with previous research, maternal support was found to be very strongly associated with children's emotional resilience and improvement. The best predictor of children's improvement, however, was the number of times a child was required to testify. The more often a child testified, the less likely he or she was to improve. Case disposition was the source of another interesting finding, with children showing less improvement when the defendant received a more severe sentence.

Chapter six presents data on the children's personal reactions to testifying and their suggestions for change. Overall, before testifying the children expressed negative feelings about testifying, and especially about having to face the defendant. Older children consistently expressed more negative feelings about the entire experience than younger children.

Personal observations of the children as they testified are discussed in chapter seven. One very interesting observation was that children appeared more confident and provided more effective testimony if their abuse experience was severe.

Chapter eight discusses how the children felt about testifying after they left the courtroom. Contrary to their pre-trial attitudes, after testifying the children generally found the experience less aversive than they feared. Even after testifying, however, the children maintained their negative feelings about having to face the defendant during testimony.

The families' attitudes about the legal systems are discussed in chapter mine. While the families viewed the effects of not testifying as more positive than testifying, children who did not testify regretted not doing so if the defendant was found not guilty.

Chapter ten presents an exhaustive review of all the study's findings, their implications, and suggestions for changing how child abuse victims testify in criminal trials.

Two different yet very thought-provoking commentaries on this Monograph are provided at the end, one by John E. B. Myers and the other by Gary B. Melton.

Testifying in Criminal Court is an unparalleled scientific study of child abuse victims as criminal court witnesses. Goodman and colleagues provide sound scientific evidence that testifying in criminal court is associated with short- term negative effects for many, but not all, child sexual abuse victims. This

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Book Reviews

–Kathleen Kendall-Tackett, PhD

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Monograph challenges some long-held but scientifically unsupported beliefs about children as witnesses, yet provides rich soil in which new policies and courtroom practices for child witnesses can be planted.

Anyone interested in children as witnesses, and certainly anyone who works with abused children in court, will find this Monograph an invaluable reference. For attorneys who represent abused children, prosecutors, judges who hear child abuse cases, and even state legislators, Testifying in Criminal Court should be required reading.

Thomas F. Curran, M.S.W.,JD, is a staff attorney with the Child Advocacy Unit of the Defender Association of Philadelphia. He represents abused and neglected children in Philadelphia Family Court. He is also a member of APSAC's Board of Directors.

▼ ▲ ▼

Slaughter of the innocents: Child abuse through the ages and today, by Sander J. Breiner, M.D.. 1990, 314 pages. Publisher: Plenum Publishing Corporation, 233, Spring Street, New York, NY 10013. $23.50, hardbound.

—Reviewed by Deborah Fisher

Sander Breiner is a psychiatrist and psychoanalyst with more than a passing interest in history. *Slaughter of the innocents* details the ancient cultures of Egypt, Greece, the Hebrews, Rome and China in order to understand the genesis of child abuse in our own times. Breiner allows the reader to wander the banks of the Nile 5,000 years ago, witness the routine spectacle of death in the Roman Colosseum of 82 A.D., and be privy to the intimacy of Chinese family life in 800 B.C. Along the way, he examines these cultures for clues about how they treated their children. But he also examines other cultural characteristics in order to flesh out a more complete picture of society. These include historical records of family life, laws, how each culture treated its slaves (they all had slaves at one time or another) and, what he considers most important, how women were treated.

Breiner's central premise is that the treatment of women is the crucial measure of a culture. Because so many women are mothers, how they are treated has a direct impact on how children are treated. Writes Breiner,

> With mutual respect in a family, love will grow. Where there is love in a family, the mother will be loved. When the mother is loved, she is much more likely to love her children. When the children are loved, they are likely to grow up in a healthy way, and have healthy families themselves when they mature. Because of their identification with a loving object, and feeling lovable, children will be healthier. A community or a nation of healthy families with healthy children will not have a pattern of child abuse.

The book's premise that as women are treated so goes the culture transcends the traditional view of women as mothers. Breiner repeatedly points out that a culture willing to debase any of its own kind will prey upon its most vulnerable members. At some point or another, all of the cultures examined by the author exploited women, slaves, children, the elderly, or captives of war. In fact, Breiner notes, the more the warlike a culture became, the more child abuse was present.

Of the five cultures discussed, the author concludes that the Hebrews treated women and children the best. Despite the fact that the Hebrews were regularly scattered and on the move, they managed to maintain strong values oriented around family and marriage. Each member of the society was valued and considered to have important rights. They had an extensive legal system interwoven with their deep religious beliefs and stressed education for both boys and girls. The Hebrews also had an understanding of psychological problems and outlets for expression of feelings, particularly grief. This doesn't mean the Hebrews were perfect. Reverence for women in the culture sometimes took on the patina of commodity brokering. Overall, however Hebrew women did enjoy a much stronger voice in daily family life than in most cultures.

Children were treasured among the Hebrews, seen as great gifts of responsibility from God. They were to be nurtured, educated, cared for, disciplined and protected. Parents were directed to teach the children about appropriate sexuality, and traditional Hebrew law strictly forbade incest, rape or even the marrying of a daughter to an older man. One interesting note is how the Hebrew's reliance on the biblical phrase, "spare the rod and spoil the child," has been misinterpreted. According to Breiner, "(t)he rod here, instead of being a rod to whip (shavat), was rod (shevet) which was used as staff or scepter of instruction. In other words, to spare the education of a child was to ruin the child."

It's difficult to determine whether the Greeks or the Romans were the worst in their treatment of women and children. The author's conclusions about the Greeks are the most surprising, because we equate them with the Golden Age. But Breiner points out that the Golden Age lasted only about 50 years and those years were surrounded by constant turmoil. The Greek civilization was focused on war and violence. Infanticide was very high and women were not well treated. Slavery was essential to the Greek economy and the more slaves they acquired, the worse they treated them. Slaves cared for the children, who were largely ignored by their mothers. Education was for a few privileged males and there was no consistently stable legal system. The Greek religion was full of harsh, destructive and vindictive Gods and many of the culture's crippled, weak, ill and defenseless were sacrificed to them.

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Book Reviews

-Kathleen Kendall-Tackett, PhD

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The Greeks were known for their extensive use of young male prostitutes, particularly slaves. They hated women, seeing them as necessary evils for procreation. Breiner notes that free Athenians began having homosexual intercourse at age 16 when they began going to the gym and wrestling school. "Sodomy was considered reprehensible to do to older men, but not to young males...It was rare for a boy not to have had a male lover."

Generally, children were not treated well by the Greeks. They were kept uneducated and frightened and could be killed at birth by their fathers without question or sold to slave dealers. In fact, the poor commonly sold their children to pay off creditors. These practices were eventually devastating to the culture. For example, the citizen class of Attica decreased from 43,000 in 432 B.C. to 22,400 by 313 B.C.

The book is interesting reading, especially the chapters comparing cultures and Breiner's conclusions about our own culture. It is not without is flaws, however. Breiner fails to provide much needed context or analysis for some of the information he supplies, such as how the Greeks came to be so repulsed by women. He seems to completely miss an important point about the Egyptians' treatment of women. He describes them as equals with men in many ways, pointing out that women were often depicted in tomb paintings and murals. But many other points, such as the assumption that a child was an orphan if his father died but mother did not, suggest that the portraits might mean something else. I suspect if a future historian were to look back at some of this country's advertising, he or she might draw some erroneous conclusions about the reverence of women in our culture.

Breiner's central premise is that the treatment of women is the crucial measure of a culture. Because so many women are mothers, how they are treated has a direct impact on how children are treated.

The book suffers somewhat from a lack of organization. Lists comparing the five cultures point by point don't always match up in content, making clear cross-referencing difficult. More charts showing the complex changes in families, clans and dynasties in each culture would have been helpful. Maps would also have been helpful.

Despite the structural problems, *Slaughter of the innocents* is fascinating and very readable. The author's enthusiasm is clear and his language is simple. The reader is left with some recommendations about what changes need to occur in our culture so that we do not devastate ourselves by devastating our children.

Deborah Fisher is a writer and consultant in Bellevue, Washington. A journalist and former legal affairs reporter for Minnesota Public Radio, she specializes in media, community education and child abuse prevention. She is currently serving as a Board Member for the Washington Council on Crime and Delinquency.

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Sexualized children: Assessment and treatment of sexualized children and children who molest. By Eliana Gil and Toni Cavanagh Johnson, 1993. Rockville, MD: Launch Press. 360 Pages. Hardback, $35.00. Paperback, $21.95.)

—Reviewed by Katharine Lee Weille

Although the title of this book suggests—and indeed the book does offer—a "how-to" manual of evaluation/treatment for a particular population, the authors have far exceeded this purpose by presenting ground-breaking theoretical work on their topic. In this volume, Johnson presents the most in-depth outline to date of the complex "continuum" of sexual behaviors manifested by pre-pubescent children. The authors have first grounded this continuum in a comprehensive review of normal childhood sexual development and behavior. This review may be almost equally new and useful for the multitude of clinicians who, in encountering sexualized children, have come to realize how little we know about the wide range of *normal* childhood sexual behaviors. The continuum represents a major theoretical and practical advance in work with the burgeoning population of young children who molest and/or exhibit other inappropriate sexual behaviors. Two crucial foci in the remainder of the book render this initial theoretical base even more valuable. First, thorough analyses of important contextual constellations (e.g., intrapsychic dynamics, family variables, histories of prior victimization), provide a more comprehensive view of the way in which inappropriate and abusive sexual behaviors may manifest and be reinforced in children. Secondly, an equally detailed and practical presentation of assessment and treatment methods provides a thorough integration of theory with practice, making this book very useful for practitioners.

The book contains fourteen chapters and a selection of resource-filled appendices. The first chapter's overview of childhood sexual development spans every conceivable domain, including biology, cognition (e.g., sexual knowledge), and societal/cultural influences (e.g., gender stereotypes). Chapter Two extends this overview in more detail into the behavioral realm. This provides a crucial foundation, helpfully illustrated with case examples, for differentiating normative from problematic sexual behaviors. The differentiations are further solidified in the formal categorizations of the continuum, set forth in chapter Three. Chapters Four through Seven move into the contextual variables mentioned above, first touching on the question of etiology, and moving on to individual and family dynamics.

The second half of this book turns to the complex and challenging issues of assessment, intervention and treatment. This begins in Chapter Eight, with case examples from different states that illustrate the vast discrepancies that currently exist in identification of, and community response to, problems of sexual

continued on next page

Book Reviews

-Kathleen Kendall-Tackett, PhD

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behavior in children. The following chapters, entitled "Clinical Evaluation," "Individual Therapy," "Group Therapy," "Family Treatment," and "Out-of-home Care," cover their indicated topics so thoroughly and in such an organized fashion, that they comprise a sort of procedural manual. The "Group Therapy" chapter, for example, offers a listing—complete with instructions—of therapeutic activities to use in group-work with this population. The "Risk Index" in Chapter Nine ("Clinical Evaluation") is especially useful for organizing the highly complicated panoply of information gathered in the evaluative process. Finally, a refreshing look at "Transference and Countertransference" in work with sexualized and molesting children completes this volume. This chapter touches on the sensitive and sometimes volatile emotions that are ever-present in the treatment process, experienced powerfully by both members of the therapeutic relationship.

Sexualized children is an extremely valuable resource for almost anyone who works with sexually victimized or victimizing children, or for anyone who wishes to better understand sexuality in prepubertal children.

Sexualized children is an extremely valuable resource for almost anyone who works with sexually victimized or victimizing children, or for anyone who wishes to better understand sexuality in prepubertal children. It is written in a practical, jargon-free fashion, and explains even the most basic therapeutic concepts, rendering it entirely accessible to persons outside of the mental health profession. At times, the thorough, detailed style becomes somewhat repetitive if one is setting out to read this book from cover to cover. However, there is something of theoretical interest and practical value for almost every reader, including the most seasoned professional, and the volume is clearly organized with clinical utility in mind.

Katharine Lee Weille, ACSW, is Clinical Director of the Pediatric Sexual Abuse Program at St. Anne's Hospital in Fall River, MA.

▼ ▲ ▼

Working with adult incest survivors: The healing journey. by Sam Kirschner, PhD, Diana Adile Kirschner, PhD, and Richard Rappaport, PhD. Brunner/Mazel, 1993, 214 pp., $28.95 hard cover.

— Reviewed by Sandra Foti.

This book captures the dynamics apparent in incestuous families, including how to treat survivors of incest with a multidimensional approach and also techniques to discover if a client is an incest survivor.

Chapter 1 describes the range of symptoms often found in survivors, with and without memory of the actual abuse. In Chapter 2, the authors build upon knowledge presented in Chapter 1, and help clinicians determine whether a client could have been a victim of incest. Chapter 3 describes characteristics of three types of incestuous families: male dominant, female dominant, and chaotic. Chapter 4 highlights for the reader how incest affects the formation of the child's identity through the major themes of trust, gender and power.

Chapter 5 makes general statements concerning the survivor's patterns in choosing different types of partners. This chapter has relevance for the clinician working with survivors and provides knowledge about how clinicans can empower survivors and help them make positive choices in relationships. In Chapter 6, the authors outline how to build an appropriate therapeutic alliance with the survivor and his or her partner. Issues of countertransference/transference and their impact on the therapeutic alliance are described in this chapter. Chapter 7 offers the clinician solid, concrete, and detailed methods to keep the survivor engaged and working towards healing. This chapter underscores the importance of the therapist's corrective emotional response, and the participation of the partner in treatment so splitting and sabotaging can be avoided. In Chapter 8, the survivor has progressed from being an impotent victim to being more comfortable with the aftereffects of incest trauma, and is working toward becoming a more fully functioning adult. The role of the clinician becomes more challenging due to resistance from the survivor. Again, the need for involvement from the partner is emphasized, for the survivor's growth can be challenging to the relationship, and an uninvolved partner may sabotage the survivor's continued improvement.

The "family-of-origin work", Chapter 9, highlights the need for the survivor to receive and accept acknowledgement by the perpetrator and non-protective family members. Chapter 10 focuses on reintegrating the healed survivor with his or her partner as a fully functioning and sexual being. Sex therapy and marital counseling are suggested with the goal of moving the partners toward continued growth, support and healing. Chapter 11, The Male Survivor, describes differences between the victimization experiences of male and female survivors, how males typically present in treatment, and the therapeutic stance that is most effective.

This book would be helpful for skilled clinicians in incest survivor work. Overall, the book was informative. However, the beginning chapters (information on the incestuous family) may be too generic to hold the interest of experienced clinicians, yet not sufficiently theoretical to educate the novice. The book also highlights how various approaches help the survivor heal, but few clinicians are skilled in all the treatment approaches mentioned (sex therapy, couples therapy, memory retrieval, cognitive therapy, psychodrama and family work). This can be both intimidating and prohibitive. Chapters 6 through 10 were most informative, as they offered clinicians a blueprint of a successful treatment plan to use as a guide and example.

Sandra Foti, MA, is a psychotherapist at Cambridge Family and Children's Services, Cambridge, MA.

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 six 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

Ards, S. and Harrell, A. (1993). Reporting of child maltreatment: A secondary analysis of the national incidence surveys. *Child Abuse and Neglect, 17* (3), 337-344.

By examining the 1980 and 1986 National Incidence studies, this article reviews discrepancies between cases known to CPS agencies and those known to professionals who regularly come in contact with children. In both studies the only child characteristic consistently related to CPS knowledge of a case was age: older victims were less likely to be known to CPS than younger children. Also, sexual abuse was the type of maltreatment most likely to be reported to CPS.

Kolko, D.J., Kazdin, A.E., Thomas, A., and Day, B. (1993). Heightened child physical abuse potential. *Journal of Interpersonal Violence, 8* (2), 169-192.

Child, parent, and family factors related to parents' heightened potential for physical abuse are evaluated in this study. Mothers (N=113) of child psychiatric patients and non-patients (ages 6-13) were classified as being at low, moderate, or high risk for child abuse. The high risk mothers reported greater child antisocial behavior, depression, self-injury, personal psychological dysfunction, and family stress than the low and moderate risk mothers, but no difference in parent management practices or family violence.

Wolfner, G.D. and Gelles, R.J. (1993). A profile of violence toward children: A national study. *Child Abuse and Neglect, 17* (2), 197-212.

Based on the results from the Second National Family Violence Survey of over 6,000 households, this article presents a profile of family violence against children. The highest rate of abusive violence occurred in families living in the East, families whose annual income was below the poverty line, families in which the father was unemployed, families with four or more children, male children, and with children ages 3 to 6 years old. The data were consistent with a structural social stress model of family violence, where social and economic stressors positively correlate with abuse against children.

Schrier, H.A. (1992). The perversion of mothering: Munchausen Syndrome by Proxy. *Bulletin of the Menninger Clinic, 56* (4), 421-437.

This article provides a thorough overview of Munchausen Syndrome by Proxy, along with various case examples and possible explanations to some complex scenarios. Possible cultural, historical, and psychological factors which contribute to Munchausen Syndrome by Proxy are discussed. (MC)

SEXUAL ABUSE

Briere, J. and Conte, J. (1993). Self-reported amnesia for abuse in adults molested as children. *Journal of Traumatic Stress, 6* (1), 21-31.

A sample of 450 adult clinical subjects reporting childhood sexual abuse histories were studied regarding their repression of sexual abuse incidents. A total of 267 subjects (59.3%) identified some period in their lives, before age 18, when they had no memory of the abuse. The variables most predictive of abuse-related amnesia were greater current psychological symptoms, abuse at an early age, extended abuse, and variables reflecting violent abuse (e.g., multiple perpetrators, being physically injured, etc.). In contrast, abuse characteristics more likely to produce psychological conflict, such as feeling guilt or shame, were not associated with abuse-related amnesia. The clinical, research, and forensic implications of the prevalence of sexual abuse-related repression are discussed.

Deblinger, E., Hathaway, C.R., Lippman, J. and Steer, R. (1993). Psychosocial characteristics and correlates of symptom distress in non-offending mothers of sexually abused children. *Journal of Interpersonal Violence, 8* (2), 155-163.

Three groups of non-offending mothers of sexually abused children were compared in this study on 17 psychosocial characteristics. Study findings challenge several commonly held negative stereotypes associated with mothers of incest victims, and indicate that these women appear to be secondary victims of abuse. In addition, the incest mothers were just as likely as mothers whose children experienced extra-familial abuse to believe their children's allegations.

Gellert, G., Berkowitz, C., Gellert, M., and Durfee, M. (1993). Testing the sexually abused child for the HIV antibody: issues for the social worker. *Social Work, 38* (4), 389-394.

This article suggests that social workers, often aware of family patterns and dynamics possibly unavailable to other disciplines, take a lead role in an interdisciplinary team approach to facilitate testing for the HIV antibody in children suspected of infection through sexual abuse. The paucity of data available on HIV infection in pedophiles is discussed, along with various relevant legal and ethical concerns. (MC)

continued on next page

Journal Highlights

-Thomas F. Curran

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Kohl, J. (1993). School-based child sexual abuse prevention programs. *Journal of Family Violence, 8* (2), 137-150.

One hundred twenty-six major school-based child sexual abuse prevention programs throughout the country were identified and surveyed in this study. The results indicated that the programs reached hundreds of thousands of students, and offered a prescribed curriculum. Most of the programs aimed to meet the ne[illegible] of disabled students, and there was rather wide variation in training format, duration, and materials used.

Olafson, E., Corwin, D.L., and Summit, R.C. (1993). Modern history of child sexual abuse awareness: Cycles of discovery and suppression. *Child Abuse and Neglect, 17* (1), 7-24.

This article reviews and offers thoughtful explanations for the cyclical suppression of child sexual abuse throughout history. The authors reveal how the current "backlash" against the rediscovery of child sexual abuse utilizes very old but often successful arguments. Knowledge of these earlier arguments and the resulting suppression surely may help professionals understand and counter the modern day "backlash."

Peterson, R.F., Basta, S.M., and Dykstra, T.A. (1993). Mothers of molested children: Some comparisons of personality characteristics. *Child Abuse and Neglect, 17* (3), 409-418.

The Clinical Analysis Questionnaire (CAQ) was used to study the personality characteristics of three groups of mothers: those whose children had been molested by a family member (N=13); those whose children had been molested by a teacher (N=15); and a control group of mothers whose children had not been molested (N=12). Few differences were found between the two groups of mothers of abused children. Significant differences between mothers of molested children and control mothers were found on 7 of the 12 scales measuring abnormal functioning, such as schizophrenia and anxiety. The study's results presented a relationship between maternal clinical symptoms and a child's maladjustment to abuse.

Reidy, T.J. and Hochstadt, N.J. (1993). Attribution of blame in incest cases: A comparison of mental health professionals. *Child Abuse and Neglect, 17* (3), 371-382.

This study examined mental health professionals' attributions of blame in father-daughter incest cases, examining the influence of professional affiliation, gender, experience in treating victims and perpetrators, and years of clinical experience. Contrary to earlier research, the results did not indicate that mental health professionals blame the victim; rather, they appeared to blame the perpetrators completely. The amount of clinical experience various professionals had was a significant factor in blame attribution.

Rowan, A.B. and Foy, D.W. (1993). Post-traumatic stress disorder in child sexual abuse survivors: A revi[illegible] of the literature. *Journal of Traumatic Stress, 6* (1), 3-20.

Research examining the consequences of child sexual abuse in terms of the applicability of a Post-Traumatic Stress Disorder (PTSD) diagnosis is discussed in this article. This review examines studies which have investigated relationships between exposure and symptom development among child sexual abuse survivors. An interesting discussion of some criticisms and benefits of applying the PTSD diagnosis to sexual abuse survivors is presented.

Summit, R.C. (1992). Abuse of the Child Sexual Abuse Accommodation Syndrome. *Journal of Child Sexual Abuse, 1* (4), 153-163.

In this thought- provoking article, Roland Summit comments on the original purpose of the Child Sexual Abuse Accommodation Syndrome (CSAAS). Summit explains how and why the CSAAS, like the phenomenon it describes, continues to be met with misunderstanding and denial. In this article Summit reflects upon the CSAAS, about the sexual abuse of children, and about why professionals continue to be so uncomfortable with both.

OTHER ISSUES IN CHILD MALTREATMENT

Duquette, D.N. (1992). Child protection legal process: Comparing the United States and Great Britain. *University of Pittsburgh Law Review, 54* (1), 239-294.

This article examines the history and cultural context of child protection laws in the United States, England, and Wales and Scotland. The different court structures, legal actors, and their respective roles are discussed. Finally, the substantive legal standards for formal court intervention in child abuse cases in each country are outlined.

Goldman, J., Graves, L., Ward, M., Albanese, I., Sorensen, E., and Chamberlain, C. (1993). Self-report of guardians ad litem: Provision of information to judges in child abuse and neglect cases. *Child Abuse and Neglect, 17* (2), 227-232.

Reporting patterns of guardians ad litem to judges in child abuse and neglect cases were studied. In abuse [illegible] neglect cases, Guardians most frequently reported to the court on the child's physical safety, the interact[illegible] between parent(s) and child, and personality characteristics of the parent(s).

The Journal Highlights editor wishes to express his sincere thanks to Marjorie Cahn for her contributions to this issue.

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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

NOT AVAILABLE

____ 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 are not available on audiotape.

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

NOT AVAILABLE

____ 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

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PAYMENT MUST BE MADE IN U.S. FUNDS, BY CHECK, MONEY ORDER, OR NEW YORK DRAFT.

RESOURCES

New APSAC Task Force on Child Fatalities

Due to the increasing number of child abuse and neglect deaths and the implementation of child fatality review teams across the nation, the American Professional Society on the Abuse of Children (APSAC) has established a national Child Abuse Fatality Task Force. This task force is designed to provide an interdisciplinary approach to the issues surrounding abuse-related deaths and child death review teams.

The first organizational task force meeting was held on June 24, 1993 in Chicago in conjunction with APSAC's First National Colloquium.

If you would like more information about this task force, please contact Sheila Thigpen, Task Force Coordinator, at 405-271-8858.

NTPETA Field Test Accepting Registrations

The National Training Program on Effective Treatment Approaches in Child Sexual Abuse is accepting registrations for its field test November 15-17, in Hunstville, Alabama. The field test is the first of a year of regional trainings to be presented throughout the country. Field test participants will have benefit of the same curriculum and instructors as the other trainees, but will have the opportunity to make suggestions and recommendations before the training goes "on the road." The NTPETA field test is $50 per person, a special price for this training only.

The NTPETA field test and regional trainings will provide information for treatment providers of child and adolescent victims of sexual abuse. The training is especially appropriate for treatment providers with two or more years clinical experience.

For more information on the field test or the regional trainings, contact NTPETA at 1-800-239-9939. NTPETA is a project of the National Children's Advocacy Center and is funded by a grant from the National Center on Child Abuse and Neglect of the U.S. Department of Health and Human Services.

Training for Child Death Review Teams

M/CAP (Missing and Exploited Children Comprehensive Action Program), in conjunction with several state and Federal agencies, will sponsor a national teleconference on child death review teams to be broadcast on February 16-17, 1994. Experts from around the country will present practical information about organizing and maintaining a team, including the roles and responsibilities of participating agency representatives. For more information write:

M/CAP, Special Projects / Telecon 2
2101 Wilson Boulevard, Suite 135
Arlington, VA 22201

ISPCAN

The International Society for Prevention of Child Abuse and Neglect (ISPCAN) was founded in 1977. It is a multidisciplinary international organization of people working to prevent child abuse and negl The aim of the organization is to prevent cruelty to children in every nation, whether cruelty is in the form of abuse, neglect, or exploitation. ISPCAN is a membership organization, providing all members with *The International Journal of Child Abuse and Neglect*, and the newsletter, "The Link." In 2994, the Journal will be published monthly. Membership costs $85.00 per year. For more information on joining, please write Cheryl Walker, c/o ISPCAN, 332 S. Michigan Ave., Suite 1600, Chicago, IL 60604.

CLASSIFIED

University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine seeks:

Pediatrician

Child Psychologist

Grant/Program Development Specialist

Post Doctoral Fellow

Pediatric Nurse Practitioner

The Center for Children's Support is expanding its program and is seeking applicants in the disciplines as noted above. The Center is the pimary provider for diagnostic and therapeutic services for victims of sexual abuse in Southern New Jersey. This is an ideal opportunity to be part of a team engaged in clinical service, research, and education. Experience in working wiht sexually and/or physically abused children preferable. Both full and part-time applicants considered. We are located in Metropolitan Philadelphia area. Very competitive salary and excellent benefits. Positions available immediately. Please submit resume and inquiries to:

Martin Finkel, DO
UMDNJ-SOM Suite 3400
310 South Central Plaza - Laurel Road
Stratford, NJ 08084
(609) 566-7036
UMDNJ is a AA/EEO employer M/F/H/V

APSAC members represent a broad diversity of professional disciplines, geographic locations, and conceptual orientations. Membership in APSAC in no way constitutes an endorsement by APSAC of any member's level of expertise or scope of professional competence.

CALL FOR PAPERS

Special Issue of *Violence and Victims*

Violence Against Women of Color

Guest Editors: Anthony J. Urquiza, PhD; Gail E. Wyatt, PhD; Maria P.P. Root, PhD.

This issue will focus on empirical research that addresses violence perpetrated against women of color. The editors seek manuscripts from various disciplines that may be broad in focus; based upon quantitative or qualitative research methodology; offer a theoretical perspective on existing empirical literature, and/or may address any form of violence perpetrated against women of color. Editors encourage manuscripts which provide innovative approaches to research, prevention, or intervention with attention to cultural context.

Deadline for manuscript submissions is December 1, 1993. Please send an original and three copies of your manuscript to: Anthony J. Urquiza, PhD, Child Protection Center, UC Davis Medical Center, Pediatrics, 2516 Stockton Blvd., Sacramento, CA 95817. For further information, call 916-734-7614.

REWARD THE MEDIA

Each year APSAC seeks to pay tribute to media professionals who have provided responsible and balanced coverage of issues relating to child abuse and neglect. If you are aware of media coverage of child maltreatment which deserves special recognition, please bring it to APSAC's attention by nominating it for APSAC's Second Annual Outstanding Media Coverage Award. To make a nomination, write a letter describing the coverage and stating why you think it deserves the award. If coverage was in the print media, enclose two copies of the article(s) being nominated; if in the electronic media, enclose a transcript of the program, or information about how to secure a transcript. **Deadline for submissions is December 31, 1993.** Send nominations to the Media Relations Committee Chair, Paul Stern, Snohomish County Prosecutor's Office, Snohomish County Courthouse, M/S 504, Everett, WA 98201. Help APSAC reward good media coverage of child maltreatment!

CONFERENCES

APSAC DISCOUNTS

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 24-28, 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.*** Cambridge, MA. Call the APSAC national office, 312-554-0166.

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 20-22, 1993. ***17th Annual Governor's Conference on Prevention of Child Abuse and Neglect.*** Topeka, KS. Call Julie Reed, 913-354-7738.

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.

October 24-28, 1993. ***121st Annual Meeting.*** San Francisco, CA. Sponsored by the American Public Health Association. Call 202-789-5670 for details.

November 10-13, 1993. ***12th Annual Research and Treatment Conference.*** Boston, MA. Sponsored by the Association for the Treatment of Sexual Abusers. Call ATSA at 503-233-2312.

November 18-19, 1993. ***Special Issues of Treatment of Abused Children and Adults with Dr. Eliana Gil & Dr. John Briere.*** Indianapolis, IN. Sponsored by Arbor Hospital and the Indiana Chapter of National Committee to Prevent Child Abuse. Call 317-637-2906..

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 301-589-8242.

December 8-12, 1993. ***Brief Therapy: Essence and Evolution.*** Orlando, FL. Sponsored by the Milton H. Erickson Foundation. Call the Erickson Foundation office, 602-956-0519.

Announcing!

Second National Colloquium

The American Professional Society on The Abuse of Children

●

May 4–7, 1994

●

Hyatt Regency Cambridge, Massachusettes

MARK YOUR CALENDAR NOW!

Membership Plans

❑ New Membership ❑ Renewal

Regular Membership

One year membership

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

Two year membership

Over $50,000 annual income	$160
Under $50,000 annual income	$100

Student Membership

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

Life Membership

Includes framed membership certificate.

Flat rate regardless of income $850

Group Membership

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

Applicants outside North America add $10 per year to annual dues. In order to be enrolled as a member, please enclose your payment with this form. Payment must be made in U.S. funds, by check, money order, or NY draft.

Application for Membership

(Please print or type all information clearly)

Name _____ Degree _____

Title _____

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

❑ Office Address (Agency name) _____

Street _____ City _____ State ___ Zip ___

❑ Home Address (Optional) _____ City _____ State___ Zip___

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

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

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

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

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

Total amount enclosed: $ _____

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

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

In making this application, applicants certify their compliance on a continuing basis with the standards of conduct appropriate for APSAC members, including, but not limited to, the professional and ethical standards of, and all laws and regulations relating to, their respective professions or fields.

In advertising professional services, no member shall utilize the APSAC name or logo or state or imply that APSAC has certified his or her professional competence.

American Professional Society on the Abuse of Children

332 S. Michigan, Suite 1600 • Chicago, IL 60604 • 312-554-0166