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RESEARCH REVIEW

Ritual Abuse: A Review of Research

-by

Kathleen Coulborn Faller

The term "ritual abuse" is applied to acts that subject children to sadistic and terrorizing physical, sexual, and psychological abuse. However, children are not necessarily its only victims. Children sometimes describe adults being harmed in ritual abuse situations, and adults report such experiences as children and sometimes in later life. In many but not all instances, these reported activities appear to be supported by a belief system which may be satanic. Although historical roots can be found (Goodwin, 1993), ritual abuse is a relatively recently identified type of child maltreatment. Cases were first noted in 1983 (Waterman et al., 1993).

Professionals disagree about appropriate terminology to describe ritual abuse, the range of situations to include in the category, whether ritual abuse actually exists, and if it does, its extent and significance. Moreover, the debate about ritual abuse has been greatly influenced by emotional reactions and personal beliefs. This article cannot address in depth all of these issues. This article will focus on findings from selected empirical studies of reports of ritual abuse, attending particularly to the reported characteristics of ritual abuse, findings regarding differential effects of sexual abuse and ritual abuse, and available corroboration of victims' accounts. The author hopes that focusing on empirical findings will inform the discussion of this very controversial kind of maltreatment.

The Research

Thus far, the studies on ritual abuse are small in number but nevertheless instructive. Those reviewed below have been selected for their rigor. They will be covered under four topics: research on professional experience with ritual abuse, research on ritual abuse in day care, research on community-based cults, and research on intergenerational ritual abuse.

Research on professional experience with ritual abuse.

Bottoms, Shaver, and Goodman

An ongoing study by Bottoms, Shaver, and Goodman (1991; 1993) funded by the National Center on Child Abuse and Neglect, examines the extent to which professionals in the helping and legal professions have encountered persons reporting ritual abuse. The researchers are exploring two categories of abuse: (1) those that fit a generally accepted definition of ritual abuse (to be further documented below); and (2) cases of religion-related abuse. The latter commonly involve abuse by a religious professional or in a religious setting. Altogether, 41,000 agencies and professionals have

continued on page 19

NEWS

New Board Elected: New Journal Officially Approved

-by

Theresa Reid

New Board members elected

Five new members were elected to APSAC's Board of Directors for terms beginning January 1, 1994 and ending December 31, 1996: **Randell Alexander, MD, PhD**, University of Iowa, **Mark Chaffin, PhD**, University of Arkansas Children's Hospital, **Howard Dubowitz, MD**, University of Maryland, **Donna Pence**, Special Agent, Tennessee Bureau of Investigation, and **Diane Willis, PhD**, University of Oklahoma.

The following Board members were re-elected for their second terms as well: **Veronica Abney, MSW**, UCLA Neuropsychiatric Hospital & Institute; **Kathleen Coulborn Faller, PhD, ACSW**, University of Michigan School of Social Work; **Thomas Curran, MSW, JD**, Defender Association of Philadelphia; **Deborah Daro, DSW**, National Committee to Prevent Child Abuse; **Susan Kelley, RN, PhD**, Boston College School of Nursing; **Paul Stern, JD**, Snohomish County Prosecuting Attorney's Office; and **Linda Williams, PhD**, University of New Hampshire, Family Research Laboratory .

APSAC is very fortunate to have leadership of this calibre on the Board of Directors. I am confident that all of these outstanding professionals will serve APSAC well during the period of enormous growth that lies ahead.

Patricia Toth, JD (National Center for the Prosecution of Child Abuse) took office as APSAC's President on January 1, 1994. The Board elected the following officers at its annual meeting on January 23, 1994, in San Diego: **Linda Meyer Williams, PhD**, President Elect (Chair, Membership Committee), University of New Hampshire, Family Research Laboratory; **Benjamin Saunders, PhD**, Second Vice President (Chair, Program Committee), Medical University of South Carolina; **Paul Stern, JD**, Treasurer (Chair, Finance Committee), Snohomish County Prosecutor's Office; and **Kathleen Coulborn Faller, PhD, ACSW**, Secretary (Chair, Nominating Committee), University of Michigan, School of Social Work. Other Executive Committee members include **Veronica Abney, MSW**; **Randell Alexander, MD, PhD**; **Barbara**

continued on next page

News

-Theresa Reid

continued from page 1

Bonner, PhD; Deborah Daro, DSW; Harry Elias, JD; Susan Kelley, RN, PhD; and Robert Reece, MD.

In addition, three new professionals were added to APSAC's Advisory Board: **Mark Everson, PhD,** University of North Carolina; **Terry Cross, MSW,** Northwest Indian Child Welfare Association; and **Charles Wilson, MSSW**, Tennessee Department of Human Services.

A full list of APSAC's distinguished Board of Directors can be found on p.42.

Annual meeting achievements

The Board conducted a great deal of important business at its 1994 annual meeting.

New journal approved. No later than January, 1996, APSAC members will begin to receive an outstanding new benefit of membership: *The American Professional Journal on the Abuse of Children (APJAC)*. To be published by Sage Publications, the new journal will replace *The Journal of Interpersonal Violence* as the journal APSAC members automatically receive. (APSAC members who wish to continue their subscriptions to *The Journal of Interpersonal Violence* will receive a deep discount from Sage as a benefit of membership.)

APJAC will be designed specifically to meet APSAC members' needs, and to express clearly the purpose and mission of APSAC. *APJAC* will be practitioner-oriented, clearly interdisciplinary, and focused on practice and policy issues. In addition to publishing submitted research articles, *APJAC* will undertake to address current controversies. Editors will solicit review articles and policy pieces of immediate relevance to the field.

The *APSAC Advisor* will remain much as it is when *APJAC* appears. In general, *Advisor* articles will be shorter than those in the new journal, limited in the number of references, and in a more informal style. Research reported in the *Advisor* will be brief, and very limited in any description of methodology; *Advisor* research articles will primarily concentrate on implications for practice and policy. Most news, announcements, society business, and guidelines would appear in the *Advisor*.

An *ad hoc* Editor Search Committee is now seeking nominations for the position of Editor-in-Chief of *APJAC* (see announcement, p.41). You are encouraged to nominate either yourself or a colleague whom you believe to be qualified for the job. In addition to the Editor-in-Chief, *APJAC* will be created by an interdisciplinary Editorial Board representing all of the areas of expertise reflected in the APSAC membership.

Few undertakings of an organization could be as important or exciting as the production of a new journal. APSAC's Board and staff look forward to working with you to ensure that *APJAC* is designed to meet your professional needs, both immediately and throughout *APJAC*'s long, bright future.

Site chosen for 1995 Colloquium. APSAC's Third National Colloquium will be held June 7-11 in the beautiful desert resort "La Paloma," in Tucson, Arizona. APSAC received the outstanding room rate of $89.00 per night, single or double, for this world-class resort hotel. Mark your calendars now!

Cultural Diversity Committee approved. The Board also approved a new standing committee on cultural diversity. The committee, proposed by Anthony Urquiza, PhD, will serve in an advisory capacity to all other APSAC committees (including the Executive Committee) as they strive to make APSAC responsive to the increasing cultural diversity of the U.S., its membership, and its membership's client populations. The Cultural Diversity committee will work with other committees to help ensure, for example, that research in the field takes cultural factors into account, that APSAC's professional trainings and publications reflect an understanding of cultural differences, and that professionals of color working in this field learn about APSAC and ways in which they can become involved. The committee is a welcome addition to APSAC's structure.

Ballot format debated. APSAC's Board contiues to debate ways to make the process of electing directors as democratic as possible while meeting the requirements of Illinois law and the Society's aims of ensuring diversity in representation of disciplines, areas of expertise, geographical regions, and cultural groups on the Board. Meeting all these goals is no easy feat.

Last December, APSAC memebers received a request to ratify the Board election that had just been held. More than 30% of the membership--triple that required for a quorum--returned the ballot ratifying the Board. The ratification process was necessary because Illinois law requires that candidates receive a majority of the votes cast in order to be elected. APSAC's ballot had been constructed to to give members the maximum range of choice in selecting among candidates for the board. Unfortunately, with so many names on the ballot, some of the highest vote-getters still don't receive the majority of all the votes cast.

The Board has debated several possible ballot constructions: one offering a complete slate for a vote up or down; one offering only 30% more candidates than there are seats to be filled (allowing the requisite number of candidates to receive a majority of the votes cast); and one in which two people run against each other for specified slots. The Board could also institutionalize the two-stage process used last year, offering an initial ballot with a long list of candidates, then asking for a vote up or down on the group of candidates who receive the highest number of votes.

Your input would be greatly appreciated as the Board works to find the ballot construction that will best meet APSAC's aims of fairness, diversity, and maximum member participation.

Theresa Reid, MA is APSAC's Executive Director

OFFENDER TREATMENT

The Perils and Pitfalls of Profiling Child Sex Abusers

-by William D. Murphy, Terri J. Rau, and Patricia J. Worley

Case report: A mother notices, while bathing her three-year-old daughter, that the girl has a vaginal discharge. Pediatric exam and laboratory tests indicate gonorrhea and physical findings consistent with child sexual abuse. The mother feels the child's father, from whom she is separated and who has visitation rights, is the offender. The child is unable or unwilling to identify the offender. The father vehemently denies the abuse. The CPS worker and law enforcement officer investigating the case find the father to be resistant and hostile. Through further investigation, they determine that the father has a significant alcohol problem and was physically abusive to the child's mother during the marriage. Both the CPS worker and law enforcement officer, with many years' experience in investigating child sexual abuse cases, feel strongly that the father is the offender. The prosecutor feels that there is insufficient evidence to charge the father. The investigative team decides to refer the father to the local "expert" in offender evaluation.

Professionals working in the field of child sexual abuse (including CPS workers, law enforcement officers, prosecutors, judges, physicians, and mental health professionals) share the common goal of protecting children. The above case, however, makes us all face the professional and scientific limitations of our disciplines. Such cases require us to face the harsh reality of these professional limitations within the compelling urgency of a child at risk for further abuse.

In numerous other cases, for whatever reason, insufficient evidence exists for prosecution. In many of these cases, investigators are tempted to refer the alleged offender for evaluation. Whatever is explicitly stated in such referrals, the implicit hope is that the evaluation will somehow provide evidence that the alleged offender fits some profile of known offenders, or that the evaluator can make some statement of the likelihood that the individual is guilty of a certain crime. However, both from a legal standpoint (Peters & Murphy, 1992) and from a scientific standpoint (Murphy & Peters, 1992), evaluation of the denying offenders in such cases will be of little to no assistance to investigating authorities. This article will discuss the scientific evidence underlying the evaluation of child sexual abusers, clarifying what these evaluations can and cannot do. A recent article in *The APSAC Advisor* (Chaffin & Milner, 1993) reviews many of the general psychometric principles that underlie the current article, and this review will not be repeated here.

General Considerations

Although our knowledge has increased significantly over the last 20 years, there is still much we do not know about sexual offenders against children. In any case, much of what we have learned has refuted early clinical descriptions which suggested that all offenders against children shared certain characteristics. What we now know is that offenders against children are a very diverse group, showing a range of psychological dysfunction from none to severe and a variety of sexual arousal patterns from normal to quite deviant. On many psychological instruments they overlap considerably with general psychiatric and criminal populations (Murphy & Peters, 1992; Levin & Stava, 1987).

There is moderate consensus in the field of offender evaluation and treatment regarding important areas for evaluation (Murphy & Smith, in press). In general, offender evaluation involves assessment across a variety of areas, including: (1) intellectual functioning, (2) assessment of personality/psychopathology, (3) assessment of social competence, (4) determining the level of denial, (5) identifying risk factors, (6) identifying the degree of cognitive distortion used, (7) assessing the degree of understanding of victim impact/empathy, (8) assessing marital and family functioning, and (9) assessing deviant sexual arousal. There is not necessarily agreement within the field regarding which specific instruments should be used to assess each of the areas, but there is general agreement that the above are prime areas to be included in a comprehensive offender assessment. Nevertheless, there are still significant limitations with regard to how evaluation information can be legally and ethically used. The inherent limitations of using offender assessment to profile offenders will now be outlined using examples of the most commonly used assessment methods.

Specific Assessment Approaches

The MMPI. One of the most frequently used instruments in the assessment of sexual offenders is the Minnesota Multiphasic Personality Inventory (MMPI). The MMPI and the recently revised MMPI-2 each contain 10 scales assessing various types of psychopathology and 3 scales assessing validity (that is, any attempt by the patient to place him/herself in a "good" or "bad" light, or potentially reflecting the patient's inability to comprehend items).

Numerous studies tend to suggest a consistent MMPI "profile" among child sexual abusers, with the "4-8" profile being most commonly found (Anderson & Kunce, 1979; Armentrout & Hauer, 1978; Kalichman, 1991; Kirkland & Bauer, 1982; Quinsey, Arnold, & Pruesse, 1980). The 4-8 profile, or one showing elevations on Scales 4 and 8, is clinically interpreted as an individual who is resentful, irritable, impulsive, and hostile, who fears emotional involvement, distrusts others, and has strong needs for attention. Although this pattern has been found consistently across studies, there are a number of problems in interpreting group profiles.

continued on next page

CONTENTS

Offender Treatment

-William D. Murphy,
Terri J. Rau,
and Patricia J. Worley

continued form page 3

The first problem is that the most common (or modal) profile of a group may not accurately reflect individuals within the group. For example, two recent studies with large samples (Erickson, Luxenburg, Walbek, & Seely, 1987; Hall, Maiuro, Vitaliano, & Proctor, 1986) both found that the modal MMPI profile was represented by the 4-8 pattern. However, this pattern was found in only 13% of the sex offenders in the Erickson et al. study and in only 7% of the child molesters in the Hall et al. study. Furthermore, almost every possible MMPI profile was observed in the individuals within these two samples, and a substantial percentage of the individual profiles were clinically normal (19% in Erickson et al., 1987; and 7% in Hall et al., 1986). When one looks at the individual profiles within these larger groups, it is quite clear that no one profile characterizes even the majority offenders.

In summary, what the MMPI literature actually suggests is that individual offenders against children vary tremendously in their psychological functioning, as measured by the MMPI. No particular profile predicts a propensity for sexual offending. A significant proportion of offenders may exhibit no measurable psychopathology.

A second problem is that the 4-8 profile is not unique to child sexual abusers and has been observed in other forensic groups. Quinsey et al. (1980) compared child sexual abusers to rapists, murderers of family members, murderers of non-family members, arsonists, and property offenders, and found no differences between any of these groups, as measured by their MMPI scale elevations.

A third major problem is that most of the MMPI research to date has examined individuals who have been convicted and are in correctional facilities. The applicability of these findings to an outpatient population, to a population of denying individuals, and to those with no prior legal history is limited. For example, Scott and Stone (1986), investigating outpatient incest offenders, found basically "normal" profiles, that is, their clinical scales were not elevated. McCreary (1975), comparing child molesters with no arrests to those with one or more arrests, found that those with no prior legal history exhibited normal mean profiles, while those with previous convictions showed the typical 4-8 mean profile. Lanyon and Lutz (1984), comparing subjects who were admitting their offense versus those who are in partial or full denial, found that the most common profile among those in some denial was a normal one, while those admitting their offenses produced the 4-8 modal profile.

In summary, what the MMPI literature actually suggests is that individual offenders against children vary tremendously in their psychological functioning, as measured by the MMPI. No particular profile predicts a propensity for sexual offending. A significant proportion of offenders may exhibit no measurable psychopathology.

Penile Plethysmography. A second assessment approach with the most empirical support and the one that may be the most appealing in terms of face validity is the use of penile plethysmography. This assessment method involves measuring changes in penis size and/or volume while the individual is exposed to sexual material in a controlled laboratory situation. The sexual material tends to be slides of various age male and female children and/or audiotapes describing various sexual acts with children. As with the MMPI, numerous studies have shown significant differences between the responses of sexual offenders against children and nonoffenders (Frenzel & Lang, 1989; Freund, 1965, 1967; Freund & Blanchard, 1989; Freund & Watson, 1991; Lang, Black, Frenzel, & Checkley, 1988; Marshall, Barbaree, & Butt, 1988; Marshall, Barbaree, & Christophe, 1986; Quinsey, Chaplin, & Carrigan, 1978; Quinsey, Steinman, Bergensen, & Holmes, 1975). However, this is again based upon aggregate data and the picture is much different if one looks at the actual number of subjects who show such deviant patterns. Using fairly stringent criteria, Marshall et al. (1986) could only correctly classify 40% of the non-familial child molesters, while classifying the vast majority of nonoffenders and incest offenders as normals. Using less stringent criteria, they still classified only 60% of the child molesters correctly and misclassified 18% of the nonoffenders. Similarly, Frenzel and Lang correctly classified 42% to 50% of extra-familial child molesters, while just less than 10% of the incest cases showed pedophilic arousal patterns. Although other studies have shown classification rates in the 70% to 80% range (Abel, Becker, Murphy, & Flanagan, 1981; Murphy, Haynes, Stalgaitis, & Flanagan, 1986), neither study had adequate control groups to examine misclassification.

It also appears that incest offenders are more likely to show normal arousal patterns (Murphy et al., 1986; Marshall et al., 1986; Frenzel & Lang, 1989). Although there are exceptions to these findings, particularly when audiotapes are used as stimuli (Abel et al., 1981; Murphy et al., 1986), the weight of the evidence clearly indicates that nondeviant arousal patterns are expected in incest cases.

A third issue, similar to that observed with the MMPI, is that much of the research has been based upon individuals who were admitting their offenses or where there was clear evidence that the offenses were committed. Arousal measures become much less useful in nonadmitters. For example, Freund and Blanchard (1989) found that only 55% of nonadmitters could be identified as pedophiles. Somewhat better classification rates in nonadmitters (44% to 88%) were reported by Freund & Watson (1991), depending upon the number, age and sex of

continued on page 28

EVALUATION AND TREATMENT

Can We Believe What Children Say About Sexual Abuse?

-by John E. B. Myers

Child sexual abuse is tragic and common (Finkelhor, 1994). In most cases there is no medical evidence of abuse, and the child is the only eyewitness (Bays & Chadwick, 1993). It often happens, therefore, that the child's word is the only proof. But is the word of a young child--perhaps only three or four years old--worthy of belief? Increasingly, the print and broadcast media raise doubts about young children's memory, suggestibility, and truthfulness, and about the questioning techniques used by professionals who interview children about suspected sexual abuse (Myers, 1994).

At the outset it is worth asking whether children deliberately lie about sexual abuse. By age three, children learn to bend the truth. There is no evidence, however, that children are any more or less prone to lie than adults (Berliner, 1988; Melton, 1981). Although children sometimes deliberately fabricate allegations of sexual abuse, research reveals that fabrication is uncommon, particularly among young children (Myers, 1992, § 4.4). Moreover, young children are not adept at maintaining a lie (Yates & Musty, 1988).

No, it is not the deliberate lie that is worrisome. Rather, concern focuses on the possibility that young children who are *not* abused may be coached or led into believing that they are! Is this possible? If it is, who would do such a thing? Some harsh and unbalanced critics envision an army of corrupt and malevolent professionals on a witch hunt of false allegations (Eberle & Eberle, 1993). There is no proof of a witch hunt. There is anecdotal evidence, however, that a few well-intentioned but misguided interviewers use questioning techniques that could distort or contaminate children's memories (State v. Michaels, 1993). In rare cases, improper interviewing may actually create a "memory" of abuse that never happened, or distort recollection of events that did occur (Loftus, 1993). In such cases children describe nonexistent abuse, all the while believing what they say. Although wholesale creation of abuse "memories" appears to be rare, the possibility cannot be ignored.

Although children sometimes deliberately fabricate allegations of sexual abuse, research reveals that fabrication is uncommon, particularly among young children. Moreover, young children are not adept at maintaining a lie.

Primary concern about interviewing young children focuses on their suggestibility and memory. Although memory skills increase with age, young children, including preschoolers, have good memories (Ceci & Bruck, 1993; Fivush & Hudson, 1990; Steward, Bussey, Goodman & Saywitz, 1993). Robyn Fivush of Emory University observes that research on children's memory has shown that their recall can be quite accurate (Fivush, 1993). Moreover, preschoolers are often as accurate as older children. Some research indicates that young children's recall for some events may not be as strong as the recall of adults, and that young children's recall may fade more quickly than adults' (Warren & Hagood, in press). Nevertheless, the developmental literature clearly demonstrates that young children have the memory capacity to recall events. Lynne Baker-Ward of North Carolina State University, and her colleagues, write that "Recent investigations of preschoolers' long-term retention of selected personal experiences have successfully challenged earlier views of young children's recall abilities as being quite restricted. . . . Young children's reports of personally experienced events can be extensive and accurate" (Baker-Ward, Ornstein, Larus & Clubb, 1993, pp. 1519, 1530). Concern about interviews should not focus on children's memory ability, which is good. Rather, the focus should be on suggestibility.

By age ten or eleven, children appear to be no more suggestible than adults (Saywitz & Snyder, 1993). This is not to say, of course, that children approaching adolescence are not suggestible. Psychologists have long documented suggestibility in adults (Loftus, 1979). The important point is that concern about suggestibility does not have to be greater in older children than in adults. Turning to young children, most studies find that young children, particularly preschoolers, can be more suggestible than older children and adults (Ceci & Bruck, 1993; Ceci & Bruck, 1993a; Doris, 1991; Lepore & Sesco, in press). Research also discloses, however, that young children are better at resisting suggestive and misleading questions than many adults believe (Goodman & Bottoms, 1993). Thus, concern about young children's suggestibility is well-founded, but should not be exaggerated.

Psychologists continue their research on young children's suggestibility. All the researchers share the goal of greater understanding, although they approach children's suggestibility from differing perspectives. One group of researchers emphasizes children's suggestibility (See Ceci & Bruck, 1993). Stephen Ceci of Cornell University typifies this approach. Ceci structures some of his experiments to highlight children's suggestibility. Not surprisingly, experiments designed to demonstrate suggestibility do just that. Given the right circumstances, young children can be quite suggestible. Thus, when preschoolers are interviewed over and over again with highly misleading questions, many children eventually make inaccurate statements.

A second group of researchers take a different approach (Goodman & Bottoms, 1993). Although they fully appreciate the suggestibility of young children, researchers in this second group design experiments that highlight children's strengths as well as their weaknesses. Gail Goodman of the University of California at Davis and Karen Saywitz of UCLA are prominent in the second group. Research by Goodman, Saywitz and others discloses that young children often are able to resist misleading questions (Saywitz, Goodman, Nicholas & Moan, 1991).

continued on next page

Evaluation and Treatment

-John E.B. Myers

continued from page 5

The two approaches described above are not at loggerheads. Researchers like Ceci, who concentrate on children's suggestibility, remind us of the critical need to improve the skills of the police officers, social workers, and other professionals interviewing children. At the same time, researchers like Goodman and Saywitz highlight children's strengths, and give us confidence that when children are interviewed by competent professionals, it is appropriate to have reasonable confidence in what children say.

Research psychologists like Ceci, Goodman, and Saywitz play a decisive role in the debate over children's suggestibility. Judges, legislators, policy makers, mental health professionals, attorneys, and the media, pay close attention to the research findings and public pronouncements of academic psychologists. Because their statements have direct implications for policy and practice, prominent researchers have an obligation to present a balanced picture of children's suggestibility. Society is predisposed to discount children's statements about sexual abuse. With this predisposition in mind, researchers whose work emphasizes children's greater suggestibility have a special duty to remind listeners that children do not have a monopoly on suggestibility, and that adults are suggestible as well. Too often in public discourse about children's suggestibility, influential professionals leave the impression that the "suggestibility problem" is unique to children. This inaccurate impression does a disservice to children and to the truth.

The second reason suggestive questions may be necessary is youth itself. Although preschoolers have excellent memories, young children often need very specific questions to trigger their memories.

How then should interviews of young children proceed? Most experts agree that suggestive questions should be avoided when possible (APSAC, 1990; Faller, 1990). But here's the rub! With young children it is often impossible to avoid suggestive questions, and it is the need for suggestive questions with young children that raises the central dilemma facing interviewers. Although young children are most at risk of suggestibility, young children often *require* suggestive questions to trigger memory (Fivush, 1993; Pipe, Gee & Wilson, 1993). This is so for two reasons, one having to do with the psychological dynamics of sexual abuse, the other with normal child development.

The first reason for suggestive questions during interviews of young children relates to the nature of child sexual abuse. Many sexually abused children hesitate to disclose their abuse (Summit, 1983). Abused children often are threatened into silence, many are ambivalent about disclosing, and some are embarrassed. Teena Sorensen and Barbara Snow examined interviews of 116 sexually abused children and found that nearly 80% of the children initially denied their abuse or hesitated to disclose (Sorensen & Snow, 1991). Thus, the very nature of child sexual abuse inhibits disclosure, and professionals sometimes have little choice but to help children along by asking suggestive questions.

The second reason suggestive questions may be necessary is youth itself. Although preschoolers have excellent memories, young children often need very specific questions to trigger their memories. Young children usually do not provide much information in response to non-specific, open-ended questions like, "Do you know why I'm asking these questions?" or, "Why are we talking today?" To add an illustration that parents can relate to, ask your four- or five-year-old, "What happened at preschool today?" and the answer is predictable, "Nothing" or, "I played." It is not that the child cannot remember. Rather, the youngster needs specific questions to facilitate memory and encourage descriptive communication. Thus, during interviews of young children who may be sexually abused, it is often necessary *for developmental reasons* to ask specific questions, some of which are suggestive.

When suggestive questions are postponed until less worrisome techniques prove unsuccessful, interviewers are often justified in asking such questions. Of course, as the number of suggestive questions goes up, confidence in the child's statements goes down. It must be remembered, however, that answers to suggestive questions are often *true*! The challenge is to reduce the dependence on such questions while, at the same time, respecting the need for them. Fortunately, Gail Goodman, Karen Saywitz, Amye Warren, and others are producing valuable research on techniques to lower children's suggestibility (Batterman-Faunce & Goodman, 1993; Saywitz & Snyder, 1993; Warren, Hulse-Trotter & Tubbs, 1991).

In the final analysis there is no single "correct" way to interview young children, although professionals increasingly agree on basic "dos" and "don'ts." Interviewers usually begin by making children feel comfortable. Young children are better at resisting misleading questions when they are put at ease (Goodman, Bottoms, Schwartz-Kenney & Rudy, 1991). Children should be told in language they understand that it is "okay" to say, "I don't know" or "I don't remember," and that they should feel free to correct and disagree with the interviewer (Geiselman, Saywitz & Bornstein, 1993). Initial questioning should be as open-ended and non-specific as possible. If the child does not respond to such questions--and many young children do not then the interviewer asks specific questions that focus the child's attention on particular topics. When specific questions are asked, the interviewer proceeds along a continuum, usually beginning with questions that focus the child's attention on a particular subject, and, when necessary, moving gradually to more specific questions, some of which are suggestive (Myers, 1992a).

continued on page 33

OPINION

Children's Suggestibility: Reflections on the Tone of the Dialogue

-by Mark Chaffin

Adversarial controversies, particularly when they involve sex abuse and witch hunts, have good entertainment value. Indeed, jumping into the fray on this issue is to virtually submit one's application for a spot on *Geraldo* or the lead article in a popular weekly, providing of course that the opinion proffered is sufficiently polemic, unencumbered by caveats, and makes for a good sound bite. Good entertainment, however, does not always make for good argument. When it comes to the debate on children's suggestibility in the area of sexual abuse, I would argue that the polemic tone of at least some of the literature has transformed the interchange into more of a spectator sport than a vehicle for knowledge to inform practice. Unfortunately, real people and real lives are at stake.

Our response to child sexual abuse has been, and remains, reactive--both against generations of secrecy and denial, and against the slogans of "believe the children" or the notion that sexual abuse is ubiquitous and responsible for any given mental health symptom or social ill. Ours is not the first generation to struggle with these vicissitudes, as Olafson, Corwin and Summit (1993) have clearly described. Judging by past cultural cycles, it would seem fairly clear that some retrenchment is currently under way. The growing body of research on the suggestibility of children and the suggestiveness of child interviewing is evidence of this retrenchment.

When it comes to the debate on children's suggestibility in the area of sexual abuse, I would argue that the polemic tone of at least some of the literature has transformed the interchange into more of a spectator sport than a vehicle for knowledge to inform practice.

What was once considered simply a cheap legal maneuver of attacking the interviewer because attacking the child might offend juries, is now, given some of the data on suggestibility, a legitimate and fair concern. The issue is complex, and because no laboratory manipulation can ethically achieve complete ecological validity, the data are almost universally open to caveat, alternative explanations, and questions about generalizability. Although important questions remain about the *science* of the issue, I would argue that it is the *tone* of the dialogue which poses a potentially destructive problem.

This is a tone that has been frankly *ad hominem*, not so much directed at a particular individual as at a class of individuals--child sexual abuse specialists, therapists and interviewers. No longer limited to the excoriating personal attacks leveled by essayists and critics of the field like Richard Gardner (1991, p.48-53), elements of this tone have now found their way into the broader scientific community and empirical research reports. Consider, for example, this passage from a recent literature review, commenting on therapists and law enforcement personnel who interview allegedly molested children:

> We reiterate, however, that the conditions created in these studies differ markedly from those that occur in actual therapy or in law enforcement investigations: these latter two contexts are seldom as sanitized of affect and free of motives as those in the research setting...In some cases, children are interviewed and reinterviewed under emotionally charged circumstances, entailing the use of bribes and threats, and often in the presence of highly distressed parents; under such conditions, some children may finally utter reports that are simply consistent with the interviewer's expectations (Ceci and Bruck, 1993, 16).

Continuing to address the issue of ecological validity in laboratory research, the same article later states, "It is highly unlikely that we will ever mimic [in the laboratory] the assaultive nature of some acts or interviews perpetrated on child victims and witnesses" (p16). The authors seem here to suggest that interview practice and actual sexual assault are fairly comparable in their maliciousness.

The problem with these statements is not necessarily the existence of the phenomena they describe. Bad practice in the field of sexual abuse investigations and treatment is a reality, just as it is in all other fields. The problem is stereotyping. Bad practice has been so loudly decried by critics that an accepted popular perception has arisen, based entirely on anecdotal evidence, that bad practice is modal practice. As with any stereotype, once established, it is extremely difficult to dispel. Even scientists who would otherwise never equate anecdote with prevalence can be swayed by the widespread acceptance of such a stereotype. To be a child sexual abuse investigator or therapist is to be automatically known in some circles as a "child-saver," "zealot," or "brainwasher." The fact is, we do not empirically know modal practice, what is typical or what is rare. While interviewer practices are sometimes explicated when they are problematic or egregious, I am aware of no data objectively coding representative practices of a representative sample of child sexual abuse interviewers or therapists.

What we do know, however, is that well circulated practice guidelines exist (AACAP, 1985; APSAC, 1990) which are clear in their recommendations. Neither has endorsed, and in fact both have specifically recommended against, the sorts of coercive and suggestive practices which the stereotypes suggest are the rule. The guidelines of the major professional organizations in the field are the best reflection available of what a majority feel is codifiable good practice: why would that majority espouse one standard when their practice embodies the opposite?

Perhaps these harsh critics have a sampling problem. Perhaps their work exposes them disproportionately to extremely poor and biased practices.

continued on next page

Opinion

-Mark Chaffin

continued from page 7

I am usually asked to evaluate interviewer or therapist practices when there has been a problem or controversy. If these cases formed the sole sample from which I extrapolated my perception of the world, I suspect my opinion of practice in the sexual abuse field would be largely negative. My experience being other than this (the majority of cases I see being ones in which sexual abuse is eventually confirmed by admission of the abuser), I tend to think that most interviewers and therapists are far removed from the witch hunting stereotype.

The danger here is not so much that professionals who practice in the area of child sexual abuse will be disparaged by stereotyping. That's not pleasant, but they can probably weather it. The real danger is that the *ad hominem* tone of the children's suggestibility discourse will be so personally offensive to so many professionals in the field that they will be tempted to dismiss a body of important empirical data about children's suggestibility as simply "backlash literature."

A second concern about the tone of recent suggestibility literature is its implicit emphasis on false allegations as the sole outcome of interest. For example, the article cited earlier (Ceci and Bruck, 1993), examines the child suggestibility research with an eye towards its implications for children's interviewing, policy, and expert testimony, and provides a thoughtful and well reasoned examination of many of the scientific and methodological aspects of our current knowledge base. Nowhere, however, is there even a token acknowledgement that suggestive processes can be exerted on children to deny bona fide abuse. The entire focus is on the vulnerability of children to suggestive processes which might create false statements of abuse where none actually occurred. Yet aren't children also exposed to interviewers and other adults single mindedly biased towards finding *no* abuse? What about the use of implicit or explicit coercion, up to and including threats of death, used to enforce secrecy and gain recantation, or repeated suggestions to believe that "Nothing happened" or "You misunderstood," which are described as common experiences among abused children (cf. Myers, 1992, p. 134-136)? If young children are relatively more vulnerable to suggestion, doesn't it seem reasonable to consider that this vulnerability may lead to false negatives as well as false positives? In fact, false negatives have been documented as common and related to the biases of significant adults in the child's life (Lawson and Chaffin, 1992; Sorenson and Snow, 1991). Again, the danger here is that the dialogue on children's suggestibility becomes polarized and focused on a hollow contest between those who investigate abuse and those who investigate "hysteria."

The real danger is that the ad hominen tone of the discourse on children's suggestibility will be so personally offensive to so many professionals in the field that they will be tempted to dismiss a body of important empirical data about children's suggestibility as simply "backlash literature."

There is no litmus test for the validity of a sexual abuse allegation, and there never will be. Some cases may be independently confirmed (e.g., videotaped abuse, admission of the abuser), but most will not. In the absence of clear independent confirmation, professionals must make judgments based upon interview data. We cannot ignore the necessity or shirk the responsibility of making these judgments. Like all human judgments, even when informed and impartial, some will be wrong. When the wrong judgement is made, people can be hurt--children's fearful and hesitant disclosures can be discounted and they can be placed, with official blessing, at the mercy of their molesters. Conversely, innocent people can lose their freedom, their reputations, and their children, while the children can be torn from their families and incorporate a false tragedy as part of their personal history. Either outcome is unacceptable, yet probably inevitable. Some techniques may increase the probability of one type of error while reducing the probability of the other. Others are designed to increase accuracy although possibly reducing the volume of information. Yet others (e.g., bribes) clearly have no place in professional practice. In order to inform practitioners of the risks and benefits of any of these practices, and to suggest when and with whom they can appropriately be used, it is critical that our overall knowledge base be balanced in the aspects and outcomes of suggestibility it addresses as well as the tone taken.

References

American Academy of Child and Adolescent Psychiatry (AACAP). (1985). *Guidelines for the clinical evaluation of child and adolescent sexual abuse*. Subcommittee on guidelines for evaluation of child sexual abuse. Washington DC: American Academy of Child and Adolescent Psychiatry.

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

Ceci, S., & Bruck, M. (1993). Child Witnesses: Translating Research into policy. *Social Policy Report, Society for Research in Child Development, 7*(3), 1-30.

Gardner, R., (1991). The "validators" and other examiners. *Issues in Child Abuse Accusations, 3*, 38-53.

Lawson, L., & Chaffin, M. (1992). False negatives in sexual abuse disclosure interviews:Incidence and Influence of caretaker belief in abuse in cases of accidental abuse discovery by diagnosis of STD. *Journal of Interpersonal Violence, 7*, 532-542.

Sorenson, T., & Snow, B. (1991). How children tell: The process of disclosure in child sexual abuse. *Child Welfare, 70*, 3-15.

Myers, J.E.B. (1992). *Legal issues in child abuse and neglect.* Newberry Park: Sage.

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

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INVESTIGATION

Juvenile Prostitution: An Overlooked Form of Child Sexual Abuse

-by Byron Fassett and Bill Walsh

The authors maintain that juvenile prostitution is a form of child sexual victimization and must be treated as such. It is not just a younger version of the "world's oldest profession." It is the exploitation of children for sexual gratification and/or money.

The problem of juvenile prostitution

The patrol car, with its headlights turned off, slowly approaches the suspicious vehicle reported to 911. Not knowing if they will find young lovers or a rape in progress, the officers shine their flashlights to illuminate the car's interior. They find neither. What the officers do find is a well-known local businessman engaged in oral-genital sex with a thirteen-year-old girl. A radio check reveals that the man has no criminal history, not even a traffic violation on his record. The girl is another story. A call to the Juvenile Division reveals that she is a runaway from a nearby suburb. In fact, the girl is a chronic runaway, twelve incidents in the last eighteen months. Her juvenile record includes arrests for drugs, burglary, assault on a police officer, and prostitution.

How do you think the officers will handle this call? Release the man and take the girl into custody? Charge them both with public lewdness or engaging in prostitution? Arrest the man for sexual abuse of a child and take the girl into protective custody? Take no action? The answer is any of the above. Depending on the jurisdiction, training, departmental policies, and the attitudes of the individual officers involved, any of the above can and does occur. What these officers do, or fail to do, may be part of the problem.

In this article, the authors will address what they believe may be one of the most overlooked forms of child sexual victimization today: juvenile prostitution. In the last decade we have produced improved strategies for identification, investigation and intervention in child sexual victimization. This progress has not however, included much advancement in the area of juvenile prostitution.

The authors maintain that juvenile prostitution is a form of child sexual victimization and must be recognized and treated as such. It is not just a younger version of the "world's oldest profession." It is the exploitation of children for sexual gratification and/or money. Though the element of consent may appear to be present, if the child is under legal age, it is still sexual victimization of a child by an adult. In many ways it differs from what we see in more traditional cases of sexual abuse. Thus, if we are ever going to help those children involved, we must understand the dynamics and unique problems for identification, investigation and intervention that juvenile prostitution presents.

This article will primarily present a law enforcement perspective on juvenile prostitution. The observations contained herein are based on the authors' personal experiences in dealing with juveniles involved in prostitution. These children were identified through proactive investigations into the sexual exploitation of children. While both male and female teenagers engage in prostitution, the issues involved for each appear to be different. This article will focus on the involvement of juvenile females in prostitution and other sexually exploitive activities.

The scope of the problem

How significant is the problem of juvenile prostitution in this country? In this regard, it is similar to other forms of child maltreatment: nobody knows for sure. National estimates range from 300,000 (Chesney-Lind, 1992) to as high as 600,000 (Cohen, 1987). If the problem is truly this large, we must ask the following questions: Why don't we hear more about it? Where are these children? How do you find them? Whose responsibility are they? What should be done with them?

There are no state agencies charged with the responsibility of identifying and investigating juvenile prostitution, or recording its incidence, as there are for other forms of child abuse. As a result, the issue is often overlooked. Every day the children involved are allowed to slip through the cracks and rarely get the help they need. Recently, a director of a runaway shelter told one of the authors that approximately 250 juveniles served by his agency in the last year have admitted being involved in prostitution at one time or another.

Why are they overlooked?

Incidents where juveniles are involved in prostitution are often undetected by many professionals for a myriad of reasons. One reason is that they may be mistaken for adults. Outfitted with fake identification and the right clothes and makeup, these teenagers can easily pass as adults. They know this to be true and use it to their advantage. For example, if they are arrested by the police for prostitution or any other crime, they know it is better to be booked into jail as an adult rather than placed in detention as a juvenile. If they are placed in jail, they are routinely allowed to pay a small fine or bond and be back on the streets in very little time. But if they are processed as a juvenile, the procedures usually call for them only to be released to a parent or other family member. Since many of them have run from home, they do not want their parents to be contacted.

Another factor that may contribute to the failure of these juveniles being properly identified is the division of investigative responsibilities in many law enforcement agencies. Prostitution is usually investigated by vice divisions and treated as a nuisance crime. In some situations, once a prostitute is identified as a juvenile, the vice officer may feel that it's just not worth the effort to make the prostitution arrest; inexperienced in the juvenile justice system, these officers may believe, "Nothing ever happens to juveniles anyway." The juvenile may be released in the field or charged with another violation, i.e., possession of drugs, etc., and thus never officially

continued on next page

Investigation

-Byron Fassett
and Bill Walsh

continued from page 9

It is difficult for some law enforcement officers to view a seductively dressed, profane, thirteen-year old girl as a victim....A conversation one of the authors recently had with a fellow officer about juvenile prostitution may reveal an attitude shared by many police officers. The officer said, "What's the big deal? They're just little whores."

identified as being involved in prostitution. If asked, most police departments would probably say they have very few cases involving juvenile prostitution. Maybe, in fact, those that they do have are being overlooked.

Another reason these juveniles are not identified as prostitutes is that sexual activity between these girls and adults is often not viewed or investigated as a crime. Adults who engage in acts of prostitution with juveniles are usually not viewed as offenders. In some cases, the argument can be made, the child dressed, looked, and acted like an adult. Therefore, the customer did not knowingly engage in sexual activity with a minor and should not be arrested. While this may be true on occasion, it does not excuse the adult's behavior. These customers, or "tricks" as they are commonly called, should be charged with the appropriate criminal charge (solicitation or sexual victmization), and let a judge or jury decide accordingly. Sometimes the customers are not fooled. The authors have heard of some customers who prefer juvenile prostitutes for sexual activity and actively seek them out, even asking them their age.

Another obstacle to detection is the belief that the juvenile consented to the activity, thus no crime took place. We would not accept this argument in any other case of child sexual victimization, nor should we accept it here. This indifference to the victimization of these girls may be partially due to an attitude about the juvenile's demeanor and her past. It is difficult for some law enforcement officers to view a seductively dressed, profane, thirteen-year-old girl as a victim. Juveniles who engage in prostitution are often involved in other criminal activity, including selling and using drugs, robbery, theft, and other related crimes. Similar to some adolescent sex offenders, many juveniles involved in prostitution are both offenders and victims. While they are sometimes identified and dealt with as offenders, they are rarely viewed or treated as victims. Often, they are viewed as unworthy of the protection society affords to other victims of child sexual abuse. This reasoning is not only faulty, it is contrary to what the law provides. A conversation one of the authors recently had with a fellow officer about juvenile prostitution may reveal an attitude shared by many police officers. The officer said, "What's the big deal? They're just little whores." Rarely is the question as to why they are acting this way ever asked.

Who is involved?

To effectively intervene with juveniles involved in prostitution, we must first understand the dynamics of their victimization. There seem to be some common steps on the road to prostitution. To begin with, most of these juveniles have a history of multiple runaway episodes and prior involvement with the juvenile justice system. Frequently they have many personal problems and have been labeled as a "troubled" or "bad" kid. Involvement in prostitution requires that they are away from home, either voluntarily or otherwise. Some of these children are throwaways--they have been forced to leave home. If they are running, these children are not running to something, but from something. Many have suffered physical and sexual abuse. It is common for them to have drug or alcohol problems. A check of their school records often shows poor school performance, truancy or complete withdrawel from school. As expected, these children often come from dysfunctional families with multi-faceted problems. Without parental support, these children are vulnerable, emotionally and physically, and must provide for themselves in any way that they can. Being hungry, cold, and lonely can make people do things they may later regret.

Runaways who become involved in prostitution have run from inner cities, suburbs and small towns alike. In the cases the authors investigated, the girls have first become involved in prostitution between the ages of 12 and 16 years of age. They have come from all races and socio-economic groups. Poverty, while sometimes a factor, is not always the rule. In one recent investigation, the girl involved was from a middle-class suburban family where the father was a police officer. The problem of juvenile prostitution appears to be more prevalent in larger cities, as they may appear a more attractive destination for runaways, affording anonymity and hiding places lacking in small towns. Often, cities only prove to be a place that will provide the combination of factors needed for this type of victimization to exist.

The authors have observed low self esteem in all the girls involved in prostitution investigated to date. It appears that this poor self image makes them perfect victims for sexual exploitation. Like many victims of sexual victimization, these children are vulnerable because they crave attention and affection. Unlike most other such victims, these girls are usually exploited for financial as well as sexual purposes. It is not unusual for these "pimps" to have sexual relations with the girl prior to involving them in prostitution. This sexual victimization serves several purposes besides the gratification of the pimp. It is used to break down the child's inhibitions. After a time, the girl may be asked to engage in sexual activity with a friend of the pimp. Gradually, the girl will be taught that people will pay her girl for sex. Pimps will then teach the girls about contraception, and different sexual techniques and the price to charge for each.

Following is part of a taped conversation between a thirteen-year-old girl and her pimp. This

continued on page 30

PREVENTION

Postpartum Depression and the Mother- Infant Relationship: How Can Nurture Attachment

-by

Kathleen A. Kendall Tackett

In our culture, we have such pretty images of life with a new baby. The mothers are attractive and well-rested; the babies are either smiling or sleeping. And, of course, the house is spotless. Yet professionals who work with new mothers recognize that the postpartum period can be very stressful. It is a time when support can really make a difference. Perhaps at no other time are parents as eager to learn as when they are caring for a newborn. No wonder the postpartum period has been described as a "window of opportunity" for intervention in the lives of young families (Helfer et al., 1987).

As essential as support is to new mothers, the majority are left to go it alone. Not surprisingly, many mothers become depressed. Unfortunately, little empirical research simultaneously addresses issues of postpartum depression and child abuse and neglect, even though these appear to be co-appearing symptoms in many troubled families. We know that many women suffering from postpartum depression do not abuse their children, and that many people who do abuse their children are not at all depressed. This article will outline how postpartum depression can affect the mother and baby relationship, which is especially pertinent if we are concerned about mothers already at risk for abuse and neglect.

Infanticide is the most sensational but not the most common effect of postpartum depression. The more pernicious effect of postpartum depression is that it can emotionally distance a mother from her infant, and therefore undermine the mother/infant relationship.

Definition of Postpartum Depression

Simply put, postpartum depression is depression that occurs after a woman has a baby. It can occur at any time in the first postpartum year. Postpartum depression is a general term that refers to three conditions: postpartum blues, postpartum depression, and postpartum psychosis. "The blues" and "postpartum depression" are characterized by lability of mood, despair, hopelessness, helplessness, loss of appetite, loss of interest in the baby, anxiety, sleeplessness, or suicidal ideation. "The blues" are very common. In our culture, occurred in 50-85% of new mothers (O'Hara, 1987). They are considered less severe than depression, occur within the first two weeks postpartum, and are generally self-correcting. "Postpartum depression" is estimated to occur in approximately 10-20% of new mothers (O'Hara, 1987), and symptoms can occur any time in the first year. The line between the "blues" and depression is blurry. They have similar symptoms, and the blues may be either a less severe form of depression or a precursor to depression. Since the relationship between depression and the blues is unclear, and they lie on a continuum, it is essential that professionals working with new mothers take any symptoms of depression seriously, and not write them off as insignificant. Postpartum psychosis, the most serious condition, occurs at a rate of 1 to 2 per 1,000 women (O'Hara, 1987). Symptoms of postpartum psychosis include heightened or reduced activity; hallucinations; severe depression, mania or both; confusion; and delirium. It generally occurs within the first two weeks postpartum and may require hospitalization.

The Relationship Between Postpartum Depression and Child Abuse

We have all heard stories in the popular press about women killing their infants while suffering from postpartum psychosis. These stories provide the most salient examples of the relationship between child abuse and postpartum illness. Angela Thompson became delusional after she stopped nursing her son at age nine months. She drowned him in the bathtub after hearing the voice of God tell her that the baby was the devil (Toufexis, 1988). In another well-publicized case, Sheryl Massip drove her car over her six-week-old son after being compelled to do so by imaginary voices (Lachnit, 1990).

As horrifying as these examples are, however, the actual incidence of infanticide related to postpartum illness appears to be low. In the only empirical study of this phenomenon, 82 women who had been hospitalized for severe postpartum depression were followed upon their release. The infanticide rate among women who were identified as having the most severe cases of postpartum illness was 4% (Davidson & Robinson, 1985). Even though this incidence appears to be low, health professionals should realize that infanticide is a possibility, and be prepared to take appropriate action.

Infanticide is the most sensational but not the most common effect of postpartum depression. The more pernicious effect of postpartum depression is that it can emotionally distance a mother from her infant, and therefore undermine the mother/infant relationship. Postpartum depression can tip the scales if a mother is already at risk for abuse or neglect. Some mothers suffering from postpartum depression may become neglectful because they are unable to rally their resources in order to care for their children. Research reveals that maternal depression is similar to maltreatment in its effects on children's development. The findings on maternal depression include increased emotional, cognitive or social problems for the children (O'Hara, 1987); increased levels of behavioral disturbances at two months and three years (Whiffen & Gotlib, 1989; Wrate, Rooney, Thomas, & Cox, 1985); and lower IQ scores (Cogill et al., 1986). Field (1992) described how depressed mothers tend to show two different profiles of behavior: withdrawn or intrusive. The withdrawn mothers spent approximately 80% of their time disengaged from their infants and only responded to infant distress. The mothers with a more intrusive style expressed irritation or roughly handled their infants approximately 40% of the time. In either case, the infants of these depressed mothers showed depressive symptoms.

continued on next page

Prevention

-Kathleen A. Kendall Tackett

continued from page 11

In my own research on postpartum depression, I conducted 23 in-depth interviews with women across the country. They were recruited from the National Office of Depression after Delivery, a self-help organization for women suffering from postpartum illness. All had suffered from either postpartum depression or psychosis. I have used their stories to illustrate many of the issues raised by research studies. Below is one woman's description of how postpartum depression affected her ability to care for her infant son:

Research reveals that maternal depression is similar to maltreatment in its effects on children's development. The findings on maternal depression include increased emotional, cognitive or social problems for children; increased levels of behavorial disturbances at two months and three years; and lower IQ scores.

"I didn't care about anything. I didn't want to eat, I couldn't even get out of bed. I couldn't tell my son was jaundiced. My mother kept saying, 'Your son is sick. You need to do something about your son,' as she tried for the tenth time that day to get me out of bed. That's when I realized how bad that depression was and that I needed help. Everyone could tell the baby was sick but me. I didn't even notice it. I don't know what I would have done if my mother hadn't been there" (Kendall-Tackett, with Kantor, 1993, p. 87).

This woman's story was particularly poignant because she was generally a high-functioning mother, she had good support, and she was able to recognize a problem. This story may have turned out quite differently for a woman at greater risk for abuse or neglect.

Causes of Postpartum Depression

A broad range of factors contribute to postpartum depression including fatigue; negative birth experiences; infant characteristics; the mother's expectations, feelings of self-efficacy and self-esteem; and the mother's level of social support. Each woman who is affected by postpartum illness may be influenced by one or more of these factors. Below I highlight the factors that my research reveals have the most influence on the mother and baby relationship.

Fatigue and Sleep Deprivation. Sleep deprivation is a fact of life for new mothers. Perhaps because it is so common, its influence on a mother's emotional state is often overlooked. Fatigue can be due to a variety of factors, including infant characteristics; a difficult birth; or hypothyroidism, allergies, or anemia that develop in the postpartum period. Fatigue can also be a symptom of depression, which complicates our understanding of the relationship between fatigue and postpartum depression. Sleep deprivation also appears to have some relationship to postpartum psychosis, and several days of sleeplessness may precipitate a psychotic break (Lahey, 1992). When working with new mothers, it is important to take fatigue seriously (see Appendix for a screening instrument for postpartum fatigue). This might include helping mothers to develop strategies for getting more rest, screening for physical problems such as hypothyroidism, anemia, or allergies, and nutritional counseling aimed at modifying the mother's diet. One line of research has demonstrated a link between depression, serotonin levels, and the amount of complex carbohydrates a person consumes (Wurtman & Wurtman, 1989). Higher levels of carbohydrates in the diet were related to reduced levels of depression. Even validating a mother's feeling of fatigue can go a long way toward helping her cope.

Negative Birth Experiences. The effect of birth experiences on women's ability to parent is often overlooked as a variable in child abuse research. It is complicated enough to warrant a future article, but I will also briefly describe it here.

During labor, a woman is extremely vulnerable emotionally. Events that take place during those hours can have a long-range impact. One recent longitudinal study (Simkin, 1992) demonstrated that women could accurately remember details of their first births 20 years after the fact. If this experience is negative, it has been shown to affect how women relate to their babies. Below, two women describe how their frightening birth experiences affected their relationships with their babies for the first year and beyond. The first woman went into a coma for several days as a result of her delivery complications (eclampsia and renal failure), the second had an obstetric emergency (prolapsed cord).

> I woke up Wednesday and found out I had a baby girl. . . . I knew I had a baby, but it didn't make any sense. I couldn't take care of her. The last thing on my mind was my baby. . . . Sometimes I still feel like she's not really mine, that someone else could take her away, that I don't have the right to make decisions about how to take care of her. . . . I'm afraid to give up nursing because it's the only tie that makes her mine (Kendall-Tackett, with Kantor, 1993; p.52).

> It's taken a long time to bond with my baby. I haven't had any of the "new mother" euphoria people talk about. I did not get to hold my daughter until 8:30 the next morning. I let the nurses take care of her. I just wasn't up to it. I didn't even change a diaper until I went home. It's still hard for me to think of myself as a mother, sometimes (Kendall-Tackett, with Kantor, 1993; p.52).

Providing women with a sense of control over their labor and delivery, and providing them with emotional support during labor have both been related to women's positive perceptions of their birth experiences. If a woman has a negative or troubling birth experience, she needs to be able to talk about it. Affonso (1977) found that women frequently need to resolve troubling aspects of

continued on page 35

EVALUATION AND TREATMENT

Recognizing Invasive Genital Care Practices: A Form of Child Sexual Abuse

-by Nancy Berson and Marcia Herman-Giddens

Until we published "Harmful genital care practices: A type of child abuse" (Herman-Giddens and Berson, 1989), the literature had not addressed harmful genital "hygienic" care by parents or caregivers. Our paper described what we defined as abnormal and harmful genital care practices in 17 case studies of children who were referred to the Duke Child Protection Team for evaluation of possible child sexual abuse. The invasive and abusive practices included painful washing of the child's genitalia, sometimes with vaginal or anal penetration, frequent and ritualistic or compulsive inspection of the genitalia, application of inappropriate creams and medicinal preparations, and enlistment of unnecessary medical intervention for alleged genital or urinary problems.

One purpose of the article was to help professionals become aware of these practices, their abusive nature, and their harmful impact on children. The reaction to the article was surprising and instructive. Professionals from fifteen different countries requested reprints, and several wrote of similar experiences with patients. However, the most enlightening and confirmatory responses came from lay people--women who had experienced harmful genital care as children. One woman wrote:

> "Between the ages of five and eleven, I was subjected to the following procedure by my mother during my daily bath: Forcing me to stand in the tub, mother would scrub my crotch briskly with soapy hands, forcing the labia apart. She would then insert her forefinger several times into my vagina, introducing as much soap as possible. I remember distinctly the peculiar look on her face during the ritual....In looking for a therapist, I would appreciate a copy of your paper....I have met with a good deal of disbelief, you understand, and find it difficult to state my case aggressively."

Unfortunately, we too often think of sexual abuse as perpetrated by men, not women. Although men may sexually abuse children under the guise of "genital care," in our experience women are more commonly the perpetrators.

Another woman described similarly painful experiences:

> "I endured 'bathroom days.' Those were the times that I was called into the bathroom to be 'washed.' Being washed consisted of lying on my mom's lap and having my labia separated and being 'washed' quite painfully and prolonged....What will never fade from my mind is the feeling of utter hopelessness and helplessness, the feeling of being less than everyone....I now weigh over 400 pounds. You'd think I would have discovered that I am safe now."

The feedback received from these letters raises the issue of our continuing failure to recognize this type of intrusive behavior as abusive. Unfortunately, we too often think of sexual abuse as perpetrated by men, not women. Although men may sexually abuse children under the guise of "genital care," in our experience women are more commonly the perpetrators. Although no one actually knows the extent of abuse by females, especially by mothers, Diana Russell's 1983 study found only 1% of the women stated that their sexual abuse was perpetrated by their mother. The actual rate is probably much higher and continues to be studied by researchers. Nicholas Groth contends that women offenders are able to disguise their abusive behavior in the form of childcare (Vanderbilt, 1992).

One of the difficulties in assessing inappropriate hygienic care is the dearth of research on what constitutes "normal" genital care in typical families. In addition, a review of the literature, pediatric textbooks, nursing textbooks, and current popular child care books reveals that guidelines for parents on appropriate genital care are sorely lacking and focus mainly on circumcision of infant boys (Berson, 1993).

To begin to identify this type of abuse, it is necessary for the professional to feel comfortable asking pertinent questions in relation to the genital care provided to children. For parents believed to be using age-appropriate practices, it is sufficient to ask if they have questions or concerns regarding their child's genital care during the child's annual physical exam. On the other hand, for parents or caretakers suspected of sexual abuse or abusive genital care practices, the following should be asked in some form as a part of the assessment process:

1. Does your child have symptoms of dysuria, urine retention, excessive retention, excessive masturbation,or swollen and red genitals?
2. Do you feel that it is necessary to wipe your child's genitals after he/she urinates or has bowel movement? (For children over four years of age.)
3. Describe how you bathe your child.
4. How frequently do you bathe your child?
5. Specifically describe how you bathe your child's genitalia. Describe the position of your child during this time. While bathing your child's genitalia, do you use soap? Do you use a washcloth? Do you use your hand? Do you insert a finger or object into your child's vagina or anus as part of washing your child?
6. After bathing or at other times, do you feel the need to inspect your child's genitalia or underwear?
7. If "yes" to 6, where do you inspect the child (on the bed, in the tub, on your lap)? After inspecting your child's genitalia do you ever find it necessary to re-wash your child in this area?
8. Does your child have any genital odors that are bothersome to you?

continued on next page

Evaluation and Treatment

-Nancy Berson and Marcia Herman-Giddens

continued from page 13

9. Do you ever have to use any creams or medications on your child's genital or anal area?
10. Do you find yourself worrying about your child's genitals being clean?
11. Do you use enemas on your child? If so, how frequently? Why does the child need enemas? What is the composition of the solution, soap, medicine, etc.? Is the solution hot, cold or warm? Do you use enemas for yourself?
12. Do you have to give your child laxatives? Why does your child need them? What kind? What dose?
13. Does your child ever ask you to clean or examine his or her genitals?

Sound clinical judgment is required during an assessment which takes into account such contextual variables as age appropriateness, medical necessity, and cultural practices.

During the child's interview, the questions listed above should also be asked of the child. It is often easier for the child and parent in their respective interviews to demonstrate the washing or care by using dolls. It is helpful to have a small cloth and plastic tub available. Other inappropriate practices which may need exploring are inspection by the parent for "normal maturation," medical procedures performed on the child by the parent, and repeatedly seeking medical care for the child for constipation, vaginal discharge or other anal or genital symptoms when there is no medical confirmation of the problem.

It is important to note that not all of the practices referred to in the questions above are necessarily abusive. These behaviors become a concern when they are intense, prolonged, frequent, or compulsive. Sound clinical judgment is required during an assessment which takes into account such contextual variables as age appropriateness, medical necessity, and cultural practices.

Intervention

Due to lack of research in the area of invasive genital care, little is known to date about how to prevent or intervene in these behaviors effectively. It is probable that the interventions would differ according to the "driving force" behind these practices. In our experience, the underlying cause of these behaviors may include parental obsessive-compulsive disorders, the sexual use of the child under the guise of genital care, and lack of appropriate knowledge by the parent. With regard to the latter, we have experienced some apparent success in helping mothers when specific and concrete instructions are provided regarding appropriate care. These instructions include, but are not limited to, asking the mother to refrain from inspecting the child's genitals daily, inserting her finger or wash cloth in the vaginal area, inspecting the child's underwear for odor or staining in front of the child, and wiping an older child's anus after a bowel movement. There are few medical conditions which require enemas; therefore, the use of enemas should occur only by or under the direction of a medical provider. The majority of the mothers with whom we have worked appear comfortable in accepting these instructions. Several mothers have commented that it was more difficult to refrain from these invasive practices than they anticipated.

The child's responsibility for personal hygiene is also addressed during treatment. Structured play therapy can be helpful during therapeutic sessions with the child. The goal of the child's treatment is to help empower the child to take care of his/her own hygienic needs. In extreme cases of compulsive or deliberate behaviors by the perpetrator, little is known about effective intervention, and prevention of invasive genital practices. It is essential that professionals begin to explore these critical issues routinely as a part of the overall assessment process.

References

Berson, N. (1993). Genital hygiene: Implications for social work practice. Unpublished master's essay, School of Social Work, University of North Carolina, Chapel Hill.

Herman-Giddens, M., Berson, N. (1989). Harmful genital care practices in children: A type of child abuse. *Journal of the American Medical Association*, *261*(4), 577-9.

Russell, DE. (1983). The incidence and prevalence of intrafamilial sexual abuse of female children. *Child Abuse and Neglect*, (7):133-146.

Vanderbilt, H. (1992). Incest. *Lears*, February.

Author's note: We are grateful to the women who wrote to us regarding their childhood experiences. They taught us a great deal.

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REACH OUT

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APSAC wants to ensure that everyone affected by child maltreatment receives the best possible professional care. To reach that goal, we need to deliver *The APSAC Advisor* and other training resources to as many professionals in this field as possible.

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Thanks for your help in spreading the word!

STATE CHAPTER NEWS

-by Claudia Soldano

I am happy to be able again to tout the accomplishments of APSAC's twenty-three chartered chapters and ever-increasing number of organizing groups.

Educational Forums

As anyone who has planned a large meeting for colleagues knows, it is not easy to coordinate the hundreds of details that such an event generates and to do it successfully! APSAC state chapters continue to take the lead in providing educational opportunities for their colleagues around the country. Several groups have sponsored workshops or annual meetings with program content, open to APSAC members and non-members, in an effort to increase the knowledge of those in the field of child maltreatment.

In January, the **Northern New England** chapter (**NNEPSAC**) provided an all-day educational forum in connection with their annual membership meeting. Lincoln Soldati, JD, Stafford County Attorney, provided a presentation entitled "Expert Witness Testimony." Robert Kinscherff, PhD, JD, Massachusetts General Hospital, Harvard Medical School, spoke on "The Ritual Abuse Controversy." Turnout from the chapter's three states was good, even with the traditional inclement weather conditions.

The **Massachusetts** chapter (**MAPSAC**) took a break from assisting with **APSAC's Second National Colloquium** in January to present a half-day workshop which drew on members and non-members statewide. The workshop, entitled "Overrule of the Stockhammer Decision: The Creation of New Process for Access to Privileged Information" dealt with the impact of a recent ruling on the use by a defendant of a victim's privileged communications in cases of rape and sexual abuse. A mutually beneficial dialogue developed between legal and mental health practitioners. **MAPSAC** was able to offer continuing education credits for the training and attracted 75 participants.

The San Diego Conference on Responding to Child Maltreatment, co-sponsored by APSAC, was the site for the annual luncheon meeting of the **California** chapter (**CAPSAC**). APSAC's President, Patricia Toth, JD, addressed the group and answered questions about issues in the field as well as about the recent **APSAC-CAPSAC** merger. (Sometimes it takes being 1,000 miles away from home to meet up with your local colleagues, as the **Iowa** organizing group found out in San Diego. Plans were discussed for the structure of the chapter and member involvement--see the chapter contact list for the **Iowa** contacts if you wish to join their efforts.)

Child Victimization 1994: Changes and Challenges, The Quest Continues, February 22nd - 24th, was co-sponsored by our **Texas** chapter (**TXPSAC**). A series of workshops featuring many APSAC members as presenters discussed the issues of sexual and physical abuse of children from a multidisciplinary perspective. **TXPSAC**'s annual meeting was also held during the conference, which featured an address entitled, "Family Preservation: What Will it Mean for Texas," and an awards presentation. Professional colleagues from around the state attended.

Also in February, the **Illinois** chapter (**IPSAC**) presented their annual membership meeting entitled "The Sexually Reactive Child." The featured morning speaker was APSAC Board member Beverly James; in the afternoon, a panel of local experts, representing the disciplines of law, medicine, child advocacy, therapy, adoption and foster care discussed James's talk and its implications for practice in Illinois.

The **North Carolina** chapter (**NCPSAC**) co-sponsored a statewide conference, "Abused Children: Diamonds in the Rough," March 21st and 22nd. Several APSAC members were among the extensive array of presenters during the two-day training, which focused on the prevention and treatment of abuse. Continuing education credits were provided to those who attended. Until now, **NCPSAC** has concentrated on smaller, local meetings so this was a new challenge for the organizers.

In addition to these accomplishments, there are plans for more events in the coming months from both established and organizing groups.

APSAC-WA, the **Washington** chapter, is co-sponsoring the Second Annual Children's Justice Conference in April 25th and 26th, where they will present media awards to *The Herald*, *The Wenatchee World*, KIRO-TV, and KOMO-TV 4 for outstanding coverage of child maltreatment issues. **APSAC-WA** is also presenting an afternoon of training on child sexual abuse at the April meeting of the Judicial Association. Local professionals will be called on to provide their expertise in **APSAC-WA**'s effort to increase informed decisions in child maltreatment cases.

The **Arizona** chapter (**AZPSAC**) is planning a second statewide meeting in early fall. "Voices for Children: The Second Annual AZPSAC Conference," is scheduled for September 23rd and 24th. The two-day event will focus on adolescent sexual offenders and feature Judith Becker, PhD and John Hunter, PhD as speakers. **AZPSAC** utilized their first meeting as a launching point for the chapter and have successfully maintained the momentum which was generated there.

Similar to **AZPSAC**'s beginnings, organizers in **New Mexico** are planning a statewide conference, March 24-25, in an effort to develop interest in the chapter . Entitled "Strengthening Our Communities' Response to Child Abuse in the Southwest," the two-day conference will focus on the issues of cultural diversity and healing. Several APSAC members and experts in multiculturalism are among the presenters providing a multidisciplinary educational experience. The re-

continued on next page

State Chapter News

continued from page 15

sponse has been tremendous, with registrants coming from as far away as Oregon.

The range of information and expertise represented in these events is certainly impressive. As this list demonstrates, APSAC's chapters are playing an increasingly important role in reaching APSAC's major goal of ensuring that professional practice in this field is well informed and constantly improving. Congratulations to all of those behind-the-scenes planners on jobs well done.

Chapter Status

Since the summer of 1993, we have welcomed seven more chapters into APSAC's charter system. **Alabama, Wisconsin, Maryland, Virginia, Kentucky, South Carolina, and Utah** have all gathered the support of their local membership to take on the issues of their state as an APSAC chapter. Considerable hard work on the part of the officers, Board members and founding members went into making these accomplishments possible. To date we have twenty-three chapters operating in twenty-five states so we are well on our way to reaching our goal of having a successful chapter in every state by the year 2000.

If you are interested in helping out your state contact your chapter coordinator listed below. If there is not one identified, call the APSAC office to learn about the responsibility of chapter organization.

STATE CHAPTER CONTACTS

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

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MOVING?

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

MEDIA REVIEWS

***A moral emergency: Breaking the cycle of child sexual abuse*, by Rev. Jade C. Angelica, MDiv, Sheed & Ward, Kansas City, MO, 1993, 169 pp. $10.95 softcover.**

-Reviewed by Katherine Lee Weille

A moral emergency: Breaking the cycle of of child sexual abuse calls itself a "comprehensive introductory handbook for religious leaders." It is indeed targeted at religious leaders, and, as such, represents an important contribution. Its comprehensiveness is somewhat limited, however, and the book is at times quite elementary. The book is written in an exhortatory style that repeats a message over and over, along the lines of "hear the children."

Perhaps this evocative, sermon-like tone of "A moral emergency: Breaking the cycle of child abuse" is an effective manner in which to inspire religious leaders to act in response to the problem of child sexual abuse.

Each chapter of *A moral emergency* opens with vignettes of abuse, written by survivors. These seem to reflect the author's intent to drive home an emotional point throughout the book about the children behind the statistics on child sexual abuse. In Chapter One, the different perspectives of a prosecutor and an ethicist are presented, opening up the philosophical and moral questions that arise when grappling with the religious or spiritual dimensions of sexual abuse. The final chapter returns to this dimension, as it valiantly tackles universal questions such as, "Why do adults abuse children?" and "How can God let this happen?"

Chapters Two and Three outline basic information about sexual abuse, giving statistical information about its prevelance, and debunking a host of stereotypical myths with factual information. The statistics are laid out in an unusual sort of graphic apparently designed, again, to make one think about the real people they represent. Although for the most part these statistics have substantive sources, the extropolation of Massachusetts data to the nation via the equation of "multiply by 50" is rather an extreme blow to scientific sensibilities!

Unlike many tapes of this kind, in "Investigative interviewing techniques in child sexual abuse cases," the enactments are unmarred by melodrama or intrusive background music and are of excellent technical quality.

Chapter Four adds history to the information given in the previous two chapters. Interestingly, Angelica's research shows much discussions both condoning and forbidding adult-child sexual contact, in religious writings. This brings the focus back nicely to the perspectives of religious communities on sexual abuse. The next two chapters summarize the responses of a variety of Christian denominations. Unfortunately, only Christianity is included, leaving a big gap in information about Judaism and other major religions.

Perhaps the most valuable contribution of this book is in its proposed "Program for Prophetic Ministry." I am still unclear as to the exact meaning of the term "prophetic ministry"; putting aside suspicions that this term may be yet another exhortatory phrase, the idea of a practical plan of action that can be put into practice by religious leaders is very useful. Here the book accomplishes its mission to be a "handbook," even providing "sample sermons," as well as an example of liturgy that incorporates the experiences of abuse survivors (p. 48). The proposed program is very comprehensive, incorporating education, outreach, and support/therapy in a multi-pronged approach that is conceptualized as occurring in stages.

Perhaps evocative, sermon-like tone of *A moral emergency* is an effective manner in which to inspire religious leaders to act in response to the problem of child sexual abuse. In spite of the criticisms made earlier, it is heartening to see a serious effort to address the religious communities that hold such a major influence in the lives of millions of sexual abuse survivors.

Katherine Lee Weille, MSW, is a Clinical Director of the Pediatric Sexual Abuse Program, Fall River, MA.

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***Investigative interviewing techniques in child sexual abuse cases*. Produced by Sage Publications, Newberry Park, CA. $125for individual tapes; $325 for series.**

-Reviewed by Lisa Fontes and Penny Nelson

"What about your penis, Mr. Talbott?" This is one of the many direct, objective and empathic questions asked by Detective Richard Cage and protective services professional Linda Blick in the videotape series by Sage, "Investigative interviewing techniques in child sexual abuse cases." The series consists of three forty-minute dramatic enactments of investigative interviews with a child victim, a non-offending parent, and an offending parent.

Unlike many tapes of this kind, the enactments are unmarred by melodrama or intrusive background music and are of excellent technical quality. On occasion a narrator comments on the scene, provides reasons for using specific techniques, and alerts potential interviewers to feelings which are often evoked in conducting these interviews. The tapes make clear that high quality investigative interviews take hours, and that the segments presented are highlights in what is often a long and painstaking process.

In the first videotape, "Jamie," a nine-year-old boy is interviewed by Detective Cage about possible sexual abuse by a neighbor. A protective services worker, also male, is present and is almost silent throughout the interview. Cage uses anatomically correct drawings, freestyle drawings, and gentle questioning to build rapport and gather evidence.

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continued from 17

Cage does an excellent job eliciting information, and allowing the boy to correct his initial minimization of the abuse. However, Cage occasionally errs in asking questions phrased in language which may be beyond a child's comprehension. In one such infrequent example, Cage asks if the alleged offender, Eric, has "unusual characteristics." The protective services worker translates this into kid-talk and asks how someone could recognize Eric.

In the second videotape, "Anne," the non-offending mother of a five-year-old girl who alleges paternal molestation is interviewed in her home by Cage and Blick, presumably after they have interviewed Anne's daughter. They strike a wonderful balance between acknowledging Anne's feelings, gathering data, and presenting evidence which helps Anne believe her daughter. The videographers have managed to create a complex, multifaceted and sympathetic picture of the mother, even as she is shown minimizing, denying, and demonstrating how she has failed to protect her daughter. The interviewers explain the procedures for gathering evidence, the medical examination, and future options for the family. The interview portrayed demonstrates the efficacy of a strong working relationship between police and protective services. It establishes a model of integrated work which reduces the need for non-offending family members to be interviewed repeatedly about painful topics.

In the third videotape, "David," Detective Cage conducts an in-home interview with the father and alleged offender in the same case described in *Anne*. David demonstrates typical daunting denial and obfuscation. Through the use of emotional appeal, confrontation with inconsistencies, the threat of a polygraph, and sheer dogged persistence, Cage demonstrates how effective interviewing can lead to a confession.

This series of tapes by Eliana Gil is well organized and presented in a comfortable but informative manner. The fact that the panel participants are all engaged in ongoing work with children and/or adolescents who molest makes their contributions sharp and reality-based.

The goals and primary techniques of each interview are outlined at the end of each tape. The series provides a highly appropriate training for beginning and experienced investigators, victim/witness assistants, attorneys, protective service workers, judges, and therapists. Although clearly not all these people will conduct investigative interviews, the tapes allow us all to glimpse how interviews would be conducted if children really mattered. One notable gap is the lack of mention of psychotherapy for the child or family in any of these interviews. However, I have boundless praise for this series. If all investigations were conducted with the same degree of professionalism, care, and timelines as those presented here, I believe many families would be spared the trauma of unsubstantiated reports, continued abuse, and prolonged court procedures.

Lisa Fontes, PhD, is an Assistant Professor of Psychology at Keene State College in Keene, New Hampshire. Penny Nelson is a student at Keene State College in Keene, New Hampshire.

***(1) Assessment of Sexualized Children and Treatment of Sexualized Children I & II with Eliana Gil (2) Assessment of Adolescent Sex Offenders and Treatment of Adolescent Sex Offenders I & II with Eliana Gil.* Produced by J. Gary Mitchell Film Co., Sebastapol, California, 1992, (1-800-369-5367). Each tape 45 to 60 minutes, $95.00/each or $325/set of 4, $25.00 for preview tape, applicable to purchase.**

-Reviewed by Catherine Ayoub

This series of four tapes addresses two important areas of interest in the child sexual abuse field. Each topic is addressed by a panel of experts in a roundtable discussion format. Both sets of tapes intersperse client interviews to illustrate the points made by the expert clinicians. This series is well-organized and presented in a comfortable, but informative manner. The fact that the panel participants are all engaged in ongoing work with children and/or adolecsents who molest makes their contributions sharp and reality-based.

The first pair of tapes covers the assessment and treatment of young children who molest. Eliana Gil is joined by four professionals who work with young children who molest to discuss assessment in the first tape (45 minutes). A range of topics are addressed, including definitions, issues of childhood sexuality, the difference between normal play and sexual abuse, and the specific characteristics of children who molest. There is also discussion of family dynamics, community issues, and coordination of resources. Interspersed is an interview with foster parents of two young children (two and three years of age) who molest. Their issues and insights serve to illustrate and enhance the discussion.

The second tape is focused on treatment of children who molest (60 minutes). On this second tape, the group discussion continues among the same experts. Treatment process issues addressed include self disclosure, denial, modalities and setting, and family intervention. The topic areas delineated on the film lead to discussion of treatment goals and issues, treatment modalities and approach, family treatment, and countertransference and therapist self- care. The discussion contains many specific and concrete intervention strategies for individuals who clearly are engaged in treating these children on a daily basis. Interspersed in the group discussion on this tape is a continuation of the interview begun in the first tape of the series with the same foster parents of two children who molest. The

continued on page 27

Review of Research

-Kathleen Coulborn Faller

continued from page 1

Professionals disagree about appropriate terminology to describe ritual abuse, the range of situations to include in the category, whether ritual abuse actually exists, and if it does, its extent and significance. Moreover, the debate about ritual abuse has been greatly influenced by emotional reactions and personal beliefs.

been contacted. Responses have been elicited from child protection agencies, law enforcement departments, district attorneys' offices, psychologists, psychiatrists, and clinical social workers.

Presently, findings are available from responses of 2,709 members of the American Psychological Association. Of these respondents, 30% had seen cases of ritual or religion-related abuse (5,731 cases), 40% (2,292) of which were ritual abuse. There were more instances of child victims (58%) reported than of adult survivors (42%). The modal number of cases seen per professional was one and the median two, although 2% of respondents reported seeing in excess of a hundred cases.

The psychologists who had encountered cases of ritual abuse were asked to complete a second survey, describing the characteristics of the cases seen so that case profiles could be developed. Results are currently available from 297 respondents who report contact with ritual abuse cases. The most common features of ritual abuse cases were: 1. forced participation or observation of sexual practices (62%); 2. abuse related to rituals (e.g. prayers, chants, costumes) (53%); 3. abuse involving a cult (50%); 4. abuse related to symbols, beliefs, etc., involving the devil (46%); 5. abuse involving actual or staged animal sacrifice (40%); and 6. abuse involving actual or staged human sacrifice (39%). Less commonly reported characteristics, but nevertheless found in 15% to 34% of cases, were abuse involving actual or staged human torture, use of drugs, production of child pornography, cannibalism, and breeding of infants for ritual sacrifice (Bottoms, Shaver, & Goodman, 1993).

The authors note that one of the most important issues related to ritual abuse is whether it really occurred. As an indirect measure of this, they asked clinicians whether they believed the alleged harm had occurred (93% did), and whether they believed the ritual aspects took place (93% did), although 40% thought these were staged or faked. Bottoms and colleagues also queried about corroborative evidence. Forty-two percent of cases were investigated by protective services (44% of child and 12% of adult cases). Police investigated 30% of the cases (44% of child cases and 12% of adult cases). In 7% of cases a criminal conviction was obtained (11% of child cases and 1% of adult cases), although not necessarily of an offense confirming ritual acts.

Finally, the researchers asked respondents what evidence they had to support their beliefs that ritual abuse actually occurred. Clinicians cited such evidence as tattoos; letters and diaries; photographs and videotapes; satanic books and artifacts; perpetrator confession (30% of child cases and 15% of adult cases); therapeutic evidence such as affect during disclosure and sequelae consistent with accounts (57% in child cases and 50% in adult cases); and the client's account alone (13% of child cases and 35% of adult cases).

Methodologically this is among the most sound studies of ritual abuse. However, this research is in progress. Additional analyses of the APA data will examine the ritual abuse cases separately from the religion-related ones. Findings from the other professionals surveyed will also be analyzed. The results so far indicate that a significant number of psychologists encounter ritual abuse allegations, and the vast majority who hear such allegations believe their clients. However, these researchers point out that their findings do not prove that ritual abuse does or does not exist (Bottoms, Shaver, & Goodman, 1993).

Accounts of ritual abuse in day care

A good deal of what has been written about ritual abuse of children addresses reports of ritual abuse occurring in day care. Studies selected for review include two using national samples and three involving children reported to have been ritually abused in specific day care settings with comparisons to other groups of children.

Finkelhor, Williams, and Burns

With funding from the National Center on Child Abuse and Neglect, Finkelhor, Williams, and Burns (1988) conducted a study of substantiated allegations of sexual abuse in day care from all 50 states and the District of Columbia. They identified 270 cases of sexual abuse in day care involving 1,639 victims occurring between January, 1983, and December, 1985. When they examined the characteristics of these cases, they found that 36 (13%) involved ritual abuse. However, ritual abuse components were found in 66% of multiple perpetrator cases (compared to 5% of single offender cases).

Finkelhor and colleagues identified three types of ritual abuse: 1. true cult-based ritualistic abuse, 2. pseudo-ritualistic abuse, and 3. psychopathological ritualism. The first type involves an elaborated belief system that supports sexual, physical, and psychological abuse of children and could be satanic. In the second type, sexual abuse is primary, but the offender employs practices found in the first type for instrumental rather than ideological reasons, for example to inhibit disclosure. The third type of ritual abuse involves a lone offender, whose ritualism derives from delusions or obsessions. Unfortunately, the researchers do not report the number of identified cases in each category.

All ritual abuse cases in their sample had female offenders. When ritual abuse cases are compared to sexual abuse cases without such allegations, significantly more children were involved, for longer periods of time before discovery, and with more serious forms of sexual activity in ritual

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Review of Literature

-Kathleen Coulborn Faller

continued from 19

Finkelhor and colleagues also examined the criminal justice response to allegations. They found that having ritualistic elements meant the case was less likely to proceed to conviction.

abuse cases. Ritual abuse cases were more likely to have both boy and girl victims. Moreover, ritual abuse was independently associated with increased symptoms of trauma when compared to other sexual abuse in day care.

Corroboration/Criminal justice response. Finkelhor and colleagues also examined the criminal justice response to allegations. They found that having ritualistic elements meant the case was less likely to proceed to conviction. Nevertheless, 58% of the ritual abuse cases that went to trial did result in convictions. In the successful litigation, the prosecutors deemphasized the ritual elements and focused on the sexual acts, the coercion, and the identity of the offender.

Kelley

Susan Kelley (1988; 1989; 1992b 1993) conducted a study of identified ritual abuse victims in day care (N=35) and a comparison group of children whose sexual abuse in day care did not include reported ritualistic elements (N=32). Subjects were recruited nationally through the criminal justice system, a parent organization, and mental health agencies. All cases were substantiated by child protective services. In addition, Kelley had a matched sample of 67 children in day care with no reports of sexual abuse. Using a questionnaire and standardized instruments, she collected data from the children's parents on characteristics of the abuse and its impact on children and parents. Comparisons between ritually and sexually abused children will be presented.

Like Finkelhor and colleagues, Kelley found that ritual abuse was associated with multiple perpetrators, multiple victims, and a high proportion of female perpetrators. Similarly, although both types of abused children in her study reported severe sexual abuse, ritually abused children were more likely to report more severe forms. Significantly higher proportions of ritually abused children reported oral sex, vaginal and rectal intercourse, object insertion in the rectum, pornographic picture taking, and sexual activity with other children.

Kelley also collected data on physical and psychological abuse, and found significantly larger proportions of ritually abused children than sexually abused children experienced these forms of maltreatment. Almost all of the ritually abused children were physically abused (97.1% vs. 81.3%). Other important distinguishing characteristics of ritual abuse included being given drugs, being made to consume excrement, and being physically restrained. With regard to psychological abuse, the ritual abuse victims were significantly more likely to have been threatened with death and dismemberment, and with death of a parent or loss of parental love.

Compared to the sexual abuse group, children who had also been ritually abused had significantly higher overall scores on the Achenbach Child Behavior Checklist and on the internalizing behavior scale, representing greater fearfulness, inhibition, and anxiety.

Corroboration/Criminal justice response. Kelley (1992b) reports that in 92 per cent of both types of abuse in day care, criminal charges were filed. In 80 per cent of cases, there were convictions. There were no statistically significant differences in the rates of conviction for the ritual and sexual abuse cases (Kelley, 1993).

Waterman, Kelly, Oiveri, and McCord

Jill Waterman and her colleagues at UCLA (Waterman, Kelly, Oliveri, & McCord, 1993) received funding from the National Center on Child Abuse and Neglect to conduct research on the McMartin preschool case in Manhattan Beach, CA, and other cases from the area. Included in the study are 82 children reporting ritual abuse in a Manhattan Beach preschool (62% from McMartin preschool), and a comparison group of 15 children sexually abused without ritual elements in a Reno (Nevada) preschool. The Reno case involved one offender, who confessed, was sentenced, and incarcerated. In addition, there was a second comparison group of 37 preschool children, with no reports of sexual abuse, from a California community similar in demographics to Manhattan Beach.

This study is impressive in its scope, and of considerable importance given the level of media skepticism about the McMartin preschool case. It is a longitudinal study conducted over a six-year period, in four phases, using over 40 data-gathering measures. Data were collected using standardized instruments, protocols constructed specifically for this research, and interviews. Sources of information included past case records (including initial assessment for sexual abuse and medical records), the children, their parents, and their therapists in the instance of the two sexually abused groups. Articles reporting findings from this study have appeared in professional journals (e.g., Gonzalez et al. 1993), and the authors have just published a book including the findings, *Behind the playground walls* (Waterman, Kelly, Oliveri, and McCord, 1993). Here the focus will be on select material comparing the ritually abused to the sexually abused children.

The researchers constructed a "sexual abuse grid." Completed by the children's therapists, the grid documents children's disclosures during therapy. It assesses 31 characteristics of ritual as well as sexual abuse. Sexual acts are separated into three levels according to intrusiveness; 13 of the 31 activities are characterized as terrorizing acts, and seven are defined as ritualistic acts. Like Kelley (1989), the UCLA researchers found victims in

continued on next page

Review of Literature

-Kathleen Coulborn Faller

continued from page 20

both the ritual and sexual abuse groups experienced extensive sexual abuse, but the ritual abuse group was significantly more likely to report sexual games and stories, ejaculation, anal intercourse, and object penetration.

None of the sexually abused children was subjected to terrorizing acts, but 98.5% of those alleging ritual abuse were. Illustrative are the following findings for the ritual abuse group: abuse of animals, 80%; threats of death to the child, 80%; sadistic acts, 78.5%; acts involving weapons, 78.5%; acts involving use of blood, 63.1%; threats of the use of magical powers, 66.2%; drugs taken, 58.5%; acts involving excrement, 55.4%; and acts involving monsters or ghosts, 46.2%. Less commonly cited terrorizing acts were acts involving dead bodies, and the killing of babies, children, and adults.

About eighty-eight percent of children alleging ritual abuse told their therapists about an experience categorized on the sexual abuse grid as a ritualistic act (vs. 7% of sexually abused children). These included magic (67.7%), satanic rituals (58.5%), acts involving churches (50.8%), singing or chanting (49.2%), symbols (40%), fire (32.3%), and a circus or zoo (20%).

An extensive assessment of the impact of ritual and sexual abuse (and comparisons to their non-abused sample) examined effects on overall distress level, cognition and school performance, affect, sexuality, and interpersonal relationships. The researchers collected information from the children, parents, and therapists, and assessed change over time. Select comparisons between ritually and sexually abused children will be presented.

General findings were that children alleging ritual abuse displayed greater symptomatology and made less complete recovery than the sexually abused children. Seventeen percent of the children alleging ritual abuse had significant problems five years after disclosure. Like other researchers, the UCLA group employed the Achenbach Child Behavior Checklist (CBCL), using the parents' form with both parents and the teacher form with therapists. A comparison of mothers' ratings of their children "at the time of most distress" reveals that children alleging ritual abuse had significantly higher scores in terms of total behavior problems and internalizing behaviors. A comparison of therapists' ratings "at time of most distress" also reveals ritually abused children had significantly higher total behavior problems than sexually abused children, but significantly higher externalizing scores (rather than internalizing scores). The researchers interpreted discrepancies between maternal and therapists' ratings to derive from the possibility that mothers of children reporting ritual abuse might not observe the internalizing behaviors displayed in therapy. As hypothesized, no differences were found between the two groups on the sexual problems subscale of the CBCL.

Like Finkelhor and colleagues, Kelley found that ritual abuse was associated with multiple perpetrators, multiple victims, and a high proportion of female perpetrators.

Therapists' ratings of ritually and sexually abused children on both the Children's Global Assessment Scale and the Brief Psychiatric Rating Scale for Children revealed that the children reporting ritual abuse functioned less well than the sexually abused children at termination of treatment. However, there were no differences between the groups on these two measures at the "time of most distress." On several measures the children reporting ritual abuse scored higher on feelings of powerlessness than the sexually abused children, including on external locus of control.

Corroboration/Criminal justice response. The researchers note in the preface to *Behind the playground walls* that at the end of seven years of litigation, the two juries that heard charges in the McMartin preschool case were deadlocked. However, after the first and longest trial, 9 of the 11 jurors who agreed to be interviewed said they believed the children who had testified had been sexually abused, but that the evidence presented did not allow them to reach that conclusion at the level of proof required in criminal prosecution, beyond a reasonable doubt, or at the 95 percent certainty level.

A major reason for the acquittal in the McMartin case was the absence of physical evidence to corroborate the children's accounts. For example, children described going into tunnels underneath the school, as well as witnessing satanic acts and sacrifices. The parents of children from McMartin sponsored an archaeological dig of the site, results of which were available during the second trial but not used as evidence in court (Stickel, 1994). Gary Stickel, the archaeologist who conducted the excavation, reports having found the features listed below (Stickel, 1994):

One filled-in tunnel 45 feet in length, about 30 inches wide, and a little less than four feet high was discovered 30 inches below the school floor. The tunnel had a chamber nine feet wide under classroom 4, Ray Buckey's classroom. Although all the teachers were accused of abuse by the children, a great many more allegations were made against Ray Buckey than against other teachers.

A second filled-in tunnel, seven feet in length was found under the bathrooms and classroom 1, extending under a three-car garage belonging to the triplex next door. Children described entering and exiting the tunnel from the triplex yard where the tunnel was found. The archaeologists concluded that the tunnels were both dug and filled in with landfill after the buildings were constructed.

Over 2,000 artifacts, including 100 animal bones and a Walt Disney bag (copyright 1982) items were found under the school. In addition, a small white plastic plate with three green, hand-painted pentagrams was found in the playyard dirt.

continued on next page

Review of Research

-Kathleen Coulborn Faller

continued from page 21

Other relevant physical findings included a classroom with a deadbolt lock but no doorknobs, and switches marked "fire alarm" that were not wired to the fire department but could be used as a signal within the school. Because the school had been sold and was marked for demolition, the archaeologist had only 30 days to excavate and make drawings and photographs, and was not able to explore the full extent of the tunnel system (Stickel, 1993).

Faller and the Michigan Department of Mental Health

There is a need for greater clarity of definition of ritual abuse in day care. In part, definitional problems derive from how ritual abuse in day care comes to light. The relevant events are perceived and described by children to adults, who then interpret them.

About a year after the McMartin pre-school case came to the attention of authorities, a similar case, involving 172 children who made disclosures, was identified in southwest Michigan. In this case, allegations involved all teachers, including a male teacher who played a leadership role and was married to the director. This case has been studied by Faller (1988; 1990) and by researchers from the Michigan State Department of Mental Health (Bybee & Mowbray, 1993; Valliere, Bybee, & Mowbray, 1988). Faller collected data in the process of clinical interviews with 18 children and served as consultant during the investigation of the case. The Department of Mental Health researchers conducted a record review and collected data on some of the children using standardized instruments. Both studies found extensive sexual abuse, substantial physical abuse, and some acts against children that appeared ritualistic, but minimal evidence of satanic practices. Both studies also found corroboration of abuse by children who observed the maltreatment of other children.

The Department of Mental Health (Bybee & Mowbray, 1993) reviewed the records of 106 children interviewed by the state police, the department of social services, and community mental health. They identified 62 children (58%) who disclosed their own victimization and 53 children (50%) who observed others being abused. Of the children observed being abused, 92% also disclosed their own victimization. The researchers also categorized the types of maltreatment as indicated in Table 1.

Bybee and Mowbray (1993) also assessed characteristics of the 106 children interviewed that were associated with disclosure of abuse. These were younger age, greater number of interviews (although the direction of the influence is not known), and use of anatomical dolls during the investigative interviews. In some studies, younger age has been associated with increased suggestibility in children (Goodman, Bottom, 1993).

TABLE 1: Types of maltreatment

	Observed	Experienced
Sexual abuse		
Fondling	56	36
Penetration	35	14
Oral sex	34	9
Sex with children	35	39
Penetrated adult	12	3
Other abuse		
Threatened with harm	47	10
Hit or hurt	44	22
Given meds/ bad food	11	4
Ritual acts		
Rituals/bestiality	28	14

Disclosed by 106 children in Bybee & Mowbray (1993) study.

Faller (1988) used a different series of categories for sexual activity, but with similar results. Her categories for other types of maltreatment were as follow: sadistic acts (100%), threats of harm and death to children and their family members (100%), use of drugs (56%), confinement (44.4%), and animal killings or injury (22%) (Faller, 1988; 1990).

Faller (1990) compared the effects of alleged ritual abuse on the 18 children she interviewed from this setting to the impact of sexual abuse on children who were victimized by a single offender in a day care center or a day care home. Significantly higher percentages of ritually abused children were reported to have sexual acting out problems, sleep problems, emotional problems, behavior problems, and phobias.

As noted above, the Department of Mental Health researchers used standardized measures to assess the effects of victimization, comparing the children reporting abuse at this day care center to clinical and non-clinical norms, and to findings from a non-abused sample from the same community. A report is available comparing maternal responses on the Achenbach Child Behavior Checklist (CBCL) for sexually abused children and non-abused community children two years after the abuse was reported and then a year later (Valliere, Bybee, & Mowbray, 1988). The authors also compared the scores of both groups to clinical and non-clinical norms. The sexually abused children's scores were generally comparable to those of clinical norms, and significantly higher than non-clinical norms. Sexually abused girls demonstrated improvement on the CBCL between times one and two, but the boys did not (Valliere, Bybee, & Mowbray, 1988).

Corroboration/Criminal justice response. The male offender in this case was tried and convicted

continued on next page

Review of Research

-Kathleen Coulborn Faller

continued from page 22

on the strength of testimony of one five-year-old boy. However, the case was reversed on appeal five years after conviction because of hearsay admissions, and remanded for re-trial. Because of the expense and the lack of availability of witnesses, the prosecutor allowed the man a plea bargain and he received probation. None of the remaining alleged offenders was prosecuted because the first case had exhausted the resources of the small community.

Studies describing reports of ritual abuse in day care provide information suggesting that both sexual abuse and ritual abuse may occur in day care. The national study by Finkelhor and colleagues (1988) is important because it documents both sexual abuse in day care and the presence of ritual elements in some cases, especially those involving multiple offenders. It is significant that this research was conducted prior to extensive media coverage of ritual abuse.

It is also notable that all studies of ritual abuse in day care involve cases substantiated by protective services, and that some cases resulted in successful criminal prosecution.

Nevertheless, there is a need for greater clarity of definition of ritual abuse in day care. In part, definitional problems derive from how ritual abuse in day care comes to light. The relevant events are perceived and described by children to adults, who then interpret them. What is called ritual abuse in day care may represent a variety of patterns of behavior, some of which may be motivated by belief systems and others by different dynamics, for example sadism or the desire to prevent disclosure.

In addition, except in the case of the research by Finkelhor et al.(1993), the studies are not able to examine the effect of ritual abuse independent of other factors, such as the presence of multiple perpetrators.

What is called ritual abuse in day care may represent a variety of patterns of behavior, some of which may be motivated by belief systems and others by different dynamics, for example sadism or the desire to prevent disclosure.

Studies of community-based ritual abuse cases

Community-based cults are defined as those whose membership is contemporary and often made up of persons of various ages—children, adolescents, and adults in a particular community. Sometimes the locale of their activities is a church, but victims and observers from the community also speak of these events happening in houses, other buildings, or outdoors. Two studies in the literature describe findings on instances of community-based ritual abuse.

Snow and Sorenson

Snow and Sorenson (1990) describe five neighborhood-based cults in a three-county area in Utah, four in suburban neighborhoods and one rural, all bordering on open areas, including canyons, gullies, fields, and cemeteries. Thirty-nine children, ages 4 to 17, from these five cults were seen by Snow and Sorenson. The researchers documented the existence of three interlocking types of sexual activity: intrafamilial incest, adolescent perpetration, and adult ritual sex ring activity. All three components were found in four of the five neighborhoods. No adolescent perpetration was found in the fifth, but information from that site was less complete.

The researchers state that they had little understanding of ritual abuse when they began working with the children involved, and therefore their documentation of ritual elements is probably incomplete. The number of children seen from each of the five sites varied from 3 to 16. All children in the five sites reported forced sexual activity, violent threats, and multiple perpetrators and victims. However, for a child to be included in the study, he/she had to show at least six characteristics defined by the researchers as ritual abuse. At least two-thirds of children reported the following features: multiple abuse sites, pornography, ingestion and/or use of feces and urine, satanic ideology and/or paraphernalia, animal killing and/or mutilation, and drugs/magic/spells. Less common features were physical assault, bondage/isolation/confinement, berating the child, costumes, killing of adults or children, and eating flesh.

The researchers did not systematically collect data on the impact of the abuse, but they note that initially most of the children were not highly symptomatic, and the most common reason for referral for assessment was that another child had identified the index child as a victim. As the children revealed the abuse, they became more symptomatic. Moreover, symptoms previously minimized or overlooked were recognized as consistent with ritual abuse. Snow and Sorenson hypothesize dissociation, compartmentalization, and repression as the reasons the children initially were fairly asymptomatic. They also point out that the offenders were generally regarded as upstanding citizens and many were religious leaders. Moreover, before disclosure the adolescent perpetrators appeared well-functioning, and did not overtly self-identify as satanists.

Corroboration/Criminal justice response. The researchers note that 30 of the children received at least one additional evaluation, and in 28 cases their conclusions were supported. Confirmatory opinions were offered by 13 professionals representing 11 different agencies. One of the unsupporting assessments was conducted by a defense expert. Two adult perpetrators from different sites were successfully criminally prosecuted. Five adolescents from two other sites were charged. Two admitted to the charges and the other three were acquitted in bench trials.

Jonker & Jonker-Bakker

A case from the Netherlands, described by Jonker and Jonker-Bakker (1991), two general practitioners who were involved, also is probably best

continued on next page

Review of Research

-Kathleen Colbourn Faller

continued from page 23

authors state that adults, both men and women, abducted children for short periods and took them to various sites for the purposes of making pornography and ritually abusing them.

The systematically collected data were primarily on the effects of the ritual abuse, yet included some description of the ritualized activities. They report that of 98 children, ages 4 through 11, interviewed by the police, 62 provided what police considered "usable information," and 48 made clear statements about sexual victimization. They also point out that the statements of children from different schools and in different localities corroborated one another.

Given the number of reports of intergenerational ritual abuse by adults, it is somewhat surprising that there is not more research about this topic. Certainly it would be enlightening to have additional studies, especially studies of adults who do not suffer from dissociative disorders.

Characteristics of the abuse noted are as follows. The abuse included being forced to perform oral sex on adults; having objects inserted in children's vaginas, penises, and anuses; being subjected to genital intercourse; and being forced to engage in sexual activities with other children. Physical abuse consisted of being beaten with belts, being punched, being tied to poles and having knives thrown at them, having ropes tied around their necks "until their eyes rolled around in their heads," and having their heads held under water. They also report confinement, specifically victims being locked in closets and cages. Acts involving urine, feces, and semen were reported. Adults (animal costumes) and children (white robes) wearing costumes and ritual acts involving candles, a church, and an altar were described. The authors state that children spoke of ritual murder and torture of babies (black and white), a deformed brown child, and an elderly couple, apparently of foreign origin, and animal killing. Threats of death to children and their families and having their houses burned down were means used to inhibit disclosure.

Six to eight weeks after first disclosure, Jonker and Jonker-Bakker collected information from parents of 90 three- to 10-year-olds reportedly involved in this abuse, six to eight weeks after first disclosure. They documented the following sequelae: sleep disturbance, enuresis, sexualized behavior, swearing, aggression, isolation, and anxiety. They do not report any actual numbers from their survey, but the thrust of their article was to describe problems in the investigation.

They also asked parents if they thought their children had been abused. Eighty-seven per cent were certain and 12% thought it a possibility. Sixty-six of these children had been interviewed by the police, who thought 48% were definitely involved, 39% were a definite possibility, 9% a possibility, and 3% not involved. The authors also note that a child psychiatrist evaluated a number of the children (number not specified) and thought the ritual abuse began in August, 1986 and reached a peak during Easter vacation in April, 1987, one month before the authors saw their first case, a boy with unexplained rectal bleeding.

Corroboration/Criminal justice response. Two men were arrested after pressure from parents who were very dissatisfied with police investigation. However, the men were later released for lack of evidence. Thus in this case, the alleged offenders were never officially identified, nor were the locations of the abuse, nor any physical evidence, despite children's allegations of child pornography.

It is hard to draw general conclusions about community-based cults from these two studies. They deal with very different populations and in specific geographical areas. In addition, each study has its shortcomings. Despite the corroboration in terms of successful prosecution and confession, Snow and Sorenson state they knew little of ritual abuse when they started working on the cases in their sample. Jonker and Jonker-Bakker's study lacks identified suspects and legal corroboration, despite the opinions of law enforcement and parents about the credibility of accounts. Moreover, their report lacks data, as it focuses primarily on the frustration of working on the case.

Studies of intergenerational ritual abuse.

Adult survivors and, in some instances, adults who report that they are trying to extricate themselves from cults, are the primary sources of information about intergenerational ritual abuse. These adults also sometimes describe community-based cults. Many of the adults making these reports suffer from multiple personality disorder (MPD) and other dissociative disorders. However, not all of them do. Most of the accounts of intergenerational ritual abuse are found in clinical writing and anecdotal case studies (Mayer, 1991; Ryder, 1992; Stone & Stone, 1992; Wong & McKeen, 1990). However, there are two pieces of research on intergenerational ritual abuse.

Young, Sachs, Braun, and Watkins

Young, Sachs, Braun, and Watkins (1991), all clinicians providing treatment of adults with MPD and other dissociative disorders, examined the accounts of adults reporting ritual abuse as children. Most of the information about ritual abuse emerged during the course of treatment. The emergence involved intensive images, flashbacks, and material surfacing during abreaction and, in some cases, during hypnosis. They report on 37 patients, ages 18-47 (33 females; 4 males), from four separate treatment sites. To be included in the study, patients had to have a diagnosis of MPD or dissociative disorder not otherwise specified (NOS) and to describe a history of childhood satanic ritual abuse. Thus, these were very severe cases, both in terms of psychiatric diagnosis and type of alleged

continued on next page

Review of Research

-Kathleen Coulborn Faller

continued from page 24

abuse. They provide data on the proportion of subjects describing 10 characteristics of ritual abuse and the proportion displaying eight psychiatric sequelae of ritual abuse. In addition, they note the corroborative evidence for the 37 cases.

All patients reported the following experiences: sexual abuse, witnessing and receiving physical abuse/torture, witnessing animal mutilation/killing, and death threats. At least three-fourths report forced drug use, witnessing and forced participation in human adult and infant sacrifice, forced cannibalism, and marriage to Satan (women patients only). Seventy-two percent describe being buried alive in coffins or graves, and 60% of women patients report forced impregnation and sacrifice of their own child.

Of the sequelae examined, all patients had post-traumatic stress disorder (PTSD) and dissociative states with satanic overtones. All but one evidenced survivor guilt. Over eighty percent had the following symptoms: indoctrinated beliefs, unusual fears, sexualization of sadistic impulses, and bizarre self-abuse. A substance abuse problem was found in 62% of cases.

Corroboration/Criminal justice response. The authors note that corroborative evidence was difficult to secure, because of the passage of time, the lack of law enforcement involvement, and a decision not to seek corroboration from family members because of concerns about patient safety. However, in eight cases, medical exam revealed supportive physical findings, including scars on the back, a satanic tattoo on the scalp, and a disfigured nipple. Other evidence they cite included the ability of four patients to identify cult members and their roles from photographs. These pictures were apparently obtained from other patients from the same vicinity, but who had no contact with the index patients during their treatment. Finally, in one instance, a patient described her mother giving birth to an infant that was sacrificed. Her brother recalled the infant's home funeral but never saw the baby, and there was no birth record for the infant.

Virtually all types of corroboration...have their limitations. All may be open to other interpretations than supporting ritual abuse, or are low frequency findings, or both.

Kelley

A study that examines intergenerational ritual abuse from a somewhat different perspective was conducted by Kelley (1992a). She evaluated reports involving 26 children from 14 families. Half were boys and half girls. These children were on average 2.3 years at onset and 5.6 years when alleged ritual abuse ended. Data collection occurred after the abuse ceased, when children were on average seven years old. Information about possible intervention between the time of disclosure and data collection is not provided. The mean number of victims per family was two, and mean number of offenders per child was five. Abusers were parents, grandparents, and great-grandparents, as well as uncles and aunts, cousins, and siblings. As in other reports of ritual abuse, a substantial proportion of offenders was female (45%). Sixty-one per cent of children were abused by two generations of older relatives, and 57% of cases involved extrafamilial as well as intrafamilial offenders.

Ritual characteristics reported by the children or caretakers included terrorizing threats and acts (89%), including having spiders or other insects placed on them; death threats (77%), making pornography (81%), threats with supernatural powers (89%), satanic reference (92%), animal killings (54%), being made to ingest drugs (89%), songs and chants (69%), and being made to ingest or touch excrement (85%).

The Achenbach Child Behavior Checklist was completed on the children, and, despite the fact that on average abuse had ended 3.8 years earlier, scores were in the clinical range for 73% of subjects on total problems, and 81% on internalizing and 50% on externalizing scales.

Corroboration/Criminal justice response. As to corroboration of reports, all cases had been substantiated by child protective services with regard to at least one perpetrator. In all cases involving an offending parent or stepparent, the child had been removed and visitation denied. Finally, half of the cases had criminal charges pending at the time of data collection.

Given the number of reports of intergenerational ritual abuse by adults, it is somewhat surprising that there is not more research about this topic. Certainly it would be enlightening to have additional studies, especially studies of adults who do not suffer from dissociative disorders.

Conclusions

The number of studies of ritual abuse is modest; in some instances sample size is small, and some samples are drawn from a single location. Researchers' choices about what cases to include and what characteristics to study obviously influence findings. In addition, the present source of most reports of adult survivors of ritual abuse are clinicians treating MPD and other dissociative disorders. This source may introduce a bias in our understanding of adults who report ritual abuse. These clients are very disturbed and are described as highly suggestible. Moreover, techniques sometimes used in their treatment, such as hypnosis and guided imagery, are said to induce false memories. These characteristics have led some to argue that reports of ritual abuse by such clients are entirely fabricated (Ganaway, 1991; Mulhern, 1991) and others to be concerned about the veracity of their accounts (Faller, 1990). Yet clincians report treating adults who describe ritual abuse experiences and do not have dissociative disorders. It would be useful to study these kinds of clients to see if their accounts include the same bizarre characteristics.

continued on next page

Review of Research

-Kathleen Coulborn Faller

continued from page 25

Further, the categorization of contexts as used here needs refinement. There is an overlap between community-based cults and intergenerational cults. Moreover, there is a cohort of cases where one parent is allegedly involved and the other not. Perhaps this constitutes a separate category of cases. There are also out-of-home situations other than day care where ritual abuse has been reported, for example, cases of ritual abuse described as being perpetrated by a subgroup within an organized religious group. To clarify our understanding of alleged ritual abuse, future research needs to attend to all of these limitations, and others.

Especially fruitful would be multidisciplinary research using teams of professionals from mental health, sociology, religion, anthropology, and law enforcement, which would allow for diverse perspectives on findings and systematic collection of confirming and disconfirming information about this complex and bewildering phenomenon.

The research that does exist indicates that ritual abuse is reported by both children and adults who describe similar experiences in a variety of contexts. Studies suggest that ritual abuse consists of a combination of severe forms of sexual abuse, which often involves group sex and child pornography; physical abuse including acts of torture, confinement, and use of chemicals; and psychological abuse, frequently entailing threats of severe harm and death and undermining victims' belief systems. In addition, a large proportion of cases subjected to inquiry appear to involve ritual elements consistent with satanism. Moreover, research that compares victims of ritual and sexual abuse indicates that there are fairly consistent differences in the maltreatment itself, and in its effects, ritual abuse having more severe short-term and long-term effects.

Studies find some independent corroboration of allegations. Those involving children have produced a fair amount, for example substantiation by protective services and law enforcement, successful criminal prosecution, and in a few instances, offender confession. The two studies that address issues of credibility in adult cases, Bottoms and colleagues (1991) and Young and colleagues (1991), indicate that there is less corroborative information for allegations made by adults. Several factors may help account for this lack of corroboration. Adults' accounts are not subject to mandated reporting and would not be a protective services concern. Today's state child protection systems began in the mid-1970's, and would not have existed when many adult survivors were children. In addition, in old cases corroborating evidence might be less available, law enforcement might be less likely to investigate, arrests are harder to make and prosecution is more difficult.

However, it is important to bear in mind that there has been no corroborative evidence, from research or other sources, of a widespread Satanic conspiracy, particularly one involving the practice of human sacrifice (Lanning, 1991). Many reports by adults specifically refer to human sacrifice and conspiracy. In contrast, except for similarities from site to site, children's accounts do not indicate a widespread conspiracy, and less frequently entail satanic reference.

In addition, virtually all types of corroboration other victims; eyewitnesses; medical evidence; physical evidence such as documents, pornography, and ritual artifacts; substantiation by protective services or law enforcement; successful criminal prosecution; even offender confession--have their limitations. All of these may be open to other interpretations than supporting ritual abuse, or are low frequency findings, or both.

Nevertheless, further research that examines both the process of disclosure of ritual abuse and a range of types of corroborative evidence would be useful. Among the pressing questions for further research are the following: What is the range of sites where allegations of ritual abuse are found? What sorts of accounts are given by latency-aged children and adolescents who report ritual abuse? What are the characteristics of persons described as offenders in ritual abuse cases? Are there any systematic differences between children who do and do not describe ritual abuse in a multi-victim setting? What sort of interaction occurs between victim and professional in situations of delayed disclosure? What is the relationship between children's statements regarding ritual abuse and adult conceptualization and interpretation? What are the similarities and differences in descriptions of ritual abuse of adults with dissociative disorders and those without? Finally, and perhaps most important, what sorts of corroboration can be systematically documented for allegations of ritual abuse? Especially fruitful would be multidisciplinary research using teams of professionals from mental health, sociology, religion, anthropology, and law enforcement, which would allow for diverse perspectives on findings and systematic collection of confirming and disconfirming information about this complex and bewildering phenomenon.

References

Bottoms, B., Shaver, P., & Goodman, G. (1991). Profile of ritualistic and religion-related abuse allegations in the United States. Paper presented at the ninety-ninth annual convention of the American Psychological Association, San Francisco, August.

Bottoms, B., Shaver, P. & , Goodman, G. (1993,). Profile of ritualistic and religion-related abuse allegations in the United States. Updated findings provided via personal communication from B. Bottoms, June.

Bybee, D. & Mowbray, C. (1993). An analysis of allegations of sexual abuse in a multi-victim day-care center case. *Child Abuse and Neglect. 17*(6):767-783.

Faller, K.C., (1990). Sexual abuse of children in cults: A medical health perspective. *Roundtable. 2*(2).

Faller, K.C. (1988). The spectrum of sexual abuse in day care. *Journal of Family Violence. 3*(4):283-298.

Faller, K.C. (1990). Unpublished data from the Small World preschool case. Ann Arbor: University of Michigan School of Social Work.

continued on next page

Review of Literature

Kathleen Coulborn Faller

continued from 26

Finkelhor, D., Williams, L., & Burns, N. (1988). *Nursery crimes: Sexual abuse in day care*. Newbury Park, CA.: Sage Publications.

Ganaway, C. (1991). Alternative hypotheses regarding satan and ritual abuse memeories. Paper presented at the 1991 Convention of the American Psychological Association, San Fransisco: CA, August.

Gonzalez, L., Waterman, J., Kelly, R., McCord, J., & Oliveri, M.K. (1993). Children's patterns of disclosures and recantations of sexual and ritual abuse allegations in psychotherapy. *Child Abuse and Neglect*, *17*(2):218-290.

Goodman, G.S. & Bottoms, B.L. (Eds.). (1993). *Child victims, child witnesses: Understanding and improving testimony*. New York: Guilford Press.

Goodwin, J. (1993). *Rediscovering childhood trauma: Historical casebook and clinical applications*. Wash., D.C.: American Psychiatric Press.

Jonker, F., & Jonker-Bakker, P. (1991). Experiences with ritualistic child sexual abuse: A case study from the Netherlands. *Child Abuse and Neglect*, *15*:191-196.

Kelley, S. (1988). Ritualistic abuse of children: Dynamics and impact. *Cultic Studies Journal*, *5*(2):228-236.

Kelley, S. (1993). Ritualistic abuse of children in day care centers. In M. Langone (Ed.), *Recovery from cults*. New York: Norton. pp. 340-351.

Kelley, S. (1992a, Jan.). *Ritualistic abuse: Recognition, impact, and current controversy*. Paper presented at the San Diego Conference on Responding to Child Maltreatment, San Diego.

Kelley, S. (1992b). Stress responses of children and parents to sexual abuse and ritualistic abuse in day care centers. In A. W. Burgess, (Ed.), *Child trauma I: Issues and research*. New York: Garland Publishing Co., Inc.

Kelley, S. (1989). Stress responses of children to sexual abuse and ritualistic abuse in day care centers. *Journal of Interpersonal Violence*. *4*(4):502-513.

Lanning, K. (1991). Ritual abuse: A law enforcement view or perspective. *Child Abuse and Neglect, 15*: 171-173.

Mulhern, S. (1991). Satanism and psychotherapy: Rumor in search of an inquisition. in Richardson, J. and Best, J., Bromley, D. (Eds). *The satanism scare*. New York: Aldine de Gruyter.

Mayer, R. (1991). *Satan's children: Case studies in multiple personality*. New York: G.P. Putnam & Sons.

Ryder, D. (1992). *Breaking the circle of satanic ritual abuse.* Minneapolis: CompCare Publishers.

Snow, B. & Sorenson, T. (1990). Ritualistic child abuse in a neighborhood setting. *Journal of Interpersonal Violence*, *5*(4):474-487.

Stickel, Gary. (1993). *Archeological investigation of McMartin preschool site*. Manhattan Beach, CA.: McMartin Tunnel Project

Stone, L. & Stone, D. (1992). Ritual abuse: The experiences of five families. In D. Sakheim & S. Devine (Eds.), *Out of darkness: Exploring satanism and ritual abuse*. New York: Lexington Books.

Valliere, P., Bybee, D., & Mowbray, C. (1988, Apr.). Using the Achenbach Child Behavior Checklist in child sexual abuse research: Longitudinal and comparative analysis. Paper presented at the National Symposium on Child Victimization,Anaheim,CA.

Waterman, J., Kelly, R., Oliveri, M.K., & McCord, J. (1993). *Behind the playground walls: Sexual abuse in preschools*. New York: The Guilford Press.

Wong, B., & McKeen, J. (1990). A case of multiple life-threatening illnesses related to early ritual abuse. *Journal of Child and Youth Care*. Special issue: In the shadow of Satan: The ritual abuse of children. 1-26.

Young, W., Sachs, R., Braun, B., & Watkins, R. (1991). Patients reporting ritual abuse in childhood: A clinical syndrome. Report of 37 cases. *Child Abuse and Neglect*, *15*:181-189.

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Media Reviews

continued from page 18

use of one example throughout the two tapes helps give the series a unifying way in which to focus on the topics presented.

These two tapes are well prepared and well organized. At times the movement from topic to topic by different participants in the discussion is hard to follow or connect, however Eliana Gil does set the stage and summarize for the viewers. This tape is an excellent resource for therapists working with children who molest. It is probably more appropriate for experienced therapists who encounter these issues and want to direct their treatment efforts toward the specific issues of children who molest than for the neophyte practitioner learning basic skills.

The second series of two tapes addresses adolescent sex offenders. Five expert clinicians in the field join Eliana Gil to discuss first assessment and then treatment issues. This video series does an excellent job of covering the issues in an organized, interesting, and quite complete way. The first video tape (60 minutes) addresses assessment issues, including definition and types of adolescent sex abuse, characteristics of the adolescent offender, characteristics of families of offenders, and the specific process and content of a comprehensive assessment. Participants also delineate risk factors, and discuss modalities in which assessment can take place in relationship to risk and protection of the community. The discussion is thoughtful, specific, and full of examples of insightful clinical strategies and interventions. Interspersed within the group discussion by the experts is an interview with an adolescent offender and his parents which is powerful and unifying to the topics presented.

The second tape in the series (60 minutes) continues both the group discussion and further exploration of the same case to illustrate the development and course of treatment. Topics addressed include deviant arousal, denial, and the use of penile plethysmography. The process of treatment is discussed and specific techniques such as focusing, thought stopping, and overt sensitization are presented and discussed through the roundtable of experts and illustrated through the case example. Treatment modalities and relapse prevention are presented and individual, group, and family modalities as well as the appropriateness of outpatient, residential, and/or secure institutional settings are explored. Family work as an integral part of treatment is addressed. To close, issues of countertransference and the support needs of the professional engaged in this type of work are discussed with frankness and sensitivity.

This pair of tapes on adolescent sex offender assessment and treatment are highly recommended for all who are engaged in this type of treatment. They may also be excellent educational tools for

continued on next page

Offender Treatment

- William D. Murphy, Terri J. Rau, and Patricia J. Worley

continued from page 4

the victims. However, between 14% and 27% of the patients had to be excluded because of low responding or documented faking. Thus, it must be recognized that erection responses can be faked; this has been well documented in the literature for a number of years (Laws & Holmen, 1978; Laws & Rubin, 1969).

As one can see, there is very limited evidence for the use of sexual arousal data to profile an offender. Again, group data do not necessarily reflect the individual. Furthermore, in incest cases or in cases of the denying offender, the most frequently observed profiles are probably a nondeviant arousal pattern or a pattern of low arousal to all of the stimuli. Such findings will be of little help when protective services and legal investigations cannot establish and/or substantiate the abuse.

There is also no known historical variable that consistently differentiates child molesters from others. Although one of the most commonly cited historical variables is a history of sexual abuse in the background of sex offenders, there are numerous problems in generalizing this to the legal arena.

Historical Data

There is also no known historical variable that consistently differentiates child molesters from others. Although one of the most commonly cited historical variables is a history of sexual abuse in the background of sex offenders, there are numerous problems in generalizing this to the legal arena. Considering that between 1 in 8 to 10 young males are probably sexually abused before the age of 18 (Finkelhor, 1984), it is highly unlikely that the vast majority of these males grow up to be sexual offenders. It is more likely that most children who are sexually abused never become offenders. Furthermore, it appears that the prevalence rates of sexual abuse within offender populations have been overestimated. Hanson and Slater (1988) reviewed the findings from 18 different studies involving over 1700 offenders and found that reported prevalence rates of sexual abuse varied from 0% to 60%. The smaller the sample size, the greater the variability. As sample sizes became larger (i.e., samples of at least 100), the rates became quite consistent, with between 20% and 30% of the offenders reporting childhood abuse. Although this is higher than what would be expected in the general population, this rate is much lower than is often reported. From a statistical standpoint, it should be recognized that the most valid and reliable data come from larger sample sizes, where the sample is most likely to reflect the general population than from small, potentially idiosyncratic, samples.

The above review clearly indicates that no profile is characteristic of, or unique to, child sexual abusers and that evaluation data provide little useful information in making legal or child protective decisions in cases involving denying offenders. It should also be recognized that any psychological testing approach, regardless of how reliable and valid, can never determine whether an individual has committed a specific offense. Even if our test instruments could reliably classify 100% of child molesters as child molesters and misclassify no nonabusers, we would still be unable to make statements regarding whether an individual child molester committed a specific crime.

Usefulness of Evaluation Data

Even though evaluation data provide little useful information in the denying offender, evaluation of the admitting offender can play a very useful role in decision-making in child sexual abuse cases. The evaluation of the offender post-conviction or the evaluation of an admitting offender can assist in making child protection and safety plans. A thorough and detailed evaluation can identify risk situations for the offender and identify antecedents to offending behavior to assist in planning external controls and what types of monitoring . Offender evaluations can be useful in assessing offenders' motivation for and amenability to treatment, thereby addressing community safety issues. Furthermore, an evaluation can determine the presence of psychological difficulty or a personality pattern that may adversely affect the treatment process, making community-based treatment more difficult.

The evaluation can also assist in developing individualized treatment plans and targeting specific areas needing remediation. These issues are very important given the heterogeneity of offenders. Evaluation prior to treatment provides a baseline for which repeated assessment can be used to monitor progress in treatment and change in a specific treatment area. The availability of baseline assessment allows the treatment provider to determine areas that are not changing. Failure to show progress in treatment has implications for risk of reoffending and for community safety. Furthermore, baseline and ongoing assessment of offenders allows treatment programs to monitor their overall effectiveness. Evaluation of the offender also allows us to expand our knowledge base, with the ultimate goal being the development of primary and secondary prevention programs.

In summary, evaluators of child sexual offenders should not promise more than they or their tests can deliver. The case outlined above causes an-

continued on next page

Media Reviews

continued from page 27

professionals working with victims or in other youth-related assessment and intervention systems where they may have contact with these teenagers.

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Offender Treatment

- William D. Murphy, Terri J. Rau, and Patricia J. Worley

continued from page 28

guish for all who share the desire to stop abuse. However, consumers of psychological evaluations should not be seduced into thinking that psychological test data can substitute for facts, investigation, and legal evidence. Nevertheless, the evaluation of these offenders can be important and useful as a component of planning and monitoring of treatment, with the ultimate goal of preventing child sexual abuse.

References

Abel, G. G., Becker, J.V., Murphy, W.D., & Flanagan, B. (1981). Identifying dangerous child molesters. In R. B. Stuart (Ed.). *Violent behavior: Special learning approaches to prediction, management, and treatment* (pp. 116-137). New York: Brunner/ Mazel.

Anderson, W. P., & Kunce, J. T. (1979). Sex offenders: Three personality types. *Journal of Clinical Psychology, 35*, 671-767.

Armentrout, J. A., & Hauer A. L. (1978). MMPIs of rapists of adults, rapists of children, and non-rapist sex offenders. *Journal of Clinical Psychology, 34,* 330-332.

Chaffin, M., & Milner, J. (1993). Psychometric issues for practitioners in child maltreatment. *The APSAC Advisor, 6*(1), 9-13.

Erickson, W. D., Luxenburg, M. G., Walbek, N. H., & Seely, R. K. (1987). Frequency of MMPI two-point code types among sex offenders. *Journal of Consulting and Clinical Psychology, 55,* 566-570.

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

Frenzel, R. R., & Lang, R. A. (1989). Identifying sexual preferences in intrafamilial and extrafamilial child sexual abusers. *Annals of Sex Research, 2,* 255-275.

Freund, K. (1965). Diagnosing heterosexual pedophilia by means of a test for sexual interest. *Behaviour Research and Therapy, 3,* 229-234.

Freund, K. (1967). Diagnosing homo- or heterosexuality and erotic age preferences by means of a psychophysiological test. *Behaviour Research and Therapy, 5*, 209-228.

Freund, K., & Blanchard, R. (1989). Phallometric diagnosis of pedophilia. *Journal of Consulting and Clinical Psychology, 57*, 100-105.

Freund, K., & Watson, R. J. (1991). Assessment of the sensitivity and specificity of a phallometric test: An update of phallometric diagnosis of pedophilia. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 3*, 254-260.

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

Hanson, R. K., & Slater, S. (1988). Sexual victimization in the history of sexual abusers: A review. *Annals of Sex Research, 1*, 485-499.

Kalichman, S. C. (1991). Psychopathology and personality characteristics of criminal sexual offenders as a function of victim age. *Archives of Sexual Behavior, 20,* 187-197.

Kirkland, K. D., & Bauer, C. A. (1982). MMPI traits of incestuous fathers. *Journal of Clinical Psychology, 38*, 645-649.

Lang, R. A., Black, E. L., Frenzel, R. R., & Checkley, K. L. (1988). Aggression and erotic attraction toward children in incestuous andpedophilic men. *Annals of Sex Research, 1,* 417-441.

Lanyon, R. I., & Lutz, R. W. (1984). MMPI discrimination of defensive and nondefensive felony sex offenders. *Journal of Consulting and Clinical Psychology, 52*, 841-943.

Laws, D. R., & Holmen, M. L. (1978). Sexual response faking by pedophiles. *Criminal Justice and Behavior, 5*, 343-356.

Laws, D. R., & Rubin, H. B. (1969). Instructional control of an autonomic response. *Journal of Applied Behavior Analysis, 2*, 93-99.

Levin, S. M., & Stava, L. (1987). Personality characteristics of sex offenders: A review. *Archives of Sexual Behavior, 16*, 57-79.

Marshall, W. L., Barbaree, H. E., & Butt, J. (1988). Sexual offenders against children: Sexual preference for gender, age of victim and type of behavior. *Behaviour Research and Therapy, 26,* 383-391.

Marshall, W. L., Barbaree, H. E., & Christophe, D. (1986). Sexual offenders against children: Sexual preferences for age of victims and type of behavior. *Canadian Journal of Behavioural Science, 18*, 424-439.

McCreary, C. P. (1975). Personality differences among child molesters. *Journal of Personality Assessment, 39*, 591-593.

Murphy, W. D., Haynes, M. R., Stalgaitis, S. J., & Flanagan, B. (1986). Differential sexual responding among four groups of sexual offenders against children. *Journal of Psychopathology and Behavioral Assessment, 8*, 339-353.

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

Murphy, W. D., & Smith, T. A. Sex offenders against children: Empirical and clinical issues. Manuscript in preparation.

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

Quinsey, V. L., Arnold, L. S., & Pruesse, M. G. (1980). MMPI profiles on men referred for a pretrial psychiatric assessment as a function of offense type. *Journal of Clinical Psychology, 36*, 410-417.

Quinsey, V. L., Chaplin, T. C., & Carrigan, W. F. (1979). Sexual preferences among incestuous and nonincestuous child molesters. *Behavior Therapy, 10,* 562-565.

Quinsey, V. L., Steinman, C. M., Bergensen, S. G., & Holmes, T. F. (1975). Penile circumference, skin conductance, and ranking responses of child molesters and "normals" to sexual and nonsexual visual stimuli. *Behavior Therapy, 6*, 213-219.

Scott, R. L., & Stone, D. A. (1986). MMPI profile constellation in incest families. *Journal of Consulting and Clinical Psychology, 54*, 364-368.

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RESOURCE

A new computer network, Abuse-L, has been formed as a forum for professionals to discuss child abuse issues. Professionals may subscribe, free of charge, if they are linked to most computer networks. To subscribe to ABUSE-L, send the command, SUB ABUSE-L followed by your first and last name to LISTSERV@UBVM interactively or LISTSERV@UBVM.CC.BUFFALO.EDU via a mail message (as the first line in the body of the mail, not the subject line).

Once you have subscribed, you will be able to contribute to the discussions by sending mail to ABUSE-L@UBVM.CC.BUFFALO.EDU.

For more information about this service contact, Ann S. Botash, MD, Director, Child Abuse Referral & Evaluation (CARE) Program, SUNY Health Science Center at Syracuse, 750 East Adams Street, Syracuse, NY 13210, 315-464-5800, (BOTASHA@VAX.CC.HSCSYR.EDU).

Investigation

-Byron Fassett
and Bill Walsh

continued from page 10

conversation was recorded after the girl was arrested for prostitution and agreed to cooperate in the investigation of her pimp.

Girl: "Baby, I did four tricks today, okay. I got four hundred dollars . . . and this other guy, he'swaiting for me right now, he wants, he wants to do a fifty."

Pimp: "Baby do you love me?"

Girl: "Baby I do love you. You know I love you, okay?"

As with the preferential child molester, the pimp seduces these children. Finding these children on the streets and befriending them, the pimp gradually gains their trust and then exploits it. The pimp is a self-taught expert in human nature and child psychology. He can spot weaknesses and needs in these girls and knows how to manipulate these weakness to his advantage.

In a way, the pimp becomes what the child needs--a friend, a lover, or a substitute for the child's parent. He will provide what the victim perceives as comfort, affection, understanding, and protection. Initially, the pimp will make the girl feel special and loved and make no demands on her. He will emphasize the freedom she has away from home and the fact that they only have each other to depend on. As time progresses, the pimp begins to separate the child from any other sources of financial or emotional support. He will further alienate the child from her family and friends, which will allow him to increase her vulnerability and dependencey on him. During this time of transition he will convince her of his love and devotion to her.

Vice detectives may be experienced and well-trained in dealing with adults involved in prostitution, but most are ill-prepared to deal with juveniles....Conversely, child abuse detectives may have the experience to deal with children, but not the training to investigate prostitution.

The child can only be introduced into the world of commercial sexual exploitation after she is emotionally and financially dependent on the pimp. Commercial sexual exploitation includes working in nude modeling studios, dancing in topless clubs, and engaging in prostitution. Prostitution may take many forms. Some girls will work the streets known for prostitution activity. Others will work out of a motel room, for fear the police will identify them as minors. Girls who work in modeling studios often engage in prostitution in addition to nude modeling. It appears that all these activities are related. The authors have seen girls start in one activity and as time goes on, move back and forth, between all three. Some girls may be involved in more than one activity at a time. Regardless of how the girl starts out, the primary method used to convince the child to enter this lifestyle is love and affection, and not force or pure financial gain as some may believe. The girl may be told that they, the girl and the pimp, need money so they can be together. Often promises of marriage or a life together are made.

Following is more of the taped conversation between the girl and pimp introduced earlier.

Pimp: "Baby please . . . are you okay?"

Girl: "Yes, I'm fine . . . let's be happy, it went smooth as hell, I can't believe that I did it. So I got four hundred dollars in my pocket and it's waiting with your name written all over it. This is gonna be our money for our apartment baby and then we can get married and everything."

Once succeeding in involving the girl in this lifestyle, the pimp is faced with the problem of controlling his victim to ensure that she will continue to obey him and provide him with money. It appears that this control is usually done in three phases.

The first phase is the withholding of the perceived love and affection that he used to convince her to start. As a law enforcement officer or a therapist, this is a very difficult obstacle to overcome when working with these children. The emotional hold these pimps have over these young victims is enormous. These children truly believe they are loved and not being exploited.

Eventually, these young victims come to realize that this person really does not love them. This sometimes happens when the girl notices the pimp paying attention to other girls. When they challenge that love, or try to leave, the pimp will then use violence and fear to control them. During this phase, these children will suffer unimaginable brutality at the hands of the pimp or even some of the other girls. Some girls are beaten to the point of requiring hospitalization. Others have been subjected to gang rape, have been branded with hot objects, or had their faces intentionally disfigured. As with domestic violence victims, they feel that they have nowhere to turn because they have been separated from their family and friends. Because of their juvenile records, they also fear the police and usually will not call them for help.

The last phase is when the beatings and the violence are no longer effective. Now the pimp may use drugs as a form of control over his victims. On occasion, threats to hurt the girl's family or friends have been made to insure the girl's compliance. If the girl is pregnant or has a baby, that will also provide the pimp with additional leverage. Unfortunately, if left to continue in this lifestyle, the girl faces a likely future of unwanted pregnancies and abortions, sexually transmitted diseases, AIDS, a criminal record, jail, prison, violence, and death.

The professional response

The police. For law enforcement, juvenile prostitution investigations are among the most difficult sexual victimization cases to handle. They are inherently riddled with problems. Law enforcement must realize that juvenile prostitution is a crime. The real criminals who must be apprehended and prosecuted are the pimp and the people who engage in sex with the juvenile prostitute. But who

continued on next page

Investigation

-Byron Fassett and Bill Walsh

continued from page 30

should handle the specific problem of juvenile prostitution? Vice detectives may be experienced and well-trained in dealing with adults involved in prostitution, but most are ill-prepared to deal with juveniles. They usually lack experience in dealing with children and with the dynamics of sexual abuse. Additionally, cases involving juveniles are usually heard before family court or juvenile judges and involve different laws and procedures than these detectives are familiar with. Vice detectives rarely are involved with runaway shelters, child protective services or juvenile probation, and therefore may not know how these agencies can be used. Conversely, child abuse detectives may have the experience to deal with children, but not the training to investigate prostitution.

In some states, legal obstacles may discourage or prevent officers from trying to deal with or take action against juvenile prostitutes. Laws that are written to protect children may actually prevent officers from providing that protection.

In some states, legal obstacles may discourage or prevent officers from trying to deal with or take action against juvenile prostitutes. Laws that are written to protect children may actually prevent officers from providing that protection. For example, some laws prohibit the officer from taking a picture of a juvenile prostitute for future identification. Needless to say, this hampers any information-gathering function. Laws regarding confidentiality for persons seeking treatment for sexually transmitted diseases, while necessary, may inadvertently prevent juveniles involved in prostitution from being identified. Because of these and other laws, officers may start to feel their actions accomplish little and stop taking enforcement action.

The courts. Even if the police come around to view these children as victims and try to take appropriate action, the courts may not. Another inherent problem in dealing with these types of cases is the attitudes of the courts and prosecution. Because of the lifestyle and past record of these young victims, judges and juries may not feel they are credible victims or witnesses. This is often the case in spite of physical and testimonial evidence that supports their credibility.

Many times criminal prosecutions of pimps and tricks are not pursued because the girl does not want to cooperate and testify. We often see a similar situation with battered women in cases of domestic violence who are reluctant to testify. In both cases, arrest and prosecution should be considered even when the victim does not want to testify.

Intervention. If the police and courts do succeed in taking one of these victims off the street, the next problem is what to do with her. This child has experienced unimaginable abuse and needs help. When she was taken away from her pimp, an enormous void was created in her life. This void has to be filled as quickly as possible. In many cases, the child may not be able to return home. Sometimes, circumstance will prevent this from ever happening. If forced to return to the home she ran from, she will probably only run again. She cannot be mainstreamed back into society without intensive services. But who should provide these services?

Child protective services (CPS) is ill-prepared to deal with this girl. By design, CPS is primarily geared to working with young children. The average caseworker is not trained to deal with these older children, often teenagers, who are chronic runaways, drug or alcohol abusers, and potentially violent. When CPS becomes involved with these juveniles, it is obvious that the resources they have available to them are inadequate. Intervening with these children is often very difficult: they not only do not think they need help, they do not want any. Foster and group homes are usually not good placements for these children. With their budgetary constraints and overworked staff, CPS is often forced to concentrate on the younger children.

Placing the child in a typical runaway shelter may also cause problems. First, most runaway shelters provide only short-term solutions. Also, mixing runaways with juveniles that have been involved in prostitution may result in the latter recruiting the former as the authors recently discovered. Where do we place them to get the help they need?

Sometimes these children are placed in long-term, residential treatment facilities. This allows caseworkers to work with these children in a secure environment and allow them a chance to end the control the pimps have over them. Unfortunately, there are few of these types of facilities available for victims of juvenile prostitution, and costs may be prohibitive.

Suggestions for improved identification and intervention

The suggestions that can be offered for improving any community's response to child prostitution are necessarily going to be broad. The specific methods of implementation in each community will be different. In every community, the relevant leaders should be involved, including the chief of police, the director of child protective services, the district attorney, the mayor, and other key authorities with the knowledge and power to effect change.

1. To deal effectively with this problem, all professionals involved must first realize that juvenile prostitution is a form of sexual victimization and must be treated accordingly.
2. Law enforcement must make a commitment to identify juvenile prostitutes and attempt to get them the help they need to escape that lifestyle.
3. Law enforcement and prosecutors must make a commitment to arrest and prosecute pimps and the persons who engage in sexual activity with juveniles. They must also work to develop strategies that will overcome the issues of the victim's credibility.
4. Law enforcement agencies must train their staff,

continued on next page

continued from page 31

both investigators and patrol, on the issue of juvenile prostitution. Those agencies that do not have the manpower or resources to have a unit that specializes in the investigation of the sexual exploitation of children should insure that detectives who investigate child abuse and prostitution communicate and cooperate in investigations involving juvenile prostitution.

5. Professionals who work with runaway children must understand the relationship between runaways and juvenile prostitution. Systems should be developed that flag chronic runaways, who should be interviewed to see the reasons for their behavior before they become involved in prostitution or other dangerous and destructive activity.
6. Law enforcement must develop a working relationship with the area runaway shelters. Communication between shelters and the police may lead to increased identification of girls involved or at risk of juvenile prostitution.
7. Law enforcement must utilize those investigative techniques that are required to make strong cases against pimps and tricks. These include surveillance, videotaping the pimp's activities, undercover investigations, and one party consensual phone calls.
8. All professionals must work to improve the response of their respective discipline to this problem.
9. Community treatment and supportive resources for these children need to be developed.

Summary

Juvenile prostitution is a serious problem in this country. Many involved children have histories of running away from home. There is also a widely held attitude that it is a victimless crime. It is not. It is the systematic sexual exploitation of children for sexual gratification or financial gain. Attitudes of professionals, especially law enforcement, must change regarding the way they view and respond to this problem. Much work and research is needed in this area. The purpose of this article was not to give the answers to the problem of juvenile prostitution, but to raise the questions.

References

Chesney-Lind, Meda (1992). *Delinquency and juvenile justice.* Belmont, CA: Wadsworth, Inc.

Cohen, Marcia I. (1987). *Identifying and combating juvenile prostitution: A manual for action.* Tulsa, OK: National Resource Center for Youth Services.

Author's note: This article contains comments, observations, and opinions which are solely those of the authors and do not reflect the official position of any organization with which they are affiliated.

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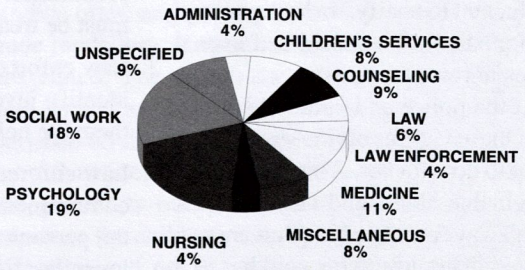
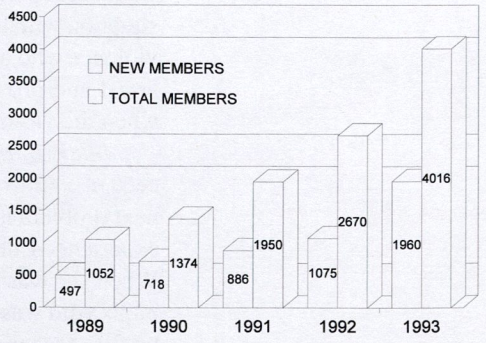
Membership Report

Many of the achievements of 1993 were reported in the last issue of *The APSAC Advisor*: the 50% membership growth, 100% growth in staff, outstanding success of the First National Colloquium. These two graphs reflect our growth since 1989, and the current distribution of our members by profession. Together they provide a snapshot of one of the most exciting professional societies in the nation.

APSAC MEMBERS BY PROFESSION, 1993



APSAC MEMBERSHIP GROWTH 1989 - 1993



Evaluation and Treatment

- John E. B. Myers

continued from page 6

Interviewing young children is a delicate and difficult task. Done poorly, interviews undermine the ability to protect children and raise the specter of false allegations. Done well, interviews help children reveal their memories.

References

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

Baker-Ward, L., Gordon, B.N., Ornstein, P.A., Larus, D.M., & Clubb, P.A. (1993). Young children's long-term retention of a pediatric examination. *Child Development, 64*, 1519-1533.

Batterman-Faunce, J.M., & Goodman, G.S. (1993). Effects of context on the accuracy and suggestibility of child witnesses. In G.S. Goodman & B.L. Bottoms (Eds.). *Child victims, child witnesses: Understanding and improving testimony*. New York: Guilford Press.

Bays, J., & Chadwick, D. (1993). Medical diagnosis of the sexually abused child. *Child Abuse & Neglect, 17,* 91-110.

Berliner, L. (1988). Deciding whether a child has been sexually abused. In E.B. Nicholson & J. Bulkley (Eds.). *Sexual abuse allegations in custody and visitation cases* (pp.48-69). American Bar Association. National Legal Resource Center for Child Advocacy and Protection (Center on Children and the Law).

Ceci, S.J., & Bruck, M. (1993). Suggestibility of the child witness: A historical review and synthesis. *Psychological Bulletin, 113*, 403-439.

Ceci, S.J., & Bruck, M. (1993). Child witnesses: Translating research into policy. *Social Policy Report: Society for Research in Child Development, 7*, 1-31.

Doris J. (Ed.). (1991). *The suggestibility of children's recollections: Implications for eyewitness testimony*. American Psychological Association: Washington, D.C.

Eberle, P., & Eberle, S. (1993). *The abuse of innocence: The McMartin preschool trial*. New York: Prometheus Books.

Faller, K.C. (1990). *Understanding child sexual maltreatment*. Newbury Park, CA: Sage.

Finkelhor, D. (in press). Answers to important questions about the scope and nature of child sexual abuse. *The Future of Children*. Los Altos, CA: Center for the Future of Children. The David and Lucile Packard Foundation.

Fivush, R. (1993). Developmental perspectives on autobiographical recall. In G.S. Goodman & B.L. Bottoms. *Child victims, child witnesses: Understanding and improving testimony*. New York: Guilford Press.

Fivush, R., & Hudson, J.A. (Eds.). (1990). *Knowing and remembering in young children*. New York: Cambridge University Press.

Geiselman, R.E., Saywitz, K.J., & Bornstein, G.K. (1993). Effects of cognitive questioning techniques on children's recall performance. In G.S. Goodman & B.L. Bottoms (Eds.). *Child victims, child witnesses: Understanding and improving testimony*. New York: Guilford Press.

Goodman, G.S. & Bottoms, B.L. (Eds.). (1993). *Child victims, child witnesses: Understanding and improving testimony*. New York: Guilford Press.

Goodman, G.S., Bottoms, B.L., Schwartz-Kenney, B.M., & Rudy, L. (1991). Children's testimony about a stressful event: Improving children's reports. *Journal of Narrative & Life History, 1,* 69-99.

Lepore, S.J., & Sesco, B. (in press). Distorting children's reports and interpretations of events through suggestion. *Journal of Applied Psychology.*

Loftus, E.F. (1993). The reality of repressed memory. *American Psychologist, 48*, 518-537

Loftus, E.F. (1979). *Eyewitness Testimony*. Cambridge, MA: Harvard University Press.

Melton, G. (1981). Children's competence to testify. *Law and Human Behavior, 5,* 73-85.

Myers, J.E.B. (1992). *Evidence in child abuse and neglect cases*. New York: John Wiley & Sons.

Myers, J.E.B. (1992a). *Legal issues in child abuse and neglect*. Newbury Park, CA: Sage.

Myers, J.E.B. (1994). The literature of the backlash. In J.E.B. Myers (Ed.). *The backlash: Child protection under fire*. Newbury Park, CA: Sage.

Pipe, M.E., Gee, S., & Wilson, C. (1993). Cues, props, and context: Do they facilitate children's event reports? In G.S. Goodman & B.L. Bottoms (Eds.). *Child victims, child witnesses: Understanding and improving testimony*. New York: Guilford Press.

Saywitz, K.J., Goodman, G.S., Nicholas, E., & Moan, S.F. (1991). Children's memories of a physical examination involving genital touch: Implications for reports of child sexual abuse. *Journal of Consulting and Clinical Psychology, 59*, 682-691.

Saywitz, K.J., & Snyder, L. (1993). Improving children's testimony with preparation. In G.S. Goodman & B.L. Bottoms (Eds.). *Child victims, child witnesses: Understanding and improving testimony*. New York: Guilford Press.

Sorensen, T., & Snow, B. (1991). How children tell: The process of disclosure in child sexual abuse. *Child Welfare, 70,* 3-15.

State v. Michaels, 625 A.2d 489 (N.J. *Super.* 1993).

Steward, M.S., Bussey, K., Goodman, G.S., & Saywitz, K.J. (1993). Implications of developmental research for interviewing children. *Child Abuse & Neglect, 17,* 25-37.

Summit, R.C. (1983). The child sexual abuse accommodation syndrome. *Child Abuse & Neglect, 7,* 177-193.

Warren, A., Hulse-Trotter, K., & Tubbs, E.C. (1991). Inducing resistance to suggestibility in children. *Law & Human Behavior, 15,* 273-285.

Yates, A., & Musty, T. (1988). Preschool children's erroneous allegations of sexual molestation. *American Journal of Psychiatry, 145*, 989-992

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NTPETA State of the Art National Training Program

A model training program, NTPETA, funded by the National Center on Child Abuse and Neglect, has developed an accessible, affordable curriculum for therapists who treat sexually abused children. NTPETA is the acronym for the National Training Program on Effective Treatment Approaches in Child Sexual Abuse, funded by NCCAN, presented by the National Children's Advocacy Center, and hosted by a number of regional community-based organizations across the country. The goal of NTPETA is to enhance mental health treatment and other services provided to sexually abused children and their families.

The curriculum is designed to be for intermediate professionals with at least one year of clinicalexperience, including those with some experience in treating child sexual abuse. The training is designed to increase child sexual abuse treatment providers' knowledge and skills in assessment and treatment planning, language skills to enhance communication with children and adolescents, specific treatment methods, expressive techniques, specific treatment provider issues, working with sexually reactive children, serving children with disabilities, serving non-offending parents and siblings, legal and ethical issues, offender treatment, how to be an effective witness, confidentiality and liability issues, and appropritae termination of treatment.

For further information regarding dates, sites, and registration, contact NTPETA at 1-800-239-9939.

WASHINGTON UPDATE

-by Tom Birch

Editor's Note: We are pleased to introduce a new column designed to inform APSAC members of the current events on Capitol Hill. Written by Tom Birch, JD, Executive Director of the National Child Abuse Coalition, the column will convey news about budget changes, grant deadlines, appointments, and resources that may affect APSAC members' professional lives. We hope you find the column helpful.

Clinton's 1995 Budget Proposal

The Clinton Administration's final 1995 budget proposal would shift funding for the National Center on Child Abuse and Neglect (NCCAN) to emphasize prevention efforts and eliminate discretionary funds specifically designated for programs addressing substance abuse and child maltreatment.

NCCAN's emergency protection grants, first funded in 1991 as part of a federal effort to address the drug crisis in America, aim at helping agencies handle substance abuse-related cases of child abuse and neglect. Under the Clinton budget proposal, money for emergency grants--$19 million--would go to increase community-based prevention grants from $5 million to $23 million, and an additional $1 million would be allocated to NCAAN's basic discretionary grant program.

Basic state grants for NCCAN are held even at $22 million, still short of the $40 million threshold needed to trigger implementation of the child protective service systems improvements mandated by the 1992 amendments to the Child Abuse Prevention and Treatment Act (CAPTA). Although total appropriations for NCCAN would be frozen at a budget level of $63 million, the funding for NCCAN is more than double the amount four years ago.

As anticipated, the President's budget for the Department of Health and Human Services (HHS) increases the funding to $150 million for the new family preservation and support program, just getting underway this year with $60 million to states for planning grants and services support.

Overall, the President's budget would reduce funding for 300 federal programs. The new budget is about $30 billion less than Clinton's request of a year ago. Total discretionary funding for HHS is up for 1995, while discretionary money government-wide would decrease for the first time in 25 years.

The budget proposed for the Department of Justice includes a 45 percent increase in funds for juvenile justice programs to a level of $172.2 million--almost two and one-half times the appropriation two years ago--for programs in preventing and treating juvenile crime and delinquency.

The Justice Department's Victims of Child Abuse program, which went from $2 million to $8 million last year, is budgeted at the current level for funds to support improvements in prosecution of child abuse cases and court handling of cases. The money assists children's advocacy centers, programs of court appointed special advocates (CASA), and training of prosecutors and judges.

Advisory Board Appointments Named

New appointees to the U.S. Advisory Board on Child Abuse and Neglect have been selected by Secretary of Health and Human Services Donna Shalala. The seven individuals named to serve on the Advisory Board were sworn in by Shalala on March 15, 1994, in Washington, DC. They represent a variety of disciplines and experiences in the field of child abuse and neglect, as required by the Child Abuse Prevention and Treatment Act in establishing the board.

The new members slated to join are: *Dr. Randell C. Alexander*, pediatrician and chair of the Iowa Governor's Advisory Council to the Child Abuse Prevention Fund; *Nancy R. Hoit*, volunteer advocate, member of the Executive Committee of the Massachusetts Children's Trust Fund Board and past president of the Massachusetts Society for the Prevention of Cruelty to Children; *Frances E. Jemmott*, Executive Director of the California Self Help Center at UCLA and Chair of the National Black Women's Health Project; *Dr. Murray Levine*, Professor of Law and Psychology and Director of the Research Center on Children and Youth at the State University of New York at Buffalo; *Elba Montalvo*, founder of the Committee for Hispanic Children and Families, working with Latino families in New York City affected by domestic violence; *J. Tom Morgan*, district attorney of the Stone Mountain Judicial Circuit in Georgia, special prosecutor for child sexual assault and physical abuse cases, and Board member of the National Network of Children's Advocacy Centers; and *Michael W. Weber*, Director of the Community Protection of Children in Minneapolis, past Director of the Hennepin County Community Services Department, and Board member of the American Public Welfare Association.

Family Preservation and Support Guidelines

Program instructions for the new $60 million Family Preservation and Support Services have been sent to each state child welfare agency to guide planning for the new program aimed at strengthening families and preventing child abuse and neglect. States are encouraged to use the new program as a catalyst for developing coordinated, family-focused services for children and families.

Applications for the FY94 planning grants are due by June 30, 1994, and the five-year state plans developed through the state planning process are due by June 30, 1995.

Child Abuse and Neglect CD-ROM

A database of bibliographic records on child abuse and neglect is offered free of charge to qualifying organizations, including libraries, universities, social and health care providers, law firms,

continued on next page

Washington Update

-Tom Birch

continued from page 34

policymakers, public agencies, and professional associations. The database, being offered by National Information Services Corporation in association with the National Clearinghouse on Child Abuse and Neglect Information, includes more than 17,00 citations and abstracts of professional literature produced from 1965 to the present. Materials are culled from books, journals, government reports, conference papers, federally-funded grants, curricula, and unpublished papers.

Descriptors used in the databases are taken from the Child Abuse and Neglect Thesaurus containing over 1600 descriptor items. References are primarily to English-language materials originating in the United States. The offering includes a free annual subscription with updated discs sent semi-annually.

Inquiries should be addressed to: National Clearinghouse on Child Abuse and Neglect Information, PO Box 1182, Washington, DC 20013-1182.

Maternal and Child Health Application Deadlines

The U.S. Bureau of Maternal and Child Health has announced 1994 application deadlines for new and competing renewal grant projects and cooperative agreements for special projects of regional and national significance under MCH federal set-aside program. Up to twenty five-year research grants will be awarded, with application deadlines March 1, 1994- August 1, 1994. Funding is also available for ten school health programs, due date to be announced; ten maternal, infant, child and adolescent health projects, due April 29, 1994; five data utilization projects, due June 15, 1994; ten Healthy Tomorrows Partnerships for Children, due May 2, 1994; and ten field-initiated projects, due between April 1, 1994 and August 15, 1994.

The complete announcement appears in the February 2, 1994 Federal Register on page 4925. For more information, please contact Chief, Grants Management Branch, Office of Program Support, Maternal and Child Health Bureau, Health Resources and Services Administration, Room 18-12, Parklawn Building, 5600 Fishers Lane, Rockville Maryland 20857; Phone (301)-443-1440.

Tom Birch, JD is Executive Director of the National Child Abuse Coalition.

Prevention

-Kathleen A. Kendall Tackett

continued from page 12

Two anthropologists noted that in many cultures blues are virtually non-existent. This is in stark contrast to Western cultures, where the blues are so common that we assume that they are inevitable.

their birth experiences so they can focus on the present and care for their babies.

Childhood abuse of the mother. Surprisingly, there are no empirical studies linking childhood abuse to postpartum depression (although some anecdotal and clinical evidence suggests a link). However, a recent line of inquiry examines the effect of past child sexual abuse on birth, and indicates that past abuse can affect a woman's birth experience (e.g., Courtois & Riley, 1992; Grant, 1992). Some of these effects include flashbacks of the abuse during labor, and even an increase in medical interventions such as anesthsia, analgesia, and cesarean sections. In popular literature, some women describe their birth experiences as revictimizations. Future research may also reveal a direct relationship between past abuse and postpartum depression, and/or an indirect relationship between past abuse and postpartum depression through birth experiences.

Infant Characteristics. Understanding the *infant's* role in postpartum depression is a relatively new, since most research has focused on the mother. There have been two broad classes of infant characteristics that have been directly related to postpartum depression: infant temperament and infant illness. "Difficult" infants are those who react negatively and cry frequently, are slow to accept new experiences, and do not engage in regular routines. In one study (Cutrona & Troutman, 1986), the authors found a direct causal link between infants with difficult temperaments and postpartum depression in their mothers. The authors hypothesized that these infants contribute to the onset of depression since they diminish their mothers' feelings of self-efficacy and make them feel helpless. These difficult infants are also at increased risk for being abused, perhaps because they do not soothe easily and cry a great deal (Schmitt, 1987). Below, two women describe how their children's temperaments made them feel out of control as mothers.

> My first baby screamed from the day he was born. He screamed all the time, even in the hospital. He reacted oddly to all kinds of different things. The pediatrician said he was a "difficult" child. Even now, he has to have things always the same....When I went back for a checkup at two weeks, a nurse asked me how the baby was. She said, "Aren't they wonderful?" I didn't know what to say. I thought he was the pits (Kendall-Tackett, with Kantor, 1993, pp. 85-86).

> The baby had a difficult temperament. Even now, she's very stubborn and strong willed....I wanted this baby so bad. When she came, I hated her. I thought of throwing her out the window. I just wanted her to die. I spanked her when she was 3 or 4 weeks old, and I'm still dealing with the guilt of it....I'd yell at her, right in her face, "I hate you. I wish you would die." (Kendall-Tackett, with Kantor, 1993, pp. 85-86)

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Prevention

-Kathleen A. Kendall Tackett

continued from page 35

Another factor related to postpartum depression is the effect of infant illness, prematurity, or disability on the mothers' emotional state. Not surprisingly, illness of infants has also been causally linked to postpartum depression; the higher the risk for the infant, the greater the depression in the mother (Blumberg, 1980). Again, mothers may feel that they have no control and are powerless to help their babies. They may also be extremely anxious about their infants and may be experiencing anticipatory grieving.

Social support clearly affects not just post - partum depression but the mother/infant relationship. Lack of social support or connection with the community is an important correlation of child maltreatment. Similar findings emerge in the literature on mother-infant bonding.

The goals in these cases are to help mothers resolve their grief and become attached to their infants. But their babies' illness may prompt emotional distance, making it difficult to resolve grief and attach to the infants. These babies may also react in unusual ways and be difficult to predict or read, thus lowering mothers' sense of self-efficacy. Mothers may perceive that their babies are rejecting them. In one study, mothers with the sickest babies became less responsive to them and responded negatively to their distress over time, whereas mothers of moderately ill babies improved over time (Jarvis et al., 1989). Again, these were not mothers otherwise at risk for abuse, and yet mother-infant bonding was strongly affected by their infants' illnesses.

Social Support. Providing women with adequate social support significantly lessens their chances of developing postpartum depression. A woman's husband or partner is a key source of support. Numerous research studies conducted with married women have demonstrated that both emotional and instrumental support from the woman's husband significantly decreases her risk of postpartum depression. Women who indicated that their husbands did not provide adequate support were significantly more likely to be depressed (e.g., Campbell, Cohn, Flanagan, Popper, & Meyers, 1992; O'Hara, 1986).

The support of peer networks is also very important. Two anthropologists (Stern & Kruckman, 1983) noted that in many cultures, postpartum depression, and even transient postpartum blues, are virtually non-existent. This is in stark contrast to Western cultures, where the blues are so common that we assume that they are inevitable. Stern and Kruckman have analyzed the protective elements of these non-Western cultures. In particular, they note that in cultures with a low incidence of postpartum depression, many elaborate rituals are enacted that take place after a woman has given birth. These rituals serve several functions, including (1) giving the mother time to recuperate, (2) offering her respite from her daily activities, and (3) recognizing her status as a new mother. In at least one of these cultures, well-wishers give presents to the mother and a special "stepping out" ceremony takes place within a few weeks of her giving birth. Stern and Kruckman describe these rituals as "mothering the mother," which is also an important aspect of the "doula" movement in the United States (Klaus et al., 1993; Raphael, 1976). "Doula" is a term that is used both for a woman who attends a laboring woman and for a woman who provides postpartum support. Clearly, this type of postpartum care is not the norm for the majority of mothers in the U.S. This absence of care for the mother is a cause of great concern, especially since maternity hospital stays are now being reduced to 24 hours with no follow-up care.

Social support clearly affects not just postpartum depression but the mother-infant relationship. Lack of social support or connection with the community is an important correlate of child maltreatment (Polansky, Gaudin, Ammons, & Davis, 1985). Similar findings emerge in the literature on mother-infant bonding. For example, instrumental social support has been related to mothers being able to be more sensitive to their infants in the first year of life (Crockenberg & McCluskey, 1986). This trend continued until the children were older. In a study of 38 mother-child dyads (with children ages 27 to 55 months), the more support a mother received in her role as a parent, the better were her interactions with her child. This result applied to mothers who were single parents as well as to those who were in two-parent families (Weinraub & Wolf, 1987).

Conversely, perceived lack of support from fathers was related to insecure attachments between 34 Japanese mothers and their 12-month-old infants (Durrett, Otaki, & Richards, 1984). The authors interpreted their findings by stating that mothers who did not have support may have had higher levels of stress, and were therefore psychologically unavailable to their infants. Other research found that lack of social support was also characteristic of mothers who neglected their children, even when controlling for the effects of socioeconomic status (Polansky, Gaudin, Ammons, & Davis, 1985). Social support also facilitated attachment between mothers and their handicapped infants (Capuzzi, 1989), as well as mothers and their premature infants (Crnic et al., 1986). In general, mothers with high support are more satisfied with their babies, their maternal roles, and their lives overall (Crnic & Greenberg, 1987).

Knowing that social support is so essential to new mothers, it is important to keep in mind that what helping professionals think of as support is not necessarily support for the new mothers. "Support groups" or "nurse home visits" are often suggested to to prevent postpartum depression, and "parent education" is also frequently suggested for preventing child abuse. These types of intervention do work for some families, but not for everyone. One recent study involving visiting nurses (Affleck, et

continued on next page

continued from page 36

al., 1989) demonstrated that for the intervention to be effective, the recipient must *perceive* it as support. If she does not perceive the support as helpful, it can actually make matters worse. The bottom line is that these programs are most successful when the mother sees a need for them and/or when the mother feels nurtured and cared for.

Suggestions for the Field

1. **Be alert for possible postpartum depression**. Postpartum depression is a problem in and of itself, and can also indicate other problems within the family. Using a screening instrument such as the *Edinburgh Postnatal Depression Scale* is often helpful (see Appendix p.38).

2. **Don't assume you know the cause of the woman's distress**. Postpartum depression is caused by such a wide variety of factors that it is unwise to assume you know which ones are involved for a particular woman. Many mothers I've spoken to have told me how frustrating it was when someone kept trying to tell them why they were depressed. In the same way, don't assume that the same intervention will work for everyone. If at all possible, offer women a variety of options and let her choose those with which she is most comfortable. Treatment could include support groups, psychotherapy, social support (including practical assistance with the baby), physical screening for medical problems that might increase fatigue, and antidepressant medications.

3. **Find out about resources in your community**. Many professionals do not get involved with the concerns of new mothers because they feel that cannot provide the needed support. The good news is that *you don't have to*. Find out about groups working with new mothers, and don't limit your search to organizations concerned with child abuse. I was recently impressed as I listened to La Leche League leaders describe some of their "helping calls." La Leche League leaders are volunteer mothers who provide breastfeeding support and assistance. It was apparent that they were helping to prevent child abuse in many cases as mothers called them when they were at their wits' end. Yet this group is never included in child abuse prevention programs. Many organizations have toll-free numbers for women to call when they have questions or concerns. Find out about these organizations and tell the mothers you work with about them (see Appendix p.38 for a list).

Knowing that social support is so essential to new mothers, it is important to keep in mind that what helping professionals think of as support is not necessarily support for new mothers.

4. **Consider some activism on behalf of new mothers.** Contact HMO's or hospitals in your community and express your concerns about the possible outcomes on families of 24-hour maternity discharges with no follow-up care. Suggest that they offer follow-up care, mentioning that it is likely to save them money in the long run (see Appendix p.38 for organizations that can help).

Conclusion

Providing support for new mothers is well worth our efforts. By nurturing women during this vulnerable time, we can prevent both postpartum depression and at least some child abuse and neglect.

References

Affleck, G., Tennen, H., Rowe, J., Roscher, B., & Walker, L. (1989). Effects of formal support on mothers' adaptation to the hospital-to-home transition of high-risk infants: The benefits and costs of helping. *Child Development, 60,* 488-501.

Affonso, D.D. (1977). "Missing pieces"--A study of postpartum feelings. *Birth and the Family Journal, 4,* 159-164.

Blumberg, N.L. (1980). Effects of neonatal risk, maternal attitude, and cognitive style on early postpartum adjustment. *Journal of Abnormal Psychology, 89*, 139-150.

Campbell, S.B., Cohn, J.F., Flanagan, C., Popper, S., & Meyers, T. (1992). Course and correlates of postpartum depression during the transition to parenthood. *Development and Psychopathology, 4,* 29-47.

Capuzzi, C. (1989). Maternal attachment to handicapped infants and the relationship to social support. *Research in Nursing & Health, 12,* 161-167.

Cogill, S.R., Caplan, H.L., Alexandra, H., Robson, K.M., & Kumar, R. (1986). Impact of maternal postnatal depression on cognitive development of young children. *British Medical Journal, 292*, 1165-1167.

Courtois, C.A. & Riley, C.C. (1992). Pregnancy and childbirth as triggers for abuse memories: Implications for care. *Birth, 19*, 222-223.

Crnic, K., & Greenberg, M. (1987). Maternal stress, social support, and coping: Influences on the early mother-infant relationship. In C.F.Z. Boukydis (Ed.). *Research on support for parents and infants in the postnatal period.* Norwood, NJ: Ablex.

Crnic, K.A., Greenberg, M.T., & Slough, N.M. (1986). Early stress and social support influences on mothers' and high-risk infants' functioning in late infancy. *Infant Mental Health Journal, 7,* 19-33.

Crockenberg, S., & McCluskey, K. (1986). Change in maternal behavior during the baby's first year of life. *Child Development, 57,* 746-753.

Cutrona, C.E., & Troutman, B.R. (1986). Social support, infant temperament, and parenting self-efficacy: A mediational model of postpartum depression. *Child Development, 57*, 1507-1518.

Davidson, J., & Robertson, E. (1985). A follow-up study of post-partum illness, 1946-1978. *Acta Psychiatrica Scandanavica, 71*, 451-457.

Durrett, M.E., Otaki, M., & Richards, P. (1984). Attachment and the mother's perception of support from the father. *International Journal of Behavioral Development, 7,* 167-176.

Field, T. (1992). Infants of depressed mothres. *Development and Psychopathology, 4*, 49-66.

Grant, L.J. (1992). Effects of childhood sexual abuse: Issues for obstetric caregivers. *Birth, 9*, 220-221.

Helfer, R. (1987). The perinatal period, a window of opportunity for enhancing parent-infant communication: An approach to prevention. *Child Abuse & Neglect, 11,* 565-579.

Jarvis, P.A., Myers, B.J., & Creasey, G.L. (1989). The effects of infants' illness on mothers' interactions with prematures at 4 and 8 months. *Infant Behavior and Development, 12,* 25-35.

Kendall-Tackett, K.A., with Kantor, G.K. (1993). *Postpartum depression: A comprehensive approach for nurses.* Newbury Park, CA: Sage.

Klaus, M., Kennell, J., & Klaus, P. (1993). *Mothering the mother.* Reading, MA: Addison-Wesley.

Lachnit, C. (1990). Appeals court won't order retrial in postpartum psychosis killing. *The Orange County Register, May 24,* B1.

Lahey, B.B. (1992). *Psychology* (4th Ed.). Dubuque, IA: William C. Brown.

O'Hara, M.W. (1986). Social support, life events, and depression during pregnancy and the puerperium. *Archives of General Psychiatry, 43*, 569-573.

O'Hara, M.W. (1987). Post-partum "blues," depression, and psychosis:

continued on next page

A review. Special issue: Maternal development during reproduction. *Journal of Psychosomatic Obstetrics and Gynaecology, 7*, 205-227.

Polansky, N.A., Gaudin, J.M., Ammons, P.W., & Davis, K.B. (1985). The psychological ecology of the neglectful mother. *Child Abuse & Neglect, 9*, 265-275.

Raphael, D. (1976). *The tender gift: Breastfeeding.* New York: Schoken.

Schmitt, B.D. (1987). Seven deadly sins of childhood: Advising parents about difficult developmental phases. *Child Abuse & Neglect, 11*, 421-432.

Simkin, P. (1992). Just another day in a woman's life? Part II: Nature and consistency of women's long-term memories of their first birth experiences. *Birth, 19*, 64-81.

Stern, G., & Kruckman, L. (1983). Multi-disciplinary perspectives on post-partum depression: An anthropological critique. *Social Science and Medicine, 17*, 1027-1041.

Whiffen, V.E., & Gotlib, I.H. (1989). Infants of postpartum depressed mothers: Temperament and cognitive status. *Journal o f Abnormal Psychology, 98*, 274-279.

Wrate, R.M., Rooney, A.C., Thomas, P.F., & Cox, J.L. (1985). Postnatal depression and child development: A 3-year follow-up study. *British Journal of Psychiatry, 146*, 622-627.

Wurtman, R.J., & Wurtman, J.J. (1989). Carbohydrates and depression. *Scientific American, January,* 68-75.

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RESOURCES FOR INTERVENTION WITH NEW MOTHERS

Single copies of instruments for assessing postpartum fatigue and postpartum depression (*Edinburgh Postnatal Depression Scale)* are available at no cost from:
The Perinatal Education Group, 129A Concord St., Suite 38, Framingham, MA 01701
These can be copied for individual use.

ORGANIZATIONS THAT WORK WITH NEW MOTHERS

C/SEC (Cesarean/Support, Education, Concern)
22 Forest Rd.
Framingham, MA 01701
(508) 877-8266

Depression After Delivery, National
P.O. Box 1282
Morrisville, PA 19067
(215) 295-3994

Federation for Children with Special Needs
95 Berkeley St., Suite 104
Boston, MA 02116
(617) 482-2915

International Cesarean Awareness Network (I CAN)
P.O. Box 152
Syracuse, NY 13210
(315) 424-1942

LaLeche League International
9616 Minneapolis Ave.
Franklin Park, IL 60131
(708) 455-7730
(800) LaLeche

National Association of Mothers' Centers
336 Fulton Ave.
Hempstead, NY 11550
(800) 645-3828

National Association of Postpartum Care Services
c/o MotherCare, Inc.
17 Highland
Lexington, MA 02173
(617) 863-1333

National Down Syndrome Congress
1800 Dempster St.
Park Ridge, IL 60068
(708) 823-7550
(800) 232-6372

National Information Center for Children and Youth with Handicaps
P.O. Box 1492
Washington, D.C. 20013
(800) 999-5599

National Organization of Mothers of Twins Clubs, Inc.
P.O. Box 23188
Albuquerque, NM 87192-1188
(505) 275-0955

Parents Anonymous, National
520 S. Lafayette Park Pl., Suite 316
Los Angeles, CA 90057
(213) 388-6685
(800) 421-0353

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 represented in an annotated bibliography form. APSAC members are invited to contribute to Journal Highlights by sending a copy of current articles (preferbly published within the past six months), along with a two or 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

Crittenden, P.M. (1993). An information processing perspective on the behavior of neglectful parents. *Criminal Justice and Behavior, 20* (1), 27-48.

This article examines research on neglectful parents to develop a theory on how and why neglectful behavior occurs. Using cognitive theory on information processing, four stages at which parents could fail to respond to signals of children's needs are identified. The author proposes that failure at each stage represents a different type of child neglect, calling for different types of intervention. (TFC)

Crouch, J.L. and Milner, J.E. (1993). Effects of child neglect on children. *Criminal Justice and Behavior, 20* (1), 49-65.

This article reviews empirical studies which have examined the effects of child neglect on children's development. Despite the fact that neglect is the most frequently reported form of maltreatment, these studies show how poorly understood the developmental impact of neglect experiences remain. In addition, the numerous conceptual and definitional difficulties which have impeded research on the sequelae of neglect are examined. (TFC)

Dubowitz, H. and Black, M., Starr, R.H., and Zuravin, S. (1993). A conceptual definition of child neglect. *Criminal Justice and Behavior, 20* (1), 8-26.

A conceptual definition of neglect is presented in this article, based on an ecological model of child maltreatment. This definition focuses on the basic needs of children that are not met, rather than on the intentions or behaviors of parents. The authors present child neglect as a heterogeneous phenomenon which varies by type, severity, and chronicity. (TFC)

Trupin, E., Tarico, V., Low, B., Jamelka, R., and McClennan, J. (1993). Children on child protective service caseloads: Prevalence and nature of serious emotional disturbance. *Child Abuse and Neglect, 17* (3), 345-355.

The prevelance of serious emotional disturbance among children of protective service caseloads was assessed. Over 72% of the children studied were statistically indistinguishable from children in Washington State's most intensive mental health programs. The need for greater interdisciplinary and systematic cooperations is discussed. (TFC)

SEXUAL ABUSE

Draucker, C.B. (1993). Childhood sexual abuse: Sources of trauma. *Issues in Mental Health Nursing, 14* (3), 249-262.

The purpose of this study was to delineate the sources of trauma resulting from a childhood sexual abuse experience as described by adult survivors who were asked to reflect on aspects of their experience which they considered traumatic. Participants were free to interpret "trauma" in any way that was meaningful to them. Eight categories identified by the participants as reflecting a source of trauma are discussed in detail. A sense of abandonment was the most often-cited source of trauma. This article should aid therapists in helping abused survivors identify, understand and resolve the traumatic aspects of their abuse experience. (TFC)

Fontes, L. (1993). Considering culture and oppression: Steps toward an ecology of sexual child abuse. *Journal of Feminist Family Therapy, 5* (1), 25-54.

This article urges the adoption of an ecological view of child sexual abuse, with attention to the individual, the family, the ethnic culture, and the society at large. Case material is drawn from work with Puerto Rican families and research with Puerto Ricans in the United States on issues of child sexual abuse. (LT)

Gellert, G., Berkowitz, C., Gellert, M., and Durfee, M. (1993). Testing the sexually abused child for 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 professionals, take a lead role in the interdisciplinary team approach to facilitate testing for the HIV antibody in chldren suspected of infection through sexual abuse. Noted in the discussion is the paucity of data on HIV infection in known pedophiles. (MC)

Gutman, L.T., Herman-Giddens, M.E., and McKinney, R.E. (1993). Pediatric Acquired Immunodeficiency Syndrome: Barriers to recognizing the role of child sexual abuse. *American Journal of Disease in Children, 147*, 775-780.

This study discusses issues which have inhibited the study of the role sexual abuse plays in HIV

continued on next page

Journal Highlights

-Thomas F. Curran

continued from page 39

transmission in younger children. Means of removing barriers to the understanding of the role of abuse in pediatric HIV transmission are reviewed. Preliminary recommendations are made for HIV testing of sexually abused children, along with indicators for evaluation of HIV infected children suspected of being sexually abused. (LTG)

Jenny, C. and Roelser, T.A. (1993). Quality--A response to "The Backlash" against child abuse diagnosis and treatment. *Journal of Child Sexual Abuse, 2* (3), 89-98.

In this article the authors provide a thought-provoking examination of the child sexual abuse "backlash." A challenge is presented to child abuse professionals to use valid criticisms to improve interventions by all disciplines. A proposal which would remove quality assurance responsibility from the courts and place it with the diverse professions involved in child sexual cases is outlined. (TFC)

Kaplan, M., Morales, M., and Becker, J. (1993). The impact of verbal satiation on adolescent sex offenders: A preliminary report. *Journal of Child Abuse and Neglect, 2* (3), 81-88.

The effectiveness of one cognitive behavorial treament procedure, verbal satiation, was measured in this study of 15 adolescent sex offenders against children. Using the penile plethysmograph pre-and post-treatment, the results indicated an overall decrease in all but one of the participants' arousal to atypical stimuli. Shortcomings of this study are discussed.

Mennen, F.E. (1993). Evaluation of risk factors in childhood sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry, 32* (5), 934-939.

Multiple measures were used to examine interactional effects to evaluate whether specific factors in child sexual abuse increase the risk of serious distress in its victims. Seventy-five abused girls completed measures on depression, anxiety, and self-worth. When the sexual abuse included penetration, higher levels of distress on depression and self worth were reported. Force predicted higher levels of distress on those measures when the perpetrator was not a father figure, and lower levels when he was. (TFC)

Yama, M., Fogas, B., Teegarden, M., and Hastings, B. (1993). Childhood sexual abuse and parental alcoholism: Interactive effects in adult women. *American Journal of Orthopsychiatry, 63* (2), 300-305.

A group of 364 university women were studied to examine symptoms associated with both childhood sexual abuse and parental or adult alcoholism. Study results indicated a significant association between childhood abuse and alcoholism in adult survivors. (MC)

OTHER ISSUES IN CHILD MALTREATMENT

Berliner, L. (1993). Is family preservation in the best interest of children; and **Gelles, R.J.** (1993). Family Reunification/Family Preservation: Are children really being protected? *Journal of Interpersonal Violence, 8* (4), 556-562.

In this brief commentary the issue of family preservation and reunification as the guiding U.S. welfare policy is analyzed. Gelles points out the absence of scientific evidence to support the key assumptions underlying family preservation/reunification doctrines, including the assumption that such programs work. A child-centered policy is recommended to replace reunification/preservation as the guiding welfare policy. (TFC)

Burnett, B.B., (1993). The psychological abuse of latency age children: A survey. *Child Abuse and Neglect, 17* (4), 441-454.

This study aimed at identifying potential definitions of psychological abuse by submitting vignettes with adult behaviors to be rated as abuse or not abuse by a group of citizens, and also by comparing these results with a professional social work cohort. Both groups identified nine types of adult behavior as abusive. (TFC)

Doueck, H.J., Levine, M., and Bronson, D. E. (1993). Risk assessment in child protective services: An evaluation of the child at risk field system. *Journal of Interpersonal Violence, 8* (4), 446-467.

This article presents information about one risk assessment system: The Child at Risk Field (CARF) system, along with the results of an independent evaluation of the CARF system. Although the CARF system was imperfectly implemented, the data indicated, among other things, that CARF may provide workers with a potentially useful tool for structured decision-making. (TCF)

Heartz, R.H. (1993). Guardians ad litem in child abuse and neglect proceedings: Clarifying the roles to improve effectiveness. *Family Law Quarterly, 27* (3), 327-347.

The historical and legislative development of Guardian Ad Litem (GAL) appointments in abuse and neglect proceedings is reviewed. Various ethical and practical problems surrounding the current system for appointing GALs are also discussed, including the lack of uniformity regarding who should be a GAL and precisely what role that person should play. The CASA/GAL

continued on next page

Journal Highlights

-Thomas F. Curran

continued from page 40

programs are discussed at length, along with studies documenting the effectiveness and benefits of volunteers. Although no definite solutions are presented, this article adds an interesting perspective on the current ethical debate about the role and duties of GALs.

Johnson, E.K. and Howell, R.J. (1993). Memory processes in children: Implications for investigations of alleged child sexual abuse. *Bulletin of the American Academy of Psychiatry and Law, 21* (2), 213-226.

This article provides a discussion of certain developmental aspects of long-term memory functions in children, along with events and cognitive processes that may contribute to memory distortion. (TFC)

Myers, E.B. (1993) Expert testimony describing psychological syndromes. *Pacific Law Journal, 24* (3), 1449-1464.

This article presents a clear description of psychological syndromes and how they should be used during civil or criminal litigation. The author analysis of the battered child syndrome and the child sexual abuse accomodation syndrome to distinguish diagnostic from non-diagnostic syndromes is particularly helpful. (TFC)

The Journal Highlights editor wishes to express his sincere thanks to the following individuals for their contributions to this issue. Marjorie Chan of NNEPSAC; Lisa Fontes, PhD, of Keene State College, Keene, NH, and Laura T. Gutman, MD, Duke University Medical Center.

CALL FOR NOMINATIONS for Editor-in-Chief

Nominations for Editor-in-Chief of the American Professional Journal on the Abuse of Children (APJAC) Solicited

APSAC is starting a new journal, to be called the *American Professional Journal on the Abuse of Children (APJAC)*. The first issue of *APJAC* will be published in February, 1996. The journal is to be a policy and practitioner-oriented journal which will clearly express APSAC's mission and goals.

The Editor Search Committee is now seeking nominations for candidates for the position of Editor-in-Chief of *APJAC*. Self nominations are welcome.

Process

The call for nominations will be distributed to all APSAC members through *The APSAC Advisor* and in separate mailings to APSAC's Board, Advisory Board, and state chapter presidents and coordinators. In addition, the Editor Search Committee will solicit nominations as needed.

Editor Qualifications

The Editor-in-Chief of *APJAC* should possess the following qualifications:

- Experience in clinical, research, writing, editing, and educational activities related to child abuse and neglect.
- A commitment to interdisciplinary cooperation and mutual respect.
- Organizational skills and the ability to work effectively with associate editors.
- Originality and high quality research and publications.
- A commitment to the Society and its goals, demonstrated through previous participation in APSAC activities at the state or national level.
- A grasp of the historical scope of the field of child maltreatment: its past, its evolution, and the most pressing issues facing it now. A vision about the field's development and how this development should be achieved.
- A vision for *APJAC* and its place in the field of child maltreatment.

Nominations for co-Editors-in-Chief will be considered if the candidates can demonstrate the ability to work together and complement each other.

Materials to be submitted

Candidates for Editor-in-Chief should submit the following materials:

- A letter stating their commitment, including the amount of time they envision being able to contribute as Editor and the strengths they bring to the position.
- An expanded vita, including samples of editorial work, original work, and references.
- Information regarding their clinical work.
- Information regarding their university's or employer's willingness to support the time commitment required by the Editor-in-Chief.

Procedure and deadline

Mail nominations to: Jon R. Conte, PhD, Chair, Editor Search Committee, APSAC, 332 S. Michigan Avenue, Suite 1600, Chicago, IL 60604. **Nominations must be received by May 30, 1994.** For further information, call APSAC at 312-554-0166.

POSITION ANNOUNCEMENT

Medical Director. The Department of Pediatrics at Vanderbilt University School of Medicine seeks a BC/BE pediatrician for medical director of a children's sexual abuse diagnostic clinic at the assistant/associate professor level. Responsibilities include supervision of nurse practitioners and residents in the clinic, quality assurance activities, and related research. Reply with CV to Deborah Bryant, MD, Community Pediatrics, 1900 Hayes St., Nashville TN 37203-2317; EOE.

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July 31-August 2, 1994. ***National Symposium on Child Fatalities: The Missouri Experience.*** St. Louis, MO. Sponsored by the Missouri Department of Social Services, and others, in cooperation with APSAC. Call Karen Rhodes, 314-644-8803.

October 9-11, 1994. ***17th National Conference of the National Association of Counsel for Children (NACC).*** San Francisco, CA. Co-sponsored by CAPSAC. In cooperation with APSAC, ABA Center on Children and the Law, National Council of Juvenile and Family Court Judges, and C. Henry Kempe Center. Call 303-322-2260. APSAC discount offered as one-year membership in NACC.

October 17-20, 1994. ***Midwest Conference on Child Sexual Abuse and Incest.*** Madison, WI. Sponsored by Health and Human Issues of the University of Wisconsin at Madison, and Family Sexual Abuse Treatment, Inc. For more information call Jim Campbell, 608-262-2352.

January 24-27, 1995. ***The San Diego Conference on Responding to Child Maltreatment.*** Sponsored by San Diego Children's Hospital Center for Child Protection. Call Robbie or Diane at 619-576-5814.

June 7-11, 1995. ***APSAC's Third National Colloquium.*** Tucson, AZ. At the beautiful desert resort, "La Paloma." Watch for the Call for Abstracts. Call 312-554-0166 for information.

Other Conferences

May 13-15, 1994. Washington, DC . ***The Second National Clinical Social Work Conference on Clinical Social Work in the 21st Century: Creative Responses to Critical Issues.*** Arlington, VA. Call 703-522-7237, or FAX 703-527-9419.

May 22-25, 1994. ***29th Annual Conference: Dreams, Schemes, & Flying Machines: Tools for Pediatric Health Care in the '90's and Beyond.*** Bethseda, MD. Sponsored by Association for the Care of Children's Health. Call, 301-654-1205.

May 23-27, 1994. ***Windows of Opportunity: The 22nd Annual Child Abuse and Neglect Symposium.*** Keystone, CO. Sponsored by The C. Henry Kempe National Center. Contact Isabel Schultz, 303-321-3963.

May 26, 1994. ***Dissociation, "Repressed Memory" and "False Memory Syndrome": Working with Abuse Survivors in the Age of Denial.*** DesMoines, IA. Sponsored by the Iowa Coalition Against Sexual Assault. Presenter is John Briere, PhD. Call 515-242-5096.

June 19-24, 1994. ***National Data Archive on Child Abuse and Neglect's Annual Research Institute.*** Ithaca, NY. Sponsored by the National Data Archive on Child Abuse and Neglect, Family Life Developmental Center, and Cornell University. Call 607-255-7794 or FAX 607-255-8562.

June 20-26, 1994. ***International Child and Youth Care Conference.*** Milwaukee, WI. Sponsored by the International Federation of Educative Communities and National Organization of Child Care Workers Association. Call 414-229-5795 or FAX 414-229-2840.

August 4-7, 1994. ***12th Annual Voices In Action Conference.*** Chicago, IL. Sponsored by VOICES. Contact, Nina Corwin, VOICES, Box 148309, Chicago, IL 60614, 800-7VOICE8.

August 31-September2, 1994. ***Sixth Annual Seminar on Crimes Against Children.*** Dallas, TX. Sponsored by the Dallas Police Department and the Dallas Children's Advocacy Center. Call Leigh Ann Lozano, 214-670-4982.

September 28-30, 1994. ***Second Oklahoma Conference on Child Abuse and Neglect.*** Tulsa, OK. Sponsored by Center on Child Abuse and Neglect, University of Oklahoma Health Sciences Center and the Oklahoma Department of Human Services. Contact Tricia Williams, 405-271-8858.

October 19-22, 1994. ***Social Work '94.*** Nashville, TN. Sponsored by National Association of Social Workers. Contact, NASW, 1-800-638-8799.

November 10-12, 1994. ***National Conference on Children and Violence: Intervention and Prevention Programs for Youth, School and Media Violence.*** Houston, TX. Sponsored by the University of Houston-Clear Lake. Contact P.A.C.E. at 713-283-3030.

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

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