APSAC

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AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

LAW

The Statute of Limitations and Legal Remedies for Adults Abused as Children

—by Mark J. Horwitz and Josephine A. Bulkley

Introduction

Sexual abuse of children is associated with serious short-term and long-term psychological effects.[1] When maltreatment of a child is reported to authorities, criminal prosecution, juvenile court intervention, or civil lawsuits may be initiated. Many children, however, do not disclose the abuse,[2] and for various reasons, an official report or legal action does not occur. In response to this delay in disclosure, since the mid-1980's, many courts and legislatures have re-examined the statutes of limitations which apply to child sexual abuse legal actions.

Many advocates for sexually abused children, adults with a history of childhood sexual abuse, therapists, and lawyers assert that a rigid application of traditional statutes of limitations often prohibits the legal system from holding childhood sexual abuse perpetrators responsible for their abusive acts. These critics have encouraged policy makers to suspend or expand limitations periods so that child sexual abuse legal actions can be brought against the perpetrators of abuse many years after the abuse has occurred.

This movement has elicited a negative reaction from a variety of sources (including defense attorneys, insurance companies, accused persons and their families, memory experts, and others). They reason that the dangers inherent in suspending or expanding the limitations periods outweigh any gains. This article examines the rationale for altering statutory periods in these cases, considers how these periods have been altered in jurisdictions which have chosen to do so, and analyzes the ramifications of these alterations.

Child sexual abuse and statutes of limitations

Civil lawsuits or criminal prosecution may be initiated when the alleged victim is beyond the age of majority (juvenile court action occurs to protect minors). A civil suit (sometimes called a "tort" action for negligence, assault or intentional infliction of mental distress) may be brought by the victim seeking financial compensation from the alleged offender for harms which resulted from the abuse. Criminal proceedings are brought against the defendant by the state prosecuting attorney under child sexual offense criminal statutes. Either proceeding can provide a sense of vindication to a victim who prevails in court.

Most states have legislation establishing statutes of limitations for various civil and criminal actions. Statutes of limitations place a limit on the time within which court actions can be initiated. This time limit is intended both to protect potential

continued on page 6

NEWS

Second National Colloquium A Major Success; APSAC's Growth Continues

—by Theresa Reid

Second National Colloquium outperforms the First

Five hundred seventy-five professionals registered for APSAC's Second National Colloquium, a 10% increase over registration for the First National Colloquium. With faculty, distinguished guests, and volunteers, more than 650 people attended the expanded three-day Colloquium, held in Boston May 4-7.

"Field Day" added

Like its first, APSAC's Second National Colloquium focused on intensive, in-depth training for advanced professionals from all disciplines. This year, however, APSAC enhanced the program with a "Field Day"—a day-long forum in which professionals from all over the country presented their latest work. The day began with a plenary session in which current controversies in the field were aired. Lucy Berliner articulated therapists' dilemmas in relation to their legal obligations and liabilities, David Finkelhor probed the data about the benefits and risks of prevention programs, and Richard Gelles argued provocatively against the prevailing orthodoxy about family reunification.

After the plenary session, participants had the rest of the day to attend dozens of presentations made by their colleagues in the field. Many of these were oral presentations in a workshop format; others were made in the more visual medium of the poster presentation, giving presenters and viewers the opportunity for extended dialogue. The day ended with a reception in the poster area, so everyone would have the opportunity to view posters while their authors were present; the night ended with a dance party which was attended by many Colloquium participants.

Interdisciplinary, international attendance

Professionals came from 48 states to attend the

continued on page 22

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1994 RESEARCH CAREER ACHIEVEMENT AWARD

OF THE AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

Is Awarded To

MURRAY R. STRAUS, PHD

University of New Hampshire, Family Research Laboratory

For outstanding contributions to research on child maltreatment.

Dr. Murray Straus is widely recognized as the father of family violence research in the United States. Dr. Straus not only pioneered this avenue of research—publishing (with Sue Steinmetz) the first academic book on the topic of family violence, undertaking the first National Survey of Family Violence (with Sue Steinmetz and Richard Gelles), and developing the Conflict Tactics Scale (with Richard Gelles); by establishing the Family Violence Research Training Program at the University of New Hampshire, Dr. Straus has trained many of the field's most active researchers, including David Finkelhor, Linda Meyer Williams, Gerald Hotaling, and Kathleen Kendall-Tackett. Below is a brief excerpt from the award presentation made by David Finkelhor.

Dr. Straus has not been afraid of letting explicit value positions govern his choice of research, but has been rigorous to a fault in implementing the scientific method of inquiry and abiding by its judgment. He has a truly open mind, open to good arguments and open to good evidence. He has consistently cut through divisive polarizations, of theory or of ideology or even of methodology, by arguing that social phenomena are almost always multicausal, that different vantage points elucidate different aspects of a problem, and that evidence needs to come from the most diverse array of sources.

Dr. Straus has, despite many obstacles and much opposition, pursued a calling that resonated deeply with the person he is and the ideals he has. That families are the crucible in which individuals and ultimately the whole quality of social life are molded. That violence in all its forms is toxic to this development. That knowledge of reality, not just knowledge as ammunition for a particular policy argument, but knowledge of reality in its subtlety, complexity, and even perversity is the most powerful remedy. In maintaining this vision of the importance of research and the crucial role a researcher can play, he has been a great inspiration to all of us. Please join me in honoring someone whom so many of us have come to admire for his deep commitment to the transformative power of research.

1994 OUTSTANDING PROFESSIONAL AWARD

OF THE AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

Is Awarded To

KEE MACFARLANE, MSW

Children's Institute International

For outstanding contributions to the field of child maltreatment and to the advancement of APSAC's goals.

Lucy Berliner, MSW, presented APSAC's 1994 Outstanding Professional Award to Kee MacFarlane, MSW, in one of the most moving presentations of the evening. Afterward, Lucy wrote the following thoughts on Kee's receipt of the award.

I had the great pleasure of presenting APSAC's Outstanding Professional Award to Kee MacFarlane. Unlike David Finkelhor, who typed up his eloquent remarks about Murray Straus, I scribbled mine on progress notes which I later tossed. But the awards ceremony was memorable. Particularly moving was that Harry Elias, Kee's husband, had arranged to surprise Kee by having her parents attend. As Kee said in her acceptance remarks, part of why she is in this business is because she knows first hand that having parents like hers makes all the difference.

Kee deserves this award for at least two big reasons. First, it was Kee who put child sexual abuse on the federal map when she was at NCCAN in the late 1970s. She got money for programs and training, she brought experts together, and through her leadership she gave legitimacy to a then new area of child abuse. In the intervening years Kee has often been associated with the early stages of recognizing and responding to newly identified concerns: sexual abuse of preschoolers in day care settings, children with sexual behavior problems, sexual abuse allegations in divorce situations, the intersection of child maltreatment and drug abuse.

The other and maybe even bigger reason why Kee deserves this award is that she gives so much on a personal level to professionals in the field. Kee will give you the shirt off her back. Many have been the beneficiaries of her generous heart: she has welcomed us into her home, spent hours on the phone, given support and comfort to those who have become disheartened or been the subject of personal attack. When she responds to your need, she can't help but give her all. There can never be enough of Kee to go around.This award is our way of acknowledging all she has given.

1994 OUTSTANDING SERVICE AWARD
OF THE AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

Is Awarded To

JOHN E.B. MYERS, JD

University of the Pacific,
McGeorge School of Law

For outstanding contributions to APSAC through leadership and service to the Society.

John E.B. Myers, JD, is clearly one of the leading legal scholars in the field of child maltreatment. Among his myriad contributions to the field are three major books: *Evidence in child abuse cases (1992), Legal issues in child abuse and neglect (1992),* and *The backlash: Child protection under fire (1994).* Impressive as his contributions to the field have been, they are rivalled by his contributions to APSAC.

John Myers was the first Executive Editor of *The APSAC Advisor*, working closely with David Corwin, Susan Kelley, and Thesesa Reid to shape *The APSAC Advisor* into the highly professional publication it is today. Professor Myers was responsible for producing most of the copy in several of the early issues of the newsletter. In addition, Professor Myers was principle author of two *amicus* briefs submitted by APSAC in cases pending before the U.S. Supreme Court. One of these briefs, in the case *Idaho vs. Wright*, was joined by several prestigious national organizations, and appeared to contribute language to the Court's decision. In addition, Professor Myers is the lead author of an extensive *Nebraska Law Review* article on expert testimony in child sexual abuse cases, from the sales of which APSAC has benefitted. Professor Myers has taken the lead in a number of APSAC's efforts to respond to or improve poor media coverage of child maltreatment, and is an active and invaluable member of APSAC's Advisory Board.

Barbara Bonner, PhD, presented Professor Myers's award: "When I was President of APSAC, it seemed that John Myers was working nearly as much for APSAC as he was for his professorship. John regularly called me with ideas for ways to increase APSAC's effectiveness in the field. Everyone concerned with child maltreatment is extremely fortunate that John E.B. Myers has dedicated his considerable legal talents to the amelioration of child abuse and neglect. APSAC is particularly blessed that Professor Myers has dedicated so much of his remarkable energy, expertise, insight, and humaneness specifically to advancing APSAC's mission."

1994 OUTSTANDING MEDIA COVERAGE AWARD
OF THE AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

Is Awarded To

THE CHICAGO TRIBUNE

Anne Marie Lipinski,
Deputy Managing Editor

For the 1993 series, "Killing Our Children," which provided sustained, thoughtful coverage of child maltreatment in America.

In 1993, *The Chicago Tribune* made an extraordinary commitment: it dedicated a Pulitzer-prize-winning editor and a team of reporters and photographers to give front-page coverage to every homicide of a child under 15 that occurred in the city of Chicago. As a result, *The Chicago Tribune* devoted hundreds of pages to child homicides in 1993. Announcing the series on January 3, 1993, the Editor wrote, "A society can be fairly judged by how it treats its children. Caring for and guiding them to maturity is its most essential work, for they are the means by which it survives. By this measure, something has gone terribly wrong with our own community. In appalling and unprecedented numbers, the children are being killed. During the next year, the *Tribune* will not let the murder of a single child in our metropolitan area go unnoticed. It will document every one, both to accord the loss of each young life the significance it deserves and to see if detailed knowledge can bring an end to the escalation of violence against those we all have the greatest duty to protect."

In the inaugural article, the reporter Steve Johnson wrote of the 57 children killed in 1992, "Most of these children you know little about. Many made the journey from birth to a slab in the morgue with little notice from middle-class Chicago. But each of these 57 deaths is its own short story. Taken as a whole, the list is a tragic novel of epic proportions."

Presenting the award, Media Committee Chair Paul Stern noted that "The general public's misperceptions about child abuse and neglect makes our jobs as professionals so very much more difficult. One of the guiding principles of APSAC is 'to change ignorance to knowledge' about the realities of child maltreatment. It is, perhaps, the popular media which can accomplish this goal more quickly and more effectively than any other single entity. No media organization in the country achieved this better in 1993 than *The Chicago Tribune*."

CONTENTS

Features

Law
Statutes of limitations 1
When the child victim has an STD 15

Legal News
Important NJ Supreme Court Decision 21

Medicine
Evaluating STDs in children .. 11

Prevention
Negative birth experiences 9

Research
New incidence data 5
Sexual abuse treatment practices 17

Columns
Conferences 35
Journal Highlights 31
Media Reviews 19
News 1
State Chapter News 27
Washington Update 23

1994 OUTSTANDING RESEARCH STUDY AWARD

OF THE AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

Is Awarded To

KATHLEEN KENDALL-TACKETT, PHD, LINDA MEYER WILLIAMS, PHD, AND DAVID FINKELHOR, PHD

For the article, Impact of sexual abuse on children: A review and synthesis of recent empirical studies, *Psychological Bulletin, 113* (1).

Dr. Catherine Ayoub presented the 1994 Award for Outstanding Research Study. Below is an excerpt of her remarks.

The award-winning article is a comprehensive and insightful review of 45 studies on the effects of sexual abuse on children. Synthesizing the information from these diverse studies, the authors are able to make important conclusions. Among these is that, although sexually abused children across studies clearly demonstrate more symptoms than nonabused children, they display no clear syndrome. No symptoms are reliably found in a majority of children; few are found exclusively in sexually abused children. The many symptoms that may occur in sexually abused children vary with a number of intervening variables. This sophisticated meta-analysis of research studies yields important insights with major implications for child sexual abuse assessment, treatment, and research.

1994 OUTSTANDING DOCTORAL DISSERTATION AWARD

OF THE AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

Is Awarded To

JENNIFER WALTZ, PHD

For the dissertation, The long-term effects of sexual abuse on women's relationship with partners.

Dr. Jennifer Walsh received her PhD from the University of Washington in 1993. She is now Assistant Professor of Psychology at the University of Montana in Missoula, Montana. Dr. David Kolko presented her award, with these remarks.

No dissertation is easy, especially one dealing with such a sensitive and complex topic as the effect of child sexual abuse on women's relationships with their partners. This award acknowledges Dr. Waltz's dissertation for its conceptual foundation, clinical relevance, and methodolotical rigor. As part of her work, Dr. Waltz developed an instrument designed to assess the specific relationship difficulties experienced by sexual abuse survivors. Dr. Waltz found that such couples experienced relationship difficulties that are conceptually consistent with an abuse history, and not simply reflective of general relationship distress. Her study was distinguished by a carefully specified sample, a coherent statistical framework, and the use of observational assessment methods. This study will help us evaluate and treat the long-term effects of sexual abuse.

1994 PRESIDENT'S HONOR ROLL

OF THE AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

Every year, a number of APSAC members distinguish themselves by making an extraordinary contribution of time, energy, and talent to further APSAC's goals. Each year, fifteen of these members are named to the APSAC President's Honor Roll in recognition of their exemplary service to abused children and their families, and to APSAC. We are delighted to present the members of the 1994 APSAC President's Honor Roll.

Mary Kay Barbieri, JD, MA (Washington)
Jane Bingham, MDiv (Texas)
Denise Everett, MD (North Carolina)
Joel Feinstein, MD (Illinois)
Sylvia Gale, MSW (New Hampshire)
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Monica Roizner-Hayes, MA (Massachusetts)
Alan Rosenfeld, JD (Vermont)
Laurie Sorensen, MEd (Washington)
Sheila Thigpen (Oklahoma)

RESEARCH

New National Child Abuse Numbers Released

—by David Finkelhor

New child abuse statistics for 1993 have been published by the National Committee to Prevent Child Abuse (NCPCA) as part of its annual 50-state survey. The most interesting finding to emerge from this report is that from 1992 to 1993 the estimated number of reports of suspected child abuse nationwide saw the smallest increase in years (up only 2.5%) and for the first time ever substantiated child abuse cases actually declined by a small amount from 1,021,000 to 1,016,000.

NCPCA researchers Karen McCurdy and Deborah Daro caution against jumping to hasty conclusions. Much of the state data on which the report is based are still tentative, and will be revised later on. Moreover, since year-to-year estimates of child abuse reports can bounce around quite a bit, it takes several years of data to establish a clear trend. Still, it is possible that 1993 will mark a year when the tide of child abuse reporting, which has grown 50% since 1985, or at a rate of more than 5% per year, will start to level off.

For the first time ever, substantiated child abuse cases actually declined by a small amount.

A leveling off of the reports and substantiations does not, of course, necessarily mean that there has been any decline in the actual amount of child abuse. Just as much of the increase in reports may have to do with changes in awareness and investigatory practices, a leveling off may have to do with such factors. The fact that substantiated cases actually declined, while reports increased, clearly suggests the possibility that CPS capacities have reached a saturation point, with many possibly true cases of abuse not getting adequate investigation.

The report reveals that also in 1993 for the first time in four years, the funding picture for CPS agencies actually improved.

However, another section of the report reveals that also in 1993 for the first time in four years, the funding picture for CPS agencies actually improved, with 52% of the states reporting a budget increase and only five experiencing budget cuts. It is possible that the effects of such increased funding—more case workers to investigate and substantiate more cases—would not be reflected in 1993 statistics because new staff are just being hired. States will also be getting a new infusion of federal funds from the new Family Support and Preservation Act of 1993. So it will be interesting to see if the number of substantiated cases stays level in the face of these developments.

Curiously, and supportive of the idea that the leveling off may be part of a larger national trend, the Uniform Crime Report figures on violent crime also showed an overall decline for 1993. One interpretation is that the economic upturn, perhaps combined with more general political and social optimism, is having some generalized effect.

Unfortunately, however, the 50-state survey and the comparison to general crime figures highlights again the rather dubious state of child abuse statistics. There still really are no true complete and accurate national child abuse statistics. Unlike crime statistics, states do not yet have a uniform system of counting child abuse. For example, some states count child abuse by the case (which can include several children) while others count by the children. In addition, many states do not have any way of eliminating children who may have been subject to several reports from being counted multiple times.

Later this year the federal government will publish the National Child Abuse and Neglect Data System (NCANDS) report, which will contain the most complete statistics for 1992 (its data is over a year behind the 50-state survey). But this report also has most of the same problems, including no uniformity in state definitions, some duplicated counting, and some states' inability to provide crucial information. The goal of NCANDS is to work with the individual states on their data collection procedures to ultimately weave together a uniform national data system. How long this will take is unclear.

Finally, keep your eye out next year for the third National Incidence Study, which like previous efforts is using systematic data-gathering in a sample of U.S. counties to (1) try to project national estimates, including cases known to professionals but not to child protection authorities, and (2) to report on trends since its last effort in 1986. The results will almost certainly show a huge increase compared to 1986, which may be what grabs the headlines. They will not tell us much about whether reports and substantiated cases have plateaued in the last year or two.

For copies of the 50-state survey, "Current trends in child abuse reporting and fatalities" (Working Paper 808), write National Committee to Prevent Child Abuse, 332 S. Michigan Av., Suite 1600, Chicago IL 60604. A donation of $2.00 is suggested.

David Finkelhor, PhD, is Co-Director of the Family Research Laboratory at the University of New Hampshire, and is a member of APSAC's Advisory Board.

APSAC FACTS

Twenty-nine states are home to approved APSAC chapters. Professionals are actively forming chapters in 12 additional states and in Puerto Rico. Professionals in Australia, Canada, and the U.S. Armed Forces stationed overseas have expressed interest in developing APSAC chapters as well.

APSAC's Fourth National Colloquium will be held June 26-30, 1996, in Chicago. Mark your calendars now!

Law

—by Mark J. Horwitz and Josephine A. Bulkley

continued from page 1

defendants and to preserve the integrity of legal proceedings. Trial evidence can become increasingly unreliable with the passage of time, and unreliable evidence compromises the integrity of legal proceedings. A lack of time limits can also encourage manipulative tactics on the part of litigants, who might attempt needlessly to delay proceedings in an effort to force a weaker party to capitulate to their demands. Statutes of limitations are designed to ensure admission of accurate and reliable evidence and to discourage manipulative litigants, all by placing a limit on the time within which court actions can be initiated.

Statutes of limitations are designed to ensure admission of accurate and reliable evidence and to discourage manipulative litigants, all by placing a limit on the time within which court actions can be initiated.

Court actions only may be initiated within the time period established by a statute of limitations. This is referred to as the period during which the statute runs. Sometimes the statutory period begins to run when the act in question, i.e. the abuse, occurs. In other situations the statutory time period "tolls" (is put on hold or suspended), until a secondary act occurs.

While courts value the prompt initiation of legal actions, timely actions might not be possible where child sexual abuse has occurred. Victims might be threatened not to disclose abusive incidents, or a victim's dependence on a perpetrator might inhibit the reporting of abuse. In each of these scenarios abuse could go unreported for a period of time greater than that allowed by the statutory limitations period. Subsequent criminal or civil legal actions, then, could not be initiated even after the inhibiting effects of coercion and dependence had passed.

Civil and criminal actions also could be delayed when the harms caused by child sexual abuse are not apparent until many years after the abuse has occurred. This could happen when a psychological problem related to the abuse does not develop for many years (i.e., sexual difficulties), is not recognized as being related to the abuse (i.e., an eating disorder), or when the abuse simply is not remembered until many years after it occurred.

Child sexual abuse survivors reason that the delayed discovery rule should be invoked when they either do not know of the harms caused by the abuse, or have no memory of the abuse until after the statute of limitations expired.

Rigid interpretation of statutes of limitations prohibits criminal or civil proceedings despite legitimate reasons for not bringing such actions earlier. As discussed below, state legislatures and courts have created exceptions to such rigid applications of the limitations period in various areas of law. The following sections discuss how courts and legislatures have analogized child sexual abuse to other areas of law to allow legal remedies many years later.

Civil Cases

Courts traditionally have invoked the delayed discovery rule in civil negligence suits when not to do so would result in inequity or unfairness. The delayed discovery rule commonly is used in cases involving construction defects and medical malpractice. The faulty installation of a pipe, for example, located behind an internal wall in a home, might not become apparent until the pipe malfunctions, perhaps many years after installation. While the applicable statute of limitations relating to this construction defect may have been one year, the fact that the pipe was hidden caused the discovery of the defect to be delayed. Since the defect could not be discovered until the pipe malfunctioned, the statute of limitations might toll until the defect is in fact discovered. Another classic example where courts have suspended the statute of limitations involves a sponge left in a patient's stomach during an operation that does not result in injury until years later.

Similarly, child sexual abuse survivors reason that the delayed discovery rule should be invoked when they either do not know of the harms caused by the abuse, or have no memory of the abuse until after the statute of limitations expired. Most courts have refused to apply the delayed discovery rule when a victim always remembered the abuse but did not know until after the limitations period had expired that the abuse had caused a specific psychological harm.[3] Many courts, however, have applied this rule to permit a civil action when a previously repressed memory of abuse is remembered by a survivor.[4] On the other hand, some courts have held that the delayed discovery rule does not apply even in repressed memory cases, reasoning that these claims are overly subjective and present courts with stale, unreliable evidence.[5]

Courts also might use the delayed discovery rule to toll the statute of limitations in civil proceedings under the doctrine of constructive concealment or fraud. This doctrine can be invoked to ensure that a defendant who attempts to hide a harmful act does not benefit from the concealment. Thus, when a child was threatened not to tell by a teacher, one court held that the child's delayed disclosure was caused by the defendant's threats, a form of fraud or concealment.[6] Or, a child might be misled to believe that a sexually abusive act is a "normal" occurrence between parent and child, and therefore the limitations period could be tolled until the child understands that the abuse was not "normal" (typically before the age of majority).

In addition, more than one-third of state legislatures have altered their statutes of limitations in child sexual abuse civil proceedings.[7] In all states, the statute of limitations in any civil action tolls until the age of majority. This means that the period of time allowed to file a civil action, usually one year,

continued on next page

Law

—by Mark J. Horwitz and Josephine A. Bulkley

continued from page 6

does not begin to run until the child reaches the age of majority, on the theory that a person should not lose the right to bring a legal action until they have reached this age of responsibility.

In child sexual abuse cases, some states have extended the length of the statutory period (as in Idaho) for five years from the age of majority.[8] Nine (9) states have allowed a civil action to be initiated within a certain number of years either after a child reaches the age of majority, or after the person discovers the injury was caused by sexual abuse.[9] And when legislatures disapprove of court rulings, they can enact statutes which establish new law. For example, after a Washington court in *Tyson v. Tyson*[10] decided that repressed memories could not form the basis for tolling the statute of limitations, the state legislature passed a statute which allows such actions.

Criminal cases

Courts also apply the doctrines of concealment or continuing crimes to extend the statutes of limitations in criminal cases. The doctrine of concealment allows a court to calculate a limitations period beginning not when the crime is completed but rather from the moment that efforts to conceal the crime have ceased. While the Nevada Supreme Court has permitted tolling for the period when a defendant concealed a pornographic film[11], other courts have not been willing to apply this doctrine to child sexual abuse cases. Under the continuing crimes doctrine, the crime is not completed, and hence the limitations period does not begin to run, until any coercion designed to inhibit a child from disclosing the abuse has ceased.

Many state legislatures have changed their statutes of limitation for crimes against children, child abuse or child sexual offenses. Some simply have no statute of limitations for serious felonies, while 37 states have altered the time periods specifically in child sexual abuse cases.

Many state legislatures also have changed their statutes of limitation for crimes against children, child abuse or child sexual offenses. Some simply have no statute of limitations for serious felonies, while 37 states have altered the time periods specifically in child sexual abuse cases.[12] The methods used to achieve these alterations include eliminating all time limits, extending the length of the period, and tolling the period until the child either reaches the age of majority, notifies a law enforcement agency that the abuse occurred, or ceases to be dependent on the perpetrator of the abuse.[13]

Pros and cons of delayed legal actions

There are both advantages and disadvantages to bringing these actions many years later. Sexual abuse survivors might benefit psychologically by being able to confront their abusers in the formal setting of a civil or criminal courtroom.Sexual abuse survivors who prevail in civil suits may derive a sense of vindication and validation when society, through the vehicle of judge or jury, decrees that they were unreasonably violated and are entitled to compensation. Monetary damages can be used to pay for necessary treatment, and any punitive damages might provide a further sense that a wrong has been committed against them. Adult survivors also may feel vindicated in seeing a perpetrator convicted and sentenced. Even if defendants prevail, some survivors still might feel a sense of empowerment or control by calling on the defendant to explain his actions, or benefit from the "secret" finally being exposed and the allegations made public.

But the potential negative psychological consequences to the victim inherent in an adversarial legal system, including being subjected to depositions, cross-examination and testifying in open court, must be considered by any sexual abuse survivor choosing to pursue a legal remedy. In addition, these cases may be very difficult to prove, due to lack of witnesses or other evidence, and faded memories. The negative emotional effects of bringing accusations and then having a judge or jury find for the defendant cannot be underestimated. Moreover, the financial costs to the victim of bringing civil suits may deter many survivors.

These court actions might also have broader social effects.Criminal and civil sanctions taken against child sexual offenders may deter the offender from sexually abusing others, as well as discourage other perpetrators from future acts of childhood sexual abuse. Other adults who were abused as children may feel a sense of satisfaction in knowing that increasing numbers of sexual offenders are being held accountable by the courts. On the other hand, if substantial numbers of these actions are decided in the defendant's favor, it may have a chilling effect on survivors bringing such actions, and even may inhibit disclosure of their childhood abuse or prevent psychological treatment.

Statutes of limitations primarily function to preserve the integrity of court proceedings by ensuring the reliability of evidence. As noted earlier, however, states already have extended the statutory period in civil matters until the age of majority, and some have eliminated a statute of limitations for serious crimes.[14] Thus, the law in some states recognizes that the need for timely proceedings is not sacred and can give way when justice demands.

Extending the statute of limitations in child sexual abuse cases makes more sense when the issues are similar to other areas of law in which exceptions have been created. For example, when a criminal conceals a crime by threatening the victim not to disclose the criminal act, child abuse victims should benefit from a tolling of the statutory period as would any other crime victim. Or, when harm from the abusive act does not become apparent

continued on next page

Law

—by Mark J. Horwitz and Josephine A. Bulkley

continued from page 7

until many years after the abuse occurred, again there are precedents in other types of cases for preserving a civil remedy for these plaintiffs.

A more complicated question is posed by the issue of whether statutes of limitations should be extended to preserve a legal remedy for survivors of sexual abuse whose sole reason for not pursuing a timely legal remedy was amnesia or repression of memories which only recently have been recovered. Criminal prosecutions or civil actions based on delayed memories has led to a controversy concerning the veracity or accuracy of these memories, and the popular press has been inundated with analyses of the repressed memory phenomenon.[15]

Both the popular press and recent professional articles reflect growing concern that overzealous psychotherapists "create" memories of abuse in clients who were never abused. Psychotherapists might at times explore a client's history in ways which either overly influence the client or confuse psychic and actual reality. Mental health professionals and researchers on both sides of this issue seem to agree that it is difficult to distinguish a true from false memory, and that more research is needed.[16] Exacerbating the situation are stories in the press and lawsuits involving alleged victims who have recanted, claiming that their memories were created by suggestive therapeutic techniques and are in fact false.[17]

On the other hand, recent studies indicate that the phenomenon of amnesia regarding a memory of a traumatic abuse experience may occur in a significant proportion of adults who experienced child sexual abuse.[18] Moreover, respected clinicians note that corroborative evidence supports many recently recovered memories.[19]

> ***Legal actions based solely on such forgotten-then-recovered memories threaten the integrity of the legal system by relying on evidence the veracity of which cannot be adequately assessed...Just as importantly, legal actions based on such evidence may be one factor contributing to the backlash movement in the child sexual abuse field.***

While amnesia or repression of traumatic memories may be a real and common occurrence, at present scientific uncertainty remains as to when adults might be mistaken in their memories of actual childhood events. Legal actions based solely on such forgotten-then-recovered memories threaten the integrity of the legal system by relying on evidence the veracity of which cannot be adequately assessed. As one expert recently stated:

> ...when we move from the privacy of the therapy session, in which the client's reality may be the only reality that is important, into the courtroom, in which there can be but a single reality, then we as citizens in a democratic society are entitled to more solid evidence.[20]

Just as importantly, legal actions based on such evidence may be one factor contributing to the backlash movement in the child sexual abuse field. One researcher notes that "uncritical acceptance of all allegations" strengthens disbelief about genuine cases of child abuse.[21] Indeed, society was not able to acknowledge the widespread presence of child sexual abuse until the past 15 years, and there is danger that controversies such as the repressed memory debate may jeopardize the ability to address this serious problem.

Conclusion

Although statutes of limitations traditionally set a limit on the time period within which legal actions can be initiated, recognized exceptions to these time periods have been established across different areas of law, including most recently child sexual abuse cases. Child sexual abuse cases frequently cannot be initiated in a timely manner for the reasons noted above and due to no fault of the abuse victim. Nevertheless, due to the current controversy and lack of research in this area, it may be wise for states to refrain from passing new legislation at this time. Instead, it may be better to allow the courts to decide on a case-by-case basis whether the statute of limitations should be tolled or extended depending on the particular circumstances of the case.

If states continue to reform their statutes of limitations in these cases, several recommendations might be made. First, any legal action, criminal or civil, only should be allowed if there is corroborative evidence of the abuse. Second, in civil actions, a higher burden of proof, called "clear and convincing evidence," could be required in lieu of the usual preponderance of evidence standard. Third, as some states have done, legislatures could limit the number of years beyond which an action could not be brought (e.g., five years after the age of majority), rather than permitting actions until the time a person discovers the injury from sexual abuse. Finally, another option is to extend or eliminate the statute of limitations only in criminal child sexual abuse cases, where the burden of proof is higher and there are greater constitutional safeguards.

A more extended discussion of these issues can be found in Josephine Bulkley & Mark Horwitz, Adults Sexually Abused as Children: Legal Actions and Issues, 12 Behav. Sci. & L. 65 (1994).

Endnotes

1. Kathleen A. Kendall-Tackett et al., *Impact of Sexual Abuse of Children: A Review and Synthesis of Recent Empirical Studies*, 113 Psychol. Bull. 164 (1993).
2. Lucy Berliner, American Bar Association, *Nature and Dynamics of Child Sexual Abuse*, in A Judicial Primer on Child Sexual Abuse 1 (J. Bulkley & C. Sandt eds., 1994).
3. See E.W. v. D.C.H., 754 P.2d 817 (Mont. 1988).
4. See Evans v. Eckelman, 265 Cal. Rptr. 605 (Ct. App. 1990).
5. See Tyson v. Tyson, 727 P.2d 226 (Wash. 1986).
6. John R. v. Oakland Unified Sch. Dist., 24 Cal. Rptr. 319 (Ct. App. 1987).
7. See NOW Legal Defense and Education Fund, Legislative Reform of Statutes of Limitations for Civil Incest and Child Sexual Abuse Cases (1992).

continued on page 26

PREVENTION

The impact of negative birth experiences on mother/infant relationships

—by Kathleen Kendall-Tackett

Having a baby is a pivotal event, and one that women tend to remember. In fact, women have been shown to accurately remember details of their first births even 20 years later (Simkin, 1992). If a woman has a negative or traumatic birth experience, its impact may be felt for years. But does a woman's birth experience influence how she interacts with her baby? As child abuse professionals, we have a stake in the answer to that question. In the present article, I describe what we know about the influence of birth experiences on mother/infant interactions.

Does a woman's birth experience influence how she interacts with her baby? As child abuse professionals, we have a stake in the answer to that question.

What is a negative birth experience?

A surprising number of professionals minimize the impact of birth experiences or feel that negative birth experiences do not exist. Two years ago, an editor of a prestigious journal in obstetrics told me that negative birth experiences were a thing of the past. Other professionals are quick to point out that women's negative perceptions of birth are the result of their "high expectations." While many women have acceptable or pleasant births, not everyone does. Some women have had horrifying birth experiences: two women I have spoken with, for instance, had cesarean sections with no anesthesia. Other women have had birth experiences that appear to be "normal," and yet the women were negatively affected by them. Negative reactions included depression, anxiety, persistent thoughts about the experience, or fear of hospitals and doctors. This casual dismissal of women's feelings about a major life event is naive. It would be much more fruitful if we listen to what women have to say about birth, and consider how it could influence their relationships with their babies.

When research studies have considered the question of negative birth experiences, the general paradigm is to compare emotional reactions to cesarean sections and vaginal births. While women's reactions to different types of births vary a great deal, some general statements can be made. First, cesarean sections are more likely to be perceived negatively than are vaginal deliveries (although this is not always the case). Among women who have had cesarean sections, the reactions are more likely to be negative if a women was under general anesthesia, if it was an emergency rather than a planned operation, and if no support person was present (see Kendall-Tackett, with Kantor, 1993, for a complete review of this research).

But wide variations in reactions suggest that we should make a habit of considering women's subjective reactions to childbirth. For example, did the woman feel powerless during her labor? Was she afraid that she or her baby might die? Did she feel betrayed by her doctor, the hospital, the baby's father, other members of her family, or her body? Did she feel physically damaged by the experience? A women's experience of birth can be related to her childhood as well. A woman who is a survivor of sexual abuse is more likely to have a negative birth experience. Recent research has revealed that women can have flashback of their sexual abuse experiences during labor (Courtois & Riley, 1992), and sexually abused women may have more medical interventions than their non-abused counterparts (Jacobs, 1992). These medical interventions include use of anesthesia and analgesia, forceps or vacuum extraction, and cesarean sections. Psychological variables, such as those described above, help explain some of the divergent reactions to births.

How does a birth experience influence the mother/infant relationship?

In their recent book, Klaus, Kennell, and Klaus (1993) compiled the results of six studies that examined the effects of doula support during labor (a "doula" is an experienced woman who provides emotional support during labor). Women were randomly assigned to "doula" or "no doula" conditions when they arrived at the hospital. This support was in addition to any they might have received from husbands or other labor companions.

The women who had doulas had significantly shorter labors and fewer medical interventions (i.e., pain medications, assisted births, or cesarean sections). Particularly intriguing were the mothers' perceptions of their infants at six weeks postpartum. The mothers who had doulas were significantly more likely to describe their babies as beautiful, clever, and easy to manage, and to report that they cried less, and were "better" when compared to a "standard baby." They also perceived themselves as closer to their babies and communicating better with them. They were pleased to have their babies and found that becoming a mother was easy. In contrast, the no-doula mothers were more likely to describe their baby as "just slightly less good" or "not as good" as a "standard baby." They were also more likely to think that anyone could care for their babies as well as they could. The women in this study were not considered at-risk for child maltreatment, and yet simply having or not having emotional support during labor influenced their perceptions of their infants six weeks later.

Trowell's (1993) findings showed even longer-lasting effects. In her three-year longitudal study, women who had had cesarean births (N=16) were compared with women who had had vaginal births (N=18) on their perceptions of their infants at one month, one year and three years postpartum. At one month, the cesarean mothers were significantly more likely to be depressed and to express doubts about their ability to care for their infants. At one year, the cesarean mothers were more likely to

continued on next page

Prevention

—by

Kathleen Kendall-Tackett

continued from page 9

describe motherhood as negative, and to describe themselves as resentful, overwhelmed or angry. They were significantly less likely to have positive interactions with their children on the Strange Situation Test. At three years, the cesarean section mothers were likely to report serious problems in their relationship with their children, and to describe them as "unmanageable," "out of control," or "nasty." The mothers were also more likely to report the use of physical punishment. In addition, the children born via cesarean section were less likely to have completed their full course of vaccinations.

Wide variations in reactions suggest that we should make a habit of considering women's subjective reactions to childbirth.

While the results of the Trowell (1993) study are certainly startling, the results should be interpreted with caution. First, the sample size is small. Second, the women in the cesarean group had cesareans that were emergencies (vs. planned) and were conducted under general anesthesia. Both of these conditions have been demonstrated to increase the likelihood of a negative psychological response. Third, these results do not mean that all women who have had cesarean sections are more likely to abuse or neglect their children. Even with these cautions, the findings of Klaus, Kennell, and Klaus (1993) and Trowell (1993) at least suggest that we consider the impact of birth experiences when working with new mothers, especially those having difficulties with their infants.

How does a negative birth experience undermine a mother-infant relationship?

The mechanisms by which a negative birth experience undermines the mother-infant relationship are a matter of some speculation. One likely explanation is found in Klaus et al. (1993). Women who had doula support during labor felt more positively about themselves after their births. Specifically, they showed "significantly less anxiety, fewer signs of depression, and a higher level of self-esteem" than women who did not have doulas (Klaus et al., 1993, p. 45). On the other hand, women who had negative experiences may have felt that they needed to meet their own emotional needs before they could meet those of their babies, a reaction noted by Affonso (1977). The "no-doula" mothers were more likely to be depressed, and they may have felt socially isolated, especially if they couldn't talk to anyone about their birth experiences (a phenomenon Silver [1985] describes as "sanctuary trauma"). If mothers feel depressed and alone, they are not as likely to feel good about themselves as parents. This belief is underscored by the Klaus et al. (1993) finding that non-supported mothers felt that anyone could take care of their babies as well as they could. Baumrind (1993) has convincingly argued that parents need to believe in their own effectiveness, and this belief enhances their caregiving ability.

A woman who is a survivor of sexual abuse is more likely to have a negative birth experience.

One woman's experience

Elizabeth is a white middle-class woman who gave birth in a prestigious hospital in a large city. She had an assisted vaginal delivery. I selected her story because it would not fit the normal definitions of a "negative" experience used in research studies, and yet many of the themes I've described are present. (Note: In research studies, "negative" is often defined by objective factors such as whether she had a cesarean section. This type of data is usually collected from patient records. It is rare for a study to ask a woman how she felt about her experience.) Elizabeth was clearly troubled by her birth experience, and felt its influence for months as she tried to get to know her infant son.

> I had 25 hours of labor. It was long and hard. I was in a city hospital. It was a dirty, unfriendly, and hostile environment. There was urine on the floor of the bathroom in the labor room. There were 100 babies born that day. I had to wait 8 hours to get into a hospital room post-delivery. . . . There were 10-15 women in the post-delivery room waiting for a hospital room, all moaning, with our beds being bumped into each other by the nursing staff. I was taking Demerol for the pain. I had a major episiotomy. I was overwhelmed by it all and in a lot of pain. I couldn't urinate. They kept catheterizing me. My fifth catheterization was really painful. I had lots of swelling and anxiety because I could not urinate. My wedding ring had stuck on my finger from my swelling. The night nurse said she'd had patients that had body swelling due to not urinating and their organs had "exploded." Therefore, she catheterized me again. They left the catheter in for an hour and a half. There was lots of pain. My bladder was empty but they wouldn't believe me. I went to sleep and woke up in a panic attack. I couldn't breathe and I couldn't understand what had happened.

Later, she described her relationship with her son.

> I felt completely out of control when he cried from 5 p.m. to 10 p.m. nightly with colic. A couple of times I shook him, and one time I hit him on the back. That was the most I did. I was completely desperate. After three weeks I was afraid to be alone with my son. I was feeling completely inadequate as a mom. My mother-in-law was there looking over my shoulder and telling me what to do, telling me I wasn't giving him enough milk. She was bonding with him—I wasn't. I did not have the emotional strength to fight for him back. She took over, thinking that was the right

continued on page 25

MEDICINE

Evaluating Sexually Transmitted Diseases In Children

—by Robert Shapiro

Introduction

When a sexually transmitted infection (STD) is diagnosed in a child, sexual abuse must be considered and evaluated. Although there is no consensus among experts regarding the certainty of abuse when an STD is found, there is less controversy about some STDs than others. For example, most experts agree that infections beyond the neonatal period from *Neisseria gonorrhoeae* and *Chlamydia trachomatis* are primarily transmitted by sexual contact and that a determination of sexual abuse should be made whenever these infections are diagnosed. However, there is widespread disagreement over the probability of non-sexual transmission of *Condyloma acuminata* (genital warts). This uncertainty creates difficulties for those who investigate abuse allegations and for those who are mandated to protect the child. When there is an infection but there are no physical signs of abuse nor any history of abuse, investigators must assess the potential risk to the child while recognizing that medical opinion may vary.

> ***Although many studies have examined the prevalence of sexual abuse and STDs, the research is limited by a number of barriers, including the difficulty in diagnosing sexual abuse, long incubation periods for some infections, low overall prevalence of infection among sexually abused children, and asymptomatic infections that may persist from birth.***

Although many studies have examined the prevalence of sexual abuse and STDs, the research is limited by a number of barriers, including the difficulty in diagnosing sexual abuse, long incubation periods for some infections, low overall prevalence of infection among sexually abused children, and asymptomatic infections that may persist from birth. Some studies identify a high prevalence of STDs in abused children, while others find the prevalence to be low. Some studies cite a very high relationship between infection and abuse, while others report low correlation. These differences are partly explained by the difficulties in studying this subject, as described above. Variations in the prevalence of STDs in each community may also cause differences in the prevalence of STDs in children. It is important to recognize that there is still much to be learned about this subject, and that harm to a child and family can result both from overconfidence about the diagnosis of abuse and from paralyzing indecision.

An STD in a child may be symptomatic or asymptomatic. For example, genital warts can usually be diagnosed by findings on physical examination alone, but chlamydia is frequently asymptomatic and can only be diagnosed if appropriate cultures are obtained. In prepubertal girls, common genital tract symptoms such as dysuria, itching, redness and pain, are very non-specific and do not indicate an STD. Most girls with these complaints have no specific infection diagnosed, nor are these symptoms sensitive indicators of abuse. Because of the important legal and social consequences of finding an STD, cultures are often obtained in asymptomatic patients who are evaluated for abuse even though the prevalence of infection is very low. Microbiology labs handling these specimens must be certain of their results and, when necessary, carry out additional tests to guarantee that no infections are reported mistakenly. This article will review the typical presentation of specific STDs, diagnosis, treatment, and information about sexual and non-sexual transmission.

Specific infectious agents

Neisseria gonorrhoeae

Neisseria gonorrhoeae is the most common STD diagnosed in sexually abused children. At Children's Hospital Medical Center in Cincinnati (CHMC), the prevalence of gonorrhea in prepubertal children evaluated for sexual abuse is about 2%. The prevalence is higher in adolescents, about 5%. Although asymptomatic infection is common in adolescents, it is our experience that almost all prepubertal children with vaginal gonorrhea have vaginal discharge when examined. In a prospective study recently completed at CHMC, no cases of gonorrhea were diagnosed in asymptomatic prepubertal girls evaluated for sexual abuse, but the prevalence of gonorrhea in girls with vaginal discharge was 11%. In another relevant CHMC study, prepubertal girls who were evaluated for complaints of vaginal discharge but in whom sexual abuse was not suspected were cultured for STDs. The prevalence of gonorrhea in these symptomatic girls was 9% and all of these girls were thought to be victims of sexual abuse. We recommend therefore that all prepubertal girls with vaginal discharge on exam must be cultured for gonorrhea, whether sexual abuse initially is suspected or not. Those girls who test positive for gonorrhea must then be reported for alleged sexual abuse to the mandated agencies.

Pharyngeal and rectal gonorrhea infections are often asymptomatic but are much less common. Most reports of asymptomatic vaginal infection in young children come from studies of children who were close contacts of children with gonorrhea infection. A prevalence of 15%-50% has been identified for gonorrhea infection in this group of "close contact" children. Therefore, when a child has been diagnosed with gonorrhea, all other children living in the same household, as well as close playmates who may also have been abused, should be cultured for gonorrhea.

The prevalence of gonorrhea in asymptomatic prepubertal children is very low and the decision to culture should be made on a case-by-case basis. Factors which may influence a decision to obtain cultures include the type of sexual abuse, STD history and risk factors of the perpetrator, and the overall prevalence of gonorrhoeae in the community. In adolescents, cultures for gonorrhea should

continued on next page

Medicine

—by Robert Shapiro

continued from page 11

always be obtained. Children evaluated within 72 hours of an assault may need to be re-evaluated in 2 weeks because infections transmitted at the time of assault may not yet have reached sufficient concentrations to yield a positive test.

Cervical cultures are recommended for adolescents, but not for prepubertal girls. When discharge is present, a culture of the discharge is sufficient. If no discharge is present, the mucosa just proximal or distal to the hymen should be swabbed with a moistened calgiswab. I have found that by moistening the calgiswab with non-bacteriostatic saline, the test will be more comfortable for the child. Specimens must be plated immediately on Thayer-Martin media or chocolate blood agar. If gonorrhoeae is found, the lab must perform at least two additional tests to confirm the accuracy of the diagnosis.

Neisseria gonorrhoeae infection is a marker of sexual contact. There have been no reports of non-sexual transmission of gonorrhea beyond the neonatal period and asymptomatic, persistent neonatal infection is not thought to occur.

Neisseria gonorrhea infection is a marker of sexual contact. There have been no reports of non-sexual transmission of gonorrhea beyond the neonatal period and asymptomatic, persistent neonatal infection is not thought to occur. Experts agree, therefore, that any child who is not sexually active and who is infected with gonorrhea is almost certainly a victim of sexual abuse.

For treatment of uncomplicated gonorrhea infection, a single 125mg IM injection of Ceftriaxone can be given to children of all ages. Ceftriaxone is effective against vaginal, rectal, urethral, and pharyngeal infection. It is also effective for the treatment of incubating syphilis. It may be mixed with 1% lidocaine to reduce the discomfort of injection. Oral Cefixime, 400mg, is an alternative to IM treatment but its effectiveness against pharyngeal infection has not been extensively studied. Penicillin is no longer recommended because of the high prevalence of penicillinase-producing *N. gonorrhea* (PPNG). Patients who are allergic to cephalosporins should receive Spectinomycin. Although the Center for Disease Control and Prevention (CDCP) no longer recommends follow-up cultures for adults with gonorrhea, infected children should be re-cultured to demonstrate a cure. These follow-up cultures may become significant if the patient, on a future date, must be re-evaluated for abuse.

Chlamydia trachomatis

Chlamydia is the second most prevalent STD diagnosed in sexually abused children. At CHMC, almost all cases of chlamydia have been diagnosed in adolescent patients. In our studies, the prevalence of chlamydia among sexually abused patients is 0.8% in prepubertal children and over 9% in adolescents. In all age groups, chlamydia is often an asymptomatic infection and, in prepubertal children, ascending infection is very unusual. Because of the low prevalence in prepubertal children, the decision to culture should be made on a case-by-case basis. Factors that may influence this decision are the same as for gonorrhoeae. Cultures obtained within 72 hours of an acute assault will need to be repeated in two weeks because infection transmitted at the time of assault will not yield a positive test.

Children tested for chlamydia infection must be cultured to make an accurate diagnosis. Enzyme immunoassay, direct fluorescent antibody tests. and DNA probes of recto-vaginal specimens are inaccurate. Pharyngeal infection is quite rare, and there is no need to culture the pharynx. Successful recovery of the organism requires the culture of infected epithelial cells. Therefore, culture of a discharge alone is inadequate. The culture method described in the section above on gonorrhoeae should be followed except that the calgiswab must be gently scraped against the mucosa so that cells are obtained. In addition, certain culture materials are toxic to chlamydia and may prevent recovery of the organism. Specifically, swabs made with wood should be avoided. Calgiswabs (calcium alginate swabs on metal wires) are the most commonly used swabs used for chlamydia testing. Specimens must be placed on ice in an appropriate transport media immediately and transported quickly to the microbiology lab.

As with gonorrhoeae infection, most experts agree that any child who is not sexually active and who is infected with chlamydia has almost certainly been sexually abused. However, unlike gonorrhea, asymptomatic neonatal infection may persist, possibly for up to 3 years or longer. The likelihood of infection through non-sexual transmission outside of this period is very unlikely and has never been documented.

In children over 8 years old, treatment with Doxycycline 100mg BID x 7 days is effective. Azithromycin, 1 gram orally, is an alternative to Doxycycline. Although Azithromycin therapy requires only a single dose, it is more expensive than Doxycycline and it is not approved for children under 15 years. In children under 8 years, Erythromycin 50mg/kg/day (max 2 grams) divided into 4 doses for 10-14 days is recommended. Follow-up cultures should be obtained 2-3 weeks after the completion of treatment.

Syphilis

There have been very few reports of syphilis in sexually abused children. However, the prevalence of syphilis in the adult and adolescent population is increasing nationally. In the future, we may see more infections in abused children as well. The highest number of cases reported in the literature are in children who have been diagnosed with other STDs; it is reasonable therefore to test for syphilis

continued on next page

Medicine

—by Robert Shapiro

continued from page 12

in any child who has been diagnosed with an STD. Syphilis testing should be obtained in all children with a genital ulcer or chancre and in those who show signs of secondary syphilis infection (rash, mucocutaneous lesions, and adenopathy). Darkfield examination of lesions or serologic testing of serum is required for the diagnosis. Both nontreponemal and treponemal serologic tests must be done to make a diagnosis of syphilis. After an acute assault, repeat testing is necessary 12 weeks later because initial serum titers will be low.

There have been very few reports of syphilis in sexually abused children. However, the prevalence of syphilis in the adult and adolescent population is increasing nationally. In the future, we may see more infections in abused children as well.

Non-sexual transmission of syphilis has never been documented outside of the neonatal period. Child abuse is presumed to have occurred if syphilis is diagnosed after the newborn period in a patient who is not sexually active.

Benzathine penicillin G, 50,000 units/kg IM (max 2.4 million units) x1 is the treatment for syphilis. There are other important management considerations in treating the child with syphilis that are beyond the scope of this article.

Condyloma acuminata (genital warts)

There has been much controversy over the prevalence of non-sexual transmission of ano-genital warts. Over the last 10 years, studies linking recto-genital warts with sexual abuse have shown an association ranging from 3% to nearly 100%. Many of the studies are limited by small numbers of patients studied and by incomplete sexual abuse evaluations. Many clinicians believe that children can get recto-genital condylomata by means other than sexual abuse, including perinatal infection, autoinnoculation, non-sexual contact, or by fomites. Perinatal infection can be difficult to exclude in some cases because the incubation period may be 2 years or longer. However, recto-genital warts are most often are transmitted through sexual contact in the adult population and when diagnosed in children may indicate sexual contact and abuse. Therefore, it is important that children with recto-vaginal warts be evaluated for sexual abuse. The extent of this evaluation should minimally include a disclosure interview and physical examination. The decision to report alleged sexual abuse and to obtain tests for other STDs should be made on a case by case basis.

It is important to recognize that there is still much to be learned about this subject, and that harm to a child and family can result both from overconfidence about the diagnosis of abuse and from paralyzing indecision.

The diagnosis of condylomata can usually made by physical examination alone, but a biopsy can be obtained when the diagnosis is in doubt. Treatment options include local application of podophyllin, surgery, and cryotherapy.

Trichomonas

Trichomonas infection is caused by the protozoan *T. vaginalis*. Infection in males is often asymptomatic but it frequently causes a malodorous discharge in females. Infection in prepubertal children is occasionally found and may cause a discharge. Perinatal transmission does occur but persistent infection is thought to be unlikely past the first few months of life. Trichomonas can theoretically be spread through fomites such as shared towels, but this has never been documented. The most likely transmission of trichomonas to a child is by sexual contact.

The diagnosis is made by wet prep examination of vaginal secretions or by microscopic examination of the urine. Culture techniques are now available and may be superior to wet prep and urine analysis. Treatment with Flagyl (metronidazole) 40mg/kg (maximum 2 grams) PO given in a single dose should be effective in 95% of individuals.

Laboratory evaluation for STDs

The CDCP *1993 Sexually Transmitted Diseases Treatment Guidelines* states that the "decision to evaluate the child for STDs must be made on an individual basis. Situations involving a high risk for STDs and a strong indication for testing include the following: 1) A suspected offender is known to have an STD or to be at high risk for STDs (e.g., multiple partners or past history of STD), 2) The child has symptoms or signs of an STD, 3) There is a high STD prevalence in the community" (1). Many authorities recommend culturing all children who give a history of contact with the perpetrator's genitalia as well as children too young to provide a detailed history of the abuse. It is my impression that past experience and local STD rates influence individual practitioners to develop a specific protocol that best serves their patients. There appears to be a trend to culture fewer patients compared with past practices.

When screening for STDs, consideration should be given to the risk of Hepatitis B infection as well as HIV. Hepatitis, HIV and syphilis testing may all need to be repeated if initial screening is negative and the patient was seen soon after the assault. Follow-up for RPR testing can be obtained in 12 weeks and repeat HIV testing can be obtained in 3 to 6 months.

Prophylactic Treatment

Prophylaxis for STDs is not recommended in prepubertal children because of the low prevalence. Exceptions to this rule might include symptomatic children or children assaulted by a perpetrator who is known to have an STD. Prophylaxis for adolescent victims should always be considered along with pregnancy.

continued on next page

Medicine

—by Robert Shapiro

continued from page 13

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ANNOUNCEMENT

NTPETA MOVES INTO NEW TRAINING PHASE

A model training program, NTPETA, funded by the National Center on Child Abuse and Neglect (NCCAN), 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.

Now, following each regional NTPETA training, participants will have the chance to ask additional questions of a recognized expert in the field during a follow-up teleconference. Experts donating their time to answer participants' questions during teleconferences include Ethel Amacher, Barbara Boat, Mark Chaffin, Jan Hindman, Eliana Gil, and Kee MacFarlane. The teleconferences last approximately one hour and are free to the first ten sites for which registrations are received.

In addition, NTPETA will present three satellite video conferences on specific topics related to child sexual abuse treatment.

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APSAC is delighted to thank the sixth grade class of Ms. Kathleen Holleran at the Roycemore School in Evanston, Illinois, for a whopping donation of $230.00. Ms. Holleran's students held a bake sale and a car wash, and donated all of their proceeds to APSAC, in the hope of helping abused children. We think Ms. Holleran's class sets an example for sixth graders everywhere!

HELP APSAC GROW

Do you belong to another professional organization—national or local—which shares APSAC's interest in child maltreatment? Would those colleagues benefit from knowing more about APSAC and the work we do? Contact the national office for information that can be distributed to other groups. Phone 312-554-0166 or Fax 312-554-0919

LAW

Pre-Trial Preparation: When the child victim has a sexually transmitted disease

—by Susan Perlis Marx

When a child victim has a sexually transmitted disease (STD), prosecutors may become overly confident: surely, with such clear medical evidence, the jury will believe that the child was sexually abused. However, in a recent study conducted in Philadelphia, no significant difference in the rate of felony conviction was found in cases with and without physical evidence of injury, seminal fluid, or sexually transmitted disease (DeJong & Rose, 1991). Jurors may believe the defense argument that an STD can be contracted by non-sexual means, or that the child was sexually assaulted, but not by the defendant.

A child victim can contract a variety of STDs during a sexual assault. Most common are gonorrhea, chlamydia, and syphilis. Others include herpes simplex, condlomayloma, trichomonas infection, human immunodeficiency virus (HIV), and pediculosis pubis (Reece, in press). Through pre-trial investigation, prosecutors and investigators must educate themselves about the relevant STD and, most importantly, find the clues that support the contention that the defendant had the STD and transferred it to the child during the sexual assaults. The guidelines outlined below should be adapted to the law and practice in your jurisdiction.

> ***Through pre-trial investigation, prosecutors and investigators must educate themselves about the relevant STD and, most importantly, find the clues that support the contentions that the defendant had the STD and transferred it to the child during the sexual assaults.***

Testing the victim for STDs

The Centers for Disease Control recommended in 1989 that sexually abused children who report oral-genital, oral-anal, genital-anal or genital-genital contact must be tested for gonorrhea, trichomonas, herpes simplex, syphilis, and HIV (Reece, in press). Medical professionals and laboratories should have protocols governing the collection of specimens, including,

a. standardized labeling and packaging of specimens;

b. guidelines to ensure that all appropriate specimens will be collected;

c. standardized collection kits;

d. procedures to explain specimen collection to children and caretakers;

e. consent forms;

f. documentation guidelines to maintain proper chain of custody (Finkel & DeJong, 1994).

Talk with a medical expert

Take time prior to trial to discuss the specific STD and facts that the investigation has uncovered with an expert in the area of sexually transmitted diseases. Most doctors who are experts in the treatment of child sexual assault victims have had experience diagnosing and treating STDs in children. Consider consulting, in addition, doctors who specialize in communicable diseases. A medical expert must educate you and then the jury about the mode and frequency of transmission of the particular STD, the symptoms (or lack thereof) that accompany the STD, the methods of cure, and whether an expert can tell when the child contracted the STD. The experts may have to explain the testing procedures used on the child, unless you decide to present an expert from the hospital laboratory to do so. Assemble charts, diagrams or other demonstrative evidence that will aid the expert in his/her trial testimony.

Medical records of the victim

Make sure that you have complete medical records of the victim. Obtain a release from the child and from his or her parent or guardian. Alternatively, send a subpoena to the hospital or doctor's office. The records should include laboratory reports. Lab paperwork may furnish critical information about the types of testing procedures done, the specific site(s) on the child's body where STD was isolated, and details about the nature of the STD. Complete and accurate information about the STD will enable a medical expert to better evaluate the medical evidence in the case.

Treating physician and laboratory personnel

Contact the physician who examined the child. Discuss the victim's medical records, including the history, symptoms, lab test results, and prescribed treatment. Have laboratory personnel identify the staff member who actually conducted the tests. Talk to the lab staff member about the procedures used both to do the testing and to ensure a proper chain of custody of the test samples. Subpoena the treating physician and the lab staff member for the trial date in the event that you need one or both to testify at the trial. If possible, keep these medical professionals "on call" during trial; the "on call" arrangement will avoid unnecessary waiting at the courthouse and will be appreciated by the witnesses.

Previous medical records of the victim

Obtain all of the medical records of the child regarding any prior hospitalizations and routine medical care. The defense attorney may argue that, if the sexual assaults were perpetrated by a family member and ongoing for years, as the child reports, regular check-ups would have revealed the presence of the STD. Generally, however, medical records will establish that the child had no genital exam or testing for an STD prior to disclosure of the sexual abuse. Detection, particularly when the child has no overt symptoms of the STD, would have been impossible. Should a medical expert inform you that the child's STD could have been contracted from the child's mother during the birth process, check the child's neonatal records and the mother's

continued on next page

Law

—by Susan Perlis Marx

continued from page 15

medical records for any indication of the presence of the STD. Maternal transmission of human papilloma virus (HPV), for example, has been documented in children up to two years of age (Reece, in press).

Defendant's medical records

Interview the non-offending parent or members of the defendant's family regarding clinics, doctors, and pharmacists that the defendant may have approached for treatment. Check the case law in your jurisdiction concerning any limitation on access to the defendant's medical records. Some states allow access to the defendant's medical records when the abuse of the child is at issue; subpoena the medical institution's medical records department to obtain those records. Other states require an *in camera* hearing prior to the release of medical records. At the hearing, a judge reviews the records privately to determine their relevance to the prosecution. If the defendant's medical records reveal evidence of the existence of the STD, the judge should disclose the records to the prosecutor and the defense attorney.

Defendant's prison medical records

Prison health procedures often mandate routine testing of incoming prisoners for certain sexually transmitted diseases. Subpoena the prison's medical records to ascertain if the defendant submitted to tests and to receive the results of those tests. If the defendant refused to take a test for an STD, such a refusal may be admissible to show consciousness of guilt. Scrutinize the list of medications prescribed for the defendant while in custody. Often, a defendant will complain of ailments, i.e., flu, chest cold, and toothache, until he obtains medication which then clears up symptoms of an STD.

Should a medical expert inform you that the child's STD could have been contracted from the child's mother during the birth process, check the child's neonatal records and the mother's medical records for any indication of the presence of the STD. Maternal transmission of human papilloma virus (HPV), for example, has been documented in children up to two years of age.

Health history of the defendant's adult sex partners

The non-offending parent of the child may have had sex with the defendant. A jury or a judge will want to know whether the defendant's sex partner had the STD, particularly absent direct proof that the defendant had the STD himself.

Ask the defendant's adult sex partner whether she noticed any symptoms of an STD on her own body or on the defendant's. Was there ever a time that the defendant stopped having sex with her? Did he use a condom? Was she ever tested or treated for an STD? Obtain a release from the non-offending parent or the defendant's other adult sex partner to procure all medical records. If the defendant's adult sex partner had the same STD as the child, the inference clearly can be made that the defendant gave the STD to both of them.

Note, however, that an adult sex partner may not appear to have the STD. A medical expert can explain the possibility that the adult sex partner was asymptomatic and never tested; further, certain STDs may disappear without medication. Finally, determine if the adult partner took antibiotics for another purpose which then might have cured the STD.

Investigation and testing of other potential child victims

Whether or not they have disclosed sexual abuse, other children in the household or with whom the defendant has had contact must be tested for sexually transmitted diseases. A child may first disclose sexual abuse to the medical professional who discovers an STD. If a child in the household tests positive for an STD but does not disclose sexual assault, the child's safety can still be ensured; an appropriate placement will avoid continued contact with the perpetrator, and a supportive environment, including therapy, will provide the opportunity for later disclosure. Should other children reveal that the defendant sexually assaulted them, arrest the defendant on additional charges. Check your case law concerning consolidation of charges for trial.

Miscellaneous clues of defendant's STD

Interview members of the defendant's family or his friends who may be willing to provide information concerning the defendant's medical history. Family members may know, for example, that the defendant stole a health clinic card, returned it several days later, and then took large white pills every day for a week. A medical expert can explain to the jury that ampicillan, used to cure gonorrhea, may come in the form of large white pills. In closing to the jury, the argument is clear: the defendant cured himself of the disease.

Contact family members and friends to determine if the defendant's adult sex partner confided in them that the defendant had symptoms of an STD (e.g., penile discharge). Given the possible ambivalence on the part of the defendant's family members to testify against him, have the family members sign statements, give sworn depositions and/or testify under oath at a grand jury proceeding or preliminary hearing concerning their knowledge of the defendant's STD. By doing so, you will lock the family members into their statements and have the ammunition with which to impeach them should they recant at trial.

Testing the defendant for STDs

Jurors want to know if the defendant was tested for the STD and, if not, why no testing was done. Failure to provide this information could easily result in an acquittal. Discuss the viability of testing with a medical expert. Obtain a court order or search warrant as early as possible in the investi-

continued on page 21

RESEARCH

Sexual Abuse Treatment Practices: A Survey

—by W. N. Friedrich, Theresa M. Jaworski, Lucy Berliner, and Beverly James

Although many children are referred each year for therapy because of sexual abuse, the types of treatment they receive and the beliefs of their therapists have not been studied. There are a number of reasons for this, including the fact that sexual abuse is a heterogenous phenomenon resulting in a diverse set of outcomes.

Other contributors include the fact that sexually abused children are treated by a broad range of professionals reflecting different training backgrounds. Therapists also differ in their experience with different modalities, their focus on the child victim or the family, and their beliefs about the degree to which the treatment should be abuse-focused.

Hampering the development of consensus is the nascent state of treatment research. With almost no exceptions, studies that have empirically evaluated treatment samples of sexually abused children have not compared the relative efficacy of different treatment modalities. Research that points to the relative benefit of treatment over no treatment is only now being completed, with the results still not available.

Until empirical support for one or more treatment methods exists, it makes sense to determine the beliefs and practices of experienced professionals. This could help determine if there is a consensus, derived from clinical experience, about the best practices of sexual abuse treatment. This knowledge could also guide treatment outcome studies, providing information on an agreed upon length of treatment, for example. Information from a survey of professionals' beliefs regarding treatment can also be used to guide the APSAC Guidelines Task Force on treatment, of which one of the authors (B.J.) is currently the co-chair.

Until empirical support for one or more treatment methods exists, it makes sense to determine the beliefs and practices of experienced professionals. This could help determine if there is a consensus, derived from clinical experience, about the best practices of sexual abuse treatment.

Some of the questions about which a clinical consensus possibly exists include the following: preferred length of therapy; directive versus non-directive treatment; preferred treatment modality; the need for family therapy and family reunification; whether or not treatment needs other than sexual- abuse-related sequelae exist; and how capable therapists believe themselves to be in managing a range of treatment needs.

In addition, because of differences in training and experience, we believed that the age, gender, and background of the therapists would have shaped their experience and beliefs. Because there is no consensus as yet about most treatment practices in this area, we did not develop *a priori* hypotheses about different questions or beliefs.

Method

Sample

A convenience sample of 130 therapists, recruited from treatment programs and workshop attendees in the United States and Canada, was recruited to complete a survey of therapy practices. Social workers were the most frequent participants (N=63), among counselors (N=33), psychologists (N=13), child care workers (N=4), psychiatric nurses (N=3), and other (N=13). The majority of professionals were female (N=104; 80%).

Participants were also asked to indicate their primary treatment focus. The majority worked primarily with child victims (N=72), followed by adolescent victims (N=18), adult victims (N=12), juvenile offenders (N=5), families of victims (N=5), adult offenders (N=3), trauma victims (N=2), and undetermined (N=13).

We also obtained information on the participants' terminal mental health degree as well as years of experience in the field. The most frequent degree listed was MSW/MA (N= 93), followed by Ph.D./Ed.D (N= 13) and BSW (N= 12). The mean years of experience for this sample was 13.6, s.d. = 21.4, median = 7.0, range 0 - 30 years.

Measure

A 46-item questionnaire was developed utilizing a three point format, disagree, neutral, and agree. The topics surveyed and the number of items in each area are as follows: length of treatment (2); group therapy (3); individual therapy (4); family therapy and reunification (9); therapist characteristics and training (12); the place of uncovering/abuse disclosure (6); structured approaches (6); the relation between investigation and treatment (2); and other (2). The items were developed by two of the authors (B.J. and W.N.F.) and reflected agreed-upon areas of concern regarding treatment practices.[1]

Procedure

Workshop attendees and treatment program therapists were invited to complete the questionnaire anonymously and return it to the authors. They were informed prior to completing the measure of our interest in determining professional opinion about best treatment practices.

Results

The frequency of responses were calculated for each item. We grouped the items into those where *clear consensus* existed. This was determined to be the case when at least 66.7 percent of the respondents clearly agreed or disagreed with the item. Items where agree or disagree was endorsed 50.1 - 66.6 percent were labeled *majority* responses. *No consensus* items were those where neither agree nor disagree reached 50.1 percent.

continued on next page

Research

—by W. N. Friedrich, Theresa M. Jaworski, Lucy Berliner, and Beverly James

continued from page 17

Clear consensus

A total of 16 of 46 items fell into the clear consensus category. Six of these items pertained to therapist characteristics and training, another four items regarding family therapy and reunification, two items about structured approaches, and one each regarding group treatment, uncovering, and structured approaches.

To elaborate about therapist characteristics and training, respondents believed that therapists must have training in child development, be able to treat a broad range of child behavior problems, and be familiar with how offenders are treated. Respondents believed that female co-therapists were helpful with the group therapy of male victims, but disagreed that the best therapists had been victimized themselves or that psychiatric medications were routinely helpful.

Clear consensus was also evident in that two-thirds or more respondents disagreed that family reunification should be a routine goal, that treatment issues were similar for intrafamilial and extrafamilial cases, that family therapy should be delayed until individual therapy was complete, or that reunification should take precedence over the acknowledgment of guilt by the incest perpetrator.

The need for a goal-oriented approach also reached a clear consensus, as did the need to assess treatment outcome. In addition, respondents strongly agreed that group therapy was not appropriate for all sexually abused children, that talking about the trauma was necessary, but that most children could not be successfully treated in less than eight sessions.

> ***Generally, therapists did not feel very competent dealing with sexually reactive or aggressive behavior.***

Majority

Another 9 items were supported by the majority of respondents. Four of these pertained to therapist qualifications and indicate that the respondents felt they could treat a broad range of child, adolescent, and adult issues. They also were generally supportive of male co-therapists. Two items reflected family issues and respondents were supportive of caregiver involvement in the child's therapy, but in disagreement about the need for a divorce to occur following father-child incest. Finally, they believed that treatment issues were affected by race, that an abuse focus was more effective, and that the investigatory phase can lead into good treatment.

No majority

That left 21 items for which there was no majority agreement or disagreement. These were distributed across all of the categories assessed. For example, there was a failure to clearly support group therapy or individual therapy as the preferred treatment modality, and there wasn't a consensus about family-based treatment being the most effective, either. Respondents did not endorse one treatment mode over the other, including structured or cognitive-behavioral treatment. Generally, therapists did not feel very competent dealing with sexually reactive or aggressive behavior. Even a time-honored clinical rule about the need for confrontation in juvenile offender treatment was not clearly endorsed one way or the other.

Differences among professional groups

We next examined whether therapist background was related to differential endorsement. First, we examined therapist role identification using chi-square. Because of number frequencies in each cell, we only examined the three largest professional groups, social workers, counselors, and psychologists. Analyses indicated significant differences ($p \leq .05$) for three items. Psychologists were more likely to agree with the need for child therapists to know about offender treatment practices, and differed from both social workers and counselors alike in remaining neutral about the primacy of individual therapy approaches. The final question pertained to competence in treating issues of adolescence, to which social workers and psychologists were less likely to agree.

The next contrast was by primary treatment focus, analyzing whether child, adolescent, and adult therapists differed in their responses. Chi-square analyses indicated no differences across all three groups.

Discussion and Summary

This initial survey of therapists' attitudes and practices revealed a considerable level of agreement as well as areas about which there is no clear consensus. An example of the lack of clear consensus is the finding that no single therapy approach is recommended as the primary method of choice. Fairly similar levels of respondents were neutral about any one mode being the preferred treatment. This included individual, group and family approaches, along with no clear consensus for either a cognitive-behavioral approach or a structured, time-limited approach. This finding is actually rather heartening given the variable impact of abuse and the absence of empirical support for any treatment modality.

Other findings include a consensus regarding the need for therapists to have broad-based clinical skills, training in child development, the need to establish treatment goals, and the utility of psychological assessment in planning treatment. However, the majority of the respondents do not believe that a victimization history makes you a better therapist. These results certainly indicate the need for well-trained professionals who operate in a planful, task-oriented approach.

A treatment debate persists regarding how

continued on page 24

MEDIA REVIEWS

The child's attorney: A guide to representing children in custody, adoption, and protection **cases, by Ann M. Haralambie. 1993, 338 pages. Publisher: Family Law Section, American Bar Association, 750 North Lake Shore Drive, Chicago, IL 60611. Paper, $69.95 ($64.95 for Family Law Members).**

—Reviewed by Gail Garinger

The role of representing children in child custody or child protection proceedings is frequently misunderstood and undervalued. In this comprehensive volume, Ann M. Haralambie, an attorney specializing in juvenile and domestic relations cases, provides an excellent overview for beginning as well as experienced practitioners representing children in child custody, adoption, and child protection cases. The book is also a useful resource for other professionals involved in the legal aspects of these cases.

> ***One issue that has divided courts, practitioners, and commentators in the field is whether a lawyer for the child should advocate the lawyer's own judgment about what is in the child's "best interest" or rather argue for the child's expressed wishes. Haralambie skillfully analyzes the principles on which this conflict turns.***

The book begins with a discussion of the confusion which often surrounds the role of the attorney appointed to represent the child and the importance of early clarification of that role. Defining the nature of the representation — guardian ad litem, attorney for the guardian ad litem, or attorney for the child — has important implications for all aspects of the representation. One issue that has divided courts, practitioners, and commentators in the field is whether a lawyer for the child should advocate the lawyer's own judgment about what is in the child's "best interests" or rather argue for the child's expressed wishes. Haralambie skillfully analyzes the principles on which this conflict turns.

Other important subjects addressed in the second chapter are privileged communication with a minor client and communications with third parties such as teachers, medical and mental health professionals, parents, and the like.

Chapters three and four provide a useful practical guide for preparing and trying a case. The author offers valuable information on establishing the child-client relationship; communicating effectively with children; evaluating visitation, relocation, or out-of-home placement options; negotiating with parents and their lawyers; deciding whether to call the child as a witness; and preparing the child to testify and withstand cross-examination. In addition, current research on memory and credibility of child witnesses is presented.

Chapter five, written by two clinical psychologists, Rachel B. Burkholder, Ph.D. and Jean M. Baker, Ph.D., provides an overview of the five stages of child development and then discusses custodial and visitation considerations that pertain to each stage of development.

Haralambie next provides some basic information about the various categories of child abuse and neglect and points out the need for a culturally-sensitive and multidisciplinary approach.

Chapter seven raises issues pertaining to permanency planning. The author points out that a knowledgeable and vigilant child's attorney can be a prime mover in overcoming the enormous caseload of the social service system and the inertia of the legal system in developing the preferred permanent placement option.

Finally, *The child's attorney* contains extensive references to other resources and includes sample forms and a table listing over 250 cases and over 400 statutes from all 50 states.

The child's attorney is an extremely valuable resource for any attorney representing children. Haralambie's extensive experience in the child welfare field is reflected in her interdisciplinary approach to the subject matter as well as her juxtaposition of the theoretical with the practical aspects of case handling. It should be a required element of any professional training for attorneys appointed to represent children.

Gail Garinger, JD, is an attorney in private practice in Newton, Massachusetts. She is formerly the Director of the Office of Legal Counsel of Children's Hospital in Boston, and serves as a member of the Massachusetts Supreme Judicial Court's Commission on Juvenile Justice.

Residential treatment and the sexually abused child**, by Thomas A. Plach. 1993, 161 pages. Springfield, IL: Charles C. Thomas. 161 pages. Hardback, $31.75.**

—Reviewed by Angelo P. Giardino and Eileen R. Giardino.

This book describes residential treatment as a distinct treatment modality for children and adolescents suffering from the effects of sexual abuse. The author proposes residential treatment for sexual abuse victims requiring services beyond those available in community outpatient settings, specifically for those whose "suffering has been so enormous and their resources so few that costly and lengthy treatment in a 24-hour-a-day program is necessary for them to overcome the problems that were spawned by the abuse" (p.4).

Residential treatment and the sexually abused child could be used as an introductory resource for those professionals who work with sexually victimized children and adolescents. The author combines his own experiences with the results of a survey of 20 residential facilities (12 of the 20 from Illinois) as a means to introduce and discuss a variety of issues related to such treatment. The content of the book represents a descriptive overview of the value of residential treatment for a specific group of

continued on next page

Media Reviews

continued from page 19

sexually abused children and adolescents.

The book has seven chapters. The introduction briefly describes the distinction between community outpatient mental health services and residential treatment. The survey used in the book is described and demographic information is provided on the 20 respondents. Chapter two, "The Client," begins with a detailed discussion of Illinois statutes dealing with the criminal aspects of sexual abuse, and then presents an overview of the characteristics of sexual abuse. A general discussion draws upon the seminal work of S. M. Sgroi and her five-stage conceptualization of the process of child sexual abuse. The chapter closes with a discussion of common behavioral problems prevalent in victims of sexual abuse.

The reason for writing this book is given early in the first chapter when the author decries the paucity of published material in the area of residential treatment for secually abused children and adolescents.

Chapters 3, 4 and 5 ("The Residential Treatment Setting," "The Therapeutic Living Environment" and "The Treatment Process") are the core of the book. These chapters focus on the theoretical and practical underpinnings of residential treatment and the therapeutic process that may unfold during successful residential treatment.

Chapter 6 deals with the potential for sexual abuse in the residential setting itself. The author provides an insightful discussion of this difficult problem, which is a troubling topic to all professionals who work in this field. The chapter focuses on the structure and environment created and maintained within the residential treatment facility by the professionals working there. Using fictitious case descriptions, the author discusses the importance of appropriate pre-job screening and meticulous attention to the professional environment within the facility. He stresses that such care can minimize the potential for abuse of the already victimized client/patient.

Finally, chapter 7 contains the author's miscellaneous comments and observations. He asks three questions of three different professional audiences, and provides an answer to each. Of the residential treatment community, he asks, "Can you survive?" He asks the professional who helps the sexually abused child outside of the residential treatment setting, "Has the system stopped re-traumatizing the child?" Finally, of the professional who provides referrals to the residential treatment setting, he asks, "Do you know where your child belongs?"

Its high caliber makes it suitable for students in medicine, nursing, and social work, as well as those in law enforcement and child protection agencies.

The reason for writing this book is given early in the first chapter when the author decries the paucity of published material in the area of residential treatment for sexually abused children and adolescents. He finds this dearth of information astounding in light of this country having at least 1,000 residential treatment centers for troubled children and adolescents. He cites data reporting that 66-75% of all children entering these facilities having some history of prior sexual abuse. This book is a first step towards stimulating more published material in this area. Unfortunately, the book has some flaws that limit its usefulness. The survey reported upon had a low response rate, and 60% of respondents were from one state. Additionally, the core chapters do not contain references, and do not represent a clearly documented synthesis of scholarly literature.

In conclusion, *Residential treatment and the sexually abused child* is an introductory overview of this important topic. Any professional working with sexually abused children and adolescents will find the discussion interesting,and it should serve to stimulate questions that can be rigorously studied and reported upon.

***The best of intentions*, by The Children's Burn Awareness Program, 5841 S. Maryland, MC-6035, Chicago, IL, 60637 (Telephone: 312-702-6302). 1993. Video: 29-1/2 minutes.**

—Reviewed by Angelo P. Giardino and Eileen R. Giardino

This video is a sensitive documentary directed at raising audience awareness of both the medical and psychosocial aspects of abusive childhood burns. The one-half hour program begins with an overview of childhood burns and abuse by burning. The statistics provided come alive through the words of a mother who describes her child's intentional burning at the hands of a male care-giver. The mother's appearance alternates with the appearance of a variety of professionals (physicians, nurses, child protection, and social workers), and each provides a unique perspective on the topic. The professionals detail a number of issues related to the care and treatment of children who have been burned. In a non-technical manner, each expert contributes knowledge about burning and child abuse. The mother describes what she and her child experienced during her son's injury, acute treatment, and long rehabilitation course. She speaks of feelings concerning the abusive injury, the pain she sees in her child, and the care-taking burden as she seeks rehabilitative care for her child. Additionally, she provides insight into her perceptions of "helping" professions.

The best of intentions is professionally produced and substantial in content. It could serve as a useful teaching tool for both professionals and lay people. The tape could be used for awareness raising sessions and would stimulate discussion at various levels. Its high caliber makes it suitable for nursing, and social work, as well as those in law

continued on next page

Media Reviews

continued from page 20

enforcement and child protection agencies. Additionally, the video could be used in parenting classes and with teachers and court officials. Any curriculum that addresses child abuse will find this video a useful addition.

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Law

—by Susan Perlis Marx

continued from page 16

gation process to compel testing of the defendant. Did child protective services workers request that the defendant get tested? Again, if the defendant refused to be tested, the refusal may be admissible at the trial to show consciousness of guilt. If the test results show that the defendant had the same STD as the child, the case may end in a plea.

A jury or a judge will want to know whether the defendant's sex partner had the STD, particularly absent direct proof that the defendant had the STD himself.

If, however, the tests results show no evidence of the STD, analyze the entire investigation. Speak to the medical expert: could the testing procedure fail to pick up the disease? Did the defendant have notice that the child had an STD? Did he have time prior to the test to clear up the infection? Did the defendant agree to be tested only after a delay, during which time he procured medication to destroy any evidence of the STD? Use a medical expert to describe the ease and secrecy with which the defendant could obtain medication and the rapidity and thoroughness of the cure.

Conclusion

A case involving an STD will be particularly challenging for an investigator and prosecutor. With thorough preparation, prosecutors can use the presence of an STD to convincingly corroborate the child victim's testimony at trial and to secure a just result.

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LEGAL NEWS

New Jersey Supreme Court Hands Down Child Abuse Ruling With National Implications

—by John E.B. Myers

In 1984, Margaret Kelly Michaels was hired as a preschool teacher in Maplewood, NJ. Not long after Ms. Michaels left the preschool seven months later, a child made a statement that was interpreted as evidence of possible sexual abuse. A large-scale investigation followed, and eventually Ms. Michaels was charged with sexually abusing many children at the preschool. The case went to trial in 1987, and, following a nine-month trial, Ms. Michaels was convicted of multiple counts of abuse. In 1993, Ms. Michaels's conviction was reversed by New Jersey's intermediate court of appeal. Among the several reasons for reversal, the intermediate court expressed grave concern about the clearly improper way some of the children were interviewed by social workers and police. In an unprecedented ruling, the court held that if the prosecution decided to put Ms. Michaels on trial again, a separate pretrial hearing—called a "taint" hearing—would be necessary to determine whether defective interviewing rendered the children's statements so unreliable that the children should be barred from testifying.

The prosecution appealed the ruling of the intermediate court of appeal to the New Jersey Supreme Court, and on June 23, 1994, that Court handed down its unanimous decision in *State v. Michaels* affirming the intermediate court's decision to require a pretrial taint hearing. The New Jersey Supreme Court's *Michaels* decision is unquestionably one of the most important child abuse rulings in recent years, one that will likely have national ramifications. Although reasonable minds can differ on whether the Court reached the correct decision, there is little doubt that defense attorneys throughout the country will soon begin requesting taint hearings in child sexual abuse prosecutions.

The *Michaels* decision highlights more than ever the importance of good interviewing. The decision also joins the rising judicial chorus calling for videotaping of investigative interviews. The Court wrote that, "As a matter of sound interviewing methodology, nearly all experts agree that initial interviews should be videotaped." The Florida Supreme Court made a similar statement, writing that "Experts generally agree that contacts between a child and an expert evaluating the child for sexual abuse should be videotaped to ensure trustworthiness and to ensure that the expert did not lead the child during the evaluation" (1994). In a report issued in July of this year, an advisory panel to the California Attorney General recommended that "investigative interviews conducted at well run multidisciplinary interview centers be videotaped." The advisory panel went on to state that its recommendation "does not pertain to therapy sessions with children. The Panel recommends that therapy sessions not be videotaped unless videotaping is done for therapeutic reasons" (1994).

The *Michaels* decision promises to make the already difficult job of prosecution even more difficult. Yet, the New Jersey Supreme Court is clearly right in its insistence on competent interviewing. If *Michaels* leads to better interviewing, the decision will do more good than harm.

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John E.B. Myers, JD, is Professor at McGeorge School of Law, University of the Pacific, and a member of APSAC's Advisory Board.

News

-by Theresa Reid

continued from page 1

Colloquium (only the Dakotas were unrepresented), and from several other countries, including Argentina, Australia, the Bahamas, Bermuda, Canada, and Iceland. As intended, participants were an interdisciplinary group, with 31% from social work, 19% from psychology, 10% from medicine, 7% each from the law and children's services, 6% each from law enforcement and licensed counseling, 4% from administration, 3% each from nursing and research, and 5% from education, psychiatry, offender treatment, the judiciary, and probation.

Awards ceremony a highlight

The Colloquium offered many highlights, different for different people. Some of the most moving moments for those who were able to attend came during the opening session on Wednesday night, when APSAC's annual awards were presented. After a welcome from Massachusetts's Attorney General, long-time APSAC member Scott Harshbarger, and a characteristically thoughtful keynote address from distinguished Harvard psychiatrist Gloria Johnson Powell, MD (another long-time APSAC member), awards were presented in the five major categories, and the 1994 President's Honor Roll was read. Many people were deeply touched by Lucy Berliner's presentation of APSAC's 1994 Outstanding Professional Award to Kee MacFarlane, and by Ms. MacFarlane's acceptance speech. "Kee," Ms. Berliner said, "was the first person to make us aware that very young children were being sexually abused. Of course," she addressed Ms. McFarlane, referring to the traumatic McMartin preschool case," that didn't turn out quite the way you'd anticipated." David Finkelhor presented APSAC's 1994 Research Career Achievement Award to Murray Straus, citing Dr. Straus's extraordinary contributions to the research literature on child maltreatment, both through his mentorship of a new generation of outstanding researchers and through his own research and writing. In their acceptances, Dr. Straus and Ms. MacFarlane both stressed that their awards were more meaningful because of their source: the commendation of their peers is especially deeply felt.

> ***Ann Marie Lipinski, Deputy Managing Editor of The Chicago Tribune, informed the audience that APSAC had, unbeknownst to us, provided her staff with invaluable education: when the First National Colloquium was held in Chicago last June, she sent a dozen reporters to attend every session they could, and they soaked up a great deal of information that was critical to the success of The Tribune's award-winning series.***

Especially impressive because of *its* source in someone outside the organization, was the acceptance of APSAC's 1994 Outstanding Media Coverage Award by Ann Marie Lipinski, Deputy Managing Editor of *The Chicago Tribune*. In accepting her award, Ms. Lipinski noted that the 1993 series for which it was received—"Killing Our Children," which gave front-page coverage to the homicide of every child under 15 in the city of Chicago in 1993—had received major awards, including the Pulitzer Prize and the Robert F. Kennedy Award for Excellence in Journalism. "But," Ms. Lipinski continued, "this award means more than all the others, because of who's giving it." Ms. Lipinski informed the audience that APSAC had, unbeknownst to us, provided her staff with invaluable education: when the First National Colloquium was held in Chicago last June, she sent a dozen reporters to attend every session they could, and they soaked up a great deal of information that was critical to the success of *The Tribune*'s award-winning series. Ms. Lipinski continued, "Covering these stories was very hard, emotionally, on the writers, photographers, and editors, and on me. We all have immense respect for you, for the professionals in this field, who face these stories day in and day out. We cannot thank you enough for doing the work that you do, or for giving us this award."

APSAC's growth continues rapid

APSAC moves into first solo offices

For the first time in its history, APSAC has its own office space. First housed in half a small office at the University of Chicago, APSAC moved in July, 1990 to a whole small office in the suite occupied by the National Committee to Prevent Child Abuse. To make room for the new staff in publications and professional training, APSAC moved to its first own home on July 5, 1994. Our new address is 407 S. Dearborn St., Suite 1300, Chicago, 60605. Our phone and FAX numbers remain the same.

APSAC's Board of Directors, Advisory Board, and staff are delighted by the constant growth in APSAC's members and activities. With this move, we are much better equipped to serve our members' growing needs and respond to the needs of the field: fostering the development of APSAC's state chapter network, sponsoring the production of national guidelines for practice, publishing *The APSAC Advisor* and the upcoming *American Professional Journal on the Abuse of Children*, offering the San Diego Advanced Training Institutes, the national Colloquium, and additional on-site trainings now in the works, and serving as a clearinghouse for information and referrals for our members and others.

APSAC dues increase for first time in over four years

A membership dues increase became effective June 15, 1994. Only the second dues increase in APSAC's history (and the first in more than four years), this increase makes dues for most members $75.00. We know that this increase will be important to APSAC's members, so have devoted two pages of this issue of *The APSAC Advisor* to its explanation (see p. 29-30). APSAC's Board of Directors and staff have taken every possible mea-

continued on next page

WASHINGTON UPDATE

—by Tom Birch

> ***The new funding authority is intended to leverage more dollars into the Children's Trust Funds to provide more flexibility in shaping services for families served by community programs, and to help states develop a more collaborative system of child abuse prevention and family resource services.***

Restructuring state prevention grants

In early May, the House and Senate passed legislation to combine family support and child abuse emergency protection grant programs with the community-based prevention grants going to Children's Trust Funds. The consolidation measures would combine appropriations currently available for family resource centers, emergency protection grants, and community-based prevention grants. The grants, aimed at Children's Trust Funds as the lead recipients, would go to support prevention services for strengthening families.

If the new program is funded at the combined current level of appropriations for each of the components, money for grants to Children's Trust Funds would grow from the current amount of $5 million to $30 million. The legislative proposal under consideration in Congress is independent of the Clinton Administration's budget request to fold the NCCAN emergency protection grants into the community-based prevention grants.

The new measure, proposed by Sen. Christopher Dodd (D-CT), combines the community-based prevention funds, going to state Children's Trust Funds at $5.2 million, with the emergency protection grants at $19 million and the family resource program at $5.9 million, for a total of $30.1 million in appropriated funds.

No hearings were held in either the House or Senate on the consolidation bill, and the legislation moved to completion within a matter of weeks. Although no formal position was taken by the administration, the plan did receive its informal approval, following the intent of the Clinton White House to bring greater focus and efficiency to federal funding. In fact, the President's budget for fiscal 1995 also proposes folding respite and crisis child care funds into the child care block grant.

The bill, part of S. 2000 reauthorizing Head Start and the community development block grants, creates a new Title II in the Child Abuse Prevention and Treatment Act (CAPTA) with authorized funding for just one year at $50 million in fiscal 1995. Next year, when all provisions of CAPTA are due to expire, the House and Senate will hold hearings on consolidation and decide whether to continue the legislation. Congress will also address the question of including other programs in the package. Originally, funding for respite and crisis child care was in Dodd's proposal but was dropped by the House.

The legislation designates the Children's Trust Funds as the lead eligible grantees, with an opportunity to designate another agency if appropriate. A focus of the activities funded under the consolidated program would be support for the establishment of family resource programs of community-based services offering support to families. The new funding authority is intended to leverage more dollars into the Children's Trust Funds to provide more flexibility in shaping services for families served by community programs, and to help states develop a more collaborative system of child abuse prevention and family resource services.

Parental resource centers in education bill

Programs offering support and resources to parents of young children can receive federal funding under the Goals 2000: Educate America Act, signed into law by President Clinton on March 31, 1994. The new law authorizes federal funding for programs to establish parental information and resource centers. Programs will work with parents of children through age 5, and the parents of children in elementary and secondary schools, to increase knowledge in child-rearing activities and assist parents in better understanding their children's educational needs. At least half the funds must serve parents in areas with high concentration of low-income families. Nonprofit organizations eligible for the grants may choose to work in collaboration with local school boards. Part of the funds received must be used to establish or operate Parents as Teachers programs or Home Instruction for Preschool Youngsters programs.

The newly enacted legislation authorizes an unspecified level of funding for the grants for fiscal years through 1998. No money was proposed for the program in President Clinton's FY95 budget.

Tom Birch, JD, is Executive Director of the National Child Abuse Coalition in Washington, D.C., and Associate Editor of The APSAC Advisor.

News

-by Theresa Reid

continued from page 22

sure to keep costs low and to maximize the effectiveness of your dues dollar, and will continue to do so. This increase is necessary, however, if APSAC is to continue the work it has begun. We hope you will find that work well worth the $0.21 per day it costs you to be a member.

Don't miss. . .

In this issue are three very important documents:

1. A Call for Abstracts for APSAC's Third National Colloquium, to be held in Tucson, Arizona, June 7-11, 1995. APSAC's Program Committee looks forward to receiving abstracts from many of APSAC's members. The deadline for submission is October 15, 1994.
2. Draft guidelines for the photodocumentation of physical abuse. Qualified members are encouraged to review and comment upon these draft guidelines by September 15, 1994.

Research

—by W. N. Friedrich, Theresa M. Jaworski, Lucy Berliner, and Beverly James

continued from page 18

central a discussion of the abuse needs to be for treatment to be successful (Friedrich, 1990). These respondents generally seemed to think that uncovering was a worthwhile therapy task, although there was less certainty about whether or not treatment-success depended on it.

Another debate revolves around whether family reunification is a positive or necessary goal. The fact that most respondents supported the need for family therapy early on in treatment would suggest that a family focus is seen as important. However, the majority did not feel family reunification should be a routine goal. It may be that therapists preferred examining the merits of reunification on a case-by-case basis rather than as a generic policy.

Although the respondents did not agree generally to any one treatment mode, there is literature that supports the use of cognitive-therapy for the treatment of PTSD-specific symptoms in latency-aged child and adolescent victims.

Although some consensus emerged in this study, several cautions need to be raised. First, the sample size was small and not randomly obtained. Second, there are numerous questions about treatment practices that were not asked and need to be asked, in the absence of empirical support. For example, although brief therapy (less than eight sessions) was not seen as optimal in the majority of cases, we did not ask questions designed to provide information about varying lengths of therapy for different ages, genders, and abuse and premorbid histories.

Another caution is that only after the surveys were returned did we realize that our wording of several items was unclear. For example, Question 5 was designed to determine whether therapists agreed that different issues presented themselves at different stages in the life cycle, e.g., adolescence, onset of sexuality, parenting. However, that was not clear from the wording of the question. Other confounds were present as well.

In addition, although the respondents did not agree generally to any one treatment mode, there is literature that supports the use of cognitive-therapy for the treatment of PTSD-specific symptoms in latency-aged child and adolescent victims (Deblinger, McLeer, and Henry, 1990). In future surveys it would be useful to determine whether practitioners are aware of and agree with the relevant literature. While individual therapy was not the treatment of choice for preschoolers, play therapy or family therapy may be, but these modalities were not asked about in this survey.

In future surveys it would be useful to determine whether practitioners are aware of and agree with this literature.

Therapist experience and training background were surprisingly unrelated to the various survey items. Whether or not their primary focus was with children, adolescents, or adults, or whether they identified themselves as social workers, counselors, or psychologists, there were only three significant differences. The fact that 2 of these 3 differences could be chance alone underscores similarities across professionals of differing role and therapy focus.

This study was prompted by the ASPSAC Guidelines Task Force on Treatment of Sexually Abused Children, but the findings, while useful, are not being suggested as guidelines. Future research would do well to obtain a larger random sample, word questions more precisely, develop clinical vignettes, and examine more carefully therapist experience, e.g., number of clients treated. Reader input would be appreciated.

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Friedrich, W. N. (1990). *Psychotherapy of sexually abused children and their families.* New York: W.W. Norton.

Endnotes

[1] A copy of the measure can be obtained by sending a self-addressed, stamped envelope with your request to APSAC, 407 S. Dearborn St., Suite 1300, Chicago IL 60605.

William N. Friedrich, PhD, is Associate Professor in the Department of Psychiatry (Psychology) and Diplomate in Psychology at the Mayo Clinic in Rochester, MN, and a member of APSAC's Board of Directors. Theresa M. Jaworski, PhD, is Senior Associate Consultant at the Mayo Clinic. Lucy Berliner, MSW, is Director of Research at Harborview Sexual Assault Center in Seattle, and a member of APSAC's Advisory Board. Beverly James, MSW, is President of James Associates in Honaunau, Hawaii, and is a member of APSAC's Board of Directors.

CONFERENCE NEWS

Don't miss the San Diego Conference on Responding to Child Maltreatment, January 23-27, 1995. The Center for Child Protection at San Diego Children's Hospital is again offering an outstanding and varied program. All-day APSAC Advanced Training Institutes will open the week, on Monday, January 23. For information about the Advanced Training Institutes, call Joye Knight at 312-554-0166. For information about the rest of the program, call Robbie Webb or Diane Martin at 619-576-5814.

HELP APSAC GROW

Word of mouth is APSAC's best form of advertising. More than 50% of members first heard about APSAC from other members. If you are attending conferences or meetings with professionals who could benefit from knowing about APSAC, the national office is happy to supply brochures for your use. Call 312-554-0166 any time.

Prevention

—by Kathleen Kendall-Tackett

continued from page 10

Although no study to date has directly examined the relationship between birth experiences and maltreatment, several studies indicate that a negative birth experience can undermine the mother-infant relationship, and may be particularly dangerous for women already at risk for abuse.

thing to do. Six weeks after he was born, I went back to work. This was really helpful. When I went back to work, the major anxiety and depression lifted. Work was something I could do. When the colic stopped, that helped too.

Elizabeth's story is interesting because prior to her birth, we would not have considered her at risk. She had adequate prenatal care, was in a stable relationship, she was well educated, and had financial resources. She feels that her birth experience started a downward spiral for her initial relationship with her son. Her mother-in-law, although trying to be helpful inadvertently undermined Elizabeth's already shaky confidence. She was eventually able to resolve her difficulties because she was persistent in seeking out answers and assistance. When she had her second child, her birth experience was much more positive and she did not experience depression or other feelings of inadequacy.

Other mothers I have interviewed have described an intense feeling of disconnection or lack of "bonding" with their babies following difficult births. Underlying these feelings are often intense feelings of failure and feelings of inadequacy as mothers.

The women I have interviewed, and those in research studies, are generally white, middle-class, and married. I believe that mothers who are poor, single, or young are even more likely to feel powerless in a hospital setting, and threfore to be at increased risk for negative birth experiences. Although no study to date has directly examined the relationship between birth experiences and maltreatment, the above-cited studies indicate that a negative birth experience can undermine the mother-infant relationship, and may be particularly dangerous for women already at risk for abuse.

What can you do?

Professionals in the field of child maltreatment should, first, be sensitive to the potential impact of women's birth experiences. Professionals I have trained in this area frequently report that they are amazed at the number of times these issues arise once they are aware of them. Sometimes, these professionals are the only people who have taken the mother's concerns seriously. Many women who are afraid to complain about their births because they do not want to appear ungrateful for a healthy baby will confide in a professional who seems ready to hear and to help.

The second step is to validate the mother's experiences by empathizing with her feelings of anger, grief, or failure. She may achieve some

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THANK YOU!

APSAC has a lot of people to thank for support during the Second National Colloquium. They include—

Federal agencies that underwrote some of the Colloquium costs:

The Office of Juvenile Justice and Delinquency Prevention (OJJDP), U.S. Department of Justice, *John Wilson, Director*, and OJJDP's ***Center for Missing and Exploited Children***, *Ron Laney, Director.*

The National Center on Child Abuse and Neglect (NCCAN), U.S. Department of Health and Human Services, *David Lloyd, Director.*

Exhibitors who provided substantial financial support:

Sage Publications, in Newbury Park, California, publisher of *The Journal of Interpersonal Violence*, and of professional social science books. Address: 2455 Teller Road, Newbury Park, CA. Phone: 805-499-0721.

Lexington Books and The Free Press, in New York, New York, publishers of social science books for professional and lay readerss. Address: 866 Third Av., New York, NY 10022. Phone: 800-323-7445.

The Center for Trauma and Dissociation in Denver, Colorado, specializing in the treatment of adults, adolescents, and children who have suffered severe trauma. Address: 4400 E. Iliff, Denver CO 80222 Phone: 303-759-6140.

Cabot Medical Corporation of Langhorn, Pennsylvania, which develops, manufactures, and markets medical devices and systems for minimally invasive surgical and diagnostic procedures. Address: 2021 Cabot Blvd., West Langhorne PA 19047. Phone: 215-752-8300.

Volunteers and consultants who provided hundreds of hours of work:

Bobbi Ausubel • Renee Brant • Douglas Brink • Kelly Brown • Vicki Craft • Anne Douglass • Sylvia Gale • Karen Gaw • Sophie Glikson • Seth Goldstein • Sandi Gubin • Joe Heasly • Vicky Katzung • Jill Cohen Kolb • Kristi Music • Nancy Peddle • Laurie Rovin • Gina Scarmella • Kate Sinclair • Edgar Stewart • Eric Sween • Sheila Thigpen • Lorraine Turner • Dalia Vidunas • Sherry Walls • Sue White

And all of the speakers, who donated their invaluable time.

THANK YOU TO ALL OF THESE PEOPLE, WHO HELPED MAKE APSAC'S SECOND NATIONAL COLLOQUIUM POSSIBLE.

Prevention

—by Kathleen Kendall-Tackett

continued from page 25

clarity and sense of control by securing a copy of her medical records and discussing them with someone who can answer her questions about why certain things occurred. Her feelings of failure may be diminished if you help her re-frame her experience so that she sees that she did the best she could under difficult circumstances.

It is better not to become too "political" about the mother's experience until (if ever) she is ready to hear it. Some of the mothers with whom I have spoken have told me about well-meaning professionals who rail against unnecessary medical interventions or uncaring physicians. These women felt worse, not better, after hearing such criticisms.

Finally, refer the mother to organizations that can help (see box.) Also encourage her involvement in activities with other new and/or more experienced mothers. As she becomes more confident, she may be better able to face the challenges of parenting an infant—no matter how difficult her start.

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HELPFUL ORGANIZATIONS FOR NEW MOTHERS

C/SEC (Cesarean/Support, Education, Concern)

Provides information and support for those who have had Cesarean sections, and referrals to local support groups. They also have information on c-section recovery, Cesarean prevention, and vaginal birth after Cesarean.

22 Forest Road, Framingham MA 01701 • 508-877-8266

I CAN (International Cesarean Awareness Network)

A nationwide, volunteer-run, peer support organization. I CAN's priority is woman-to-woman support, particularly around the emotional issues associated with Cesarean birth.

P.O. Box 152, Syracuse NY 13210 • 315-424-1942

Law

—by Mark J. Horwitz and Josephine A. Bulkley

continued from page 8

[8] Id.

[9] Id.

[10] 727 P. 2d 226 (Wash. 1986).

[11] Walstrom v. State, 752 P.2d 225 (Nev. 1988).

[12] See National Center for the Prosecution of Child Abuse, Summary of Legislation Extending or Removing the Statutes of Limitation for Offenses Against Children (1992).

[13] Id.

[14] Id.

[15] *See, e.g.*, Keith Russell Ablow, "Recovered Memories: Fact or Fantasy," Wash. Post, June 22, 1993, (Health) at 7; Carol Tavris, "Beware the Incest-Survivor Machine," N.Y. Times Book Review, Jan. 3, 1993, at 1; Lawrence Wright, "Remembering Satan-Part I," The New Yorker, May 17, 1993, at 60; Lawrence Wright, "Remembering Satan- Part II," The New Yorker, May 24, 1993, at 54.

[16] John Briere, *Studying Delayed Memories of Childhood Sexual Abuse*, The APSAC Advisor (American Professional Society on the Abuse of Children, Chicago, IL), Summer, 1992, at 17; Roland C. Summit, *Misplaced Attention to Delayed Memory*, The APSAC Advisor (American Professional Society on the Abuse of Children, Chicago, IL), Summer, 1992, at 21; Elizabeth Loftus, *The Reality of Repressed Memories*, 48 Am. Psychol. 518 (1993).

See also Sandra G. Boodman, "At 28, Kathy O'Connor of Arlington Says She Remembered That Her Father Raped Her. She Sued Him and Lost. Are Delayed Memories Like Hers True or False?", Wash. Post, April 12, 1994 (Health) at 12; John Taylor, *The Lost Daughter*, Esquire, May, 1994, at 76.

[17] See, e.g., Jane Gross, "Suit Asks, Does 'Memory Therapy' Heal or Harm?", N. Y. Times, Apr. 8, 1994, at A1.

[18] John Briere & Jon Conte, *Self-reported Amnesia for Abuse in Adults Molested as Children*, 6 J. Traumatic Stress 21 (1993); Judith L. Herman & E. Schatzow, *Recovery and Verification of Memories of Childhood Sexual Trauma*, 4 Psychoanalytic Psychol. 1 (1987); Elizabeth Loftus, et al., *Memories of Childhood Sexual Abuse: Remembering and Repressing*, Psychol. Women Quar. (in press); Linda Meyer Williams, *Recall of Childhood Trauma: A Prospective Study of Women's Memories of Child Sexual Abuse*, J. Consul. & Clin. Psychol. (in press).

[19] *See, e.g.*, Herman & Schatzow, *supra* note 19.

[20] Loftus, *supra* note, at 534.

[21] Id.

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STATE CHAPTER NEWS

—by Claudia Soldano

State chapter network continues to thrive

Second Annual State Chapter Training completed in Boston

It becomes increasingly clear that chapters are the most direct mechanism for members to make their voices heard regarding issues in the field and regarding APSAC's response to those issues. At the second annual State Chapter Training, held in conjunction with APSAC's Second National Colloquium, some 40 chapter representatives gathered throughout the day to share their chapters' work and explore ways to strenghthen the ties among chapters and between the chapter network and the national organization.

At the training, chapter leaders presented some of the chapters' latest work, including newsletters, brochures, and conference announcements and programs. The mentorship program was reviewed as well. Initiated by the national organization, the mentorship program is intended to stimulate chapter-to-chapter interaction by pairing more experienced chapter leaders with leaders of newly-forming chapters to provide peer guidance and support. Pairs are being matched based on areas of expertise and chapter demographics. In addition, suggestions were raised for new, unusual chapters: some want to extend the APSAC chapter network to South America, others to Senegal and other African countries. The suggestion was made as well that there be a "floating" chapter for military personnel that is not rooted to any one site.

The mentorship program is intended to stimulate chapter-to-chapter interaction by pairing more experienced chapter leaders with leaders of newly-forming chapters to provide peer guidance and support.

In addition to this input from chapters, the training featured formal presentations on member recruitment and fundraising activities. As the chapters grow in number and span the organizational development range from nascent to accomplished, chapter trainings will change to accomodate them. Next year's training may include formal presentations from chapters, small group discussions on particular topics, and "tracked" training geared to the experience level of the chapters.

The next national chapter event will be a brown-bag lunch get-together at the San Diego Conference on Responding to Child Maltreatment, to be held January 23-27, 1995 (see conference page). The next formal, day-long chapter training will be held in conjunction with ASPAC's Third National Colloquium, June 7-11, 1995, in Tucson, Arizona. I hope to see you there!

Chapter highlights

After much hard work, **Connecticut** (CTPSAC) became our twenty-fifth chartered chapter in June. Chapter officers include **Cheryl Burack-Lynch**, **Mario Thomas Gaboury**, and **Jennifer Sawyer-Karnoff**. Members in New Mexico used the momentum created by their first conference to build a chapter quickly. Officially chartered in June, **NMPSAC** (officers **Caryl Trotter**, **Roe Bubar**, **Karen Griest**, and **Lynn Rawls**) completes our southwestern border. On the other coast, **New York (NYPSAC)** members held a successful organizing meeting in May, gathering enough petitions to be granted a charter. The interim Board (officers **Margaret McHugh**, **Anne Meltzer**, **Jeanne Bell**, and **Cathy Moraitis**) plans to meet on a regular basis to discuss the goals and direction of the chapter. Congratulations to all chapter officers and Board members, who have worked so hard to make state chapters a reality.

APSAC's affiliated and chartered chapters have also been busy affecting state policy and working through the organization process. Members of the recently-chartered **South Carolina** chapter (**SCPSAC**) are busy planning their first formal membership meeting for February, 1995, as part of a conference which will focus on working with victims and perpetrators of sexual abuse. The event is being co-sponsored by the Medical University of South Carolina's Crime Victims Research and Treatment Program. In February, several members of the **Ohio** chapter (**OHPSAC**) were appointed to three-year terms on the Governor's Task Force on Abuse Investigation and Prosecution. Congratulations to **Jan Akers, Kelly Castle, Georgette Constantino, David Gemmill, Keith Kaufman,** and **Jan Sites** on this honor.

This brief report represents just a few of the activities in which APSAC's chapters are involved, giving APSAC members the opportunity to meet their colleagues statewide and to organize to accomplish important professional goals. To become involved in your state chapter, check the following page for the contact person in your area. If there is not an APSAC chapter in your state, contact the national office for information on how to start a chapter.

CALL FOR NOMINATIONS

Nominations are now being sought for candidates to stand for election to APSAC's Board of Directors. Candidates must be APSAC members in good standing and actively committed to the organization. The Board of Directors is seeking candidates who are diverse along the lines of discipline, are of expertise, race or ethnicity, gender, and geographic region. Nomination forms are available from the national office, and are due on **September 1, 1994.** Call 312-554-0166 to receive a form.

STATE CHAPTER CONTACTS

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

States with approved charters:

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

AR - ***Mark Chaffin, PhD***
Arkansas Children's Hospital,
Dept. of Pediatrics
800 Marshall St.
Little Rock AR 72202
501-370-1013

AZ - ***Cheryl Karp, PhD, PC***
5190 E. Farness, Suite 112
Tucson AZ 85712
602-323-3156

CA - ***John Shields, MA***
Barbara Sinatra Children's Center
39000 Bob Hope Drive
Rancho Mirage CA 92270
619-340-2336

CO - ***Mary Ricketson, JD***
303 E. 17th Ave. #700
Denver CO 80218
303-830-2966

CT - ***Cheryl Burack-Lynch, MS***
Coordinating Council for
Children in Crisis
131 Dwight St.
New Haven CT 06511
203-624-2600

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

IL - ***Cheryl Wolf, MA***
KC-CASA
657 E. Court St.
Kankakee IL 60901
815-932-7273

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U. KY Medical Center
Lexington KY 40536
606-233-6426

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OK - ***Richard Kishur, PhD***
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& Associates
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NOTICE OF APSAC MEMBERSHIP DUES INCREASE

For only the second time in APSAC's history, membership dues are being increased. The dues increase, the first in over four years (since January, 1990), is necessary to support the greatly increased services and benefits that APSAC offers to its members.

This increase was carefully considered by members of the APSAC Board of Directors, who are aware of and concerned about its financial impact on members. In determining the amount of the increase, the Board looked at dues for comparable professional associations, together with the resources APSAC requires to continue to respond to the needs of its members.

The new dues structure, which goes into effect on June 15, 1994, is as follows:

* Full-time students[1] — $35
* Professionals making under $25,000/year[1] — $50
  (Does not include a journal as a benefit of membership.)
* Professionals making $25,000 - $50,000/year — $75
* Professionals making over $50,000/year — $100

[1] *Availability of these categories is based on verification of full-time student status and income category.*

In addition, an organizational membership is being developed, which the Board hopes will make membership more accessible to some professionals.

WHAT DO YOU GET FOR YOUR DUES DOLLAR?

APSAC delivers much more for your dues dollar in 1994 than in 1990.

1990	1994
16-page *Advisor*	36-44 page *Advisor*.
No state chapters	National staff and funds dedicated to the development of a chapter network that now consists of 30 official chapters and more than 20 formative chapters
Journal of Interpersonal Violence	*Journal of Interpersonal Violence*, plus active development of a new journal for APSAC members, the *American Professional Journal on the Abuse of Children,* to begin publication in January, 1996.
No APSAC-sponsored training	Two major APSAC-sponsored training events: the Advanced Training Institutes offered every January in San Diego, and the APSAC National Colloquium, offered every May or June at various sites throughout the country.

(Over)

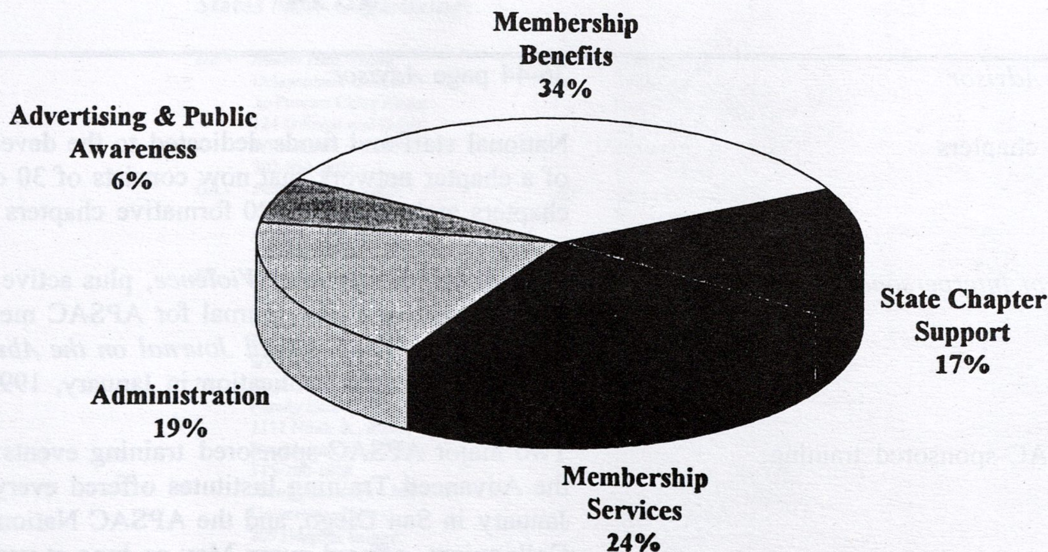
1990	1994
2-3 conference discounts per year	6 or more discounts on conferences all over the country, including deep discounts on the APSAC National Colloquium and the APSAC Advanced Training Institutes in San Diego
No additional training materials available	Discounts on enough training audiotapes, back issues of *The APSAC Advisor*, and other publications to more than fill a six-page brochure.
No independent national headquarters	On July 1, 1994, APSAC will move into its first set of independent offices (until now, APSAC has sublet shared space). At its new national headquarters, staff will be better able to handle the hundreds of resource and referral calls now pouring in monthly from all over the world.

MEMBERSHIP STILL COSTS LESS THAN $0.21 PER DAY.

APSAC's Board and staff know that there are many demands on your income, and do everything we can to maximize the effectiveness of your dues dollar. We hope you agree with us that, at less than $0.21 per day (at the new $75 dues rate), your membership in APSAC--bringing you *The APSAC Advisor*, a new journal, a thriving state chapter network, discounts on abundant training materials, discounts on conferences all over the country, instant access to a nationwide referral network, and a clear professional "home" for you as a professional in the field of child maltreatment--represents one of the best investments you can make.

WHERE DO YOUR DUES DOLLARS GO?

Below is a chart showing where your dues dollars go. We look forward to working with you in the years to come to ensure that APSAC meets your professional needs and exceeds your expectations as a source of information, leadership, and support.



MEMBERSHIP BENEFITS include production and mailing of *The APSAC Advisor*, the *Journal of Interpersonal Violence*, and APSAC Guidelines for Practice.
MEMBERSHIP SERVICES include the production and mailing of membership packets, and the costs of answering members' questions, making referrals, etc.
ADMINISTRATION includes financial management, association insurance, public auditing, Board meeting costs, staff training and development, etc.
ADVERTISING AND PUBLIC AWARENESS include production and dissemination of press releases, print ads, and brochures.
(Conferences are not listed because dues do not pay for APSAC's conferences; the conferences pay for themselves.)

JOURNAL HIGHLIGHTS

—Edited by Thomas F. Curran

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

PHYSICAL ABUSE AND NEGLECT

Caliso, J.A., and Milner, J.S. (1994). Childhood physical abuse, childhood social support, and adult child abuse potential. *Journal of Interpersonal Violence, 9* (1), 27-44.

By using the Childhood Social Network Questionnaire and the Child Abuse Potential Inventory, this study examined the role of social supports in the discrimination of physical child abusers and non-abusers. Contrary to expectations, none of the social support factors identified distinguished physical child abusers with a history of childhood physical abuse from the group of non-abusers with histories of childhood physical abuse. One finding consistent with previous research was that non-abusing adults with and without a history of childhood abuse were found to be less rigid in their child expectations and happier in their interpersonal relationships than were the abusers.

Coody, D., Brown, M., Montgomery, D., Flynn, A., and Yetman, R. (1994). Shaken Baby Syndrome: Identification and prevention for nurse practitioners. Journal of Pediatric Health Care, 8, 50-56.

Health care professionals experienced in identifying child abuse and those with little or no experience will find this article a very useful description of the clinical findings of Shaken Baby Syndrome (SBS). Following a brief case study, a clear and concise overview of the identification and diagnostic evaluation for SBS is presented.

McCurdy, K. and Daro, D. (1994) Child maltreatment: A national survey of reports fatalities. *Journal of Interpersonal Violence, 9* (1), 75-94.

Pertinent findings from the National Committee to Prevent Child Abuse's most recent nationwide survey on the number and characteristics of child abuse reports, the number of abuse fatalities, and scope of the child welfare system are presented in this article. The results indicate that rates of reported and substantiated cases of child maltreatment, as well as abuse and neglect-related confirmed deaths, have steadily increased over the past eight years.

Nelson, K.E., Saunders, E.J., and Landsman, M.J. (1993). Chronic child neglect in perspective. *Social Work, 38* (6), 661-671.

Various dynamics of child neglect identified in previous research are examined in this longitudinal cohort study of three groups of families referred to a county child welfare agency due to child neglect allegations. The results, which were reached by interactional factor analysis, provided strong additional evidence of the role extreme poverty plays in the etiology of child neglect. This important study also raises some social policy and intervention issues which are inextricably linked to the prevention and effective treatment of neglect.

Reece, R.M. (1993). Fatal child abuse and Sudden Infant Death Syndrome: A critical diagnostic decision. *Pediatrics, 91* (2), 423-429.

This brief article provides an excellent overview of Sudden Infant Death Syndrome (SIDS), including its clinical presentation, epidemiology, and characteristics which distinguish it from child abuse. The section on the importance and role of the autopsy in SIDS cases is especially useful.

Wolf, D.A. (1993). Prevention of child neglect: Emerging issues. *Criminal Justice and Behavior, 20* (1), 90-111.

The article presents an excellent overview of some identified maltreatment risk factors, particularly those pertaining to neglect. Suggestions of ways to conceptualize prevention goals from these identified risk factors are discussed, along with recent intervention programs which appear promising.

Zaidi, L.Y. and Foy, D.W. (1994). Childhood abuse experiences and combat-related PTSD. *Journal of Traumatic Stress, 7* (1), 33-42.

By using a standardized measure of childhood abuse, this descriptive study provides preliminary data on the prevalence and severity of physical discipline experienced during childhood by combat veterans with post-traumatic stress disorder (PTSD), and examines the association between childhood abuse and the severity of current PTSD symptomatology. Data compiled reflected a statistically significant correlation between childhood punishment history and the severity of PTSD symptomatology. This is a fascinating study, with important potential implications for the diagnosis and treatment of PTSD in combat veterans.

CHILD SEXUAL ABUSE

deYoung, M. (1994). Immediate maternal reactions to the disclosure or discovery of incest. *Journal of Family Violence, 9* (1), 21-33.

This study explored the immediate reactions of mothers to the disclosure or discovery of paternal

continued on next page

Journal Highlights

—Edited by Thomas F. Curran

continued from page 31

incest. Unlike some other studies of this issue, in this study the women, themselves, were the sources of the data. Contrary to previous reports, the findings revealed much less collusion, less disbelief of the incest allegation, more shock and outrage upon its disclosure or discovery, and more protective actions post-discovery by the mothers.

Everson, M. and Boat, B. (1994). Putting the anatomical doll controversy in perspective: An examination of the major uses and criticisms of the dolls in child sexual abuse evaluations. *Child Abuse and Neglect, 18* (2), 113-129.

Based upon an extensive review of guidelines and protocols developed for the use of anatomical dolls in sexual abuse evaluations, the authors identified seven functional uses of the dolls. These functional uses are then examined in light of the major criticisms that have been raised about using the dolls in child sexual abuse evaluations or investigations. Four such criticisms are explored in detail. The authors provide convincing support for each of their conclusions, including that blanket condemnations of use of the dolls in sexual abuse evaluations are unjustified. In addition, the most common criticism of the dolls, that they are suggestive and overly stimulating to young children, is exposed and refuted by the available research.

Kendall-Tackett, K.A., Meyer Williams, L., and Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin, 113* (1), 164-180.

Forty-five research studies conducted on the impact or effect of sexual abuse on children are examined in this meticulously detailed literature review. Overall, sexually abused children had more symptoms than non-abused children. No single symptom, however, characterized a majority of the sexually abused children. After an excellent theoretical discussion of traumatization, this review failed to establish any specific syndrome in children who have been sexually abused or any single traumatizing process.

McLeer, S., Callaghan, M., Henry, D., and Wallen, J. (1994). Psychiatric disorders in sexually abused children. *Journal of the American Academy of Child and Adolescent Psychiatry, 33* (3), 313-319.

This study compared the prevalence of Axis I DSM-III-R psychiatric disorders in a sample of clinically referred children who had been sexually abused and a sample of non-sexually abused children referred for psychiatric outpatient evaluation. Attention-deficit hyperactivity disorder was the most frequent diagnosis in both groups, but the sexually abused group had a significantly higher prevalence of post-traumatic stress disorder (PTSD) than did the comparison group (42.3% to 8.7%). Earlier findings that sexually abused children are at heightened risk for the development of PTSD were confirmed, and a significant comorbidity among the children with PTSD was found.

Runyan, D., Hunter, W., Everson, M., Whitcomb, D., and DeVos, E. (1994). The intervention stressors inventory: A measure of the stress of intervention for sexually abused children. *Child Abuse and Neglect, 18* (4), 319-329.

This article described the development and initial validation of the Intervention Stressors Inventory (ISI), a new scale which attempts to measure the intrusiveness and stress which criminal justice and social service interventions cause sexually abused children. Although early results suggest the ISI has place as a research tool, both the instrument and its usefulness will surely be the subject of some controversy within the child protection field.

OTHER ISSUES IN CHILD MALTREATMENT

Bulkley, J.A. and Horwitz, M.J. (1994). Adults sexually abused as children: Legal actions and issues. *Behavioral Science and the Law, 12* (1), 65-87.

Delayed memories, the long-term effects of child sexual abuse, current trends in bringing civil lawsuits, and the criminal prosecution of sexual abuse cases are discussed in this highly informative article. An excellent analysis of civil and criminal statutes of limitations in sexual abuse cases is provided, along with various arguments for and against extending these legislatively established periods within which legal actions may be brought. Although its substance and language will likely appeal primarily to attorneys, this article presents a thorough and refreshingly balanced examination of some highly controversial issues involving child sexual abuse and the legal system.

Finkelhor, D. and Leatherman-Dziuba, J. (1994). Victimization of children. *American Psychologist, 49* (3), 173-183.

This article presents a comprehensive examination of the victimization of children. Drawing from various data sources for support, the authors examine why children are more prone to victimization than adults, and provides an interesting statistical analysis of child victimization, unique characteristics of child victims, and a typology of child victimizations which provide important observations for future research. The discussion of age and victimology is particularly thought-provoking. Anyone involved in child maltreatment, whether as researcher, clinician or investigator, will find this article helpful.

continued on next page

Journal Highlights

—Edited by Thomas F. Curran

continued from page 32

Urquiza, A.J., Wirtz, S.J., Peterson, M.S., and Singer, V.A. (1994). Screening and evaluating abused and neglected children entering protective custody. *Child Welfare, 73* (2), 155-171.

Phase One data from the Screening and Evaluation Project (SEP), a short-term longitudinal applied research project developed to screen and assess the magnitude and severity of mental health problems of children very shortly after being placed in out-of-home care, are discussed in detail. Initial findings indicate that, of the 167 children studied, a large percentage displayed high levels of risk and/or mental health problems upon their entry into the dependency system. The authors present convincing arguments for screening or evaluating all children who enter out-of-home care, and thus developing a system which therefore responds to their needs early.

The Journal Highlights editor wishes to thank David Finkelhor, PhD, Family Research Laboratory, University of New Hampshire, Josephine Bulkley, JD, ABA Center on Children and the Law, and Kay Lynch, MSW, Child Advocacy Unit, Defender Association of Philadelphia, for their kind assistance and contributions to this issue.

ANNOUNCEMENT

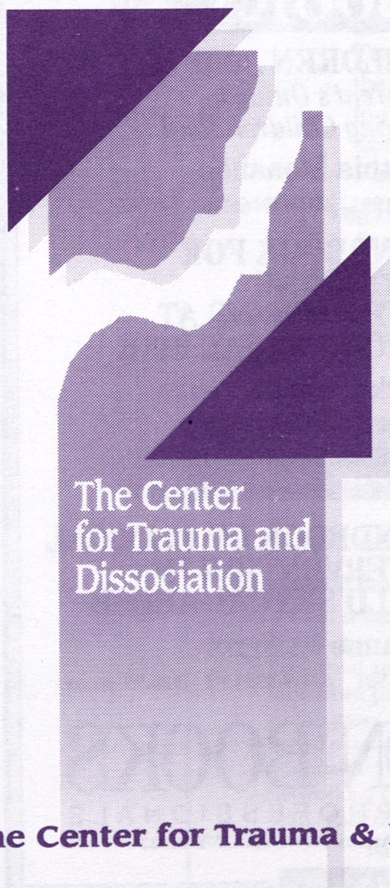
The University of Michigan Interdisciplinary project on Child Abuse and Neglect is conducting a study of the use of the polygraph in cases of suspected sexual abuse. We will examine the relationship of polygraph results to other indicia of the likelihood of sexual abuse, such as the child's statements, child behavioral indicators, medical findings, other victims or witnesses, and offender confession.

If you have been involved in cases where the polygraph was used in conjunction with other indicia and are willing to provide information for the study, or if you have questions about the study, please contact us, at the University of Michigan, IPCAN, 1015 E. Huron, Ann Arbor MI 48104-1689. Phone: 313-763-3785. FAX: 313-936-2514.

—Kathleen Coulborn Faller, PhD

NEWS/RESOURCES

According to the National Committee for the Rights of the Child (NCRC), Congress is gearing up to ratify the U.N. Convention on the Rights of the Child, and may join a UNICEF-sponsored drive for universal ratification of the Convention by 1995. From NCRC, interested parties can learn how to expedite the ratification process, and can receive (for $5.00) an informative booklet that answers 30 questions about the U.N. Convention on the Rights of the Child. Contact NCRC, 125 Cathedral St., Annapolis MD 21401. Phone: 401-268-1544.



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THE CHILD SEXUAL ABUSE CUSTODY DISPUTE ANNOTATED BIBLIOGRAPHY

by **WENDY DEATON**, *Private Practice, San Luis Obispo, California,*
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This book is an important and valuable resource to all professionals—legal, medical, mental health, judiciary, child protection, and law enforcement—having any involvement with child abuse allegations in custody disputes.

A supplement covering the literature from 1993 through 1994 will be published in 1995. All royalties from the sales of this book will go to CAPSAC.

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October 9-11, 1994. ***17th National Conference of the National Assoication 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 a complimentary 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.

November 9-12, 1994. ***Association for the Treatment of Sexual Abusers (ATSA) 13th Annual Research and Treatment Conference.*** San Francisco, CA. Co-sponsored by the California Coalition on Sexual Offending, Safer Society Program, and New England Forensic Associates.

January 23-27, 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." See inside this issue for the Call for Abstracts. Call Joye Knight, 312-554-0166, for information.

June 26-30, 1996. ***APSAC's Fourth National Colloquium.*** Chicago Hilton & Towers. Chicago, IL.

Other Conferences

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 17-19, 1994. ***Child Abuse Prevention Trainer Training.*** Seattle, WA. Sponsored by the Committee for Children. Enables participants to train others to teach Talking about Touching and Personal Safety and Decision Making curricula. Call Tracy Honour at 800-634-4449.

August 31-September 2, 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.

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October 4-7, 1994. ***The Eighth Annual Rochester Symposium on Developmental Psychopathology.*** Rochester, NY. Sponsored by Dante Cicchetti and Sheree Toth, of the Mt. Hope Family Center, University of Rochester. Call Jeanne Ledtke, 716-275-2991.

October 13-15, 1994. ***Violence in the Family, an International Conference.*** Amsterdam, the Netherlands. Contact Conference secretariat, Bureau PAOG Amsterdam, Tafelbergweg 25, 1105 BC Amsterdam. FAX: +31-20-696 3228. Phone: +31-20-566 4801.

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.

February 16-21, 1995. ***First Annual Conference on Trauma, Loss, & Dissociation.*** Alexandria, VA. Call 1-800-844-2789.

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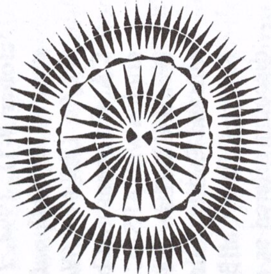

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(013) Psychiatry	(014) Psychology	(016) Social Work

Method Of Payment

Payment must be made in US funds, by check, charge, money order, or New York draft.
Visa or MasterCard payments may be FAXed to 312-554-0919.

$ ________ is enclosed for membership dues.
$ ________ *Please also accept this voluntary tax-free gift for APSAC's Endowment Fund.*
$ ________ **Total amount enclosed.**

Check # ________ ❑ Visa ❑ MasterCard

Card # □□□□–□□□□–□□□□–□□□□ Expires: __/__ Phone: ________

Signature: ______________________

Please note: *In renewing a membership, APSAC members certify their continuing compliance with the standards of conduct appropriate for APSAC members, including, but not limited to, the professional and ethical standards of, and all laws and regulations relating to, their respective professions.*

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

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

American Professional Society on the Abuse of Children
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