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CULTURAL ISSUES

Culturally Relevant Violence Research with Children of Color

—by Anthony Urquiza and Gail Wyatt

By most accounts, clinical and research interest in the field of child abuse and neglect have increased substantially during the last decade and a half (National Research Council, 1993). Notably understudied in this research is violence within ethnic minority families and/or violence against children of color. While clinical research has been conducted with children of different ethnic groups, this research has rarely examined the contribution of ethnicity in understanding the prevention, mediation, treatment, and/or outcome of child maltreatment.

In general, clinical research approaches to the problems of violence against children of color can be compromised in several important ways: by failing to address important socioeconomic, cultural, and racial factors; by using biased or skewed sampling strategies; by using ineffective or insensitive subject recruitment strategies; and by misinterpreting the data. We believe that the primary reason for these problems is that traditional clinical research practices are "embedded in a context of race, class, and ethnic stratification" (Landrine, Klonoff, & Brown-Collins, 1992). To promote a more culturally relevant approach to research on the neglect and physical and sexual abuse of children of color and within ethnic minority families, we must revise traditional clinical research methodology. Doing so entails many difficulties not encountered in traditional paper-and-pencil research studies with readily accessible samples. However, in order to ensure the safety of all children, we must utilize research techniques that provide useful, relevant information about violence against children of color. This article provides an overview of some of the important issues in conducting culturally competent research with ethnic minority children, and proposes research strategies which may provide a greater understanding of the cultural context in which this maltreatment occurs.

Developing a hypothesis: Incorporating context

One of the fundamental issues in conducting research with children and families of color is the development of hypotheses which are culturally relevant and appropriate to the focus of the investigation. To develop culturally relevant hypotheses, researchers must adopt both a perspective about the importance of cultural context, and specific research methods that reflect this perspective. Adopting the perspective means embracing the assertion by Belsky (1980) and Garbarino (1977) that to understand individuals we must understand the dynamic system within which they exist. Whether or not researchers are members of the cultural group

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NEWS

Editor-In-Chief Chosen for American Professional Journal on the Abuse of Children; New Resource Available to Prosecutors

—by Theresa Reid

Mark Chaffin, PhD, to be Editor-in-Chief of *APJAC*

APSAC's Board of Directors has chosen Mark Chaffin, PhD, Assistant Professor in the Department of Pediatrics at the University of Arkansas, to be Editor-in-Chief of the *American Professional Journal on the Abuse of Children (APJAC)*, to be published quarterly beginning in February, 1996. An APSAC member for many years, Dr. Chaffin was Book Review Editor, then Executive Editor, for *The APSAC Advisor*, and was elected to APSAC's Board of Directors in 1993.

Dr. Chaffin has significant expertise in both research and practice in the field of child maltreatment. Founding Director of the Family Treatment Program at the Child Health and Family Life Institute at the Arkansas Children's Hospital, Dr. Chaffin has published research in the *Journal of Interpersonal Violence*, the *Journal of Child and Family Studies*, *Child Abuse and Neglect: The International Journal*, and the *American Journal of Public Health*. Dr. Chaffin's clinical work and research have addressed the assessment and treatment of child, adolescent, and adult sexual offenders, the role of substance abuse and depression as prospective risk factors for physical abuse and neglect, the psychophysiological aspects of PTSD in sexually abused children, and the role of dissociation in children's disclosure interviews.

In his nomination for Editor-in-Chief, Dr. Chaffin wrote, "I would hope that *APJAC*'s culture would be one which values many of the things we think are important in our field—diversity, rigor, fairness, respect, and integrity. These values must apply not only to the professional conduct of APSAC's members, but also to how the journal is operated." Dr. Chaffin is assembling an interdisciplinary Editorial Board comprised of APSAC members to ensure that the different disciplines reflected in APSAC's membership are represented in the

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LETTERS TO THE EDITOR

Dear Editor:

Kathleen Kendall-Tackett's article, "The impact of negative birth experiences on mother-infant relationships" (*The APSAC Advisor*, 7 (2), p.9) raises a number of important considerations in understanding the potential impact the birth experience can have on the mother-infant relationship. As noted in this piece, the research is far from conclusive. On the other hand, it does suggest that understanding not only what the birth experience was like for a new mother but also how the new mother perceived the experience may be important variables in determining a woman's risk level.

Before one begins labelling another group of women as being "at-risk for maltreatment," however, I think it is important to keep at least two things in mind in reviewing the research Kendall-Tackett summarizes. The relationship between the birth experience and and the mother's use of prenatal care and overall health status is unclear. Certainly, many cesarean sections and difficult labors have nothing to do with the mother's prenatal history or degree of preparation for childbirth. In other cases, however, failure to obtain adequate prenatal care, substance abuse, smoking, and other negative behaviors during pregnancy can increase the odds of a difficult labor. Those women who experience difficult labor may be different in kind from those who travel smoother roads in the delivery room. The difference observed between those with positive versus negative birth experiences in the abuse rates or attitudes toward infants, therefore, may be partially a function of these "other" pre-birth group differences.

Second, once one allows women to make subjective judgments about their labor experiences (i.e., remove any objective standards as to what constitutes a difficult labor), classification into one group or the other becomes totally a matter of personal choice and definition. It is quite possible that women who interpret their labor as very negative (particularly when the objective conditions do not suggest a troubled labor) may be less optimistic about life, less flexible, and less able to cope with adversity than those who define their labor as just a means to an end. Those who dwell on the negativity of the birth process may do so not because the experience was bad but because they tend to dwell on the negatives in all aspects of their lives. In other words, it may not be the negative birth experience itself that puts women at higher risk for maltreatment; rather, the risk may lie in the underlying attitudes a woman brings into the labor room.

In assessing a new mother's risk for maltreatment, it is important for medical and social service providers to understand a new mother's actual and perceived birth experiences. The influence of that experience on the mother's capacity to care for her infant, however, is neither universal nor absolute. Determining level of risk involves understanding, as completely as possible, the mother's overall attitude toward parenting, her physical and mental capacity to handle the needs of a new infant, and her ability to identify and utilize social supports. I would hate to see the field begin classifying all those with difficult labors as constituting the latest "high risk" population for maltreatment.

Sincerely,
Deborah Daro, DSW

Kathleen Kendall-Tackett responds:

Deborah Daro raises many valid points in her letter to the editor regarding my recent article on negative birth experiences. I would like to address each of her concerns.

As Dr. Daro points out, lack of prenatal care and other health factors can influence difficulty of labor. Women who are low income and do not have prenatal care would constitute a specific sub-group of birthing women who are more prone to difficult births. The majority of the research on reactions to birth experience, however, has not been conducted with low-income women. Most of the women were middle-class, had received prenatal care, and had participated in a childbirth education class. In fact, many of the women were recruited from these classes because a high percentage of the researchers were childbirth educators. I find the results of these studies (especially those that have examined the impact of birth on mother-infant relationships) to be troubling. The women in these studies have given birth under what many would consider optimal circumstances. What happens when the circumstances (such as lack of prenatal care) compound problems of labor?

Dr. Daro makes another excellent point when she describes how coping and attributional style could influence how women perceive their birth experiences. Women (and men) with a less functional style are going to perceive events more negatively than are those with a more healthy coping style. However, the same can be said for any negative life event (including child abuse): some will cope better than others. However, just because some cope more effectively does not mean that the experience itself was not negative. Second, in studies that examine women's reactions to birth, there are often at least 100 subjects (usually more). Presumably, there are a range of coping styles within these groups of subjects. And yet some common themes and negative reactions emerge.

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CHILD PROTECTIVE SERVICES

Keeping Maltreated Children At Home: When Is It Safe?

—by Maria Scannapieco and Diane DePanfilis

"While there are indeed many child maltreators who can be helped to be competent parents with timely and effective social services," Richard Gelles wrote in the Summer, 1993 issue of *The APSAC Advisor*, "other parents cannot be assisted to be caring and nurturing parents" (Gelles, 1993). Most professionals working in public child protection for more than a year or two have gained painful experience that seems to support Dr. Gelles's assertion. How are these professionals supposed to determine when to keep families together? Gelles suggests that this decision be based on the severity of the maltreatment. Thus, children of "parents who fracture the skulls or bones of 6-month-old children [or] who have sexual intercourse with twelve-month old daughters" (Gelles, 1993) are clearly not safe in their current environment. However, as most child protective services (CPS) workers will affirm, these are the easy decisions.

Assessment of safety is more difficult with the majority of families reported to CPS agencies. Family preservation philosophy does not suggest that all children be kept at home reunited with families regardless of safety concerns. Rather, it suggests that "growing up in their family is optimal for children, as long as children's safety can be assured" (DePanfilis and Salus, 1992, p 4). However, deciding when a maltreated child is safe is clearly one of the most difficult decisions facing CPS staff today.

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How does research help with this question?

In our search for reliable means for determining children's safety, we looked at three bodies of research for guidance: studies that examined (1) predictors of child maltreatment recurrence, (2) casework decision-making, and (3) predictors of child placement.

The literature on the recurrence of child maltreatment encompasses retrospective studies of child abuse and neglect, risk-assessment-related research, and treatment outcome studies. Taken as a whole, this literature offers little help in determining what factors predict recurrence, since the studies exhibit major differences in operational definitions of risk, types of child maltreatment, and recurrence. A review of the risk assessment literature confirmed both consistencies and discrepancies in predictors between studies (McDonald and Marks, 1991).

Even if the recurrence literature were more conclusive, the ability to predict recurrence of child maltreatment would not fully answer the pressing questions for CPS workers. There is an important distinction to be made between risk and safety. A child may be at risk of maltreatment at some time in the future, yet be safe from an immediate threat of serious harm. For example, consider a situation of marginal neglect that has yet to result in any observable consequences to the child. This situation is likely to persist (recur), and over the long term, we certainly want to help the family to improve their parenting adequacy. However, for the immediate future the child may be safe from any severe consequences. As emphasized by Wald and Woolverton (1990) in their critique of risk assessment systems, it is "unlikely that the same set of factors is equally predictive of future behavior under quite different conditions" (p. 496). Research in this field has yet to isolate broad, general predictors of recurrence from predictors of a risk of immediate severe consequences (a safety concern).

The second group of studies we reviewed examines how caseworkers make decisions about when it is necessary to place a child in out-of-home care. A previous review of this research (DePanfilis and Scannapieco, 1994) found that caseworkers consider the following family characteristics: severity and frequency of past harm, risk to the child and necessity of immediate action to prevent harm to the child, age of the child, maternal behavior, functioning of primary caregiver, father's interest in and affection for the child, absence of a caregiver, household management, existence of a hazardous environment, family insight, and cooperation of the caregivers. Several studies found overlap in criteria used by workers; however, the studies offer no basis for concluding that these criteria are the most effective for evaluating the safety of maltreated children. The value of this literature for our current discussion is limited also because most of it is more than 10 years old, and was not framed to answer questions about the wisdom of the family preservation philosophy.

The third body of research we reviewed attempted to establish predictors of when children will be placed. This body of research is primarily descriptive in nature—documenting the reasons children were placed—and dates to the 1960s, 1970s, and early 1980s (DePanfilis and Scannapieco, 1994). Even one of the most extensive and methodologically sound studies (Runyan, Gould, Trost, and Loda, 1981) found that we are far from being able to predict which maltreated children will be placed in out-of-home care.

What factors are proposed by safety evaluation models?

In a recent article (DePanfilis & Scannapieco, 1994), we contrasted ten safety evaluation models developed between 1972 and 1993. Models varied considerably; while there was some overlap in the criteria used for evaluating safety, the models in total considered thirty-three separate elements, some of which were only represented by one model. One of the deficits in the current safety assessment models is their lack of distinction among the different types of abuse.

There was some consensus regarding areas of assessment, however, across the research and

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models. In this section, we will present proposed safety criteria that are supported by multiple sources. Children's safety is a function of many variables. While these criteria may not prove to be the most reliable or only criteria, they are based on our current best knowledge. For the sake of clarity we divide areas of assessment into five general categories: child, parent, family and environment, maltreatment, and intervention. The proposed criteria in total are depicted in Table 1.

Rather than take the deficit approach usually used in the field (focusing on risk factors and ignoring strengths), we choose to view these criteria on a continuum. Thus for each criteria, we consider how a strength or risk concern may affect the safety of children.

There is an important distinction to be made between risk and safety. A child may be at risk of maltreatment at some time in the future, yet be safe from an immediate threat of serious harm.

Child-Related Assessment Areas

Three domains of consensus were found related to children in the home: (1) age of child, (2) vulnerability due to physical/mental abilities, and (3) basic needs. Each of these elements can increase or decrease children's risk of maltreatment.

Age. The child's developmental stage is a critical factor in risk assessment. The younger children are, the less able they are to protect themselves or tell others that they are being abused or neglected. Furthermore, because younger children are more dependent upon their caregivers to meet all of their needs, the consequences of maltreatment at younger ages are more likely to be severe and life threatening.

Mental and physical abilities of the child. Children's mental and physical abilities must be considered along with their chronological age. Children who are developmentally delayed are often less able to protect themselves or to communicate effectively with others. This criterion also entails the assessment of the physical and emotional consequences of maltreatment. A sexually abused child who is experiencing night terrors may be more vulnerable than one who is not experiencing such extreme consequences. Safety decisions should involve assessment of mental and physical abilities, and of the emotional effects of prior maltreatment.

Basic needs. The safety evaluation models and research agreed that a child who suffers serious harmful consequences due to not being fed, appropriately dressed for the weather, or provided adequate shelter, needs an immediate safety plan. However, basic needs must be viewed in terms of minimum standards. Worn but seasonally appropriate clothes are not considered a risk to safety. A child not being fed at all, but given small amounts of alcohol or drugs to suppress his/her hunger and crying, is in a dangerous situation. A family's ability to provide for the basic needs of a child is considered a strength, despite other problems that may be evident.

Parent-Related Assessment Areas

According to one review of the literature, parent-related problems were precipitating factors in 75% to 80% of all foster family placement cases (Kadushin and Martin, 1988, p. 358). In our review, two parent-related areas of assessment had almost complete unanimity among the research and the models: (1) parents' ability to control their behavior, and (2) their basic parenting knowledge and skill.

Control of parental behavior. A number of factors are grouped under this criterion. For example, parents or caregivers who have a history of violent behavior, serious mental health problems, and/or substance abuse problems pose a significant jeopardy to children if the effect of this behavior is not controlled. Substance-abusing parents often pose a great risk to children because the parents may be so self-consumed that they rarely consider their children's needs. Similarly, a parent out of control due to schizophrenia will not be able to provide a protective environment. Again, however, these areas must be evaluated on a continuum. If a parent is mentally ill but able and willing to control his or her behavior through medication, then this criterion should be assessed more positively.

Parenting knowledge, skills, and motivation. Caregivers' capacity to meet the basic physical and psychosocial needs of their children largely determines their children's safety. An intellectually impaired parent who cannot be taught to make sure a newborn takes an established amount of formula everyday poses a serious and immediate threat of harm to this infant. At the other end of the continuum, it is a strength when parents understand what to expect developmentally from their children and are motivated to learn appropriate parenting knowledge and skills.

Family/Environment-Related Assessment Areas

Consensus exists across the research and models about three areas of assessment in the family/environment: (1) level of family conflict/stress, (2) social support network, and (3) availability of a protector for the child.

Level of family conflict or stress. Children's safety may be endangered when there is either serious crisis or chronic stress within the family. Assessment of the level of stress should take into account such factors as socio-economic status, housing, number of children, violence between family members, birth of a child, and loss of a job.

Social support network of families. Families who are connected to community organizations, churches, extended families, and friendship

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MEDICINE
Abdominal Injuries In Child Abuse

—by Dirk Huyer

Major blunt abdominal trauma due to child abuse is a serious, if infrequent form of morbidity and mortality in childhood (Cooper et al., 1988). The vast majority of abusive abdominal injuries result from blunt trauma, with penetrating injuries being much less common, although a recent increase has been reported (Ramenofsky, 1987). Several authors (Caniano, Beaver, & Boles, 1986; Cooper et al., 1988; Kirks, 1983) have reported between 0.5 and 2.0% and one study (O'Neill et al., 1973) found that 8% of physically abused children suffer serious abdominal injury, with 40-50% mortality (Cooper et al., 1988; McCort & Vaudagna, 1964; Sivit, Taylor & Eichelberger, 1989; Touloukian, 1968). Abdominal injuries are second only to head injuries in causing death in inflicted childhood trauma (Cooper, 1992; Ledbetter et al., 1988). Inflicted trauma accounts for 1-11% of all presentations of abdominal trauma in childhood injury (Cywes et al., 1990; Gornall et al., 1972; Ledbetter et al., 1988). Pediatricians practicing in the field of child maltreatment need to know how to discriminate reliably between inflicted and accidental abdominal trauma.

Abdominal injuries are second only to head injuries in causing death in inflicted childhood trauma.

The high mortality rate in cases of inflicted abdominal trauma is due to a variety of factors. Perpetrators are usually aware that the child is injured but fail to seek prompt medical attention because of fear of self-incrimination or lack of understanding of the seriousness of the injury. While caretakers are waiting, watching, and hoping for improvement, deterioration to a critical state may result, such as severe peritonitis and septic shock secondary to intestinal perforation or hemorrhagic shock secondary to liver laceration. Further delay in diagnosis occurs because inaccurate or misleading histories are provided. The history is often the most important component guiding the physician in planning investigation and treatment. When historical information is absent or unclear, a high index of suspicion is required. Children who suffer abdominal injuries are often preverbal (24 months +/- 12 months) (Cooper et al., 1988) limiting additional information collection. Older children may be too ill or fearful of further injury if they speak of the incident.

A child's abdomen is relatively small, with the organs in close proximity. A single abdominal blow may injure more than one organ, with greater consequences than in an adult.

Mortality rates are also high because of unique anatomical and physiologic features of children. A child's abdomen is relatively small, with the organs in close proximity. A single abdominal blow may injure more than one organ, with greater consequences than in an adult. The abdominal wall offers limited protection from external trauma because the muscles are less developed and only a small layer of fat is present. The ribs are flexible, with the lower rib cage only covering a small portion of the upper abdomen because of the widely spread costal margins. Finally, significant difficulties may occur from hemorrhagic injuries because of smaller blood volumes and the proportionately larger size of pediatric organs (Cooper, 1992).

Blunt abdominal injuries result when forces are produced (1) from direct blows, such as a punch or a kick, or (2) from indirect shearing forces generated during rapid deceleration of the body, as when a child is thrown across a room. Direct blows crush organs against the immobile vertebral column or the lower rib cage with resultant laceration and hemorrhage. The hollow visceral organs (the stomach and intestine) are filled with food, liquid, air, or stool. A direct blow compresses the contents, leading to sudden overdistension with rupture spilling the contents into the abdominal cavity. With rapid deceleration of the body, internal partially mobile organs continue in motion with resultant tearing of the intestinal mesentery (Haller, 1966).

When evaluating abusive injuries, questions arise about the amount of force required to produce the injury and the means by which this force was applied. A description of accidental forces required to cause similar injuries is helpful. The literature on accidental abdominal injuries suggests that significant violent force is required to cause a life-threatening abdominal injury.

In a South African study of 732 abdominal organ injuries, motor vehicle accidents accounted for 85% of the accidental injuries (88% motor vehicle/pedestrian accidents, 11.5% passengers, 0.5% cyclists), while falls from a height accounted for 12.5%, and sporting injuries accounted for most of the remainder (Cywes et al., 1990). A Seattle study of 139 accidental abdominal organ injuries in children found motor vehicle accidents accounted for 70% of the accidental injuries (57% pedestrians, 17% passengers, 20% cyclists, 6% motorcycle passengers), while falls accounted for 20%, followed by a number of other causes (contact sports, struck by a falling object, and being kicked by a farm animal) (Ledbetter et al., 1988). These accidental injuries in the Seattle study were described as high-velocity incidents with frequent coexistence of major associated injuries. Much of the 21% mortality in the accidentally injured children resulted from associated head injuries, with only two of the seven deaths in that group having isolated abdominal injury. In contrast, 53% mortality was present in the comparison group of 17 abused children, with eight of the nine who died having isolated abdominal injuries.

An additional study of children with abdominal injuries found four deaths, all with associated severe cranial or thoracic injuries, in a group of 69 accidentally injured children. In comparison, two of six abused children died with isolated abdominal

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injuries (Gornall et al., 1972). These studies illustrate that even with the degree of force generated in a high velocity motor vehicle accident, it is rare to see the death of a child from isolated abdominal injury. For an abdominal injury to cause death, a great deal of force must be applied specifically to the abdominal region.

Presentation of abusive vs. accidental injuries

In abusive abdominal injuries, common explanations for the child's condition include children falling (from bed, down stairs, from the couch), cessation of breathing, vomiting, trivial episodes of head trauma or no explanation (Cooper et al., 1988; Ledbetter et al., 1988). Presenting symptoms vary with the different organs involved; symptoms suggestive of individual organ damage will be discussed below. Boy victims outnumber girl victims, and the children are frequently about two years of age (accidentally injured children tend to be older, around 7.5 years of age). Major associated injuries are infrequent, whereas injury patterns typically seen in child abuse are often observed (65% of cases) (Ledbetter et al., 1988), such as occult skeletal injury, evidence of past burns or multiple bruises of different ages in different locations. Bruising of the abdominal wall is not a typical finding because the majority of the force resulting from abdominal blows is transmitted to the intra-abdominal organs.

In accidental abdominal trauma, single solid organ injuries are more frequently observed, whereas in abusive injuries hollow viscus injuries are more common, although overlap exists between the two. The kidney, spleen, and liver are the most frequently injured in accidents. In contrast, kidney and spleen injuries are infrequent in inflicted trauma, with the liver being the most common solid organ injured. Hollow viscus injuries are the most common finding in abuse, with the majority occurring in the proximal small intestine (the duodenum and the jejunum). Pancreatic and mesenteric injury are occasionally seen. Improved imaging studies coupled with increased awareness has shown that non-fatal abusive abdominal injuries may be more common than previously reported and at times asymptomatic (Coant et al., 1992; Hennes et al., 1990; Sivit, Taylor & Eichelberger, 1989). This is consistent with the discovery of other occult injuries as one of the classical findings in child abuse.

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Hollow viscus injury

Rupture of the stomach from abusive trauma has been reported (McCort & Vaudagna, 1964). Gastric rupture is more likely to occur in children who suffer direct blows soon after a large meal. The children present in serious condition and plain abdominal radiographs reveal substantial free intraperitoneal air. Immediate operative treatment is required.

Intestinal injuries are relatively common in children who suffer abusive injuries to the abdomen. The small intestine is the most common location for these injuries (Gornall et al., 1972; Ledbetter et al., 1988; McCort & Vaudagna, 1964). Perforations of the small intestine are seen most often in the jejunum (60%) with 30% in the duodenum and 10% in the ileum (Kleinman, 1987). The frequent finding of damage in the duodenum and the jejunum typically close to the Ligament of Trietz suggests that the proximal small intestine is more susceptible to compression injury because of its fixed location. Deceleration forces or direct local traumatic blows are likely responsible for intestinal injuries in those portions suspended by mesentery. Tearing of the mesenteric attachment may occur with hemorrhage from the contained vessels. Abnormal intestinal fixations such as postoperative adhesions may predispose for injury (Schimpl, Schmidt & Sauer, 1992).

The signs of intestinal perforation in a child are frequently subtle, with a variable delay in the appearance of symptoms (Fossum & Descheneaux, 1991; Ramenofsky, 1987). Mild abdominal tenderness may be the only initial sign, although fever, vomiting, abdominal distention, diminished bowel sounds and peritoneal signs may be observed. Pneumoperitoneum is seen on plain radiographs of the abdomen only in a minority of children with intestinal perforations (Brown et al., 1992; Bulas, Taylor & Eichelberger, 1989) because early sealing of the perforation may occur. If the patient is clinically stable, the most sensitive radiographic view to detect pneumoperitoneum is an upright chest film. A left lateral decubitus is next in sensitivity, followed by an upright abdominal view. CT scan may assist in establishing the diagnosis, although false negative examinations do occur (Bulas, Taylor & Eichelberger, 1989; Schimpl, Schmidt & Sauer, 1992). Discovery of intraperitoneal fluid on CT scan in cases of suspected abdominal trauma without evidence of other injury is suggestive of a sealed hollow viscus perforation. The most reliable indicator of perforation is repeated clinical examinations looking for the development of peritoneal irritation. Typically, abdominal signs will develop within hours.

Intramural hematomata of the intestine are frequently the result of inflicted abdominal injuries. Without definite history of blunt trauma to the upper abdomen, duodenal hematomata are highly suspicious for child abuse. Located in a fixed position close to the vertebral column, the duodenum is susceptible to crushing injuries with resultant intramural hematoma (Woolley, Mahour & Sloan, 1978). Blood leaks from the abundant vasculature between the layers of the wall, producing an intramural

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hematoma which encroaches into the intestinal lumen with variable degrees of obstruction.

The clinical picture is one of vomiting, often bilious vomiting (dehydration may occur), abdominal pain, and tenderness without other observable abnormality. Appearance of symptoms is typically delayed following the injury with delays of 1 hour to 2.5 days reported (Pokorny, Brandt & Harberg, 1986; Woolley, Mahour & Sloan, 1978). Abdominal bruising and masses are infrequent. Blood loss may be significant. Coagulation defects should be considered. Because of the close association of the pancreas with the duodenum, concurrent injury is not uncommon and blood and urinary amylase levels should be measured.

The literature on accidental abdominal injuries suggests that significant violent force is required to cause a life-threatening abdominal injury.

Plain films of the abdomen will frequently be normal, although significant dilation of the stomach may be observed. Upper GI (gastrointestinal) series is the gold standard for diagnosis. A large smooth rounded intramural mass in the lateral wall of the duodenum encroaching on the lumen is typically outlined by the contrast material (Kleinman, 1987). With passage of contrast material a "coiled spring" appearance is frequently seen. This results from trapping of contrast material in the mucosal folds adjacent to the hematoma. Ultrasound (Orel et al., 1988) and CT scans may demonstrate an intramural hematoma but an upper GI series should be done for confirmation. Kleinman has documented characteristic radiological features which may persist following symptomatic improvement in children with duodenal hematoma. He recommends completion of an upper GI series in children who were suspected to have abusive abdominal injury despite symptom resolution (Kleinman, Brill & Winchester, 1986).

Hematoma of the intestine distal to the Ligament of Trietz are typically located at the mesenteric borders frequently with accompanying mesenteric hemorrhage.

Pancreatic injuries

Pancreatitis in children is unusual and should raise the question of trauma (Slovis et al., 1975). Because the organ is deeply situated in the abdomen, injury is uncommon, although its fixed position immediately anterior to the vertebral column makes it susceptible to deep crushing injuries. Isolated accidental pancreatic injuries have been reported following falls onto small objects such as bicycle handlebars (Dahman & Stephens, 1981; Sparnon & Ford, 1986; Young & Adams, 1967). A review of 27 cases of children suffering abdominal injuries after being accidentally run over by cars revealed elevation of serum amylase in only one (Chadwick, Merten & Reece, 1994), indicating the level of force required to cause traumatic pancreatic injury. Frequently, other organs in the proximity are injured and evaluation of these should also be undertaken.

Pancreatitis occurs following tissue injury with release of pancreatic enzymes. These enzymes digest the organ with resultant hemorrhage and edema. Severe pancreatic trauma may result in complete transection of a portion of the organ (Cooper, 1992; Grosfeld & Cooney, 1975). Medical causes of pancreatitis should be considered, including gallstones, hyperlipidemia, hypercalcemia, viral infections, and medication reactions (Cooney & Grosfeld, 1975; Hartley, 1967).

Clinically, abdominal pain, vomiting, and fever are seen. These symptoms may gradually develop after the injury, leading to occasional delay in presentation. Epigastric tenderness with an accompanying abdominal mass may be found. Serum and urine amylase levels are significantly elevated. With severe traumatic transections chemical peritonitis may result with serious clinical implications.

Pancreatic pseudocysts are collections of pancreatic juice in and around the pancreas which are confined by non-epithelialized capsules of fibrous and granulation tissue. Most pseudocysts in the pediatric age group arise after blunt trauma to the abdomen (Burnweit et al., 1990; Cooney & Grosfeld, 1975; Kilman et al., 1964; Pena & Medovy, 1973; Pokorny, Raffensperger & Harberg, 1980). Abdominal pain, fever, vomiting, elevation of the urinary and serum amylase levels, and the presence of an abdominal mass are the presenting clinical features. The time interval between injury and diagnosis varies between 6 days and 16 weeks (Cooney & Grosfeld, 1975; Pokorny, Raffensperger & Harberg, 1980; Sparnon & Ford, 1986).

In acute pancreatitis, ultrasound often reveals enlargement of the gland owing to edema (Kleinman, 1987). Ultrasound allows noninvasive repetitive evaluation of pancreatic size and early diagnosis of pseudocyst formation (Kleinman, 1987; Slovis, VonBerg & Mikelic, 1980). Spontaneous resolution of pseudocysts occurs and is well documented with ultrasound (Burnweit et al., 1990; Slovis, VonBerg & Mikelic, 1980). Computed tomography of the abdomen clearly delineates the pancreas and any accompanying pseudocysts. Advantages of ultrasound in abdominal imaging are the lower cost, the mobility, and the lack of radiation (Kleinman, 1987; Luks et al., 1993). Disadvantages of use in imaging of the upper abdomen include interference of the image by ribs, intestinal gas, and air in the stomach (Kane et al., 1988; Kaufman et al., 1984; Slovis, VonBerg & Mikelic, 1980).

Liver injuries

The liver is the most commonly injured solid organ in cases of inflicted abdominal trauma (Coant et al., 1992; Cooper, 1992). The organ is injured by a direct crushing blow, although decelerating injuries

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also occur. Lacerations of the liver parenchyma result from direct trauma with resultant hemorrhage. Decelerating injuries may result in damage to areas of ligamentous attachment with vascular disruption. Vascular injury and significant parenchymal lacerations may lead to serious blood loss and death prior to hospital arrival. As previously noted the child's clinical condition may be further compromised by delay in seeking medical attention. Intrahepatic and subcapsular hematoma are often small and may result in little blood loss (Bass et al., 1984). Bile duct injury has been reported (Gornall et al. 1972; Oldham et al., 1986). In accidental abdominal injuries the right lobe is frequently injured in contrast to the frequent left lobe injury in abusive trauma (Coant et al., 1992). This finding likely represents trauma from anterior abusive blows. Mild hepatic injuries may heal within one week, while more severe hepatic injuries may continue healing for many months (Bulas et al., 1993).

In cases of serious liver injury the child will present in shock with marked intraperitoneal bleeding. Abdominal distention may be found as well as decreased or absent bowel sounds. Pain in the upper right abdomen coupled with tender enlargement of the liver may be observed if the child is conscious without other significant intra-abdominal injury. Minor liver injuries may remain asymptomatic (Bulas et al., 1993; Coant et al., 1992; Cooper, 1992; Sivit, Taylor & Eichelberger, 1989).

Evaluation of liver function tests as predictors of liver injuries has been done for three reasons: 1. physical examinations are often unreliable in children with multiple injuries, and in the unconscious child, 2. less severe liver injuries are often unsuspected on clinical grounds, 3. biochemical testing is cheaper and readily available as compared with CT scans (Coant et al, 1992; Hennes et al., 1990; Oldham et al., 1986). In one study of 53 children who had suffered blunt liver injury, elevations of SGOT (AST) greater than 200 IU coupled with SGPT (ALT) levels greater than 100 IU resulted in a 61% probability of discovering a liver injury by CT scan. No children with liver enzymes below these levels had demonstrable liver injury (Oldham et al., 1986). Alkaline phosphatase levels are often normal in cases of blunt liver trauma (Cywes, Rode & Millar, 1985). Another study of 43 hemodynamically stable children with blunt abdominal trauma revealed that SGOT levels greater than 450 IU coupled with SGPT levels greater than 250 IU identified all of the patients with hepatic injury detected on CT scan (Hennes et al., 1990). Two patients had elevations without CT scan evidence of hepatic injury. Finally, liver function tests were collected from 49 cases of suspected child abuse who did not have clinical signs of abdominal injury. Four of the children had elevated liver transaminases with CT scan confirmation of liver injury present in three patients (6% of the total sample) (Coant et al., 1992). Only one of the four had elevation of the alkaline phosphatase. The elevation of the transaminases appears transient, with normalization within days. Use of enzymes may therefore be useful adjuncts in evaluation of the physically abused child both with and without suspicion of abdominal injury.

In accidental abdominal trauma, single solid organ injuries are more frequently observed, whereas in abusive injuries hollow viscus injuries are more common, although overlap exists between the two.

Plain abdominal radiographs may demonstrate gross abnormalities in the liver size and shape as well as rib fractures. Computed tomography is the most sensitive non invasive technique to assess for hepatic injury (Kleinman, 1987). Advantages include: 1. superior anatomic detail, 2. the ability to survey the entire abdomen and retroperitoneum, 3. the ability to detect small amounts of intraperitoneal blood or gas, 4. the ability clearly to visualize bony abnormalities, and 5. the ability to assess vascular integrity of intra-abdominal organs with contrast enhancement (Kane et al., 1988; Kaufman et al., 1984). Scintigraphy in the form of liver-spleen scanning was previously used to assess for injury but anatomical detail is poor (Kane et al., 1988; Kleinman, 1987). Ultrasound may identify hepatic hematoma but often misses small lacerations, although it has proven useful in following progression of liver lesions (Cywes, Rode & Millar, 1985; Kleinman, 1987).

Kidney and spleen injuries

The kidneys are the second most commonly injured solid organ in abusive abdominal trauma. These likely result from direct blows to the flanks as well as decelerating forces (Cooper, 1992). Injury may be 1. minor, such as local contusions or intracapsular lacerations, 2. major, with parenchymal damage and capsular tearing or parenchymal lacerations with extension into the collecting system, and 3. critical, involving fragmentation of the kidney or vessel damage (Kirks, 1983). Children may present with flank pain and tenderness with an accompanying mass and external bruising. Hematuria is generally present in cases of renal trauma and the quantity of blood may be predictive of the seriousness of injury (Stalker, Kaufman & Stedje, 1990).

CT scans reveal the range of renal abnormalities, delineating the extent of parenchymal damage, perirenal hematoma, extravasation of urine and renal vascular damage. Ultrasound and intravenous pyelography also have a role in imaging of renal injuries.

Splenic injuries, while common in accidental abdominal injuries, are uncommon in abusive injuries. Left upper quadrant pain and tenderness will likely be present often accompanied by left shoulder referred pain. Plain films may document rib frac-

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WASHINGTON UPDATE

Crime Bill Contains Provisions Relevant To Child Maltreatment

—by Tom Birch

The crime bill provisions that passed the U.S. Congress before its August recess contains many provisions relevant to professionals in the field of child maltreatment.

Prevention

Among the crime prevention programs aimed at working with children and youth are the following:

- *Ounce of Prevention:* Establishes a federal interdepartmental Ounce of Prevention Council to coordinate crime prevention programs and award $88.5 million in grants over five years for crime prevention efforts, including outreach programs for at-risk families, summer and after-school education and recreation programs, mentoring, job placement, and prevention and treatment programs to reduce substance abuse, child abuse, and adolescent pregnancy.
- *Local Crime Prevention Block Grant Program:* Authorizes Department of Justice (DOJ) to award $377 million over five years to local governments for a variety of crime prevention activities. including juvenile gang and juvenile violence and substance abuse prevention; prevention of crimes against the elderly; services to children to prevent gang activity; employment opportunities for young adults; midnight sports leagues; sports and recreation programs; youth anticrime councils; establishment of Boys and Girls Clubs in public housing; supervised visitation centers to protect children from violence who are in shared custody or foster care; family outreach teams for training in mentoring and community organizing; and law enforcement and child services teams to respond to violent incidents involving a child as perpetrator, witness, or victim.
- *Community Schools Youth Services and Supervision Grant Program:* Provides Department of Education grants to community-based organizations for after-school, weekend, and summer sports, extracurricular and academic programs: and Family and Community Endeavor Schools Grant Program: Provides Department of Education grants to communities with high rates of poverty and crime to support programs for at-risk youth, including homework assistance, nutrition services, mentoring, family counseling, and parental training. Authorizes a total of $913.5 million in grants over five years for the two programs.
- *Delinquent and At-risk Youth:* Authorizes $36 million over five years in DOJ grants for residential services to youth in preventing crimes and delinquent activities.
- *Local Partnership Acts:* Authorizes the Department of Housing and Urban Development (HUD) to award $1.62 billion over five years in grants to local governments for variety of programs identified under existing statutory authorities, including drug abuse education, national youth sports program, community service act, Head Start, literacy, vocational education, runaway and homeless youth, transitional living for homeless youth, family violence, and the community-based family resource programs.
- *Family Unity Demonstration Project:* Authorizes $19.8 million over five years to DOJ for competitive grants to states to support projects that enable parental offenders to live in community correctional facilities with their children.
- *Prevention of Sexual Abuse and Exploitation:* Authorizes $30 billion for FY96-98 for Runaway and Homeless Youth Act grants to private, nonprofit agencies for street-based outreach and education for runaway and homeless youth subjected to or at risk of sexual abuse.

Domestic Violence:

The crime bill's focus on domestic violence prevention and intervention efforts includes these provisions:

- *National domestic violence hotline:* Authorizes $1 million in FY95 and $400,000 annually in FY96 to FY2000 for a grant from HHS to a private, nonprofit organization to operate a national toll-free hotline for information and assistance to victims of domestic violence.
- *Youth education and domestic violence:* Authorizes $400,000 in FY96 for four model school programs to educate young people about domestic violence.
- *Community Programs on Domestic Violence:* Amends the Family Violence Prevention and Services Act, authorizing $4 million in FY96 and $6 million in FY97 in HHS demonstration grants to nonprofit groups to establish community coordination projects for the intervention and prevention of domestic violence, including among others "human services entities such as State child services division." The project will include a community action component to improve and expand current intervention and prevention strategies.
- *Rural domestic violence and child abuse enforcement:* Authorizes $30 million over FY96-98 in DOJ grants to state and local governments and public and private agencies in rural states to establish cooperative efforts for investigating and prosecuting domestic violence and child abuse, to treat and counsel victims, and to develop community education and prevention programs.

Criminal Justice

Among the criminal justice provisions in the bill are several addressing issues of youth in crime,

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Washington Update

-by Tom Birch

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as perpetrators or victims:

- *Capital punishment for child molestation murders:* Imposes the death penalty for child molestation murders and sexual exploitation of children that ends in death.
- *Youth handgun safety:* Prohibits possession, sale or transfer of a hand gun or ammunition by or to a juvenile.
- *Prohibition of Firearms Sale to Child Abuser:* Prohibits sale of firearms to anyone under a restraining order for child abuse or domestic violence.
- *Jacob Watterling Crimes Against Children Registration Act:* Requires persons convicted of certain criminal offense against minors to register a current address with the state law enforcement agency for ten years after release from prison or being placed on parole. Crimes include kidnapping, false imprisonment, criminal sexual conduct, and the solicitation of minors for sexual purposes.
- *Morgan P. Hardiman Task Force on Missing and Exploited Children Act:* Establishes a task force of federal agency law enforcement officers to work with the National Center on Missing and Exploited Children in coordinating federal law enforcement resources to help investigate difficult cases of missing children.
- *Right of victim of sexual abuse to address court:* Affirms belief of the Senate that states should allow a victim of violence or sexual abuse, or the victim's parents or family members, to speak at the offender's sentencing hearing or parole hearing.
- *Admissibility of evidence of similar crimes in sex offense cases:* Expands the Federal Rules of Evidence to admit evidence of similar crimes in criminal and civil cases of sexual assault or child molestation.
- *Child abuse statute of limitations:* Amends U.S. Code to allow prosecution for an offense involving the sexual or physical abuse of a child under age 18 at any time before the child reaches 25.

Religious Exemptions

The fiscal 1995 appropriations legislation for the Department of Health and Human Services (HHS) passed the Senate in August. The Senate bill drops the House appropriations provisions that would force HHS to let parents use any non-medical means to treat the health care needs of their children reversing the status quo in the Child Abuse Prevention and Treatment Act (CAPTA). The Senate version of the bill defers the religious exemption issue to the authorizing committees, which will take up CAPTA next year in the course of reauthorizing the statute.

A House-Senate conference committee will meet after Labor Day to settle on legislative language about HHS requirements that states intervene in cases of medical neglect where religious issues are involved. Assurances from congressional staff advise that the conference will adopt the Senate position on this matter.

NCCAN User Manuals

NCCAN has published additional user manuals in its series initated in 1977 to guide professionals in the treatment and prevention of child abuse and neglect. Because of the increase in knowledge and improvements in practice since the series was first developed, existing manuals have been revised and new ones created. Recent additions to the series include the following:

- **Protecting Children in Substance-Abusing Families** is designed for professionals in child welfare, mental health, health care, education, law, the faith community, and substance abuse prevention and treatment. The manuals are intended to help identify various forms of parental substance abuse, assess the strengths and needs of the affected families, develop service plans, and provide intervention.
- **Substitute Care Providers: Helping Abused and Neglected Children** is aimed primarily at child welfare staff as a foundation for serving abused and neglected children in family foster care and adoption. The manual is also intended for child protective services staff, law enforcement, mental health, legal, health care, and early childhood professionals.
- **Supervising Child Protective Services Caseworkers** describes the roles and responsibilities of the CPS supervisor. This publication, is an update of a similarly titled manual published in 1979, is designed primarily for CPS supervisors and administrators, but it is relevant to all child welfare supervisors.

Information on the availability and ordering of the manuals may be obtained by contacting: Clearinghouse on Child Abuse and Neglect Information, P.O. Box 1182, Washington DC 20013, Phone 703-385-7565 or 800-FYI-3366.

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

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.

STATE CHAPTER NEWS

Indiana Chapter Brings Official Chapter Count to 28

—by Claudia Soldano

Thanks to APSAC members' commitment of untold volunteer hours, we are well on our way to achieving the goal of having a viable chapter in every state by the year 2000. Our latest addition to the official chapter ranks (now twenty-eight and counting) is the **Indiana** chapter (**APSAC-IN**). Officers are **Diane Burks, Kelly Benedict, Gloria Hood, Sheila Timms, Vicki Smith, and Julia Sanders**. Congratulations and thanks to these professionals and their colleagues for working so hard to establish an organization that will give professionals in Indiana a vital "hub" around which to meet and work.

Plans are underway to the highlight chapters' achievements and expertise at APSAC's Third National Colloquium in Tucson, Arizona, June 7-11, 1995. Chapter leaders will participate as presenters for the State Chapter Training, to be held on June 7, and members from across the country will display their chapter's accomplishments. Everyone involved in or interested in chapter formation is urged to attend this daylong training.

Chapter Highlights

Our chapters have been busy organizing members into active task forces and working groups, providing educational meetings, and producing regular newsletters.

- Members of the **Alabama** chapter (**ALPSAC**) held their first annual meeting in conjunction with the 10th National Symposium on Sexual Abuse in Huntsville. The event was a great success, with the membership hearing from APSAC Board member Harry Elias, JD. The chapter will hold a fall membership meeting on November 5th at the Gulf Shores Holiday Inn. A special room rate is available for ALPSAC members. Contact Michael Taylor (205-348-1309) or Pat Guyton (205-432-1101) for more details.
- **AZPSAC**, the Arizona chapter, will hold its second conference, ***"Voices for the Children: A Multidisciplinary Conference on Child Maltreatment,"*** September 23-24, with a distinguished national and local faculty.
- Our **California** and **Arizona** chapters (**CAPSAC** and **AZPSAC**) are providing invaluable assistance in the program and logistical planning of APSAC's Second National Colloquium. The presidents of both chapters are on the planning committee, and are providing program and logistical suggestions, mailing lists, and other support.
- The **Kentucky** chapter (**KYPSAC**) has been working on the education of state legislators on the issue of child sexual abuse as they consider legislative packages this year.
- **Minnesota** members (**MNPSAC**) are hosting a two-day conference, October 5th-7th, on the legal issues in child sexual abuse. A pre-conference seminar on juvenile sexual offenders and interviewing young children will complement the general conference topics. John Meyers, JD, and Lucy Berliner, MSW, will be featured presenters.
- The **Nebraska** members of APSAC are using the upcoming satellite conferences sponsored by the National Training Program on Effective Treatment Approaches in Child Sexual Abuse (NTPETA-CSA) as a chapter formation activity. They will host the three sessions scheduled in October and use the opportunity to discuss membership in APSAC and a Nebraska chapter.
- **New Jersey** members made clear their interest in establishing a chapter over the summer and are busy mustering the support of their colleagues. Their first official organizing meeting takes place on the 28th of September.
- Educational opportunities are plentiful through our **North Carolina** chapter (**NCPSAC**). The member workshop held in June was entitled ***"Multidisciplinary Investigation."*** For the fall, a session on the ***"Dynamics of Abusing Families"*** is scheduled for September.
- Members in **Northern New England** (**Maine, New Hampshire and Vermont**) can look forward to the fall **NNEPSAC** membership meeting on September 23rd in Portland, Maine. A clinical roundtable discussion of the roles of therapist and evaluator in child abuse cases will be followed by a presentation by Martha Strauss, PhD, on the development of children who live with battered mothers. The meeting will take place at the Maine Medical Center.
- **Tennessee** members (**TAPSAC**) will be very active this fall, first by sponsoring three sites for the NTPETA-CSA teleconference across the state. Volunteers will handle the publicity and registration for the October events. On November 21st-23rd, TAPSAC will offer discounts to APSAC members for the ***"Sixth Annual Statewide Conference on Child Maltreatment: Networking in the '90's"*** in Nashville. Contact Judith Brown at 901-525-2377 for more information.
- The **Texas** chapter (**TPSAC**) held a general information and membership meeting in conjunction with the Crimes Against Children seminar, August 31st in Dallas. The conference focused on the child maltreatment issues confronting law enforcement personnel.
- Members of the **Virginia** chapter meeting (**VAPSAC**) will be holding an organizing meeting on September 16th for interested members and non-members which will include a presentation entitled "How to Impact the Legislative Process." For information contact Mim Golub Scanlin at 804-264-1026.
- The next **Washington** chapter meeting (**APSAC-WA**), to be held on September 23rd, will include a presentation entitled "Ethical Issues in Mandatory Reporting."

For information on any of these or other chapter activities, please contact the chapter representative listed, or consult the following page of chapter contacts to reach the chapter liaison in your state.

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 - ***Jan Church, PhD***
Arkansas Children's Hospital
Department of Pediatrics
800 Marshall Street
Little Rock AR 72202
501-320-3810

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***
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8551 W. Sunrise Blvd., Suite 206
Plantation FL 33322
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IL - ***Cheryl Wolf, MA***
KC-CASA
657 E. Court St.
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815-932-7273

IN - ***Diane Burks, MS***
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Lexington KY 40536
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Newton Highlands MA 02161
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MD - ***Gail Bethea-Jackson, LCSW***
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612-348-5094

NC - ***Erverine Henry, MSW***
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919-279-8955

NM - ***Caryl Trotter, MA***
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Albuquerque NM 87110
505-883-4373

NY - ***Jeanne Bell, JD***
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Croton on Hudson NY 12520
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212-966-6420

OH - ***Linda Lewin, RN***
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OK - ***Richard Kishur, PhD***
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OR - ***Robert Sewell, MD***
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Bellevue WA 98004
206-462-5130

WI - ***Mark Lyday, ACSW***
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NNEPSAC (Northern New England - ME, NH, VT)
Pat Cone, PhD
Assistant Professor, Dept of Psychiatry
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States still organizing:

DE - ***Robert Hall, MDiv***
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GA - ***Paul Cardozo, Ed.D.***
1150 Milledge Ave., #100
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BOOK REVIEWS

***Sexual abuse and consensual sex: Women's developmental patterns and outcomes*, by Gail Elizabeth Wyatt, Michael D. Newcomb, and Monika H. Rierdale. Sage Publications, 1993. 250 pp. $24.95 hardcover.**

-Reviewed by Teresa Johnston Sparrow and DeeAnna P. Merz

Sexual abuse and consensual sex provides a framework for exploring the wide range of women's sexual experience. Healthy and unhealthy sexual behavior and attitudes are examined, providing the reader with a gauge of appropriate and inappropriate experiences.

The insight in* Sexual abuse and consensual sex *was gained from an exhaustive study of a community sample of African-American and European-American women's consensual and abusive sexual experiences.

This book is divided into three sections, with a total of 19 chapters. Part I (Chapter 1) discusses effects of sexual abuse on women's sexual and psychological functioning. Various frameworks of the effects of rape are presented.

In section II, consisting of six chapters, a thorough analysis of sexual behavior is given. The difference between voluntary, consensual sexual experiences and abusive experiences of women is defined; both types of experiences are considered in light of a woman's lifespan.

Section III, with 12 chapters, is a broad analysis of the effects of sexual experiences on psychological and sexual functioning. Topics of interest include psychological well-being, sex guilt, sexual satisfaction, and implications. The final chapter gives action-oriented suggestions for intervention. Education is seen as primary in breaking the cycle of victimization.

The insight in *Sexual abuse and consensual sex* was gained from an exhaustive study of a community sample of African-American and European-American women's consensual and abusive and sexual experiences. The fact that this book is based on one study distinguishes its style from other clinically-oriented books. Although the book reads like an extended professional journal article, the text is easy to follow. A complete statistical analysis is offered, along with implications for further research. In addition, a review and critique of existing literature is offered with each idea that is presented.

This book offers an excellent reference point for professionals exploring women's sexuality. Because the research is based on a community sample, results and implications may be more easily generalized to the overall population. Watt, Newcomb, and Riederle provide a much-appreciated addition to the body of literature currently available concerning women's issues of sexuality.

Teresa Johnston Sparrow, M Ed, CRC and DeeAnna P. Merz, M Ed, CRC are consultants with the McKinley Group, Inc., Decatur, Georgia specializing in abuse issue as related to people with disabilities.

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***Trauma and recovery*, by Judith Lewis Herman. Basic Books, 1992. $14.00, softcover, $29.95 hardcover.**

-Reviewed by Holly Ramsey-Klawsnik

Trauma and recovery is a powerful, clear and compelling description of the effects of traumatic events of human design on those victimized and on those who attempt to assist victims. The book is organized into two major parts. The first discusses the "forgotten history" of the study of trauma, including the study of hysteria, combat neurosis, and sexual and domestic violence. Herman traces the history of these lines of research which have been accomplished, and subsequently forgotten by a society which finds it easier to dismiss acts of human cruelty than explore them.

Traumatic symptoms, including hyperarousal, intrusive experiences, and constriction, which are inflicted by child abuse, domestic violence, rape, combat, and political terror are discussed. Herman demonstrates the ways in which these diverse terrors similarly affect the human psyche. She delineates the limitations of the present diagnostic system in defining and dealing with the effects of these traumas. Also discussed is diagnostic mislabeling and the historic tendency of the mental health system to blame victims for the difficulties which they experience.

The second part of the book discusses the process of recovery from traumatic experiences, including the stages of establishing safety, reconstructing the trauma story and restoring the connection between survivors and their community. Diverse composite case examples illustrate the healing process. Clinicians are provided theoretical as well as practical guidance regarding the provision of individual and group therapy to trauma survivors.

The book offers two unique contributions. First is its elucidation of the similarities of seemingly disparate traumatic experiences, including those most commonly experienced by women (rape, battering, domestic violence) and those usually experienced by men (combat and political terrorism). The second unique contribution is Herman's formulation of a new diagnostic category for understanding and labeling the impact of prolonged, repeated trauma: Complex Post-Traumatic Stress Disorder. The limitations of the presently utilized diagnosis of Post-Traumatic Stress Disorder for explaining the impact of serious trauma are described.

The book is comprehensive and sophisticated, and provides the reader a solid, in-depth understanding of the impact of trauma on the victim. Herman also discusses the impact of the trauma on those who attempt to assist the victim. Her descriptions of traumatic transference and traumatic countertransference are insightful. Clinicians will also find

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Book Review

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valuable Herman's description of the healing process. Guidance is provided on the stages of recovery and therapy, approached to facilitate the survivor's advancement through these stages.

Trauma and recovery is scholarly and comprehensive, broad in scope, yet also specific in terms of providing clinical guidance. As a trauma therapist, I found the discussions of the impact of working with trauma victims to be especially valuable and validating. Herman's basic tenet is that terror and trauma disconnect the victim from the self and others, and that healing reconnects the victims to self and others, a sense of safety, and community. In Herman's words, "This is a book about restoring connections". Readers, even those quite sophisticated in trauma work, will gain new insights regarding the effects of human cruelty and the process of helping those victimized to regain a sense of worth and connection.

Trauma and recovery is a powerful, clear and compelling description of the effects of traumatic events of human design on those victimized and on those who attempt to assist victims.

Holly Ramsey-Klawsnik, PhD is a sociologist and licensed psychotherapist in private practice in Canton, MA, specializing in the assessment, treatment and study of family violence and sexual abuse.

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***Hurting for love: Munchasen Syndrome by Proxy*, by Herbert A. Schreier and Judith A. Libow. Guilford Press, 1993. 222 pp. $26.95 hardcover.**

This readable book is divided into three sections. The first four chapters define Munchausen Syndrome by Proxy, explain why it is so difficult to diagnose (and why clinicians are so reluctant to diagnose it), discuss the prevalence and varying presentation of symptoms, and assess the risk of misdiagnosis. This section is dominated by case example, references to the medical, sociological, and psychological literature, and a discussion of how care-providers are trained to ignore this potentially fatal disorder.

The second section, Chapter 5 through 8, is weaker, offering a psychoanalytic interpretation of the motivations and etiology of the disease. Readers who subscribe to the psychoanalytic perspective may find this section helpful; other practitioners are likely to be unconvinced at best.

Section Three, "Management of the Problem" is practical and useful for practitioners, administrators, consultants, and persons involved in the legal system. Again, it is peppered with references to relevant literature and illuminating case examples.

Overall, this reviewer found Hurting for love very helpful and informative, with the exception of the middle, theoretical section. It is highly recommended for medical, psychological, social work and legal audiences at all levels of training.

Melinda S. Warner, Ed D, is in private practice in Boston, MA.

COMING NEXT ISSUE

The Winter, 1994 issue of *The APSAC Advisor* will be a double Special Issue on Child Fatalities edited by Randell Alexander, MD, PhD. Among the articles to be published are these:

The view of the U.S. Advisory Board on Child Abuse and Neglect	Deanne Tilton Durfee
The history and status of child death review teams	Michael Durfee, MD
Child death review teams in action	Barbara Bonner, PhD(U.S.); Dirk Huyer, MD (Canada); Paul Tate, MD (Australia), and others
The spectrum of violence	Richard Gelles, PhD
Abusive head trauma	Wilbur Smith, MD
Abusive abdominal trauma	Seth Asser, MD
Forensic approaches to child fatalities	Hugh Wilson, MD
Fatal falls	David Chadwick, MD
Risk assessment and fatal child abuse	Susan Wells, PhD
Crisis intervention by CPS	Charles Wilson, MSSW
Law enforcement investigation of suspicious child death	Lt. Bill Walsh
Prosecuting fatal child abuse	Ryan Rainey, JD
Helping surviving siblings	Michelle Kelly, PhD, and Michael Durfee, MD
Preventing fatal child abuse	Deborah Daro, DSW, and Randell Alexander, MD, PhD

With an Introduction by U.S. Attorney General, Janet Reno.

JOURNAL HIGHLIGHTS

The purpose of Journal Highlights is to inform readers of current research on various aspects of child maltreatment. Selected articles from journals representing APSAC's multidisciplinary membership are represented in an annotated bibliography format. 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 or three sentence review, to Thomas F. Curran, MSW, JD, Child Advocacy Unit, Defender Association of Philadelphia, 121 N. Broad Street, Philadelphia, PA 19107-1913.

PHYSICAL ABUSE AND NEGLECT

Hegar, R.L., Zuravin, S.J., and Orme, J.G. (1994). Factors predicting severity of physical child abuse injury: A review of the literature. *Journal of Interpersonal Violence, 9*(2), 170-183.

This article reviews the research literature on predictors of severe and fatal physical abuse. Of the various factors relating to the victim, the perpetrator, and abuse reports, the only one found in this literature review to relate consistently to the severity of injury is the age of the child.

SEXUAL ABUSE

Abel, G. Lawry, S., Karlstrom, E., Osborn, C., and Gillespie, C. (1994). Screening tests for pedophilia. *Criminal Justice and Behavior, 21*(1), 115-131.

As one article in a special issue of Criminal Justice and Behavior edited by Robert A. Prentky on the assessment and treatment of sex offenders, this article reviews several clinical cases demonstrating typical patterns of how pedophiles victimize children within their places of employment, describes some of the screening symptoms currently in use by child-serving organizations, and discusses their limitations. The efficiency of a relatively new and less intrusive screening test for pedophilia, the Abel Screen, is reviewed, and compares favorably with phallometry in identifying those inclined toward sexual involvement with boys.

Cross, T., DeVos, E., and Whitcomb, D. (1994). Prosecution of child sexual abuse: Which cases are accepted? *Child Abuse and Neglect, 18*(8), 663-677.

This detailed study examines the relationships of case characteristics, maternal support, and child psychopathology to the acceptance of child sexual abuse cases for prosecution, and raises many questions for future research. In the single predictor analyses, acceptance for prosecution was significantly related to the child's age, the relationship between alleged perpetrator and child, severity of the allegation, availability of different forms of evidence, and how the case was disclosed and investigated. Penetration did not significantly increase the likelihood of acceptance for prosecution. The need to strengthen children's ability to testify and improve investigation practices is discussed.

Deblinger, E., Lippman, J., Stauffer, L. and Finkel, M. (1994). Personal versus professional responses to child sexual abuse allegations. *Child Abuse and Neglect, 18*(8). 679-682.

This preliminary investigation compares professional expectations of non-offending parents' responses during sexual abuse investigations with the professionals' personal responses to a hypothetical discovery that their own child had been sexually abused by a spouse or lover. The results find a discrepancy between the personal responses and professional expectations expressed by female professionals. No such divergence is indicated by the male respondents. An interesting discussion of professional role socialization and training is presented.

Elliott, D.M. and Smilijanich, K. (1994). Sex offending among juveniles: Development and response. *Journal of Pediatric Heath Care, 8*(3), 101-105.

Directed primarily at health care providers, this article supplies basic information on normal and aberrant sexual activity in children. Various characteristics and risk factors associated with juvenile sex offenders are examined, along with some treatment approaches.

Haywood, T.W. and Grossman, L.S. (1994). Denial of deviant sexual arousal and psychopathology in child molesters. *Behavior Therapy, 25*, 327-340.

Based on a sample of 116 men, 75 of whom were accused of molesting children, this study uses a subjective index of self-reported sexual interest known as the Pictorial Sexual Interest Card Sort (PSICS) and the MMPI to determine whether alleged offenders honestly report their sexual interests and whether this varies with self-reported symptoms of psychopathology. Results suggest caution in interpreting subjective self-reports of sexual interests by alleged child molesters who deny engaging in deviant behaviors. In addition, lower self-reports of deviant sexual arousal was significantly associated with minimization of psychopathology on the MMPI.

Herman-Giddens, M.E. (1994). Vaginal foreign bodies and child sexual abuse. *Archives of Pediatrics and Adolescent Medicine, 148*, 195-200.

A sample of twelve girls, ages ten and under, was examined to determine whether vaginal foreign bodies (VFBs) in prepubertal girls was associated with child sexual abuse. On examination, all the girls presented in the general pediatric clinic with vaginal discharges, and a total of 28 foreign bodies were removed from the total sample of twelve. Eleven of the girls were either suspected or confirmed victims of sexual abuse.

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Journal Highlights

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Hartman, G., Karlson, H., and Hibbard, R. (1994). Attorney attitudes regarding behaviors associated with child sexual abuse. *Child Abuse and Neglect, 18*(8), 657-662.

Two prosecutors and two defense attorneys from each county in Indiana were asked to complete a questionnaire indicating if they believed certain behaviors were acceptable, inappropriate, or sexual abuse if they occurred on one or on multiple occasions. Behaviors that weren't "obviously sexual" in nature weren't considered abusive by a majority of both groups, even if the behavior occurred on several occasions. Not surprisingly, defense attorneys were more likely to indicate behaviors as acceptable, regardless of their frequency. Prosecutors, on the other hand, were more likely to regard the behaviors in question as abusive or at least inappropriate. Cognitive dissonance theory is offered as one explanation for the groups' differences.

Hunter, J.A., and Becker J.V. (1994). The role of deviant sexual arousal in juvenile sexual offending: Etiology, evaluation, and treatment. *Criminal Justice and Behavior, 21*(1), 132-149.

This article reviews the construct of deviant sexual arousal and its application to understanding juvenile sexual offending. Studies relevant to the etiology of deviant juvenile sexual arousal are reviewed, along with efforts to alter such arousal patterns through cognitive-behavioral therapies. Noting that juvenile sex offenders are a heterogeneous group with diverse evaluation and treatment needs, the authors conclude that research to date suggests that deviant sexual arousal in juveniles can be changed and the risk of recidivism diminished.

Jenny, C., Roesler T., and Poyer, K. (1994). Are children at risk for sexual abuse by homosexuals? *Pediatrics, 94*(1), 41-44.

The hospital charts of 352 children referred for suspected child sexual abuse were reviewed to determine what percentage, if any, had been molested by someone who might have an identifiable homosexual orientation. In the 269 cases where sexual abuse was suspected, only two children (0.7%) were molested by someone identified as potentially homosexual or lesbian. Problems generated by efforts to establish an alleged offender's sexual orientation and the retrospective nature of this study are discussed. No evidence was produced from this study that children are at greater risk of sexual assault by identified homosexuals than by other adults.

Lodico, M.A. and DiClemente, R.J. (1994). The association between childhood sexual abuse and prevalence of HIV-Related risk behaviors. *Clinical Pediatrics, 33*(8) 498-502.

This study, with a sample of over 5,000 high school students from one state, examines the links between childhood sexual abuse and a wide range of HIV-related risk behaviors. Sexually abused adolescents were much more likely than their non-abused peers to report being sexually active. Neither sexually abused males nor females, however, were likely to change their sexual behaviors because of the risk of HIV or AIDS.

Mennen. F.E. and Meadow, D. (1994). A preliminary study of the factors related to trauma in childhood sexual abuse. *Journal of Family Violence, 9*(2), 125-142.

With a sample of 75 sexually abused girls, this study examines levels of depression, anxiety, and self-worth. Examination of certain abuse-specific variables produces some interesting and significant interactions. The abused girls' scores were much different from standardization samples, and none of the abuse predictor variables alone significantly affected outcome. For example, this study supported previous studies finding that neither duration of abuse nor age of the child when abuse began are, taken alone, significantly related to outcome.

OTHER ISSUES IN CHILD MALTREATMENT

DePanfilis, D. and Scannapieco, M. (1994). Assessing the safety of children at risk of maltreatment: Decision-making models. *Child Welfare, 73*(3), 229-245.

Ten child protective decision-making models are reviewed in this informative article. Results indicate that although some criteria overlap in these models, there are also very wide differences in definitions, purposes, and level of research support for the decision-making criteria being used.

Myers, J.E.B. (1993). Investigative interviews of children: Should they be videotaped? *Notre Dame Journal of Law, Ethics and Public Policy, 7*(2), 371-386.

This article presents some of the more popular arguments for and against videotaping investigative interviews of abused children. Arguments on both sides of this heated issue are discussed in an unbiased and clear manner.

Rorty, M., Yager, J. and Rossotto, E. (1994). Childhood sexual, physical and psychological abuse in bulimia nervosa. *American Journal of Psychiatry, 151*(8), 1122-1126.

This study sought to determine if rates of childhood sexual, physical, and psychological abuse differed between women with lifetime histories of bulimia and women with no history of eating disorders. As hypothesized, women with a lifetime history of bulimia reported higher rates of childhood abuse, especially physical and psychological abuse. Overall, the bulimic women were found to have experienced higher level of childhood trauma.

The Journal Highlights editor wishes to thank Marcia E. Herman-Giddens, PA, MPH, of the Duke University Medical Center, Duke Children's Hospital, for her contribution to this issue.

Cultural Issues

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they are investigating, they need to undergo a systematic process of educating themselves about the people they choose to investigate.

The first step in the process of developing a hypothesis is identifying clearly the cultural group to be studied. As articulated by Abney and Gunn (1993), the researcher needs to be clear about the distinctions between race, ethnicity, and culture, and about the subtlety of distinctions within and between groups. Distinctions by race are minimally useful: they identify differences based on common ancestry and genetic physical characteristics, but obscure the enormous variability within these groups. People referred to as "Blacks" are identified by skin color, hair texture, and facial features, yet have diverse cultural origins which span the globe (Wyatt, 1990). To include people of similar skin color in one category is to suggest that genetic similarities rather than culturally bound belief systems, customs, and behaviors are the predictors that best explain violence occurring in communities and families.

Whether or not researchers are members of the cultural group they are investigating, they need to undergo a systematic process of educating themselves about the people they choose to investigate.

"Ethnicity" is typically used to refer both to race and land of origin, but does not explicitly encompass the influence of culture. To identify subjects as "Latino" or "Hispanic," for instance, is to identify them by ethnicity, but not by culture. Individuals of Latino or Hispanic origin are more accurately described by terms such as "Mexican," "Cuban," "Puerto Rican," "Dominican," and "Guatemalan." All of these more specific ethnic groups have unique and highly structured cultural traditions. Yet these are still insufficient descriptors of individuals' *cultural* groups. Mexico is a country of 85 million people, with very diverse cultures, socioeconomic groups, values, and practices.

Since most research on violence focuses on learned behaviors and their environmental context (Yee, Fairchild, Weizman, & Wyatt, 1993), sensitive hypotheses will take culture specifically into account. "Culture" is the set of beliefs, attitudes, values, and standards of behavior that are passed from one generation to the next. Cultural variables include language, worldview, dress, food, styles of communication, notions of wellness, healing techniques, childrearing patterns, and self-identity (Abney & Gunn, 1993, 19-20).

Hypotheses may also take into account subjects' "embeddedness" in their culture, or their level of acculturation (i.e., the degree to which members of a group adhere to traditional cultural practices) (Berry, 1990). At a minimum, assessing acculturation entails collecting data concerning generational immigration status, ethnicity of peer associations, language use, celebration of traditional holidays, and religion and spirituality. It is also important to acquire information about education and socioeconomic status, as these are often mediators of an individual's cultural experience. Such information aids in addressing complex clinical research issues such as understanding ethnic identity among racially mixed children, or the impact of including them in studies that examine child maltreatment along with other ethnic minority children (Kerwin, Ponteroto, Jackson, & Harris, 1993; Root, 1992).

Bringing members of the group under study into the investigative process may be the most effective means of acquiring the contextual knowledge necessary to develop culturally relevant hypotheses. Some researchers have incorporated community organizations and developed culture-based focus groups as a means of guiding the development of investigative hypotheses (Newcomer, 1993). In fact, such groups and organizations may be a way to develop and ensure community cooperation through the investigative process (e.g., in acquiring human subjects' approval, recruiting subjects, addressing subject-related problems, interpreting results).

As a culturally sensitive hypothesis is being developed, researchers need to embark on a series of steps to implement culturally competent methodologies. These steps require amending traditional research methodologies in the process of designing studies, developing hypotheses, recruiting subjects, and collecting and interpreting data.

Study design

Traditional experimental or quasi-experimental designs may not be appropriate with people of color. Of particular concern are comparisons between ethnic groups and/or between an ethnic group and the majority culture as a means of explaining behavior, values, and cognitions. One of the problems in comparing ethnic groups to the majority culture (or to other ethnic groups) is that such comparisons support a perception of minorities as being deficient or less able in a particular psychological domain; that is, it supports a "deficit hypothesis" perspective (Katz, 1974). The assumption of the deficit hypothesis is that ethnic minority communities have for generations experienced economic and cultural deprivation that has resulted in several psychological (intellectual, characterological, and motivational) deficits. Historically, this "deficit hypothesis" has been implicit in and buttressed by studies which compare ethnic minority groups and majority groups on instruments which have been standardized on majority samples (Padilla & Wyatt, 1983).

Sue (1991) described three basic research designs which have been used with ethnic minority groups: point, linear, and parallel. *Point research* entails "isolated group comparisons on one construct or group of constructs derived from one culture" (p. 67). This design clearly lends itself to the support of the deficit hypothesis. Furthermore,

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Sue criticizes this design on the basis of the limited amount of information that can be acquired from taking only one reference point in making conclusions about a group under study, eliminating any broader cultural context as providing explanatory variables. In the area of physically abusive parent-child relationships, a practical example of point research would be to study one group of physically abusive parents, derive a hypothesis about the rigid and authoritarian parenting styles that contribute to their abusive behavior, then assess the rigidity and authoritarianism of abusive parents from another ethnic group.

Bringing members of the group under study into the investigative process may be the most effective means of acquiring the contextual knowledge necessary to develop culturally relevant hypotheses. Some researchers have incorporated community organizations and developed culture-based focus groups as a means of guiding the development of investigative hypotheses.

Linear research refers to a sequence of studies "aimed at systematically testing the set of hypotheses predicted by the theory underlying the single construct of interest" (p. 67). The linear research model utilizes two or more points of reference on which to compare cultural groups. However, the construct is still developed from a single perspective which is assumed to be normative or universal. In the example used above, linear research might examine the constructs of authoritarian parenting, child compliance, and family control to understand cultural differences in physically abusive parenting. This approach may provide greater information about the parenting styles of ethnic groups, but still clings to concepts of parenting and parent-child relationships that derive from the perspective of one (usually the dominant) cultural group.

Sue (1991) argues that research must "develop separate but interrelated ways of conceptualizing the behavioral phenomenon of interest, one based on a Western conceptualization, the other reflecting an ethnic minority interpretation" (p. 68). The third approach, a *parallel* research design, consists of utilizing two linear strategies which are developed from alternative cultural viewpoints. Using this design entails generating constructs of parent-child relations from observations and measures acquired from parents and children belonging to each specific cultural group. To return to our example, constructs such as authoritarian parenting style, child compliance, and family control may be relevant to one cultural group; may be relevant in a second, but in a different form; and may not be relevant at all in a third.

Differences between cultural groups may play an important part in understanding many phenomena. When research comparing cultural groups is undertaken, however, researchers should be scrupulous about designing parallel studies that avoid the deficit hypothesis and use constructs generated from within the context of the different cultural groups they are comparing. Clearly, researchers should never interpret results as evidence that one group is better or worse than another. Researchers should also ensure that other variables within and between samples are controlled (Wyatt, 1994). For example, educational or economic factors can confound results presumed to derive from cultural differences (Wyatt, 1991).

We suggest that investigators attempt to design studies as well which utilize an intra-ethnic perspective, rather than making comparisons between ethnic groups. The intra-ethnic approach acknowledges that there is as much or more variation within ethnic groups as there is between ethnic groups, and encourages researchers to discuss and explain their findings from within the context of the culture. Furthermore, research is desirable that focuses on group strengths and competencies, rather than on problems or weaknesses. For example, rather than examining cultural family factors which predispose a child to be victimized (e.g., low SES, single-parent family, parental history of victimization), it may be more valuable to identify factors which appear to protect children (e.g., extended social and family contacts, participation in church-based activities).

Subject recruitment

One of the more difficult aspects of conducting clinical research with people of color is recruiting subjects. Often, cultural groups are not familiar with traditional scientific methods of subject recruitment and/or participation in a research project. They may not have an understanding of recruitment strategies and/or they may not value strategies commonly used by clinical researchers (e.g., telephone surveys, door-to-door community interviews, and advertisements in newspapers). Requests to participate may be viewed with suspicion, as not relevant to their daily lives, or as a possible threat or source of danger (Sue & Sue, 1972). Additionally, subjects may view a researcher who inquires about personal and private family matters as offensively intrusive, especially when the topic of investigation involves strongly culture-bound issues such as parent-child relationships, the use of physical punishment, discipline, family violence, and sexual behaviors and beliefs. To overcome some of these problems, it may be important to employ alternative strategies to contact and acquire ethnic minority research subjects. Unfortunately, such strategies often require extensive efforts on the part of researchers, which typically translates into the need for supplemental sources of research funding.

A fundamental requirement of this process is for researchers to leave the confines of their laboratories and universities, and "step into" the community they are seeking to understand. Researchers must develop thorough familiarity with the commu-

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nity and culture they wish to investigate, and must acquire some level of permission and acceptance by the community. As suggested above, involving the community—for example, by developing a collaborative community board or organization—can be a very important part of the process. Researchers might contact the following groups:

- churches and medical clinics in agricultural areas to recruit migrant farmworkers.
- community-based family support, political, and health organizations.
- neighborhood churches to recruit inner city families.
- organizations designed to support new immigrants.

Rogler and Cortes (1993) suggest utilizing a culture's traditional institutions (e.g., street-front churches, stores dispensing curative herbs, neighborhood curanderos) as a means of acquiring a better understanding of mental health help-seeking pathways.

Data collection

Research instruments that have been standardized on samples from the dominant culture are of limited usefulness in collecting data on people from other cultural groups. Only recently have differences in culture, language, and social status been examined as possible factors of ethnic minority group performance on these instruments. With this awareness, researchers have given increasing attention to the degree of cultural bias in standardized tests and to the development of tests which are more responsive and appropriate for people of color (Helms, 1992; Miller-Jones, 1989).

The intra-ethnic approach acknowledges that there is as much or more variation within ethnic groups as there is between ethnic groups, and encourages researchers to discuss and explain their findings from within the context of the culture.

There is not a standard or stable set of procedures for conducting clinical research with people of color. In discussing the process of conducting culturally sensitive mental health research, Rogler (1989) asserts that, "In general, research is made culturally sensitive through a continuing and open-ended series of substantive and methodological insertions and adaptations designed to mesh the process of inquiry with the cultural characteristics of the group being studied" (296). In practice, this means viewing culturally sensitive research as a process which includes extensive field testing of measures and procedures, pretesting and pilot data, translating and "back-translating" instruments. Cauce and Gonzales (1993) suggest that research with people of color "should move beyond the examination of status or categorical variables and concentrate on the processes and transactions between individuals and their environment" (1993, 8). This may mean a move away from traditional "paper and pencil" methods of assessment and toward methods which respond to hypotheses related to a richer view of individuals within their environments (e.g., clinical interviewing, video-recording, interactions, and recording observations in the field).

Aside from fundamental problems with language and the inappropriateness of administering standardized measures to people of color (Bass, Wyatt, & Powell, 1982; Cole, 1981), the process of collecting information for later analyses may not be valued by some cultures. That is, some cultural groups may engage in patterns of communication which do not perceive written questions and inquiries as meaningful to their lives and therefore may not respond accurately. In a similar manner, there may be cultural prohibitions in discussing certain family practices (e.g., child-rearing, discipline) with individuals outside of the family or outside a circle of close family friends (National Research Council, 1993). Focus groups from the community under study can be very helpful in developing appropriate instruments and methods for data collection.

Because of the difficulty in acquiring sensitive personal data from some people of color, an ideal method of data collection may be clinical interviews and/or observation of subjects in a familiar environment. Conducting clinical interviews is not without its problems, however. Interviewers must be extensively trained about the community into which they will be entering, able to administer interview protocols reliably, and fluent in the language of their subjects. When family or parent-child interviews are needed, interviewers may need to be bi-lingual, as parents may be more comfortable speaking their native language, while their children may be more comfortable speaking English. Because the disclosure of violence-related behaviors and values is highly sensitive, researchers must facilitate interviewer-subject rapport (i.e., develop trust, comfort, and an ease of communication in the interview setting). The use of ethnically similar interviewers may substantially enhance the subject's willingness and ability to discuss family and violence-related behaviors and values.

Interpretation of data

Researchers who have developed their investigation from a perspective which acknowledges the role and contribution of cultural variables will give substantial attention to the operation of these variables when they analyze and interpret data. In addition to identifying a given behavior and recording its frequency, researchers must examine its cultural meaning. Adopting a singular perspective in interpreting data is likely to lead to misinterpretation. In issues of family violence, the intention and motivation of specific behaviors, when interacting with culturally-derived values, raise complex issues for both clinicians (Chioto, Tilden, Schmidt, &

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Urquiza, in press) and researchers. Landrine et al. (1992) suggest a two-fold methodology based on the distinction between etic (i.e., the researcher's outsider's perspective of the subject) and emic (i.e., the research participant's insider's perspective of the description and meaning of their behavior). Etic approaches to data interpretation rely on traditional empirical research tools such as operationalizing variables, searching for reliable instruments, and quantifying relationships between variables of interest. In contrast, emic approaches employ more qualitative methods, such as open-ended questions and semi-structured clinical interviews. The intent of this suggestion is not to challenge the validity of empirical research, but rather to place a greater emphasis on cultural variables such as spirituality, values about parenting, and beliefs about sexuality, which may be important in addressing child maltreatment-related clinical issues. Emic approaches allow greater opportunity for data interpretations to be framed from within the culture – i.e., by the cultural group under investigation–rather than solely from without. A two-fold methodology recognizes that behaviors and viewpoints different from those of the culture under investigation are a valuable source of interpretation.

When family or parent-child interviews are needed, interviewers may need to be bi-lingual, as parents may be more comfortable speaking their native language, while their children may be more comfortable speaking English.

Conclusion

We have attempted to provide preliminary information which will assist readers to be more informed in reviewing research involving people of color. Furthermore, we have highlighted issues that require attention for future family violence research with ethnic minority groups. The revisions in methodology we have outlined here require adjustments in practice and outlook that many researchers will find difficult to accomplish. However, we believe that current research methodology in the field of family violence can serve to support racist and class-biased viewpoints in our society. In order to ensure the safety of all children and to be relevant to diverse cultural groups, family violence research methodology requires substantial revision.

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MEMBER REVIEW OF GUIDELINES INVITED

This mailing of *The APSAC Advisor* contains three special inserts: (1) Draft Guidelines for Descriptive Terminology in Child Sexual Abuse, (2) Draft Guidelines for Psychosocial Evaluation of Suspected Psychological Maltreatment of Children and Adolescents, and (3) additional information about APSAC's Third National Colloquium, to be held next June in Tucson. Your input on the guidelines (and your attendance at the Colloquium!) is important. If you don't find these inserts, please call the office at 312-554-0166. We'll be happy to mail them to you.

News

-by Theresa Reid

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journal's content, and that the journal meets APSAC's members needs.

Members are invited to contribute articles and ideas for articles and special issues immediately. Dr. Chaffin can be reached at the Arkansas Children's Hospital, Department of Pediatrics, 1120 Marshall St., Suite C-401, Little Rock AR 72202.

APSAC makes new resource available to prosecutors facing "taint" hearings

The last issue of *The APSAC Advisor* carried news about a New Jersey Supreme Court ruling (*State v. Michaels*) which could present child abuse prosecutors nationwide with a new and difficult challenge: to establish in pre-trial "taint" hearings that the testimony of child witnesses has not been irremediably compromised by leading or suggestive investigative interviews (see *The APSAC Advisor*, *7*[2], 21).

Prosecutors are able to gain fast, early access to an extensive article that outlines the context from which the *Michaels* decision emerged, analyzes the *Michaels* decision, argues that *Michaels* is wrongly decided, and presents a framework for conducting taint hearings. The article, by John E.B. Myers, JD, is entitled, "Taint hearings for child witnesses? A step in the wrong direction." To be published in December, 1995, in *Baylor Law Review*, the article is available immediately from APSAC. To receive a copy of the article, send $5.00 to cover reproduction, shipping, and handling to APSAC, 407 S. Dearborn, Suite 1300, Chicago IL 60605. Or FAX your request, with credit card number and signature, to 312-554-0919.

Coming events

Special issue on child fatalities

This issue of *The APSAC Advisor* is briefer than usual, in preparation for a special double issue on child fatalities, coming in November. Edited by Randell Alexander, MD, PhD, that issue promises to be a significant contribution to the literature on child fatalities. See page 14 for a list of its contents.

Board election to be held in early November

The election for APSAC's Board of Directors will be held in the next few weeks. Be sure to look for your ballot in the mail. The ballot mailing will include a brief membership survey designed to inform APSAC's Board and staff how they can better meet your professional needs. We hope you will take a few minutes to help us ensure that APSAC is meeting your professional needs.

Letters to the Editor

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Women with the more functional styles may be better able to cope with these negative feelings and move on.

With regard to assessing objective vs. subjective reactions to birth, I do not advocate a willy-nilly approach to the subjective. Rather, I believe that it is possible to take a more educated approach. We have gained a great deal of understanding in the past 25 years about the way in which people process troubling events. In *Trauma and its wake*, Charles Figley states that an event will be troubling to the extent that it is sudden, dangerous, and overwhelming. This would be an excellent place to start if we are to understand whether a woman had a difficult birth experience. Indeed, women in their subjective accounts often mention themes of powerlessness or being overwhelmed. Other women I've spoken with mention that they truly believed that they or their babies would die. Even if this was not "true" from a medical standpoint, it could still have an impact on the way a woman felt about her birth, influence her confidence in her mothering abilities, and affect how she relates to her baby. This is not the type of information that would be listed on a medical chart, a common source of "objective" information regarding birth. Yet it is highly relevant to understanding where a mother is coming from.

Finally, I absolutely agree that women who have had a difficult birth should not be singled out as "high-risk" mothers. I believe that would only compound their negative feelings and further undermine their confidence. I would like women's feelings about their births to be added to the list of what we need to know about women with whom we are working. So often we don't even ask. If the studies of Klaus et al. and Trowell show us anything, it is that we should ask about birth experiences along with all the other questions we ask mothers.

Sincerely,
Kathleen Kendall-Tackett, PhD

THANK YOU!

APSAC has many people to thank for their generous help with our recent move:

- **Amoco Foundation**, for donating nearly $30,000 worth of used office furniture.
- **Keith Belknap**, APSAC's *pro bono* attorney, for negotiating our novel-length lease.
- **Lyle Levin**, APSAC's leasing agent, for donating his commission to APSAC.
- **Nexus**, an office machine company in Chicago, for giving APSAC an excellent rebuilt copier at cost.

We would be happy to give you a tour of our new space. Next time you're in Chicago, please stop by the office so you too can appreciate all the gifts that have been made to APSAC.

Child Protective Services

-by Maria Scannapieco and Diane DePanfilis

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networks are safer than families who are isolated. Families who do not make connections with outside systems may be doing so in order to hide what is occurring in the home. These families also lack any potentially beneficial feedback on their parenting.

Protector in the family or environment. Despite concern about some of the other assessment areas, if the child has someone in his or her life who serves as a protector to offset the negative impact of the other factors, the child may be safe from immediate harm. In contrast, if a mother is unable or unwilling to protect the child from an abusing father, and if there is no one in the extended family or community to take over this role, the child is at a greater safety risk. It is a strength if a protector can be identified for the child.

Maltreatment-Related Assessment Areas

Consensus in the research, safety assessment models, or both was found for six areas of assessment related to the maltreatment itself. These criteria are applicable to all forms of maltreatment—physical abuse, sexual abuse, neglect, or emotional maltreatment—and regard the risk of immediate harm for repeated abuse.

The CPS worker's job is so difficult, and success so unpredictable, because so many factorsmust be taken into consideration simultaneously.

Abandonment. Clearly, when a parent is providing adequate supervision, the child is likely to be in a more protected environment; when parents abandon their children, the children's safety is endangered. Abandonment can occur prior to referral to the CPS agency or as a response to CPS and law enforcement intervention.

Frequency and severity of past harm and maltreatment. Again, viewing this factor on a continuum is important. At one end of the continuum is maltreatment that has not yet led to major consequences for the child; at the other end is a history of chronic maltreatment and/or severe injury to the child.

Intention to harm the child. Parents whose conscious purpose was to hurt the child should be distinguished from parents whose intention was to discipline the child but inadvertently hurt the child. For example, a parent who deliberately puts the hand of a four- year-old on a lit match or cigarette lighter knows that the child will experience pain. Preventing this action from occurring in the future may be more difficult than helping a parent realize that use of a paddle to spank a child can result in both physical and emotional harm to a child.

Admission, remorse, and guilt of perpetrator. Mothers and fathers who deny and/or show no remorse or guilt about maltreatment they inflicted upon their children pose a serious threat of harm. When a worker asks the parent if s/he feels bad about leaving multiple welts on the back, buttocks, arms, and legs as a result of a "whipping" and the parent indicates that the child "deserved it," an immediate safety plan is needed. On the other hand, the parent who states that s/he feels terrible about the incident and seems sincere is much more likely to cooperate with a safety plan to ensure the child's safety at home.

Explanation of injury/incident/conditions. It is a strength when parents are able and willing to explain how their child got injured. Parents who refuse to tell you how an injury occurred or who are evasive may be hiding something which places their child at a greater risk of immediate harm.

Perpetrator access to the child. If the perpetrator is incarcerated as a result of the maltreatment, the child may be at no safety risk due to perpetrator access. Since this is usually the exception and not the rule, it is important to know if the perpetrator will have continued contact with the child and under what conditions. Perpetrator access, however, should not be the only criterion used to evaluate safety. Other family members may pose a risk to the child as well.

Intervention-Related Assessment Areas

We found two intervention-related assessment areas with support in both research and models: (1) level of cooperation of the family and (2) use of past help.

Level of cooperation of family. When parents acknowledge that they need assistance and indicate that they will participate in a safety plan to control the negative influence of behaviors or conditions that increase the threat of harm, they are more likely to be able to keep their family together. In all cases, the worker needs to evaluate specifically the parents' level of cooperation. Often, parents may be initially willing to participate in developing a plan, but are not as cooperative once on-going work begins. This is difficult to ascertain at first, but it is an integral part of the safety assessment.

Use of past help. The more parents have been involved in services in the past without benefit, the higher the safety risk. Parents who have improved in areas of functioning in the past due to some intervention are more likely to benefit from future services. These families usually provide a safer environment for their children.

Conclusions

What makes the CPS worker's job so difficult, and success so unpredictable, is that all of the factors within these five broad areas of assessment—child, parent, family and environment, maltreatment, and intervention—must be taken into consideration simultaneously. Strengths in one area (for example, parent's level of cooperation and involvement in

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Child Protective Services

-by Maria Scannapieco and Diane DePanfilis

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support systems) may outweigh weaknesses in other areas (such as the age of the child).

If a child is considered at risk for maltreatment, it is the CPS worker's responsibility to develop a safety plan in conjunction with the community and the family that will protect the child within the family if at all possible. Safety concerns should be matched with immediate interventions that offset them. The first risk assessment model to consider the concept of safety, separate from risk (Holder and Corey, 1987) proposes the following process for evaluating and addressing the safety of maltreated children: (1) determine if maltreatment has occurred; (2) assess the risk of future maltreatment; (3) evaluate the immediate safety of maltreated children who are at risk of future maltreatment; (4) determine what in-home services will secure the safety of children; (5) identify who will provide this service in a timely fashion at the level that is needed to protect the child; (6) assess the family's willingness to accept intervention at the level that is needed to ensure safety of the child. Finally, (7) if safety cannot be secured within the family, decide when children need to be placed in out-of-home care or when an abusive parent should leave the home.

If a child is considered at risk for maltreatment, it is the CPS worker's responsibility to develop a safety plan in conjunction with the community and the family that will protect the child within the family if at all possible. Safety concerns should be matched with immediate interventions that offset them.

This article presents the best information we have in guiding us in the difficult task of assessing a child's safety. Future research is certainly needed, but this is a beginning in understanding which behaviors and conditions increase the threat of immediate harm and which family strengths are needed to keep children safe.

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Table 1.
Criteria for Evaluating Safety of Maltreated Children

Assessment Area	Specific Condition/Characteristic
CHILD	• age • physical/mental abilities • basic needs
PARENT	• parental control over behavior, e.g., substance abuse, mental illness, violence • basic parenting knowledge, skill, & motivation
FAMILY/ ENVIRONMENT	• family conflict/stress • social support network • protector in family/environment
MALTREATMENT	• abandonment • frequency & severity of past harm • perpetrator intended to harm child • explanation of injury/incident • admission/remorse of perpetrator • perpetrator access to child
INTERVENTION	• level of cooperation of family • use of past help

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tures, and displacement of the stomach medially. CT scanning of the abdomen typically delineates splenic injury.

Conclusion

In summary, inflicted abdominal injuries in children, while infrequent, have significant morbidity and mortality. Because children with abdominal injuries have variable and sometimes subtle symptoms, a lack of external markings, and a false or misleading history, a high index of suspicion must exist to diagnose these injuries correctly. Computed tomography provides excellent detailed images of the abdominal organs generally demonstrating the majority of injuries. Difficulty in diagnosis occurs in cases of hollow viscus organ injuries. Diagnosis of inflicted childhood abdominal injuries is important both from a medical perspective and one of child protection.

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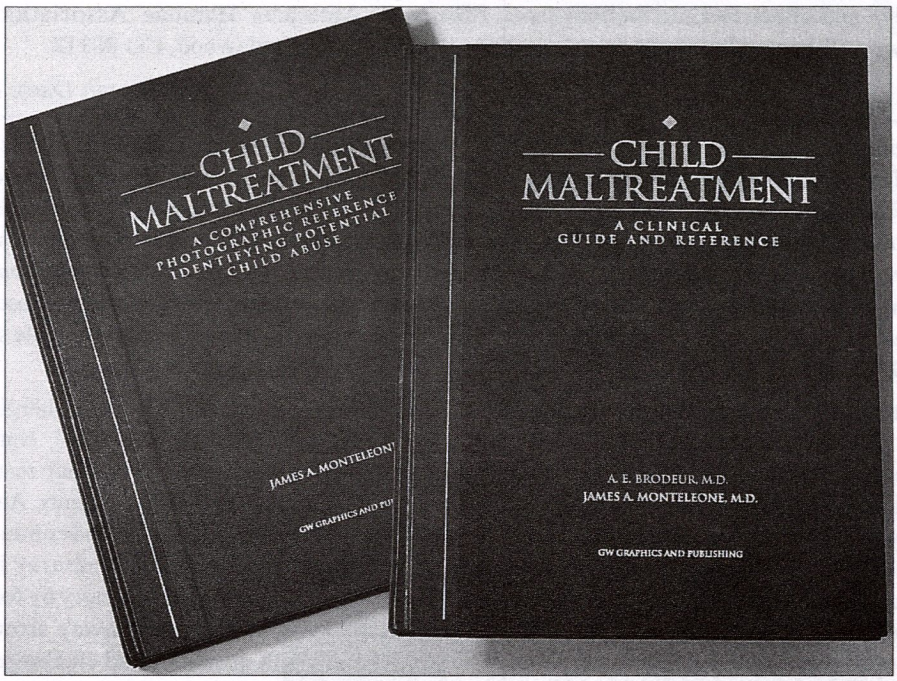

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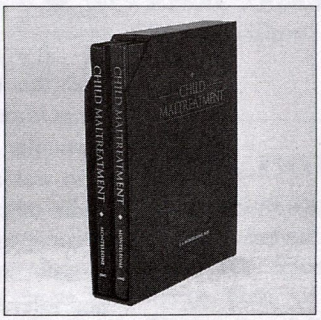

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IN MEMORIAM Vincent DeFrancis

The field of child abuse treatment and prevention lost a great friend this summer with the death of Dr. Vincent DeFrancis, Director Emeritus of the Children's Division of the American Humane Association. In a field that is constantly looking for new ideas, it is important to remember those professionals who worked on this issue long before it was a component of any government agenda.

Dr. DeFrancis was one of a small number of early pioneers in this field who fought to establish public recognition of the child abuse problem and to create responsive and effective child welfare services. While we still have a long way to go as a society and as a field to fully protect children, our journey is notably shorter today thanks to the efforts of Dr. DeFrancis.

In honor of his memory, the Children's Division of the American Humane Association will produce a special issue of their journal, *Protecting Children*, summarizing Dr. DeFrancis's life and achievements. The American Humane Association is also establishing a memorial fund for Dr. DeFrancis. Contributions to the special journal issue or to the fund should be sent to Nina Williams-Mbengue, American Humane Association, 63 Inverness Dr. E., Englewood, CO 80112.

- by Deborah Daro, DSW

IN MEMORIAM Dan Sexton

Dan Sexton, MA, former Director of the IOF Foresters child abuse hotline and a founding member of APSAC's Board of Directors, died on August 28, 1994. His close friend and colleague, Karen Gunn, PhD, wrote the following eulogy. Donation in Dan's memory can be made to The Center for the Vulnerable Child, 1129 N. State St., #130, Los Angeles, CA 90033. Attn: Astrid Heger, MD.

It was January, 1981, in a graduate psychology class that I was first struck by the persistent, sometimes impertinent, always incisive comments of one particular student. That student was Dan Sexton, who was always, I learned over the next thirteen years of our friendship, willing to go against the grain of his peers and perch, sometimes self-righteously, on his principles: speak principles of fairness and tolerance, openness and vigilance, and social responsibility.

Dan rose from the poignant roots of his own childhood abuse with a heart of gold and a determination to help others recapture their confidence, compassion, and self-love. He was tireless and sometimes contentious, provoking fresh debate on "indelicate" issues, choosing to speak for those who were often ignored and misunderstood: male survivors, people of color, gays, and lesbians.

Dan freely contributed his vital energies to many organizations, including APSAC, National Adult Children of Alcoholics, National resource Center on Child Sexual Abuse, Parents Anonymous, Parents United International, and community groups and survivor networks. I will miss my friend terribly, but will try to honor his memory by following his example: by having the bravery always to ask the most difficult questions and challenge myself to the fullest. Any by never forgetting to stop, listen to the music, and laugh.

- by Karen Gunn, PhD

APSAC Discounts

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.

November 21-23, 1994. ***Networking in the '90's. Sixth Annual Statewide Conference on Child Maltreatment.*** Nashville, TN. Contact Judith Brown, 901-525-2377.

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

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.

November 3-4, 1994. ***Child maltreatment: Innovation in assessment and treatment.*** Waikiki, HI. Contact Kapiolani Medical Center for Women and Children, 808-973-8713.

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

June 8-12, 1995. ***Eastern Regional Conference on Abuse & Multiple Personality Disorder.*** Alexandria, VA. Call Barry Cohen, ATR, at 1-800-950-6463.

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❑ Home Address (Optional) _____ City _____ State____Zip_____

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

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

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

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
407 S. Dearborn, Suite 1300 • Chicago, IL 60605 • 312-554-0166