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EVALUATION AND TREATMENT

The Clinical Use of the Child Sexual Behavior Inventory:

Commonly Asked Questions

—by W. N. Friedrich

The Child Sexual Behavior Inventory (CSBI) seems to have met a need by clinicians and researchers to evaluate sexual behavior in sexually abused children. I have received numerous requests for information on the clinical use of the CSBI. Although preliminary comments on the clinical use of the CSBI have been published in *Psychotherapy of Sexually Abused Children and Their Families* (Friedrich, 1990), my thinking about the CSBI has evolved over time and this paper reflects new data and additional experiences. This evolution in my thinking about sexual behavior, along with strong clinician interest, prompted this article, which recounts the most common questions I receive about the CSBI.

The CSBI was developed to better assess sexual behavior in children. Empirical findings with sexually abused children indicate that sexual behavior is one of the more reliable and valid markers of sexual abuse (Friedrich, 1993b; Kendall-Tackett, Williams, & Finkelhor, 1993). The original 36-item CSBI has been researched extensively and the majority of the original items were found to differ significantly between a sample of 880 non-abused children with no history of psychiatric disturbance and 276 children with a history of sexual abuse (Friedrich, et al., 1992). The CSBI has been revised twice. The CSBI-R was the first revision, and a recent paper (Friedrich, 1993a) indicated that all but one item of the CSBI-R differed significantly between sexually abused and non-abused children. The second revision is the CSBI-3, and research is currently underway that will contrast a demographically diverse normative sample of 1200 two- to twelve-year-old children, with 300 nonabused outpatients and 500 sexually abused children. Data collection is currently underway at a number of sites in the United States and Canada. A normative sample from Sweden is also being gathered at this time.

All versions of the CSBI were designed for use with children ages two to twelve. The child's primary female caregiver is asked to complete a 36-item measure that rates the numerical frequency of each behavior over the previous six-month period. The behaviors included in the CSBI, CSBI-R, and CSBI-3 measure such aspects of sexual behavior as self-stimulation, sexually intrusive behavior with other children or adults, sexual interest, boundary permeability, and gender-based behaviors. An advantage of the CSBI-3 is the use of several validity and attitudinal items.

The CSBI must be used with interviews and other forms of assessment in order to understand the child, particularly the sexually abused child. It must

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NEWS

Annual Report

—by Theresa Reid

Membership Survey

APSAC's first membership-wide satisfaction survey elicited responses from nearly 900 members, more than 19% of those polled. APSAC's leaders were pleased by the high response rate, and very interested in the results. The questions of most immediate importance to the Board were, in effect, "How do you like what we're doing?" and "What do you want us to do next?"

Responses to the first question were surprising. While we weren't surprised that *The APSAC Advisor* was the highest-rated benefit of the association, we were surprised that three of the four top-rated benefits or activities of the association are intangibles. In addition to *The APSAC Advisor* they were

- belonging to an association focused on child maltreatment,
- efforts to influence media coverage of child maltreatment, and
- efforts to influence federal legislation.

Answers to the second question, "What do you want us to do next?" were illuminating as well. The proposed new activities members most endorse are

- a new practice- and policy-oriented journal,
- one-day regional trainings,
- additional practice guidelines, and
- a brief quarterly newsletter supplement with news and information.

These responses seem likely to reflect the perceptions of APSAC members generally; although, not surprisingly, those who have been members for more than three years were overrepresented among the survey respondents, the various disciplines that comprise APSAC membership were proportionally represented among respondents. Seventy-six percent of respondents said that the field of child maltreatment is a primary career choice for them.

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

LETTERS TO THE EDITOR

Dear Editor:

The recent medical review by Dirk Huyer in *The APSAC Advisor* was a very good specific review of abdominal injuries to physically abused children (V7, n3, "Abdominal injuries in child abuse," page 5). While the intestines, pancreas, liver, spleen, and kidneys are the most frequently injured organs, another deserves mention—the bladder. Dr. Huyer failed to note that bladder rupture has also been reported as a consequence of child abuse.

The Child Advocacy and Protection Team at The Children's Hospital, Denver, recently evaluated a child admitted to the surgery service with gross hematuria (Sirotnak, in press). The child told the hospital staff that his stepfather had punched him in the abdomen because he had soiled his pants. A large intraperitoneal bladder rupture which required surgical repair was diagnosed by cystogram.

The bladder in children occupies a more abdominal position and is, therefore, more vulnerable to injury. Renal failure can result from peritoneal reabsorption of urine and blood which extravasates into the abdominal cavity. Elevated blood urea nitrogen levels can be a sensitive predictor of bladder rupture (Shah, et al. 1979).

When evaluating children with suspected child abuse abdominal injuries, screening the urine for blood is important to rule out not only kidney damage but also bladder injury.

Sincerely,
Andrew Sirotnak, MD

References

Shah, P.M., Kim, K-H., Ramirez-Schon, G., Reynolds, B.M. (1979). Elevated blood urea nitrogen: An aid to the diagnosis of intraperitoneal rupture of the bladder. *Journal of Urology, 122,* 741-743.

Sirotnak, A.S. (in press). Intraperitoneal bladder rupture: An uncommon manifestation of child abuse. *Clinical Pediatrics*

Dirk Huyer responds:

Intraperitoneal bladder rupture is recognized in accidental blunt traumatic abdominal injuries. The causative mechanisms are similar to those noted in my article, i.e., motor vehicle accidents and falls of great height. When distended with urine, the bladder is susceptible to rupture through the weakest portion (the dome) with resultant intraperitoneal spillage from a compression blow. Dr. Sirotnak's contribution helps to highlight the importance of a detailed history while maintaining an index of suspicion in cases of childhood abdominal injuries.

News

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Other findings of particular interest concerned APSAC's Colloquium and continuing professional education generally:

- 39% (of those responding to this question) plan to attend APSAC's Third National Colloquium;
- by far the most important feature of APSAC's Colloquium is the advanced training provided;
- the five cities most favored for future Colloquia are (in order of preference) San Francisco, Seattle, Washington, D.C., Chicago, and Atlanta.
- 46% prefer that conferences be located at big-city hotels, as opposed to mid-sized cities or isolated resorts.

We are pleased to find that most respondents are acquiring continuing professional education, if not through APSAC then through other means: only 9% attended no child abuse conferences in the previous year (the same percentage of respondents indicated that less than 20% of their work is focused directly on child maltreatment). Fifty-two percent attended one or two conferences in the previous year, and 40 percent attended three or more.

It is gratifying that so many members took the time to give constructive feedback to APSAC's leadership. We hope to have as high a response rate for future satisfaction surveys. I am happy to be able to report several activities of the Board that directly address members' expressed needs and preferences.

1995 Annual Board meeting highlights

APSAC's 1995 annual meeting was held in San Diego on January 22, 1995, in conjunction with the San Diego Conference on Responding to Child Maltreatment. Several important items of business were conducted at the meeting.

New officers were elected

President-Elect (First Vice President and Chair of the Membership Committee) is **Deborah Daro, DSW**, Director of the National Center for Child Abuse Prevention Research, in Chicago.

Second Vice President (Chair, Program Committee) is **Robert M. Reece, MD**, Director of the Institute for Professional Education at the Massachusetts Society for Prevention of Cruelty to Children, in Boston.

Treasurer (Chair, Finance Committee) is **Paul Stern, JD**, Deputy Prosecuting Attorney in Everett, Washington.

Secretary (Chair, Nominating Committee) is **Veronica Abney, MSW**, who is clinical faculty

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LAW ENFORCEMENT

The Use of Search Warrants in Cases of Crimes Against Children

—by Bill Walsh

For many reasons, investigators frequently under-utilize search warrants in the investigation of crimes against children.

Most investigators would agree that crimes against children are among the most difficult cases encountered by law enforcement. These cases routinely have no physical or medical evidence, no witnesses, and a victim who may be viewed as less credible than the adult defendant. Many times these investigations result in cases that go to court with the testimony of the child as the only evidence presented against the defendant. While in some situations such "swearing contests" are unavoidable, in many other instances the use of search warrants could have produced additional evidence.

Search warrants are investigative tools that are well understood and routinely utilized by law enforcement in the investigation of crimes involving drug dealing, violence and property loss. But for many reasons, investigators frequently under-utilize search warrants in the investigation of crimes against children. Child abuse—physical, sexual, and fatal abuse, neglect, sexual exploitation, and child pornography—may present the investigator with numerous opportunities to utilize search warrants. The investigator must be able to recognize and seize these opportunities. Properly executed search warrants resulting in the recovery of evidence will result in stronger cases and fewer "swearing contests." Search warrants can be indispensable tools in answering the investigator's questions of who, what, where, when, how, and why.

The purpose of this article is to familiarize investigators with the use of search warrants during the investigation of crimes against children. Since state laws, as well as agency policies and procedures related to search warrants vary greatly, readers are advised to contact their local prosecutor or agency legal advisor on the specific statutes and policies that apply in their jurisdiction.

Recovery of physical evidence

The primary use of a search warrant is to recover physical evidence from a location, vehicle, object, or person. In sexual abuse cases, physical evidence may include items used by the offender during the assault, such as lubricants, sexual devices, pornography, restraints, lingerie, etc. During some assaults, blood, semen, or hair may have been deposited on clothing, tissues or sheets, and these items should be seized. If collections of adult pornographic videos are discovered during a search of the offender's home, investigators should determine if the offender showed the videos to his victims. In cases where the offender has photographed or videotaped the child, the equipment, photos, and/or videos of the child should be listed in the warrant. Homemade child pornography that depicts the offender and the child involved in sexual contact is very powerful evidence against a defendant. In one case the author investigated, nude pictures of the offender and the child were found on a roll of film that was left undeveloped in the offender's camera. Offenders may videotape themselves molesting the child as well. In non-familial cases, clothing or possessions left by the child or taken by the offender as souvenirs could also be included in the search warrant.

Search warrants can also be used to obtain evidence from a subject's body. In some sexual assaults, the child may have observed that the offender had a particular tattoo, birthmark, or malformation on a part of the body normally covered by clothing. A search warrant could be used to photograph it and verify the child's account. Search warrants may also be used to collect blood and hair samples for DNA analysis. Such samples must be collected in a manner that meets legal requirements as well as accepted scientific and medical practice: proper evidence handling and maintenance of the chain of custody are critical when the evidence will be subjected to laboratory analysis.

In physical abuse cases, the implements used to inflict the child's injuries should be searched for and seized. Belts, extension cords, paddles, and curling irons are commonly used to abuse children. In some instances, it may be advisable to submit these items for analysis to determine if they contain blood or tissue that can be linked to the child. Additionally, these items may serve as valuable pieces of demonstrative evidence in the prosecution of the offender. In cases where a child has been scalded in a tub, search warrants can be useful in allowing an investigator the opportunity to examine and photograph the location where the injury occurred and search for possible evidence.

Search warrants can also be useful in cases where a child is reported to have suffered a suspicious fall. While it may be impractical to take a couch into evidence, a warrant could provide for its examination, measurement and photographing. The same applies to the flooring that the child is alleged to have fallen on. In some cases, however, it might be advisable to actually remove a section of the rug and pad that a child is alleged to have fallen on. If the caretaker claims the child was injured because a high chair or crib collapsed, these items should be seized so that they can be tested.

Corroboration of the child's testimony

The absence of physical or medical evidence in a crime presents the investigator with the challenge of proving or disproving the case through other means. In these cases, investigators must consider other ways to corroborate the child's account of the abuse. The child may be able to describe details of the assault, the location, or the suspect that they would not know had they not been victimized. A thorough investigative interview of the child may reveal details that can later be verified through the execution of a search warrant. In one case, a grand-

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father molested his granddaughter in his bedroom and "locked" the door by inserting a knife across the door facing into the doorjamb. This temporary lock was used to prevent anyone from walking in during the assault. When the child told this detail to investigators, a search warrant was used to examine the doorjamb for the resultant knife marks. They were found and photographed. The suspect, unable to offer a more plausible explanation for the marks than the child, changed his plea to guilty. It was later learned from the suspect's daughter that he had employed this same technique when he molested her, twenty years earlier.

Some offenders show children adult pornography, either in magazines or on videos, in an attempt to lower their inhibitions. If the child can describe this material and where it is hidden, a search warrant can be used to recover the material. In some states, it is a crime for an adult to show such material to a child (Texas Penal Code, 1994).

The investigator should also determine if the offender attempted to insure that child's silence about the assault. The recovery of any material things the offender gave the child, as well as evidence of threats, can be used to corroborate this "secrecy pact." Evidence that threats were employed may be proven by the recovery of a weapon the suspect used to threaten the child. "Cognitive interviewing" techniques may be useful in obtaining these details (Saywitz, 1992).

Occasionally, a child with a behavior problem may appear less credible than the suspect. This is often the situation in cases involving adolescents or those who admit to prior sexual activity. In one case, a counselor at a residential facility for troubled teenage girls was accused of sexually assaulting several girls at his off campus residence. The counselor had no criminal history and enjoyed a very favorable reputation with his superiors. The girls had juvenile records and were viewed by some as being less credible that the counselor. There was no medical evidence to corroborate the victims' accounts. When questioned about the allegations, the counselor not only denied that he sexually assaulted the girls, he denied that they were ever in his home. Separate interviews of the girls resulted in detailed descriptions of the counselor's house as well as its furnishings. When the case went to court, the suspect was unable to explain how each of the girls was able to describe the wine bottle lamp next to his bed, the picture on the wall above it, and the business card for his mother's nail salon that was stuck in the mirror of the medicine cabinet. Each of these items was photographed and seized during the execution of the search warrant of the offender's house. While these items did not absolutely prove that the sexual abuse had occurred, they did serve to increase the victims' credibility and decrease that of the defendant. The judge found the counselor guilty and sentenced him to prison.

Many times these investigations result in cases that go to court with the testimony of the child as the only evidence presented against the defendant. While in some situations such "swearing contests" are unavoidable, in many other instances the use of search warrants could have produced additional evidence.

Identification of other victims

In many cases, offenders have numerous victims, either at once or over a period of time. This fact provides investigators with the opportunity to strengthen their case by identifying additional victims and filing additional cases against the offender. Investigators should always ask the child involved in the instant case if he or she has knowledge or suspicion of any other children that may have been assaulted by the offender. Photos, diaries, letters, address books, or child pornography found at a suspect's residence may lead investigators to the identification of other victims. The fact that an offender has multiple victims may increase the tactical advantage of the prosecutor, especially in plea bargaining situations.

Identification of other offenders

On occasion, offenders may act together. Even if not actively involved in the abuse of children together, offenders may correspond or trade child pornography. Search warrants may uncover evidence of abuse being committed by other offenders, locally or in another community, previously unknown to the investigator. By identifying an accomplice who can be persuaded to testify against another offender, the instant case can be strengthened.

In one case, a search warrant led to the discovery of letters from an out-of-town offender in which he bragged about molesting and photographing his daughter. These letters had been sent, along with child pornography, to the first offender under investigation, and were found during a search of his home. As a result, the second offender was identified, prosecuted, and convicted.

Recovery of other contraband

A person under investigation for child abuse may be involved in other criminal activity. A search of his or her residence for items related to the abuse investigation may lead to the discovery of evidence of drug violations, theft, or possession of illegal firearms. While search warrants cannot be used to conduct a "fishing expedition," investigators may legally look anywhere that is physically capable of holding the item they are searching for. For example, looking in a jewelry box to find photographs is reasonable. Evidence of other criminal activities may corroborate a child's account or provide additional leverage for the investigator or prosecutor handling the abuse case. Conversely, looking for evidence in other cases may lead to the discovery of evidence of child abuse.

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Photodocumentation of injuries

Some state laws provide that search warrants can be used for purposes of photographing an injured child (Texas Code of Criminal Procedure, 1994). These statutes usually include provisions stipulating which particular crimes are applicable. Additionally, they may specify the procedures to be followed in photographing the child if the child and the investigator are of different genders.

A search warrant specifying the photodocumentation of injuries can prove useful in cases where abuse is suspected and the caretakers are being uncooperative. In one case, it was believed that a child had been injured because of screams the neighbors heard the night before. When investigators went to the house, no one would answer the door or the telephone. The investigators obtained a search warrant to photograph the "Jane Doe" child they believed to be injured. When the investigators went inside, they discovered a child that had been intentionally scalded with boiling water the night before. The child was taken into protective custody and the mother was charged with the assault.

If an offender uses computer bulletin boards, he may be in contact with other offenders and even children without leaving his home.

Providing for arrest

In some jurisdictions, search warrants can also order someone's arrest (Texas Code of Criminal Procedure, 1994). If investigators believe that the suspect will be at the location to be searched, they may want to consider having the warrant provide for the arrest of that person at the same time the search warrant is executed. If the suspect is not present, he may be arrested at a later time if the warrant is still valid.

Information for the interrogation

Many offenders will confess to their crimes if properly interrogated. The more investigators know about the offender, the better prepared they will be to conduct the interrogation. Information learned about the offender during the execution of a search warrant may prove to be useful in the interrogation. Knowing about a suspect's past may give some clue to his current behavior. In one case, the author discovered that an offender had, years before, been convicted of sexually abusing his son and had his parental rights terminated. During the interrogation of the offender for the sexual abuse of a different boy, the author asked the suspect to think of his own son. The suspect eventually gave a full confession. He later told the author he confessed because he did not want his latest victim to experience the same embarrassment his own son experienced when he had to testify in court.

Information for the child interview

In the case described above, a child, whom police had strong reason to suspect had been victimized, initially denied that the offender had molested him. During a search of the offender's home, however, pornographic videotapes of the child were found. The child was told about these tapes during an interview, and he eventually disclosed all the details of the abuse. In another case, a search warrant led to the discovery of numerous pictures of adolescent males. Police officers who worked in nearby schools were asked to identify the children in the pictures. Most of the children in the photographs were later identified and most of them admitted to being victimized by the offender. Not only did this successful search result in additional cases being filed against the offender, it led to the discovery of victims who needed help and had not yet disclosed their abuse.

Computer equipment

Occasionally, offenders use computers to further their activities. Computers can be used by offenders to maintain correspondence, diaries, and information related to children. Photographs of children can be scanned into the computer's memory for safe storage. Offenders can also allow children to play computer games, including sexually explicit games. If an offender uses computer bulletin boards, he may be in contact with other offenders and even children without leaving his home. In one case, an offender pretending to be a teenage boy conversed with a girl through a bulletin board and arranged to meet her. When they met, he sexually assaulted her.

If investigators suspect that an offender has used a computer for any of the purposes described above, they should consider the computer a possible source of evidence. A properly worded search warrant can be used to seize the computer and examine its files. Careful planning and caution must be exercised when computers are seized and their files are searched, however; investigators and their agencies could be subject to civil lawsuits if information contained in computer files is damaged or lost due to the investigator's actions. Investigators should obtain assistance from someone knowledgeable about computers for this task. It is helpful to copy the original files before they are searched so as to ensure that the original files are not changed or damaged in any manner.

Practical considerations

Move quickly

In child abuse cases, a lack of physical evidence does not prove an allegation is untrue. However, any physical evidence that is found may help corroborate the child's account. The chance of recovering such evidence is greatest if attempts are made to obtain it early in the investigation. Ideally, this is done before the suspect knows he or she is under investigation. Delays give the suspect the opportunity to move, destroy, or alter evidence. Even if the suspect is in custody, delays may allow him the time to contact someone who will do the job.

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Obtain consent if possible

Before executing a search warrant, investigators should attempt to have the owner, landlord, or person in charge of the location sign a consent to search form, whether or not that person is the suspect, and before that person is advised of the existence of a search warrant. A valid consent, granted by a person or persons with the authority to give consent, can prevent suppression of evidence if the search warrant is ruled invalid at a later time. Do not, however, rely solely on a consent to search. A suspect who grants consent may later withdraw it if he or she feels the investigators are about to discover something incriminating. At this point, the investigators would have to discontinue the search, secure the premises and then obtain the warrant that should have been obtained initially. Relying solely on a consent to search can also cause problems if the suspect later claims to have been tricked or coerced into giving consent, or the court rules that the person who gave consent was not legally authorized to do so.

A valid consent to search, granted by a person or persons with the authority to give consent, can prevent suppression of evidence if the search warrant is ruled invalid at a later time.

Photograph or videotape the search

It is advisable to photograph and/or videotape the location prior to, during, and after the execution of the search warrant. Photographic documentation serves several purposes. Pictures or videos can document where items were found and protect the investigators from claims that they damaged property or left the location in total disarray after the search. Without documentation, holes in walls, overturned furniture, broken lamps, and other disarray that preceded the search can be blamed on investigators. Pictures and videos also serve to create a permanent record of items found in the background of pornographic photographs or videos: furniture, fixtures, wallpaper, etc. In another of the author's cases, locations seen in child pornography videos seized from a suspect's home were later matched to photographs and videos taken during the execution of the original search warrant. If investigators are going to videotape a search warrant being executed, all members of the search team must be reminded that an audio recording is being made, or the audio function turned off. Items taken as evidence during the search and listed on the inventory or search warrant return should be photographed or videotaped as well.

Drugs are quickly cut and sold, but child pornography is almost always retained forever by the collector.

Take every videotape listed as evidence

If videotapes are listed as items to be seized in the warrant, investigators must resist the urge to view the tapes at the location in a random fashion. Every video to be taken as evidence should be viewed carefully in its entirety at a later time. Offenders have been known to incorrectly label pornographic tapes with innocuous titles or put the pornography in the middle of a tape. In one case, a videotape was recovered on which the offender had taped a child masturbating. For some reason, the offender handed the child the camera, and the child began taping the offender before he realized what was happening. Prior to that point there was no proof as to the identity of the offender. Investigators should also listen carefully to videotapes; the offender or the child may say something of importance, or the audio track of the videotape may contain a conversation or radio or television broadcast in the background that may help establish the date the video was made.

Timeliness of information

There are no clear cut rules about when information related to an offense may be considered "stale"; it depends on the nature of the evidence sought and the crime committed. Drugs are quickly cut and sold, but child pornography is almost always retained forever by the collector. Expert knowledge of child abusers should be included in the affidavit for the warrant, explaining that child pornography and child erotica are kept forever by the pedophile, not consumed like drugs. Up to date information should be supplied in the affidavit for the warrant whenever possible.

Safety issues

The execution of a search warrant should always be conducted with officer safety in mind. People accused of child abuse can be dangerous. They may fear the effects of disclosure; some offenders may feel that their life is no longer worth living and may be considering suicide. They may decide to take someone with them, someone responsible for their troubles—i.e., the investigator. If the offender is present during the search, he should be carefully patted down for weapons. If he is arrested, he should be handcuffed. The offender should never be left alone while a search is being conducted. Investigators must exercise caution if family members or other associates of the offender are present, and should request that they either stay in one room or leave the location while the search is being conducted. Remember, weapons can be hidden anywhere throughout the house. Investigators must also be aware of other hazards hidden at the location, including hypodermic needles, chemical hazards, attack dogs, and explosives. Officers should always wear rubber gloves when conducting a search and look carefully before reaching into dresser drawers or other places sharp objects could be located.

Summary

Child abuse investigations are difficult cases for law enforcement. Investigators should view their role as fact finders and view search warrants as

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tools that can assist fact finding. Search warrants can be used to recover evidence and identify victims and offenders. Information gained through the execution of a search warrant may better prepare the investigator to interview the victim and interrogate the offender. Investigators must move quickly when search warrants are used so as to prevent the removal or destruction of evidence. As in all other areas of police work, investigators executing search warrants must be careful and follow proper officer safety procedures. Investigators should consider search warrants an important investigative tool and use them whenever justified.

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CHILD PROTECTIVE SERVICES

Working with CPS families with alcohol or other drug (AOD) problems

—by Ronald Zuskin and Diane DePanfilis

Numerous child welfare professionals have called attention to the fact that children from families with alcohol or other drug (AOD) problems are overwhelming the service delivery capacities of the child protective services (CPS) system (Besharov, 1994; Curtis and McCullough, 1993; McCurdy and Daro, 1993; Tutara, 1990). AOD cases present complex circumstances for CPS workers to sort out; further complicating this growing epidemic is the inadequate understanding of AOD related parenting problems held by the typical CPS worker[1].

It is the responsibility of the CPS worker to (1) recognize alcohol or other drug related symptoms; (2) collect information about AOD use as part of the risk assessment; (3) conduct family assessments that evaluate the specific effect of AOD problems on parenting adequacy; (4) design treatment plans and service agreements that address AOD problems; (5) coordinate meaningful referrals and interventions provided by addiction counseling agencies; and (6) evaluate progress of parents in recovery. The coexistence of AOD problems and child maltreatment is an area in which the development and dissemination of knowledge have not kept pace with the need. The purpose of this article is to help meet this need.

Recognizing a problem

The coexistence of AOD problems and child maltreatment is an area in which the development and dissemination of knowledge have not kept pace with the need.

When does use of alcohol or an illegal substance become a problem? Three levels of AOD involvement are commonly identified: use, abuse, and dependence (addiction). R. E. Griffin offers a helpful summary, worth quoting at length:

> Use refers to taking a drug for pleasure in order to achieve a sense of well-being. A drinker who has a martini after work while fulfilling his or her usual responsibilities fits this category. This type of drinker is likely to discontinue use if he or she notices undesirable consequences. For those who abuse drugs, the drug and its effects interfere with the individual's ability to carry out expected responsibilities.
>
> For instance, the abuser may risk eviction by purchasing drugs instead of paying the rent or mortgage. The abuser actively pursues opportunities to use drugs and continues despite untoward results. Often the boundaries between drug abuse, dependence, and addiction are blurred. The drug-dependent individual persists in using drugs, disregarding any negative consequences and exhibiting tolerance to the drug and withdrawal symptoms when he or she cannot have the drug. Preoccupation with acquiring and using the drug results in poor judgment. For example, drug dependent parents may leave an infant unsupervised while they seek the next "fix." In their denial, these individuals often believe that their drugged state is normal and strive to sustain it. Such psychological dependence is difficult for the addict to overcome. They are unable to control their drug use and their social functioning is inadequate (Griffin, 1993).

AOD and behavior

Drugs of abuse are used for their mood or mind altering effects. They are grouped by families based on related chemical properties. Persons susceptible to tolerance or addiction to one chemical in a family are susceptible to tolerance or addiction to all drugs in that family. Table 1 lists all drugs of abuse by family and charts the different effects of various drug families on behavior during intoxication, acute withdrawal, and chronic protracted withdrawal.

Drugs affect behavior, as well as the mood and mind of the user; therefore, the user's parenting will also be affected by AOD problems.

Intoxication

"Intoxication" literally means being poisoned by a toxin. CPS workers are most concerned about the risks for maltreatment generated by intoxication; a review of behaviors associated with intoxication — loss of inhibitions, poor judgment, irritability, depression, paranoia, mood swings, aggression, violence, etc. — support such concerns. However, risks to children from a parent's AOD problems are not limited to the parents' intoxicated state.

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[1] While this article is directed toward CPS workers, all professionals in the fields of child maltreatment and substance abuse need to be aware of these concurrent problems, and able to respond appropriately.

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Table 2. Behavioral and Emotional Consequences during intoxication, acute withdrawal, and chronic protracted withdrawal.

Drug Family	Intoxication	Acute Withdrawal	Chronic Protracted Withdrawal
Cocaine (Stimulant)	Extreme alertness Irritability Emotional augmentation Euphoria Depression Talkative Paranoia Aggressive Fornication Craving Compulsion Insomnia Seizures	Sexual dysfunction Psychosis Paranoia Violence Shakes Emotional augmentation Agitation Insomnia Hallucinosis Anorexia Fatigue Weakness Aches Cramps Suicidal ideation Craving	Anhedonia Paranoia Craving Emotional augmentation
Dissociative Anesthetics (PCP)	Power, strength No pain Agitation Confusion Incoherent Flushing Memory Speech impaired Seizures Hallucinosis Violence Suicide Emotional augmentation Delusions Stimulation Depressant Psychosis	Insomnia Craving Sweat Nausea Yawning Emotional augmentation Agitation Psychosis	Blocked speech Sparse speech Memory impaired Cognitive impaired Poor judgement Emotional augmentation Perceptual distortion Auditory hallucinosis Depression Mood swings Paranoia Psychosis
Other Sedative Hypnotics (Tranquilizers, Barbs)	Loss of inhibitions Poor judgement Confusion Emotional augmentation Staggering Lack of coordination Slurred speech Craving	Insomnia sweats Nausea Tremors Anorexia Hallucinosis Emotional augmentation Seizures Depression Isolation Confusion Suicide Preoccupation Craving	Agoraphobia Insomnia Fatigue Depression Psycho-social problems Confusion Emotional augmentation Phobias Health problems Confusion Cognitive/emotional impairment Craving
Stimulants	Decreased appetite Loss of sleep Paranoia Hallucinations Convulsions Emotional augmentation Mood swings Aggressive Antisocial Coma	Crash followed by: Insomnia Anxiety Cravings Emotional augmentation Brain damage Psychosis Violence Suicide	Violence Sexual Dysfunction Emotional Augmentation Suicide
Marijuana/Hashish	Euphoria Lowered pain Dry mouth Nausea, vomiting Diarrhea Hunger Dilated pupils	Anxiety Insomnia Emotional augmentation Craving	Apathy Amotivational syndrome Lowered attention span Brain atrophy Paranoia Lowered immunity Emotional augmentation Craving
Narcotics	Euphoria Loss of appetite Itching Nausea Constipation Amenorrhea	Chills Gooseflesh Tears Runny nose Yawning Elevated heart beat Elevated blood pressure Insomnia Diarrhea Emotional augmentation	Lacks attentiveness Decreased sexual desire Decreased activity
Sedative Hypnotics Alcohol	Loss of inhibitions Poor judgement Confusion Emotional augmentation Staggering Lack of coordination Slurred speech Craving	Insomnia sweats Nausea Tremors Anorexia Hallucinosis Emotional augmentation Seizures D.T.'s Depression Isolation Confusion Suicide Preoccupation Craving	Insomnia Fatigue Depression Psycho-social problems Confusion Emotional augmentation Phobias Health problems Confusion Cognitive/emotional impairment Craving

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Acute withdrawal

The ingestion of a toxic substance initiates pharmacological and biochemical reactions which affect the brain and the central nervous system; intoxication by psychoactive substances alters the user's mood. Everyone, with regular use of a drug, develops some tolerance for it; alcoholics and addicts show a capacity, often from the first use, to tolerate abnormally large quantities of a drug. Continued use of a substance literally trains the body to expect to receive the chemical. Cells in the body adapt to require a certain amount of the drug, and when the amount of the drug in the body drops below the maintenance level, the body goes into withdrawal. This is referred to as "acute withdrawal," and it may occur several times during the course of a day as the substance level drops following ingestion. The addict becomes very active in seeking and ingesting the drug in order to fend off withdrawal. Additionally, the alcoholic/addict may show any or all of the signs of acute withdrawal listed in Table 1. Many alcoholics and addicts—known as "maintenance" alcoholics and addicts—may appear functional and never present the dangers associated with intoxication. CPS workers must understand that acute withdrawal presents as many risks to children as does intoxication. These risks may occur several times a day with alcoholic/addicted parents. Behaviors associated with acute withdrawal—confusion, psychosis, violence, suicidal ideation, agitation, hallucinations, etc.—indicate the risks a parent's behavior presents to children even when the alcoholic/addicted parent is not intoxicated.

A parent fresh out of detoxification is at high risk of relapse, and will remain at high risk for maltreatment for months if not years.

Chronic protracted withdrawal

When alcoholics or addicts are unable to ingest their drug of addiction for a period of time, they enter "chronic protracted withdrawal." Depending upon the particular substances used the duration of their use, this withdrawal may last up to two years. During early, middle, and even late stages of recovery, a person may be dealing with the effects associated with chronic protracted withdrawal: insomnia, fatigue, depression, confusion, paranoia, lack of attentiveness, violence, etc. A parent fresh out of detoxification is at high risk of relapse, and will remain at high risk for maltreatment for months if not years. CPS interventions and case planning need to take this into account.

An addicted client may be very cooperative, yet unable to stop drinking or taking drugs when his or her body goes into withdrawal. This doesn't necessarily mean that the client is non-compliant; it means he or she is addicted.

One effect associated with all types of drugs during acute or chronic protracted withdrawal is emotional augmentation. "Augmentation" refers to the intensifying and distorting of everyday emotions (Rogers & McMillin, 1992). While the use of substances may blunt or heighten emotional responses, withdrawal from drugs frequently results in emotional augmentation. The brain of a person in acute or chronic protracted withdrawal is agitated, and actually boosts all ordinary feelings related to parenting. This augmentation of everyday emotions serves to generate risks for maltreating behaviors in addition to those symptoms more specifically associated with each drug family.

Models of addiction

Models offer an explanation of the cause of addiction, define treatment related to the view of causality, and generate prognoses related to the application of such treatment approaches to alcoholics and addicts. The Chronic Disease Model (Rogers & McMillin, 1988, 1992) has yielded the most consistent treatment outcomes for the most clients. From the perspective of the Chronic Disease Model, addiction is a disease of the central nervous system having genetic components, thus creating higher risk for offspring of alcoholics and addicts. Numerous studies, cited by Zuskin (1994), report the biochemical and genetic vulnerabilities to alcoholism and addiction which are transmitted intergenerationally.

A summary of a study by Kendler and colleagues in the *Harvard Mental Health Letter* ("In Brief," 1994), reported on twin studies with more than 1,000 pairs of females. Concordance for alcoholism was almost twice as high for identical twins as for fraternal twins. Concordance between parents and children was about the same as fraternal twin concordance. Liability to alcohol problems was shown to have an underlying heritability of about 50%. There was no indication that shared environment or culture played any direct part in the transmission of alcoholism. Apart from heredity, alcoholism in a parent did not raise the risk of alcoholism in a daughter, but, if anything, slightly lowered it. These and other findings give strong credence to the definition of AOD dependency as the result of a genetically transmitted chronic disease process.

When viewed as the result of a disease process, AOD dependency or addiction is seen as chronic, progressive, and potentially fatal. Addiction is an event that occurs in the brain, uninfluenced by reason or insight. An addicted client may be very cooperative, yet unable to stop drinking or taking drugs when his or her body goes into withdrawal. This doesn't necessarily mean that the client is non-compliant; it means he or she is addicted. Remember that clients can be toxic without being intoxicated; clients with abnormal tolerance may function — and even function well — with extremely high levels of drugs in their blood, but will go into withdrawal if they don't continue to ingest drugs.

Treatment in the context of the Chronic Disease Model includes medically-managed detoxifi-

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cation abstinence, supported by attendance at Alcoholics Anonymous or Narcotics Anonymous, education about the disease, promotion of self-diagnosis, and planning around relapse prevention. Prognosis for persons compliant with treatment in this model is good. It is important to note that treatment for alcoholism and addictions is cumulative. Relapse is not uncommon, but long-term successful outcomes are possible when treated in accordance with the principles of the Chronic Disease Model.

Assessment and intervention

Given the risks that AOD dependency pose to children and families, proper and timely assessment of AOD dependency is crucial. The CPS worker will not be directly involved in treating a client's addiction. But eliciting information, screening, assessing, securing a referral to a qualified program, and following up with the client's progress are critical skills in working with alcoholic and addicted clients who maltreat their children. All families experiencing child maltreatment should be screened for addiction, and referred for diagnosis and treatment when necessary. Likewise, as Bays (1990) emphasizes, all addicted families should be screened for maltreatment, as some degree of neglect is almost inevitable.

Young children have great needs for parenting which may be impossible for an active addict to meet.

Assessment

AOD abuse and dependence, like child maltreatment, are wrapped in denial and secrecy. Workers need to be skilled at eliciting information from clients who may be well defended against candidly disclosing abuse-related information. Assessment tools can be extremely helpful in eliciting information for AOD abuse and dependence screening in CPS clients. The CAGE Questionnaire (Bush, et al., in King and Lorenson, 1989), consists of four questions for the initial screening:

1. Have you ever felt you should cut down on your (substance use)?
2. Have people ever annoyed or angered you by criticizing your (substance use)?
3. Have you ever felt bad or guilty about your (substance use)?
4. Do you ever use (substances) after waking up?

A positive response to any of these questions indicates the need for further assessment. However, since parents who have AOD abuse or dependence problems will often deny a problem, it is sometimes necessary to start with less direct questions. Two indirect approaches to this screening are: (1) developing a genogram adapted to collect information about alcohol and drug problems among at least three generations, and (2) conducting a typical day interview, questioning clients in detail about their day in order to reveal risk factors, indicators of AOD dependency, and/or child maltreatment (Zuskin, 1994).

A genogram is a family tree that records genealogical relationships, major family events, occupations, losses, family migrations and dispersal, identifications and role assignments, and information about alignments and communication patterns over at least three generations of a family (Hartman 1978). The traditional genogram can be enhanced graphically to highlight information about AOD problems in a family's history. The genogram can indicate both genetic susceptibility and the environmental factors which may contribute to the risk of intergenerational transmission of AOD abuse or dependence (Leikin, 1986; Zuskin, 1994).

A typical day interview consists of asking for a detailed account of a typical day in the client's life. Through a typical day interview, indicators of AOD problems such as times of unexplained absences or typical times of parent-child conflicts, can be identified without being specified as AOD-related.

Intervention

Clients who present with indications of either substance abuse or dependency should be referred for further evaluation, including physical examination, blood workup, and treatment. Referrals for evaluation and treatment should not be "recommendations," but need to be supported by available leverage and followed up through each step of the process—screening, intake, assessment, treatment, and aftercare.

The worker must ensure that the treatment program to which referral is made provides viable services. As indicated above, the best available research indicates that treatment approaches based on the Chronic Disease Model will be most effective. Rogers and McMillin (1992) list ten keys to look for in selecting a program which maximizes outcome effectiveness:

1. The program uses a disease model.
2. The program is oriented towards measurable goals.
3. The program emphasizes education.
4. The program emphasizes group counseling.
5. The staff is expert in addictions treatment.
6. The program reliably differentiates those receiving in patient vs. outpatient care.
7. The program has good aftercare.
8. Abstinence is the criteria for successful outcome.
9. The program should give good value for the cost.
10. The program should educate the family as well as the addict.

Ensuring the safety of the child

AOD problems significantly heighten the risk of child maltreatment (Kinscherff and Kelley, 1991). Even the parent in treatment and recovery continues to present risks of maltreatment to children in his or

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her care due to the effects of chronic protracted withdrawal. If families are to remain together, both problems—drug abuse and child maltreatment—must be treated simultaneously (e.g., Bavolek and Henderson, 1990). Services must be long-term, issue-specific, family-focused, multi-modal, and interdisciplinary. Throughout the stages of treatment, progress needs to be monitored and necessary leverage, including court involvement, utilized to secure and support treatment.

When considering risks to the child, age is an important consideration. Young children have great needs for parenting which may be impossible for an active addict to meet. The younger the child, the greater the risk for maltreatment. Critical issues for workers to assess, in descending order of urgency, include the child's immediate safety given the using patterns of the parent(s), protection from ongoing maltreatment, available nurturance (with assessment of development and attachment), and permanency. Termination of parental rights may need to be considered based upon the following criteria: abandonment of newborns, refusal to enter drug treatment, age of the child, poor bonding, availability of suitable alternative placements, repeated child maltreatment, recurrent relapses, lack of non-addicted adult in the home, repeated drug-exposed births, and a long history of treatment failure.

Family services

If families are to remain together, several good resources regarding intervention and treatment issues are available for CPS workers involved in case planning, including the Child Welfare League of America's (CWLA) *Children at the Front* (1992), Besharov's *When Drug Addicts Have Children* (1994), and the work of Bays (1990), Tracy (1994), and Zuskin (1994).

Treatment for addictions is cumulative; it is a process in which rapid and dramatic change is unlikely.

Whenever possible, all family members should be included in treatment. In many CPS caseloads, however, this means a single mother and one or more young children, infants, and toddlers. Services delivered at this level need to focus on parenting. In the early stages of recovery, family treatment focusing on the here and now, on specific tasks, and on cognitive-behavioral parenting interventions should coalesce with drug treatment. With very young children, treatment should strengthen the parental attachment to the child and promote the mother's awareness of the child's needs and her acquisition of anger management skills. Drug treatment which includes the care or treatment of young children of single mothers can support the mother's involvement in treatment. Also, drug treatment provided in a child-oriented context, such as a pediatric health center, can support compliance. Many single mothers may need an opportunity to focus on their own needs before they are able to focus fully on meeting those of the child. The Nurturing Program (Bavolek and Henderson, 1990) has been recommended as a means of meeting the needs of all family members.

A full range of child welfare services may be helpful to families, including intensive family services, long-term in-home services, residential parent-child treatment, kinship care, and long-term, stable foster care. A key premise for case planning is that treatment for addictions is cumulative; it is a process in which rapid and dramatic change is unlikely.

Research and policy

Addictions and child maltreatment are at epidemic proportions in the United States. The CWLA's North American Commission on Chemical Dependency and Child Welfare (1992) and Bays (1990) join many other authors listed here in recommending that further research be done into the relationship between these twin epidemics. Such research could begin with the gathering of data from addictions treatment sources and from child welfare sources. Research into the risk and protective factors for addictions and maltreatment could be used to plan prevention and treatment. Research on the effectiveness of various approaches to treat this population would obviously follow.

The CWLA's Commission and the National Association of Public Child Welfare Administrators (1991) have made policy recommendations regarding the social work response to these problems. Recommendations include providing accessible services which are non-punitive; securing interdisciplinary participation, financing, and training; providing outreach services to clients at risk; developing a comprehensive national policy on addictions and child welfare; and improving coordination among relevant funding and service agencies at all levels of government.

Social workers must recognize that the presence of one of these problems is a signal to assess for the other. Social workers must acquire the skills and knowledge base to make the appropriate assessments and referrals. And it is critical that the professional community begins to collaborate in serving these families, who cannot be successfully treated without multi-agency and interdisciplinary involvement. Interdisciplinary training which promotes self-awareness, cultural competence, and awareness of the co-occurrence of drug addiction and child maltreatment is a critical first step. Relevant professional communities must organize so that coordination of available and accessible resources becomes a priority. Workers need case management skills to be able to secure appropriate services and coordinate their delivery among a service team. Programs need to be developed which provide strategic addictions and parenting services by skilled, empathic professionals working together in multi-modal, collaborative, interdisciplinary treatment

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programs. These are some of the steps by which we can assist families in which addiction and child maltreatment occur together—perhaps the most daunting challenge facing CPS workers today.

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LAW
Thoughts on How Prosecutors Can Inform Judges on Child Abuse and Neglect Issues

—by Paul Stern

They are stories of frustration for professionals.

A child sees a therapist for behavioral problems. After a thorough evaluation, the therapist is convinced the child has suffered long term abuse by a parent. The child will likely continue to be abused and needs to be removed from the home, the professional concludes. But the judge refuses the request, not wanting to disrupt the family.

A 12-year-old is testifying about the many times her father entered her room late at night and molested her. When the judge hears that she had a lock on her bedroom door, but never used it, that she waited three years to make her disclosures, and that the disclosures were not made until her mother began divorce proceedings, the judge rules that the child can't be credible, and dismisses the case.

A jury has convicted a defendant for sexually molesting three of his grandchildren. His own children come forward and report that he abused them when they were younger. The defendant denies all the abuse allegations. The judge, whose father is the same age as the defendant, can't bear to send him to prison. Even though the defendant is still in denial, the judge orders him to sexual deviancy treatment.

Many of the most important decisions affecting the lives and safety of abused children are made by judges. These decisions are informed by what the particular judge believes to be true about child abuse. And those beliefs are significantly shaped by the amount and quality of the knowledge the judge has acquired about the subject. Most child abuse professionals acknowledge that, by and large, judges do an outstanding job dealing with these complex issues. Unfortunately, even the best-educated and most well-intentioned judges may have little accurate knowledge of child sexual abuse.

Until recently, little formal training about sexual abuse was available for judges. The National Judicial College did not offer a specific program dealing exclusively with child abuse issues until May, 1993. Specific judicial training in this area remains limited.

Many child abuse professionals might question the difficult decisions made by judges, examples of which opened this article. Professionals have an obligation to do more than question judicial decisions and walk away, however: they have an obligation to help judges reach decisions that are as well informed and accurate as possible. Prosecutors are in a particularly good position to bring relevant information to judges' attention.

Below are seven principles for prosecutors who wish to credibly, ethically, and effectively inform the bench.

Try self-examination before criticism.

A prosecutor who thinks a judge has made a terrible decision should not react in anger, but as a professional. Examine critically whether the judge really was wrong. Just because the decision went against you doesn't mean it was wrong.

If you are convinced the judge is in error, review why your arguments were not accepted.

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Perhaps the failure is not as much with the decision made as with your argument. Did you explain the reasons for the relief you sought? Did you throw literature at the judge without explaining the significance of it? Did you make assumptions without clearly spelling out the logic of your position? An effective advocate should provide counsel and information. Teaching others requires that you first learn and be able to articulate the material.

Before casting blame, look within. Only then should the next steps be explored.

Recognize that education is a long term project.

The child abuse community has been battling myths about child abuse for years. As soon as the myths die down, the backlash begins. A cycle of information and misinformation will always sweep across this field.

Many of the most important decisions affecting the lives and safety of abused children are made by judges.

To inform and change attitudes takes time. When we talk about child abuse, we are generally discussing acts that no one wants to believe humans are capable of committing. Don't expect judges to become child abuse experts overnight. One article or argument, no matter how persuasive, is unlikely to effect a permanent transformation in the judge's thinking. Time, leadership, and consistent, high-quality information will be required.

Do literature briefs.

If you want a judge to have particular information, put it in a brief. If you want a judge to read a specific article, attach it to a brief.

Whenever a significant article is published that you think would be of value to a judge, make a motion which touches on the subject. Then write a very short (1-2 page) brief which asks for something in reliance upon the article. Attach two copies of the article to the brief. The judge will read the article; most likely the second copy of the article will find its way into the judge's files. Even if you do not get the relief you sought in your motion, you have at least introduced the judge to the latest research.

To inform and change attitudes takes time. When we talk about child abuse, we are generally discussing acts that no one wants to believe humans are capable of committing.

In a later case, when a similar issue is raised by another lawyer, the judge will probably recall your brief and article. The judge is likely to find your papers and read them again. Although your client might not receive immediate benefit from your motion, the next child who comes before the judge might gain.

When you file the motion, supply a copy of the brief and article to the judge's law clerk. If the judge doesn't read the article, the law clerk will—and the clerk, hopefully, has the judge's ear. If the judge learns from the law clerk, you have achieved your aim.

If you can afford it, use experts.

The courtroom is as good a place as any for an expert to provide a presentation on a specific issue regarding child abuse. The expert gets to answer just about any question you can think of, either before the jury or before the judge during the making of an offer of proof.

Remember, if the goal is educating judges you are not primarily concerned about the short term. You want the judge to develop a gradual but consistent understanding of the field, the dynamics of child abuse, the nuances, ethical issues and vocabulary. What a judge learns today might be incorporated into a decision made a year from now.

There are, of course, fiscal restraints in using experts. And there are tactical concerns as well. The wisdom of the State's using expert witnesses in its case in chief is subject to reasonable debate (APRI, 1993). Arguments against the use of experts include the "battle of the experts," and a refocusing of the trial away from the child and onto these competing professionals. Those concerns are valid. Caution and careful trial strategy is vital in making the determination of whether to use an expert. In seeking to achieve the long term goal of educating judges, there may be no better way than to bring the experts to them; however, for the instant case, the use of experts might do more harm than good.

Share resources.

You come back from a child abuse conference, laden with a conference notebook three inches thick, chock full of articles and outlines that you know you won't look at again until a specific issue arises. Instead of filing it away, share it.

Find a reason to talk to a judge before whom you have no cases pending. Mention that you are back from a conference. Suggest that the information you heard, especially from the judge who spoke at the conference, was very interesting (if this is true), and that you would be willing to let the judge borrow the program material. Even if the judge did not want it at that precise moment, he or she is unlikely to decline your invitation to provide information. Then deliver the entire notebook. Sometime, perhaps when a trial settles early, or while two lawyers are painstakingly picking a jury, the judge will browse through the material.

The judge might not read the material carefully at first, but will at least be aware that it is there, available for his or her closer examination when a relevant issue arises.

Invite the judge to lecture, to moderate, to attend, to write.

There is always child abuse training going on in or around your community (if there isn't, start some!). A judge might feel it inappropriate to go as an attendee, concerned that attending a conference

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put on by prosecutors will violate the judicial obligation to maintain neutrality.

But if the judge is a speaker or a program moderator or delivering the keynote, then he or she is arguably in a different ethical position. (Inviting judges to speak is particularly effective in states where judges run for election.) Having agreed to give a presentation, the judge will be eager to learn more about child abuse. Provide resources on the presentation topic: literature briefs, articles and conference materials reflecting the most advanced knowledge of the issues.

The courtroom is as good a place as any for an expert to provide a presentation on a specific issue regarding child abuse.

If possible, ensure that the judge arrives at the conference early enough to listen to other speakers. If the judge is willing to stay for lunch, be sure he or she is seated at a table with those prepared to summarize their conference presentations.

Be credible yourself.

"What we choose to believe depends on whom we rely on as teachers," wrote Dr. Roland Summit (1992). If we want judges to believe the literature we put before them, we must be certain they can rely on us as teachers.

Be credible. Be ethical. Be honest. Be informed. If the judge cannot trust you, the judge cannot trust the material you present.

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ANNOUNCEMENTS

Child Fatalities Report to be Released

The U.S. Advisory Board on Child Abuse and Neglect will release its report on child fatalities on April 25 at a major news conference in Washington, DC. For press releases and Public Service announcements related to the Board's public awareness campaign, contact Deanne Tilton-Durfee at 818-575-4362 or Conrad Kenley at 301-490-1693.

Resolution on Facilitated Communication Issued

The Board of Directors of the American Psychological Association (APA) recently endorsed a resolution on facilitated communication. The Council of the APA adopted the position that facilitated communication is a controversial and unproven communication procedure with no scientifically demonstrated support for its efficacy. The resolution states, "Studies have repeatedly demonstrated that facilitated communication is not a scientifically valid technique for individuals with autism or mental retardation. In particular, information obtained via facilitated communication should not be used to confirm or deny allegations of abuse or to make diagnostic or treatment decisions." To receive a copy of the resolution and its references, call the APA at 202-336-5500.

Awards Nominations Sought

The National Council of Juvenile and Family Court Judges is calling for nominations for its 58th Awards Program. The awards recognize outstanding projects and persons in the juvenile and family law system. For more information, contact Marie Mildon at 702-784-6686.

Resources Available

The Dallas Children's Advocacy Center is offering copies of its 1994 Crimes Against Children Seminar Book for $30.00 each. Contact Jessie Shelburne at 214-818-2600 for more information.

CALL FOR PAPERS

Child Maltreatment, APSAC's new journal, will be publishing a special section in Volume 1 on "Child Interviewing" We are especially interested in receiving research and practice manuscripts relating to interviewing special populations of children (e.g. adolescents, children with disabilities, children belonging to specific cultural groups). To be considered for the special section, submissions should be received by August 30, 1995.

Articles should be no more than 30 typewritten, double spaced pages; reviews of literature should be no more than 50 typewritten, double-spaced pages. Include an abstract of approximately 150 words, with footnotes, references, tables, and figures on separate pages. Author's name and affiliation should appear on a separate cover page for anonymous review. For style, follow the *Publication Manual of the American Psychological Association* (4th Edition). Submission to *Child Maltreatment* implies that the manuscript has not been published elsewhere, nor is under consideration by another journal.

Please send five copies of the manuscript to the attention of Kathleen Coulbourn Faller, PhD, ACSW, and Mark Everson, PhD, Special Section Editors, APSAC, 407 South Dearborn, Suite 1300, Chicago, IL 60605.

MEDIA RELATIONS

Letter to the *New York Review of Books*

The following letter was published in the January 12, 1995 (volume 42, number 1) issue in response to a lengthy article by Frederick Crews, PhD.

To the Editors:

In his two-part article, "The Revenge of the Repressed" (*NYRB*, November 17 and December 1, 1994), Frederick Crews offered a cogent critique of many aspects of the "recovered memory movement." Crews quite rightly denounces the naive use of diffuse "symptom checklists" and very broad definitions in the diagnosis of a childhood history of incest; reliance upon "therapeutic" modalities with no support in the empirical literature; insistence on unquestioning belief in patients' tentative emerging memories, no matter how bizarre; and the poor training and marshy theoretical basis of some practitioners in this field. Crews argues reasonably against the presumed therapeutic benefits of unearthing and "abreacting" all traumatic experiences, and trenchantly analyzes the shortcomings of the Freudian concept of repression, which authorizes the irresponsible assertion that the lack of memory for trauma is itself evidence of trauma.

We share Crews's belief in the necessity of a measured and well-informed response to adults' allegations of sexual abuse in childhood.

Because we share Crews's belief in the necessity of a measured and well-informed response to adults' allegations of sexual abuse in childhood, we regret that Crews himself strayed so far from the empirical evidence on which he rightly insists we all rely, and reserved his skepticism for those who make or believe allegations of childhood incest. We wish to correct the misimpressions Crews's intemperate article may have left regarding (1) the criminal justice system response to allegations of sexual abuse in childhood, (2) the standard of therapeutic practice in this field, and (3) the concept of repression. First, however, we would like to point out how egregiously Crews commits the very sin he finds most damning in others: that of credulity.

Crews' vitriol against professionals is hard to understand, and his depiction of zealous incompetence as the rule is indefensible.

Crews praises the False Memory Syndrome Foundation (FMSF)—most of whose members are parents who have been accused of incest by adult daughters—for making "steady progress in public enlightenment" on the issue of adult recollections of childhood incest. The cruel fact for all parties to such accusations is that both the wrongly accused and the rightly accused vociferously and convincingly deny the accusations against them. Crews acknowledges, "Pedophiles will undoubtedly try to portray any accuser as deluded by a trick of memory" (52, II). When Crews refers to the members of FMSF as "slandered relatives of survivors" (50, II), he claims an access to wisdom that Solomon himself would envy (not to mention the thousands of American judges who, according to Crews's caricature of the judicial system's response to child sexual abuse allegations, are doing so lamentable a job of adjudicating these cases).

Crews displays a similar credulity in bestowing lavish praise upon a forthcoming book by a Mark Pendergrast, both of whose grown daughters have accused him of incest. Crews lauds Pendergrast's 603-page compilation of interviews and lore (to be issued by the obscure "Upper Access" publishers) as "the most ambitious and comprehensive, as well as the most emotionally-committed, of all the studies before us" (51, II). While Pendergrast may be innocent of the charges against him, Crews applies very different criteria in assessing his work than in assessing that of "survivor" therapists. Whereas Crews finds "confirmatory bias" in the beliefs of alleged survivors and their therapists, in Pendergrast's book he finds a thoroughly laudable emotional commitment.

Crews's credulity for one set of claims is reflected in significant bias throughout the article. Among the empirical knowledge Crews flouts is that regarding the operation of the criminal justice system in cases of child sexual abuse and adult recollections of incest. Certainly, we would all have a great deal to worry about were in fact accusations launched by "a vengeful or mentally unhinged adult...immediately believed by police and social workers" (59, I), or "draconian sentences...being served and plea bargains...being coerced in the face of transparently clear signs that the charges are bogus" (49, II). However, empirical data regarding the operation of the child protective services and criminal justice systems do not support these crude caricatures.

In fact, a large percentage of reports of child sexual abuse—up to 60% in some states—are not substantiated by child protective services workers. Only 42% of sexual abuse allegations that have been substantiated by child protection authorities or reported to the police are actually forwarded for prosecution, according to a study by the American Bar Association. Moreover, because sexual abuse is so frequently a crime without other witnesses or physical corroboration, and prosecutors are concerned about children's credibility, people arrested for sexual offenses against children are somewhat less likely to be prosecuted than are other violent offenders. One detailed study of allegations of sexual abuse in day care found that 82% of such allegations were dismissed by investigators. When prosecutions do occur, the majority—about 75% according to one study—result in convictions. However, most of these convictions (over 90%) result from guilty pleas and plea bargains. Sexual abusers are convicted somewhat more frequently than other violent offenders, probably because prosecutors are so selective in the cases they take to trial. Even when convicted, however, child sexual abusers receive light sentences. Three studies suggest that 32% to 46% of convicted child sexual abusers serve no jail

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Media Relations

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time at all. Only 19% receive sentences longer than one year, which is about the same as those convicted of other violent crimes.

Crews's depiction of the standard of practice among therapists working with women who recall a childhood history of incest is similarly skewed. Crews cites with indignation the results of an unnamed "survey" indicating that "well over 50,000" of America's 255,000 licensed psychotherapists are now "willing to help their clients realize that they must have endured early molestation." Victims of childhood physical and sexual abuse are, not surprisingly, heavily overrepresented in clinical therapeutic populations. Since several empirical studies indicate that 40% to 85% of psychotherapy patients suffered abuse in childhood, we are somewhat distressed to learn that only 20% of psychotherapists may be willing to help their patients explore this possibility.

More important, Crews leaves the impression that modal practice in this field is carried on by wild-eyed zealots. Of course bad practice occurs in the field of child maltreatment, as in any other. We fully agree with Crews that bad practice in this field can have tragic results, and should energetically be opposed. But no empirical evidence suggests that the practice displayed on *Geraldo* is typical. Child interview guidelines distributed by such major organizations as the American Academy of Child and Adolescent Psychiatry (1985) and the American Professional Society on the Abuse of Children (1990) specifically recommend against the coercive and suggestive questioning practices that Crews suggests are the rule. The writers and lecturers on "adult survivor" therapy who are most admired and sought after by professionals in this field caution against the use of hypnosis and sodium pentothal, and against the tenet that remembering and "working through" all traumatic material is necessary or positive. Given this and other evidence that modal professional practice is thoughtful and responsible, Crews' vitriol against professionals is hard to understand, and his depiction of zealous incompetence as the rule is indefensible.

The most conservative data available on the prevalence of father-dauther incest suggest that 1.3 percent of American women will experience it....Even at this low estimate, 1.6 million American girls and women are now or have been victims of father-dauther (or stepfather-daughter) incest.

Finally, Crews very effectively demolishes the naive concept of repression in which memories are hermetically sealed and stored intact for future revelation. However, he fails to shed any light on the processes that are at work in the very well-documented phenomenon of imperfect recall of traumatic events. His categorical statement, "Reputable scientific research . . . offers no support to the concept of repression even in its mildest form" (49, II), is misleading. A vast scientific literature on memory offers no consistent definition of repression, but a great deal of information about variously defined memory lapses. Full or partial amnesia for traumatic events has been well-documented in combat veterans, people who have survived natural disasters and other traumas, and people who have experienced physical and sexual abuse in childhood. Saying that such amnesia does not conform to the naive depiction popularized on talk shows and in some books or to the very narrow, specific definition of repression used by Crews does nothing to explain how such amnesia does occur, how once-forgotten or faded memories re-emerge, or how to assess the veracity of such memories.

The most conservative data available on the prevalence of father-daughter incest suggest that 1.3 percent of American women will experience it. These data are from upper middle class white college students in the Northeast responding to a paper-and-pencil questionnaire. Everything we know about differential prevalence rates and the efficacy of different methods of information-gathering suggest that this prevalence estimate is low. However, even at this low estimate, 1.6 million American girls and women are now or have been victims of father-daughter (or stepfather-daughter) incest. A number of factors have converged in the last several years to encourage these women to speak out about their victimization, including a greater attention to child sexual abuse generally and a feminist reinterpretation of father-daughter incest as, like rape, a victimization rather than a shameful secret.

These allegations challenge us intellectually and emotionally. Like many allegations of child sexual abuse, allegations by adult women of childhood incest often pit one person's word against another's. In response to such extraordinarily difficult epistemological situations, a natural impulse is to make a summary judgment in favor of the least painful alternative. For the vast majority of Americans, that alternative is to believe that adults do not victimize children in the ways now being alleged. It takes the greatest discipline for individuals and for the society to fairly weigh the veracity of these reports. Crews effectively chronicles the failure of some people to maintain this discipline. We regret that he was not able to serve the readers of *NYRB* better by maintaining such discipline himself.

Sincerely,

Theresa Reid
Executive Director

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

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Dr. Crews, author of the original articles, responded at some length to this letter, which he characterized as "an adroit brief for her guild's rank and file." Crews urged APSAC's members to call its leaders to task for a "whistle-while-you-work approach to a national tragedy." For Crews's full response, see *NYRB*, Volume 42, Number 1, January 12, 1995.

The clinical use of the Child Sexual Behavior Inventory

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never be used by itself, and it should never be the sole basis for a determination of sexual abuse. There is no item, or combination of items, that without fail, are solely indicative of sexual abuse. Even the CSBI-3 is a face valid measure, and it is very easy for a caregiver to exaggerate or minimize.

How should the CSBI be used?

The questionnaire is designed to be used with two- to twelve-year-old children, and norms are based on the responses of exclusively female caregivers who are familiar with the child. In addition, the behavior problem portion of the Child Behavior Checklist (Achenbach and Edelbrock, 1983) is typically obtained for the purpose of placing the CSBI responses in a larger behavior context.

The CSBI should be completed by a caregiver who knows the child very well. Preferably, two caregivers are used, particularly if the veracity of one is in doubt. Inter-rater reliability scores for the CSBI and the CSBI-3 are typically positively correlated. In the case of the CSBI, parents correlated with teachers, and with the CSBI-3, parents correlated with psychiatric nurses. These correlations are significant, but low ($r = .3 — .4$).

In addition to assessment, the CSBI can be used to guide treatment. The child's behaviors that are endorsed can be discussed with the caregiver, identified as treatment targets, and addressed with a variety of modalities, e.g., behavioral, cognitive, and play.

There is no item, or combination of items, that without fail are solely indicative of sexual abuse.

Other people use the CSBI information to reassure parents that their children are displaying normative behavior. I have received numerous letters from pediatricians and therapists who have been able to reassure parents that a five-year-old boy touching himself, for example, is exhibiting normative behavior.

How is the CSBI scored?

Each CSBI item can be answered 0, 1, 2, or 3. Simply total the sum of all items (less the validity items in the CSBI-3) to arrive at a total score. For example, if only two items are endorsed at the "1" level, the total score would be 2. This total score can then be contrasted with published means (Friedrich, et al, 1992). For example, a five-year-old boy who receives a CSBI score of 10 would fall within one standard deviation of the mean for two-to-six-year-old nonabused boys. A score of 38 in a 10-year-old girl is more than two standard deviations above the mean for sexually abused girls aged seven to twelve.

The version of the CSBI in the Friedrich, et al. (1992) paper is the original measure. Research with the CSBI-R has found that 35 of 36 items significantly discriminate abused from non-abused children, whereas in the original CSBI, 27 of 35 items significantly discriminated between the two groups. Thus, the mean scores have changed somewhat, with children who have no history of behavior problems and no history of sexual abuse rarely receiving a total score of more than 5. The mean scores for sexually abused children on the CSBI-R, depending on age and sex, range from 7 to 15, with younger and older girls typically scoring lower than same-aged, sexually abused boys. However, the standard deviations for each age-sex mean are typically equal to or larger than the mean, again suggesting the wide range of behaviors in both abused and non-abused children (See Table 1).

The CSBI can also be used to identify the types and frequencies of behaviors reported by parents. This is a qualitative approach that can be quite useful with individual cases. For example, a parent of a seven-year-old boy may indicate moderate levels of masturbation both in public and private, along with heightened sexual interest and the sexual touching of other children. In most cases, the combination of these behaviors, along with the fact that the child is seven, and presumably of normal intelligence, would be suggestive of exposure to adult sexuality, and possibly of sexual abuse. Again, however, these behaviors are only suggestive, not definitive.

Are there any single best questions?

In the original CSBI research, we found that every single item was endorsed by parents of at least some non-abused children. I continue to believe that non-abused children can demonstrate, at least minimally, any of the behaviors on the CSBI-R. What is important is the context of the behavior. The context implies the developmental level, setting, and history of the child. For example, a five-year-old boy who masturbates at home in his bed is likely to have a different history than a nine-year-old boy who masturbates in public. A three-year-old boy who sees his younger sister breast fed by his mother may try to touch his mother's breast. This is benign in contrast to a 10-year-old boy who impulsively grabs his teacher's breasts. In addition, initial analyses of the CSBI-3 indicate that psychiatric outpatients without a history of sexual abuse show elevated levels of sexual behavior.

Regrettably, the wording of some CSBI-3 items is confusing or misleading. For example, the item inquiring about whether the child inserts objects into her vagina or rectum is asking about a behavior that technically cannot be done, without considerable pain, to the young female's vagina. Typically, when a parent endorses that question with a young female, they do not technically mean "insertion into the vagina"; they mean insertion between the labia. There are exceptions to this rule, and sexually abused female children have been accurately reported as inserting fingers or objects into their vaginas. There are other examples of subjectively worded items which I have tried to avoid but which

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The clinical use of the Child Sexual Behavior Inventory

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continue to have discriminant validity. These include "makes sexual sounds" and "knows more about sex than other children their age."

There is no single item or cluster of items that can say definitively whether or not a child has been sexually abused. To reiterate, for the CSBI to be valid, it must be used in combination with careful clinical interviewing, an assessment of other behavior problems in children, such as the Child Behavior Checklist (Achenbach & Edelbrock, 1983), and a determination of family stress, chaos, and sexual climate.

What about the differences between sexually abused children and children who have not been sexually abused but who have psychiatric problems?

Children who need mental health services more likely grow up in families where greater aggression and unpredictability occur, along with a greater possibility of exposure to adult sexuality.

In collaboration with several colleagues at the Mayo Clinic, I am collecting data, with the CSBI-3, on a sample of psychiatric outpatients and inpatients. They have been carefully screened, and as far as we know, do not have a history of sexual abuse. Preliminary analyses with fewer than 100 of these children have found that they exhibit significantly more sexual behavior than the normative, non-psychiatric sample. Considerably more overlap exists between psychiatric patients and sexually abused patients regarding CSBI-3 scores than between non-abused, non-psychiatric children and abused children. However, as a group the psychiatric, nonabused children exhibit fewer behaviors, at lower frequency, than sexually abused children.

A number of factors might explain why nonabused psychiatric patients score higher on the CSBI-3 than do the normative, non-psychiatric children. Children who need mental health services more likely grow up in families where greater aggression and unpredictability occur, along with a greater possibility of exposure to adult sexuality. These children have problems with modulating behaviors of all types. In addition, life stress and exposure to adult sexuality have been shown to correlate with sexual behavior (Friedrich, et al., 1992).

Studies with the CSBI and CSBI-R, and initial studies of the CSBI-3, have also reported that life stress and exposure to adult sexuality correlate directly with behavior problems (Friedrich, et al., 1992; Friedrich, 1993b). For example, in an ongoing study on sexual behavior in children with a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), parents frequently report problems with interpersonal boundaries and increased levels of masturbation (Friedrich, 1994a). However, as a group they report that their children exhibit less sexual interest and less sexual aggression than children who have been sexually abused. In addition, ADHD children whose parents do not have a psychiatric history and whose parents and teachers do not report accompanying oppositional or defiant behavior show low levels of sexual behavior and look quite similar to nonabused children.

Since all versions of the CSBI are face valid, do you have any problems with parents deliberately slanting their reports about their child?

If a parent wants to report more sexual behavior or less sexual behavior in their child than is actually the case, it is very easy for them to do that with the CSBI. In a recent study, the CSBI did not discriminate between sexually abused and non-sexually abused children 35 months old or younger (Hewitt, Friedrich, & Allen, 1994). A number of these children were involved in custody disputes, and several of the highest total scores on the CSBI were obtained in children that we determined most likely had not been sexually abused.

The same phenomenon occurs if the parents are denying their child's sexual abuse or if they are unsupportive of their child vis-a-vis the perpetrator. These parents are likely to report very few, if any, sexual behaviors. We attempt to counter biased reporting by enlisting other reporters who may be more objective. The CSBI can be used with day care providers and has been used with teachers, although the full range of behaviors in the measure are not likely to be seen in school settings. There can also be marked differences between parents, e.g., fathers vs. mothers, although the developmental psychological literature reports that mothers tend to be more accurate in reporting their children's behavior problems.

How can the CSBI be used to monitor treatment progress?

The total score of the CSBI can be a very good marker of treatment progress. Sexual behavior is more resistant to change than more affective symptoms, such as anxiety and depression (Lanktree and Briere, 1992). However, a significant course of treatment will typically result in a drop in the CSBI score (Friedrich, Luecke, Beilke, & Place, 1992), particularly if the child's sexual behavior has been specifically addressed in therapy. In addition, specific items can be followed over time and targeted as part of treatment. If the parent endorses a number of items pertaining to masturbation, a behavior management focus on the masturbation can be developed. The CSBI can also monitor variations in behavior during treatment. The sexual behavior in some children may actually increase after disclosure of sexual abuse, at least briefly, and particularly if the child is not feeling supported in his or her home environment. I have also found that disclosure of previous sexual abuse, in a supportive context, will be followed by a reduction of sexual

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behavior in some children, as measured with both the CSBI and by the parent (Friedrich, 1994b).

What are the differences between younger and older children?

It is very important to look at each of the CSBI behaviors in terms of context. Developmental level is one critical context. For example, on the CSBI, 43.5 percent of two- to six-year-old boys in the normative sample were reported as touching their mother's breasts and 48.8 percent of two- to six-year-old abused boys were reported as displaying the same behavior. In the seven- to twelve-year-old range, these frequencies had dropped to 11.7 and 22.9 percent, respectively. Thus you can see that for younger boys, this behavior was hardly discriminating, whereas for older boys, it was twice as common among abused boys (Friedrich, 1993a).

On all versions of the CSBI, sexual behavior in girls decreases in terms of frequency and range as the girl gets older. That is not true with boys who have been sexually abused; in fact, there appears to be a trend towards a broader and more aggressive range of sexual behavior in older sexually abused boys.

How does parental perception influence the reporting of sexual behavior?

A number of factors influence parental report of sexual behavior in their child. They include: parental attitudes about their own and their child's sexuality; attitudes toward the child; belief in their child's victimization; the need to protect the possible perpetrator; whether the parents are good monitors of their child's behavior; the parents' history of victimization; and the SES and cultural background of the parents. Not all of them have been empirically validated with the CSBI.

There appears to be a trend towards a broader and more aggressive range of sexual behavior in older sexually abused boys.

Parents may not perceive sexual behavior in their children because they do not view children as sexual, or they are avoidant of sexuality. A parent who negatively perceives his or her child may see the child as quite sexual, as well as aggressive and exhibiting a variety of other behavior problems. Lower-income parents are also less likely to report as much sexual behavior in their children as are middle-class parents.

Has the CSBI been used with children in other cultures?

Currently, French, Spanish, and Swedish translations of different editions of the CSBI exist. These were prompted by studies of sexual behavior of children in Montreal, California, Stockholm, and Cologne. The small sample of Hispanic children in the CSBI normative study (Friedrich, et al, 1992) did not differ from other children, but a true test of cultural and ethnic differences remains to be done.

What research is currently being conducted with the CSBI?

As mentioned above, the CSBI-3 has been developed. Each item has been reworded to read simply, close to an eighth grade level. Several validity items have also been included to assess for how closely the parent pays attention to each individual item. A multi-site normative study is under way, with research sites including Bangor and Portland, Maine; Portland, Oregon; Baltimore, Maryland; Rochester and Minneapolis, Minnesota; Los Angeles, Sacramento, and San Fernando Valley, California; Seattle,Washington; Philadelphia and Pittsburgh, Pennsylvania; Salt Lake City, Utah; Calgary and Montreal, Canada; and Oklahoma City, Oklahoma. A significant subset of this new sample will have had pediatric evaluations of their sexual abuse as well. We are also attempting to pay much closer attention to family stress levels, exposure to sexuality in the home, and parental attitudes towards sexuality in children as possible moderators of sexual behavior in children.

In addition, the CSBI is an outcome measure in two NCCAN-funded grants on the treatment of sexually aggressive children. It has also been used in several other federally funded research studies. Finally, we have developed an adolescent version and are obtaining normative behavior with it as well.

What do I do if caregivers differ in their report of sexual behavior on the CSBI?

Let's assume that you have reports from both a mother and a female day care provider. The mother's report is high and the caregiver's report is low. Reasons can include 1) exaggeration by mother; 2) minimization by caregiver; 3) differences in settings, e.g., more sexual behavior at bedtime,witnessed only by the mother; more structure in day care; the mother's presence reminds child of the abuser; and 4) different attitudes about sexuality in children. In addition, don't assume that day care parents are neutral. It is important to know with whom they are allied. If an accused father also completes a CSBI, the permutations in reasons for differences increase. Again, the range of possibilities underscores the complexity of sexual behavior in children.

In summary, the Child Sexual Behavior Inventory is one measure that can be used as part of a broad-based assessment of children two to twelve years of age who are suspected of being sexually abused. It should never be used by itself, and findings of sexual abuse based largely or solely on the Child Sexual Behavior Inventory are invalid. Despite the relative primacy of sexual behavior in sexually abused children, there is no single "cutting tool" to identify sexually abused children. The validity of the caregivers' reports depends upon a

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broad range of variables, and sexual behavior is influenced by a number of contextual variables as well. These include the child's developmental level, psychiatric history, exposure to family nudity and aggression, and life stress. However, the CSBI is reasonably well validated, research with it continues, and it is a useful measure for both initial assessment and for monitoring treatment progress.

To obtain a copy of the CSBI and supporting articles, write to:

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Table 1. Mean Scores and (Standard Deviations) on CSBI-R

	Sexually Abused (N=191)		Non Abused (N=270)	
Males				
2-6	15.3	(12.6)	3.1	(3.4)
7-12	11.9	(11.2)	1.8	(2.1)
Females				
2-6	14.1	(12.5)	2.5	(2.9)
7-12	7.3	(8.1)	1.6	(2.4)

COLLOQUIUM UPDATE

The brochures for APSAC's Third National Colloquium should have reached you by the time you read this. (If you haven't received one, let us know!). There are, however, a few updates for your attention:

The Saturday seminar S26, "Old memories, new technologies: Current medical issues in child sexual abuse," is being changed to "Advanced medical issues in physical abuse." Carole Jenny, MBA, MD, is still the faculty. This session will present a "potpourri" of issues commonly faced by medical practitioners evaluating abused children. The list of issues to be discussed includes the following:

1. *Coagulation and head trauma.* "Shaken babies" often are found to have abnormalities on clotting studies.We will review the "clotting cascade" and how it is affected by brain and body trauma. Appropriate work-ups for coagulation disorders in child abuse cases will be discussed (and debated).
2. *Factitious illness*—How has our clinical management and perception of "Munchausen Syndrome by Proxy" changed over the last five years? Is MSBP a "treatable" condition, or should children in these families always be removed from their parents' care? We will also discuss a proposed MSBP national data base.
3. *Child physical abuse—the toughest cases.* Ten cases will be presented and discussed. Each of these cases will represent "tough calls" where abuse is in the differential diagnosis, but other conditions also need to be considered. The cases will be presented in a step-wise fashion, using group process to determine how the treating physician should proceed to reach the best clinical answer. History, physical examination findings, radiologic studies and laboratory tests will be analyzed.
4. *Perpetrators of child physical abuse*—What does the epidemiologic literature say about who is likely to abuse, seriously injure, and kill children? How does this information affect approaches to physical abuse prevention?

The program became richer as well when the U.S. Department of Justice offered two lunch-time trainings on multidisciplinary child abuse teams. These presentations will be offered from 12:15 to 1:15 on Friday and Saturday.

We hope to see you in Tucson!

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at UCLA's Neuropsychiatric Institute, in Los Angeles.

New guidelines were adopted

The Board officially adopted three new sets of guidelines:

- The Use of Anatomical Dolls in Child Sexual Abuse Assessments (Mark Everson, PhD, Chair)
- Photographic Documentation of Child Abuse (Larry Ricci, MD, Chair)
- Descriptive Medical Terminology in Child Sexual Abuse (Joyce Adams, MD, Chair)

Soon to be approved are guidelines on the psychosocial assessment of psychological maltreatment, from the task force chaired by Stuart Hart, PhD, and Marla Brassard, PhD.

Copies of the Photographic Documentation and Medical Terminology guidelines are enclosed as a benefit of membership. Finishing touches are being put on the Anatomical Dolls guidelines, which will be available in the next several weeks. Additional copies are $5.00 to members, $8.00 to non-members.

A new standing committee on Professional Education was formed

The Board formally approved the creation of a Professional Education and Training Committee. This committee will oversee the development of additional professional education efforts, such as one-day regional trainings and videoteleconferences which will be more affordable and accessible to our members.

The committee is very clear that state chapters are to be integrally involved in the development of these trainings: the national office and state chapters will be working together at every point to ensure that APSAC is the source of the most reliable, high-quality training in the field.

Current efforts and activities

Media Relations

A letter sent by APSAC to the *New York Review of Books* was published early this year. The letter, in response to a two-part series by Frederick Crews, PhD, about repressed memory, entitled "Revenge of the Repressed," was the first of several printed, and drew a lengthy response from the author of the original articles. We have reprinted the letter in this issue (p.15). APSAC's Media Relations Committee and Urgent Issues Analysis Committee are planning much increased activity this year in an effort to provide some balance in the public discourse about child abuse and the professionals who respond to it.

CAPTA Reauthorization

As you know, the Child Abuse Prevention and Treatment Act (CAPTA) is up for reauthorization this year. APSAC has been active in trying to convince the U.S. Congress of the need for a continuing federal role in child abuse policy. While reasonable people can debate many aspects of the federal-state relationship on child welfare issues, APSAC has energetically attempted to convince legislators that children will be at greatly increased risk if the federal government fails to provide the following:

- **Immunity for mandated reporters.**
- **Federal funding for research.**
- **Continuing collection of national incidence data.**
- **Continuing insurance that states will devote adequate funds to prevent and treat child maltreatment.**

APSAC's letter to U.S. Senators is reprinted on page 23. You may want to call the national office (312-554-0166) for an update.

Statement on Therapist Roles and Responsibilities

A draft statement on the role of therapists in assessing allegations of child sexual abuse by clients is printed on page 29. This statement was drafted by Lucy Berliner, MSW, and Mark Chaffin, PhD, and has been reviewed by APSAC's Board of Directors.

This statement was drafted in response to a verdict in the malpractice suit, in which a judgment was made against a therapist who provided psychotherapeutic treatment for alleged child sexual abuse. The jury found the therapist at fault because she did not adequately investigate the charges made by her client that abuse had occurred. The judgment is being appealed.

This statement is offered to members for comment before being adopted as an official position of the organization. Please send your comments on this draft statement to the national office by May 31, 1995.

Mandated reporter survey

There has been much talk about retaliation against mandated reporters in the form of lawsuits or threats of suits, complaints to licensing boards or professional societies, and other acts. In the absence of any but anecdotal data, it is hard to gauge the true scope of this problem. In an effort to understand what is really being experienced by professionals who report suspected child maltreatment, APSAC is conducting a survey of its members. **Please complete the enclosed brief survey and return it to APSAC by May 31, 1995.** Survey results will be published in V.8, n.3 of *The APSAC Advisor*.

We hope that you will keep the leadership at both the state and national levels informed of your professional needs, and will participate actively in APSAC's attempts to meet them.

1994 APSAC Financial and Membership Report

1994 was a big year for APSAC, with a mid-year move to new offices and the addition of staff and computer infrastructure to better serve members' needs. In May, APSAC's Executive Committee had unanimously approved substantial deficit spending for 1994 and 1995 as an investment in these much-needed improvements. Stringent cost-saving measures resulted in a 1994 deficit less than half that projected, and in a balanced budget for 1995. APSAC is, as a result, on a much firmer financial footing than predicted.

APSAC's membership grew 16% in 1994, from 4,016 to 4,662. More than 78% of "regular" members renewed; 37% of those who gained membership by default through conference registration fees chose to renew. The table below shows net membership gain and loss by state for 1994.

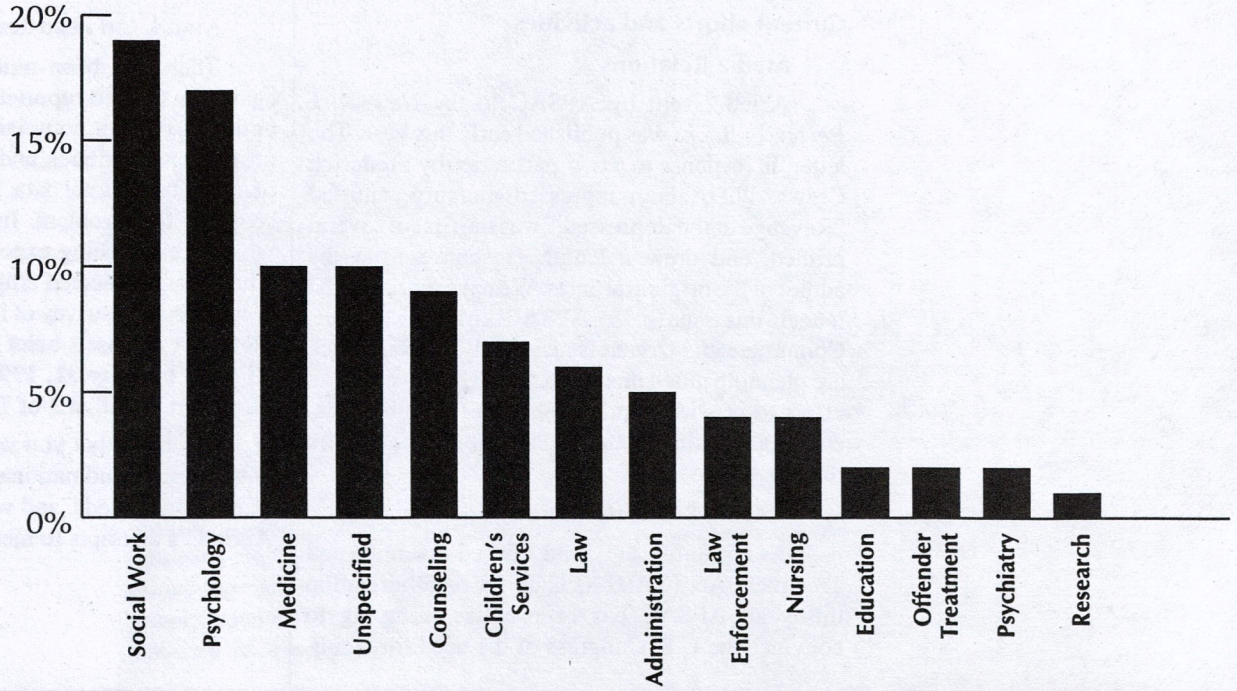
The bar graph shows the distribution of APSAC's 1994 members by discipline.

As you look at the membership numbers for your state or discipline, please remember that APSAC's best form of advertising is word of mouth. The national office has striking new membership brochures that will help in recruiting your colleagues who should add their weight to APSAC's. Call the office any time for a supply (312-554-0166).

MEMBERS BY STATE - Changes since 1993

States	Total 1994	Net Increase (#)	States	Total 1994	Net Increase (#)	States	Total 1994	Net Increase (#)
AK	22	-3	KY	53	14	NY	179	42
AL	61	-7	LA	19	3	OH	137	14
AR	50	18	MA	228	23	OK	93	-1
AZ	92	14	MD	85	13	OR	85	24
CA	657	114	ME	46	6	PA	99	13
CO	85	-5	MI	82	-10	RI	31	6
CT	67	24	MN	82	2	SC	66	27
DC	36	0	MO	82	-7	SD	7	2
DE	6	5	MS	18	-1	TN	102	-5
FL	134	25	MT	20	1	TX	186	8
GA	58	4	NC	160	11	UT	46	9
HI	44	8	ND	9	-2	VA	132	27
IA	48	12	NE	22	3	VT	18	0
ID	22	8	NH	61	10	WA	244	30
IL	208	-16	NJ	106	39	WI	128	31
IN	63	-8	NM	58	25	WV	8	1
KS	41	10	NV	38	5	WY	6	1

MEMBERS BY PROFESSION



WASHINGTON UPDATE

The major news for professionals in child abuse coming from Capitol Hill these days regards the reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA). APSAC has been active in trying to ensure that a federal role in child maltreatment policy and programs is maintained. APSAC leaders have worked closely with the National Child Abuse Coalition to plan and implement efforts to make legislators aware of the impact for children of proposed legislation such as HR4, the "Personal Responsibility Act." APSAC's Board has alerted members to the need for action, worked with state chapter leaders to mobilize activity, and written to, called, and met with Senators.

The status of legislation affecting CAPTA is changing quickly. Interested members are urged to call the national office for the most current information.

Below is the letter sent by APSAC to all U.S. Senators:

Honorable _____
U.S. Senate
Washington DC 20510

Dear Senator_____:

At this time, it appears as if the U.S. House of Representatives will eviscerate federal child abuse policy. We call upon you and your colleagues on the Senate Labor and Human Resources Committee to maintain the federal rules that benefit all Americans by ensuring that suspected child abuse is promptly reported, that a national research program on child abuse is continued, that states devote adequate funds to preventing and treating child abuse, and that the nation continue to track the incidence of this plague among its population.

Few epidemics have been as costly to this nation as has the ongoing epidemic of child abuse. Many research studies show that children who are abused and neglected often grow up wreaking havoc on the society that has allowed their maltreatment. A large percentage of teen runaways, juvenile criminals, juvenile prostitutes, and pregnant teens were abused and neglected in childhood. Studies show that as many as 90% of prison inmates and 60% of drug abusers were victims of child maltreatment. The social costs of crime and wasted human potential traceable to child maltreatment are incalculable.

An epidemic of these proportions, affecting all aspects of American life, requires a coordinated federal response. Since 1974, that response has been provided in the Child Abuse Prevention and Treatment Act (CAPTA, P.L. 93-247), which is up for reauthorization this year. The House of Representatives would submerge CAPTA and all of its provisions within the omnibus H.R. 4 (the "Personal Responsibility Act"). H.R. 4 would eliminate the National Center on Child Abuse and Neglect (NCCAN), the only federal agency charged with coordinating the nation's response to the abuse and neglect of its children. With NCCAN would disappear four indispensable aspects of federal child abuse policy:

Immunity for mandated reporters. In an effort to identify children and families in trouble, the federal government requires professionals who have contact with children to report suspected child maltreatment to investigative authorities. Balancing the perils for professionals who report with the rights of well-functioning families to be undisturbed, the federal government requires state reporting laws to provide immunity from liability for mandated reporters who act in good faith.

H.R. 4 would continue to mandate reporting, but would eliminate the requirement of immunity for mandated reporters. Clearly, without immunity from liability, many professionals will decide that reporting is not worth the risk. Already, many professionals do not report suspected abuse: studies have shown that more than 60% of children killed by their caretakers were not previously known to child protective services; that only 15% to 20% of child sexual abuse is reported to authorities; that more than 40% of professionals have failed to report one or more cases of suspected abuse. If anything, we need reporting laws with more protections, not fewer. Removing the immunity provision would paralyze our existing identification and response system.

Federal funding for research. NCCAN is the only federal agency specifically charged with funding scientific research on child abuse and neglect. Only $3 million per year is expended in this effort, yet the very small amount of money invested in this research program has yielded much of what we know about child maltreatment.

The wise use of limited resources requires that certain functions be performed at the national level. Funding scientific research is one of those functions. States simply will not pick up this activity, nor are they technically or organizationally equipped to do so. Imagine trying to conduct all cancer research at the state level by eliminating the National Cancer Institute and block granting the money to the states with no restrictions on how it would be spent. The result would be 50 unrelated cancer research programs, none with the proper resources or technical infrastructure to support appropriate scientific review and oversight. Such an approach would cripple cancer research, yet is exactly what is being proposed for scientific research on child abuse.

Research has clearly demonstrated that child maltreatment is a serious but preventable contributor to many of our most devastating social problems; to eliminate the agency primarily responsible for conducting scientific research in this area is unconscionable. We need more research to help us

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Washington Update

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cope with this blight on our society, not less.

Collection of national incidence data. The only program for collecting national data on child abuse and neglect is funded through CAPTA and conducted through NCCAN. H.R. 4 would eliminate this national data collection effort. We have better data about monthly sales of kitchen appliances than about child abuse, one of the major perils faced by children. These data are the indispensable foundation for effective social policies about child maltreatment, and only the federal government has the wherewithal and the authority to gather them.

Federal ensurance that states will devote adequate funds to prevent and treat child maltreatment. H.R. 4 does not require states to match federal dollars for prevention and treatment of child abuse and neglect, or even to continue spending on child abuse and neglect services. The federal government needs to articulate clearly its awareness that child maltreatment is at the root of major social ills, and that to alleviate those ills we need to respond to their causes, not just to their symptoms. The federal government should mandate that the states spend adequate funds on programs designed to prevent and treat child maltreatment—ideally, programs whose effectiveness has been demonstrated through federally funded research and demonstration projects.

H.R. 4 attempts much that we support: block granting monies that currently are passed through federal agencies to states for service programs will likely eliminate red tape and increase the resources available for services to citizens. The unintended consequences of the bill, however, would be disastrous for America's maltreated children and, by extension, for the nation as a whole. The staggering social cost of child maltreatment is one of this society's greatest problems. We call upon you and your Senate colleagues to ensure that we do not as a nation shrink from the critical federal role in child abuse policy and programs.

Sincerely,
Theresa Reid, Executive Director
for the Board of Directors of American Professional Society on the Abuse of Children (APSAC)

MEDIA REVIEWS

Child abuse: Medical diagnosis and management **Robert M. Reece. Williams & Wilkins, 1994. 466 pp. $72.00.**

—Reviewed by Angelo P. Giardino and Eileen Riviello Giardino

Child abuse is a comprehensive medical textbook that provides state-of-the-art reviews of a wide range of topics important to professionals who care for maltreated children. Each chapter is written by a noted clinician or investigator in the field of child abuse. This is a consistent, even-reading volume that offers a wealth of information. The text is organized, well-written and up to date.

Child abuse: Medical diagnosis and management is written for both clinicians and scholars. It is an excellent reference for the professional involved in the medical evaluation of maltreatment, as it focuses primarily on physical findings.

Child Abuse has 19 chapters carefully indexed for quick reference with numerous tables and diagrams. Topics covered in the chapters are: 1) head trauma; 2) skeletal manifestations; 3) thoraco-abdominal injuries; 4) poisoning; 5) fatalities and SIDS; 6) opthmalogic manifestations; 7) facial and dental manifestations; 8) dermatolgic manifestations; 9) sexual abuse; 10) photodocumentation; 11) MSBP; 12) neglect; 13) FTT; 14) pathology of fatal abuse; 15) and 16) differential diagnosis of physical and sexual abuse; 17) genetic syndromes that mimic abuse; 18) legal aspects; and 19) an overview of medical research on child abuse.

Chapters are substantive in content and approach, and each contains extensive references. Several chapters include color plates depicting the subtle clinical findings described in the text. The chapters on sexual abuse, differential diagnosis of both physical and sexual abuse, and genetic syndromes are especially thorough and clinically relevant. For example, the chapter on differential diagnosis of physical abuse contains several useful tables that summarize a large collection of case studies. Each table—bruising, burns, intracranial bleeding, ophthalmologic findings, fractures, and miscellaneous findings—lists the citation for the case report, a description of the case(s), if the child was referred as abuse or neglect, and final diagnosis attributed to the case.

Child abuse: Medical diagnosis and management is written for both clinicians and scholars. It is an excellent reference for the professional involved in the medical evaluation of maltreatment, as it focuses primarily on physical findings. Nurses, physicians, and medical social workers will be comfortable with the material present. Non-clinical professionals may find it a useful text to help understand the health care provider's perspective, although mental health and psychosocial issues related to child abuse are not addressed. Dr. Reece's book is a welcome addition to the libraries of primary care providers, scholars, and clinical educators.

Angelo P. Giardino, MD, FAAP, is clinical assistant professor of Pediatrics at the University of Pennsylvania School of Medicine and Eileen Riviello Giardino, PhD, RN, is Associate Professor of Nursing at La Salle University, Philadelphia, PA.

▲▼▲

1) True/Not True: When Memories Can be Trusted. $39.50 2) Identifying Dissociation in Children. 3) Treating Dissociation in Children. $150.00 each; both for $250.00. **Cavalcade Productions, Ukiah, CA. 1994**

— Reviewed by Daniel Smith, PhD

continued on next page

Media Reviews

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Although all three of these videotapes address important and relevant issues in the field of trauma and memory, all three put the cart before the horse. *True/Not True* is intended for patients and their relatives who have questions about the phenomenon of "repressed" memory, or about the validity of events remembered after having been forgotten for a time. Such an effort is clearly worthwhile, as such issues are likely to be very confusing and distressing to those involved. However, this tape is unlikely to provide its intended audience with much satisfaction. Although the information is empathically and authoritatively presented, the vocabulary is likely too sophisticated and full of psychological jargon ("long term potentiation", "global autobiographical memory impairment") to be understood by most clients, and is more likely to befuddle or intimidate. Furthermore, the program's title implies that some information will be provided that would allow the viewer to differentiate "true" memories from those that are "not true." However, no such information is offered, and the clear overarching point of view in the video is that all "recovered" memories are genuine if they are connected with strong, unpleasant feelings, or "body memories." The empirical knowledge base about memories does not warrant such a conclusion at this time. Although this point of view may "make sense" to practicing clinicians, it may be less convincing to the truly curious or skeptical patient or family member. It is unfortunate that this tape is not more practical, because the individuals that appear on it are some of the most knowledgeable persons in the field. However, I believe that the nascent state of the empirical work on this issue simply does not yet permit definitive statements about how to determine the truth or untruth of memories.

Similar issues also colored my reactions to the *Identifying Dissociation in Children and Treating Dissociation in Children* tapes, which are not so much about childhood dissociation as about childhood Multiple Personality Disorder. This is doubly unfortunate, as MPD has been replaced in the DSM-IV by the more refined diagnosis of Dissociative Identity Disorder. The tapes, which are targeted primarily at therapists working with traumatized children, feature several experienced clinicians and researchers offering insight into their assessment and therapeutic techniques. They accurately point out that behavioral manifestations of dissociation, such as mood swings, attention deficits, or aggression, might be mislabelled as common childhood behavior problems. However, very little is provided in the way of information to assist in discriminating a depressed child's mood swings from the same problems in a child with MPD. This important omission very likely occurred because such data do not exist. As a result, the viewer unfortunately is left with the impression that if a traumatized child has attention problems, mood swings, etc., it is likely the child has MPD. Equally troubling is the assertion in the Identifying tape that teachers need to be educated about the symptoms of MPD in order to prevent misdiagnosis. Such a recommendation implies that MPD is commonplace in children, but no data exist to support that view.

In *Treating Dissociation*, the same group of experts share their model for working with children who have multiple personalities. They highlight the importance of insuring the continued safety of the victimized child, and of getting the various personae to "work together as a team." Unfortunately, they also assert that if little progress is being made in treatment, it is likely that the child is still undergoing abuse. Such bold generalizations, offered with little or no empirical basis, are troubling; certainly alternative explanations for lack of progress might exist. Excerpts from interviews of children with MPD are included to illustrate the particular aspects of treatment discussed by the experts. Such excerpts are often helpful, but those who fear that MPD has an iatrogenic source, such as poor interviewing skills, will find much to disturb them in these vignettes. The video also describes techniques for working with children with MPD, but these amount to little more than projective drawing and other relatively common techniques for helping children express affect about their traumatic experiences. Such shortcomings seriously detract from the tape, which might otherwise be useful for moderately experienced clinicians looking for tips on working with this very disturbed population. In general, then, it seems premature to issue these tapes at a time when dissociative phenomena are not well understood, when the state of knowledge is incapable of identifying prescriptive treatments or therapeutic interventions, and while no empirical data exist to support many of the points made on the tapes.

Daniel Smith, PhD, is a post-doctoral fellow at the Medical University of South Carolina's Crime Victims Center.

NEW AGENCY SUBSCRIPTION OFFERED

APSAC OFFERS NEW "AGENCY SUBSCRIPTION" FOR CPS AND LAW ENFORCEMENT.

APSAC is reaching out to professionals in child protective services (CPS) and law enforcement by offering agency subscription to *The APSAC Advisor* and APSAC Guidelines for Practice near cost. CPS and law enforcement agencies must purchase a minimum of ten subscriptions to qualify.

Members can further APSAC's effort to deliver relevant professional education to CPS and law enforcement professionals by informing agency leaders about the new subscription. For further information, call 312-554-0166.

THANK YOU! APSAC's Endowment Fund

The people listed below have made cash contributions to APSAC's Endowment Fund in the last twelve months. We thank them very warmly for their willingness to "dig a little deeper" to support an organization that means so much to them.

Contributions to APSAC's Endowment Fund are preserved in a separate bank account to help ensure APSAC's long-term financial security. More than $19,000.00 has been contributed by individuals in the last few years to help grow this fund.

Late in 1994, APSAC's Development Committee created several additional ways for members and friends to support APSAC's activities. Individuals can now make contributions earmarked for specific activities of the organization, including efforts to influence media coverage of child maltreatment, to influence legislation affecting child maltreatment, to produce more guidelines for practice, to support research in the field of child maltreatment and for scholarships to APSAC's Colloquium. Donations made to these efforts will be added to APSAC's operating funds to underwrite the activities specified.

APSAC's leaders extend their warmest thanks for donors' show of confidence and support.

We thank the following friends for making cash contributions to APSAC in 1994-94:

Veronica Abney, MSW
Catherine Ayoub, RN, EdD
Christopher Barthel III, PhD
Barbara Bates, MA
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Carol Berkowitz, MD
Barbara Bonner, PhD
Nancy Bottorff, MFCC
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Kathy Holleran's 6th grade class of the Roycemore School, Evanston, Illinois
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Cassandra Lowe, MA
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Harry Elias, JD & Kee MacFarlane, MSW
Phillip Madonna, MSW
Glenda Ann Mathias, RN, BS, and colleagues in memory of Siegfried Mathias
Kim McCollum
Karen McKay, MSW, JD
Irene Mellick, LCSW
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Theresa Reid, MA & Mark Hershenson, MD
Anita Remignanti, EdD
Carolann Roberts, MS
Karen Ross, BSW
Theoharis Seghorn, PhD
Robin Semas, MSW
Bert Sewell, MD
Edward and Janet Sharkey in memory of Ann Sharkey
Ellie L. Smith, MEd
Sandra Block Steiker, MSS
Paul Stern, JD
Richard P. Stoughton Jr.
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Theresa Tucker
Deborah Daro, DSW & A. Coleman Tuggle
Lt. Bill Walsh
Linda Williams, JD

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PLEASE ACCEPT THIS TAX-DEDUCTIBLE CONTRIBUTION:

$ _____ for promising student research in child maltreatment
$ _____ for efforts to promote accurate public awareness about child maltreatment.
$ _____ for scholarships to APSAC's Colloquium.
$ _____ for the production of Guidelines for Practice.
$ _____ for APSAC's general Endowment Fund.
$ _____ **TOTAL AMOUNT ENCLOSED**

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AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN
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JOURNAL HIGHLIGHTS

Edited by
Thomas F. Curran

The purpose of Journal Highlights is to inform readers of current research on various aspects of child maltreatment. Selected articles from journals representing APSAC's multidisciplinary membership are represented in an annotated bibliography 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

Berliner, L. (1994). The problem with neglect; and **Dubowitz, H.** (1994). Neglecting the neglect of neglect. *Journal of Interpersonal Violence, 9(4)*, 556-560.

In this brief "Commentary," the neglect of child neglect by child maltreatment literature, research funding sources, and professionals who routinely work with maltreated children is examined. Dubowitz offers some possible explanations for this omission of what is the cause of nearly half of all child maltreatment-related fatalities each year. From his observation that "the term `abuse' connotes a ring of urgency in a way `neglect' does not," to the difficulty in defining child neglect, this short piece offers a great deal for practitioners and policy makers to consider regarding the most commonly reported type of child maltreatment.

Buntain-Ricklefs, J., Kemper, K., Bell, M., and Babonis, T. (1994). Punishments: What predicts adult approval. *Child Abuse and Neglect, 18*(11), 945-955.

A total of 527 parents completed the Parent Discipline Attitudes Survey, which was derived from the Emotional and Physical Abuse Questionnaire (EPAB) to assess: a) the prevalence of various types of physical and emotional punishment received during their childhoods; b) the prevalence of current parental approval of these types of punishments; and c) risk factors associated with current approval of physical and emotional abuse. While few parents approved of most types of physical and emotional punishment, 19% approved of hitting children with objects; 25% approved of hitting with a belt; and 88% approved of spanking. In addition, receiving more punishment as a child was strongly associated with current acceptance of physical and emotional forms of punishment, lending support to the theory that physical punishment of children serves to legitimize the later use of violence.

Carey, T.A. (1994). Spare the rod and spoil the child. Is this a sensible justification for the use of punishment in child rearing? *Child Abuse and Neglect, 18*(12), 1005-1010.

This brief article examines the proverb, "Spare the rod and spoil the child," in both its modern and commonly misquoted Biblical forms, as well as concepts and theoretical support for punishment and corporal punishment. A behaviorist perspective suggests that corporal punishment does not result in a prolonged reduction in targeted behaviors and, therefore, cannot be considered punishment. Instead, the author argues that corporal punishment is unnecessary and inherently abusive.

Hemenway, D., Solnick, S., and Carter, J. (1994). Child-rearing violence. *Child Abuse and Neglect, 18*(12), 1011-1020.

A national random sample of 801 adults was questioned about the punishment they received as children and the way they (now) discipline their children. Data analysis from this study revealed that verbal and physical discipline co-occur: parents who yell frequently are also more likely to hit frequently, and parents who rarely yell, rarely hit. In addition, both physical and verbal violence appear to be transgenerational.

SEXUAL ABUSE

Deblinger, E., Stauffer, L., and Landsberg, C. (1994). The impact of a history of child sexual abuse on maternal response to allegations of sexual abuse concerning her child. *Journal of Child Sexual Abuse, 3*(3), 67-75.

With a total sample of 183 nonoffending mothers of suspected victims of child sexual abuse (CSA), this study compared mothers with (n=83) and without (n=100) a history of CSA with respect to demographic variables, psychosocial functioning, and personal responses to abuse allegations concerning their children. Results indicated only two significant differences in psychosocial adjustment as a function of maternal history of CSA: mothers with a history of abuse exhibited significantly higher levels of general symptom distress, and felt more alone in facing their child's abuse.

Gilbert-Evans, C.M., and Redditt, C.A. (1994). Adolescent sexual offenders: Potential for a healthier lifestyle. *Issues in Mental Health Nursing, 15*(5), 505-518.

A general overview of research on adolescent sex offenders is provided, along with some of the assessment and treatment roles and responsibilities which are unique to psychiatric/mental health nurses. The authors argue in favor of family system-based intervention which focuses on individual variables that contribute to the sexual offense, understanding victim impact, and resolution of family-related factors that precipitated and maintained the offending behavior. The authors call for violence-related content as a mandatory part of all nursing education, and for psychiatric/mental health nurses to provide holistic assessment and treatment that includes attention to physical health-related issues.

Levesque, R.J.R. (1994). Sex differences in the experience of child sexual victimization. *Journal of Family Violence, 9*(4), 357-369.

This study analyzed 390 cases of child sexual abuse (303 girls; 87 boys) to expand on existing research on gender differences in child sexual victimization. Three areas which have received consider-

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able empirical attention were focused upon: victims' relationship with the offender, type and extent of abuse, and disclosure. Findings largely replicated previous studies regarding sex differences in victims' relationships with offenders, and for differences in disclosure patterns. Contrary to previous findings regarding the type and extent of abuse, this study found significant gender differences, including that girls were more likely to report directly to police, while boys were more likely to be identified as suspected victims by anonymous reports. In addition, girls were found to be victims of more physical injury, violent threats, and use of force. These results also contradict the popular belief that children do not self-initiate disclosures of sexual abuse.

Lisak, D. (1994). The psychological impact of sexual abuse: Content analysis of interviews with male survivors. *Journal of Traumatic Stress, 7*(4), 525-548.

Autobiographical interviews with 26 adult male survivors of childhood sexual abuse were audiotaped, transcribed verbatim, and content analyzed to identify common psychological themes. Interestingly, a near equal number of the men were abused by male and female perpetrators. Clinical observations of previous studies of adult male survivors were validated. Fifteen psychological themes/states were identified and discussed in detail. One of the most salient aspects of this analysis was the impact of childhood sexual abuse on the victims' current perception of their gender and sexual identities.

Pescosolido, F.J. (1993). Clinical considerations related to victimization dynamics and post-traumatic stress in the group treatment of sexually abused boys. *Journal of Child and Adolescent Group Therapy, 3*(1), 49-73.

Clinical considerations inherent in the development of a boy's time-limited psycho-educational sexual abuse group are described. The boy's presenting problems are divided into two categories: victimization dynamics and post-traumatic stress. Five impact-specific dynamics are discussed, including victim-victimizer identity struggle, abandonment fear, accelerated sexual arousal, body conflict, and shame. Post-traumatic stress dynamics are psychophysiological dysregulation, post-abuse reenactment potential, post-abuse triggers, intrusion, and numbing.

Zlotnick, C., Begin, A., Shea, M.T., Pearlstein, T., Simpson, E. and Costello, E. (1994). The relationship between characteristics of sexual abuse and dissociative experiences. *Comprehensive Psychiatry, 35*(6), 465-470.

This study of 56 severely traumatized female psychiatric inpatients found that a reported history of sexual revictimization by a greater number of offenders (four or more) was significantly related to a higher level of adult dissociative experiences. In addition, the women in this study reported histories of both sexual and physical abuse, and on average, high scores on the Dissociative Experience Scale (DES). Two plausible explanations are offered for the relationship between high dissociators and being abused by several offenders: first, that initially dissociation is used successfully as an escape mechanism against trauma; and second, that individuals who suffer from dissociative pathology are more vulnerable to revictimization.

OTHER ISSUES IN CHILD MALTREATMENT

Brody, A.L. and Green, R. (1994). Washington State's unscientific approach to the problem of repeat sex offenders. *Bulletin of the American Academy of Psychiatry and Law, 22*(3), 343-356.

Policy makers, attorneys, and clinicians who treat sex offenders will find this examination of Washington's 1990 Sexual Predator Act interesting. Despite the authors' clear bias, they raise important legal and ethical issues surrounding this Act.

Myers, J.E.B. (1994). Taint hearings for child witnesses? A step in the wrong direction. *Baylor Law Review, 46*, 873-945.

A thorough analysis of the New Jersey Supreme Court's June 1994 decision in State v. Margaret Kelly Michaels (136 N.J. 299, 642 A.2d 1372, 1994) is presented. The Court ventured into previously uncharted waters by ruling that where a substantial likelihood exists that interviews of child sexual abuse victims were improperly conducted, a pretrial "taint" hearing is required, and that the State must show by clear and convincing evidence that statements contained a sufficient degree of reliability to warrant admission at trial. This article argues, quite convincingly, that Michaels was wrongfully decided. However, given the Court's decision, a framework for conducting "taint" hearings is presented.

Toubia, N. (1994). Female circumcision as a public health issue. *The New England Journal of Medicine, 331*(11), 712-716.

This article reviews the most common types of female circumcisions, or as the author describes the practices, female genital mutilation; their complications; problems in caring for circumcised women; and a brief review of legal and ethical issues associated with this practice. Noting that the mildest form of female circumcision, clitoridectomy, is anatomically equivalent to amputation of the penis, the author argues that any form of female circumcision will result in damage to the clitoris. Physical complications, along with psychological and sexual side effects of female circumcision, are discussed in detail, along with an examination of its cultural meanings. Citing four through ten as the ages at which girls are most commonly circumcised, this article invites important discussion of how a culturally accepted practice can still be abusive to a child.

The Journal Highlights Editor wishes to thank Robert M. Reece, MD, and Francis Pescosolido, MEd, MSW, MPH, for their assistance with this issue.

MEMBER COMMENT SOLICITED

DRAFT STATEMENT: THERAPIST ROLES AND RESPONSIBILITIES IN THE CLINICAL ASSESSMENT OF CLIENT ABUSE HISTORY

THIS DRAFT STATEMENT IS PRESENTED TO APSAC'S MEMBERSHIP FOR COMMENT, IN ACCORDANCE WITH APSAC'S POLICIES AND PROCEDURES FOR ISSUING STATEMENTS ON BEHALF OF THE ORGANIZATION. MEMBERS ARE ENCOURAGED TO COMMENT NO LATER THAN MAY 31, 1995, BY WRITING OR FAXING APSAC, ATTN: THERAPIST STATEMENT. 407 S. DEARBORN ST., SUITE 1300, CHICAGO, IL 60605. FAX: 312-554-0919.

The following statement is issued to clarify the position of the American Professional Society on the Abuse of Children (APSAC) regarding the methods for assessing client abuse histories used by mental health professionals providing non-forensic clinical services to children and adults.

SCIENTIFIC BASIS

Research indicates that people maltreated in childhood are more likely to experience a range of medical, psychological, emotional, and behavioral problems as children and adults. Reliable studies have also revealed that a substantial percentage of individuals seeking medical or mental health treatment have experienced child abuse. Child abuse is a significant risk factor, and presumably an important etiological factor, for the development of a variety of medical and psychological disorders. The scientific research literature indicates that abuse history is relevant to understanding current and past functioning, and to developing an appropriate treatment plan.

SCREENING FOR ABUSE HISTORY

In non-forensic clinical practice, standard practice is to rely primarily on client self-report, or in the case of children, information presented by caretakers. Competent therapists recognize the limitations of self-report information and understand that it is not always completely accurate. Clinicians also understand that many other sources of information have limitations on their accuracy as well. From a clinical standpoint, the accuracy of self-report information may be less important than the subjective meaning and impact of past events as perceived by clients.

Practitioners routinely make judgments about the accuracy of client-reported historical events. As with other potentially relevant experiences, practitioners should attempt to form a professional opinion regarding the plausibility of child abuse histories reported by clients. Ordinarily, this opinion is based upon clinician assessment of the quality and nature of the abuse reports, reports of other historical events, client functioning and psychological status, and consideration of possible alternative explanations. In some cases, interviewing outside parties or reviewing materials may be useful. However, taking such actions is neither an obligation of the clinician nor necessary to arrive at a professional opinion. In many cases arriving at a firm conclusion about whether or not child abuse occurred is impossible.

LEGAL VERSUS CLINICAL ROLES

Forensic evaluations conducted at the request of legal authorities or for the explicit purpose of gathering information as part of an investigation or legal action differ from clinical assessments. The results of these evaluations are intended for use in legal decision-making or proceedings. These evaluations usually do involve seeking independent information to supplement or support/contradict client self-reported information.

It is not standard clinical practice for therapists to conduct independent investigations of histories of child abuse and neglect or other historical events as described by their clients. Investigations are the domain of child protective service and law enforcement agencies. These legally authorized investigations may be compromised if therapists conduct their own investigations. The use of investigative procedures in clinical assessments is not standard clinical practice and is not recommended.

Clinicians must observe the requirements of state laws with regard to child abuse reporting and client confidentiality. If clinicians seek or convey information outside the therapist/client relationship, client consent must be obtained, unless abrogation of confidentiality requirements is legally mandated or permitted. Practitioners who choose to use other sources of information to supplement the standard client assessment process may only do so with client consent. They should not provide information to other interested parties except as permitted by law or with client consent. Therapists do not have any affirmative duty to report information learned in the clinical setting except as legally required. Therapists should make every effort to maintain the confidential nature of the therapeutic relationship.

This draft statement is for discussion only. It is subject to change, and should not be quoted, used in court testimony, or otherwise represented as a statement endorsed by the American Professional Society on the Abuse of Children (APSAC).

APSAC Discounts

April 7, 1995. ***Child maltreatment: The primal wound.*** New York, NY. First annual meeting of APSAC's New York chapter, NYPSAC. Keynote speaker: James Garbarino, PhD. Contact Anne Meltzer (914-722-0042). Leah Harrison (718-920-5833), or Eileen Treacy (718-823-5988).

April 7-9, 1995. ***Fifth Annual Mental Health and the Law Symposium.*** Ft. Lauderdale. Sponsored by the University of Miami School of Law. Fourteen presenters, including J. Becker, S. Brodsky, C.P. Ewing, C. Slobogin, B. Sales. Contact Bruce Frumkin, 305-666-0068.

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 312-554-0166, for information.

October 11-14, 1995. ***The Association for the Treatment of Sexual Abusers' 14th Annual Research and Treatment Conference.*** New Orleans, LA. Call Connie Isaacs at 503-233-2312.

May 24, 1995. ***"Advocating for Children in the 21st Century,"*** Chicago, IL. Sponsored by APSAC's Illinois chapter, IPSAC. Keynote speakers include Patrick Murphy and Senator Tom Dart. Contact Erin Sorenson at 708-885-0100 for more information.

June 1, 1995. ***"Child Sexual Abuse in the Latino Community."*** Cambridge, MA. Co-sponsored by APSAC's Massachusetts chapter, MAPSAC. Keynote speaker: Dr. Anthony Urquiza, PhD. Contact Monica Roizer-Hayes at 617-484-6392 or Dalia Llera a 617-349-8313.

November 2, 1995. ***"Responding to Child Abuse: Collaboration in the 1990's."*** Sturbridge, Massachusetts. Co-sponsored by the Massachusetts Society for the Prevention of Cruelty to Children and the Massachusetts Chapter of the American Professional Society on the Abuse of Children. For more information, contact the MSPCC, 43 Mt. Vernon, Boston, Massachusetts, 02108.

November 6-9, 1995. ***Midwest Conference on Child Sexual Abuse and Incest.*** Madison, Wisconsin. Co-sponsored by Family Sexual Abuse Treatment and the University of Wisconsin. Contact Jill Cohen at 608-244-4022 or Jim Campbell at 608-262-2352 for more information.

November 9-12, 1995. ***National Symposium on Child Victimization.*** Sponsored by the Children's National Medical Center.

November 20-22, 1995. ***"Networking in the Nineties."*** Stouffer National Hotel. A multidisciplinary conference sponsored by the Tennessee chapter of APSAC. Contact Judith Brown at 901-525-2377 for more information.

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

Other Conferences

April 4-7, 1995. ***Finding Better Ways: Working with High-Risk Youth and Their Families.*** Cambridge, MA. Sponsored by the Albert E. Trieschman Center and Boysville of Michigan. Call Trieschman Center 617-449-0625, Ext. 125.

April 19-28, 1995. A 9-day intensive clinical workshop on ***Intervention and Treatment of Child Sexual Abuse*** will be offered by the Giarretto Institute in San Jose, California. Call Susan Denison at 408-453-7611, extension 144.

April 20-21, 1995. ***"Sexual Abuse, Memory, and the Law: A Feminist Perspective."*** University of Pennsylvania, Philadelphia. Sponsored by the Women's Law Project of Penn Women's Center. For more information, contact Michele Friel at 215-928-9801.

April 24-28, 1995. ***Comprehensive Child Sexual Abuse Intervention: Advanced Training in the Multidisciplinary Approach - Discipline Specific Case Management.*** and **September 18-22,** ***Accountability and resolution.*** Huntsville, AL. Sponsored by the National Children's Advocacy Center and the National Resource Center for Child Sexual Abuse. Registration limited to 100 participants. Call 800-239-9938

April 25-27, 1995. ***13th Annual Protecting our Children National American Indian Conference on Child Abuse and Neglect.*** Minneapolis, MN. Sponsored by the National Indian Child Welfare Association and the American Indian Institutes, University of Oklahoma. Call Larry Douglas 503-222-4044, Ext. 14 or Fax 503-222-4007.

May 15-19, 1995. ***The 23rd Annual Child Abuse and Neglect Symposium.*** Keystone, CO. Sponsored by the C. Henry Kempe National Center. Call 303-321-3963. Fax 303-329-3523.

May 20-23, 1995. ***National Court Appointed Special Advocate Association Conference.*** Scottsdale, Arizona. Contact Yvonne Sanchez at 1-800-628-3233.

May 24-26, 1995. ***The UC Davis 14th Annual Child Abuse and Sexual Assault Conference.*** Sponsored by the University of California Davis Department of Pediatrics. Call the UC D Office of Continuing Education at 916-734-5390

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

September 28-October 1, 1995. ***The 6th National Conference on Abuse, Trauma & Dissociation.*** The Driskill Hotel, Austin, Texas. Sponsored by the Texas Society of Trauma and Dissociation and the American Coalition for Abuse Awareness. Contact Mary Lewis at 903-595-6600 for further information.

MOVING?

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

NEW BOOK RELEASE

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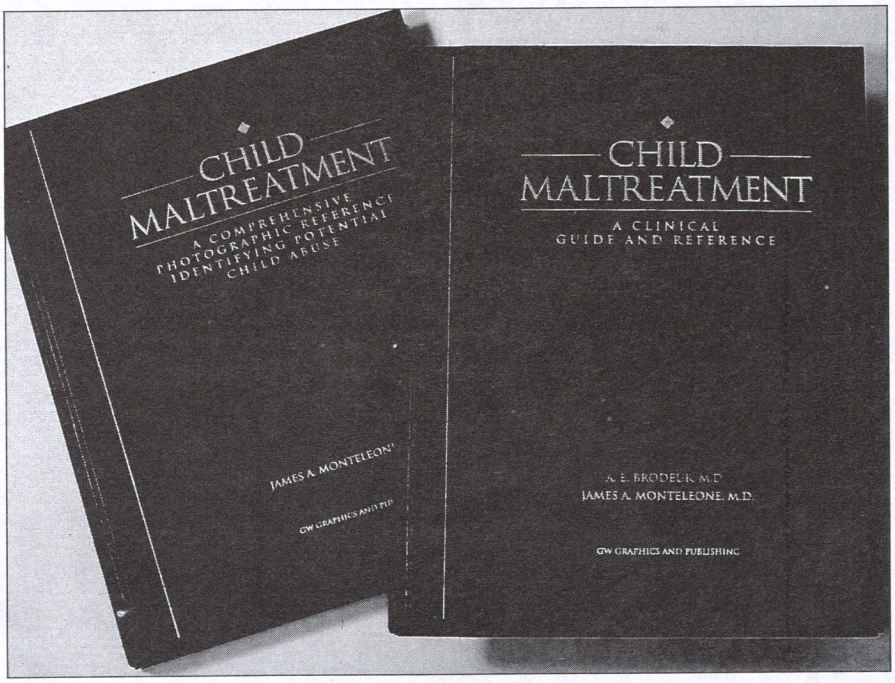

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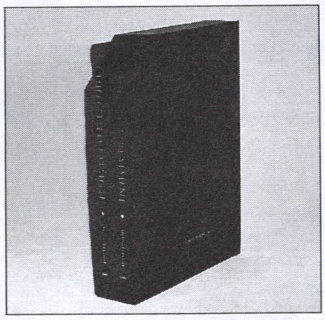

The clinical guide and reference book is the first publication on child abuse without gaps. ***General practitioners, pediatricians, EMTs, radiologists, lawyers, psychiatrists, police and safety personnel,*** and ***state agencies*** cannot afford to be without it. While addressing the physical finds in sexual abuse, the reference emphasizes the most important components of the process– disclosure and interview of the suspected victim. In-depth information is provided on medical, psychological, social, and legal aspects of child abuse. Readers will learn how to testify in court, and how the legal and social systems process a child abuse case.

The atlas, a valuable reference and teaching tool, presents quality color photos of the various aspects of child abuse, principally physical and X-ray. Emotional aspects are represented by abused children's drawings. A brief descriptive history of the case accompanies most of the photos, with an explanation of the salient features demonstrated. In addition to the professions listed above, this text would benefit psychologists and forensic specialists.

Inside this volume...

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9. Sexual Abuse – the Interview
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