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APSAC ADVISOR

AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

CHILD PROTECTIVE SERVICES
The Health Status and Care of Children in Out-of-Home Care

—by Christine Risley-Curtiss

Introduction

One intervention frequently used to protect children who are at risk for maltreatment is placement in out-of-home care. Nationally, approximately 75% of children placed in out-of-home care are there primarily because of abuse, neglect, or abandonment (U.S. Department of Health and Human Services, 1988). At the time of placement most of these children have experienced inadequate physical and psychosocial care (Hochstadt et al., 1987; Chernoff et al., 1994). Unfortunately, while placement in out-of-home care (i.e., removal from the home) is intended to be a therapeutic intervention, it may contribute to a child's poor health (Eisenberg, 1962; Fine, 1989; Schor, 1988). The placement experience itself means separation from significant adults, siblings, and familiar surroundings. Many children come into care from crisis situations and may soon experience changes in placement. Any ongoing health care they may have had is interrupted.

In light of these circumstances, children in out-of-home care represent one of the most vulnerable groups in the United States in terms of their emotional, mental, and physical health needs. Ensuring that such needs are met is recognized as a responsibility of the child welfare agency (National Commission on Foster Family Care, 1991; United Way, 1987). However, the probability is small that the comprehensive health needs of these children will be served, with medical and mental health services to children in out-of-home care often duplicated, inefficient, and fragmentary (e.g., Halfon & Klee, 1987; Moffat et al., 1985: Schor, 1982; Shah, 1974a).

The purpose of this article is to review what is currently known about the health status and care of children in out-of-home care, and to provide recommendations to help ensure that the health needs of these children are better met.

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NEWS
1997 Colloquium, APSAC Code of Ethics, Nearing Completion

—by Theresa Reid

APSAC's commitment to involving members in the planning of their annual Colloquium has paid off again. For the past several months, more than 40 members have worked in disciplinary and topical subcommittees (child protective services, law enforcement, mental health, law, medicine/nursing, cultural issues, and research) to develop a 1997 Colloquium — to be held June 18-21, 1997, in Miami Beach, Florida — that is rich and diverse enough to address all aspects of child maltreatment.

They have succeeded admirably. One hundred scheduled seminars address such issues as the importance of corroboration in child maltreatment investigations, supervision in child protective services, biomechanics of abusive head trauma, assessing and intervening in neglect, conducting psychotherapy with adult survivors and child victims of trauma, forensic interviewing of children, representation of children in court, coordinating responses to fatal maltreatment, and interventing with women and children involved in domestic violence. Intensive, empirically-based skills training seminars range from three hours to six hours in length. Dozens of high quality ninety-minute field-generated presentations on all aspects of child maltreatment add breadth and diversity to the program.

A special pre-Colloquium institute — *"Enfrentando el maltrato:* Facing child maltreatment in Latino communities" — is open to all Colloquium registrants, and cultural issues in child maltreatment will be addressed throughout the program. The latest research in child maltreatment will be presented in daily research breakfasts, poster presentations, and in a daylong research symposium. In Open Forums every evening, Colloquium participants will meet in less formal settings to participate in case consultations on various aspects of maltreatment, discuss ambiguous physical findings, explore ways of "helping the helper," and debate ethical and legal issues for professionals who work in this field.

A complete Colloquium program will be sent to APSAC members in early February.

APSAC's annual national Colloquium is the

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A Swan Song and Thanks from the Editor-In-Chief

—by Susan Kelley, RN, PhD

My formal role with the *APSAC Advisor* began in 1989 when David Corwin, MD, founding Editor-in-Chief, appointed me Associate Editor of, "Journal Highlights." Little did I know what I was in for! When David stepped down in 1990, I was asked to attempt to fill his shoes.

My two terms as Editor-in-Chief of the *APSAC Advisor* have been one of the most rewarding aspects of my professional life, primarily because of the colleagues with whom I have had the privilege to work. Planning and executing each issue of the *Advisor* is a team effort of editors and APSAC staff. I thank each of the Executive Editors, Associate Editors, and Guest Editors with whom I have worked over the past six years, both for their inspiration and for the hard work with which they have followed it up.

A special thanks goes to Theresa Reid, APSAC's Executive Director, who has kept the *Advisor* running since its inception in 1988 and who is largely responsible for its success.

I also extend my gratitude to each of the *Advisor* authors who have generously shared their expertise with the Advisor readership. The willingness of these authors, who simultaneously publish in prestigious and scholarly journals, to write for the *APSAC Advisor* is responsible for the outstanding reputation of the *Advisor* and is a moving testament to their commitment to APSAC's mission.

Beginning with V.10, n.1, Debra Whitcomb, MA, will be Editor-in-Chief of the *APSAC Advisor*. Debra is well known as the author of *When the Victim is a Child*, and is President of MAPSAC, APSAC's Massachusetts chapter. I know you will join me in wishing Debra the best as she assumes the helm of the *Advisor*.

Thank You!

—by Theresa Reid

Much as Susan Kelley has given to the *APSAC Advisor* over the years, these contributions are only part of what she has given to APSAC. Susan also serves as chair of APSAC's Awards Committee and as a member of several other committees, is currently APSAC's Treasurer, and has been an indispensable galvanizing force for APSAC chapters in both Massachusetts and Georgia. Wherever Susan goes, APSAC thrives. So, happily, we can extend our warmest thanks to Susan for her exemplary work as Editor-in-Chief even as we anticipate continued work with her on many fronts to achieve APSAC's goals.

News Bulletin: APSAC Joins *Amicus* Brief to U.S. Supreme Court

—by Theresa Reid

In late November, APSAC joined an *amicus* brief to the U.S. Supreme Court challenging the constitutionality of the Religious Freedom Restoration Act (RFRA), passed in 1993. The brief was spurred by Children's Health Care is a Legal Duty (CHILD, Inc.), and signed by APSAC and by the Center for the Constitutional Rights of Children.

The brief argues that RFRA grants preference to any litigant who maintains that another's actions restrict free exercise of religion. In such a conflict, the party accused of restricting religious freedom must prove by the highest standard of "strict scrutiny" that religious freedom is not affected.

One of the results of granting unqualified preference for religion in settling disputes is to give the religious freedom of parents higher priority than compelling government interest in child protection.

According to the brief, RFRA violates "the fundamental constitutional right to life of all children in the custody or care of spiritual treatment providers and the constitutional right to have their disputes adjudicated under religiously neutral principles of law guaranteed by the equal protection and due process clauses of the Fourteenth Amendment."

Further, the brief points out that, because of RFRA, the recently reauthorized version of CAPTA (see the *APSAC Advisor,* V. 9, n. 3) includes "the first religious exemption in federal law from a caretaker's obligations to provide necessities of life for a child." That exemption reads, "Nothing in this Act shall be construed as establishing a federal requirement that a parent or legal guardian provide a child any medical service or treatment against the religious beliefs of the parent or legal guardian."

The brief argues that, in addition to influencing federal lawmakers to abandon previous conditions (for receipt of CAPTA funds) with respect to one class of children based on their parents' religious beliefs, RFRA overrides state laws and reduces state options for protecting children.

The U.S. Supreme Court is scheduled to hear the case (*City of Boerne, Texas vs. P.F. Flores, Archbishop of San Antonio*) soon. We will report the outcome in the next issue of the *Advisor.*

Out-of-Home Care

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Health status of children in out-of-home care

Out-of-home care usually refers to three main types of substitute care: regular foster family care, group home care, and kinship care, or placement with relatives (Dubowitz et al., 1993a). A growing body of evidence indicates that many children, regardless of the type of out-of-home care they receive, are not in good health. Recent studies of children entering care have found that 87% to 95% have at least one physical health problem; 50% to 60% have multiple physical abnormalities (Hochstadt et al., 1987; Chernoff et al., 1994). Studies on the health status of children already in care provide additional evidence that these children continue to be at high risk for multiple health problems while in placement. Some kind of physical problem has been almost uniformly identified for 86% to 90% of the children (Dubowitz et al., 1992; Moffat et al., 1985). Abnormalities in growth, vision, and hearing are common (Chernoff et al., 1994; Hochstadt et al., 1987; Kavaler & Swire, 1983; Moffat et al., 1985; Simms, 1989; White & Benedict, 1985).

Studies on the health status of children already in care provide additional evidence that these children continue to be at high risk for multiple health problems while in placement.

Chronic health problems such as anemia, asthma, and short stature also are common. Kavaler and Swire (1983) reported that, of 688 children in out-of-home care for varying lengths of time, nearly half (45%) had at least one chronic problem, and 20% of these had multiple disabilities. Additional reports show similar results, with chronic health problems affecting 34% to 76% of foster children and 15% or more having multiple disabilities (Chernoff et al., 1994; Gruber, 1978; Hochstadt, et al., 1987; Moffat et al., 1985; Schor, 1982; Shah, 1971; Simms, 1989).

The most prevalent problems found in children in out-of-home care have been psychological and/or behavioral. Maas and Engler (1959) found that 40% to 60% of foster children in nine communities across the United States had symptoms of psychological disturbance, in contrast to an estimated 10% prevalence in the general school population. Shah (1972), Schor (1982), Moffat et al. (1985), and McIntyre and Keesler (1986) found psychological problems in 35% to 49% of children in out-of-home care, while Hochstadt et al. (1987) recommended that 56.9% of those children over three years of age receive psychological treatment. Reports by Eisenberg (1962), Shah (1974b), Swire and Kavaler (1983), and Frank (1980) documented that 30% to 80% of children examined for psychological problems were moderately to severely impaired. Finally, depending on the cut-off score used, Thompson & Fuhr (1992) found evidence of psychopathology in 60% to 80% of the children in their out-of-home-care sample. Stein et al. (1994) found evidence of one or more problems in 41% to 63% of their sample.

Behavioral and emotional problems have been reported in 30% to 50% of children in out-of-home care (Dubowitz et al., 1993b; Keane, 1983; Kendall, Dale & Plakitsis, 1995; Risley-Curtiss, 1990; Simms, 1989). Hulsey and White (1989) found that the mean behavior scores on the Achenbach Child Behavior Checklist for maltreated children in out-of-home care were significantly higher than those for a control group of children who had never been in care. Shah (1972) found a high incidence of drug use among the children in his sample (27.5% for marijuana and/or hashish).

Children in out-of-home care also appear to have elevated rates of developmental delay and educational problems. Evidence of developmental delay has been found in 25% to 61% of preschool children (Hochstadt, 1987; Kendall et al., 1995; Simms, 1989; Swire & Kavaler, 1983) while 45% to 75% of school-aged children have had school problems (Fanshel & Shinn, 1978; Hochstadt et al., 1987; Moffat et al., 1985). Thirty-five percent to 48% have failed at least one grade (Chernoff et al., 1994; Moffat et al., 1985; Sawyer & Dubowitz, 1994) and many are functioning academically and cognitively in the low average range (Chernoff et al., 1994; Dubowitz et al., 1990; Eisenberg, 1962; Fanshel & Shinn, 1978; Fox & Arcuri, 1980). Twenty percent of Shah's (1972) sample had dropped out of school.

Finally, the little research that exists on the sexual development needs of children in out-of-home care suggests that these children are at high risk for early sexual activity, sexually transmitted diseases (STD), and pregnancy. In one study of children entering out-of-home care, children as young as eight years old reported being sexually active (Risley-Curtiss, 1996). More than one third of the 846 children in that study (aged 8 to18) reported being sexually active, with more than a third of those not using any form of contraception. Over 12% had already had an STD.

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Another study of teen women in care found that 41.1% had had intercourse, with 56.8% having had sexual intercourse while in their current placement (Polit, White & Morton, 1987). Fifty percent of the sexually active teen women in care had never used condoms, and 73% had not used them at most recent intercourse.

Health service use by children in out-of-home care

In light of their relatively poor health and increased vulnerability, one would hope that children in out-of-home care are getting the health care services that they so obviously need. Many of the studies cited here, however, suggest that they are not, and that the foster care system may not be adequately identifying and addressing their comprehensive health needs (Gruber, 1978, p. 89).

Kavaler and Swire (1983) reported that 14% of 668 foster children had no admission medical examination documented. Further, of those children who, upon study examination, had visual problems, almost half (47%) had not been evaluated by an optometrist or ophthalmologist during the five years preceding the study, and 56% of them had no recorded evidence of such a problem in their medical records. Over 40% of children assessed as needing dental care had not seen a dentist during those same five years. Only one quarter of the children identified as having emotional or developmental problems had received treatment, and nearly all (93%) of the children who failed the hearing test had no medical record of such a problem.

Data from some of these studies also indicate that even when problems are known or suspected by caseworkers, and recommendations for health services are made, these services often are not obtained.

Similarly, Schor (1982) found that, of a random sample of 387 foster children enrolled in a Health Maintenance Organization (HMO), 12% had not received any medical care since their enrollment and another 1% had received care for acute problems only; that is, they had received no health assessment. In addition, 70% of children were inadequately immunized, and 80% of the chronic health problems identified were newly recognized since enrollment in the HMO. Schor (1982) reported that nonusers tended to be male adolescents and that the foster children in general tended to be low users of health care services, with visits other than health assessments averaging barely more than one per year.

Moffat et al. (1985) reported from a sample of 257 foster children, 79% of whom had been in care more than one year, that 18% had no known source of health care and nearly half had not been examined in the past year. Immunizations were complete for only 48% of the children, and of 77 problems uncovered by the study examination, the agency was aware of only 40 of them. Finally, Simms (1989) reported that 60% of the children with developmental delays were not involved in any treatment program, although they had been in foster care an average of six months.

Mental health services seem especially neglected. Gruber (1978) found that almost 30% of children with behavioral or emotional problems had never seen a mental health professional (p. 89). Frank (1980) reported that 12% of a group of foster children with moderate to severe psychosocial problems had never seen a mental health professional during the five-year study period.

The situation does not seem to have improved with time. Moffat et al. (1985) concluded that the "diagnosis, monitoring, and treatment of behavioral problems seem to have been the most neglected areas..." (p. 134). Even more recently, Dubowitz et al. (1990) reported that of 144 children diagnosed as depressed or having emotional problems, only 18 (12.5%) were receiving treatment. They concluded that:

> The frequency of mental health services currently received by these children is alarmingly low....few children have received a mental health evaluation and even fewer are receiving mental health services. (p. 67)

Data from some of these same studies also indicate that even when problems are known or suspected by caseworkers, and recommendations for health services are made, these services often are not obtained. Gruber (1978) reported that the treatment process had not been started for approximately 9% to 50% (varied by the handicap) of children known by caseworkers to have specific handicaps (overall rate = 23.7%). Further, 10.1% to 76.6% of those who had been evaluated and recommended for a specific treatment program were not receiving treatment (overall 26.2%). Kavaler and Swire (1983) related that of 363 referrals made over a five-year period, only 59% (216) were accomplished, while Shah (1974b) reported that of 308 recommendations

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for mental health follow-up services, fewer than half (144) were followed.

Finally, Risley-Curtiss et al. (1996) reported on health care use by 291 children entering foster care. They found that despite the fact that the children were part of a new health project designed to improve their health care and in the custody of an agency under a federal consent decree specifically requiring the provision of adequate health care, fewer than 50% of referrals for physical, dental, and mental health care were completed.

In summary, research clearly documents that children in out-of-home care typically are unhealthy and that they often are not getting the care they need. This failure to ensure adequate preventive and primary health care for such children has long- and short-term costs for the children as well as for the foster care system itself. For example, children with behavioral and emotional problems are at high risk for re-placement (Cooper, Peterson, & Meier, 1987; Miller, Mackey, & Maginn, 1981; Pardeck, 1985), for remaining in care longer (Lawder, Poulin, & Andrews, 1986; Sauber, 1967), and for returning to out-of-home care after discharge (Block & Libowitz, 1983; Rzepnicki, 1987). In 1987, 72% of the increase in out-of-home care placements in New York was caused by children reentering the system (Ooms, 1990). Thus, failure to provide treatment for some types of problems can contribute to increases in workload, numbers of children in care, and subsequent financial costs to the system itself. Even more critically, failure to provide needed services can lead to untold human suffering.

Failure to provide treatment for some types of problems can contribute to increases in workload, numbers of children in care, and subsequent financial costs to the system itself. Even more critically, failure to provide needed services can lead to untold human suffering.

Implications for child welfare practitioners

While some health services have been routinely provided by many substitute care agencies, health care for children in out-of-home care has generally received low priority (Kavaler & Swire, 1983: Schor, 1988: Simms & Halfon, 1994). Standardized health care for children in care has been advocated by such professional organizations as the American Academy of Pediatrics (Committee on Early Childhood, Adoption and Dependent Care, 1994) and the Child Welfare League of America (1988). Nevertheless, uniform models, policies, and procedures defining services to be provided and ensuring that all children in care receive appropriate health care have been lacking (Combs-Orme, Chernoff, & Kager, 1991; Kendall et al., 1995).

The concept of parens patriae (i.e., the state as parent) obligates child welfare agencies to meet the basic needs of children in its care. Failure to do so constitutes institutional neglect and the risk of lawsuits. Administrators and direct practitioners need to intensify efforts to ensure that children in care get the services they require. One major bureaucratic obstacle to adequate health care for foster children is the absence, in many agencies, of an adequate tracking mechanism (Chernoff et al., 1994, Kavaler & Swire, 1983; Risley-Curtiss et al., 1996). Such a mechanism could help caregivers, caseworkers, supervisors, and health providers ensure ongoing and timely care. For interventions to succeed, however, consensus on the importance of health care for children in out-of-home care must be obtained within the child welfare agency and its affiliated organizations, and with the public at large. Such consensus has been lacking.

In addition, practitioners may have to take it upon themselves to access the health care services that children in their caseloads need. To start with, all children in out-of-home care should receive the following:

- A physical examination, preferably before placement, but if not, then as soon after placement as possible. Since children often enter care lacking an accessible documented health history, this initial exam should be followed by a comprehensive follow-up evaluation within a month or so after placement.
- A mental health evaluation, in light of the high rate of psychosocial problems in this population. While the validity of a mental health examination at the time of placement has not been determined, an initial screening for serious mental health problems (e.g., suicidal potential) should be done at the time of placement, to be followed within the next month by a more comprehensive evaluation.
- A dental screening, also at the time of entry into care, and routine preventive dental care.

In addition, practitioners need to consider recommendations in the following areas.

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Training

Those practitioners who lack knowledge of health issues need access to training that emphasizes the importance of health care and increases appreciation for the critical nature of some of the problems these children have (e.g., mental health problems, sexually transmitted disease risks). Sharing such information with coworkers and administrators can broaden the impact of such training.

For example, practitioners should understand the fact that the presence of one high-risk behavior (e.g., suicidal ideation, sexual activity) often is an indicator of the existence of others (Risley-Curtiss, 1996). Research also suggests that the needs of African-American children, older children, and girls, especially their mental health needs, frequently are not adequately addressed (Benedict et al., 1988; Eisenberg, 1962; Risley-Curtiss, 1993; Takayama, Bergman, & Connell, 1994). Training can equip workers and caretakers to better identify the needs of children in their care.

The roles of the primary substitute caretakers (e.g., foster parents) and of caseworkers also may need to be clarified, documented, and communicated to all relevant parties.

Other training needs for both practitioners and caretakers may include:

- The administration of family health histories
- Assessment for certain problems such as clinical depression, the potential for suicide and homicide, drug and alcohol addiction, and sexual activity.
- Health needs of African-American children
- Health needs of older children
- Health needs of girls, especially regarding mental health

Role clarification

The roles of the primary substitute caretaker (e.g., foster parents) and of caseworkers also may need to be clarified, documented, and communicated to all relevant parties. Caseworkers, as representatives of the agency and state, usually have the ultimate responsibility for ensuring that the health needs of children in care are met. However, it is often unclear who—the caseworker or the foster parent—is supposed to actually acquire services. Thus the worker waits for the foster parent to take the child to the doctor, while the foster parent waits for the worker to do so; meanwhile, the child suffers. Once these responsibilities have been clearly delineated, the need for supports (e.g., transportation and lists of available providers) should be assessed and such services made available as necessary.

Education and advocacy

Practitioners outside of the standard child welfare agency system also may have a role to play. For example, medical practitioners may have a good grasp of the connections among the biological, psychological, and social needs of children. When they come into contact with children in out-of-home care, they have the opportunity to educate caretakers and caseworkers (and the children if age appropriate) about the general importance of health care as well as about specific problems (e.g., STDs).

In all out-of-home care settings, practitioners need to pay close attention to children's biological as well as psychosocial needs. When any of these individual needs are unmet, a practitioner can serve as an advocate for that child, to facilitate the child's access to care. While low use rates are prevalent for children of all ages and ethnic groups, practitioners particularly may need to advocate for African-American children, for older children, for female children with mental health needs, and for children with extensive mental health problems (Risley-Curtiss, 1993). In one study, children who had extensive recognized mental health problems were less likely to be referred for physical health services (medical and referrals), despite the fact that they did not have fewer medical problems than other children (Risley-Curtiss, 1993).

Research

More research is also needed, especially in the area of use relative to need. Practitioners can assist in this endeavor by keeping adequate and accurate records regarding the need for, and access to, health services. Documentation of barriers and gaps in services can be helpful in advocating for increased resources. Participation in the evaluation of service provision to children in care also is important.

Finally, practitioners need to keep current with what others are doing to help address the needs of these children. To this end, a future issue of the *Advisor* will include information about a model program's approach to meeting the health care needs of children in out-of-home care.

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OPINION
The "Witch Hunt," the "Backlash," and Professionalism

—by Kenneth Lanning

The sexual victimization of children is a highly emotional issue. Publicity and controversy over complex topics such as repressed memory, satanic ritual abuse (SRA), and suggestibility of children have divided and polarized many child advocates, the media, and the American public. Especially in controversial cases, those at one extreme often claim that children are easily manipulated and that the allegations are part of a "witch hunt" led by overzealous fanatics or incompetent and money-hungry "experts." Those at the other extreme often claim that victims do not lie about sexual abuse, that everything alleged happened exactly as alleged, and that protestations to the contrary are part of a powerful "backlash" led by child molesters or those denying the extent and reality of child sexual abuse. The continuing media coverage, movies, articles, and opinions about cases such as the McMartin case in Manhattan Beach, California, exemplify this highly polarized controversy.

One problem in discussing this situation is the selection of terms to identify these extremes. I have reluctantly decided to use the terms they call each other: the "witch hunt" and the "backlash." The terms, however, are subjective, judgmental, derogatory, and poorly defined. To address this problem, I will attempt to define the terms as used in this discussion.

The "witch hunt" is characterized by the tendency to exaggerate child sexual abuse, to emphasize believing the children, and to criticize the criminal justice system only for the lack of investigation or for acquittals. When child sexual abuse is alleged, they assume it has happened and try to prove it.

The "backlash" is characterized by the tendency to minimize child sexual abuse, to emphasize false allegations, and to criticize the criminal justice system only for aggressive investigation or for convictions. When child sexual abuse is alleged, they assume it has not happened and try to disprove it.

In spite of their profoundly opposing views, the witch hunt group and the backlash group are very much alike: two sides of the same coin.

I enjoy the distinction of having been accused of being part of both the witch hunt (a zealot spreading exaggerated stories of child sex rings) and the backlash (a satanist infiltrating the FBI to prevent the uncovering of SRA).

Of course, because of the vagueness of these definitions, nothing said about the witch hunt or the backlash is true of all individuals who might be considered members of either. In describing their characteristics, each extreme is presented as a caricature of itself.

Common characteristics

In spite of their profoundly opposing views, the witch hunt and the backlash are very much alike: two sides of the same coin. Some of the characteristics they share are discussed in the following section.

Cross labeling

Each side labels and defines the nature and characteristics of the other. Neither side, however, uses this label to identify itself. No one in the witch hunt, for example, believes that he or she is participating in a witch hunt, and no one in the backlash believes that he or she is participating in a backlash. In fact, each side vehemently denies it. Both sides are quick to use the derogatory labels of witch hunt or backlash to refer to the other side, but resent the use of these terms against them. Most important, each side takes great delight in talking about and criticizing the other.

Polarization

Each side tends to take an all or nothing approach to complex issues. One is either with them or against them. From each side's point of view, dialogue with the other side is consorting with the enemy and constitutes guilt by association and betrayal. Each side disseminates written material and brings together individuals of like beliefs. When someone from one side is invited to participate in the other side's publications or conferences, it is primarily as a token to be ridiculed for his or her "absurd" views. Both sides attack anyone who seems to take a position in the middle.

Attack the messenger

Each side focuses its attacks and criticism on the person of the messenger rather than on the substance of the message. It is easy to claim (and difficult for the groups to prove otherwise) that the witch hunt is composed of fanatics with personal agendas, antifamily views, and one-world government plans, or that the backlash is composed of pedophiles and satanists attempting to conceal their activity. One way to personally attack and dismiss a messenger is to simply label him or her as part of the witch hunt or the backlash.

Appeal to emotion

Each side relies heavily on raw emotion and frequently brings forward victims, adult survi-

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vors, and falsely accused parents to describe in graphic detail their personal tragedies. In the public debate between emotion and reason, emotion almost always wins. Regardless of intelligence and education, and in spite of common sense and evidence to the contrary, adults tend to believe what they want or need to believe. The more emotionally involved someone is, the greater the need. Not many issues are more emotional than sexual victimization of children.

Distortion of facts

Each side conveniently fails to define its terminology, or inconsistently uses the terms it does define. When volume is needed, a child is anyone under 18 years old. When impact is needed, a child is under 12 years old. Both sides frequently cite information out of context and selectively quote only that portion of an article that supports their views. They fail to verify information and cannot resist using hearsay, rumor, gossip, myth, and legend. In spite of their well-known inaccuracies, newspaper articles and television tabloid or news magazine programs are often used as prime sources of information. Rarely does either side seek the full and original research. They generalize from a few cases to all cases, and make the unusual and atypical seem common and typical. These distortions are now quickly and widely disseminated to eager believers by fax, e-mail, the Internet, and other online computer services.

In the public debate between emotion and reason, emotion almost always wins. Regardless of intelligence and education, and in spite of common sense and evidence to the contrary, adults tend to believe what they want or need to believe.

Conspiracy theories

Both sides seem to need to believe that the other side is part of a national or international, well-disciplined organization with a carefully orchestrated and implemented master plan and strategy. Any meeting or contact of three or more people with similar views is seen as proof of this conspiracy. They believe their side simply meets, trains, and disseminates information, while the other side conspires, brainwashes, and disseminates propaganda. For some, this conspiracy theory incorporates the notion that they are the special target of persecution by the other side. They find it difficult to understand that each side, and every group in between, suffers from the same disorganization, dissension, and disagreements. Because it is difficult to prove the negative, it is essentially impossible to disprove these theories. It is only when we are accused of being part of a conspiracy that we know does not exist that we can prove the accusers wrong; however, we can prove it only to ourselves.

Claim to special knowledge

Those on each side somehow know with absolute certainty the facts of any case. They know things that the investigation, prosecution, and courts cannot determine with certainty. They infallibly know who is guilty and who is innocent. They are certain of this in spite of the fact that most of what they "know" is based on gossip, rumors, or media accounts.

Selective use of the criminal justice system

Each side decides when an investigation, conviction, or acquittal has meaning. Using and citing court decisions only when it suits their purposes, they quote court decisions as proof of their positions only if someone they believe is guilty is convicted. If someone they believe is innocent is convicted, then the court decision is irrelevant, ignored, or attacked. If the conviction is overturned on appeal, the court decision is again praised and cited. They also decide for themselves which court orders should be obeyed and which children should be hidden in the "underground" in violation of court order.

Manipulation of and by the media

Both sides aggressively try to influence the media. They will cooperate with any level of the media if they believe their views will be aired and supported. In their zeal to manipulate the media, they forget that the media often manipulate them. The media often fluctuate between witch hunt or backlash stories depending on which way the wind is blowing. Today, backlash stories seem to have the upper hand. But this too will change. Much of the media also seem to gravitate toward emotional rather than professional responses when covering these issues.

Self-deception

Both sides believe that they do none of the above and the other side does all of the above. "We" are objective and right. "They" are devious and wrong. Both sides accuse the other of doing these things, but are outraged that someone would accuse them of the same. They cite every example of exaggeration and bias of the other side, but ignore and deny that they do the same. Both sides condemn and protest unfair,

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distorted personal attack by the media, but only if the media is attacking their own side. Without realizing it, both sides believe, hear, and see what they want to believe, hear, and see.

Professionalism

For child sexual abuse intervenors concerned about the witch hunt or the backlash, the best approach is not imitate their tactics but to respond with professionalism. We may not totally agree about what constitutes professionalism; however, most would agree that the following characteristics are consistent with integrity and professionalism.

Deal with issues, not personalities

Professionals understand that individuals who disagree with them are not necessarily bad or evil. They recognize and admit the merit in the dissenting views of others. Because no one person's views or opinions are unique, professionals minimize the focus on individuals and maximize discussion of issues. In this article, I have deliberately avoided "naming names" or citing specific detailed examples. This would serve no purpose except to inflame and polarize. Even the use of the terms "witch hunt" and "backlash" is derogatory and should be kept to a minimum. Professionals understand that the extremists on both sides will eventually self-destruct. The extremists will get caught in their own distortions and exaggerations, the media will turn on them, and their credibility will be destroyed, which is good reason not to follow their lead.

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Evaluate hidden agendas

We can examine a complex problem such as the sexual victimization of children from three major perspectives: personal, political, and professional. The personal perspective encompasses the emotional: how the issues affect our individual needs and wants. The political perspective encompasses the practical: how the issues affect our getting elected, obtaining funding or pay, and attaining status and power. The professional perspective encompasses the rational and objective: how the issues affect abused children and what is in their best interest. Often these perspectives overlap or are applied in combination. Because most of us use all three, sometimes which perspective is in control may not be clear.

The personal and political perspectives tend to dominate emotional issues like child sexual abuse. The personal and political perspectives are a reality and will never go away. In fact, many positive things can and have been achieved through them. It is my opinion, however, that abused children need more people addressing their needs from the professional perspective and fewer from the personal and the political perspectives.

This raises the complex and difficult question of whether individuals with strong political or personal agendas can even be professionals. While many can rise above their direct or indirect victimization and their individual or practical needs, some are deluding themselves in claiming to have done so.

Strive for objectivity

Objectivity is most critical for professionals in law enforcement and prosecution. Professionals need to keep an open mind and try to control their emotions. The idealization of children, common at child abuse conferences, fuels emotionalism. Children are not innocent angels from heaven; they are human beings with human needs and flaws. Professionals dealing with child abuse are not the guardian angels of America's children; they are dedicated, hardworking individuals trying to do an important job. This desire to idealize children leads to the question of whether investigators and prosecutors who identify themselves as "child advocates" can claim or appear to be objective fact finders.

As professionals, we cannot assume that someone is guilty just because an allegation is made. We cannot assume that someone is innocent just because he or she is a "pillar of the community" or because the person making the allegation is a young child or a dysfunctional adolescent. Criminal justice professionals must identify or develop fair and objective criteria for evaluating the accuracy of allegations of sexual abuse and for filing charges against the accused. Alternative explanations need to be considered and explored. Neither blindly believing everything in spite of a lack of logical evidence nor simply ignoring what seems impossible or improbable and accepting

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what seems possible is professional behavior. Avoiding cases because they are complex, difficult, or "bizarre" is not acceptable either.

Consider the middle ground

Most complex issues have room for difference of opinion. Reality is often somewhere between the two extremes. Most people would agree that just because one detail in a victim's story turns out to be accurate does not mean that every detail is accurate. But many people seem to believe that if you can disprove one part of a victim's allegation, then the entire allegation is false.

There is a middle ground—a continuum of possible activity. Some of what victims allege may be true and accurate, some may be misperceived or distorted, some may be screened or symbolic, and some may be "contaminated" or false. The problem and challenge, especially for law enforcement professionals, is to determine which is which. This can only be done through professional and objective investigation. To either totally believe or totally disbelieve everything is always easier than acknowledging the complexity of a situation. One way to defuse extremist attacks is to occasionally admit that in some cases mistakes were made.

Professionals should spend more time thinking about what they are doing and less time worrying about what the extremists are doing.

Critique yourself first

This may be the most difficult responsibility of a professional. It is easier to admit the mistakes of others, especially when admitting your own might expose you to a lawsuit. Professionals should spend more time thinking about what they are doing and less time worrying about what the extremists are doing. We need to make sure our own houses are in order and our information is accurate and reliable before criticizing others. The most effective way to counteract the influence of the witch hunt and the backlash is not to attack them, but to do one's job in a competent, objective, professional manner.

Strive to improve knowledge and skills

Professionals recognize the need to grow and improve their knowledge and skills. They read a variety of books and articles, including some that present alternative or different views. They attend seminars and conferences with minds open to a diversity of thoughts and ideas. They engage in honest dialogue with responsible individuals with differing views. Those who listen only to opinions that agree with their own may find it difficult to grow professionally. Professionals try to stay current on the latest research in their fields. They join organizations such as APSAC. As its name implies, APSAC should be a model for professional standards and behavior.

Evaluate and use information properly

Professionals do not use newspaper articles and television programs as their primary sources of information and research findings. Anyone significantly involved in a publicized case knows that many of the details reported in the press are not accurate. Yet we all assume the details of other reported cases are accurate, especially if those details happen to agree with our opinions and beliefs. Professionals should verify original sources of information and properly reference research. For example, although cited again and again, the FBI has not said, nor has it data to support the claim, that one in four females are sexually abused as children. This may or may not be accurate, but the FBI is not the source of this statistic.

Professionals should resist the temptation to overcome denial or influence opinion by exaggerating or misrepresenting the problem. The documented facts are bad enough, and need no embellishment. Professionals should clearly define their terms and then consistently use those definitions unless indicating otherwise. Operational definitions for terms (e.g., child, sexual abuse, ritual abuse) used in cited research should be clearly communicated and not mixed to distort findings. Loss of credibility can be devastating. Once someone is caught using distorted or misleading information and labeled an extremist, no one has to listen to what he or she says no matter how brilliant or profound.

Summary

The "backlash" has had both a positive and negative impact on the investigation and prosecution of child sexual abuse cases. In a positive way, it has reminded criminal justice intervenors of the need to do their jobs in a more professional, objective, and fact-finding manner. In a negative way, it has cast a shadow over the validity and reality of child sexual abuse and has influenced some to avoid properly pursuing cases.

Much of the damage caused by the backlash is actually self-inflicted by the witch hunt, and by some well-intentioned child advocates. The mistakes of some overzealous intervenors and the insistence by a few of the literal accuracy

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of unfounded bizarre allegations of "satanic ritual abuse" make up the primary fuel that currently runs the backlash and enables it to influence public opinion. On the other hand, the debate over the validity of such grotesque allegations has obscured the well-documented fact that children can be reliable witnesses, and that there are such things as child sex rings, bizarre paraphilias, and cruel sexual sadists. Even if only a portion of what these victims allege is factual, it may still constitute significant criminal activity.

Professionals dealing with child sexual abuse must address the legitimate issues raised by the backlash and not just personally "attack the messengers." Professionals must also admit the existence of and address the damage done by the witch hunt. It could be argued that the witch hunt has in fact done more harm to sexually abused children than the backlash has done. In my opinion, the best way to counteract the influence of the backlash and the witch hunt is not to become defensive or to imitate their tactics, but rather to recognize the existence of both while simply doing one's job in a professional manner.

To advocate professionalism is not to deny that we can have and express strongly held beliefs and opinions. However, we must carefully consider and evaluate the basis for those beliefs and opinions. The characteristics of professionalism set forth here are difficult to attain, but well worth striving for. To use an emotional argument to defend an objective response, abused children deserve no less than truly professional intervention.

Kenneth Lanning, MS, is a Supervisory Special Agent at the FBI Training Academy in Quantico, Virginia, recipient of APSAC's 1996 Outstanding Professional Award, and a member of APSAC's Advisory Board.

CALL FOR NOMINATIONS
APSAC Board of Directors

APSAC is seeking nominations of members to stand for election to the Board of Directors for three-year terms beginning on June 1, 1997 and ending on May 31, 2000. Nominees must have been APSAC members for at least one year, and must have agreed to be nominated before their nominations are submitted.

Board members' contributions of time, energy, and talent play an enormous role in APSAC's success. To be as effective and powerful as possible, APSAC needs the active participation of all members of the Board of Directors. Members who are enthusiastic and supportive but unable to perform the duties of a Board member are highly valued and can serve APSAC in many capacities, but should not be nominated to serve on the Board unless they can devote the time necessary to discharge a Board member's duties. These duties include but are not limited to attending at least one Board meeting each year, chairing a committee or subcommittee, waiving speaking fees for at least two APSAC-sponsored training events each year, and actively working to generate members and revenue for the association.

APSAC's Nominating Committee (consisting of all members of the Executive Committee not standing for re-election, and five members at large appointed by the President) will select among nominees based on a number of criteria, including (1) diversity in discipline, area of expertise, culture, and geography; (2) a consistent record of service to APSAC; (3) excellence in professional reputation and practice; and (4) stature in and contributions to the field.

Nominations are due at APSAC's offices on February 7, 1997. Complete nominations consist of a nomination form, a 200- to 400-word letter of nomination outlining the candidate's qualifications for serving on APSAC's Board of Directors, and a copy of the candidate's resume or curriculum vita. Call 312-554-0166 to receive a nomination form.

MEASUREMENT AND ASSESSMENT TOOLS

Child Sexual Behavior: An Update with the CSBI-3

—by William N. Friedrich, Lucy Berliner, Judy Butler, Judith Cohen, Linda Damon, and Constance Shafram

Sexual behavior continues to be one of the most valid markers of sexual abuse in children (Kendall-Tackett, Williams, & Finkelhor, 1993). This is the primary reason for our continued refinement of a measure, the Child Sexual Behavior Inventory-3 (CSBI-3), to assess sexual behavior in 2- to 12-year-old children. A secondary reason is that research in this area enables collaboration with a large group of skilled clinicians who have an interest in furthering the scientific base for the field of child abuse and neglect. This article could not have been written without the assistance of those listed in Table 1.

Because this article concerns research in progress, the focus here is the most convincing findings thus far. These include 1) the relative absence of significant sexual behavior problems in psychiatrically disturbed children without a history of sexual abuse; 2) the direct relationship between family sexuality and sexual behavior in children; 3) the direct relationship between life stress and sexual behavior; 4) the direct relationship between aggressive behavior and sexual behavior; 5) the direct relationship between maternal attitude regarding childhood sexuality and reported sexual behavior; and 6) the underlying variability of childhood sexual behavior as revealed by factor analysis.

The relative absence of significant sexual behavior problems in psychiatrically disturbed children without a history of sexual abuse

Currently, the sample includes 293 children referred for outpatient psychological or psychiatric evaluation. The children were screened for the absence of suspected or confirmed sexual abuse, and range in age from 2 to 12 years old with a mean age of 7.8 (2, 8). Total sexual behavior problem scores were developed for boys and girls aged 2 to 6 and 7 to 12. As Table 2 illustrates, the total scores for the psychiatric samples were quite similar to the nonabused normative samples and quite different from the sexual abuse samples. This is an important finding, adding to earlier research with the CSBI that included only a normative sample and a sexual abuse sample (Friedrich et al., 1992). The finding suggests that elevated sexual behavior in children referred for an outpatient evaluation should not simply be attributed to their psychiatric problems, but may reflect abuse issues.

The direct relationship between family sexuality and sexual behavior in children

The CSBI-3 includes eight questions that reflect relaxed attitudes about sexually explicit media and family sexual behavior (e.g., "my child has seen adults having sex on TV or in a movie"). The total score of these eight items correlates significantly with total sexual behavior as measured by the CSBI-3 with the normative sample alone ($r = .34$, $p < .001$). This confirms findings with an earlier version of the CSBI (Friedrich et al., 1992). This finding suggests that sexual behavior in children may reflect modeling of adult sexual behavior, separate from sexual abuse.

Table 1 CSBI-3 Research Collaborators

Name	Affiliation	Location
Robert Acton	Children's Hospital	Calgary, Alberta, Canada
Lucy Berliner	Harborview Medical Center	Seattle, Washington
Barbara Bonner	University of Oklahoma HSC	Oklahoma City, Oklahoma
Judy Butler	Emmanuel Hospital	Portland, Oregon
Judith Cohen	Allegheny Medical Center	Pittsburgh, Pennsylvania
Beth Cuddy	Eastern Maine Medical Center	Bangor, Maine
Linda Damon	San Fernando Valley Child Guidance	Panorama City, California
Hobart Davies	Children's Hospital	Milwaukee, Wisconsin
Alison S. Gray	STEP Program	Underhill, Vermont
Sandra K. Hewitt	Private practice	St. Paul, Minnesota
Ellen Popenoe	Maine Medical Center	Portland, Maine
Constance Shafran	Private practice	Malibu, California
Bart Trentham	Family Services	Tulsa, Oklahoma
John Wright	University of Montreal	Montreal, Quebec, Canada

Table 2 Mean Values Across Samples: Normative, Psychiatric, and Sexually Abused

Ages	Normative	Psychiatric	Sexually Abused
2-6 boys	4.8 (4.4)	3.8 (4.2)	15.8 (12.8)
2-6 girls	4.3 (4.6)	3.7 (3.9)	16.4 (14.5)
7-12 boys	2.5 (3.7)	3.0 (4.2)	11.4 (11.2)
7-12 girls	2.4 (3.5)	3.3 (5.2)	13.2 (14.2)

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An Update with the CSBI-3

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The direct relationship between life stress and sexual behavior

Life stress is assessed in the CSBI-3 with 11 questions (e.g., "parents divorced"). The total score of these events correlates significantly with total sexual behavior as measured by the CSBI-3 with the normative sample alone ($r = .31$, $p < .001$). This is a replication of earlier findings (Friedrich et al., 1992) and suggests that distressed children are more likely to exhibit behavior that reflects problems with self-regulation, including sexual behavior.

The direct relationship between aggressive behavior and sexual behavior

Aggression was measured with the Aggression Subscale of the Child Behavior Checklist (Achenbach, 1991). In the normative sample of more than 1,100 children, the Aggression Subscale was significantly correlated with total sexual behavior as measured by the CSBI-3 ($r = .34$, $p < .001$). This suggests that externalizing behavior and sexual behavior are directly related.

The direct relationship between maternal attitudes regarding childhood sexuality and reported sexual behavior

Several questions were added that assessed maternal attitudes about sexual behavior in children. One item in particular, "It is normal for children to have sexual feelings and curiosity," was studied further and correlated with each individual item. The majority of mothers in all three samples answered "yes" to this question. In addition, this item correlated signficantly with each of the 37 sexual behavior items on the CSBI-3. This suggests that if parents view sexual behavior in children as normal, they are more likely to report it. Interestingly, mothers of sexually abused children were significantly less likely to answer "yes" to the question.

The variability of childhood sexual behavior as revealed by factor analysis

Earlier research with the CSBI has consistently pointed to the unidimensional nature of sexual behavior in children. However, factor analysis, which helps to determine underlying dimensions of behavior, has suggested six to eight factors for the CSBI-3. A final determination of factors will be made only when all data are collected; however, this finding suggests that sexual behavior is not the unidimensional phenomenon thought earlier. An example of some of the underlying dimensions that are consistent across a variety of factor solutions include self-stimulation, sexual interest, sexual intrusiveness, and boundary problems. It is expected that sexual abuse may have a differential effect on different factors of sexual behavior.

Summary

Although sexual behavior continues to be one of the best markers of sexual abuse, information that we present in this article adds to earlier evidence that sexual behavior in nonabused children without psychiatric problems is related to a range of family variables, including family sexuality and life stress. Our findings suggest that clinicians need to examine a child's exposure to family sexuality as well as the presence of a range of stressful events as part of their evaluation of a child referred for concerns regarding sexual abuse. At the same time, the rather powerful finding of only low levels of sexual behavior in psychiatrically disturbed children underscores the validity of sexual behavior as a marker for possible sexual abuse in 2- to 12-year-old children.

Because the CSBI-3 is quite useful in assessing sexually abused children, and because sexual behavior in children is a complex phenomenon, William Friedrich, PhD, has agreed to publish this CSBI-3 with Psychological Assessment Resources (PAR) of Odessa, Florida. The published test is expected to be available for practitioners by 1997.

NOTE: This research was supported by grants from the Mayo Foundation. A version of this article was presented at "Trauma and Memory: An International Research Conference," at the New England Center, Durham, New Hampshire, July 26-28, 1996.

William N. Friedrich, PhD, is a professor at the Department of Psychiatry and Psychology at the Mayo Clinic in Rochester, MN 5590 (e-mail: friedrich.william@mayo.edu). Lucy Berliner, MSW, is with the Harborview Medical Clinic Sexual Assault Center in Seattle, WA; Judy Butler, M.Ed is at Emmanuel Hospital in Portland, Oregon; Judith Cohen, MD, is with the Center for Traumatic Stress in Children and Adolescents, Allegheny General Hospital; Linda Damon, PhD, is at San Fernando Valley Child Guidance in Panorama City, California; and Constance Shafram, PhD, is in private practice in Malibu, California.

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main opportunity for members from across the country to meet each other and to advance APSAC's work by talking with Board members, participating in the annual members' meeting (to be held on Wednesday evening, June 18), providing suggestions for future Colloquium programming, and participating in task forces, committee meetings, and the annual state chapter training.

The 1997 Colloquium Committee was co-chaired by **Catherine Ayoub, RN, EdD**, of the Harvard Graduate School of Education, and **Nancy Lamb, JD**, of the District Attorney's office in Elizabeth City, North Carolina. Subcommittees were chaired by **Lisa Fontes, PhD** (cultural issues), **Ryan Rainey, JD** (law), **Lt. Jack Solomon** (law enforcement), **Diane DePanfilis, PhD, MSW**, (child protective services), **Robert M. Reece, MD** (medicine and nursing), and **Rochelle Hanson, PhD** (mental health). **Judith Cohen, MD** and **David Kolko, PhD**, co-chair APSAC's Research Committee, which reviewed research abstracts and designed the research breakfasts and symposium. **Shay Bilchik, JD**, Director of the Office of Juvenile Justice and Delinquency Prevention (OJJDP, U.S. Department of Justice) and **Ron Laney**, Director of OJJDP's Office on Missing and Exploited Children, have provided invaluable program suggestions and support. The many additional hardworking members of these committees and subcommittees are too numerous to list here.

Pulling together a program as diverse and complex as that of the 1997 Colloquium requires an enormous amount of work. Great thanks are extended to the busy professionals who gave so many of their precious hours to the effort. We hope to see you there!

APSAC Code of Ethics nearing completion

APSAC's members have also been actively involved in the development of a Code of Ethics being produced by the task force chaired by **Jon R. Conte, PhD**. Developing a code of ethics that is substantive enough to be meaningful for a highly diverse interdisciplinary group has been an arduous task. Dr. Conte began by surveying a sample of APSAC members about the ethical dilemmas of most concern to them. Drafts of the code of ethics have been reviewed by selected APSAC members, members of the Board of Directors, professional ethicists, and by members who attended an open APSAC task force meeting at the San Diego Conference on Responding to Child Maltreatment.

The draft now being reviewed formally by APSAC's Board of Directors cites five basic principles that should guide our work. These include commitment to the best interest of the child, to the dignity of the individual, to the principle of individual accountability, to rehabilitation, and to the least restrictive alternative in interventions. Five additional sections stipulate principles and standards in professional competence, confidentiality and privacy, multiple relationships, relationships with clients, and relationships with other professionals.

The draft Code of Ethics will be presented for comment to APSAC's members in early 1997. Your response will be important in shaping a final version of the Code, which we hope to release formally at the Colloquium in Miami Beach. Please use the form below to request a set of draft guidelines for review.

Nominations due for Board election

Please note the Call for Nominations to APSAC's Board of Directors on p.12 of this issue. Your participation at all stages of the Board election process is an important way to influence the direction of the association. Please take a moment to consider whether you are willing to serve, or to think of colleagues who might be suited and willing to stand for election to APSAC's Board of Directors, and contribute to the list of candidates from whom members will be able to choose.

This issue of the *APSAC Advisor* should be reaching you right around the end of December. I hope you are able to take a respite from the cares of your demanding work to enjoy a happy and safe holiday season.

Request for draft ethics guidelines for review

To receive a draft copy of APSAC's Code of Ethics, fax or mail this form to APSAC by 2/15/97.

Name

Address

Agency (if applicable)

Street

City State Zip

E-mail

Phone

Fax

407 S. Dearborn, Suite 1300, Chicago, IL 60605, Fax: 312-554-0919

BOOK REVIEW

Psychotherapy with sexually abused boys: An integrated approach. **William N. Friedrich.** Thousand Oaks, CA: Sage Publications, 1995. 249 pp. $46.00 cloth; $21.95 paperback.

—Reviewed by Rochelle F. Hanson, PhD

Several recent books have addressed the treatment of victims of child sexual abuse, but few have been specifically devoted to the treatment of sexually abused boys. This book splendidly fills the void. Organized around solid theoretical underpinnings, the chapters reflect the author's well-reasoned approach to the treatment of sexually abused boys. Friedrich considers and identifies the unique issues facing abused boys, offering a psychotherapy approach that meets their special needs.

The author begins by highlighting differences between sexually abused boys and girls, providing a rationale for devising a specialized treatment approach. For example, he discusses such findings as the higher prevalence of physical abuse among sexually abused boys; the difficulties that mothers may have supporting their sons, as opposed to daughters; the importance of delayed language development in boys; and boys' special concerns about sexuality and gender identity following victimization. These unique aspects of the sexual abuse of boys support the need for a treatment program specifically designed for male victims.

The model that forms the basis of Friedrich's treatment integrates existing theory and research from attachment, behavior/emotion regulation, and self-perception theories. Friedrich labels it an "integrated contextual model" because contributions from the various theoretical perspectives are placed within the context of the child's family and social environment. Corresponding to the model, the volume is comprised of three principal sections: attachment, dysregulation, and self-theory. These sections are divided into 13 chapters, with tables interspersed to highlight suggested assessment tools, treatment goals, and treatment techniques.

Within each section, Friedrich provides an overview of the relevant principles and their applicability to the treatment of child sexual abuse. In keeping with his notion that abuse must be conceptualized within a child's unique social context, each chapter offers techniques for individual, group, and family therapies.

For example, in the section on attachment, Friedrich discusses different attachment styles (e.g., avoidant, securely attached) and how each may be manifested by the child in the therapy setting. This in turn leads neatly into a discussion of the treatment techniques best suited for each attachment style. Evident throughout the book is how well Friedrich ties theory to treatment, which should be particularly useful to both clinicians and researchers. Clinicians will appreciate the intuitive sense of the theory-driven interventions, while researchers will find numerous testable hypotheses to investigate.

In the final section of the book, "Self-Theory," Friedrich presents a thought-provoking argument for the use of pair therapy. He provides a strong rationale for dyadic work with sexually abused boys, specifically as a way to reduce arousal, to provide control and structure, to enable a child to form a secure peer relationship, and to avoid victim/victimizer relationships that can form in larger group settings with this population. On a more practical note, he advocates pair therapy as a solution to the difficulties many clinicians have experienced in finding adequate numbers of similar children to make a group treatment strategy feasible. This is particularly the case for sexually abused boys.

Throughout the volume, Friedrich's outcome-oriented approach is particularly welcome. He emphasizes the importance of assessment and goal setting as ways to measure treatment efficacy and to assist in treatment planning, and throughout the book he offers several examples of how to accomplish these tasks. He also provides some of his major assessment and goal-setting instruments in appendices. When one of his own instruments is not sufficient for a particular purpose, he makes concrete, helpful suggestions about the use of other standardized tests. To drive home the importance of measurement, Friedrich compellingly notes that in our managed care environment, accountability has become increasingly important. Assessment not only provides a tool for demonstrating treatment efficacy, but also gives the clinician a basis for recommending the length and content of treatment.

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Friedrich candidly acknowledges that his model of treatment has not been empirically tested. However, it would be ridiculous to argue that the approach is not firmly grounded in sound

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Book Review

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theoretical principles and empirical findings. The nearly 300 references demonstrate a comprehensive review of the relevant literatures. In addition, Friedrich's writing style is straightforward and engaging. He avoids jargon that would weigh down the material, but does furnish some case examples that are particularly illustrative of the techniques being described. In these examples, the author's impressive clinical expertise is evident, as is his compassion for the boys he treats. Even more of these examples would have been useful.

Overall, this excellent book is best suited for therapists who have had some prior experience working with child abuse victims. Several techniques are suggested, but none is described sufficiently for a novice clinician to implement without guidance. My only concern is that less experienced clinicians would read this book and then prematurely feel prepared to work with this population. This is clearly not a "how-to" treatment manual; rather, it should become an invaluable resource for experienced clinicians, or a starting point for therapists new to the field.

Rochelle F. Hanson, PhD, is Clinical Assistant Professor and Coordinator of the Center for Sexual Assault/Abuse Recovery and Education (CARE) at the University of Florida, Gainesville, and is also Associate Editor—Journal Highlights for the APSAC Advisor.

It's Working!

Membership recruitment efforts have increased the number of new members joining in September, October, and November by 36% over the same period last year. Please keep up the good work!

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THANK YOU!

These APSAC members have made generous contributions in the last several weeks to support vital work of the organization. Their donations have strengthened APSAC's efforts to educate legislators, policymakers, reporters, and editors; to produce additional guidelines for practice; and to encourage promising student research in the field of child maltreatment. We greatly appreciate their generosity and commitment.

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JOURNAL HIGHLIGHTS

—Edited by Rochelle F. Hanson

The purpose of Journal Highlights is to inform readers of current research on various aspects of child maltreatment. 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 Rochelle F. Hanson, PhD, CARE/SHCC, P.O. Box 117500, University of Florida, Gainesville, FL 32611-7500 (Fax: 352 846-1030).

Sexual Abuse/Physical Abuse

Brand, E.F., King, C.A., Olson, E., & Ghaziuddin, N. (1996). Depressed adolescents with a history of sexual abuse: Diagnostic comorbidity and suicidality. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*, 4-41.

This article examines the nature of comorbid psychopathology and suicidality associated with a history of sexual abuse. A group of 24 depressed adolescent inpatients (aged 13-17 yrs) with a history of sexual abuse (SA) were compared with a matched control group of 24 nonabused, depressed, adolescent inpatients on measures of depression, suicidal behavior, and posttraumatic stress disorder (PTSD) symptoms. Depressed subjects with a history of sexual abuse had a higher prevalence of comorbid PTSD than did those without a sexual abuse history. Chronicity and severity of abuse were significant contributors to a PTSD diagnosis. No group differences were found in depression severity, specific depressive symptoms, or suicidal behavior.

Celano, M., Hazzard, A., Webb, C., & McCall, C. (1996). Treatment of traumagenic beliefs among sexually abused girls and their mothers: An evaluation study. *Journal of Abnormal Child Psychology, 24*(1), 1-17.

This study evaluates and compares the efficacy of two short-term (8-week) individual therapy interventions with 32 sexually abused 8- to 13-year-old girls and their nonoffending female caretakers. Subjects were assigned either to an unstructured comparison program or to a structured experimental treatment: Recovering from Abuse Program (RAP). RAP was based on D. Finkelhor and A. Browne's traumagenic model of sexual abuse. Measures of child outcome for both programs yielded decreases in subjects' posttraumatic stress disorder (PTSD) symptoms and traumagenic beliefs reflecting self-blame and powerlessness, and increases in subjects' overall psychosocial functioning. RAP was more effective than the comparison program in increasing abuse-related caretaker support of the child and in decreasing caretaker self-blame and expectations of undue negative impact of abuse on the subject.

Hafemeister, T.L. (1996). Protecting child witnesses: Judicial efforts to minimize trauma and reduce evidentiary barriers. *Violence and Victims, 11*, 71-80.

A nationwide survey of judges was conducted to determine the relative use of various means to minimize trauma or reduce evidentiary barriers in child sexual abuse cases, how judges evaluate these means, and the impact of educational programs in this area. The survey indicated that judges are likely to use techniques that are relatively easy to implement and which they consider both effective and fair to the parties appearing before the court. Attending educational programs appears to influence the judges' use of these approaches. Survey results also indicated the best methods for disseminating relevant information on child sexual abuse to judges.

Polusny, M. A., & Follette, V. M. (1996). Remembering childhood sexual abuse: A national survey of psychologists' clinical practices, beliefs, and personal experiences. *Professional Psychology: Research & Practice, 27*(1) 41-52.

A national survey of 1,000 psychologists, to which 223 responded, assessed professionals' clinical practices and beliefs about the treatment of adult survivors of childhood sexual abuse (CSA), personal CSA history, and the phenomenon of clients remembering CSA in therapy. Results indicated that more than 25% of therapists reported using such memory retrieval techniques as guided imagery, dream interpretation, bibliotherapy regarding sexual abuse, referral to sexual abuse survivors' group, and free association of childhood memories with clients who had no specific memory of CSA. However, the majority of therapists reported that they had not seen any cases of adult clients entering therapy with no memory of CSA who subsequently recalled abuse in the course of therapy. The implications for training and establishing scientific standards of psychological practice are discussed.

Stein, M.B., Walker, J.R., Anderson, G. & Hazen, A.L. (1996). Childhood physical and sexual abuse in patients with anxiety disorders and in a community sample. *American Journal of Psychiatry, 153*, 275-277.

This study investigated whether childhood histories of physical or sexual abuse were reported more frequently in a clinical sample of 125 patients (aged 18 to 64 years) with anxiety disorders (e.g., panic disorder with or without agoraphobia, social phobia, or obsessive-compulsive disorder) than in a matched community comparison sample of 125 18- to 61-year-olds. Childhood physical abuse was higher among both men and women with anxiety disorders than among comparison subjects. Childhood sexual abuse was higher among women with anxiety disorders than among comparison women and was higher among women with panic disorder than among women with other anxiety disorders. Results confirm the association between anxiety disorders and reported childhood physical and sexual abuse.

Toth, S.L., & Cicchetti, D. (1996). Patterns of relatedness, depressive symptomatology, and perceived competence in maltreated children. *Journal of Consulting and Clinical Psychology, 64*, 32-41.

In this article, an attachment theory framework is applied toward understanding the emergence of depressive symptomatology and lower perceived competence in maltreated and nonmaltreated children. Hypotheses that maltreated children with nonoptimal patterns of relatedness show elevated depressive symptomatology and lower competence, whereas nonmaltreated children with optimal or adequate patterns of relatedness exhibit low depressive symptomatology and higher competence, were confirmed. Differentiations between maltreated children with and without optimal or adequate patterns of relatedness also emerged, suggesting that relatedness may mitigate against the adverse effects of maltreatment.

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Journal Highlights

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Zlotnick, C., Davidson, J., Shea, M. & Pearlstein, Teri (1996). Validation of the Davidson Trauma Scale in a sample of survivors of childhood sexual abuse. *Journal of Nervous & Mental Disease 184*(4), 255-257.

The construct validity and the reliability of a self-report measure of posttraumatic stress disorder (PTSD), the Davidson Trauma Scale (DTS), were evaluated in a sample of 62 psychiatric female patients with histories of childhood sexual abuse. The relationship between the DTS and a standardized structured interview for PTSD was examined. The DTS was also compared with several measures that conceptually overlap the DTS to assess convergent validity. Twenty-three subjects were randomly assigned to a 15-week treatment group or to a 15-week wait list, and posttreatment measures were completed. To evaluate whether the DTS is sensitive to change, the pretreatment and posttreatment scores on the DTS for the treatment and wait-list subjects were compared. The DTS showed good internal consistency, adequate concurrent validity, and good construct validity. The DTS was also able to detect treatment effects.

Other Issues in Child Maltreatment

Bottoms, B.L. Shaver, P.R., & Goodman, G.S. (1996). An analysis of ritualistic and religion-related child abuse allegations. *Law & Human Behavior, 20,* 1-34.

This article presents results of a stratified random sample survey of 2,722 members of the American Psychological Association intended to determine the number and nature of cases involving alleged ritualistic and religion-related child abuse, whether reported directly by children or retrospectively by adults. Only a minority of the subjects reported encountering ritual cases, but of those, the majority believe their clients' claims. Even so, the purported evidence for the allegations, especially in cases reported by adults claiming to have suffered the abuse during childhood, is questionable. Most clients who alleged ritual abuse have been diagnosed as having multiple personality disorder or as posttraumatic cases. Issues addressed in the article include the role psychotherapists play in uncovering or helping to co-create alleged abuse experiences and the need to clarify the definition of ritualistic abuse.

Finkelhor, D., & Asdigian, N.L. (1996). Risk factors for youth victimization: Beyond a lifestyles/routine activities theory approach. *Violence and Victims, 11,* 3-18.

The authors point out in this article that previous work has focused on lifestyle or routine activity theory to identify and understand risk factors for youth victimization. The authors argue that other personal characteristics put youth at risk by making certain individuals more "congruent" with the needs, motives, or reactivities of potential offenders. Three specific types of characteristics discussed are those that increase the potential victim's "target vulnerability" (e.g., physical weakness, psychological distress), "target gratifiability" (e.g., female gender for sexual assault crimes), or "target antagonism" (e.g., behaviors or ethnic or group identities that may spark hostility or resentment). Data from a national youth survey are used to test variables measuring these characteristics and to show that they make a significant contribution in predicting nonfamily, sexual, and parental assault.

Jouriles, E. N., Norwood, W. D., McDonald, R., & Vincent, J. P. (1996). Physical violence and other forms of marital aggression: Links with children's behavior problems. *Journal of Family Psychology, 10,* 223-234.

Two studies examined whether physical marital violence and other forms of marital aggression (e.g., threats, throwing objects) correlate with children's behavior problems in families marked by recent spousal violence. Study 1 included 55 families seeking marital therapy. Study 2 included 199 families at battered women's shelters. In the marital therapy sample, both physical marital violence and other forms of marital aggression correlated positively with children's externalizing problems. In the women's shelter sample, physical violence and other forms of marital aggression correlated positively with children's externalizing and internalizing problems.

Kinard, E. Milling (1996). Conducting research on child maltreatment: Effects on researchers. *Violence and Victims, 11,* 65-69.

This brief report discusses the potential negative psychological consequences of conducting child maltreatment research on the researchers themselves. Illustrations of these effects are drawn from the experiences of a study of child maltreatment. Common themes of anger, sadness, frustration, and powerlessness emerged as reactions to reviewing case records of child maltreatment. The author argues that research protocols should include methods for helping researchers cope with the emotional distress brought about by their work. Several strategies are suggested for ensuring that research staff receive sufficient support to minimize the negative effects of conducting research on sensitive topics.

Warner, B.S., & Weist, M. D. (1996). Urban youth as witnesses to violence: Beginning assessment and treatment efforts. *Journal of Youth & Adolescence, 25,* 361-377.

This article reviews literature on witnessing violence ("covictimization") in children and adolescents. As violent incidents have increased dramatically in urban areas, so has inner-city youth's exposure to violence in the home, school, and community. In reaction to witnessing violence, youth may present symptoms of posttraumatic stress disorder (PTSD), separation anxiety, and depression; evince disturbed grieving and bereavement; show a number of externalizing behaviors, including aggressiveness; have impaired interpersonal and family relations; and show declines in academic performance. A number of factors may mediate the impact of violence exposure, including age, gender, and history of prior trauma. Directions for future investigation are highlighted.

Westman, J. C. (1996). The child advocacy team in child abuse and neglect matters. *Child Psychiatry & Human Development, 26,* 221-234.

This article describes the child advocacy team as a means of counteracting the fragmentation and lack of continuity of professional and volunteer services for children and their families in child abuse and neglect cases. The experience of the University of Wisconsin Child Advocacy Service is used to illustrate the formation, operation, and efficacy of the child advocacy team. Data are provided on 36 child advocacy team outcomes, as well as a case example of a six-person family undergoing investigation for child neglect.

Directory of Related Agencies and Resources

As a service to its readers, *APSAC Advisor* offers the following list of related agencies and resources. This list is by no means exhaustive and will change from time to time. If you know of an agency or resource of benefit to interdisciplinary professionals in the field of child maltreatment, please send the information to APSAC Publications, 407 S. Dearborn, Ste. 1300, Chicago, IL 60605. (Thanks to the National Committee to Prevent Child Abuse [NCPCA] for providing many of these listings.)

Need Materials?

National Committee to Prevent Child Abuse (NCPCA). 332 S. Michigan Ave., Suite 1600, Chicago, IL 60604. 312-663-3520. The NCPCA publishes a variety of educational materials that deal with parenting, child abuse, and child abuse prevention—a free catalog can be obtained by calling 1-800-835-2671. It also produces public service announcements for radio, television, and print media with the goal of making the public more aware of child abuse and teaching alternatives to abusive behavior, and provides many other resources and services.

Clearinghouse on Child Abuse and Neglect Information. P.O. Box 1182, Washington, DC 20012. 703-385-7565. The Clearinghouse provides annotated bibliographies of documents about specific aspects of child abuse or neglect (e.g., the relationship between alcohol abuse and maltreatment), and can provide statistics on various topics as well.

National Center on Child Abuse and Neglect (NCCAN) U.S. Department of Health and Human Services, P.O. Box 1182, Washington, DC 20013. 1-800-FYI-3366. Established by the Child Abuse Prevention and Treatment Act (CAPTA) in 1974, the NCCAN publishes manuals (the 21-manual *User Manual Series*) designed to provide guidance to professionals involved in the child protection system and to enhance community collaboration and the quality of services provided to children and families.

Need Statistics?

American Humane Association (AHA), Children's Division. 63 Inverness Drive East, Englewood, CO 80112-5117. 303-792-9900 or 1-800-227-4645. A national center promoting responsive child protection services in every community through program planning, training, education, and consultation, the AHA also operates the **National Resource Center on Child Abuse and Neglect.** National statistics on a number of issues are available from the AAPC.

National Committee to Prevent Child Abuse (NCPCA). 332 S. Michigan Ave., Suite 1600, Chicago, IL 60604. 312-663-3520. In addition to all of the other resources it provides, the NCPCA publishes the results of an annual fifty-state survey that disseminates statistics relevant to child abuse issues.

Need Information on Children's Legal Rights and Advocacy?

ABA Center on Children and the Law. 740 15th St. NW, Washington, DC 20005. 202-662-1720. The center provides consultation, technical assistance, and training for professionals in using the legal system to protect children, and also publishes materials on child abduction.

The National Children's Advocacy Center. 106 Lincoln St., Huntsville, AL 3580. 205-533-KIDS. In addition to sponsoring training conferences, disseminating research findings, providing resource materials, and providing technical assistance, the center provides multidisciplinary resources in a model community response to child sexual abuse.

National Association of Counsel for Children (NACC). 1205 Oneida St., Denver, CO 80220. 303-322-2260. The NACC is a professional organization for lawyers and other practitioners who represent children in court, and publishes a variety of materials relating to children's legal rights as well as sponsoring child abuse training.

Need Medical Resources?

American Academy of Pediatrics. Department C, P.O. Box 927, Elk Grove Village, IL 60009. 708-228-5005. The academy publishes a free brochure on child sexual abuse, including the history of child abuse, identification of child abuse, effects on child victims, and information about child care centers.

American Medical Association. Department of Mental Health, 515 State St., Chicago, IL 60610. 312-464-5066. The AMA provides referrals related to child abuse and family violence and free copies (single) of two brochures containing guidance on diagnosis, treatment, and medicolegal issues concerning child abuse and neglect.

Need Family Resource Information?

Family Resource Coalition (FRC). 200 S. Michigan Ave., 16th Fl. Chicago, IL 60604. 312-341-0900. FRC is a membership organization of social service agencies concerned with strengthening families through preventive services. FRC maintains a clearinghouse for information on family resource programs throughout the United States, publishes a quarterly newsletter, sponsors conferences, and provides technical assistance.

National Coalition Against Domestic Violence. Address for membership information: P.O. Box 34103, Washington, DC 20043-4103. 202-638-6388.To order publications: P.O. Box 18749, Denver, CO 80218-0749. 303-839-1852. The coalition is a national organization that works to end violence in the lives of battered women and their children. The coalition provides information, technical assistance, publications, newsletters, and resource materials.

Need Culture-Specific Information?

People of Color Leadership Institute (POCLI). 714 G St., SE, Washington, DC 20003. 202-544-3144. Among POCLI's goals is to improve cultural competence in child welfare systems that serve children and families of color. POCLI has developed a cultural competence training guide, an agency self-assessment tool regarding cultural competence, a bibliography of publications about the field of child welfare as it relates to people of color, and a network of professionals of color in the field.

Need Substance Abuse and Self-Help Group Information?

Children of Alcoholics Foundation. 555 Madison Ave., 20th Fl., New York, NY 10163. 212-754-0656. The foundation promotes public and professional awareness of children of alcoholics' problems and develops programs and materials to break the cycle of family alcoholism.

National Clearinghouse for Alcohol and Drug Information (NCADI). 11426 Rockville Pike, Suite 200, Rockville, MD 20852 301-468-2600 or 1-800-729-6686. NCADI is a communications service of the Center for Substance Abuse Prevention. NCADI provides information on research, publications, prevention and education resources, and prevention programs, and a catalog is available on request.

The National Self-Help Clearinghouse. Graduate School, City University of New York, 25 W. 43rd St., Room 620, New York, NY 10036. 212-642-2944. For listings of self-help groups, send a stamped, self-addressed business-sized envelope to the above address.

CHILD MALTREATMENT

Journal of the American Professional Society on the Abuse of Children

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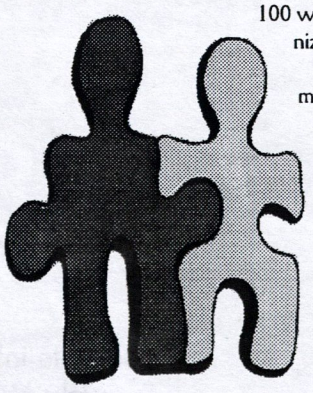

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APSAC Discounts

January 27-31, 1997. ***Eleventh Annual San Diego Conference on Responding to Child Maltreatment.*** San Diego, CA. Sponsored by the Center for Child Protection, Children's Hospital-San Diego. — APSAC Institutes are held in conjunction with this conference.— Call 619-495-4940.

March 19-21, 1997. ***13th National Symposium on Child Sexual Abuse.*** Huntsville, AL. Sponsored by the National Children's Advocacy Center. Call 205-533-0531.

June 18-21, 1997. ***APSAC Fifth National Colloquium.*** Miami, FL. Sponsored by APSAC. Brochure due out in early February. Call 312-554-0166.

October 6-9, 1997. ***Twelfth Midwest Conference on Child Sexual Abuse and Incest.*** Middleton, WI. Sponsored by the University of Wisconsin-Madison Division of Continuing Studies, Health and Human Issues. Call Denise Nolden at 608-263-2088.

Other Conferences

January 22-23, 1997. ***Stop the Hurt! Child Sexual Abuse Conference.*** Tupelo, MS. Contact Leah Headings at 601-842-7688.

February 20-22, 1997. ***Managed Care in Child Welfare Roundtable.*** Denver, CO. Sponsored by the American Humane Association. Call Mickey Shumaker at 303-792-9900.

March 6-9, 1997. ***43rd Annual Program Meeting: Navigating the Winds of Change.*** Chicago, IL. Sponsored by the Council on Social Work Education. Call 703-683-8080.

March 9-14, 1997. ***Child Welfare Leadership Institute.*** Denver, CO. Sponsored by the American Humane Association. Call Mickey Shumaker at 303-792-9900.

March 11-15, 1997. ***Interdisciplinary Approaches to Mental Health: The 74th Annual Meeting of the American Orthopsychiatric Association.*** Toronto, Canada. Sponsored by the American Orthopsychiatric Association. Call 212-564-5930.

March 12-14, 1997. ***Children 97.*** Washington, D.C. Sponsored by the Child Welfare League of America. Call 202-942-0289.

March 13-15, 1997. ***Standing Strong and Together for Children: Leave No Child Behind.*** Washington, DC. Sponsored by the Children's Defense Fund. Call Leslie Warrick at 202-662-3593.

April 3-6, 1997. ***Society for Research in Child Development (SRCD) Bi-Annual Meeting.*** Washington, D.C. Sponsored by the SRCD. Call Sue Kelley, CHGD-SRCD University of Michigan, 313-998-6578.

April 9-12, 1997. ***Opening the World to Children: Annual International Study Conference.*** Portland, OR. Sponsored by the Association for Childhood Education International. Call 301-942-2443 or 1-800-423-3563.

April 17-19, 1997. ***Outcome Measures Roundtable.*** San Antonio, TX. Sponsored by the American Humane Association. Call Mickey Shumaker at 303-792-9900.

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APSAC's National Colloquium is more than an excellent source of advanced professional education: It is where APSAC's interdisciplinary members and leaders join forces to propel APSAC's growth.

National committees, task forces, editorial boards, and state chapter leaders meet to refine publications, formulate practice guidelines, and develop strategies for addressing public policy and legislative issues.

TEACH.

In paper presentations, poster sessions, research breakfasts, the Research Symposium, and Open Forums, members and colleagues meet formally and informally to discuss vital interest areas.

Hundreds of professionals report the latest research and practice through poster and paper presentations in a rich mix of stimulating formats. Recent Open Forum topics include educating legislators effectively, surviving as a "child abuse" law enforcement officer, current issues in adult survivor treatment and politics, and representation of children for guardian ad litems and court-appointed special advocates.

"Membership in APSAC means access to the best resources in the field of child abuse and neglect: the top professionals, the most current research."
—Bette Bottoms, PhD, Assistant Professor, University of Illinois at Chicago

EMPOWER YOURSELF.

Come to the Fifth National Colloquium.

Meet colleagues face to face, share successes and challenges, brainstorm ideas, and lend your energy to the dynamic process of ensuring that everyone affected by child abuse and neglect receives the best possible professional response.

APSAC's Colloquium is designed by APSAC's members. Interdisciplinary colleagues from all over the nation work through APSAC's Colloquium committee to design seminars addressing current issues in CPS, law enforcement, medicine, mental health, law, and related professions.

"I have attended every year and the Colloquium offers both knowledge and support which enables me to continue with the difficult work we all face."
—Tara Donnelly, PhD, Montclair, New Jersey

Plan to grow with APSAC through the year 2000 by attending all of the scheduled colloquiums:

Sixth National Colloquium	**Hyatt Regency on the Riverwalk**	**Chicago**	**July 9-12, 1998**
Seventh National Colloquium	**Hyatt Regency on the Riverwalk**	**San Antonio**	**June 2-6, 1999**
Eighth National Colloquium	**Chicago Hilton and Towers**	**Chicago**	**July 10-15, 2000**

For more information about the Fifth National Colloquium, please call 312-554-0166 or fax 312-554-0919.