# APSAC ADVISOR

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**APSAC: Ensuring that everyone affected by child abuse and neglect receives the best possible professional response.**

# A Child's Right To Counsel in Maltreatment Cases

by Alan Rosenfeld, JD

APSAC has been asked to join as an Amicus Curae in support of a case pending before the California Court of Appeals, which raises the question of what standard of practice, if any, should be required of attorneys appointed to represent minor children in custody/visitation cases.[1] I believe that APSAC should join with the National Association of Counsel for Children and other public interest groups who support the protection of children from abuse and the importance of guaranteeing the right to counsel for all litigants, in urging the Court to adopt as law the evolving standard of practice which would require attorneys for competent children to act as real attorneys and vigorously represent the interests of the children while following the informed instructions of their clients.

Four professional associations have recently promulgated standards of ethical practice for attorneys who represent minors in civil proceedings: the American Bar Association, the National Association of Counsel for Children, the Fordham Conference on Ethical Issues in Legal Representation of Children, and the American Academy of Matrimonial Lawyers. Each of them would guarantee to competent minor clients the same right to zealous advocacy from their attorneys as adult clients.[2] None of these proposed standards are as yet binding on attorneys appointed to represent children.

The reasons for these evolving standards are both philosophical and practical. The goal of our child protection system is to achieve the best possible result for the children involved. Determination of the ultimate best interests of the children should be made based upon the evidence presented to the judge and not on the whim or bias of another non-expert adult. As the drafters of the American Association of Matrimonial Lawyers Standards explain in their commentary :

> The most serious threat to the role of law posed by the assignment of counsel for children is the introduction of an adult who is free to advocate his or her own preferred outcome in the name of the child's best interests. The danger is that this additional adult will make a difference in the outcome of the proceeding without any assurance that the outcome is "better" (that is, without an assurance that the outcome serves the child's best interests). (Comment to A.A.M.L Standards sect.2.7)

APSAC should join as an Amicus Curae in this case because this is a critical issue in the field of child protection that will ultimately have a profound effect—for better or worse—on how cases of alleged child abuse are handled in courts, and ultimately on the chances of achieving justice and protection for abused children. It should be one of APSAC's roles to participate in informed debates, in whatever forums, that will be deciding policy that will affect our ability to protect children from abuse. This case offers an opportunity to establish controlling standards of practice for attorneys who are appointed to represent children in child maltreatment cases.

The California case presents the kind of stark facts that make a decision on the ultimate question of law critical and inevitable. At the time of trial, a 12-year-old girl had been living with her mother, who had sole custody, and her extended family which included a stepfather and three younger siblings. Her father had residual visitation rights that he had voluntarily not exercised for almost a year and a half. According to the testimony of her psychologist, the child was "healthier than most children…whatever is happening in her life I would encourage more of it because she's doing very well."

The family was in court (after a long history of litigation that began with allegations that the father had sexually abused the child ten years earlier) because the child's mother had filed a motion seeking permission to relocate with her family from Southern California to Oregon. The child's father opposed the motion, and the Court appointed an attorney to represent the minor child at the upcoming hearing. Compelling evidence was offered that she was mature and emotionally competent to understand the implications of the legal action that involved her.

The child's expressed position was clear. She told her attorney, she told her psychologist, and she ultimately told the Court in her testimony. She wanted to move to Oregon with her family. She was angry at her father for trying to stop her from moving. She wanted nothing to do with her father and would not agree to visit with him. If forced to be with him, she would "keep running away until he got the idea."

The court-appointed lawyer, however, had opinions of his own. He asked the Court to exclude his client from the courtroom, and, contrary to clear instructions from his client, filed a motion to transfer full custody to the father. The child returned to court with her own lawyer and attempted to argue that she had a constitutional right to be heard by a lawyer of her choice who would act like a traditional lawyer. The original court-appointed lawyer refused to be removed and argued that he was not bound to follow his client's instructions, no matter how clearly they were articulated.

The minor child asked the Court to appoint a different lawyer or otherwise let her be represented by the volunteer lawyer she had retained. The Trial Court refused to remove the appointed lawyer, and ultimately granted that lawyer's motion and transferred full custody to the father. True to her word, the child followed through on her threat to run away and has not been seen or heard from since January 1997.

The issues on appeal raise the question of what standard of practice is to be required of attorneys appointed to represent minor children in custody cases. Currently there is no rule of law or binding standard of practice for attorneys representing children in custody cases in which there are allegations of child sexual abuse.[3]

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## A Child's Right

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Lawyers for children commonly behave in ways that would warrant disbarment and guarantee judgments for malpractice if these acts were committed on behalf of adult clients. Among the common problems are:

1) lawyers who see themselves as mediators between the parents in cases of child sexual abuse, rather than advocates for the protection of the children.
2) lawyers who bring their own biases into their work and refuse to believe allegations of sexual abuse, despite strong and compelling evidence supporting the claim.
3) lawyers who take a passive role in the trial on the issues of child protection, either because they lack the trial skills or knowledge of the special scientific or child development issues that are necessary to try cases of child sexual abuse.

In each of the above examples, an attorney whose client was one of the parents in a child abuse case clearly would have violated the basic canons of the legal profession. There is no excuse for allowing such malpractice to be inflicted upon the most vulnerable parties in custody cases.

In arguing against allowing children involved in contested custody cases the right to be represented by a real lawyer who follows their directions, some point to the many decisions that children are not allowed to make for themselves (including consenting to sexual relations or entering binding contracts). This is essentially a "straw man" argument. No one is suggesting that children should control the outcome of custody decisions. That remains the ultimate responsibility of the court.

It is also not suggested that an attorney for a competent child should merely be a "robot" who follows instructions with no input. That image would violate the full scope of the responsibility of lawyers to their adult clients. Lawyers must develop a trusting relationship with their clients so that ultimately they can advise their clients. Competent lawyers help their clients understand their choices, and the implications and risks of those choices, and thereby help their clients to make better choices. Lawyers for children owe their clients no less a responsibility than lawyers for adults. An attorney's responsibilities should be greater, rather than lesser, when the client is a minor.

Children do not necessarily know what is best for them, but they may still be competent to give instructions to an attorney in an informed attempt to achieve their wishes. This case on appeal is particularly compelling because the child was twelve years old and evidence was offered to show her competence to understand the nature of the proceedings that involved her. She was competent by the same standards that are required of adults. Adult clients do not have to prove that they know what is best for them, merely that they understand the nature of the proceedings and the issues.

It should be the responsibility of the judge to determine the best interests of the child based upon the judge's training and wisdom and upon the weight of the admissible evidence presented in court. Too often, however, judges rely upon the opinion of the child's attorney or guardian ad litem. Accepting the recommendations of a presumably "neutral" adult may make the process easier for judges but does not increase the chances of achieving justice for children at risk.

When lawyers are permitted to offer their own opinions on the child's best interests, rather than being required to use the testimony of expert witnesses, they are not subject to cross examination that might educate the judge on the lawyer's biases or reliance on scientifically invalid theories. We are all aware of expert witnesses who base their opinions on unreliable and false theories, such as Parental Alienation Syndrome. How will we protect the children when those false opinions are offered by children's lawyers rather than "hired gun" experts?

It is important for all parties in court proceedings to remember the responsibilities and limitations of their roles. Witnesses are supposed to tell the truth. Experts are supposed to testify within the scope of their knowledge. Judges are supposed to judge. Lawyers are supposed to advise and advocate for their clients.

I believe the Court will have the strongest chance of ultimately determining the truth and reaching the best interests of the child if all the evidence is presented and examined as thoroughly and competently as possible. Appointment of a competent, specially trained attorney, who will act as a real attorney for children involved in difficult child custody and child protection cases, will dramatically increase the number of children whose interests are protected rather than threatened by the legal process.

The APSAC Legal Committee is currently considering a request to join the case as an Amicus Curae. Comments should be sent to the Legal Committee, c/o Tom Lyon, University of Southern California Law Center, Los Angeles, CA. Readers who are interested in a more thorough discussion of these issues are referred to the special section on Children's Legal Representation in volume 2, number 3 of *Child Maltreatment.*

*Alan Rosenfeld, JD, was a founding member and past president of the Northern New England APSAC Chapter. He has recently relocated to Boulder, Colorado.*

[1]The author is the attorney for the mother in the case.

[2]An APSAC Task Force on Standards of Practice for Attorneys for Children is still at work. Although the task force has not yet formally adopted any guidelines, all of the participants at a recent task force meeting held at the Fifth Colloquium in Miami agreed that at the minimum they would support standards of practice that would prohibit conduct similar to that inflicted upon the minor child in the case in question.

[3]This case only involves the role of appointed counsel for minors in custody cases, but might theoretically also be applied to dependency cases. Some states, including California, do have specific statutes defining the role of counsel for children in dependency cases.

# LETTERS

## To The Editor:

I appreciated Brian Holmgren's article on expert testimony on children's suggestibility (*APSAC Advisor,* vol 10, n 2, Summer 1997). He writes "A cardinal principle in scientific research is results must be replicated before generalizations can be made from data." Over and over again I see Ceci's "finding" that repeated questioning causes children to make false reports hailed as an important contribution science can bring to psychology and the law (see the APA Monitor, July, 1997). This finding was based on a study shown on television's "20/20" and published in 1994 (Ceci, Huffman, Smith, and Loftus, 1994). It involved repeatedly asking young children if they ever got their finger stuck in a mousetrap (among other questions). A former graduate student, Bhavna Shyamalan, and I tried to replicate this study and couldn't (a confound in the way we did the study made our own results difficult to publish.) I then did the study alone again at a different setting with different children and still was unable to replicate Ceci's findings. In our studies, with repeated questioning, children were more likely to falsely report a real event did NOT happen than to falsely report a fictitious event did. While children did occasionally make false reports about a fictitious event, they did not do so as frequently as reported in Ceci's study, and these false reports were sporadic and did not increase over time. That is to say, there was no increase in false reporting of a fictitious event with repeated questioning.

As Holmgren suggests, lawyers need to be wary of using expert testimony on children's suggestibility, but researchers also should be careful of promoting the results of a study until that study has been well replicated.

*Sharon Lamb, Ed.D.*
*Associate Professor of Psychology, St. Michael's College, Colchester, VT*

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I am writing to call the attention of your readers to statements made by Ceci and Bruck in their book *Jeopardy in the Courtroom* — statements which severely damage its forensic value and support Brian Holmgren's argument that suggestibility research must be, at best, used cautiously in court.

Buried in the preface to *Jeopardy in the Courtroom* is an admission which invalidates the book's scientific value:

> At the outset, we wish to acknowledge some of the biases of this book. These biases become immediately evident in our selection of the seven actual cases presented in chapter 2. In six of these cases, there are reasons to be skeptical about the reliability of the children's reports. Why do we focus disproportionately on cases where children's testimony is questionable? Is it because we believe that in the vast majority of cases in which children testify, their testimony is tainted? Our answer to this question is a resounding no (p.x)

The authors go on to say that their analysis is "descriptive" and not a "quantitative analysis" (p. 82). They do not measure the number of times presumably suggestive elements occur in an interview (p. 82). They do not provide statistics on the number of children or the number of errors (p. 120).They do not report the nature of misleading questions (p. 91) or the nature of actions which the children confuse (pp. 108-109).

They justify such practices on the ground that it "increases awareness" (p.x) of the jeopardy the accused faces in the courtroom. Clearly, deliberately presenting biased evidence, especially in language which creates the appearance of revealing the truth, does not increase awareness — it obfuscates it. Holmgren quotes Ceci and Bruck's admonitions that the court should force experts "to provide scientifically adequate evidence for their interpretation" (p.282). In context of deliberately publishing a blatantly biased book, Ceci and Bruck's disclaimers and advice should be recognized as an attempt to mask their adversarial agenda in scientific rectitude.

*Madelyn Simring Milchman, Ph.D.*
*Licensed Psychologist (N.J. #2198), Roseland, N.J.*

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I have just read the article "Failure to Protect" by Jeffrey Edelson (*APSAC Advisor,* vol 10, n 2, Summer 1997). I am an intake supervisor for the Massachusetts Department of Social Services (DSS), where I have worked for 19 years. I found the tone of the article "Failure to Protect" to be simplistic regarding the intervention of DSS. I think that an issue devoted to the perspective of DSS social workers whose primary goal is the protection of children and the perspective of domestic violence staff would be very useful for all sides.

*Mary Connor, Intake Supervisor*
*Massachusetts Department of Social Services, Attleboro, Massachusetts*

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*Dr. Edelson replies:*

The writer makes several good points in her letter. Yes, the piece I wrote was somewhat simplistic. I had much more to say but so little space to do so. Child maltreatment and woman battering are incredibly complex events - when they combine their complexity is often multiplied. Ms. Connor notes that she and others in her position have a "primary goal" of protecting children. This is true, but many battered women's advocates see that goal as sometimes being too narrow and not helpful to the children DSS and similar agencies seek to protect. This "primary goal" as well as current child protection agencies were created by the human beings who make our laws and are by no means written in stone. Ironically, many people refer to Public Law 96-272 and other state laws as if they were unchangeable. That is not the case and this is the point - if we see better ways to work together to provide safety to BOTH abused mothers and their maltreated children then we should do so, even if it means changing some laws and procedures that may be close to two decades old.

# NEWS FROM THE FIELD

## Supreme Court Upholds Kansas' Sexually Violent Predator Act

The United States Supreme Court, in Kansas v. Hendricks, has upheld the constitutionality of Kansas' Sexually Violent Predator Act for the indefinite and possible lifetime commitment of sexual offenders, including those who have completed serving their criminal sentences. Holding that the state's intent to provide treatment to those committed under the Act (when treatment is possible) made the commitment civil and not criminal, the Court rejected the arguments that the Act violated substantive due process, double jeopardy, and the bar against ex post facto laws.

Under the Act, any person charged with or convicted of a sexual offense may be indefinitely committed if a jury finds beyond a reasonable doubt that the person "suffers from a mental abnormality or personality disorder" which makes it "likely" that the person will commit future acts of sexual violence. The Court approved a finding that pedophilia, as defined in DSM-IV (the Diagnostic and Statistical Manual of the American Psychiatric Association), constitutes a "mental abnormality." Since the definition of pedophilia includes any molestation that continues for more than six months and results in legal intervention, the opinion has significant implications for advocates of extending the time that child abusers are incarcerated through the use of commitment statutes.

## Combating Trafficking of Children for Prostitution

Nearly 120 prosecutors, investigators, and representatives of community-based programs convened in Lincoln, Nebraska June 26-28 at the first national gathering devoted to issues of child prostitution in the US. Organized by Marsha Liss, staff attorney with the Child Exploitation and Obscenity Section of the Department of Justice, Criminal Division, and Brian Wilcox of the Center for Children, Families and the Law at the University of Nebraska, the conference also enjoyed the support of two US Congressmen (Chris Smith of New Jersey and Joe Kennedy of Massachusetts) and the Center for Substance Abuse Prevention. Participants heard from investigators and prosecutors who have achieved convictions in interstate trafficking cases, and from outreach workers in several major cities who described the lives of the child victims and the services they need. Law enforcement officers and outreach workers engaged in spirited discussions about the nature and scope of the problem in this country. Advisor Editor-in-Chief Debra Whitcomb presented research findings on child sexual exploitation, described several existing task forces designed to mobilize resources to address the problem, and facilitated a session focusing on collaboration between law enforcement and community-based organizations. At the conclusion of the conference, participants identified challenges to more effective interventions in their geographic regions and considered strategies to meet these challenges.

## Applying Managed Care Principles in Child Welfare Agencies: American Humane Association Receives Grant from Casey Foundation

With the support of a grant from the Casey Family Program and the Annie E. Casey Foundation, the American Humane Association will be developing systems to help child welfare agencies integrate principles of managed care into their operations. With the tremendous influx of children into the child welfare system and a lack of consistent guidelines to help caseworkers make placement and treatment decisions, the AHA saw a need to help child welfare agencies incorporate managed care principles, such as outcome measures and placement guidelines, into their service delivery methods. The grant will fund a two year project, which will begin with a study of how the philosophies of managed care can be incorporated while maintaining high quality services and keeping children safe. The ultimate result will be the development of outcome measures, decision-making guidelines and other tools agencies can use in their work with maltreated children. Joining the AHA in this effort will be the American Bar Association's Center for Children and the Law and the Institute for Human Services Management.

## APSAC's Ken Lanning Honored with FBI Director's Award for Excellence

APSAC member Kenneth Lanning was recently honored by the Federal Bureau of Investigation with its Director's Award for Special Achievement, which recognizes longstanding commitment and outstanding achievement. Ken's 17-year career with the FBI has focused on the maltreatment of children, and he has worked with the Bureau to set up a special office on Crimes against Children. Congratulations to Ken on this well-deserved recognition of his outstanding work on behalf of missing and exploited children.

## APSAC's 1998 Advanced Training Institutes
## Town and Country Hotel, San Diego, California
## SATURDAY, JANUARY 31, 1998

APSAC's's 1998 Advanced Training Institutes are held in conjunction with the San Diego Conference on Responding to Child Maltreatment, to be held at the Town and Country Hotel January 26-31, 1998. APSAC's Institutes supplement the San Diego conference program by offering in-depth, intensive Institutes on selected topics, taught by nationally recognized leaders in the field of child maltreatment.

**Topics presented will include:**

- The Art and Science of Forensic Interviewing of Young Children
- Preparing Children for Court
- The Application of Behavioral Sciences to the Investigation of Sexual Victimization of Children
- Advanced Medical Evaluation of Physical Abuse
- Advanced Medical Evaluation of Sexual Abuse
- Dyad and Family Therapy in Sibling Abuse
- Coordinated Interdisciplinary Approaches to Factitious Disorder by Proxy
- Managing Resistance and Engaging Involuntary Maltreating Families in the Treatment Process

For more information, please contact APSAC's Training Department at 312-554-0166.

## APSAC Welcomes New Executive Director

by Harry Elias, JD
President
Board of Directors

As President of APSAC and on behalf of the Board of Directors, it is my pleasure to introduce APSAC's new Executive Director, Delores J. Brooks. Delores assumed leadership of APSAC as of August 2, 1997 and is ready to take APSAC into its second decade.

I know many of you knew and worked closely with Theresa Reid over the past ten years. With Theresa's leadership and boundless energy, APSAC grew from an abstract concept to a highly regarded national association, 5,550 members strong, in just ten years. When Theresa decided to move on to other challenges (most notably that of raising a child), the Board took the opportunity to carefully reflect on the type of leadership APSAC would need to move into the next stage of its growth in the increasingly competitive nonprofit arena.

A search committee of six past and current APSAC Board members reviewed more than 100 resumes, from applicants across the country. It was deeply gratifying to see the high regard many professionals in our field have for APSAC, and we were fortunate to have a highly qualified pool of applicants. After screening candidate applications, and then further interviewing candidates by phone, six finalists were invited to Chicago to meet with the search committee. Almost from the moment we met her, we felt that Delores Brooks was the person we had been seeking. Her qualifications are extremely impressive — seven years in marketing with the American Bar Association, eight years as Manager of Public Relations for the City Colleges of Chicago, and most recently, Executive Director of the Chicago State University Foundation. In addition to her excellent marketing, public relations and management skills, Delores has demonstrated a quick and keen understanding of the challenges facing APSAC, a deep commitment to its mission of providing the best possible professional response to those affected by child abuse and neglect as well as a tremendous personal warmth and sense of competence. The search committee was confident that APSAC would grow and flourish under Delores' leadership, and we were delighted that she accepted the position of Executive Director.

I ask that you join me in welcoming Delores Brooks to APSAC and offer her your support, your expertise and your ideas on how APSAC can continue to grow and meet the needs of its members and its mission.

On another note, APSAC wishes to draw upon the great wealth of knowledge and skill of its membership. I have asked all the members of the Advisory Board to become active as associate chairs of APSAC's standing committees and sub-committees. I would also ask that you further assist APSAC by offering to become a member of one of our standing committees: Operations, Development, Membership, Publications, Professional Education and Public Affairs. To become active on a committee or subcommittee, please contact Delores Brooks (APSACExec@aol.com) or Howard Griffin, Membership Services Manager (APSACMems@aol.com), phone 312-554-0166. I look forward to working with all of you in the upcoming year.

## From the New Executive Director

by Delores J. Brooks

**Dear APSAC Members and Colleagues:**

I am thrilled to have been named the new Executive Director of APSAC. The space allotted here will not allow me to cite all the reasons I feel such gratification, but I will attempt to delineate the more important ones. First, I am honored to become part of such a distinguished group of professionals who work so brilliantly, diligently, passionately and tirelessly in the field of child maltreatment. Ours is a field that is fraught with angst, with emotion, with far too many circumstances that can lead to misunderstanding, even controversy. Yet, it is just such situations, in my opinion, that make APSAC an indispensable agent for positive and much-needed change on issues related to best practice in the child maltreatment field. In fact, it is just such situations that best define why there is APSAC, and why it must thrive.

A further reason I am proud to join APSAC is that, in just ten years, APSAC has grown from a vision and an idea in the minds of a number of dedicated child maltreatment professionals into an organization that is well-respected, much consulted, and central to any review, discussion, or action in research, education, legal and other legislative areas pertaining to child maltreatment. This is no small task, particularly in such a short span of time. This is a tribute to your hard work and to that of the previous Executive Director, Theresa Reid, who set high standards which APSAC never failed to meet.

I understand the enormity of the responsibility I have accepted as APSAC's chief executive officer. It is indeed humbling, challenging, perhaps even somewhat daunting. Yet, with the special pledges of support I have received from so many of you — the very highly-regarded Board of Directors, the Search Committee, the staff, and the many members I met and talked with at the Miami Beach Fifth Annual Colloquium this past June — I face the future, APSAC's future, with enthusiasm, with commitment to our mission, and with a strong sense of energy and anticipation. If our next ten years can be as successful as the first ten have been — and I have no doubt they will be — we all can take pride in the progress we will continue to make toward our mission — and take even greater pride in the fact that the beneficiaries of our work, the children we serve, will have much improved lives.

Together, we can bring to APSAC the expanded and diversified membership base it requires to move boldly ahead into the next millennium. Thank you for your confidence in me to help make this happen.

Delores J. Brooks, MS

## Report from the Fifth National Colloquium — Mission Accomplished!

It was another successful Colloquium, thanks to the APSAC volunteers and members who have worked so hard over the past five years to make this annual event one of the best training opportunities in the field. More than 900 participants gathered at the Fontainebleau Hotel in Miami Beach for four days of intensive seminars, research presentations, and networking opportunities. Members reconnected with old friends and colleagues, and shared ideas on how to meet the challenges of caring for maltreated children in a time of increasing need and shrinking resources. Program highlights included the Presidential address by Harry Elias, JD; the Friday plenary session, moderated by John E.B. Meyers, JD, and featuring speakers Shay Bilchik, JD and J. Tom Morgan, JD on the links between juvenile crime and child maltreatment; and a Saturday evening plenary, moderated by Mark Chaffin, PhD, on a groundbreaking memory case study, published by David Corwin, MD, in APSAC's journal *Child Maltreatment.*

The Colloquium is a major effort for APSAC's small staff, and it would not be possible without the outstanding effort of the many volunteers. In particular, Colloquium Co-Chairs Catherine Ayoub, RN, EdD and Nancy Lamb, JD worked for more than a year to make the Fifth Colloquium a success. They were assisted by a committee of more than 30 multidisciplinary professionals, each of whom contributed their expertise to ensure the program would bring the most relevant, important and topical training topics to APSAC members and other attendees. All of the Colloquium faculty donated their time and expertise to benefit APSAC and the field at large, and we are very grateful for their generosity and commitment. Plan now to attend APSAC's Sixth National Colloquium, to be held July 9-12, 1998, in Chicago. We welcome your suggestions for training topics or program features. For information on volunteering for the Colloquium, please contact the APSAC training department, at APSACeduc@aol.com, or call 312-554-0166.

## Second Edition of the Practice Guidelines for Psychosocial Evaluation of Suspected Sexual Abuse Now Available

APSAC has issued a second edition of its *Practice Guidelines: Psychosocial Evaluation of Suspected Sexual Abuse in Children.* This publication is the work of APSAC's Task Force on the Psychosocial Evaluation of Suspected Sexual Abuse in Children, chaired by Lucy Berliner, MSW. In the past, Practice Guidelines were distributed at no cost to APSAC members. However, financial realities have made it necessary for us to charge a nominal fee, to cover the cost of producing the Guidelines and to help ensure that additional Guidelines can be developed. We appreciate your understanding and support, and look forward to the publication of additional Practice Guidelines in the coming year. The discounted price for members is $5.55 per copy, including first class postage. Price for nonmembers is $10 per copy, plus $2 shipping. For your copy, mail check to: APSAC, 407 S. Dearborn, Suite 1300, Chicago, IL 60605; or fax a credit card number to: 312-554-0919.

## APSAC's First Forensic Training Institute Held in Ann Arbor

Moving closer to it's goal of becoming recognized as the national leader in providing high quality, multidisciplinary training, APSAC held its first Five Day Forensic Interview Training Clinic in Ann Arbor, Michigan this past August. Organized by Kee McFarlane, MSW, Melissa Steinmetz, MSW and Eileen Schifrin, the clinic offered a theoretical overview of the issues in child interviewing, and hands-on practice conducting interviews with children. Fifty-one participants attended, and more than 100 people are on a waiting list for the next clinic. No definite date has been set, but given the tremendous response and the excellent evaluations the clinic received, an announcement about the next clinic will be forthcoming. Our deepest thanks go to the three organizers, Ms. McFarlane, Ms. Steinmetz and Ms. Schifrin, who worked tirelessly for months to make the clinic such an outstanding success. In addition, we are very grateful to the faculty, whose generous donation of time and expertise gave the clinic a level of quality and prestige that truly set it apart from other offerings in the field: Kathleen Coulborn Faller, ACSW, PhD; Karen Saywitz, PhD; Mark Everson, PhD; David Corwin, MD; John Stirling, MD; Harry Elias, JD; Donna Pence; Lance Jones, JD; and Jill Ellyn Strauss, JD. Special thanks also go to Dr. Faller, Joanne Hartmeyer and the staff of the University of Michigan Family Assessment Clinic for their work in helping to host the clinic. For more information on this or future Forensic Interview Training Clinics, or to be added to the mailing list, please contact the APSAC Training Department at 312-554-0166, APSACEduc@aol.com, or fax 312-554-0919.

## Recruit New APSAC Members and Win a Week in Hawaii

At the Fifth National Colloquium, APSAC President Harry Elias issued a challenge: the APSAC member who recruits the most new members in the coming year will win a week's stay in Kauai, Hawaii! Be sure to check out the contest details and rules on page 17 of this issue of the Advisor. Start recruiting, and start packing!

# Suggestions for Sexual History Taking with Adults Suspected of Sexual Abuse

by Kathleen Coulborn Faller ACSW, PhD with Jane Mildred, Carol Plummer, Ellen DeVoe, Sallie Churchill, Laura Sanders, Melnee MacPherson, William Almy, & Katherine Doyle

*This is an abbreviated version of Suggestions for Sexual History Taking, an article which was developed by the staff of the University of Michigan Civitas Child and Family Programs and the Family Assessment Clinic, a multidisciplinary team that conducts assessments of cases of possible child maltreatment. This article presents a composite of approaches we have found useful for gathering sexual history information during assessment of persons accused of but denying or minimizing sexual abuse.*

**Introduction**

These guidelines are for evaluators gathering information, within the context of an overall assessment, about the sexual history of accused offenders. Therefore, they represent a small part of the evaluation process. They are designed primarily for evaluators who are assessing for sexual history in situations in which the alleged offender is challenging the allegation. He/she may be actively denying, merely not admitting, partially admitting, or admitting but denying sexual intent.

Although a history of individual sexual deviancy and/or unusual family or environmental sexual patterns do not prove sexual abuse, they are very relevant to assessment of sexual abuse. Clinicians and researchers have noted that sexual abuse of children may be part of an individual's pattern of deviant sexual arousal and acts (e.g. Abel, Becker, Murphy, & Flanagan, 1981; Salter, 1988). In addition, sexual arousal to children is considered a precondition to sexual abuse of children (Araji & Finkelhor, 1986; Faller, 1990; Finkelhor, 1986). Moreover, clinicians and researchers have also noted some sexual abusers choose children as objects for sexual gratification in the absence of other sexual outlets or because they lack the ability to negotiate peer sexual relationships (Araji & Finkelhor, 1986; Faller, 1990; Finkelhor, 1986). Therefore, because of the possible relationship between sexual functioning and child sexual abuse, taking a careful sexual history of alleged offenders is important.

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There is no single empirically demonstrated right or wrong method for gathering data on a client's sexual history. However, to date most protocols have been designed for persons who admit, at least at some level, to their sexual problems. It is especially difficult to gather accurate and complete information about sexual history when individuals have been accused of sexually inappropriate behavior they do not admit. Regardless of their guilt or innocence, they are likely to be frightened and wary of disclosure of information related to sexual activity. They are also likely to be uncomfortable discussing activities that are so private and sometimes socially unacceptable. Finally, they may even become irate and challenge the interviewer for being too intrusive.

Interviewers also experience discomfort. A good interviewer is aware of how difficult this exploration is for the interviewee, may be uncomfortable discussing sexual matters him/herself, especially the more deviant sexual acts, and may lack sexual knowledge and experience. The general strategies and specific questions in these guidelines are proposed to encourage the interviewer to thoroughly investigate the client's sexual history. They are also meant to be advisory, that is, they are to give the interviewer ideas about general approaches and the kinds of questions to ask. In a given interview, not all of the questions will be necessary, nor are the suggested strategies and questions complete.

**General strategies**

In this section, we describe a number of strategies that we have found to be useful in enhancing candor and mediating distressed and negative responses from interviewees.

It is usually appropriate to delay asking questions about sexual history until well into the assessment. Nevertheless, in the introductory part of the interview, it may be advisable to prepare the client for these questions by telling him/her that you will be asking lots of questions about different aspects of his/her life, including questions about sexual matters.

Evaluators may find it useful to begin by trying to elicit a narrative about aspects of sexual history and related topics, by asking open-ended questions. This approach may elicit spontaneous accounts of relevant information. However, such an approach may also result in vague or sparse answers or social desirability responses (responding with what the client thinks is socially appropriate behavior). For example, the interviewer asks, "What was your sexual relationship like with your first wife?" and the client might reply "Fine." In this instance, the interviewer will resort to more specific questions in attempt to get a more complete picture of that sexual relationship.

Because of the reticence people in general and clients involved in cases of sexual abuse in particular have about discussing their sex lives, the evaluator should expect at some point to have to use numerous, specific questions. It is often helpful to normalize this process by explaining that all clients are asked these sorts of questions, perhaps by showing the client the list of questions. Even using many and specific questions does not guarantee an accurate and detailed sexual history. It just increases the likelihood of obtaining a better history.

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# Suggestions for Sexual History Taking

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A strategy that may mediate the impact of having to ask many questions is to ask two or three questions at a time at various points throughout the interview in conjunction with questions about other aspects of the topic being discussed. For example, when talking about childhood, partner relationships, or the child, the evaluator might also cover related sexual material. When the sexual history is gathered in this fashion, questions about sex typically follow more neutral questions about the topic. For example, after asking the interviewee "What is your partner like? What do you like about her/him? Are there any things that you don't like about her/him?", the interviewer can ask, "Can you tell me about your sexual relationship with her/him?" This question may need to be followed by specific probes about frequency of sexual activity, types of sexual acts, foreplay, and satisfaction, as needed. Other questions that might be asked about sexual activity in the context of the relationship are "How are things going for the two of you sexually?" and "Is there anything in the relationship that you are not comfortable with?" followed by "Is there anything in the sexual relationship that you are not comfortable with?"

A related strategy is to try to elicit sexual history material indirectly in response to questions about other activities. For example, the interviewer might ask a question about substance use, such as "Was there ever a time that drugs made you do something you wouldn't otherwise have done?" or "Have you ever gotten involved in things under the influence of alcohol, you don't think you would have gotten involved in if not using alcohol?" And then perhaps ask more specifically "Any sexual activities?"

Case material, records, sexual history information from partners and other intimates, and additional accounts from other sources should be sought, and the information from these sources compared to information elicited in client interviews. For example, a client may deny sexual abuse of a child, but have a past history of arrest for a sexual offense against a child. Lack of candor in response to sexual history questions does not prove sexual abuse, but should be interpreted in the context of the overall evaluation.

On the following page is a partial list of specific questions which may be used to guide interviewers in taking a client's sexual history. These questions are clustered by topic. They are not exhaustive, but rather suggestive. The interviewer should base the order of topics covered on the specifics of the case. Topics covered include:

- The child's sexual history — Although these questions are outside the bound of the interviewee's sexual history, they are included, not only because they are necessary to exploring possible sexual abuse, but also because they may form a useful transition to a discussion of the adult's sexual history.
- The interviewee's childhood sexual history
- Masturbation and sexual fantasies
- Adolescent sexuality
- Pattern of intimate relationships — The client's sexual relationships may have started in adolescence or adulthood. The interviewer is advised to begin gathering information chronologically, that is the first person, second, etc. until the interviewer understands the pattern of sexual relationships.
- Current partner relationship
- Sexual deviancy — In asking these questions, it may be useful to ask about current partner before asking about the interviewee. The interviewer can preface the inquiry by stating "Now I'm going to ask you about lots of different kinds of sexual activity. Some of them are common and others are not so common." The interviewer may be selective regarding the activities he/she asks about.

The purpose of this summarized article is to offer clinicians and interviewers a basic outline for conducting a sexual history assessment of individuals charged or suspected of sexual abuse. These questions may serve as a guide, highlighting the areas which must be covered in order to provide a complete picture. The authors invite feedback in the form of additional suggestions and other comments from Advisor readers. Copies of the complete article can be obtained by contacting:

**Because of the reticence people in general and clients involved in cases of sexual abuse in particular have about discussing their sex lives, the evaluator should expect at some point to have to use numerous, specific questions.**

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# Suggestions for Sexual History Taking

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## Interview Questions

### Child's Sexual History

1. What does your child know about sex?
2. Has your child been involved in any sexual exploration with children his/her own age?
3. What sexual experiences has your child had?
4. Do you think your child has been sexually abused?

### The interviewee's childhood sexual history

1. Do you remember what you were taught about sex as a child?
2. Many people have sexual experiences as children. Did you? Can you tell me about them?
3. Were you aware of your parents having a sexual relationship as a child?
4. Did you ever play doctor or any other sexual games?
5. As a child, did you have any sexual experiences with:
   - A. Sisters or brothers?
   - B. Parents, stepparents, foster parents, or parents partners?
   - C. Other people?
6. Do you think you were sexually abused as a child? Can you tell me about it?
   - A. Did anyone help you with this? Who? How?
   - B. Do you actually remember this, or has someone told you about it?
   - C. Was there a time you didn't remember or had a less complete memory of this?

### Masturbation and sexual fantasies

1. Most people masturbate (touch their private parts) at least sometimes. How old you were when you first masturbated? How often did you masturbate?
2. What were you taught about masturbation as a child?
3. Do you recall you sexual fantasies as a child?
4. Do you have sexual fantasies now? Please describe them.
5. What situations cause you to fantasize? How often do you masturbate?

### Adolescent sexuality

1. Most people's sex life really begins in their teens. Do you remember how old you were when you became really interested in sex?
2. Did you date as a teenager? Can you tell me about dating?
3. What kinds of sexual activity were you involved in as a teenager?
4. Many people experiment sexually during their teens. Were you involved in any experimentation?

### Pattern of intimate relationships

1. Generally how would you characterize your feelings/attitude about sex?
2. Tell me about the first person you had a sexual experience with. (Add probes to gather information about details of the relationship and the sexual activities.)
3. Tell me about the next person you had a sexual relationship with.
4. How would you describe your sexual orientation?
5. Have you ever had any problems with sexual performance?
6. Have you ever contracted a sexually transmitted disease?
7. Have you ever been worried you might have a sexually transmitted disease?

### Current partner relationship

1. Tell me about your current partner.
   - A. What do you like about him/her?
   - B. Are there any things that you don't like?
2. How would you compare this relationship to past ones?
3. What sort of sexual relationship do you have?
4. Have there been times when the sex was better or worse?
5. How satisfying has this relationship been? How frequently do you have sex?
6. What sorts of sexual activities does your partner enjoy?
7. What sorts of sexual activities do you enjoy?
8. Have you noted that your partner has any unusual sexual interests?

### Sexual deviancy

1. Extramarital sex
2. Mate swapping
3. Group sex
4. Use of pornography
5. Sado-masochistic sex
6. Bondage
7. Spanking/discipline
8. Sexual activity involving animals
9. Exposing him/herself or peeping
10. Sex for money
11. Any activities involving urination (golden showers) or defecation
12. Any other sexual activity that is somewhat unusual?

### Additional questions regarding possible sexual deviancy

1. Has anyone made a referral to protective services about you in the past? What for?
2. Have you ever been accused of inappropriate sexual activity?
3. Have you ever been reported to the police for inappropriate sexual activity?
4. Have you ever been falsely accused of sexual abuse of a child or of any other sexual offense, such as rape?
5. Do you have any criminal or misdemeanor charges pending right now? What for?
6. How old was the oldest person you have had sex with?How old were you?
7. How old was the youngest person you have had sex with? How old were you?

### Concluding question

1. Is there anything else you want to tell me about your sex life?

# Adolescents and Sexually Sadistic Serial Killing Fantasies

by Bradley R. Johnson, MD

Although there are many books in the popular press that address the issue of sexually sadistic serial murderers, there is still relatively little in the scientific literature regarding this subject. Most of the research published has been based on case studies or small collections on serial murderers. However, little has been learned that is applicable clinically, especially when considering how to intervene with children and youth to help prevent them from going on to become sexually sadistic serial killers.

As one looks back into the childhood of notorious serial killers, it becomes evident that there is no one single cause that led to their violent behaviors. It is likely that there are biological predispositions as well as sociocultural influences involved. The development of violent behaviors mixed with sexual deviancy is likely caused by multiple risk factors. Too often these risk factors are only identified after the individual has committed a violent crime such as a sexual murder. Researchers and clinicians need to begin to understand the developmental years of sexually sadistic killers, to understand the multiple influences and identifiable risk factors in children and adolescents so that these individuals can be identified and offered treatment well before they ever act out their fantasies in real life.

## What is known

Park Dietz (1992) said that before a man becomes a serial killer, the offense has already been committed in fantasy in his own mind. He identifies the serial killer as an offender who kills others in three or more separate incidences (Dietz, 1987), and is distinguished from a mass murderer who kills multiple victims during a single incident (Dietz, 1986). Many, including Dietz (1986), have proposed typologies of the serial killer. Some people assume that such deviant violent behaviors could only be committed by an individual who is psychotic or involved in organized crime. However, it is likely that the most common type of prolific serial killer is truly a sexually sadistic serial killer. Therefore, although not all sexual sadists are serial killers, most prolific serial killers are sexual sadists.

***Before a man becomes a serial killer, the offense has already been committed in fantasy in his own mind.***

It continues to be debated as to the number of actual serial killers that are at large in the United States. The majority of the world's reported serial killers exist in the United States but many question whether this is due to better crime solving techniques and record keeping versus a true surge of actual serial killers in the United States.

The author has interviewed a number of adolescents who have expressed sexually sadistic serial killing fantasies which began in their early adolescence. Many of these youth began to express their fantasies by torturing and killing animals or being cruel to other children or adults. One did go on to kill another person in a sexually sadistic manner.

To understand the development of the serial killer, we need to understand the literature on the sexually sadistic murderer. As early as 1886, Richard von Krafft-Ebing (1965) described the sexual perversions of "lust murder" and "murder through sadism." However, it was not until years later that the issue of sexually sadistic killing reemerged in the literature. Brittain (1970) attempted for the first time to draw a profile of the sexually sadistic killer in hopes of beginning to identify unique characteristics of sexual murderers. He felt that the more precise the description, the greater the likelihood that sexually sadistic murderers could be identified before they had killed. Although his observations were done retrospectively, Brittain noted that many sexually sadistic killers had development histories demonstrating an ambivalent relationship with their mother, an authoritarian father, and social ineptness. They were often introspective, solitary, studious, obsessional, prudish, vain, and hypochondriacal in their personality. Although they rarely showed outward violence, there was evidence of deep hidden aggression. Sexually, many felt inferior, were often impotent and had a rich fantasy life. Cross-dressing and fetishisms were not uncommon and a number engaged in homosexual activities. There were commonalities in some of these killers, such as interest in power, enjoyment of cruelty as depicted in books or films, an overt interest in weapons, and a history of cruelty to animals. Many had an interest in werewolves, vampires, black magic, Naziism, torture, and "escapology." Most had experienced little or no psychiatric intervention and although a few suffered from depression or anxiety, most could not be diagnosed with schizophrenia. These killers were most likely to offend when their self-esteem was low. They often planned their crimes and often committed them via asphyxiation or stabbing. Physical injury to the sexual organs and engaging in violent sexual acts was not uncommon.

McCulloch, Snowden, Wood, & Mills (1983) identified the experience of power and control in the act of sexually sadistic killings to be the most important factor. They proposed that "the wish to control another" by means of "domination, denigration, or inflicting pain" is what produces the sexual arousal for this type of sadist. In thirteen of the 16 cases that

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# Serial Killing Fantasies

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they reviewed, the perpetrators had fantasized about their sadistic offense prior to its actuality. They often masturbated to thoughts of rape, kidnap, sodomy, bondage, whipping, torture, or fantasies of killing many times prior to committing their first actual offense. The mean age that these fantasies occurred was 16 (range 13-20) and each subject had an increase in their masturbatory activity once the fantasies took on a sadistic content. The acting out of the fantasy (i.e., sexual killing) occurred less than one year after the development of the sadistic fantasy in 11 of the 13 cases. The authors proposed that if a person begins to try out his sadistic fantasy little by little in actuality, there is a higher risk for it to progress toward the act of killing as part of the actual sexual act. Based on their observations, it is essential that clinicians learn to identify youth who have such fantasies early in their development so that intervention can be made before the fantasies become reality.

**It is essential that clinicians learn to identify youth who have such fantasies early in their development so that intervention can be made before the fantasies become reality.**

The issue of serial killing is mentioned in the literature much more recently than is sexually sadistic murder. Levin and Fox (1985) concluded that most serial killers are male, Caucasian, and in their 30s. Hickey (1986) found that of identified serial killers during this century, only 14% were female. Of the 36 sexually sadistic serial killers studied by Ressler, Burgess, & Douglas (1988), all were male, 33 were Caucasian, 20 were the eldest son, and 27 had an average or greater than average intelligence. Many had family histories of psychiatric, criminal, sexual, alcohol or drug abuse problems. Many had a personal history of physical, sexual, and psychological abuse. And most importantly, most demonstrated a history of multiple sexual deviant fantasies and behaviors. Of the 36 cases, 75% reported adolescent histories of daydreaming, compulsive masturbation, isolation, chronic lying, rebelliousness, stealing, and assaults on adults. Over 50% had a history of enuresis, nightmares, destruction of property, fire setting, cruelty to children, and poor body image. Nearly half demonstrated a history of cruelty to animals. Most serial killers murder by strangulation, beating or stabbing (Dietz, 1987). These forms of killing may demonstrate a greater "intimacy" in the violent act , reflecting the sexual component of the killer's motivation. Most sexually sadistic criminals carefully plan their offenses in detail, even to the point of preparing a "torture kit" to use on their victim (Dietz, Hazelwood, & Warren, 1990).

Prentky, Burgess, Rokous, Lee, Hartman, Ressler, & Douglas (1989) compared 25 serial sexual murderers with 17 single sexual murderers. Those in the serial group were more likely to be Caucasian, possess a higher than average IQ, and experience fantasies of rape and/or murder. A higher percentage of the serial group had a history of compulsive masturbation, voyeurism, fetishism, and cross-dressing. They proposed that once a sexually sadistic fantasy is acted out for the first time, the offender is likely to engage in a series of sexually sadistic acts. Each sexual act comes closer to actually enacting the particular deviant sexual and violent fantasy. However, since it is difficult to ever exactly match the sadistic fantasy, there is an impetus to begin restaging the fantasy over and over, each time reinforcing the deviant fantasy with orgasm. The fantasy could eventually develop to combine sexual deviancy with violence that could possibly even end in killing the sexual partner. Warren, Hazelwood, & Dietz (in publication) proposed that actual murders likely become the fantasy material for subsequent masturbation, reinforcing the sadistic arousal pattern.

Langevin (1991) compared sexual killers with sexually aggressive non-killers as well as to non-sexual killers. In his study, the victims of sexual killers were more often a stranger and killed via strangulation. The use of strangulation could be a means of prolonging the sadistic suffering of the victim and in turn cause a prolonged feeling of pleasure and control by the offender. The element of total control a sexually sadistic killer has over his victim may be a critical piece to the puzzle (Weinberg & Levi-Kanel, 1983). The issue of control may lead to the sexual excitement and the actual death itself could be anticlimactic.

Although data is still sparse, biological predispositions may also be a contributing factor to sexually sadistic murder. Langevin (1991) showed it to be more common in both sexual killers and in sexually aggressive non-killers to have abnormalities in the right temporal horn area of the brain as seen on scans. He also noted elevated testosterone in both of these groups. Others (Gosselin & Wilson, 1984) have argued that left hemispheric dysfunction was more commonly seen in individuals who suffered from deviant or bizarre sexually deviant fantasies. However, Langevin (1983) noted temporal horn lobe damage in many individuals who suffer from fetishism and cross-dressing, the two types of sexual deviancy that are more commonly seen in serial killers. Although many individuals have proposed other neurological abnormalities in serial killers, many known serial killers have suffered from head injury or trauma when younger (Norris, 1988). New research is linking recurrent or obsessional-like sexually deviant fantasies with low serotonin levels (McClung & Wasyliw, 1993). Other biological causes or relations to serial

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killing are being studied and the use of multiple medications are being attempted to see if they help decrease this type of sexually deviant/violent fantasy or act.

Abel, Becker, Cunningham-Rather, Mittleman, & Rouleau (1980) have shown that it is common for an individual to generally suffer from multiple types of sexual deviant fantasies and behaviors rather than just one type. Additionally, they demonstrated that these behaviors often begin prior to the age of 18 (Abel, Becker, & Mittleman, 1985). Therefore, multiple sexual deviant fantasies and behaviors can and often do develop during adolescence. This author has seen numerous cases that have demonstrated sexually sadistic homicidal fantasies that have developed in teenage adolescents. This is consistent with the assumption made by others who have interviewed serial killers who claimed their killing behaviors began in adolescence. Therefore, once again, it is evident that these individuals need to be identified early on and intervention attempted.

**Further studies will need to occur to help identify if standard treatment for sexual offenders, or a modified version thereof, could be helpful in treating this specific population.**

### Ideas of Interviewing and Interventions

It is important to ask adolescents who have been referred for violent crimes or sexual offenses about the nature of their sexual fantasies and to take a very thorough and detailed sex history. The adolescent should be reassured that the sexual history questions are a confidential routine part of the medical or psychological interview and they should be given the opportunity to voice any general concerns or questions regarding their sexual life before being asked specific questions of interest to the examiner. One should obtain information about sex and growing up, parental attitudes toward sex, age of onset of puberty or menarche, the age of first intense romantic or sexually oriented relationship, history of abuse, sexually transmitted diseases, and masturbatory fantasies and frequency. One should continue by questioning about the age of first intercourse and the number of sexual partners as well as the frequency and type of sexual activity. Finally, a complete history should include questioning the adolescent about sexually deviant fantasies or behaviors (paraphilias). A list of common paraphilias can be found in *The Diagnostic and Statistic Manual of Mental Disorders*, Fourth Edition.

The sexual history should include asking whether the adolescent becomes sexually excited when experiencing or fantasizing about violence. They should also be questioned about fantasies or actions involving sexual sadism and killing. It helps if the interviewer is comfortable listening to material presented and is able to allow for ample time when interviewing. If the adolescent realizes that the interviewer is comfortable with the topic, they are often willing to talk openly and divulge information that has been bothering them for a prolonged period of time.

This author would propose that the evolving nature of the sexually sadistic fantasy often begins in adolescence and is a possible key factor that must be looked for in order to identify youths who are at risk for becoming sexually sadistic serial killers. Adolescents who demonstrate sexually sadistic fantasies, especially those of a violent nature that end in killing, should be red flagged, followed closely, and offered treatment to help extinguish or control the deviant fantasy before it becomes a reality. If cognitive/behavioral and psychopharmacologic treatment is offered early enough in the development of the sexually sadistic and homicidal fantasy, one would hope to decrease or even prevent the eventual possible outcome of serial homicide.

### Conclusion

The study of the development of sexually sadistic paraphilias that lead to the most common type of prolific serial killing is still in its infancy. Children and adolescents who are developing sexually sadistic fantasies and talk about single or serial killings need to be followed over time in a prospective manner to help researchers and clinicians better understand the developing nature of the sexual serial killing fantasy. In doing so, one would hopefully begin to better understand if there are specific subtleties that would help one identify those who would go on to kill and those who would not. Further studies will need to occur to help identify if standard treatment for sexual offenders, or a modified version thereof, could be helpful in treating this specific population.

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# INVESTIGATION

## Defining the Interview Process

By Wendy Deaton, M.A. and Lt. Mike Hertica

Over a decade has passed since a rash of child sexual abuse allegations occurred in day care centers across the nation. One result of these events was a new focus on the child interview process. A decade later, however, the plethora of articles and books that continues to emerge from therapeutic, social service and child abuse fields reveals a continued lack of consensus on a protocol that can be used with young children to produce effective, credible fact- finding interviews.

Questions still under debate include which professional discipline should be responsible for child interviews in cases where child abuse is suspected? Should direct questions be asked or must the child produce a totally spontaneous recounting of events? How susceptible are children to leading questions, direct suggestion, or subtle innuendo? Can the memories of children be trusted? Can anyone's memory be trusted?

This article proposes to add another to this profusion of questions, "What is the purpose of the interview?" It is the authors' contention that the question of purpose is the most critical question to be addressed in the debate about an effective, credible interview process. The purpose of an interview determines what questions can appropriately be asked of the child, clarifies the guidelines for interviewer interaction, and defines how the interviewer can respond to the child's disclosures. It defines which type of professionals, from which disciplines, should most appropriately conduct the interview.

***It is the authors' contention that the question of purpose is the most critical question to be addressed in the debate about an effective, credible interview process.***

This article draws on the authors' combined experience in law enforcement, social work and mental health to provide an outline of three types of interviews that may be conducted during a child abuse investigation: the investigative interview, the therapeutic assessment (also known as a forensic evaluation), and the treatment interview. Although there are tremendous overlaps, establishing credible and reliable protocols for interviewing children depends upon clearly differentiating the specific types of interviews that may be conducted. While all interviews with both children and adults use the three phases of rapport, information gathering, and closure, these three types of interviews have different purposes, requirements, goals, tasks and limitations. These differences are described below.

### The Treatment Interview

#### Purpose

The purpose of the treatment interview is to determine what should be done about what has happened. While the outcome of treatment may enable a child to provide a more credible accounting of traumatic events of interest to the criminal justice system, the purpose of treatment is not healthy disclosure, but a healthy child. In fact, the outcome of treatment may result in a recommendation that the child stop participation in the criminal process, as such participation may be seen as too detrimental to the child's prognosis for recovery and health.

#### Interview Content

The treatment interview identifies goals and objectives that will help the child recover from the current traumatic events. In addition to exploring the allegations of abuse, the interview includes a review of other significant life experiences which may be affecting the child's development and adjustment. The treatment interview explores the child's current level of functioning; his or her internal perceptions, beliefs and attitudes; the defense mechanisms commonly utilized; the weaknesses and strengths demonstrated.

#### Interviewer

The treatment interview is conducted as a prelude to the treatment process. As such, it is conducted by the treatment therapist, with the goal of establishing a plan of action. The specific areas the therapist explores and the historical information sought are determined, in large part, by the therapist's treatment approach and style. For some therapists, the debriefing of traumatic details may be primary, while others may look to the restructuring of cognitive beliefs, the cathartic release of emotional reaction, or the redoing

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of wounded developmental tasks and reestablishment of the normal developmental process.

In the process of conducting the interview, the therapist may model, facilitate, support, or teach his or her client. The child may learn new names and functions for body parts, new rules regarding personal boundaries, and new methods of communicating in a more assertive or aggressive way. The provision of prevention education in the course of therapy, which has the capacity to alter the child's beliefs and perceptions about past abuse events, may also be utilized in the therapeutic evaluation or assessment.

During the process of treatment, therapeutic and supportive statements can be utilized to promote growth and change in the client. The therapist may express judgments about the events, such as stating that the perpetrator was "wrong to do that to you", or promote a value system such as "children are never to blame." In treatment, issues such as other current events and significant events of the past, other concerns of the child, and concerns of the parents and teachers regarding behaviors of the child may appropriately be addressed.

### Referral Process & Confidentiality

The treatment process with a child is usually conducted at the request of the parents. Referrals may also be made by social services, law enforcement, attorneys, school or medical personnel. Ordinarily, the issue of confidentiality is established early on with the child, the parents, and the referring parties. All information, except that specifically required by law and determined appropriate for release by the participating parties, is considered confidential. The therapist will go to great lengths, appropriately, to keep confidential the child's revelations, except where disclosure is in the best interest of the child. James (1989) and Donovan and McIntyre (1990) provide examples of treatment assessment interviews.

## The Therapeutic Assessment

### Purpose

The purpose of the therapeutic assessment is to determine how the child is functioning and how the child has been affected by the events in his or her life, including those that are the focus of investigation. The therapeutic assessment examines the child's internal mental processes and emotional state related to the current events (Barker, 1990).

### Interview Content

A therapeutic assessment differs from an investigative interview in that there is less emphasis on the production of "evidentiary statements" and more emphasis on the child's view, perception, and overall reaction to the alleged events. The assessment differs from a treatment interview in that it does not detail treatment needs. The therapeutic assessment is concerned with what happened but not with how to resolve what happened. The goals of the assessment may include determining if the child can safely remain in the home during the investigative process and whether the child can participate in a meaningful way in the investigation without serious further harm.

***The therapeutic assessment is concerned with what happened but not with how to resolve what happened.***

### Interviewer

A therapeutic assessment may be conducted by a social worker, medical professional, forensic psychologist or mental health therapist whose skills include the ability to constructively deal with the child's emotional reactions to the process. A therapeutic assessment should always be conducted by a neutral party who has had no prior and will have no further dealings with the child, a significant departure from the treatment assessor, who will have an on-going relationship with the child. This limitation of role ensures that the interviewer will not be biased by prior contact with the child and will not be influenced by personal interests (further business, etc.).

The therapeutic assessment is not a true fact-finding process, in that there is a bias towards the child's perceptions of the events. The investigator may offer an opinion on the accuracy of the child's perceptions, but detailed corroboration examination is left to law enforcement personnel. Information that emerges during a therapeutic evaluation very often has significance to the criminal-justice process as well as the treatment process. It is at this point, in particular, that confusion between the investigative, evaluative and treatment purposes may occur.

While the evaluator may offer the child reassurance, the evaluator will refrain from providing prevention education or working with the child to resolve emotional reactions or cognitive perspectives. The therapeutic assessment does not provide opportunity to significantly intervene or to promote change. The evaluator limits him/herself to modeling and supportive interactions. In the therapeutic assessment, both therapeutic and supportive statements may be utilized. Although the evaluator will show concern for unrelated events and issues the child introduces to the interview, the assessment remains focused on the events which initiated referral. As with the treatment assessment, props may be used to assist the child in communicating about what happened and how they have been affected.

### Referral Process & Confidentiality

The therapeutic assessment is ordinarily conducted at the request of parents, attorney, police department or the court. As such, much of the information produced will not be held confidential. A written

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# Defining the Interview Process

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summary or report is usually prepared and made available to a number of individuals. As with the investigative interview, the therapeutic assessment has time constraints imposed upon the process by the succession of events unfolding during an evidentiary search.

Examples of therapeutic assessments are available on the San Diego Children's Hospital Tape on Child Interviewing, in MacFarlane, et al (1986) and Barker (1990).

**Investigative Interviews**

**Purpose**

The purpose of an investigative, or forensic, interview is to obtain information to be used in the criminal justice system. An investigative interview seeks to determine what happened. It is a fact finding process intended to provide information that can be corroborated and used in the prosecution phase of the case.

**Interview Content**

The investigative interview must focus on data that can be corroborated. The best methods of corroboration, in descending order of importance, are: confessions, physical evidence, other victims, and witness statements. The type, level and strength of the corroboration needed depends on the case, but it is always necessary. As a general rule, as the age of the child decreases, the necessary level of corroboration increases, as judges and juries tend to give less credibility to disclosures by younger children (Goodman and Bottoms, page 177).

**Interviewer**

The focus of attention in a trial involving testimony by children is quite often upon the professionals involved in the investigative process, rather than on the victim. The specificity and intensity of this focus requires that those involved in the process of investigating suspected child abuse be as thoroughly trained, competent and familiar with the criminal justice mandates, requirements and restrictions as possible. A criminal justice investigative interview is therefore best conducted by professionals from the criminal justice system or by someone specifically trained in the complexities of the system's process.

***There are three phases of an investigative interview: rapport building, disclosure and closure.***

To ensure that an interview meets the requirements of the criminal justice process, the primary training of the interviewer should be as an investigator, however additional training in the area of child development is critical and necessary for professionals who work with child victim-witnesses.

In the investigative interview, the interviewer scrupulously maintains a position of neutrality, refraining from giving much, if any feedback, and focusing instead almost entirely on gaining information. Positive feedback is appropriately limited to supportive, rather than therapeutic statements, as therapeutic statements have the potential to alter the child's perception and recall regarding the events. For example, a therapeutic response to a child's disclosure may be: "You are brave to talk about what happened", while a supportive response may be the more neutral "Some things are hard to talk about."

There are three phases of an investigative interview: rapport building, disclosure and closure. Much has been written about the first two stages, but equally important, and often overlooked, is closure. Child abuse victims have been exploited, used, and often feel they have been thrown away or discarded. Regardless of the fact that the interviewer has good intentions, to the child the interview may feel similar to the abusive events. The closure portion of the interview can soften this feeling of being "used". From a practical perspective, the first interview will seldom provide all the information necessary for investigative purposes. If there is not good closure in the first interview, it will make subsequent interviews more difficult for everyone involved.

In closure, the child will usually ask questions such as "Is my daddy going to go to jail?"; "Am I in trouble?"; "Am I going to a foster home?". These questions should be answered as honestly as possible, taking care to put the answer in the least frightening terms for the child. The investigator may need to explain details of the medical or social work portion of the investigative process.

Examples of investigative interviews are generally located in the law enforcement literature, however, in the therapeutic field, Hoorwitz (1992) provides a comprehensive example useful to all professionals.

We recognize that individuals in the roles of investigator, evaluator, and treatment therapist often find themselves crossing the boundaries into other disciplines' expertise in questioning. Although some crossover cannot be avoided, interviewers with a clear understanding of their purpose will find it is possible to contain their interview to their own discipline's focus.

In this article, we utilize the concept of purpose as a focal point for establishing practical guidelines for the three types of interviews that are likely to be conducted with a child victim-witness to a crime of violence. While cross-training can provide professionals with sufficient technique to conduct an interview from another discipline's purpose and perspective, the depth and completeness of such an interview are likely to be greatly reduced. Each discipline has subtleties, intricacies, and complexities that are difficult to learn

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# Defining the Interview Process

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without sufficient "in the trenches" experience. Thus, didactic cross-training alone is unlikely to provide the skill needed for a successful interview process.

This discussion has attempted to clarify some of the critical differences between the investigative or forensic interview, a therapeutic assessment or evaluation, and the treatment interview. The purpose of this differentiation is to redirect professional energy from an unproductive debate regarding interview guidelines and protocols, to a productive action-oriented multi-disciplinary approach to the problems involved in interviewing child victim-witnesses.

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## Stop for a moment, in the midst of your busy day.

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10. It is understood that members participating in this contest are responsible for their own recruitment efforts, including mailing, postage, duplicating, labels, envelopes, etc. Membership brochures and other recruitment materials are available upon request from the APSAC office.

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# The Juarez Family

## CASE CONSULTATION

*The Juarez family presents an array of challenging issues and problems. Following a brief presentation of the case, experts from a variety of disciplines will present their findings and recommendations for this family.*

## The Case: The Juarez Family

The Juarez family consists of two parents and four children. Jose, 48 (father) has a history of alcohol abuse and domestic violence while drinking, although he is reportedly not drinking presently. Alicia, 44, is the mother of Luis, age 23; Carlos, age 21; Rudy, age 17; and Elena, age 15. The family is Mexican and the parents speak only Spanish, while the children are bilingual. The two younger children live with their parents and the two eldest live outside the parental home.

The family came to the attention of Child Protective Services following an allegation of sexual abuse made by Elena, the 15-year-old daughter, against her brother Carlos, age 21. Carlos was removed from the home and criminal charges were filed against him. He is currently living with relatives. Elena reports that the family has blamed her for the upset caused by her allegation, and that her mother denies the sexual abuse happened. Elena was hospitalized for depression three weeks after making the abuse allegation and reports she has thought about suicide. She is currently being treated with anti-depressants and is receiving individual and family counseling.

Following Elena's allegation, an Assistant State's Attorney went to the home to interview the entire family. The father was not home during this interview. During the interview, Rudy, age 17, became very agitated and threatened to harm both Elena and the ASA if they continued to pursue the criminal complaint against Carlos. Rudy was very angry with Elena for making the allegations, calling her "a slut" and blaming her for breaking up the family. Elena was hysterical throughout this interaction. Alicia (mother) told the ASA that she could not protect Elena from Rudy, since Rudy is out of control and both she and her husband are frightened of him. Elena reported being afraid of Rudy, and said that in the past Rudy has hit their father and pulled a knife on him. The ASA observed that Rudy's dress and mannerisms were typical of a gang member.

A report of risk of physical harm to Elena was made and substantiated against Alicia, Jose and Rudy. The ASA and the police removed Elena from the home and placed her in temporary foster care.

The CPS investigator conducted individual follow-up interviews with the family. When asked, Elena said she would like to live with her older brother, Luis, but her parents would not allow it because they do not approve of Luis's foster mother, a woman named Cathy Roberts. The CPS investigator spoke with Ms. Roberts, who said that Jose and Alicia gave her guardianship of Luis when he was 17, due to his out of control behavior. She said the Juarez family does not approve of her because she is not Mexican, and they believe she "stole" Luis from them. Ms. Roberts is willing to accept Elena, but is afraid that the Juarezes will take Elena to Mexico (as they have done with older siblings in the past) rather than allow her to live in the Roberts home. The CPS investigator found both Luis and Cathy Roberts to be credible and helpful.

In his interview, Jose said Rudy does get out of control sometimes, but he just ignores him when he does. He stated there was no indication that Carlos had abused Elena. Alicia also stated that Carlos was always well-behaved and that she did not think he would perpetrate incest.

Shortly after this complaint was received, Carlos pled guilty to sexual abuse. He was given four years probation, with orders not to have contact with Elena.

Questions:

What placement plan should be made for Elena Juarez? What interventions can be made with Rudy and his parents to prevent further escalation of violence in the family? How should cultural issues be addressed?

## Case Response

Detective Joseph Canibano
Child Exploitation Unit
Dallas Police Department

**How would law enforcement immediately intervene in this situation and why?**

The Juarez family poses an immediate threat to the victim in this case. From a law enforcement standpoint, we would be bound to take Elena into protective custody and release her to CPS. This could be for a very short period of time until CPS was able to assess the needs of the entire family as well as the victim in this case. The victim's safety is the number one priority for law enforcement.

**Would you attempt to involve professionals from any other disciplines in this case? If so, which disciplines, how and why?**

The first professionals law enforcement would seek out to intervene would be CPS. CPS would assess the family and set up a plan to stabilize the family environment. The State's Attorneys' office should be brought into the situation to obtain a Protective Order for Elena. This would make any contacts or threats by the family members a criminal offense and hopefully would deter such conduct.

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# The Juarez Family

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**From your perspective, what are the key issues in the case?**

The key issue is the lack of support for Elena once the outcry was made. The entire family is non-supportive and her mother is not able to protect her. At least three members of the family made statements that they would cause physical injury to her. It is apparent that the family has had severe problems for several years. The problems with the violence within the home and the lack of control by the parents cannot be corrected in a short time. A social autopsy should be prepared on all the members of the family to see if any previous attempts have been made to intervene in the family such as school referrals, CPS referrals and any police contacts. The complex dynamics of this family show the need for early intervention. The history of domestic violence by the father should have been a red flag for law enforcement to intervene and bring in the appropriate social services to work with the family when it first came to police attention. From a law enforcement standpoint, if the victim is not supported by the detective conducting the investigation and made to feel secure and safe, the possibility of her recanting is very high. One of the most serious mistakes made in this case was that the victim was left in the home for a long period of time after the initial outcry of sexual abuse only because the suspect was removed. This left her at the mercy of the other family members who attacked her verbally and mentally and even made threats of physical harm.

Another mistake was the Assistant State's Attorney should have never conducted the interview with Elena and other family members at their home and Elena should not have been present while Rudy was interviewed. To sum up, Elena was never protected or made to feel safe from the beginning of this case. She should have been removed and placed in protective custody and not forced or allowed to have contact with the suspect or any other members of the family without first making sure they were supportive and understanding of what she was going through. This case shows a real need for a multi-disciplinary approach to this type of case so all the agencies affected, law enforcement, CPS, social services, and the State's Attorney's office work together from the beginning of the case and work toward the best plan for the protection of the child as well as the criminal prosecution of the case.

**What would be your long range plans for addressing this problem?**

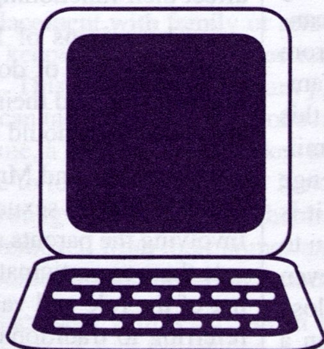
A full assessment of this case would need to be made immediately combining the talents of law enforcement, social services and CPS. A plan would need to be formulated to not only deal with the sexual abuse allegation, but to also deal with the violence exhibited inside the home by all the family members. The suspect in this case, Carlos, should be closely monitored and placed into mandatory sexual abuse counseling. The rest of the family should be involved in domestic abuse counseling. This process would hopefully work toward reuniting the victim with the family at a later date.

**Placement of Elena**

First and foremost, after the child is taken into protective custody, CPS should do a full home study of the Roberts home where the 23-year-old brother, Luis, is living. If okay, Elena should be placed with her brother, due to the fact that her parents, as well as her brother, Rudy, pose a risk to her safety. If this does not work, CPS could explore the possibility of placing Elena with other relatives.

In order to intervene with Rudy and his parents to prevent further escalation of violence in the family, it is necessary to understand that Rudy's extreme anger is because he blames Elena for breaking up his family. I would try to convince the brother Carlos, who was convicted of the sexual abuse against Elena, to talk to his family and explain to them that he is responsible for what happened and not Elena. Referrals should be made to AA, Domestic Violence and Gang Intervention programs.

The unique cultural issues involved in this family require that all professionals involved should be Spanish speaking if at all possible. This not only will solve the communication problems, but will make the mother and father more comfortable by allowing them to deal with professionals who speak their language.

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# The Juarez Family

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## Case Response

Rosanna Salcedo, EdM
Clinical Services Program
Judge Baker Children's Center

**Separation and Placement of the Abused Child**

Mental health clinicians can play a helpful role in the initial decision making process and design of service plans in child protective cases by collaborating with child protective service workers. Through consultation, CPS workers can be advised whether a situation or setting is appropriate for a child, and obtain recommendations about what a long term treatment plan should look like for a particular family. Physical and emotional safety is especially important if the abused child will undergo an evaluation or treatment. In the Juarez case, CPS's decision to remove Elena from her home for the time being is a sensible choice for obvious reasons.

In the meantime, Elena has expressed a desire to live with her brother Luis and Ms. Roberts. It appears that this may be an appropriate placement for Elena since Ms. Roberts has had guardianship of Luis since he was 17 years old. Being placed with a sibling will make the setting more comfortable and familiar to Elena. However, Luis's ability to support Elena needs to be assessed, and Ms. Roberts needs to be informed of Elena's emotional and psychological state in order to readily respond to any reactions Elena might have, and keep her safe.

**Recommendations for Treatment**

The Juarez family possesses values and traits consistent with traditional Mexican culture. Clinicians should therefore consider what obstacles may arise for this family as they engage in a process that is unfamiliar and possibly threatening to them. What may be perceived as "resistance" by clinicians about to work with such a family in therapy, could be explained in other ways.

The subjugation of Mexicans throughout history, and present day racism in the United States has deteriorated Mexican-Americans' feelings of self worth, and increased their feelings of distrust towards the dominant culture. It is likely that individuals will have strong feelings, perhaps objections, about working with systems in the dominant culture. In Mexican-American culture assistance is usually obtained from extended family members, such as elders in the family or *copadres/comadres* (godparents). Asking this family to seek professional assistance from unfamiliar institutions may present them with a challenge since this is not commonly done. Furthermore, it is not typical in traditional Mexican culture for men to openly express their emotions to anyone, and even women tend to share their intimacies only with close friends or relatives. The value of privacy within a Mexican-American family therefore needs to be acknowledged and not labeled as resistance. Clinicians can embrace the success of therapeutic interventions by becoming aware of the customs, ideals, and idiosyncrasies of a particular cultural group.

*La familia* is the most important value in traditional Mexican culture since it maintains much of the history, traditions, and beliefs that are not part of the written culture and which vary from region to region. The preservation of the family is particularly important for Mexican- Americans living in the dominant society, for its role in maintaining cultural identity. Value is therefore placed on the needs of the family rather than on the individual. Individualism is an American value that is not prioritized in Mexican-American culture. The Juarez family's response to the events in their home and to their daughter Elena is not incomprehensible, in fact it is consistent with the Mexican-American ideals stated above. Acknowledging this and reassuring the family that the goal of the intervention is ultimately the possible reunification of the family under harmonious circumstances will convey understanding of the family's values and may help appease their anxiety.

Clinicians need to be aware of the differences between Latin American cultures, and variations among regions within one culture, and not assume that all Spanish speaking people have similar ideals. Language also varies from one Latin American country to another. A Spanish word could mean one thing in Mexico and a completely different thing in Puerto Rico. In dealing with the Juarez family, a Spanish speaking clinician should be familiar with Mexican-American colloquialisms. Asking for clarification and using their terms will communicate an interest to learn more about their culture.

Although cultural issues certainly color the picture of this family, each family is unique, therefore it is important to approach the family without fixed assumptions. How long the family has been in this country will have an effect on their level of acculturation. The conditions under which they came into this country may have had a psychological effect on the family since migration can often be traumatic. However, none of this can be assumed, it must be explored. Nonetheless, it can be assumed that like most families, especially immigrant families, there are stressors which affect their functioning.

The origins of Mr. Juarez's alcoholism, the family's history of domestic violence, Rudy's gang involvement, and their views on sexual abuse/incest, are issues that should be clinically addressed.

Both Mr. and Mrs. Juarez need to address their denial of Elena's sexual abuse individually in therapy. Involving the parents right from the start could motivate them to participate by conveying an understanding of the role and value of elders in the family. By referring to traditional cultural values about family

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## The Juarez Family

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honor, Elena's actions could be positively reframed, and the parents could become empowered into taking protective action on her behalf. Elena needs to receive mental health services from a clinician with a specialization in sexual abuse and incest. In addition, all interventions should be goal oriented and structured in stages. The reunification of Elena and her family should be contingent on the progress made by the individuals involved.

Assuming that Rudy, 17, would be treated as a juvenile, the family could be encouraged to seek the services of an agency such as DYS (Department of Youth Services) to make him accountable for his actions. Their feelings about law enforcement, discrimination and immigrant status, however, should be considered.

Before reunification can occur, apology sessions would need to take place between various family members, and this should be followed by a series of family sessions, in the presence of one or more therapists. However, in a culture where respect for elders is highly valued, and where children are taught to honor their parents, it may be unrealistic to expect the children to confront their parents, or for the parents to humble themselves and offer apologies. Adapting clinical practices to cultural norms is appropriate and may be necessary. For example, a clinician could ask the parents to acknowledge their children's thoughts and feelings rather than apologize, allowing them to preserve their status as elders. The treatment goal should not be to change the family's values, but to help them understand that they may be hurting each other by behaving in certain ways.

## Case Response

Gloria de la Cruz-Quiroz, LCSW
Therapist in Private Practice in Santa Monica, CA

The Juarezs are a multi-problem family with numerous stressors, both chronic and acute, including domestic violence, alcohol abuse, intergenerational abuse, out-of-home placement, possible gang affiliation, and most recently, sibling incest. The safety of Elena and all the family members is a key consideration at this time. Mrs. Juarez is at risk for domestic violence if she is blamed for the incest and if she is not felt to support and contain her family. The father is at risk for a relapse of alcohol abuse as a coping mechanism.

**What placement plan should be made for Elena Juarez?**

It appears that an out of home placement is clearly indicated and appropriate at this time for the safety of Elena and her entire family. Consideration could be given to placement with extended family members. This type of plan could provide the family and Elena with moral support *{apoyo morale}* that this family will need during this time of disclosure, confrontation, denial and the meanings of shame for this entire family.

Placement with family or relatives can also assist in keeping a family connection to Elena's *"familia"*. This can be an important juncture for Elena which can facilitate the process of being removed from her home, a process which makes her extremely vulnerable to losing her family. It is not uncommon for these young girls to feel the shame and isolation of being removed from their homes and recant because the separation and alienation becomes intolerable.

Placement with relatives can also ease the fear and anxiety of racism or discrimination that might be anticipated in leaving the parental home.

Other options that need to be considered are a small group home for girls or a foster home. The use of a community broker or a community resource person who is known to the family or to the Latino community can provide credibility to the placement plan. The collaboration of this person along with the social worker and case workers involved is an important linkage for language and cultural translations and proper interpretations of the legal system.

A religious person or clergy might also be considered to reach out to this family and provide encouragement during the process.

There are several treatment modalities that could be considered as options for Elena. Individual therapy and group therapy for girls who have been sexually abused would provide Elena with a sense of support and compassion for her situation and help prepare her for family therapy. Conjoint sessions with her mother, when appropriate, may be helpful to the mother and daughter. These sessions could focus on helping Mrs. Juarez accept the incest in order to support her daughter.

Mrs. Juarez is in need of tremendous support and treatment given her history of domestic violence. A support group for Spanish speaking mothers could be a helpful addition to family therapy. One needs to keep in mind her vulnerable situation and have the appropriate information for her regarding shelters and hotlines for domestic violence. This type of information can be given as general information in a mother's group. If Mrs. Juarez has a mother-in-law or father-in-law who is supportive and available, this could be a resource person for the entire family. These individuals can be a source of comfort and support and serve as a positive ally to the process.

The family therapy needs to include Carlos attending a session or several sessions in which he reveals to the family that he is responsible for the sexual abuse of his sister. This family might need to be court-

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# The Juarez Family

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ordered into treatment to ensure the provision of treatment services.

**How should cultural issues be addressed?**

**Family Loyalty-Family Needs vs. Individual Need**

This family has seen Elena's disclosure as an attempt to break up the family. Within the Latino culture family loyalty is considered extremely important and "family needs" are seen as more important than "individual needs". This value stresses that the family is the beholder of all the problems and problem solving. To go outside the family violates this value. In addition an "individual need" is now being expressed and placed before the family needs. This action or behavior becomes confused and interpreted in the minds of the Juarez family as this individual {Elena in this case} thinking of herself and destroying the family with these actions. She might be considered self absorbed, calling attention to herself and discarding family loyalty.

The ideas of *sacrificio* {sacrifice} *y aguantar* {to endure} are important. In many Latino families, it is more important to *aguantar* and not express or disclose problems. The twist in cases of incest is that a female might not be believed and/or might be blamed because of her gender. Thus *aguantar* serves her in not expressing or disclosing. This is the sacrifice *{sacrificio}* you make *como mujer,* like a woman for the family and pray to God that your brother gets better *{pedir a dios que se mejora.}* This brother might be loved over his sister because of his gender and the status that comes with being male in the Latino culture. Because he is a male he might be respected before his sister and even forgiven before his sister is believed or absolved of the blame.

These are important considerations which need to be explored if appropriate in this case. It is equally important to explain to the Juarez family the tremendous stress and violation of Elena's sexual abuse and incest and the fear she had disclosing and "burdening" her family, especially when these things are not talked about in the family. This family needs to recognize Elena's strength and the courage it took for her to stop the abuse by disclosing and the self-respect she demonstrated by taking this action.

**Virginity**

Elena's virginity will also be an important treatment issue. If Elena lost her virginity in the sibling incest, it can have devastating effects for her and her family. In some cases parents have forced marriages between the abuser and the girl as a way of protecting their daughters from shame and being considered unsuitable for marriage. This is obviously not an option in this case, because they are sister and brother. It has been documented that Latino adolescent girls suffer greater psychic distress e.g. depression, anxiety, when they have lost their virginity to sexual abuse because of the meaning of virginity in the Latino culture.

**Mother's Denial**

What does this mother's denial mean to this family and to the treatment process? Initially we might understand that this woman's history of domestic violence might not provide her with the internal resources to protect her daughter and herself. This history is key and needs to be thought about in the entire dynamic picture of this mother.

There are also cultural implications in this denial that need to be thought about in the intervention and treatment phase. The Latino mother is held responsible for her daughter's sexual behaviors and is blamed for any wrongdoings of this nature. The shame of her daughter being violated and being seen as unsuitable for marriage may overwhelm Alicia. The fear of confronting this might play into her denial and self protection.

Alicia's inability to talk about sexual matters and incest might also play into her denial. She may be unable to find the proper words because in her mind this is too disrespectful and degrading — *muy bajo* — to talk about. This can get played out in the treatment process by her refusal to talk and also her discouraging Elena from talking about this.

Understanding and acknowledging this mother's many faces of denial can be helpful to all the parties involved. This understanding can also offer Alicia the compassion and assistance she needs to accept the incest that has occurred, and give her the strength to confront the reality and support her daughter.

**What interventions can be made with Rudy and his parents to prevent further escalation of violence in the family?**

It is unclear if Rudy is a member of a gang or only dresses like one and takes on defensive behavior. What is clear is that he feels violent, explosive and threatened. Rudy needs protection inside and outside this gang facade or membership. What is Rudy's role in the family? What is his relationship to his mother and Elena? Is Rudy the recipient of all the sorrow and hurt in the family? Is he the container of rage for the family? What does Rudy think of males who sexually abuse their loved ones? These are questions that are important to understand in assessing Rudy and in the therapeutic process.

A gang interventionist needs to be part of the treatment team to provide outreach in the home for Rudy and his family. Rudy needs to be assessed for depression and PTSD. Mr. and Mrs. Juarez need to be involved in order to help them deal with their son's desperation and violent behavior. One wonders what identification takes place between father and son. Is Rudy taking on his father's violent role and is Mr.

continued on next page

Juarez so identified with his son's helplessness and hopelessness that he ignores his son's violent behavior?

Mr. Juarez might be assisted by a religious personor clergy who can come to the house and provide him with support. One of the most difficult challenges for Mr. Juarez could be confronting the meaning of the incest of his daughter by his son. Many fathers refer to this as *se hizo hombre de mi hija.* In English the translation gets lost because it is a powerful statement that captures all of the meanings of the taboo of incest and sexual abuse: "my son became a man through the use of my daughter."

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—edited by
Rochelle Hanson

# JOURNAL HIGHLIGHTS

*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, Ph.D., C.A.R.E./SHCC, P.O. Box 117500, University of Florida, Gainesville, FL 32611-7500 (FAX 352 846-1030).*

## Sexual Abuse

### Children's Strategies for Coping with Sexual Abuse

This study examined strategies used by school-aged sexually abused children to cope with their abuse. Principal components analysis yielded four coping strategies: avoidant coping, internalized coping, angry coping, and active/social coping. Each coping strategy was found to be associated with a unique set of abuse characteristics, abuse-related social environment, and symptoms. Use of avoidant coping strategies was related to fewer behavioral problems, but was also associated with greater sexual anxieties. Internalized coping was found to be associated with increased guilt and PTSD hyperarousal symptoms. Active/social coping was the only strategy found to be unrelated to symptoms but was not associated with measured benefits. Angry coping was found to be associated with a wide range of behavioral and emotional problems as rated by the child's homeroom school teacher. Results are discussed in terms of a proposed mediational model.

**Chaffin, M., Wherry, J.N., & Dykman, R. (1997). School age children's coping with sexual abuse: abuse stresses and symptoms associated with four coping strategies. Child Abuse & Neglect, 21, 227-40.**

### Rates of Incidence and Disclosure of Sexual Abuse

This article reported the findings of a national survey of 1,000 parents. The survey was primarily focused on disciplinary practices and violence toward their children; however, two questions were asked about whether the children had been sexually abused. From these questions, rates of sexual abuse for children currently 0-17 were estimated at 1.9% in the last year and 5.7% ever. The cases making up these rates included a nearly equal number of boys and girls, and no female victims between the ages of 9 and 12, a distribution different from those generally obtained by other epidemiological methods, but due possibly in this case to normal sampling variation. Cases were more likely to be disclosed for children whose parents had themselves been sexually abused, who were from lower income households, or who were living with only one biologic parent.

**Finkelhor, D., Moore D., Hamby, S.L., & Straus, M.A. (1997). Sexually abused children in a national survey of parents: Methodological issues. Child Abuse & Neglect , 21, 1-9.**

### See No Evil, Hear No Evil, Speak No Evil: Male Victims of Sexual Abuse

This literature review explores the reasons why comparatively few adult males with a history of childhood sexual abuse are seen by professionals for help with difficulties relating to that abuse. Male victims are relatively unlikely to disclose their experience of childhood abuse, and (as a coping strategy) they deny the impact of sexual abuse on their lives. Professionals fail to hypothesize that their male clients may have been abused, and do not create the conditions that would enable males to talk about the abuse. It is argued that the childhood sexual abuse of males has not yet acquired legitimacy as a problem recognised by society, thus lagging behind the abuse of females. In short, the "evil' of childhood sexual abuse in the male population is not being seen or heard by clinicians, and is not being recognized or talked about by victims. Clinical implications are considered.

**Holmes, G.R., Offen, L.,& Waller, G. (1997). See no evil, hear no evil, speak no evil: why do relatively few male victims of childhood sexual abuse receive help for abuse-related issues in adulthood? Clinical Psychology Review, 17,69-88.**

### Recovered Memories of Childhood Abuse

Recently a heated controversy emerged regarding recovered memories of childhood sexual abuse, but the prevalence and nature of these memories as well as the relationship between a history of child abuse and childhood memory generally have received limited empirical examination. This study (N = 429 nonclinical participants) found that similar proportions of those reporting histories of sexual, emotional, and physical abuse reported that they had periods without memory for their abuse (19.8%, 11.5%, and 14.9%, respectively). These participants, however, appeared to be referring to both a lack of conscious access to their abuse memories as well as the intentional avoidance of the memories for some period. There was a great deal of variance found in the reported quality of general childhood memory, but this was unrelated to reporting a history of child abuse. In addition, it appears to be normative to recover previously forgotten childhood events, and this too was found to be unrelated to history of child abuse.

**Melchert, T.P., & Parker, R.L. (1996). Different forms of childhood abuse and memory. Child Abuse & Neglect 21, 125-35.**

### Predicting Recidivism of Extrafamilial Child Molesters

This study examined the predictive efficacy of 10 rationally derived, archivally coded variables for assessing reoffense risk among extrafamilial child molesters. Follow-up data on 111 child molesters who were discharged from the Massachusetts Treatment Center between 1960 and 1984 were used. Degree of sexual preoccupation with children, paraphilias, and number of prior sexual offenses predicted sexual recidivism. Juvenile and adult antisocial behavior, paraphilias, and low amount of contact with children predicted nonsexual victim-involved and violent recidivism.

**Prentky, R.A., Knight, R.A., & Lee, A.F. (1997). Risk factors associated with recidivism among extrafamilial child molesters. Journal of Consulting and Clinical Psychology , 65, 41-9.**

### Twenty Years Later: Accuracy of Memories of Childhood Abuse

This study examines the accuracy of retrospective self-reported information about childhood sexual abuse. A large group of children who were sexually and physically abused or neglected approximately 20 years ago were followed up and compared with a matched control group. Results indicate gender differences in reporting and accuracy, substantial underreporting by sexually abused respondents in general, good discriminant validity and predictive efficiency of self-report measures for women, and some support for the construct validity of the measures. Implications for researchers and practitioners are discussed.

**Widom, C.S., & Morris, S. (1997). Accuracy of adult recollections of childhood victimization, Part 2: Childhood sexual abuse. Psychological Assessment 9, 34-46.**

continued on next page

Journal Highlights

continued from page 24

## Physical Abuse and Neglect

### Physical Abuse Linked To Psychopathology and Poor Social Competence

This study examined the association between physical abuse and selected psychosocial measures in a community-based probability sample of children and adolescents. A sample of 9- through 17-year-olds (N = 665) and their caretakers in New York State and Puerto Rico were interviewed in the Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) Study. A history of physical abuse was reported in 172 (25.9%) of the sample. It was significantly associated with global impairment, poor social competence, major depression, conduct disorder, oppositional defiant disorder, agoraphobia, overanxious disorder, and generalized anxiety disorder but not with suicidality, school grades, or receptive language ability. A community probability sample of children and adolescents demonstrated significant associations between physical abuse and psychopathology, after controlling for potential confounders. This supports comprehensive screening for psychopathology among physically abused children and for physical abuse among those with psychopathology. Interventions aimed at improving social competence may be indicated.

**Flisher, A.J., Kramer, R.A., Hoven, C.W., Greenwald, S., Alegria, M., Bird, H.R., Canino, G., Connell, R., & Moore, R.E. (1997). Psychosocial characteristics of physically abused children and adolescents. Journal of the American Academy of Child and Adolescent Psychiatry; 36, 123-31.**

### Reliability of Childrens' and Parent's Reports of Parental Physical Aggression

This study examined (a)differences among mothers', fathers', and children's reports of parental physical aggression toward children; (b) the reliability and validity of family members' reports of aggression; and (c) the discriminant validity of the construct of mother-child and father-child aggression. Participants were 72 dual-parent families in which the parents were seeking clinical services for their children's (ages 7-9 years) conduct behavior problems. Results indicate that children reported lower levels of mother-child and father-child aggression than either mothers or fathers reported. Although the reliability (total systematic variance accounted for by observed variables) of family members' reports of aggression ranged from moderate to high, convergent validity was generally low. The constructs of mother-child and father-child aggression were highly correlated but could be distinguished from each other when relationships among rater effects were considered.

**Jouriles, E.N., Mehta, P. McDonald, R., & Francis, D. J. (1997). Psychometric properties of family members' reports of parental physical aggression toward clinic-referred children. Journal of Consulting & Clinical Psychology, 65(2), 309-318.**

## Other Issues in Child Maltreatment

### Survey Reports Physician Attitudes on Child Abuse Issues

This article reported findings of a questionnaire designed to assess physician attitudes and practices in controversial areas of child abuse and neglect. Responses differed according to gender, age, specialty, and practice or training status. Respondents were uncertain that reporting to CPS would lead to an improvement in the child's welfare. The article discusses whether an explanation and examination of physician attitudes may benefit medical education about child abuse.

**Marshall, W.N., Locke, C., Jr., (1997). Statewide survey of physician attitudes to controversies about child abuse. Child Abuse & Neglect, 21, 171-9.**

### Adolescents' Perceptions of Childhood Abuse

This study examined adolescents' perceptions of their maltreatment experiences. It examined the combined and unique contribution of five maltreatment types (i.e., physical abuse, sexual abuse, psychological abuse, neglect,and exposure to family violence) to variance in adolescent adjustment. Adolescents (N = 160, aged 11-17) were randomly selected from the open caseload of a child protection agency. Participants completed global severity ratings regarding their experiences of the five types of maltreatment, as well as a battery of measures assessing self- and caretaker-reported externalizing and internalizing symptomatology. The youths' maltreatment ratings significantly predicted self-reported adjustment, even when controlling for all context variables. Psychological maltreatment was the most predictively potent maltreatment type, and enhanced the predictive utility of other maltreatment types. Significant sex differences in the sequelae of perceived maltreatment were evident.

**McGee, R.A., Wolfe, D.A., & Wilson,S.K. (1997). Multiple maltreatment experiences and adolescent behavior problems: adolescents' perspectives. Developmental Psychopathology, 9, 131-49.**

### Mandated Reporting for Psychotherapists: Implications for Research and Clinical Training

In a national survey of 907 psychotherapists (29-85 yrs old) regarding mandated reporting of child maltreatment, the following predictors of outcome were revealed: therapeutic alliance, role strain, therapist explicitness, family vs individual treatment, and whether or not the client was the perpetrator. Therapists were asked to describe a case involving reporting, its impact on treatment informed consent procedures, as well as their own attitudes and beliefs. Implications for research are discussed, and recommendations for clinical training are offered.

**Steinberg, K.L., Levine, M.,& Doucek, Howard J. (1997). Effects of legally mandated child-abuse reports on the therapeutic relationship: A survey of psychotherapists. American Journal of Orthopsychiatry, 67(1) 112-122.**

### Young Children's Adjustment to Spousal Violence

This study investigated the effects of witnessing spousal violence on young children (ages 3-6). The mothers were given a structured interview which included a standardized family violence measure and child adjustment profile. Nearly half (42%) of the children exhibited behavioral problems that warranted clinical intervention. The amount of violence that the children witnessed, the children's responses when the violence occurred and whether the child copied the violent partner's behavior, were associated with the children's behavioral adjustment scores. Maternal parenting style was not found to have a significant effect on behavioral adjustment. The study provided important quantitative and qualitative data on the nature of parent-child relationships and children's adjustment in families where there is spousal violence.

**Smith, J. Berthelsen, D. O'Connor, I.(1997). Child adjustment in high conflict families. Child Care, Health & Development, 23(2) 113-133.**

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☐ **Children's Attorney Models: Emerging Models of Child Representation, by *Ann Haralambie, JD; Marvin Ventrell, JD; and Kenneth Herman, JD, PhD (2 tapes)*** This seminar covers the evolution of the modern child's attorney, including history and current state models, the new ABA/NACC Standards of Practice and the Fordham Law School recommendations for practice.

☐ **Coordinating Interdisciplinary Interventions with Children Who Witness Domestic Violence, by *Catherine Ayoub, RN, EdD; Kenneth Herman, JD, PhD and Regina Hurley, JD, MS (1 tape)*** This seminar covers the effects of witnessing violence, coordinating efforts between legal and clinical communities, and various roles in preventative efforts.

☐ **Coordinating Interdisciplinary Interventions with Battered Women Who Fail to Protect by *Catherine Ayoub, RN, EdD and Kenneth Herman, JD, PhD (2 tapes)*** This seminar provides an overview of child welfare policies, balancing the child's rights in domestic violence situations and includes a conceptual model of achieving balance through community intervention.

*This project was supported by Grant No. 97VFGX0012, Awarded by the Office for Victims of Crime, U.S. Department of Justice. Points of view in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.*

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## APSAC Discounts

**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.

**January 26-30, 1998.** ***Twelfth Annual San Diego Conference on Responding to Child Maltreatment.*** San Diego. Sponsored by the Center for Child Protection, Children's Hospital, San Diego, CA. Call 619-495-4940.

**March 17-20, 1998.** ***Fourteenth National Symposium on Child Sexual Abuse.*** Sponsored by the National Children's Advocacy Center, Huntsville, AL. Call 205-534-1328.

**July 9-12, 1998.** ***APSAC Sixth National Colloquium.*** Chicago, IL. Sponsored by APSAC. Call 312-554-0166.

## Other Conferences

**October 13-14, 1997.** ***The Loyola Forum on the Child, "The Quality of Life of the Urban Child".*** Loyola University Chicago Water Tower & Lake Shore Campuses. Sponsored by Loyola University. For more information call (312) 464-4096.

**October 14-18, 1997.** ***The Nineteenth Annual National Coalition Against Sexual Assault National Conference & Women of Color Institute.*** Cleveland, Ohio. Sponsored by the Ohio Coalition on Sexual Assault & The Cleveland Rape Crisis Center. Call 614-268-0321.

**October 15-17, 1997.** ***Strengthening Teams & Empowering Programs.*** Washington, DC. Sponsored by National Network of Children's Advocacy Centers. For more information call 1-800-239-9950.

**October 15-18, 1997.** ***Sixteenth Annual Research & Treatment Conference.*** Crystal City, VA. Sponsored by The Association for the Treatment of Sexual Abusers. Call 503-643-1023.

**October 20-22, 1997.** ***Fourth Annual San Diego Domestic Violence Council Conference, "Tomorrow's Solutions Today".*** Scripps Memorial Hospital, Schaetzel Center, LaJolla, CA. Sponsored by San Diego Domestic Violence Council. For more information call Denise Fry at (619) 581-1774.

**October 22-23, 1997.** ***Fourteenth Annual Conference,"Emerging From the Shadow of Violence."*** Century House Inn & Conference Center, Route 9, Latham, New York. Sponsored by Albany County Rape Crisis Center's. For more information call (518)447-7100.

**October 27-28, 1997.** ***Third National Roundtable on Managed Care in Child Welfare, Keeping the focus on Kids: From Ethics to Implementation.*** Holiday Inn, Denver Southeast, Aurora, Colorado. Sponsored by American Humane Association. For information call Mickey Shumaker at AHA at (303) 792-9900; Fax (303) 792-5333.

**November 3-4, 1997.** ***Family Group Decision Making: Assessing the Promise and Implementing the Practice.*** Philadelphia. Sponsored by the American Humane Association. Call 303-792-9900.

**November 6-8, 1997.** ***The National Symposium on Decision Making in Child Protective Services.*** Wyndham Hotel, Fort Lauderdale Airport. Fort Lauderdale, Florida. Sponsored by National Resource Center on Child Maltreatment. For more information call NRCCM at (404) 881-0707; Fax (404) 876-7949.

**November 6-10, 1997.** ***Thirteenth Annual Meeting: Linking Trauma Studies to the Universe of Science and Practice.*** Montreal, Quebec, Canada. Sponsored by the International Society for Traumatic Stress Studies. Call Debbie Pederson at (847)480-9028.

**November 19-22, 1997.** ***Eleventh Annual Empowering Families Conference.*** Minneapolis, MN. Sponsored by Center for Conference & Institutes. Call (319) 335-3231 or fax: (319) 335-3533.

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**November 20-23, 1997.** ***Ninth Annual Conference Voices for Change, Preparing Systems of Care for the New Millennium.*** J.W. Marriott Hotel, Washington, DC. Sponsored by Federation of Families for Children's Mental Health. For more information call 1-800-477-3677; Fax (919) 479-5247.

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# THANK YOU!

These APSAC members have generously made financial 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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# The Katie Toth Memorial Education Fund

This special fund was established in memory of Mary Katherine Toth Komie, daughter of long-time APSAC volunteer Patricia Toth. Katie died in April at the age of 20 months and her family established the memorial fund, dedicated to the purpose of furthering professional education, in honor and memory of Katie. APSAC and the family of Katie Toth extend deepest thanks to all who support this fund.

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# Thank you to our Colloquium Volunteers

APSAC's Fifth National Colloquium in Miami Beach was a great success, with fascinating discussions, informative training and excellent networking opportunities for more than 900 professionals in the field of child maltreatment. The behind the scenes work that goes into a conference of this scope is tremendous, and we simply could not have done it without the support of many fabulous volunteers. We would like to thank everyone who volunteered their time at the Colloquium, including those wonderful members who simply saw a task that needed to be done, and pitched in. If we have left any names out, please accept our thanks to all who helped make the Colloquium a success.

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