# APSAC ADVISOR

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AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

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

# PERSPECTIVES

## Child Protection Professionals Are Neglecting Young Teen Victims of Statutory Rape

By Howard Davidson, JD

Having been involved in the late 1970's and early 80's "legal discovery" of child sexual abuse, I have in the last two years been impressed by the slow emergence of still another "hidden" form of child victimization. The ABA Center on Children and the Law recently concluded an 18-month collaborative research project with the Progressive Policy Institute that examined legal system and service provider responses to "consensual" sexual relationships between adult males (age 20 and over) and young adolescent girls (age 10-15).[1] Since we began the project, we have spoken to dozens of prosecutors, front line youth service providers, legislators, teen pregnancy and child sexual abuse experts, and teenagers themselves about this "statutory rape" issue. We have also analyzed the criminal laws related to such unlawful relationships. Although our exploratory research frankly raised more questions than it provided answers, we have learned a great deal about the exploitative nature of many of these older man-young teen sexual liaisons. In these situations, romance too often leads to abuse.

Prosecutors, service providers, and teens alike suggested to us that there is (1) community (and often, family) tolerance for these relationships; (2) a lack of awareness among young girls, older men, and professionals alike as to the illegality of this behavior (acts for which men could be imprisoned and/or be labeled for life as "sex offenders"); and (3) a general perception that government agencies (police, prosecutors, child protective services) are disinterested in or not to be trusted with disclosures/reporting of such "relationships."

Our project report recommends a range of state law reforms related to these offenses, crimes which often constitute a very real, and damaging, form of child sexual exploitation. The report suggests that prosecutors should focus particularly on repeat offenders— adult males who move from one relationship with a young teen girl to another — and that prosecution should proceed without regard to the race, class, or social status of the girl or man. The report calls for (1) community as well as school-based education on this issue; (2) existing multidisciplinary structures (e.g., children's advocacy centers) to develop and implement protocols for handling statutory rape cases; and (3) increased counseling and training resources to address both victims and offenders in statutory rape situations.

### The Profoundly Negative Consequences of These Unlawful Relationships

Social workers, educators, and medical professionals are becoming increasingly aware of young girls' voluntary sexual pairings with much older partners. Many have witnessed this disturbing pattern for some time, but their concerns have not led to the development of community-wide responses. In the course of our research, we were told by youth service providers and prosecutors alike that statutory rape is a societal problem that for too long has been "swept under the rug."

While sexually transmitted disease rates among teenage males in United States have dropped since the early 1970's, the rate for teenage girls has increased (American Bar Association, 1997). Sexually transmitted disease and AIDS levels among females under age 20 are two to four times higher than the corresponding rates among males the same age. It has been estimated that seven out of ten infected teenage girls become infected with sexually transmitted diseases as a result of sexual relationships with men over 20 years of age. Data suggest that teenagers, particularly girls, acquire nearly all HIV infections from sex with older men.

Pregnancies and births to young girls are also strongly correlated to sexual relationships with older adult men. One study found 40% of 15 year-old mothers have partners five or more years older. In fact, "births to the youngest mothers in the study were disproportionately fathered by much older men who had engaged in sex nine months earlier with 14 and 15 year-olds." (American Bar Association, 1997, p. 3)

It will not surprise APSAC members to learn there is a connection between these exploitative "relationships" and a prior history of sexual abuse. Studies of pregnant adolescents report that they were often initially sexually abused by a family member or an older male acquaintance.

### The Failure of Child Abuse Professionals to Address This Problem

Since the ABA sponsored project began, I have had the opportunity to present workshops on statutory rape and appropriate professional responses at a Child Welfare League of America national conference and the national sexual abuse conference in Huntsville, Alabama. In both instances, my talks appear to have been the first presentations on this topic at these annual programs. I am unaware of this subject receiving thorough attention at annual conferences for either prosecutors or juvenile court judges, or at APSAC or NCCAN-sponsored conferences.

In my opinion, these failings are part of a larger shortcoming among the professional child protection community to adequately address teenage crime victims in general, especially teens who don't perceive themselves to be sex offense victims, or who make "difficult" witnesses. The Office for Victims of Crime of the U.S. Department of Justice is to be commended for holding an invitational conclave on teenage sexual victimization at the conclusion of the last Huntsville conference.

All of us have done too little thinking about how the criminal justice, juvenile court, and CPS systems can better identify and respond to cases of statutory rape and other forms of teenage sexual victimization. Individuals who come in contact with young teen girls need help understanding when and why cases are appropriate for justice

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## Victims of Statutory Rape

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system and child protection intervention. Youth service providers (including those working with pregnant and parenting teens) wrestle with the issue of reporting their clients' sexual relationships to CPS or the police. In about half the states, the laws appear to mandate reporting of suspicions that a minor girl is the victim of statutory rape. However, our research disclosed that most professionals working with such girls will not willingly report. They believe reporting violates the confidential nature of their relationship with their clients. They fear the girl will break her ties to the service provider, thus presenting serious risks for her physical and mental health as well as the health of her unborn child if she is pregnant.

These are the same concerns one hears from physicians and mental health professionals about child abuse reporting laws. But at least professional education on why and how to report intrafamilial child physical and sexual abuse has been widespread. Our statutory rape research reached a new set of players: youth service providers who know little or nothing about mandatory child abuse reporting laws and their application to professionals working with pregnant and parenting teens.

We also learned through our study that there are parents of young teen girls who promote, condone, or financially benefit from their daughters' unlawful sexual relationships with older adult men. These parents may be appropriate subjects for both civil child protection judicial intervention and criminal prosecution. However, I am unaware of any professional education that has been offered to train those who interact with such parents on appropriate legal responses.

In this article I have suggested that the child protection professional community has not appropriately assisted child victims of statutory rape, and that it has shortchanged adolescent victims of abuse in general. In our zeal to protect children we cannot overlook youth. According to 1994 NCCAN data, about 21% — over 1 in 5 — of all child maltreatment victims were teenagers. It is time for all of us to give this group of victims more attention.

*Howard Davidson, JD is director of The American Bar Association's Center on Children and the Law.*

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[1] *The study, directed by Sharon Goretsky Elstein, was supported by grants from the Carnegie Corporation of New York, the Annie E. Casey Foundation, and the Smith Richardson Foundation.*

## Letter to the Editor

## LETTERS

Dear Editor,

I'd like to respond to the "Perspectives" article in Volume 10, Number 2 of the *APSAC Advisor.* The article was written by Jeffrey Edleson, Ph.D and focused on the issue of charging battered women with failure to protect. I have had the opportunity to work on both sides of this issue, having been a Program Supervisor of a Domestic Violence program in Hawaii and a Child Protective Investigator in Florida.

Although I do agree with much of the article in relation to what a "battered woman" endures, we must not forget that children endure the same. Somewhere along the line, we as a society have decreased the worth and importance of our children. Anyone familiar with the dynamics of violence in the home understands the notion of violence being "a learned behavior", and often an intergenerational cycle.

As a child protective investigator, I was grateful to have had the expertise in domestic violence, as many of the child abuse cases I investigated were a tornado of violent cycles. I could always provide information and encourage services, but I couldn't force a person to break their walls of blame, minimization and denial. When we look at "battered women" or "battered men" we CANNOT lose focus of the children. At the same time, investigators should not blame the victim for the violence that befalls them.

I have never wavered from my position as a professional. I know that women in abusive relationships endure extensive physical and emotional damage and that the children endure the same. In a violent relationship, learned helplessness is a quickly sharpened skill. We need to empower victims of domestic violence and utilize the resources (and they ARE out there) in order for society's children to grow up in a healthy, non-violent setting. The needs of the children are of utmost importance, and their psychological survival relies on our ability to meet them.

Lisa Rivers
*Department of Children and Families*
*Tampa, Florida*

# NEWS FROM THE FIELD

## The Lessons of the Louise Woodward Case

The Louise Woodward "nanny" case touched a nerve, sparked an international hue and cry, and exposed some serious misunderstandings among the general public. Is shaken impact syndrome a true medical phenomenon or a figment of the imagination of "cult scientists"? Can a white, middle-class young woman commit child abuse? How could a professional couple rely on a minimally-trained au pair to care for their children? How could the jury find Louise Woodward guilty of second degree murder? How could Judge Zobel set her free?

In my mind, this case serves as a tragic reminder of the pressing need for ongoing public awareness and education, not only about the realities of child abuse but also about the intricacies of the criminal justice system. Below, several of the *Advisor's* Associate Editors consider the lessons they have learned and implications for the disciplines they represent.

Debra Whitcomb, MA
Editor in Chief

### Diane DePanfilis, PhD, MSW
### Associate Editor - Child Protective Services

As I pause to think about the "lessons learned" for CPS, I think we are best served by considering these implications broadly. CPS personnel know better than anyone the affect that the media can have on public opinion and on the decisions that evolve when our work becomes politicized. So, rather than pointing fingers, I think it is important that we consider more broadly what can we learn from this for ourselves. The best lesson, I think is to consider the things that influence us to make poor decisions. And, by understanding these influences, hopefully we can improve the quality of our own decisions in the future.

Decisions are influenced by personal characteristics of the decision maker as well as by the context in which they are made. We make mistakes when: (1) we use the wrong information processing strategies, e.g., we attend to events that are vivid and ignore data that are less vivid since our memory capacity is limited and our perception is selective; (2) the motivation and values of others affect how we decide, e.g., vested interests in certain outcomes influence our decisions; (3) our emotional reactions influence what we notice and recall, e.g., we are influenced by "liking" or not "liking" family members; (4) we don't have the capacity to distinguish between science and pseudo-science and quackery (that is where APSAC comes in to help us build and understand empirical knowledge that will aid our decision making); and (5) when the task environment does not support good decisions, e.g., large caseloads, lack of clear agency policies, etc. While we can't control our environment, we can control how we process information, recognize that our decision making can be negatively influenced by the motivation and values of others and by our emotions, and we can find ways to increase our knowledge base by relying on scientific evidence.

(Information in these comments come from Gambrill, E. (1997). Characteristics of the decision maker. In Morton, T.D., & Holder, W. (Eds). *Decision making in Child Protective Services: Advancing the state of the art.* Atlanta: Child Welfare Institute and ACTION for Child Protection.)

### Veronica D. Abney, MSW
### Associate Editor for Culture Issues

Coming from a cultural perspective, what lessons have we learned from the Louise Woodward case? Unfortunately, this case highlights how gender, social class, nationality and race can have a great influence on how people are treated in the criminal justice system. Judge Zobel and many other Americans seemed to find it hard to believe that an innocent looking young English woman could, in a state of violent rage, fatally injure an eight-month-old child. For some reason, it is easier to believe that she was simply "a little rough" with Matthew Eappen. Why?

First, Louise Woodward is English. Although we Americans fought hard for our independence from England, we have a soft place in our hearts for the English and many of us could be described as ardent Anglophiles. Second, Louise Woodward and Deborah Eappen are female; for the au pair this was an advantage, but it was a clear disadvantage for Matthew's mother. At a time when Americans are advocating a tougher stance on crime for both adults and minors, we still do not like the image of women in prison, particularly young white women like Louise. Deborah Eappen's gender worked against her in the portrayal of her as a mother whose priorities were outside the home. Third, Louise is white and middle class. Statistics clearly indicate that the white middle class get shorter and less severe sentences if convicted of a crime. The image of a young white middle class female does not seem to evoke feelings of fear in the public like the usual mug shot image shown of less desirable members of our society who have committed crimes. One could speculate that if Louise was a member of a poor and less valued ethnic group, the media might have been compelled to present her as unattractive, frightening and malicious, and Judge Zobel might have never contemplated a sentence of time served. Lastly, I wonder if the unspoken fact that the Eappen's are an interracial couple and Matthew was a brown baby made them less sympathetic victims. It is for these reasons that it may have been difficult for many Americans, but most importantly Judge Zobel, to see Louise Woodward's actions as characterized by anything but "confusion, inexperience, frustration, immaturity and some anger, but not malice" on the day she fatally injured Matthew Eappen.

### Lawrence Ricci, MD
### Associate Editor - Medicine

Some days after the conviction of Louise Woodward for the death of Matthew Eappen, I watched Barry Scheck suggest on the *Today* show that this 8-month-old child died from a minor accidental fall, that the "so-called shaken baby syndrome" was an unscientific diagnosis made by advocates, and that the defense argument in the case would soon be proven (whether that proof would occur in the courts or in the peer review literature where it belongs remained unsaid). My response and that of many forensic pediatricians was to gather on the Internet and, within 48 hours, send out a letter to all major news media with 50 signatures (now 70) clarifying for the public the state of the scientific literature on shaken baby syndrome and commenting on the bleed-rebleed phenomena. *Editor's note: The complete text of the pediatricians' letter is available on APSAC's webpage at www.apsac.org.*

The response to that letter was overwhelming and gratifying. Many of us were interviewed for national and local newspapers, TV and radio. For me, the mechanics of putting that letter together on the net (using a child abuse listserve and an e-mail

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list generated at a recent Philadelphia meeting of 90 physicians interested in forensic pediatrics as a subspecialty) was a most exciting exercise in electronic collaboration and education.

The letter generated many responses, including a response in the Wall Street Journal claiming that forensic pediatricians were part of an advocacy cult, a label that frightened me considerably. No less authorities than C. Everett Koop, the former Surgeon General of the United States and Joseph Zanga, the President of the American Academy of Pediatrics replied that the shaken baby syndrome was not blind advocacy but real science, supported by mountains of peer reviewed literature. Among all the discussion of the case, to see these two individuals speak out was most gratifying.

In the end, after the media pundits have moved on to another topic, what can a forensic pediatrician say about the tragic death of 8-month-old Matthew Eappen? The case raises a number of questions which remain to be studied:

- The circumstances of this case and its analysis in the courts should spur much needed research into the mechanics of SBS. How long must the shake last? Is impact necessary and of what force? How often are neck injures present?
- The courtroom adversarial process creates a strange brand of science. What role does peer review have in this process? Can anyone say anything in the courtroom or must scientific testimony be scientifically supportable?

## Christine Courtois, PhD
## Associate Editor - Mental Health/Adult Survivors

The judge's decision to downgrade Louise Woodward's conviction of second degree murder to manslaughter and to reduce the sentence from life to time served surprised and stunned many adult survivors just as it did the public at large. To many, this case (like OJ's) served as an example of the criminal injustice system, where influence, money and the media can influence the final outcome and where victims are revictimized rather than made whole by their day in court. The case also conveyed a disregard for the life of a child and caused many survivors to question and rage against the powerlessness of children both in society at large and in the legal system. The rejoicing of Woodward's supporters beamed from the pub in England was disconcerting: were her supporters unaware and insensitive to the fact that a tragedy had occurred and a child had died? Did they have no feelings for the parents of that dead child?

Many survivors seem to be in agreement with the sentiments expressed by one of the jurors who said he could live with the judge's reduction to manslaughter but not with the change in the sentencing to time already served. Woodward's actions towards the child may not have been malicious or intentional, yet a death still resulted and she should be held accountable for the consequences of her actions. The predominant feeling of many survivors is: are children really this expendable, and why can't we as a society do a better job of protecting them?

## Thomas Lyon, JD, PhD
## Associate Editor - Law

The Woodward case raises two legal issues with respect to Shake-Impact Syndrome (more popularly known as Shaken Baby Syndrome). First, should the defense theory of rebleeding be subject to the Daubert rule for the admissibility of scientific testimony? A number of physicians have argued that had Daubert been applied, the defense expert testimony would never have been admitted. However, whether Daubert is applicable to expert testimony that is based on clinical judgment rather than research is a matter of some dispute (for example, the 5th Circuit has recently held that Daubert is not applicable to such testimony). Consider what would happen if clinical psychologists could not testify for the prosecution in sexual abuse cases unless their experiential observations were backed by research.

Second, since Shake-Impact Syndrome suggests that shaking with no impact, or with impact against an object such as a mattress, can lead to intracranial bleeding, permanent brain damage, and death, what are we to make of the mental state of caretakers who impulsively injure their children by such shaking? Do they recognize that what they are doing can cause fatal injury? The reason the trial judge in Woodward's case reduced the verdict from second degree murder to manslaughter was that second degree murder requires that the act results in "what a reasonably prudent person would have known was a plain and strong likelihood that death would result." Although the judge did not make it clear whether he accepted the prosecution or the defense theory regarding the severity of the shaking on the day the infant died, one reading of his opinion suggests he doubted that "reasonably prudent" people recognize how devastating the effects of shaking can be.

# LETTERS

Editors of the *APSAC Advisor* welcome your letters! Appropriate topics for letters include:

- amplification on a point made in an editorial or article,
- disagreements with an author's stated position on a topic,
- disagreements with an author's interpretation of the relevant literature,
- suggestions for new features, or comments on existing ones,
- perspectives on issues in the field that you think are misinterpreted or neglected.

You can write to Debra Whitcomb, the Editor-in-Chief, via e-mail, at debraw@edc.org, or by regular mail, c/o APSAC, 407 S. Dearborn, Suite 1300, Chicago, IL 60605. You can also contact the Editor-in-Chief through APSAC's new web site, at http://www.apsac.org. Letters are typically edited for length, but every effort is made to preserve content. Letters must be typewritten and constructive for consideration for publication.

# ASSOCIATION NEWS

## 1998 Colloquium Planning in Full Swing

Plans for the 1998 Colloquium, to be held July 8-12 at the Hyatt Regency Hotel in Chicago, are in full swing. The 1998 Colloquium will be bigger than ever, with a pre-conference Cultural Institute focusing on child maltreatment in African-American families, followed by three packed days of intensive seminars, research presentations, poster sessions, and many networking opportunities. The Colloquium Planning Committee, comprised of leading professionals from the many disciplines that make up APSAC's membership, has been working since early Fall to plan an exciting and relevant program. This is the one conference you do not want to miss. A complete program brochure will be mailed to all APSAC members in late February, but be sure to hold the dates in your schedule.

## Board Nominations due by February 20

Please note the Call for Nominations to APSAC's Board of Directors enclosed with this issue. Your participation at all stages of the Board election process is an important way to influence the direction of the association. Please take a moment to consider whether you are willing to serve, or to think of colleagues who might be suited for Board service and willing to stand for election to APSAC's Board of Directors, and contribute to the list of candidates from whom members will be able to choose. To obtain a Board nomination form, please call APSAC at 312-554-0166, or fax us at 312-554-0919, or email to APSACPubls@aol.com. The nomination forms, with candidate curriculum vitae, are due in the APSAC office by 5PM, Friday, February 20, 1998. Board members elected through this process will serve a three year term, beginning June 1, 1998. Ballots will be distributed in the Spring issue of the Advisor.

## Call for Nominations for APSAC's Annual Awards

A highlight of APSAC's annual Colloquium is the presentation of awards. APSAC recognizes professionals in six categories: Outstanding Professional, Outstanding Service, Outstanding Research Article, Research Career Achievement, Outstanding Doctoral Dissertation and Outstanding Media Coverage of Child Maltreatment. A nomination form and a full listing of all the awards, previous recipients and nomination procedure is included with this issue of the *Advisor*.

## Update on the Aloha Challenge

At last year's Colloquium, APSAC Board President Harry Elias issued a challenge: The APSAC member who recruits the most new members during the coming year will win a one week stay (7 nights) in a one bedroom condominium in Kauai. (For a complete list of contest rules, please see Vol 10, n 3 of the Advisor, or call the APSAC office.) Entries have started to come in, but the field remains wide open! If sharing the many benefits of APSAC membership — our two publications, the *Advisor* and *Child Maltreatment*, the discounts on conferences, the opportunity to network with colleagues in your state and around the country — does not motivate you to recruit new members, perhaps the thought of a week on the lovely beaches of Kauai can! If you would like to receive membership brochures or other recruitment materials, please call APSAC's membership office. By increasing our membership, we can help to ensure that APSAC's mission of ensuring that everyone affected by child maltreatment receives the best possible professional response continues to be advanced.

## APSAC's Second Forensic Interview Clinic Sells Out!

APSAC's second Forensic Interviewing Clinic was a sellout before it was even officially announced! The extraordinary demand for this clinic truly speaks to the need for high quality training of professionals charged with interviewing alleged victims of abuse. The second APSAC Forensic Interview Clinic will be held in conjunction with the Huntsville Symposium in March, drawing on the resources of the Symposium faculty and offering participants the chance to make the best use of their limited training funds by attending both educational events. Plans are already in the works for a third clinic, possibly to be scheduled before the end of 1998. Priority registration is offered to APSAC members on the Forensic Clinic Waiting List, and the Huntsville Clinic was entirely filled with individuals on that waiting list. To place your name on the waiting list, please complete the form below and return it to the APSAC office. You will then be notified of the next available clinic, and have the chance to pre-register for this valuable training opportunity.

## APSAC's Five Day Child Forensic Interview Clinic

APSAC's comprehensive interview clinic is an intensive forty-hour training experience which provides personal interaction with leading clinicians, researchers, and trainers in the field of child forensic interviewing. Its interview practicum component provides participants with experience interviewing actual children in a supportive environment where constructive feedback is utilized to build and improve specific professional skills.

To add your name to the Forensic Clinic Waiting List, please complete and return this form by fax to 312-554-0919.

Name ____________________ Title ____________________

Agency Name ____________________ Address ____________________

City ____________________ State ________ Zip ____________

Phone ____________ Fax ____________ E-mail ____________________

APSAC Policy Watch

Thomas L. Birch, J.D. Legislative Counsel, National Child Abuse Coalition

## Legislation Aims for Safety and Permanence for Children

### President signs bill to protect children's sefety

On November 19, President Clinton signed into law The Adoption and Safe Families Act of 1997 (P.L. 105-89), new legislation to promote adoptions and protect children. The bill changes a number of policies established by P.L. 96-272, the Adoption Assistance and Child Welfare Act of 1980. The new law makes clear that the health and safety of children must be paramount concerns of state child welfare services in determining reasonable efforts to preserve and reunite the families of maltreated children.

The measure also identifies "aggravated circumstances" in which reasonable efforts are not required and when states must initiate proceedings to terminate parental rights (TPR), as when a parent has been convicted of murdering another child or a child has been abandoned, tortured, or chronically abused. Criminal record checks of prospective foster and adoptive parents are a new requirement in the law.

The Adoption and Safe Families Act amends P.L. 96-272 by establishing tougher time limits for making decisions about permanent placements for children. Under the new law, permanency hearings will now be held no later than 12 months after a child enters foster care, 6 months earlier than the old law. States must initiate termination of parental rights proceedings for any child who has been in foster care for 15 of the previous 22 months, except when: 1) when a child is in the care of a relative; 2) the state agency documents a compelling reason why filing TPR is not in the best interest of the child; or 3) services which could enable the child to safely return home have not been provided.

Under the newly enacted measures, the Family Preservation and Support Services Program is continued, renamed the Promoting Safe and Stable Families Program, with funds authorized to increase from $255 million in FY98 to $305 million in FY01.

Key adoption issues addressed in the legislation include provisions to extend health insurance coverage to children with special needs when they are adopted, either through Medicaid or through the new state children's health program passed by Congress last summer. New provisions also prohibit geographic barriers to adoptions across state or county lines. The new law also offers a financial bonus to states that increase the number of children who are adopted from the public foster care system. For every additional child adopted, a state will receive $4,000, with an additional $2,000 paid for each child with special needs.

> **The Adoption and Safe Families Act amends P.L. 96-272 by establishing tougher time limits for making decisions about permanent placements for children.**

At the White House signing ceremony, President Clinton said about the bill: "We have put in place…the building blocks of giving all of our children what should be their fundamental right, a chance of decent safe home; an honorable, orderly, positive upbringing; a chance to live out their dreams and their God-given capacities."

The bill signed by the President represents a final consensus which grew out of the House-passed H.R.867, the Adoption Promotion Act, and two earlier Senate measures, S.511, the SAFE Act, and S.1195, the PASS Act, neither of which made a floor vote. Through late October and early November, a bipartisan coalition of Senators worked with House members to draw up the latest version of the bill, working toward final passage as Congress prepared to adjourn for the year.

The final bill eliminates provisions from earlier Senate versions of the legislation which would have required priority substance abuse treatment for child welfare cases and extended federally subsidized foster care payment to support eligible children placed with a parent in a substance abuse treatment program or domestic violence shelter.

Another provision which was cut in the final adoption legislation was a Senate proposal requiring states to establish state multidisciplinary child death review teams to examine child abuse and neglect-related deaths, and to set up a federal child death review team to investigate deaths on federal lands, provide technical assistance to state and local teams and recommendations on preventing child deaths. In the face of HHS objection to funding a federal review panel, and with the understanding that many states already have established their own review teams, the provision was dropped.

The final version of the Adoption and Safe Families Act passed by Congress does contain a provision that recalls earlier, unsuccessful efforts in Congress to enact a parental rights bill. The provision specifies that nothing in the Act is intended to disrupt the family unnecessarily, intrude inappropriately into family life, prohibit the use of reasonable methods of parental discipline, or prescribe a particular method of parenting.

Leading the efforts in the House and Senate to pass the Adoption and Safe Families Act were; Sens. John Chafee (R-RI), Larry Craig (R-ID), Jay

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## Policy Watch

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Rockefeller (D-WV), James Jeffords (R-VT), Mike DeWine (R-OH), Dan Coats (R-IN), Christopher Bond (R-MO). Mary Landrieu (D-LA), Carl Levin (D-MI), Byron Dorgan (D-ND), and Robert Kerrey (D-NE); and Reps. Dave Camp (R-MI), Barbara Kennelly (D-CT), Clay Shaw (R-FL), and Sander Levin (D-MI).

**Volunteer Protection Measure Becomes Law**

President Clinton on June 18 signed the Volunteer Protection Act, which shields volunteers from lawsuits based on their volunteer activities. Volunteers protected from liability by the new law include individuals serving nonprofit organizations or government agencies without compensation, including as a director, officer, trustee, or direct service volunteer.

The new law recognizes a problem confronting many nonprofit groups: the withdrawal of volunteers from boards of directors and service in other capacities because of a fear of potential liability actions against them, and the higher cost of purchasing insurance faced by nonprofit groups due to high liability and litigation costs. The new federal statute exempts volunteers from any liability for harm caused by acting within the scope of the volunteer's responsibility in the nonprofit organization, excluding any harm caused by willful or criminal misconduct or by gross negligence on the part of the volunteer. The law does not exempt volunteers from liability for injury caused while operating a motor vehicle.

There are no limitations on the liability of a volunteer under this act if the volunteer's action constitutes a crime of violence or act of international terrorism for which the defendant has been convicted; constitutes a hate crime; or involves a sexual offense, for which the defendant has been convicted in court.

Nonprofit organizations covered by the law include any section 501(c)(3) group organized for public benefit and operated primarily for charitable, civic, educational, religious, welfare, or health purposes and which does not practice any action constituting a hate crime.

**Children's Health Insurance Enacted/Coverage Available to Uninsured Low-Income Children**

As of September 30, states must begin extending health care coverage to children who have no health insurance coverage. The recently enacted State Child Health Insurance Program (S-CHIP), the largest expansion of government-paid health insurance since the formation of Medicaid in 1965, is expected to provide health care coverage to a least half of the nation's 10 million uninsured children, focusing on the 7.1 million children in families whose incomes are less than 200% of the federal poverty line, or less than $32,100 for a family of four.

Most of these are working families — and two-thirds of them are two-parent families — with jobs that do not provide affordable health insurance. These families do not qualify for welfare, and therefore do not qualify for free health care via state and federal Medicaid programs. The children's health coverage has important implications for relieving some of the economic stress from overburdened families and providing extra protection for children whose health or safety might otherwise be at risk.

***As of September 30, states must begin extending health care coverage to children who have no health insurance coverage.***

S-CHIP, authorized under the Balanced Budget Act of 1997, provides block grants to states to assure access to health services for uninsured, low-income children; $ 4.275 billion for each year FY 1998-2001, $3.150 billion for each year FY 2002-2004, $4.05 billion for each year FY 2005-2006 and $5 billion for FY 2007. The health insurance coverage will be funded in part by a tobacco tax rising to 15 cents when fully phased in by 2002. Leadership on the historic children's health measure came from President Clinton and Sens. Orrin Hatch (R-UT) and Edward Kennedy (D-MA).

A state may choose to cover any or all of the services listed in federal Medicaid law, as well as services furnished in state psychiatric hospitals and residential or other 24-hour therapeutic services. S-CHIP funds may be used to purchase any of the following: (a) inpatient and outpatient mental health services; (b) home and community-based services; (c) case management and rehabilitation services; (d) outreach; and (e) transportation.

States may choose to use the S-CHIP funds in one of the following three ways:

1. The Medicaid Option: States could expand the state Medicaid program to cover children not already eligible.
2. The Private Insurance Option: States may use funds to purchase health insurance policies for uninsured children.
3. The Final Option: States may use up to 10% of the funds to purchase services directly, such as from a community program. The remaining 90% of S-CHIP funds must be used to either expand Medicaid or purchase private insurance.


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# Preventing Institutional Liability For Children Who Molest Children

by Beatrice Yorker J.D., R.N., C.S., FAAN

Professionals and institutions that care for children are increasingly aware of the risks associated with children who victimize other children. Demographic information regarding the number of sex offenders who are themselves minors is rapidly developing. Although the transition from victim to abuser is still being studied (Hanson & Slater, 1988), researchers have shown that child molesters have a higher frequency of unwanted sexual activity as children. Research has also shown a connection between childhood victimization of the offender, the age and gender of their victims, and the type of offense (Groth & Burgess, 1977; Groth & Birnbaum, 1979; Burgess, Hartman & McCormack,1987). Abel, Becker, Cunningham-Rather, & Mittelman (1988) conducted extensive studies with perpetrators and concluded that sexual offending behavior typically begins in adolescence or earlier. There is enough documentation in the literature to put professionals who work with children on notice that the risk of sexual abuse is present any time children who are victims of maltreatment are cared for in group settings.

This article will cover two general institution types that care for children, psychiatric/mental health treatment facilities and educational settings. Although a significantly higher number of children with a history of sexually abusive behavior are in residential treatment than in schools, the more specialized and treatment oriented the educational setting is, the more likely that there are increased numbers of children with clusters of behaviors such as aggressive and/or sexualized acting out. Although facilities that treat or detain juvenile offenders will not be specifically addressed in this article, professionals in those settings may also benefit from the recommended prevention and risk reduction measures that will be discussed.

**Liability**

In order for a potential plaintiff to be able to file suit against an institution because a child has been molested by another child in their care, several criteria must be met. Civil liability for children being molested falls under the general area of torts, or the laws governing personal injury. Tort law includes negligence and malpractice, as well as intentional torts such as assault, battery, false imprisonment and invasion of privacy, or infliction of emotional distress. Care providers should be aware that each cause of action listed above contains several elements that must be present in order to have a valid claim. A cause of action for negligence requires the plaintiff to establish four elements: (a) that the defendant owed a duty to the plaintiff; (b) that the defendant breached that duty; (c) that the breach of duty was the proximate cause of any injury; and (d) that the plaintiff suffered damages. The same four elements apply to a cause of action for malpractice, which is negligence by a professional who must adhere to a specified standard of care.

Institutions that care for children clearly have a duty to protect children in their care from physical and emotional injury. The standard of care is established through a variety of mechanisms. One very important determiner of the standard of care is the profession. In fact, APSAC plays a critical role in determining standards of care for professionals in the field of child maltreatment. Another source of standards is the policies and procedures established by the institution. Regulatory bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) determine the applicable standard of care. An additional way that courts establish the appropriate standard of care is through the testimony of expert witnesses. The courts often apply common sense rules regarding questions of adequate protection by institutions for children in their care.

***There is enough documentation in the literature to put professionals who work with children on notice that the risk of sexual abuse is present any time children who are victims of maltreatment are cared for in group setting.***

Although a lawsuit for an intentional tort such as assault and battery can be brought against the perpetrator of child molestation, negligence and malpractice are the most common types of suits brought against institutions. One reason for this is that it is very difficult to show that an institution intentionally caused harm to the child if another child was the perpetrator. Because institutions represent a deep pocket, some plaintiffs file a lawsuit for negligence against the institution and also file a suit for assault and battery against the perpetrator.

**Negligence Lawsuits**

Several recent lawsuits provide examples of institutional liability for children molesting other children. In Garcia v. City of New York, (1996) a public school teacher sent a five year old boy to the bathroom unescorted. The child was sodomized by an older boy who was identified but never charged. The City appealed a judgment of $535,000 in damages for the plaintiff and his family, on the grounds that the school had no prior notice that the alleged attacker posed a danger to young children (Goldstein, 1996). Attorneys for the public school argued that the court should apply a 1994 precedent requiring school officials to have "actual or constructive notice" of the potential problem in order for a school to be held li-

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# Children who molest children

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able for the misdeeds of a student (Mirand v. City of New York, 1994). The Appeals Court judge reduced the award to $462,751, but denied the City's motion to set aside the verdict on the basis that "plain common sense" dictates that a kindergarten student should not have been allowed to go to the bathroom unattended. The court went on to say that "The potential danger to the child under the circumstances of this case can be reasonably foreseen and could have been prevented by adequate supervision of the school." (Garcia v. City of New York, 1996)

A similar case involved a female student who successfully sued her school after being sexually assaulted by two other female students in her class. (Adams, 1993) The victim testified that she had been pulled out of the classroom by the larger of the two assailants and once in the hallway bathroom was forced to disrobe. Her attackers also undressed and allegedly touched her body and forced her to lick one of the girls on the buttocks. A physician who examined the victim testified that she had been forced to perform cunnilingus on both attackers and they performed oral sex on her. The plaintiff claimed that she had asked the teacher for permission to use the bathroom and that the teacher had given her permission to go to a bathroom down the hall. There was a bathroom directly accessible to the classroom, however the teacher prohibited its use during class.

A jury in the case returned a $350,000 verdict against the school. An Appellate judge dismissed the jury award on the basis that there was insufficient evidence that the school could have foreseen the danger. The plaintiff's mother appealed and testified that she had complained to the teacher that one of the two assailants, a larger girl who had been held back a year, had previous incidents of violence, such as making another student walk around school naked and forcing the plaintiff to eat a piece of cake that had fallen on the floor.

On appeal, the panel of judges reinstated the jury's award by a 3 to 1 vote. The court noted that the teacher's actions had violated school policies that prohibited more than one student being out of the class at a time and specified that classroom bathrooms were to be used where available. The first judge who reversed the jury award found the violations of the school's safety policy were not sufficient to find the school negligent since the policy was intended to protect students from outside intruders, not other students. The judge who wrote the majority opinion of the Appeals Panel countered that although the rules were created to prevent harm from intruders, "they were obviously intended to protect the students from danger, whatever the source." (Adams, 1993) The judge stressed the foreseeability of the assault, writing "It was enough that plaintiff show that [the student accused of the assault] had previously exhibited violent tendencies which should have placed the City on notice that she would, given the opportunity, assault plaintiff in the future." He noted that there was sufficient evidence to support the jury's finding that the defendant school had breached its duty to supervise students with the same degree of care "as would a reasonably prudent parent." The dissenting judge disagreed and argued that there was no unreasonable action on the part of the teacher nor was the history enough to prompt a reaction. (Adams, 1993)

**Insurance Coverage for Intentional Acts**

In general, insurance carriers exclude coverage for intentional acts that cause injury. Most insurance policies have language that specifically excludes bodily injury that is "either expected or intended from the standpoint of an insured" (Adams, 1993). In the area of sexual torts, the cause of action is relatively clear, e.g. all the elements of assault and battery are usually met. Because of this exclusion from coverage, victims will usually be unable to recover directly from a company that insures the assailant. Most sexual predators are of limited personal means, and so victims seeking to recover monetary damages in civil courts may target the liability insurance of the assailant (Walters, 1996). For example, one case involved a sixteen-year-old child who forced a eight-year-old to submit to a sex act at knife point. The parents of the victim sued the prepetrator's parents under their homeowner's policy, but the court concluded that the intentional injury exclusion from the insurance policy applied and although an assault occurred, there was no coverage under the defendants' policy (Menard v Zeno, 1990).

***Although a lawsuit for an intentional tort such as assault and battery can be brought against the perpetrator of child molestation, negligence and malpractice are the most common types of suits brought against institutions.***

**Preventing Sexual Misconduct by Minors in Care**

**Psychiatric/Mental Health Treatment Facilities**

Health care providers who work in treatment facilities that serve children and adolescents are aware of the high proportion of children in treatment who have histories of abuse. With the growing number of institutional negligence lawsuits being filed, administrators and nurses have beefed up policies designed to specifically prevent sexual assault among patients or clients. The following recommendations are the result of increasing knowledge and experience in the area of child sexual offenders.

Assessments and psychosocial histories of

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children should include a risk appraisal for their potential for being abusive. Widom (1991a, 1991b) has broadened our understanding that children who have experienced physical abuse and neglect are at far greater risk for engaging in violence than children with a history of sexual abuse alone. Questions regarding previous episodes of aggression or hurtful acts toward siblings or animals can be incorporated into admission forms. Any projective testing that reveals themes of extreme violence toward others should be communicated in the chart, along with a plan for continued assessment and intervention.

One major child and adolescent residential treatment facility established a separate unit for known sexual offenders. Any residential or in-patient treatment facility that has more than ten sexual offenders at a time should consider the costs and benefits of opening a separate unit. Some cost-effective strategies can be accomplished by having such unit-wide safety measures as single bathroom facilities, single sleeping rooms, daily structure that deters unsupervised play, and routine checks on residents' whereabouts. A specialized unit also prevents exposure between predators and children who are significantly younger or less able to defend themselves.

**_With the growing number of institutional negligence lawsuits being filed, administrators and nurses have beefed up policies designed to specifically prevent sexual assault among patients or clients._**

As a child psychiatric nurse who has worked closely with treatment facilities over the past twenty years, I can see the benefits of our collective experience with children who have issues of sexualized acting out. For example, we are all much more aware of the potential for exploitation when children of a wide variety of ages are in close proximity. We are also aware of the sometimes compulsive tendency for children to reenact aspects of trauma they have endured in the past. A simple behavioral modification program may not have the same efficacy in treating this type of behavior as with behaviors that are under conscious control.

Many in-patient units are consolidating care of diverse patient populations as a means of cost-containment. If separation of sexual predators is not possible, simple safety measures can be effectively implemented to prevent sexual acting out between children. Precautions used for self-injurious or aggressive patients can easily be extended to patients who pose a risk of inappropriate sexual activity. For example, once any incidents have occurred, the offending child should be kept in line of sight, then placed on fifteen or thirty minute checks for a reasonable period of time following the incident. Nurses can also structure bathroom activities to minimize contact between potential predators and vulnerable children. They should pay careful attention to sleeping room assignments and have the option of placing beds of children with histories of acting-out in view of the nurse's station during the night shift. Certainly there should be provisions for appropriate supervision during outings and outside activities if there is any indication that a particular child might be at risk for victimizing others. Many hospitals and other institutions place video monitors in strategic locations to enhance safety. One residential treatment unit is considering using motion detectors in areas that cannot be directly visualized by nursing staff.

### Educational Facilities

Some educational facilities, particularly those that provide psycho-educational services, may be able to use some of the suggestions for psychiatric facilities listed above. An additional complication however, is the issue of student privacy or confidentiality. It is sometimes difficult to place heightened scrutiny and supervision on a child without revealing that they have a history of sexual abuse or acting-out. The two lawsuits described above provide guidance by placing the responsibility on the school to protect students if sexual misconduct is foreseeable. Once a student has engaged in threatening or aggressive behavior, teachers and administrators should provide reasonable safety measures for potential victims. The student's mental health history does not necessarily need to be revealed if the student has not given any behavioral clues that they pose a threat to their peers or to younger children. As the judge in the first case suggested, it is not common sense to allow kindergartners to go to a communal restroom with much older children without adequate supervision.

Both educational and treatment facilities should consider offering prevention programs for all students/residents. These programs could include general education regarding personal rights followed by specific skill building for reporting incidents. The preventive potential of such educational programs has been well documented, especially if the programs include role-playing or experiential exercises.

### Conclusion

Although the media coverage of lawsuits against agencies that care for children is quite disconcerting, the field of child maltreatment has evolved to the point of providing much helpful guidance. Teachers, nurses, and administrators will generally only be held liable for sexual assaults committed by children in their care if the assaults are foreseeable. The standard of care imposed on child care institutions is not to prevent every possible adverse incident or assault, but to

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# Contemporary Issues and Innovations in the Assessment of Adult Survivors of Traumatic Abuse

Eve B. Carlson, Ph.D.

Childhood abuse experiences can have many different negative effects on children. Some abuse events are distinctive, however, in that they cause a child to experience overwhelming fear and put a child at risk for traumatization (Carlson, Furby, Armstrong & Shlaes, 1997). Such traumatic abuse experiences can result in posttraumatic responses like those seen following other, non-abuse traumas. Since the effects of unresolved traumatic abuse can extend into adulthood, it is important for clinicians who see adults to assess both experiences of traumatic abuse and posttraumatic symptoms.

Fortunately, new resources on planning and conducting effective trauma assessments have recently become available and are readily accessible. This article begins with a discussion of how more attention to trauma assessment can lead to more effective treatment. It follows with a brief review of some of the obstacles to understanding traumatic experiences and their impact and some of the challenges involved in assessing past abuse experiences and current symptoms in adult survivors of traumatic abuse. Next, some practical aspects of choosing and administering measures of traumatic experiences and trauma responses are discussed. Finally, the types of measures now available for trauma assessment and recently published resources for locating, selecting, administering, and interpreting the results of these measures are presented.

**Why Focus on Traumatic Experiences or Conduct Trauma Assessments?**

Increased understanding of a client's traumatic experiences and careful assessment of responses and symptoms can help clinicians plan and implement more effective treatment. To begin with, a better understanding of the impact of traumatic experiences, including core, secondary, and associated symptoms, allows the clinician to conduct a more thorough assessment and to be alert to the possibility that the client has a trauma history, even if undisclosed at intake. Knowing the most likely symptoms also insures that the clinician assesses all of these symptoms as well as the psychosocial variables and experiences that may moderate or exacerbate the effects of traumatic experiences.

Detailed trauma assessment and an understanding of trauma effects leads to improved treatment because the clinician can better distinguish between abuse experiences that were traumatic and those that were not. Such a distinction is important because these two types of abuse and their respective set of responses and symptoms may call for different treatment strategies and methods. Trauma theories can also help with an understanding of the psychological significance of a particular client's symptoms so that treatment can focus on the most critical issues. For example, a different therapeutic approach would be used to address anger that is part of trauma-related affective reexperiencing than would be used with a client's anger at unjust treatment by parents.

Careful assessment can improve treatment in a number of other ways. Obtaining a complete trauma history is valuable because it helps identify whether the client experienced single or discrete traumatic events versus multiple or chronic ones. On average, the individual's responses to chronic events are likely to be more complicated or compounded. A detailed trauma history can also reveal connections between experiences and current symptoms that relate to treatment planning. For example, knowing the details of early traumatic experiences may help clarify what elements of a client's current environment or behavior might be serving as reminders or reenactments of aspects of past trauma. An understanding that a particular symptom is a manifestation of reexperiencing or avoidance will help the therapist determine an appropriate and effective therapeutic approach. Finally, thorough assessment of trauma response facilitates a more rapid identification of symptoms, allowing the clinician to more rapidly focus on the most pressing presenting problems.

In a time when clinicians are expected to accomplish more in less time, many question the value of conducting specialized assessments of traumatic experiences and responses. I would argue that such assessments save time and effort in the long run and are necessary because the sources of information clinicians typically rely upon can be misleading when the client has been previously traumatized. Studies have shown that standard intake interviews very frequently fail to uncover traumatic experiences or trauma-related symptoms. Standard intake interviews typically do not include the necessary questions or do not ask the questions in a way that yields valid results. Standardized psychological tests (such as IQ tests, symptom inventories, and personality inventories) may produce misleading results because most do not assess trauma responses and standard interpretations of their results do not take into account the unique patterns of responses common to trauma survivors. For example, elevated F scale scores on the Minnesota Multiphasic Personality Inventory (MMPI) are usually interpreted as indicating malingering, but F scale scores are commonly elevated in persons with known traumatic experiences.

Finally, presenting symptoms of trauma victims often overlap considerably with those of clients with other psychological disorders. This difficulty with differential diagnosis in traumatized persons along with frequent comorbid disorders and symptoms that are secondary to trauma disorders create a symptom picture that can be quite confusing. Specialized assessment of trauma experiences and responses can

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**APSAC** American Professional Society on the Abuse of Children

# Call For Nominations APSAC Board of Directors

APSAC is seeking nominations of members to stand for election to the Board of Directors for three-year terms beginning on June 1, 1998 and ending on May 31, 2001. Nominees must have been APSAC members for at least one year, and must have agreed to be nominated before their nominations are submitted.

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

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

Nominations are due at APSAC's offices on February 20, 1998. Complete nominations consist of a nomination form, 200- to 400-word letters of nomination from two people outlining the candidates qualifications for serving on APSAC's Board of Directors, and a copy of the candidate's resume or curriculum vita. Call 312-554-0166 to receive a nomination form.

**DEADLINE FEBRUARY 20, 1998**

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# APSAC Annual Awards

APSAC's Annual Awards will be presented at the Sixth National Colloquium in Chicago, July 8-12, 1998. Nominations are sought for the following categories:

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Recognizing a member who has made substantial contributions to APSAC through leadership and service to the Society.
*Former Recipients: Jon Conte, PhD (1992); David Corwin, MD (1993); John E.B. Myers, JD (1994); David Chadwick, MD (1995); Joyce Thomas, RN, MPH (1996); Barbara Bonner, PhD (1997).*

**Outstanding Professional**
Recognizing a member who has made outstanding contributions to the field of child maltreatment and to the advancement of APSAC's goals
*Former recipients: Ann Wolbert Burgess, DNSc (1992); Lucy Berliner, MSW (1993); Kee McFarlane, MSW (1994); David Finkelhor, PhD (1995); Ken Lanning, MS (1996); Robert M. Reece, MD (1997).*

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Recognizing an APSAC member who has made repeated, significant, and outstanding contributions to research on child maltreatment over his or her career.
*Former recipients: Gail Goodman, PhD (1992); Norman Polansky, PhD (1993); Murray Strauss, PhD (1994); William Friedrich, PhD (1995); Byron Egeland, PhD (1996); Dante Cicchetti, PhD (1997).*

**Outstanding Research Article**
Recognizing the authors of a research article or book published in the previous calendar year judged to be the most significant contribution to the field of child abuse in that time period.

**Outstanding Doctoral Dissertation**
Recognizing the doctoral dissertation completed within the last calendar year that made the most outstanding contribution to research on child maltreatment.

**Outstanding Media Coverage**
Recognizing a reporter or team of reporters in print or electronic media whose coverage of child maltreatment issues in the previous calendar year shows exceptional knowledge, insight and sensitivity.

**Nomination Procedure:**
Send a completed copy of the enclosed form and a brief letter of nomination to the Chair of the Awards Committee. For Outstanding Research Study and Outstanding Doctoral Dissertation awards, please include a copy of the nominated article or an abstract of the nominated dissertation . For Outstanding Media Coverage, please include five copies of the nominated article(s) or program(s).

**Deadline for Awards Nominations is May 1, 1998. Nominations may be sent to:**

APSAC
407 S. Dearborn Suite 1300
Chicago, Illinois 60605
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Policy  Program Administration  Criminal law  Civil law  Criminal investigation

CPS investigation  Case management  Diversity issues  Other (please discuss):

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**DEADLINE FEBRUARY 20, 1998**

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DEADLINE May 1, 1998

# Assessment of Adult Survivors

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greatly clarify the diagnostic picture for many clients and need not require added expense or clinician time.

### Obstacles to Understanding Trauma Responses

The effects of traumatic experiences can be difficult to understand because of the complex relationships among aspects of the traumatic stressor, factors that mitigate or exacerbate responses, and outcomes. Great individual differences in response to trauma are found due to the influence of such factors as biological predisposition, developmental level at the time of trauma, trauma characteristics, social context, and prior and subsequent life events. Though reexperiencing and avoidance symptoms (in affective, cognitive, behavioral, and physiological modes) tend to comprise the initial core response to trauma, other symptoms may come to predominate over time. For example, symptoms that are secondary to core trauma symptoms (such as depression or guilt) or symptoms that are associated with aspects of the trauma context (such as low self-esteem) may become more prominent than initial reexperiencing and avoidance symptoms. Recently published resources that include theoretical discussions of the effects of traumatic experiences include Briere (1997), Carlson (1997), and van der Kolk, McFarlane, & Weisaeth (1996).

***The effects of traumatic experiences can be difficult to understand because of the complex relationships among aspects of the traumatic stressor, factors that mitigate or exacerbate responses, and outcomes.***

### Challenges to Assessing Traumatic Experiences and Responses to Trauma

Most therapists are aware of the clinical manifestations of trauma-related symptoms and disorders, but few have had any specific training in assessing trauma and trauma responses. Those who specialize in the assessment and treatment of survivors of traumatic abuse have felt a growing need for such specialized resources and training, especially as the accuracy of client reports of childhood abuse has been increasingly questioned. In light of research findings that highlight the inaccuracies of normal memory processes, some critics question reports of early abuse when corroboration is unavailable from official records or witnesses or when family members deny that abuse occurred. Concern has also been expressed that clients may overreport their abuse experiences (or even fabricate an abuse history) due to secondary gain motivations or because they were influenced by overzealous therapists "looking for" abuse victims. At the present time, the client reports that are most controversial are reports of sexual (and especially incestuous) abuse, reports of extreme or seemingly improbable abuse experiences, and reports of abuse that was not remembered for some period of time but was later recalled on the basis of delayed or recovered memories.

Indeed, adults' retrospective abuse reports and reports of current symptoms are subject to error from several sources. Clients may not report or may underreport past abuse or traumatic life experiences because they are not directly asked or because questions about them are imprecise or are misunderstood. For example, when asked if she has ever had "a traumatic experience" or an "experience outside the range of usual human experience," a survivor of traumatic abuse might well say "No" if she has not identified what happened to her as either traumatic or unusual. Underreporting might also result from poor encoding of trauma memories (due to such factors as young age when the trauma occurred, no social context in which to identify or consolidate such experiences, or physiological and emotional overarousal at the time of trauma); forgetting (survivors may avoid thinking about these events so that a lack of rehearsal leads to forgetting); motivated forgetting and ongoing amnesia (some may not remember traumatic events because to do so is psychologically distressing); dissociation or the splitting off of aspects of the experience including memory of its occurrence; or avoidance of thinking or talking about past upsetting events.

Overreports and erroneous reports of past traumatic abuse can also occur. These are most often the result of delusions; compliance with therapist suggestions or statements about the likelihood that the client was abused or the client's perceptions about therapist's wishes; desire for secondary gain (including sympathy, attention, financial gain, or retribution); memory errors; and reports of misperceptions at the time of the events. At present, it is unknown how often past abuse is overreported or reported in error. Some research has found that underreports of real traumatic abuse experiences occur commonly. The implication is that the therapist must assess carefully with an understanding that abuse might be either over- or underreported.

### Addressing Challenges to Assessing Trauma and Trauma Responses

Given the potential for error in reports of trauma and trauma responses, it is important to use a systematic approach to assessment. When assessing past traumatic experiences, it is advisable to avoid becoming focused on determining the veracity of abuse memories. This is because, first, the therapist is unlikely to be able to confirm or disconfirm particular memories and is not in an investigative or confirmatory role, and second, because preoccupation with the veracity of memories can hinder effective treatment. Some clients may think that knowing "the truth" will lead to relief, but this alone is not likely to ameliorate the effects of traumatic abuse. For some clients, "the

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# Assessment of Adult Survivors

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truth" will never be known and their therapeutic work involves struggling with and learning to tolerate uncertainty about what might have happened to them. It is also important for the therapist to keep in mind that overreporting or reports of improbable or impossible events does not necessarily mean that a client experienced no traumatic events. In fact, a recent research study found that fantastic elements may be more commonly reported by children in the context of corroborated versus uncorroborated abuse cases (Dalenberg, 1996). It is also possible that some adults exaggerate and report improbable forms of abuse as a screen memory or to protect themselves from facing the effects of more likely forms of abuse (especially incest and/or abuse that involves significant betrayal by someone close to the child).

Assessments of both traumatic experiences and trauma-related symptoms will be more accurate if the therapist uses measures that have been carefully developed by experts in human traumatization, that are neutral and precise in their tone and in the type of questions asked, and that are psychometrically sound in terms of reliability and validity. Neutrality of the interviewer and in the measurement items helps minimize the effects of interviewer and client bias and expectations. Precision in the wording of measure items and interview questions can also add clarity and reduce confusion and misunderstanding about what is being asked. To further maximize the accuracy of assessment results, those conducting assessments should: be alert to signs of misunderstanding, underreporting, exaggeration, and secondary gain motivations; avoid making overt or inadvertent suggestions about a client's past experiences or symptoms; and avoid assessment methods that may influence memories (hypnosis, amytal interviews, age regression exercises and the like). Additionally, whenever possible, a client's assessment and treatment should be conducted by different professionals so that bias can be minimized.

**Self-report and interview measures for adults and children are also available to measure PTSD and dissociative symptoms, generally considered the most distinctive post-traumatic responses.**

## Choosing Which Domains to Assess and Which Measures to Use

Trauma assessments should include measures of traumatic experiences and prominent posttraumatic symptoms. Self-report and interview measures of past trauma that can be administered fairly quickly are now available for both adults and children. Self-report and interview measures for adults and children are also available to measure PTSD and dissociative symptoms, generally considered the most distinctive posttraumatic responses. A few instruments are available that also assess a range of other symptoms common in adult survivors of childhood abuse such as depression, guilt, self-destructive behavior, dysfunctional sexual behavior, difficulty regulating affect, somatization, damaged self-perceptions, and difficulties in relationships. These measures include: the Trauma Symptom Inventory (Briere, 1996b) , the Clinician-Administered PTSD Scale (Blake, Weathers, Nagy, Kaloupek, Gusman, Charney & Keane, 1995) , and the Structured Interview for Disorders of Extreme Stress (Pelcovitz, van der Kolk, Roth, Mandel, Kaplan, & Resick, 1997) .

Recently, more measures have become available that are suitable for clients who may have experienced multiple traumatic events. Such measures eliminate the problems encountered when asking a client to report only symptoms related to a single traumatic stressor and include the Trauma Symptom Inventory (Briere, 1996b), the Modified PTSD Symptom Scale (Falsetti, Resnick, Resick, & Kilpatrick, 1993), the Screen for Posttraumatic Stress Symptoms (see Carlson, 1997), and the Penn Inventory (Hammarberg, 1992). The Clinician-Administered PTSD Scale also now allows reporting of up to three traumatic events. Descriptions of these measures can be found in the assessment resources listed below.

Within each category of measures, numerous instruments are available that may be more appropriate for some clients than for others. When choosing measures, the therapist should consider the following questions: What is the best measure format for this client (self-report or interview)? Are the measure's length and complexity right for this client? Is the language used in the measure appropriate to this client's level of comprehension? Is the measure's content appropriate to this client's age, experiences, level of insight, and cultural background? Has the measure been developed by an expert in traumatic stress and have the reliability and validity of the measure been studied and established?

Detailed information on the measures mentioned above and many other instruments to assess traumatic experiences and responses can be found in Briere (1996a; 1997) , Carlson (1997) , Stamm (1996), and Wilson and Keane (1996). Particular guidance on selecting, administering, and interpreting the results of trauma assessments can be found in Briere (1997) and Carlson (1997) and specialized information on the psychological assessment of adult survivors of child abuse can be found in Briere (1996a, b). With this wealth of newly available information and advice on the assessment of traumatic experiences and posttraumatic responses, it is much easier for clinicians to find the tools to conduct careful, relatively

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# Assessment of Adult Survivors

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rapid, and inexpensive assessments of adult survivors of childhood abuse.


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# Children Who Molest Children

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prevent those that are within a reasonable range of probability. It is also reassuring for professionals to know that they are only expected to act reasonably to protect children in their care. If a child with a documented history of sexually inappropriate behavior is closely supervised, if staff are aware of the potential danger, and if, in spite of precautions taken, the child succeeds in outwitting the safeguards and injures another child, the courts will simply hold the institution to the standard of care of a similarly situated institution or professional under the same or similar circumstances. The measures suggested in this article should provide guidance to professionals regarding current standards of care for the supervision of children who molest children.

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# Call for Volunteers

APSAC is issuing a "call for volunteers" to assist in handling a variety of pre- and on-site assignments for the 1998 National Colloquium in Chicago, July 8-12, 1998. Among the assignments included are: assisting with mailings; handling follow-up telephone calls to registrants; duplicating and collating materials; staffing the registration booth; distributing session materials; collecting evaluation forms; monitoring sessions and other tasks. Based on the time commitment made, it is possible for volunteers — particularly students — to donate enough hours on designated assignments to qualify for Colloquium registration discounts. To sign up for volunteer duty, call APSAC at (312) 554-0166 or e-mail the Conference Manager at APSACEduc@aol.com. See you in Chicago next July!

# CASE CONFERENCE

## The Case: Kim

Kim is a 17-year-old college freshman who was referred to counseling by the university victim advocate. At the intake appointment, Kim reported that she had been involved in a year long relationship with her 45-year-old high school teacher, Jim. The affair began when Kim was 15. Jim is married, and has no history of inappropriate contact with other students. When Kim's parents discovered the affair, they pressed charges and Jim was arrested. Kim was sad and tearful, expressing feelings of guilt and responsibility for Jim's arrest. She reports that their relationship was "completely consensual." She has been told by her parents that if she refuses to testify against Jim, they will take her out of school and force her to return home. She admitted to longterm conflicts with her mother but described a close relationship with her father. Kim is extremely intelligent and articulate and seems to be thriving in the college environment.

With Kim's permission, a telephone conference was arranged between the therapist and Kim's mother. Kim's mother informed the therapist that Jim had been charged with statutory rape, that he is in jail, and that they are currently at the plea bargaining stage. Kim's mother expressed concern that Kim was unable to see the "affair" as a criminal act and described Kim as being "immature" in romantic relationships. Kim's mother expressed a great deal of anger and wanted counseling to help Kim realize she was a "victim."

Kim struggles with her desires to help Jim. She has spoken with several different attorneys and is trying to get information on her legal options. She continues to express her love for Jim and their future plans to marry. She believes that Jim's punishment is excessive, particularly since the relationship was mutual. She is fearful of her parents and believes if she continues to try to help Jim, they will fight for an even harsher punishment.

## Case Response

Judith S. Musick, Ph.D.
The Ounce of Prevention Fund
Chicago, Illinois

**What are the key issues?**

This is a very complicated case, one in which Kim's best interests and those of the legal system may be in conflict. For a psychologist, the central and most critical issue is the need for Kim to understand and work through what really happened. Kim obviously needs to see herself as an active participant in the affair with Jim, rather than a passive victim. Can intervention simultaneously preserve the developmentally positive aspects of her sense of efficacy, while also helping her see the exploitative nature of the relationship, and understand her reasons for becoming embroiled in it?

A second key issue is the underlying motivation for her mother's behavior — the psychological meaning of her anger and insistence that Kim realize that she was a victim. Such a realization may be impossible for Kim under the current emotionally charged circumstances, especially in light of a longstanding troubled mother-daughter relationship.

**How would a psychologist intervene?**

Before any intervention, the first task for the psychologist is to obtain an accurate assessment of the individual and family dynamics in this situation. How did Kim's mother find out about the affair? Did Kim tell her, or in some way "lead" her to find out? What role does Kim's father play in this family drama, directly or indirectly? Could it be that her mother's anger is not simply at this situation, but a response to Kim's close relationship with her father? Does her mother feel that their relationship is, or was, too close? The conflictual nature of Kim's relationship with her mother, and normal developmental striving to become her own person, may mitigate against her doing what her mother requests. Further, is her mother's irate, uncompromising stand actually causing Kim to cling even more tightly to the relationship and her illusions about it? After all, Kim is away at college, and already apart from Jim. In a sense, her mother's harsh insistence continually "brings her back" to him. In all likelihood, she would have moved on with her life at college, finding more age-appropriate love interests. Forcing her to testify against Jim is legally useful, but developmentally and psychologically counterproductive. The ultimate effect may be to increase Kim's sense of guilt because of her perception of the relationship as one of mutuality. She could believe she seduced him by flirting with him, or simply by having a crush on him. The relationship clearly met some important emotional needs for her at the time, including fulfilling her adolescent fantasy of a Prince Charming.

**What other professionals would you attempt to involve?**

A teacher is in a position of authority. Thus, in addition to the legal aspects of this case, Jim's behavior has violated the trust of both individuals and society. Although the appropriate judicial authorities are already involved, it seems clear that Jim needs and should be required to have therapy, no matter what the outcome of the case. It also is clear that Kim's mother could benefit from therapy. Indeed, neither of

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## Kim

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Kim's parents are being empathic to her age and developmental stage by insisting that she testify when she is so much against it, and threatening to take her out of the college setting where she is doing so well. There are a number of intervention options, including individual therapy for the mother, or family therapy for mother and father, with Kim included when she is in town for vacation, or perhaps brought in periodically. Another possibility is conjoint therapy sessions with Kim and her mother, since they have a history of conflict. My recommendation would be that Kim have her own treatment, not with the college counselor, but with a clinician (clinical social worker, psychiatrist or psychologist) who specializes in adolescents and young adults, is skilled in dealing with intimate relationships, and is well-grounded in family dynamics.

**What is the long-range plan?**

In addition to improved family relationships, the goal in this situation is for therapy to enable Kim to sever her relationship to Jim on her own. Then, hopefully, Kim will move ahead, having learned some lessons from the experience, with an understanding of her motivations when she first became involved with Jim, as well as after the affair came to light. What were her earlier motivations? Was the relationship her way of separating from her overly controlling mother? Was she "acting out" her need for autonomy or affection? Why did she feel the need to defend him? What, in short, was her contribution? To be clear about this point, the goal of Kim's therapy is to foster an awareness and understanding of her role in the relationship, but not to encourage self-blame. Unquestionably, Jim was wrong. He should have known better and acted differently. By respecting Kim's rejection of herself in a powerless "victim" role, the therapist accepts the reality of her feelings, and works with her strengths and striving toward autonomy, rather than her weaknesses. In doing this, the therapist promotes maturity and resiliency, and ultimately, a more realistic view of her affair with Jim.

Mother-daughter relations are important throughout life, but have heightened salience in the adolescent years. Even as girls resist, they long for maternal wisdom and standard setting. Many of the teenage mothers I study attribute their early parenthood (and the troubles leading up to it, such as involvement with older men) directly to their mother's lack of caring and guidance. These girls are more vulnerable to being exploited in relationships with older men. With Kim being on the border between adolescence and young adulthood, with a history of unresolved issues with her mother, it would be best if she were not compelled to testify against Jim at this time. The courtroom is not the appropriate venue for resolving developmental and psychological issues. Nor is it the appropriate place to resolve longstanding family conflicts.

# Case Response

Patricia Toth, JD
Former Director, National Center for Prosecution of Child Abuse

As a criminal prosecutor, I would immediately intervene in this situation. I would have no qualms whatsoever about filing this case and pursuing a criminal prosecution for statutory rape against Jim, despite Kim's feelings. There are two specific factors here which greatly concern me as a criminal prosecutor-first, the significant age difference between Kim and Jim, almost 30 years, and further, the fact that Jim was Kim's high school teacher. Both of these clearly signify abuse by Jim of his power and influence as a much older adult, in a position of authority over a more vulnerable child. I view Kim's feelings of responsibility, that the "affair" was completely consensual," and of romantic "love" for Jim, as indications of just how successful of a manipulator Jim was.

Consent is not legally available as a defense in such a case. Statutory rape laws clearly place criminal responsibility for avoiding sexual contact with children on the adult. I would also worry about the threat Jim poses to other children, given his behavior with Kim. If Jim honestly "loved" Kim and wanted to marry her, he could have, and should have, waited to engage in a sexual relationship until Kim was of legal age and no longer his student, and could have, and should have, pursued a divorce with his wife. The fact that he did none of these demonstrates to me that he was plainly and simply sexually abusing her, and taking advantage of her vulnerability. I would prepare for a possible trial, however, given Kim's ambivalence about testifying, I would continue to work toward trying to negotiate a guilty plea, which would avoid the necessity of trial. I would be unwilling to let Jim plead guilty to a lesser charge, or nonsexual crime, but would instead negotiate on the basis of what sentence I would be willing to recommend.

**What other professionals would you attempt to involve?**

Even though Jim has no known history for this kind of inappropriate conduct, I would be very concerned about the risk of his offending against other children. Consequently, before reaching any final agreement about what sentence I would agree to as part of a plea negotiation, I would insist that Jim be evaluated by a competent therapist specializing in the treatment of sex offenders. If the result of this evaluation suggested that Jim was amenable to treatment and conditions could be imposed to insure he was not a threat to other children while being treated, I would be willing to agree to a probationary sentence which would allow Jim to avoid prison if he successfully completed treatment and did not re-offend.

I assume that skilled and sensitive law enforcement investigators would be involved in further investigation of the case, to try to determine more about the

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## Kim

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circumstances under which the relationship between Kim and Jim developed, to identify other circumstantial and corroborative evidence, and to try to find out if there were other victims, as yet unidentified.

Because she has obviously been sexually active, Kim should undergo a thorough and sensitive medical exam, not for the purpose of gathering forensic evidence, but to determine if she is healthy or in need of any medical treatment. Whether the medical exam would yield any relevant evidence for the criminal prosecution would depend on specific findings, such as whether Kim was pregnant, or whether she had contracted a sexually transmitted disease from Jim. Medical evidence simply confirming that she had experienced sexual contact would not be significant, unless Kim's only sexual experiences were with Jim.

Ideally, I would want to see Kim continue in counseling with a mental health professional, to resolve her feelings of guilt and responsibility, and to help her work out issues with her parents. It would be best if Kim's parents were also involved in therapy, so that all three could move forward in a positive way.

I would ask victim-witness professionals to work with Kim, to assist her in dealing with the legal process, so that her decisions were well-informed. If this case did go to trial, Kim would need to be prepared for being called as a witness, and would need to understand that lying under oath or refusing to testify could carry legal consequences.

**What do you see as the key issues in the case**

The key issues from my perspective as a criminal prosecutor are whether or not I could prove this case without Kim's testimony, and whether a jury would feel "sorry" for Jim, based on the claim that this was a "mutual" and "consensual" relationship, and acquit him despite the fact that these are not legal defenses. If Kim lied or refused to testify, I would need some other evidence to prove that sexual contact occurred when Kim was under the legal age of consent, such as testimony from someone else who witnessed it (unlikely), photos or videotapes documenting the activity (if there were any), testimony about what Kim previously said describing the abuse (which would have to fit an exception to the rule against hearsay), and/or any statements Jim made to anyone else admitting the sexual relationship. I would have to explore juror attitudes about "consensual" sexual relationships between adults and teens during jury selection, and then convince them through the evidence and argument that Jim does not deserve to escape criminal accountability for his action in this case.

In addition to pursuing the case as described above, I would like to see public awareness efforts aimed at educating students about the seriousness and criminal nature of sexual activity between adults, including teachers, and teens. This could be combined with information about the criminal nature of non-consensual sexual activity with peers, as well as any sexual activity with younger children. In some communities, police and prosecutors make regular presentations about such matters to local schools. Broad-based public awareness campaigns aimed at the general public, to apprise them of the serious consequences of sexual abuse, should continue.

# Case Response

Lucy Berliner, M.S.W.
(with assistance from Kee MacFarlane, M.S.W. and Wendy Freed, MD)

The mental health professional begins with the frame that the sexual relationship the teacher had with Kim was illegal and exploitative. Prosecution of the crime is proper, but is the domain of law enforcement. The complexity of the case for the mental health professional lies in the conflict between Kim's perspective and that of her parents, and to a lesser extent that of Kim and the legal system. As is always the case with children, it is the parents who give permission to treat and who have legal and moral authority to determine what is in the best interest of their children. Therefore they are clients as well. With adolescents this circumstance is complicated because the interest of adolescents and parents can diverge as a part of the normal developmental process. At the same time, the therapist shares the parents' goal that Kim come to recognize the potentially damaging nature of the relationship.

With respect to Kim's cooperation with the criminal justice process, the therapist maintains a position of neutrality. It is the role and responsibility of the police, prosecutor, and victim advocate to attempt to persuade Kim to cooperate. The therapist may explain the legitimacy of the state's interest in prosecuting crimes and the authority of the law to compel her participation. Because Kim is almost an adult, and adults are ordinarily free to report crimes or not, to cooperate or not, her position on the matter deserves respect. The possible consequences of any decision are explored as part of the therapy.

Although the therapist does not discuss this with Kim, she recognizes that there are potential therapeutic downsides to a vigorous prosecution. In such an instance, Kim, who is still committed to the relationship, will ally with the teacher. To the extent that he loses his livelihood or liberty, he is martyred in her eyes. He becomes the victim. His marriage may be more likely to fail under these circumstance which could promote, rather than undermine, the continuation of the relationship. On balance, while society's interest is served, Kim's may not be.

The most important initial focus of the mental health professional is to establish with Kim and her parents the parameters of the therapy relationship. Is Kim at all willing to enter into a therapeutic process? Will the parents support a therapy with Kim that is confidential? Can the parents accept an outcome that may not be what they would choose? It is unlikely that a genuine therapy can evolve unless accommodation of some degree can be achieved on these basic issues.

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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

### Innovative Program Offers Tailored Treatment Services for Offenders

This article describes a treatment program provided for sex offenders serving a community sentence. This program adapts treatment to meet the needs of clients with learning disabilities and for men who sexually abuse adult women. In addition, a victim-to-victimizer group is run parallel to the treatment group and is offered to clients who were themselves child victims of sexual abuse. Although the long-term effectiveness of tailoring treatment to suit offender characteristics is not known, client and staff feedback has been positive. Because sex offenders are not a homogeneous group, this greater program flexibility may be needed to provide effective client treatment and adequate protection to the public.

**Allam, J., Middleton, D., & Browne, K. (1997). Different clients, different needs? Practical issues in community-based treatment for sex offenders. *Criminal Behaviour & Mental Health 7*, 69-84.**

### Hearsay Evidence Found to Influence Perception of Guilt in Mock Sexual Assault Trials

Two experiments investigated how mock jurors react to hearsay testimony in a case involving child sexual assault. Subjects included male and female introductory psychology students. Subjects read a fictional criminal trial summary involving the sexual assault of a 4, 6, or 14 year old female. Results show that the hearsay testimony was believed to a considerable degree, and that this testimony led to an increase in the perceived guilt of the defendant. Moreover, these results were comparable to those of conditions in which the alleged victim testified. Results are discussed in terms of the psychosocial factors affecting the perception of hearsay testimony in a child sexual assault trial.

**Golding, J. M., Sanchez, R. P., & Sego, S. A. (1997). The believability of hearsay testimony in a child sexual assault trial. *Law & Human Behavior , 21*, 299-325.**

### Are Controversial Techniques Being Taught in Clinical and Counseling Psychology Programs?

This article presents the results of a survey of the directors of 126 American Psychological Association accredited clinical and counseling psychology Ph.D. and PsyD programs. The survey was conducted to determine whether they teach controversial memory recovery techniques for suspected childhood sexual abuse and the controversial technique, facilitated communication. The authors also asked about training in empirically validated treatments. Results show that counseling psychology programs were more likely than clinical psychology programs to teach memory recovery techniques, and counseling programs were less likely to discourage the use of both memory recovery techniques and facilitated communication. More emphasis on research, less on practice, and a higher percentage of behaviorally-oriented faculty were related to less training of controversial techniques. Empirically validated treatments were reportedly taught more in clinical than in counseling psychology programs and in programs that emphasize research and have a higher percentage of behaviorally-oriented faculty.

**Maki, R.H., & Syman, E.M.(1997). Teaching of controversial and empirically validated treatments in APA-accredited clinical and counseling psychology programs. *Psychotherapy, 34*(1) 44-57.**

### Predicting Internalizing and Externalizing Problems Among Sexually Abused Girls

This study examined which of several apparent risk variables were predictors of internalizing and externalizing problems in a sample of 11-18 year old girls referred for therapy after disclosing sexual abuse. The effects of abuse characteristics, support from nonoffending parents, victims' coping strategies, and victims' cognitive appraisals on symptomatology were assessed. As hypothesized, results indicated that internalizing and externalizing problems were associated with different sets of predictor variables.

**Spaccarelli, S., & Fuchs, C. (1997). Variability in symptom expression among sexually abused girls: Developing multivariate models. *Journal of Clinical Child Psychology 26*(1) 24-35.**

## Physical Abuse and Neglect

### Guidelines for Evaluating Possible Physical/Sexual Abuse

These practice parameters describe the forensic evaluation of children and adolescents who may have been physically or sexually abused. The recommendations are drawn from guidelines that have been published by various professional organizations and authors and are based on available scientific research and the current state of clinical practice. These parameters consider the clinical presentation of abused children, normative sexual behavior of children, interview techniques, the possibility of false statements, the assessment of credibility, and important forensic issues. These parameters were approved by the Council of the American Academy of Child and Adolescent Psychiatry in September 1996.

**American Academy of Child & Adolescent Psychiatry (1997). Practice parameters for the forensic evaluation of children and adolescents who may have been physically or sexually abused. *Journal of the American Academy of Child & Adolescent Psychiatry , 36*(3), 423-442.**

### Increased Risk Factors for Suicide Reported in Abused Adolescents

The rate of suicide attempts and the exposure to risk factors for suicide in a sample of physically abused adolescents was compared with those of a control community sample of nonabused adolescents (aged 12-18 yrs). Assessment measures included semistructured and structured diagnostic interviews. Results show that the proportion of subjects attempting suicide did not differ for the two groups. However, abused subjects showed significantly greater exposure to risk factors for suicide, including family disintegration, and diagnoses of depression, disruptive behavior disorders, and substance abuse and dependence.

**Kaplan, S. J., Pelcovitz, D., Salzinger, S., & Mandel, F. (1997). Adolescent physical abuse and suicide attempts. *Journal of the American Academy of Child & Adolescent Psychiatry , 36*, 799-808.**

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## Journal Highlights

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### Other Issues in Child Maltreatment

#### Factors That Foster False Ritual Abuse Allegations

In this article, the authors explore sociocultural, individual, and therapy-related factors that together may be responsible for the creation of ritual abuse allegations. It is concluded that there are serious problems with embracing false ritual abuse claims, and a call is made for more responsible journalistic coverage of issues relating to child abuse, more research to identify factors that contribute to false allegations, and better therapeutic practices to aid people seeking psychological help.

**Bottoms, B.L & Davis, S. L. (1997). The creation of satanic ritual abuse. *Journal of Social & Clinical Psychology 16*, 112-132.**

#### Children Witnessing Domestic Violence

This study provides data on the prevalence of children's exposure to substantiated cases of adult female assaults in five U.S. cities. Results indicate that children were disproportionately present in households with domestic violence and that young children were disproportionately represented among these children. Moreover, these children were exposed to excessive levels of additional developmental risk factors and were involved in the incidents to varying degrees. These findings underscore the importance of establishing a more rigorous interdisciplinary scientific research agenda to inform assessment and treatment efforts for a very vulnerable group of children (i.e., children aged 0-5 yrs) who witness domestic violence.

**Fantuzzo, J. Boruch, R, Beriama, A., Atkins, M. (1997). Domestic violence and children: Prevalence and risk in five major U.S. cities. *Journal of the American Academy of Child & Adolescent Psychiatry 36*, 116-122.**

#### PTSD: Prevalence and Treatment Efficacy Among Various Populations

This article discusses the literature on the prevalence, diagnostic criteria, assessment measures, and treatment of trauma and posttraumatic stress disorder (PTSD). The literature on the treatment outcomes of hypnotherapy and psychodynamic and cognitive-behavioral treatment is reviewed, using a model of an ideal treatment outcome study for PTSD. Issues specific to various trauma populations (such as veterans, sexual assault victims, and childhood abuse victims) and factors that may influence treatment efficacy across types of trauma are also examined.

**Foa, E. B., & Meadows, E. A.(1997). Psychosocial treatments for posttraumatic stress disorder: A critical review. *Annual Review of Psychology , 48*, 449-480.**

## Kim

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Two key issues are readily identified for the therapy: Kim's distorted perception of the relationship with the teacher and the parents' coercive methods for changing her perceptions. The treatment goals are for Kim to see the relationship more realistically and for the parents to learn that their relationship with Kim will be enhanced by a more supportive response. However, since both Kim and her parents appear to strongly believe that their views and actions are justified, a slow and respectful stance is essential.

The therapy with Kim begins with learning how the relationship progressed and what the relationship meant to her. The therapist develops a hypothesis about why Kim was vulnerable to such a relationship and what psychological needs it met. There is a gradual exploration with her of the implications that accrue about the teacher and his intentions. These implications include that he broke the law and violated a professional ethic, that he was and still is married, that there is a substantial developmental disparity which has meaning in terms of his character, his appreciation of her position as his student and a minor, and the nature of any future relationship between them. It is expected that there will be resistance to this understanding and that Kim will suffer a significant loss as insight occurs. A depression is likely to result.

The therapist recognizes that Kim may not be willing or able at this time to fully accomplish this therapeutic task. She may project anger and disappointment on her parents. This is an opportunity to shift therapeutic focus to the family relationships and permit examination of how the parental response reflects either caring gone awry, or underlying conflicts that produced the circumstances under which Kim sought love in all the wrong places. If the latter turns out to be the case, Kim remains vulnerable to subsequent missteps in future relationships.

The manner of addressing the parent reactions, and especially the threat to withdraw support for her college education, is determined in collaboration with Kim. The key is to keep the therapy focused on the meaning and consequences of the parental actions, instead of the relationship with the teacher. A pitched battle over whether the relationship is the real thing will be fruitless and harden their respective positions. If, in fact, the parents' actions derive from a deep concern for Kim's welfare she may be able to develop appreciation for the genuine, if misguided, nature of their response. The parents may be helped to understand that however disturbing the relationship is for them, parent/child relationships are compromised by coercion. On the other hand, it may be revealed that Kim has had long standing resentment about parental expectations and efforts to control her. In a successful therapy, the parents would come to realize that they had contributed, however inadvertently, to the current circumstances.

Ideally, a rapprochement would occur between Kim and her parents. They would become more respectful and supportive of her feelings about the relationship, without approving of it, would refrain from pressuring her regarding the criminal justice system, and would encourage her continuation in college. Kim might then be freed to move forward in her life and be more open to new experiences and relationships that are age appropriate. The therapist's best course of action, no matter what, will be to serve as a supportive presence for Kim so that she will not feel forced into an alliance with the teacher and will have a continuing outlet for her conflicted feelings.

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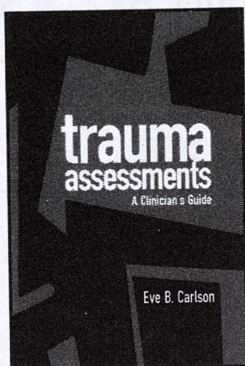


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## APSAC Discounts

**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

**January 27-31, 1998.** ***Responding to Child Maltreatment.*** San Diego, California. Sponsored by Children's Center for Child Protection. For more information call (619) 495-4940.

**February 1-4, 1998.** ***Symposium '98: Building on our Strengths.*** Washington, DC. Sponsored by National Network for Youth. For more information call (202) 783-7949.

**February 25-27, 1998.** ***The Fifth National Child Welfare Conference.*** Arlington, VA. Sponsored by the Children's Bureau Administration on Children, Youth & Families. For more information call (703) 416-4100.

**March 18-22, 1998.** ***19th Annual Nursing Conference on Pediatric Primary Care.*** Chicago, IL. Sponsored by National Association of Pediatric Nurse Practitioners. For more information call Maureen Walker at (609) 256-2300.

**March 25-28, 1998.** ***Celebrating 25 years of Standing for America's Children.*** Los Angeles, CA. Sponsored by Children's Defense Fund. For more information call (202) 662-3593.

**April 2-5, 1998.** ***Prevention '98.*** San Francisco, CA. For more information call Prevention '98 at (202) 466-2569.

**April 13-16, 1998.** ***24th Annual Critical Care Update.*** Las Vegas, NV. Sponsored by National Professional Education Institute. For more information call (800) 573-5575.

**May 28-31, 1998.** ***12th Annual Clinical Meeting.*** Palm Beach, FL. Sponsored by North America Society for Pediatric and Adolescent Gynecology. For information call NASPAG at (215) 955-6331.

**August 4-5, 1998.** ***11th Annual Preserving the Innocence of Children Conference.*** Multi-Disciplinary Conference on Child Abuse and Domestic Violence. Weber State University, Ogden, UT. Sponsored by Child Abuse Prevention Center of Ogden. For more information call Marilyn Sandberg at (801) 393-3366.

**November 16-21, 1998.** ***12th National Conference on Child Abuse and Neglect.*** Cincinnati, OH. Sponsored by the National Center on Child Abuse and Neglect (NCCAN). For more information call (301) 589-8242.

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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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