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AMERICAN PROFESSIONAL SOCIETY ON THE ABUSE OF CHILDREN

IN THIS ISSUE:

PERSPECTIVES

A National Call to Action: Approaching the Elimination of Child Maltreatment

—-David L. Chadwick, MD

Two provocative Perspectives focus on the elimination of child maltreatment in the 21st century

The notion that child maltreatment can be reduced or even eliminated is a relatively new idea. In this "call to action," Dr. Chadwick provides some strategies to move the process forward. After describing some key events that took place in 1998 and 1999, the author suggests that for such an effort to be successful, there must be interdisciplinary cooperation, establishment of an ongoing effort to resolve some of the major problems in the field, and professional consensus about what should be done. 2

Child Protection in The Twenty-First Century

—John E. B. Myers, JD

John Myers has a vision for the future of child protection. His vision calls for prevention efforts to take center stage in the fight against child maltreatment. But, he suggests, three things must happen before prevention can emerge as the dominant approach. First, we must rebuild confidence in our political institutions. Second, we must find new, multidisciplinary leadership that focuses on prevention. Third, and most difficult, we must change society. We must do something about poverty, urban decay, violence, racism, sexism, and selfishness. 6

FEATURE ARTICLES

Forensically Informed Psychotherapy: Balancing Clinical and Legal Perspectives

—Margaret L. Dominguez, PhD

The treatment of sexual abuse is a challenging field. Many therapists may be discouraged from engaging in such treatment, as the stress related to working with traumatized victims is compounded by daunting legal challenges and a threatening social climate. This article is intended to help therapists respond to the current climate in a proactive manner. Areas discussed include the role of the therapist, competence, treatment approach, case management issues, confidentiality, and documentation. 11

Practitioners and Researchers: Two Cultures Collide

—Brenda Walsh, MS, and Judith A. Myers-Walls, PhD

The need for researchers and practitioners to work together is important, particularly when it comes to program evaluation. Both groups want and need to evaluate programs, but their short-term goals and processes are very different. Often, this produces conflict between the two groups and may affect the evaluation process. Drawing on a study in which they participated, the authors provide some valuable insights into the way the two groups think and operate, the conditions to look for when conflict occurs, and some strategies for reducing and resolving conflicts when they occur. 16

Also in this issue:

A National Call to Action: Approaching the Elimination of Child Maltreatment

David L. Chadwick, MD
Director Emeritus
Center for Child Protection,
Children's Hospital
San Diego, CA

The idea that child maltreatment might be reduced or totally eliminated is relatively new and definitely audacious. In fact, the recognition of something called child abuse is new, having emerged in the 19th and 20th centuries. In 1860, Ambroise Tardieu (the father of forensic medicine) described 32 cases of children with injuries related to physical abuse. He also described injuries from sexual abuse. However, his concern that such cases should be identified and their perpetrators punished does not appear to have been widely shared (Tardieu, 1860). His seminal papers were followed by a century of silence. With the "Mary Ellen" case, at the turn of the century, and the medical recognition of abuse of infants and young children, between 1950 and 1960, definitions of abusive behaviors and their effects began to appear. The feminist movement of the 19th and 20th centuries gave substantial impetus to the developing concerns about child abuse (Olafson, Corwin, & Summit, 1993).

John Stuart Mill elaborated the principle that liberty is limited to actions that do not harm other persons (Mill, 1859). In the same essay, he called attention to the problems of abuse in the home and the neglect of children. This philosophy underlies the later laws that aim to protect children and other vulnerable persons from abuse by the persons close to them. A preliminary definition and classification of child abuse was part of the Child Abuse Prevention and Treatment Act of 1974. The four forms that were defined are: physical abuse, neglect, sexual abuse, and emotional abuse. A connection between all forms of abuse and poverty was recognized, however the complexity of this connection has been pointed out by Garbarino (1997).

PURSUIT OF CONSENSUS IN THE PROFESSIONAL SECTORS

As professional and public attention to the problem of child abuse developed, more persons began to regard abusive actions as intolerable and to propose a variety of interventions that might reduce them. Public consciousness and concern about the problem waxes and wanes, but it now seems unlikely to fade to levels that existed prior to 1960. Professional consciousness of the problem continues to grow, although consensus about solutions is not yet at hand. The advent of the "information age" is affecting public and professional attitudes profoundly, but it is difficult to know how these changes will affect the approach to child abuse.

An early step toward the elimination of child abuse is to identify the sets of persons who have concerned themselves with the problem and to determine what these professionals think should be done. At least four professional "sectors" are involved. Because each of these sectors "owns" a piece of the problem at the level of individual cases and at the policy level, the need for interdisciplinary communication and cooperation is immense.

Social Services (and Social Sciences)

Since the passage of the Child Abuse Prevention and Treatment Act in 1974, the Social Services sector has played the dominant role in dealing with child maltreatment. Most of the efforts have been provided through public social services at State and County levels throughout the U.S. The interest of the "State" in the protection of children from abuse has focused on social interventions, and more funding has been provided to this sector than to any other. Social Services rely on interventions that support families in providing better care for their children or which protect endangered children by removal to safer settings.

Justice

The "Justice Sector" includes law enforcement agencies, criminal and civil attorneys, and courts. As most acts of child abuse constitute crimes, Justice plays a major role in dealing with the problems. However, its major focus has been on relatively severe cases of physical and sexual abuse. The role of the Justice Sector has been growing rapidly in recent years as a result of public concern about crime and crime victims. The Justice Sector relies on deterrence to reduce the incidence of actions that society has decided are not tolerable.

Health

The health presence in the field of child maltreatment began with the forensic medical writings of Tardieu in 1860. However, after Tardieu, physicians pretty much ignored the problem until the work of Caffey (1946), Silverman (1953), and Kempe et al. (1962) refocused their attention. Two lines of approach developed:

Personal Health

The personal health approach looks at child abuse cases one at a time. It has provided a rapidly growing medical science and practice for the recognition and forensic medical substantiation of physical abuse, physical and medical neglect, and sexual abuse. Similarly, mental health professionals have focused their efforts on the treatment of individuals who have been abused or neglected. Personal health professionals can recognize abused persons in their care and can prevent some abuse through anticipatory guidance linked to health care. Home visiting programs linked to health care are used in a number of countries and may prevent child abuse.

Public Health

The public health approach concerns itself with the overall effects of abuse on the health of a population and looks for methods of prevention. Scattered efforts to bring this approach to bear on child maltreatment have occurred; however, there is still little activity in the public health field affecting the problem. The need to consider child abuse and other forms of violence as a public health problem has been stated by a succession of Surgeons-General, beginning with Everett Koop and continuing through Jocelyn Elders. The work of Michael Durfee (Durfee, Gellert, & Tilton-Durfee, 1992) in defining child homicide as a marker for physical abuse is exemplary.

Education

Educators can play very significant roles in the attempts to eliminate child maltreatment. Their extensive contacts with children make them a major source of case finding. They are also in a position to contribute mightily to prevention efforts by conveying information about maltreatment to children and their parents.

THE NATIONAL CALL TO ACTION

In 1997, Blair Sadler began to ask leaders in the field about their goals and objectives and about the existence of any national strategic plans. Although many individuals had very well developed ideas, there was no concerted national plan and no concerted effort in place to implement a plan. That such things might actually happen appeared to be an idea whose time had arrived. Following are events that took place in 1998 and 1999.

APSAC Meeting, June 1998, Miami

The idea of the National Call to Action was proposed in a special session at this meeting. Since then, APSAC has had this idea under consideration and has been developing ideas related to its participation.

San Diego Conference, January 1999

The timing of this Conference coincided with a decision by the U.S. Attorney General Janet Reno to enhance national efforts to deal with the problem of Children Exposed to Violence, and Deputy Attorney General Eric Holder opened the Conference with a message about the Attorney General's initiative. This was followed by five major talks about the possible elimination of child abuse, given by distinguished senior experts in the field and summarized by Jocelyn Elders. Twenty organizations that had expressed interest in the process contributed comments about the potential process, and this work has been summarized and is being circulated to a growing list of "seers." Ten action items were endorsed:

- In the public sector, significantly increase the links between social services, justice, health, and education, and dramatically increase the level of funding for prevention, treatment, education, and research.
- In the private sector, invite leaders to create a new organization or coalition of organizations that can effectively coordinate efforts.
- The new coalition should be built from the top down and the bottom up. Successful models, such as the American Cancer Society, should be examined.
- The coalition should create a clear mission statement, a powerful rallying cry, and a clear, multi-year strategic plan.
- The coalition or a lead organization should secure planning and startup funds from major national philanthropies.
- Highly respected, credible, and effective public figures should be identified to lead the effort.
- The efforts of all national organizations should be coordinated through the new coalition.
- Major national meetings of sponsoring organizations and the National Summit on Children Exposed to Violence should be systematically used to advance the agenda.
- Many key organizations should formally endorse the effort.
- A first, detailed action plan for the amelioration of child maltreatment should be presented at the San Diego Conference in January 2000.

Publication of Proceedings

The Proceedings of the Call to Action from the 1999 San Diego Conference was published in October 1999 in *Child Abuse and Neglect.* A special issue of the Journal devoted to this topic records much of the thinking that developed up to that point (Chadwick, D.L.,1999).

ESTABLISHMENT OF AN ONGOING EFFORT

Early in 1999, Anne Cohn Donnelly formally joined the effort and has since been engaged in the process of developing a professional consensus around what needs to be done. Central to this effort is the idea that child

continued on next page

maltreatment deserves the same sorts of approach as that provided for cancer, heart disease, and other major health problems.

Identification of Major Issues

A number of major issues will require resolution before we can seriously discuss the elimination of child maltreatment. A partial list of these follows.

Better Definitions and Better Measurement: What Do We Wish to Eliminate (or Reduce)?

The National Research Council identified the problem of definitions in 1993, and it remains unsolved in 1999. At present, it is still almost impossible to determine if the problem of child maltreatment is changing for better or for worse. Small or moderate changes in incidence or prevalence are not currently detectable. This is a problem requiring immediate attention by public health and the social and justice sciences. The problem of serious reduction simply cannot be intelligently addressed until definitions and measurement instruments are in place. Whereas, the counting of reported cases of child abuse probably must continue as an administrative tool, it is not sufficient as a way of measuring our progress. Survey techniques (Strauss & Kantor, 1987) consistently yield much higher rates of all forms of violence than do studies that count reported cases, however they are not utilized by public agencies to judge performance and trends. Health-generated definitions for serious physical abuse could also be developed and utilized if and when public health becomes seriously concerned with the problem.

Child Maltreatment and Other Forms of Family Violence

The co-occurrence of child maltreatment and violence affecting other family members has been noted frequently. The question then is whether child abuse can be eliminated without addressing other forms of family violence in a unified manner. Each form of violence now has its own constituency, and approaches are often competitive. Although the barriers between these professional sectors are significant, programs addressing more than one form of family violence are emerging.

Absence of a Popular Constituency

Unlike cancer, which shortens the lives of enfranchised adults, persons harmed by child abuse are disenfranchised children who often are abused by those who should protect them. Although adult survivors and supportive family members exist in large numbers, they have not generally organized themselves in a politically effective manner. This is a problem in need of early attention. Elected governmental officials are unlikely to do much if their constituents are generally indifferent to the problem. The "critical antecedents" described by Krugman (1999) as essential to effective political action cannot develop without more popular support.

The Roles of Professional Sectors: Whose Job Is It?

Multidisciplinary teams working on cases at the local level often develop very effective methods for the division of labor, but there is no national guideline that defines the role of the sectors. Somehow, this approach must be adopted by the states and by national government. The funding streams going to Social Services, Justice, Health, and Education must be blended and focused on the problems of child abuse and other forms of family violence. This probably cannot happen quickly, but the enabling policies that will bring about joint efforts must be established promptly. The answer to the question, "Whose job is it?" is "Yes!".

Can We Speak With One Voice?

A closely related issue is that of developing statements of "fact" and of policy and practice that can be agreed upon by all the professional sectors. If we cannot achieve better consensus within the "field," we are unlikely to succeed in a major national effort to eliminate the problem. For example, the question about the allocation of resources for the primary or secondary prevention of various forms of abuse versus those for punishment or repair after the fact of abuse is likely to generate considerable disagreement. And, this is just one of many questions. Here again, the answer to the question "Whose theory is best?" is "Yes!" Although, ultimately, ineffective approaches must be abandoned, our past measurements of effectiveness do not permit quick conclusions about what the best approaches are.

What Sort of Vehicle Could Carry the Process?

There is an immediate need to develop an organization that can carry on the process. Clearly, this cannot be a single hospital or any other single service-providing agency. The entity must have a very broad base of support.

Existing Organizations: Existing candidate organizations include those with broad missions and broad support, such as Prevent Child Abuse America and APSAC; however, an even broader base than either of those possesses may be needed.

A Possible New Business Entity: The necessary vehicle must be like the fabulous "One-Hoss Shay" of Oliver Wendell Holmes in that it is constructed to run for a very long time, but it must also be capable of carrying a huge

variety of individuals and organizations whose support and thinking will be essential in getting the job done. Thus, both durability and capacity for diversity are important.

Public and Private Ownership: It is inconceivable to consider the elimination of child maltreatment without involvement of the public entities that represent the State's interest in the protection of children, the integrity of families, and the enforcement of laws against abuse. Specifically, both public social services and all public components of the Justice sector must remain involved. A new not-for-profit corporation may be the best solution.

What Will It Cost?

Without a clear view of the size of the problem, the cost of solving it cannot be determined. However, the costs of not solving it must also be estimated, and this also requires better definitions and methods than what is currently available. In addition, costs must be discussed in terms other than just dollars. Some calculus that deals with the price of pain must be put into place as we approach this issue.

How Long Will It Take?

This question can only be answered when we have decided exactly what we intend to eliminate or reduce, but surely it will take some time. Expectations for quick success are likely to lead to disappointment and abandonment of the effort. Still, if we use our best brains and make a serious effort, we should be able to produce perceptible change. In fact, as deMause has pointed out (deMause, 1974), it is likely that things are better already if we take a long view of human history.

APPROACHING CONSENSUS

Utilizing a "Delphic" approach to consensus-building, Ann Donnelly and others will attempt to deal with these and other issues that affect our approach to the elimination of child maltreatment. Some of the issues, such as determining the essential vehicle, must be settled quickly. Others, such as definitional processes, will require at least two years to accomplish once they are properly launched. Existing best practice guidelines will need to be utilized and updated, as new information becomes available.

As the process progresses and when the new entity comes into existence, it will be essential to build solid systems for document management and consensus development. Without such a capability, the likelihood of informational chaos is high. The process could bog down in an information swamp.

APSAC AND THE NATIONAL CALL TO ACTION

The National Call to Action provides a number of opportunities for APSAC and simultaneously poses a number of questions. APSAC could consider stepping forward and becoming the central organization in the initiative, or it could work toward the development of a new entity. It could foster the primary role for an existing organization, such as the National Child Abuse Coalition or Prevent Child Abuse America. The most important and the most difficult task along the road to elimination is that of developing a professional consensus about what should be done. It is difficult to imagine this consensus occurring without major work by APSAC Committees and its Board of Directors. The Officers and the Board are likely to be grappling with these questions during the months to come, and input from members is important. This is a time when ideas can have a major impact.

A NEW NAME FOR THE PROCESS

The term "National Call to Action" should be replaced soon. It is great for the launch, but probably not so good for the long trip. Whether a new not-for-profit corporation is formed or an existing organization steps up to take charge of the process, both the entity and the process should be renamed to express the concepts involved in the mission—which is to greatly reduce the incidence and prevalence of maltreatment of children and other vulnerable persons.

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Child Protection in the Twenty-First Century

John E.B. Myers, JD
University of the Pacific, McGeorge School of Law, Sacramento, CA

What is the future of child protection? It is certainly simpler to look back in time than to gaze into the future. Yet, we want to know what the future holds. We want to know whether the years we have dedicated to child protection have sown seeds of hope. I offer you one person's vision of child protection in the 21st Century. To make this vision clear, however, we need to delve briefly into the past.

You may not remember the tremendous national fear caused by polio between 1942 and 1953. Once a child contracted polio, a virus that causes varying degrees of paralysis, parents and doctors could do little more than wait while the virus did its destructive and, sometimes, deadly work. Treatment consisted of helping children cope with their paralysis. There was no cure. However, dramatic changes occurred when vaccines were created; our approach to polio was transformed from one of treatment to one of prevention. Just as prevention was our salvation from polio, so too must ***prevention*** be our salvation from child abuse. Although prevention plays a role in today's response to child abuse, it must move closer to center stage if we hope to make real progress.

Before we reshuffle our approach to child maltreatment, however, we must assure ourselves that the present system—which reserves center stage for reporting, investigation, and legal intervention—needs fixing. The old saying is: "If the wheel ain't broke, don't fix it." If the child protection wheel ain't broke, let's not fix it.

I have great respect for the professionals in child protection. The current system saves children every day. However, if our goal is prevention, the present system will not work. As reported by the U.S. Advisory Board on Child Abuse and Neglect, "the system that is intended to help and protect abused and neglected children does little to mitigate the nightmare. Instead of emphasizing prevention of maltreatment, America's child protection system usually steps in when damage has already been done. We devote massive resources to investigate allegations and precious little to assist at-risk families and prevent child maltreatment from taking place. By stressing investigation over positive assistance, the child protection system may actually be increasing the possibility of maltreatment in some high-risk cases. The bottom line is that the child maltreatment crisis in this country is not being alleviated. It is worsening" (1993, pp. viii-x).

This is a sobering indictment. Rather than depress us, however, the Advisory Committee's report can serve as a catalyst for change. The child protection wheel is indeed broke and needs to be fixed. Repairing the wheel will not require us to abandon our values or commitment. Indeed, our values and commitment are essential to facilitate the three things that must happen before prevention can take center stage.

We Must Become Less Cynical About Our Government

First, we must work for a time when Americans are less cynical about their government. Lisbeth Schorr writes that "an unprecedented cynicism about the capacity of government to help solve our most serious social problems is casting a terrible pall over our national life. The collapse of confidence in our political institutions and the rampant antipathy toward government that emerged in the mid-1990s represent perhaps the greatest obstacle to the development of strategies to bring all children and families into the American dream" (1997, pp. xv-xvi). Pervasive cynicism of government is not inevitable. There have been times when government inspired people, when the best and the brightest went into government to make things better. Such times can come again. Renewed confidence in government *must* occur to make real progress in child protection. The government is often wrong. Nevertheless, when government is working at its best, that is, when the *people* in government are working at *their* best, the government does solve problems, as demonstrated by our civil rights and environmental laws and by the many ways government improves our lives. The government's inspirational values of child protection are another example: protect children, strengthen families, and build a brighter future. Thus, the first thing we must do to move forward into the 21st century is to rebuild confidence in government.

We Must Identify and Support New Leadership

The second requirement for real progress is new leadership. We have many great leaders in child protection. However, these leaders have much in common with Edward J. Smith, the captain of the *Titanic*. They are captains of a sinking ship.

We need a new vision of leadership. As Bennis points out, leadership is not the same as "managership." "Leaders are people who do the right thing; managers are people who do things right. Both roles are crucial, but they differ profoundly. American organizations are underled and overmanaged. They do not pay enough attention to doing the right thing, while they pay too much attention to doing things right" (1989, p. 18).

Where will we find new leadership for child protection? Don't look for answers in the literature on child abuse. Instead, delve into the literature on leadership, which is rich in ideas for child protection. Two excellent books are: Bennis's *Why Leaders Can't Lead: The Unconscious Conspiracy Continues* (1989) and Kouzes and Posner's, *The Leadership Challenge: How to Keep Getting Extraordinary Things Done in Organizations* (1995).

Kouzes and Posner describe five fundamental practices of exemplary leadership: challenge the process, inspire a shared vision, enable others to act, model the way, and encourage the heart. Some discussion here of one of these practices—challenging the process—may be useful. Leaders have a vision for the future, and, in most cases, that vision involves change: challenging the status quo, shaking things up. Kouzes and Posner remind us that "Without change, organizations and movements die." Without change, child protection may lose its vitality. Yet, child protection is a cumbersome bureaucracy, staggering under labyrinthine rules and procedures. Although rules and procedures are necessary, they often multiply to the point where creativity and flexibility are restricted. Schorr writes that "We are so eager . . . to eliminate the possibility that public servants will do anything wrong that we make it virtually impossible for them to do anything right" (1997, p. 70). The leadership we need is leadership to transform child protection while, at the same time, preserve the rules and procedures that are necessary for stability and efficiency.

Where will these leaders come from? If prevention is the best hope, primary leadership is unlikely to come from lawyers. Although we need strong criminal and juvenile courts to protect children, the legal system is useful primarily *after* abuse has occurred. Like the iron lung for polio, it is palliative, not preventive. How about doctors, nurses, and mental health professionals? Each of these professionals has a key role in moving prevention to center stage. However, doctors and nurses cannot play a leading role until they respond to child abuse and neglect as public health problems. Mental health professionals and social work leaders must focus on prevention as well. All of these professions must change their primary focus from after-the-fact treatment to before-the-fact prevention.

None of the professions appear to be equipped by training, experience, or dominant paradigm to provide the leadership we need. But there is hope. The answer to our need for new leadership has three facets. First, we must open ourselves to new paradigms. Second, we must support leaders who want to change the system, who want to fix the wheel, or maybe throw the old wheel in the scrap heap and start all over again. The third aspect relates to our approach to problem solving. Each profession has a role to play in moving us into the 21st Century. To move prevention to center stage, we need multidisciplinary leadership.

We Must Change Society

The third challenge is by far the most difficult. If we are serious about reducing physical abuse and neglect *we must change society*. The rate of physical abuse and neglect is closely tied to poverty and the quality of life in neighborhoods. In his classic essay *Child Abuse and Neglect: The Myth of Classlessness*, Leroy Pelton (1978) wrote that "there is substantial evidence of a strong relationship between poverty and child abuse and neglect. …Abusing and neglecting families are the poorest of the poor. …Poverty is not merely 'associated' with child abuse and neglect; there is good reason to believe that the problems of poverty are causative agents in parents' abusive and neglectful behaviors and in the resultant harm to children" (pp. 24, 28, 33). Anyone who thinks we can make real progress against abuse and neglect without first doing something about poverty, urban decay, violence, racism, sexism, and selfishness is simply fooling himself. Creating a vaccine against polio may be simple compared to creating a society that is safe for children. In the final analysis, however, a safer society is the only real hope.

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A version of this paper was presented on September 24, 1998, at the Sixth Oklahoma Conference on Child Abuse and Neglect, Oklahoma City, OK.

Erratum

In the Perspective "Comments on the Rind et al. Meta-Analysis Controversy" (v.12, n.3), the authors reported a calculated effect size of 0.12 for the data provided by Carlin on smoking and lung cancer. The correct figure should have been 0.17.

LETTERS TO THE EDITOR

To The Editor:

We need a National Center for the Study of Child Maltreatment—and we need it now. It cannot wait any longer to become a reality. Right now there is a window of consciousness in our society, resulting from the severe outbreaks of public violence that are not just part of inner city distress. People understand that it is not just adults who are violent, and not just disenfranchised minorities. It is children, any of our children, who might express their distress explosively. Violence has spread to middle class America and focused our national attention. It is time to put the weight of our professions together—counselors, therapists, clinicians and mental health researchers of all persuasions—and create a National Center for the Study of Child Maltreatment.

Do you use EMDR, cognitive therapy, play therapy, or psychodynamic therapies? Why? For a given population, do you know which one will work best? No, nobody has done that research. What is the natural history, over a generation, of childhood sexual abuse that is untreated? You don't know? Nobody has done that work either. You see children in your practice who have been traumatized. Perhaps you also work with adults who were traumatized as children. What is trauma, what is it that is really traumatic? Why do some people get PTSD and not others?

I don't need to belabor this point. I know you get it. But, how often do you ask yourself if the treatment you provide has been studied for its efficacy, in double blind controlled case studies with cross-cultural and geographic factors included? I don't even like to think about that question. I have too many patients to treat to be bothered with that consideration. Well, who is bothered while I am doing my clinical work? What kind of funding do they have? What kind of results can we expect clinically when funding for longitudinal studies is nearly nonexistent and pilot studies go undone for lack of funding, as well! We are flying anecdotally, if not blind!

What would a National Center for the Study of Child Maltreatment add to our field and to our society? It could provide better peer review of grant funding, coordinate multi-site studies, integrate federal efforts across agencies, build a services and research infrastructure, and act as a multi-modal source of information and education for clinicians, social scientists, and the judiciary. There is a lot of work going on and more that needs to be done, and there is a real danger of not funding the basic research that teaches us about the natural history of disorders. With funding so short in general, we dare not undermine our efforts with studies that duplicate rather than build on each other.

I invite APSAC to work with the other national and international organizations, such as the International Society for Traumatic Stress Studies, the American Academy of Pediatrics, amongst others, all dedicated to eliminating the horrors of child maltreatment and its consequences from our society, and to develop the intellectual framework for a National Center for the Study of Child Maltreatment. What can you do? Let me know you want to help! Let the leadership of APSAC know that you want to make this project a priority. Tell them you want them to put aside turf issues and work with other professional organizations to make a National Center for the Study of Child Maltreatment a reality. Meet with your Senators and Representatives, and tell them that we are not doing enough to uncover the roots of violence or the sources of healing for children caught in the social meat-grinder of our too violent and neglectful society. Tell them to talk to the Secretaries of HHS and DOJ and anyone else they know and ask: Why doesn't a National Center for the Study of Child Maltreatment exist? And don't let them fall prey to the notion that if we map the human genome, that will fix everything with "genie-cillin" just a test tube away.

I am not saying we have done or are doing nothing. I am saying that there is a historic opportunity to move ahead and achieve something we've never had—a fully funded public/private agency with the clout to do what needs to be done to get us where we all know we need to go. Speak up! Add your voice to mine! There's a lot to do.

Richard A. Chefetz, M.D.

The National Center for the Study of Child Maltreatment
Washington, DC, email: chefetz@erols.com

Editors of the APSAC Advisor welcome your letters! Appropriate topics 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 *dwhitcomb@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 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 to be considered for publication.

Thomas L. Birch, JD, Legislative Counsel, National Child Abuse Coalition, Washington, DC

CONGRESS PASSES HHS MONEY BILL

Before adjourning for the year, the House and Senate passed a consolidated appropriations bill covering funds for the bulk of federal agencies, including the Department of Health and Human Services (HHS). After eight continuing resolutions and much negotiation between the White House and Congress, HHS funding escaped the deep cuts predicted at the start of the process, earlier in the year. In the final bill, sent to the White House after Senate passage on November 19, most children's programs received some increase or continued funding at the 1999 level.

Funds for the Child Abuse Prevention and Treatment Act (CAPTA) discretionary grants got a $4 million increase, while funds for state grants and community-based family resource and support prevention grants remained at the 1999 levels. For the first time in three years, the House subcommittee did not zero out dollars for a single CAPTA program. In the past two years, both the discretionary grant funds and the community-based family resource support have faced elimination in the House bill.

A notable loss of funding occurred with cuts to the Title XX Social Services Block Grant, which is set in the final bill at $1.775 billion, down from $1.909 billion in 1999. In recent years, the Social Services Block Grant has been vulnerable to congressional budget cutting. In FY97, when Title XX received $2.5 billion, the states used more than 27% of their Title XX allocation to provide child welfare services in the areas of prevention and child protection.

The budget for the National Institutes of Health – the big winner in the HHS spending legislation – ended up with an overall increase of 15 percent. The institutes that collaborate to support child abuse and neglect research share in that funding growth. None of these figures reflect an across-the-board cut of 0.38 percent in spending, which the Republican leaders enforced on the bill as a means of meeting spending limits without going into Social Security reserves.

CAPE ACT PASSES HOUSE AND SENATE

A month after passage in the House, the Child Abuse Prevention and Treatment (CAPE) Act (H.R.764) passed the Senate, on November 19, and went back to the House for final approval. With time running out at the end of the session, the House did not get to a vote on the measure before adjourning for the year. It will be up for passage by the House when Congress reconvenes in late January.

On October 19, Sen. Mike DeWine (R-OH) with the cosponsorship of Sens. Patrick Leahy (D-VT) and Herb Kohl (D-WI) introduced S. 1750, identical to H.R.764 passed by the House on October 5. The bill, passed by the House of Representatives with a vote of 425-2, was an amended version of the measure originally introduced by Rep. Deborah Pryce (R-OH) and cosponsored by 54 Members of the House. The legislation addresses the protection of children and the prevention of child maltreatment in three ways:

- Provides child protection workers and child welfare workers with access to criminal conviction information and orders of protection, based on claims of domestic violence or child abuse.
- Expands the use of the Byrne law enforcement block grants to improve the enforcement of child abuse and neglect laws, and to support child abuse prevention programs.
- Allows additional dollars from the Justice Department's Crime Victims Fund to be used by HHS for Children's Justice Act (CJA) grants in CAPTA, by providing that half of any increase in the Crime Victims Fund above the 1998 level of $363 million will be shared with CJA, up to a total of $20 million, while guaranteeing a minimum of $10 million, as currently allocated.

Rep. Bill McCollum (R-FL), chair of the Judiciary Subcommittee on Crime with jurisdiction over the bill, offered a noncontroversial amendment on the floor as a substitute bill, which was agreed to by unanimous consent. McCollum's amendment made two changes in the original bill.

- First, the funding for the authority giving CPS workers access to criminal justice information was changed from a Department of Justice program, which funded equipment and training for closed circuit television and videotaping of the testimony of children in criminal child abuse cases, to the recently enacted Crime Identification Technology Act, which supports the upgrading of criminal justice record systems.
- Second, the formula for increasing the CJA share of the Crime Victims Fund was changed from a flat increase of $10 to $20 million. Instead, CJA would receive half of any increase in the fund above $363 million, up to a total of $20 million, with a guarantee of $10 million.

McCollum explained: "Victims' rights groups oppose doubling the earmark. In fact, they are not enamored with the earmark to begin with. My amendment offers an alternative to the straight doubling of the earmark."

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POLICY WATCH

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Two other amendments to the bill were adopted on the House floor:

- Rep. Sheila Jackson-Lee (D-TX) offered an amendment to add child sexual abuse (as a way of underscoring attention to the issue) in the sections that provide for the sharing of criminal justice information and expanding the use of Byrne grant funds.
- Rep. Stephanie Tubbs-Jones (D-OH) introduced an amendment guaranteeing the share of Crime Victims Fund money to CJA, even if the Crime Victims Fund is ever capped.

SENATE HEARING ON RLPA

Although the Religious Liberty Protection Act has been ready for a Senate floor vote since it passed the House on July 15, no action has been taken on the bill, despite a promise by Senate Majority Leader Trent Lott (R-MS) that the bill was on his priority agenda list.

The efforts of the National Child Abuse Coalition, along with others, to call attention to concerns about the safety of children put in jeopardy by the proposed Religious Liberty Protection Act, H.R.1691 appear to have proven productive. At a hearing on the bill on September 9, members of the Senate Judiciary Committee expressed reservations about the bill's consequences and objections to expeditious action on the legislation.

Prior to the hearing, a letter signed by 12 organizational members of the National Child Abuse Coalition—including APSAC—was sent to each member of the Judiciary Committee, explaining problems the bill would create and calling for an amendment to exempt programs for the protection of children.

At the hearing, Sen. Patrick Leahy (D-VT) cited the coalition's letter and described cases in Vermont in which religious beliefs had been raised to the detriment of children. Leahy called for additional hearings to examine the bill's unintended consequences. Sen. Russ Feingold (D-WI) urged caution on the bill, referring to concerns about the safety of children and women, saying that religious beliefs could be used, under the bill's protection, to justify child and spouse abuse. Feingold, like Leahy, called for more hearings, specifically to hear from child advocacy groups, and a full committee markup of the bill. Feingold said that he will object to floor action before the committee had a chance to examine the bill thoroughly, implying that he might choose to put a hold on the bill. The hearing presented a panel of witnesses: three university law professors and a specialist on religious legal issues.

On October 25, a panel of individuals representing an array of interests opposed to the bill sponsored a briefing for Senate staff to discuss policy concerns raised by the legislation. Marci Hamilton, law professor at Emory University and Yeshiva University, who successfully argued the Supreme Court case overturning the earlier Religious Freedom Restoration Act, chaired the panel presentations. She called RLPA "a widespread social phenomenon" being pushed in all 50 states, advising that "faith healing groups are lobbying for this law in states to avoid prosecution and civil damages."

Barbara Woodhouse, University of Pennsylvania law professor and co-director of the Center for Children's Policy Practice and Research, described the legislation's unintended consequences for child safety. She warned that the bill would have "an enormous impact…on the framework of dealing with children at risk of abuse" by requiring changes in the standards and processes for investigation and protection.

Other panel members representing groups that also oppose the legislation included the National Trust for Historic Preservation, the National League of Cities, the National Home School Legal Defense Association, and the American Correctional Association. Several groups originally backing the legislation have pulled their support from RLPA, including the ACLU, People for the American Way, the National Council of Churches, the National Council of Jewish Women, and Americans United for Separation of Church and State. The NAACP also opposes the bill.

HHS REPORT: CHILD MALTREATMENT 1997 (NCANDS)

HHS has distributed copies of its most recent survey of child abuse reporting information, "Child Maltreatment 1997: Reports From the States to the National Child Abuse and Neglect Data System (NCANDS)". The report details information released by HHS in April 1999, in an abbreviated format, finding that 984,000 children were the victims of abuse and neglect in 1997, of almost 3 million children reported for alleged maltreatment. The national rate of victimization was 13.9 per 1,000 children.

In addition to NCANDS data collected annually, the 1997 report includes findings required by the 1996 amendments to the Child Abuse Prevention and Treatment Act. Among the results reported are the following:

- More than half of all victims (56%) suffered neglect, 25% physical abuse, 13% sexual abuse, 6% emotional abuse, 2% medical neglect, and 11% some other form of maltreatment. Infants were the largest single-year age group of victims (7%).

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Forensically Informed Psychotherapy: Balancing Clinical and Legal Perspectives

Margaret L. Dominguez, PhD
Licensed Clinical Psychologist,
Santa Monica, CA

In today's climate of controversy and litigiousness, mental health clinicians face an anxiety-provoking dilemma: how to provide the services that initially led them into the field, while protecting themselves and their clients from risks related to today's complex legal and ethical issues. A task force created by The American Psychological Association to explore the impact of the legal climate on clinicians found that lawsuits have had a "chilling effect" on therapists (Seppa, 1996). Some clinicians respond by practicing "lawsuit therapy," attempting to minimize the chances of being sued by carefully screening words and actions, or avoiding certain kinds of cases altogether. Unfortunately, the cases avoided are, too often, those most in need of assistance. The treatment of family violence, particularly child sexual abuse, has been significantly affected by the current climate.

Although it is not necessary to hold a law degree in addition to clinical training, there are some valuable insights to be gained from the legal/forensic perspective, which can assist clinicians in providing legally and therapeutically sound services. This article is intended to help therapists consider how legal issues may affect and inform their clinical practice. Whereas the focus is on the treatment of issues related to sexual abuse, many of the concepts may also apply to more general cases. Forensic interviewing and evaluation, however, require specialized training that is not within the scope of this article (for further information, see Guidelines published by APSAC, 1995a; the Committee on Ethical Guidelines for Forensic Psychologists, 1991; the American Psychological Association, 1994; the American Academy of Psychiatry and the Law, 1989).

The following areas will be discussed in this article: role of the therapist, competence, treatment approach, case management issues, confidentiality, and documentation. The discussion of these areas is intended to stimulate thought, not to be held as a standard without room for exceptions or flexibility on the part of the therapist.

Therapist Role

The most important task in conducting forensically informed psychotherapy involves understanding the role of the therapist. There is an inherent conflict in trying to function as both the therapist and the investigator (Greenberg and Shuman, 1997; Deaton and Carsel, 1995a,b; and APSAC, 1995a,b). The role of the therapist is to form a therapeutic alliance with the client, allowing the symptoms and concerns of the client to be addressed by providing an atmosphere of support and acceptance. Deaton and Carsel (1995a) point out that therapists cannot also be impartial investigators, as they are not trained in investigative techniques, and the role of investigator would "interfere with their ability to provide a supportive healing environment to victims (p.3)." In fact, a therapist's efforts to investigate allegations could compromise the investigation by legal agencies.

In addition, the sources of information in therapy versus those in an investigation or forensic evaluation are very different. In contrast to the multiple sources of information obtained by an investigator on a fact-finding mission, the information a therapist obtains is primarily from the client. Even when collateral information is sought out, the therapist may do so only with consent of the client, and the information is sought to inform the treatment plan, rather than to confirm or invalidate the client's report. The APSAC (1995b) statement on therapist roles specifically notes that "clinicians whose work with a client is confined to therapeutic services are not obliged to seek corroboration of a client's account."

A guiding principle is that the therapist is not investigating the case, and it is, therefore, not within the therapist's role to make a determination regarding the veracity of allegations.

Therapists must remain firm in their role, despite requests from others to make judgements or recommendations that fall outside that role. For example, a children's social worker or judge may ask or order that the therapist make a judgement on whether a child has been abused, or whether visitation with an alleged perpetrator should occur. It is within the role of the therapist to provide information that has emerged in treatment, assuming the applicable consent has been obtained, or in cases where there is a legal and ethical obligation to do so. The therapist can describe disclosures and can identify symptoms that may be related to or consistent with alleged sexual abuse. As discussed below, it is important not to make direct causal assumptions regarding symptoms, or to define symptoms as exclusively reflective of sexual abuse or trauma. A guiding principle is that the therapist is not investigating the case, and it is therefore not within the therapist's role to make a determination regarding the veracity of allegations.

Similarly, the therapist is not evaluating all family members, and, therefore, would be generally unable to make recommendations regarding the appropriateness of reunification or visitation. Therapists may be asked to broaden their role, such as monitoring a visit and then making recommendations. However, those who are tempted to make such recommendations jeopardize their therapeutic alliance with the client. For example, the therapist's opinion may not be similar to that of the

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client, or a recommended course of action may result in problems (a child who wishes to reunify with a family is not returned home, or a child is revictimized during a recommended visit). The client, then, is left to cope with the resultant problems, without the support and safety of an independent therapeutic relationship.

An exception regarding therapist recommendations is related to the victim's expressed wishes. If a child has communicated information relevant to visitation—either fear of the alleged perpetrator or a desire to visit—the therapist can and should communicate this information to the social worker and/or court (again, with appropriate consent). While the therapist is providing relevant information, the decision-making remains in the jurisdiction of the court or child protection agency. Alternatively, a team of therapists or family preservation workers who work with all family members may collectively have enough information to make appropriate recommendations.

Competence

Ethical guidelines of all mental health disciplines require clinicians to function within their scope of competence. This is particularly true for treatment of child sexual abuse and adult victims of early abuse. Such cases may not be recommended for trainees or interns, particularly in legally complicated circumstances, or should be undertaken only with close supervision by experienced professionals. Licensed clinicians should seek out regular consultation from other professionals as well as ethics and legal committees, as appropriate, to ensure that the highest quality of care is being provided and that legal issues are being properly addressed.

Clinicians must be knowledgeable regarding mandatory reporting guidelines, as well as community standards regarding the provision of care and interaction with other disciplines and agencies. Clinicians should also make their clients aware of these issues as part of their informed consent process when beginning treatment.

Continued education and training to keep abreast of new developments in the field is imperative, as is being able to demonstrate an understanding of both sides of difficult or controversial issues. For example, the research regarding children's suggestibility illustrates the benefit of understanding both sides of an issue. Defense attorneys have used the work of researchers, such as Ceci and Bruck (1993), Leichtman (1995), and Loftus (1993), to argue that overzealous investigators, fanatical therapists, or disturbed parents (usually mothers) have suggested or implanted false memories of abuse in both children and adult clients. Recent court cases show that such arguments are being used successfully, with therapists being held liable for damages to clients as well as to third parties, including the accused perpetrators.

The suggestibility research provides useful information about the manner and circumstances in which people may be easily suggestible, such as when there is weak memory of the event, or if the questioner is seen as intimidating or already having knowledge of the event (see review by Reed, 1996). Informed therapists can incorporate these findings into clinical practice, for example, by not giving the impression that they already know about alleged abuse, by giving the client permission to say "I don't know" and to correct the therapist, and by avoiding the use of certain types of questions (for example, forced choice questions, repetitive questions). The informed clinician who is confronted about a treatment approach can address the limitations of the research, describing how research methods differ from the process of therapy and, thus, may not be directly applicable. It is important to note that the suggestibility research shows that recantation of true allegations is as much a risk as the creation of false accusations.

Therapists should rely on treatments that are empirically derived or are generally accepted by the profession (Knapp and VandeCreek, 1996). For example, cognitive-behavioral techniques to reduce post-traumatic stress symptoms have been found to be effective (Foa & Rothbaum, 1998), whereas the use of such techniques as age regression and body work has been questioned (Knapp and VandeCreek, 1996). Maintaining awareness of legal developments and liability issues helps ensure that therapeutic boundaries and methods of treatment meet professional standards of care.

Treatment Approach/ Case Management

In general, the treatment approach for the therapist dealing with an alleged victim of sexual abuse, whether child or adult, is to maintain a neutral, unbiased stance in approaching the case.

For cases in which there is more than one victim, it is recommended that a separate therapist sees each client, and that the therapists do not discuss the details of the allegations with each other. For general treatment cases, it is often clinically indicated to have separate therapists for individual clients to maintain impartiality and confidentiality and to allow clients to avoid feeling that they are "sharing" their therapist. There are additional legal concerns in cases of child sexual abuse. A major problem in the McMartin preschool case (People v. Buckey, 1990) and other multiple-victim cases was the use of staff to interview and treat multiple victims, lending fuel to the argument that the interviewer/therapist was contaminated by knowledge of other allegations and suggested the abuse across victims.

Therapists generally do not determine the veracity of sexual abuse allegations or reports by clients. However, that is not to say that therapists do not offer professional support to clients struggling with these issues. Alpert (1995) describes a number of criteria that clinicians can use to explore the sexual abuse hypothesis, including the presence of different types of validation, establishing the alleged perpetrator's character and opportunity to abuse the victim, the victim's recall of

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details of the abuse, the victim's initial sense of strong conviction that he/she was abused, coping strategies including shutting down or out, inappropriate behavior, issues around reality testing including disturbed relationship to his or her body, and evidence of phobias and prohibitions that may be abuse-related. Alpert discusses the necessity of examining competing hypotheses, such as other childhood events or trauma, and notes that the therapist "silently considers possibilities while actively helping the patient to explore (p. 386)." Courtois (1996) also recommends adopting a neutral therapeutic stance, supporting exploration of information and hypotheses by clients, using open-ended questions, and keeping cognizant of possible sources of influence on the client. Courtois urges therapists to be cautious and to explore alternative explanations over an extended period of time.

Maintaining a neutral stance requires active effort on the part of the therapist, particularly in the face of disclosures or recantations by a client. For example, a client may ask or even demand that the therapist express belief of the client's memories. Knapp and VandeCreek (1996) state:

> Although patients may become angry with a therapist who expresses uncertainty about the literal truth of their childhood memories, the patients are better off with a therapist who honestly holds judgement in abeyance. Clinical skill is required to balance the patients' need for emotional support with their need to remain open to alternative explanations in the presence of ambiguous or conflicting evidence (p. 455).

In response to new disclosures or recantations of previous disclosures, the therapist should listen objectively, allow the client to express feelings, and explore any circumstances related to the client's statements. For new disclosures, the therapist may be mandated to report the information to law enforcement officials for further investigation. The therapist should, in most cases, discuss the reporting obligation with the client, provide anticipatory guidance concerning possible events following the report, allow the client to process feelings related to the report, and address any safety issues.

When assessing clients, it is important not to attribute symptoms solely or specifically to sexual abuse. The nature of symptoms related to sexual abuse varies widely. Most symptoms are the result of multiple factors and can reflect a variety of difficulties that may or may not include sexual abuse. Up to one-third of sexual abuse victims may report no symptoms (Kendall-Tackett, Williams, & Finkelhor, 1993). Intake procedures or routine mental status exams can include assessment for abuse. Notable authors, such as Carlson (1997) and Briere (1997), identify standardized instruments available to assist clinicians who wish to take this approach (e.g., the Trauma Symptom Inventory, Briere, 1996). Therapists must remain alert to the possibility of sexual abuse, given the common use of victim coping strategies, such as denial and avoidance, but they cannot assume that a particular symptom or lack of childhood memory indicates repressed abuse. Ultimately, it is up to the client to determine what happened to him or her. Roth and Friedman (1998) note that "therapists should refrain from confirming or disconfirming the validity of memories and instead assist patients in arriving at their own conclusions (p. 98)."

The therapist structures treatment toward stabilizing the client and addressing any initial safety issues, followed by treating the presenting symptoms and problems, enhancing coping skills, enhancing social support, and addressing safety and prevention skills for the future. Treatment should assist clients in resolving trauma-related symptoms and placing the traumatic event(s) in a meaningful context or perspective (Roth and Friedman, 1998). A wide literature may be referred to for information regarding treatment modalities for victims of sexual abuse and PTSD (see Alpert (1995); Briere (1992, 1997); Gil (1996, 1991), Herman (1992), and Friedrich (1990)).

In addition to understanding mandated reporting situations, such as suspected child or elder abuse, clients should also know that a therapist's duty may include releasing information in case of danger to self or others.

Confidentiality

Informed consent procedures should be meticulously followed for cases involving allegations of abuse. Prior to beginning treatment, therapists should review with their clients the relevant mandatory reporting guidelines and other issues regarding confidentiality. In addition to understanding mandated reporting situations, such as suspected child or elder abuse, clients should also know that a therapist's duty may include releasing information in case of danger to self or others. Finally, therapists should review with the client how much and under what circumstances information will be shared with other agencies or legal professionals (e.g., children's social workers, schools, other health professionals). The consent of the client (or parent/legal guardian for a minor) is generally required before treatment information may be released to other agencies/professionals.

Therapists should release treatment information with caution, as a release may be considered to be a waiver of the privilege, and the therapist has no control over what others may do with the information once it leaves the therapy setting. It is often beneficial to provide treatment information in writing, especially when the therapist's statements are to be used in a legal context such as by a court or child protection agency. Written information is less likely to be misconstrued or taken out of context.

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Therapists and/or their records may be subpoenaed during various civil or criminal legal proceedings. In the face of a subpoena, the therapist should not automatically release information. Clinicians should discuss the requested information with their client(s) and support the clients in understanding the impact of releasing such records. Even clients who may be requesting release of records to support a legal endeavor may not fully appreciate that privilege is an "all-or-none" issue. They should be informed that once privilege is waived, all information provided by the client to the therapist may subsequently be accessed by both sides in a legal proceeding. Should the client still wish to release information following discussion of the ramifications, the therapist may then release the requested records or testify within the limits of the therapist's role. Should the client wish not to release subpoenaed information, the appropriate response by the therapist is to assert the privilege on the client's behalf and let a judge determine whether to overrule the client's wishes. The possibility that a judge may order release of information over a client's expressed wishes should be explained to the client. Seeking legal consultation is always a good idea when faced with these situations. Some malpractice insurance companies offer free legal assistance to policyholders.

Records should reflect significant events and symptoms as reported by the client, any diagnoses given, and interventions provided. Records should be kept using a neutral, fact-based approach.

For the treatment of minors, clinicians should be well versed in their respective state laws. For example, minors in California, who are over the age of 12 years and have been sexually assaulted or abused, have the capacity to consent to their own treatment. Minor clients and their parents should be made aware of how much information about the minor's treatment will be shared with the parents.

Documentation

The established standard of care is to maintain records that accurately reflect the course and progress of treatment. In today's climate, it is especially important that documentation be forensically sound. As Scheflin (1998) observes, two opposing views regarding documentation have been put forth. First, "if little is in the notes, there is little to charge the therapist with violating" (p.118). The alternate view holds that thorough notes will demonstrate due care. Gutheil (1980) confirms this second viewpoint by observing that "if it isn't written, it didn't happen." Records should reflect significant events and symptoms as reported by the client, any diagnoses given, and interventions provided.

Records should be kept using a neutral, fact-based approach. History and especially allegations should be documented as "reported by" the client. The use of neutral language is recommended, including the word "alleged" where appropriate (e.g., "alleged sexual abuse," "alleged perpetrator"). The lack of such language may imply that the therapist has made a judgement about the veracity of the information and is no longer neutral.

A distinction should be made between "progress" and "process" notes. At one time, clinicians were expected to keep two sets of notes, one reflecting in brief statements the progress of the case and one reflecting the therapist's thoughts, hypotheses, and transference/countertransference issues. Clients and legal professionals were only provided access to the "public" progress notes. Legal professionals are now knowledgeable about the dual-note system and will subpoena both sets of notes. Therefore, therapists should be very careful about what is documented. Preferably, only one set of notes should exist, which reflects the fact-based progress of the case. Guthiel (1980) recommends that the clinician writing progress notes imagine a hostile attorney perched over his or her shoulder, reading the chart aloud. Given the rights of patients to access their own records, it may also be helpful to imagine the client perched over the other shoulder. Nothing should be written in such a manner that the therapist would not want the chart read out loud in front of the client.

Good, thorough records can document not only what the therapist did but can support assertions about what did not occur in therapy. For example, Scheflin (1998) and Courtois (1996) recommend that therapists document efforts to educate patients about recovered memory issues, as well as interventions, such as not advising abuse-related confrontation with others or legal action by the client. Professional consultations may also be important to include in the record. Such an approach may assist the clinician in defending against claims that memories of abuse were suggested within the therapy.

Conclusion

Mental health clinicians, particularly those who treat victims of sexual abuse, are faced with complex legal demands relevant to every aspect of practice. The treatment of sexual abuse is a challenging field. Many therapists may be discouraged from engaging in such treatment, as the stress related to working with traumatized victims is compounded by daunting legal challenges and a threatening social climate. However, it is helpful to keep the current controversy and legal debate regarding sexual abuse in perspective. Finkelhor (1995) describes the current "backlash" in the area of child sexual abuse as an expected and limited counter-movement to

ASSOCIATION NEWS

From the President

Veronica Abney, LCSW

As you know, APSAC is involved in the development of a strategic plan to end child maltreatment; it is currently referred to as A National Call to Action. In this issue you will find a Perspective by **David Chadwick, MD**, which offers useful background and a clear explanation of the plan. I believe that APSAC's expertise in education and training and our multidisciplinary focus make our involvement in this effort essential. There are many questions to be answered before APSAC's role in this effort can be fully determined. It is crucial that you, APSAC's Members, become involved in the process of answering some of these questions. Let's begin the process now. I encourage you to provide APSAC's leadership with your feedback on the article and to consider the 10 questions proposed below.

1. Do you think now is the time to take the knowledge we have of child maltreatment and make a strategic effort to either rid our nation of the problem or to severely reduce its occurrence?
2. What would you put on an issues list?
3. Should there be a broad or narrow focus? For instance, should the focus be on one type of maltreatment or all forms of maltreatment, including exposure to domestic violence?
4. Should A National Call to Action address the problem by utilizing a public health model or some other model?
5. How can we ensure that A National Call to Action includes attention to issues related to our nation's increasing cultural and ethnic diversity?
6. Should this effort be led by a new organization or a coalition of existing organizations?
7. Beyond APSAC's initial support in the development of A National Call for Action, how do you see the organization's role?
8. Should A National Call to Action seek public support, private support or both? What would a mix of public and private support look like?
9. What sort of strategy is needed to propel such an effort?
10. What should be the new name of A National Call for Action?

I look forward to your feedback. Please send your comments to the APSAC office, attention to Audrey Kaufman, Managing Editor of the *Advisor*, by regular mail or email: APSACPubls@aol.com.

I just returned from the Chicago office of APSAC, where I met with members of the Colloquium 2000 Committee and **Thom Gauthier**. We were engaged in program planning for our July meeting, which will take place at the Chicago Hilton and Towers, across from beautiful Lake Michigan. Once again, I think we are going to have a stimulating and energizing conference; there will also be opportunities to relax and have some fun with your colleagues. Brochures should be available by the end of January 2000.

In this issue of the *Advisor,* you will find a Call for Nominations for the 2000 Board of Directors election. I often hear Members complain that only nationally known Members can be nominated to the Board of Directors. Although this certainly gives one an advantage in the election, that is not a criterion. The Nominating Committee is seeking candidates who have been active in the organization on either the state or national level, who have the time to work hard, and who reflect the discipline and ethnic diversity valued by APSAC.

You will also find in this issue a Call for Nominations for the APSAC annual awards. The Awards Committee is seeking nominations for outstanding professional, outstanding service, outstanding media coverage, outstanding research article, outstanding doctoral dissertation, and research career achievement. I urge you to take an active role in your organization and nominate your colleagues.

Finally, I want to welcome **Sandra Hodge**, Director, Division of Child Welfare, Policy and Practice, Maine Department of Human Services, to the APSAC Board of Directors!

SUMMARY OF BOARD ACTIONS

APSAC's Board of Directors meets annually in conjunction with the Colloquium. The Executive Committee, 10 members elected by the Board, in effect governs the Association and tends to immediate business. The Executive Committee "meets" monthly by teleconference and annually in person at the San Diego Child Maltreatment Conference. All Board Members are invited to join the calls and annual meeting, as schedules permit. Board and Executive Committee Members are listed on the inside pages of the *Association News*.

Recent Actions taken by the Board and Executive Committee include the following:

- Supported the principle of "Convening a National Call-to-Action: Working Together Toward the Elimination of Child Maltreatment," initiated by the San Diego Children's Hospital and Health Center, and authorized the Executive Director to represent APSAC.
- Accepted a proposal from the Development Committee to hold a silent auction in conjunction with the annual colloquium, as a way of generating additional revenues for APSAC.
- Approved a plan to hold the ninth Annual Colloquium in Washington, DC, on June 20-23 2001, at the Omni Shoreham Hotel, and appointed **Tricia Williams, JD** and **Det. Mike Johnson** as co-chairs.
- Authorized the distribution of the FY98-99 Annual Report and commended Past President **Diane DePanfilis, PhD**, for her work as President and author of the report.
- Accepted the Audit Letter and Management Letter for FY 1998-99, as presented by Sheldon Fox and Associates, and asked the Treasurer and Executive Director to develop a plan to address the issues presented. (See Annual Financial Report presented in this issue.)
- Authorized the Treasurer and Executive Director to establish a line of credit with a Chicago area community bank to support the Association, as necessary, during periods of limited cash flow.
- Accepted the resignation of Board Member **Wayne Holder, MSW**, Executive Director of ACTION FOR CHILD PROTECTION, and appointed **Sandra Hodge**, Director of the Division of Child Welfare Policy and Practices, Maine Department of Human Services, to serve the unexpired term through May 2000.
- Voted to amend the By-laws of APSAC to reduce the size of the Board from 25-30 members to 20-25 members, in order to more effectively govern the Association and manage its resources.
- Authorized the Forensic Interviewing Clinic Subcommittee, chaired by Past President **Patricia Toth, JD**, to plan three clinics in 2000—2001.
- Approved the Policies and Procedure for *Child Maltreatment*, as developed by the *Child Maltreatment* Editorial Board.
- Authorized APSAC to co-sponsor the 2002 World Congress of the International Society on the Prevention of Child Abuse and Neglect in Denver, July 7-11, 2002, and to hold two days of Advance Training Institutes in conjunction with the Congress.
- Authorized the establishment of an ad hoc membership committee, chaired by Board Member **Michael Hertica, MS**, to explore ways to reach out to law enforcement and child protective services personnel.
- Authorized APSAC to become a member of the Partnership Program of the International Society on the Prevention of Child Abuse and Neglect.

For more information, contact Thom Gauthier, APSAC Executive Director, at *APSACExec@aol.com*.

Technology Update

APSAC is in the process of upgrading its Association Management Database "MemberTrak/MeetingTrak" by Phoenix Solutions. The upgrade will allow APSAC staff to better serve our Members and improve customer and chapter services in a variety of ways. The upgrade includes: expanded communication tools, including broadcast fax and email; integrated systems for tracking membership, registrations, and publication orders; increased search capacity for locating Members and reducing duplicate records; improved reporting for generating labels and lists; and many other features.

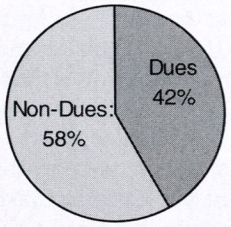
We anticipate a database transition period of October 1, 1999 through March 30, 2000. As a result, you can expect changes in our billing cycle, renewal packets, and/or other communications during this time. We may contact you to verify your address and/or membership information.

We will keep you posted as the upgrade progresses! Feel free to contact the Member and State Chapter Services Department at 312/554-0166 or *APSACMems@aol.com*, with any questions. Thank you for your patience as we work to improve our services.

ANNUAL FINANCIAL REPORT

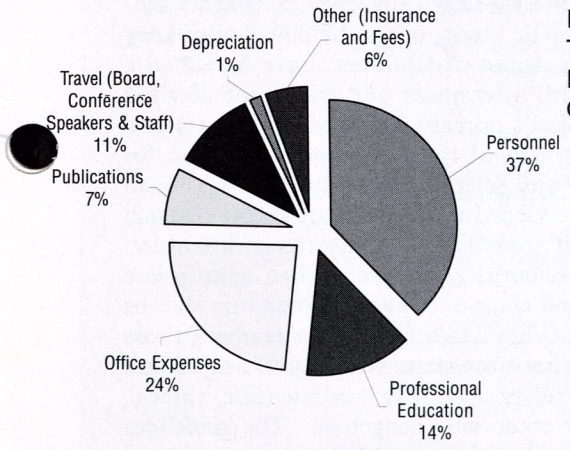
June 1, 1998 to May 31, 1999
Audited by Selden, Fox and Associates, Ltd.

REVENUES
Total: $732,218



Revenues	Amount	%
Dues	$ 306,036	42
Non-Dues:		
Conferences	359,070	49
Publications	48,139	7
Contributions	4,524	1
Merchandise	1,127	0
Investment Income	2,378	0
Miscellaneous Income	10,944	1
Total Revenues	$ 732,218	100

EXPENDITURES
Total: $877,274



Expenditures		
Personnel	$ 332,538	37
Professional Education	118,877	14
Office Expenses	207,911	24
Publications	64,587	7
Travel (Board, Conference Speakers & Staff)	92,221	11
Depreciation	11,705	1
Other (Insurance and Fees)	49,435	6
Total Expenditures	$ 877,274	100
Increase (decrease) in Net Assets	$ (145,056)	
Net Assets:		
Beginning of year	$ 128,458	
End of year	$ (16,598)	

APSAC WELCOMES TWO NEW STAFF MEMBERS

Patricia Kamara, Senior Administrative Assistant/Office Coordinator

Patricia joined APSAC in October to manage administrative support services and office operations. Her prior employment includes a recent tenure at a major outplacement services firm in Chicago and eight years as an office administrator for a nonprofit organization. Patricia received a bachelor's degree in Administrative Sciences from Southern Illinois University. She enjoys concerts and Chicago's many public festivals.

Terri Mayberry, Data Entry Clerk

Terri was hired in October to fill the data entry position serving APSAC's Professional Education and Membership Departments. Previously, she was a Customer Service Representative at the LaSalle Bank in Chicago. She enjoys listening to music and spending time with her family.

From the Executive Director

Thom Gauthier, CAE, ACSW

As we enter the new millennium, APSAC must address the challenges of providing new organizational and programmatic leadership for the field. In their Perspectives, presented in this issue of the *Advisor*, **David Chadwick, MD**, and **John Meyers, PhD**, frame the issues succinctly. As the primary multidisciplinary professional society in the field of maltreatment, APSAC needs your participation—as members at large, on committees, and in leadership positions. The Call for Nominations for Board leadership appears in this issue of the *Advisor*. Please seriously consider this challenge, knowing that it will provide you with an opportunity to make a difference in this field at a critical point in its development. If you are not yet ready to make a commitment to Board service, as you try to balance work and family, then consider volunteering for one of the many committee assignments for 2000/2001. If you are still constrained by other demands, then become an APSAC ambassador and promote APSAC membership amongst your professional colleagues, recognizing that you can make a difference with any level of service! If you know APSAC members in your community and professional network who are making significant contributions, please consider nominating them for one of the many awards offered by APSAC. What better way to show your admiration and support for your colleagues than to nominate them for an award!

Programmatically, APSAC is demonstrating its leadership in two related projects supported by the Department of Justice, Office of Victims of Crime. In the first project, the National Crime Victim's Research and Treatment Center, under **Ben Saunders, PhD,** at the Medical University of South Carolina, in conjunction with the Center for Sexual Assault and Traumatic Stress, under the direction of **Lucy Berliner, MSW,** and the American Professional Society on the Abuse of Children, have launched a collaborative project to develop guidelines for the mental health assessment and treatment of child victims of intra-familial sexual abuse and their families. This project's primary goal is to develop a useful set of practical guidelines for the clinical assessment and treatment of these children–a criterion for judging treatment procedures that has a high degree of utility and scientific integrity and has broad support within the child abuse field. The guidelines are being developed using the most recent research and assessment and treatment protocols, as well as the clinical antedoctal and theoretical literature. Whenever possible, the guidelines will be based on empirical, scientific evidence. When appropriate research is unavailable, the most accepted and scientifically sound clinical, theoretical literature will be used as a basis for the guidelines. The guidelines will identify "first choice treatments," for example, those that have substantial scientific support for their effectiveness; other treatments with significant clinical and theoretical support and wide acceptance in the field; and interventions that lack scientific, clinical, or theoretical support and should be considered experimental or potentially dangerous. The guidelines are in the process of being reviewed and revised by a committee of experts in child abuse treatment and research, which convened for its first meeting in conjunction with the San Antonio Colloquium. The first draft of the guidelines is intended to be available at the San Diego Child Maltreatment Conference, and members will be asked for comment and input. Subsequent editions of the *Advisor* and APSAC's website will also provide an opportunity for review and comment.

The second project, funded by a $75,000-grant from the Office of Victim's of Crime to APSAC, will produce a series of three training institutes on the mental health assessment and treatment of child victims of intra-familial sexual abuse and their families. The institutes will be research-based, empirically sound, and representative of a consensus of best practices in the field. The institutes will be developed in conjunction with the abovementioned effort of the Medical University of South Carolina and Center for Sexual Assault in Seattle. This project will also produce a written, replicable training curriculum that can be used to reproduce the institutes beyond the grant period and a special issue of the *Advisor* dedicated to the topics covered by the institutes. Subsequent issues of the *Advisor* will keep you updated on these two new developments.

Questions or comments: Contact Thom Gauthier at *APSACExec@aol.com.*

Forensically Informed Psychotherapy: Balancing Clinical and Legal Perspectives

the promotion of awareness of child abuse. He notes that public support remains strong for the prevention, treatment, and prosecution of abuse. Finkelhor suggests responding to the backlash proactively, rather than reactively. It is hoped that this article will assist clinicians in responding to the current climate in a proactive manner, by enhancing their understanding of their role and by promoting increased confidence in their method of practice and ability to help their clients.

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- Child abuse and neglect fatalities claimed the lives of an estimated 1,197 children in 1997. Children under age 4 accounted for more than 75% of fatalities. Two percent of fatalities (14) occurred while the child was in foster care. Twenty-three of 31 states reporting indicated no fatalities in foster care. Child fatalities in families receiving family preservation services in the past 5 years accounted for 16.3% of deaths (64). In families reunited in the past 5 years, 2.7% (10) fatalities occurred.
- Two-fifths of victims referred to CPS received no services after investigation or assessment. More than 90% of victims who received court actions had court-appointed representatives.
- Thirty-one states reported that 636,079 families received preventive services, the most frequently offered being family planning, parenting education, substance abuse treatment, crisis intervention, domestic violence services, emergency housing assistance, emergency shelter, and respite care. The most commonly cited funding sources were the Children's Trust Fund; Title IV-B-2, Safe and Stable Families; Title XX, Social Services Block Grant; and the Maternal and Child Health Block Grant.

Practitioners and Researchers: Two Cultures Collide

Brenda Walsh, MS
Graduate Assistant

Judith A. Myers-Walls, PhD
Associate Professor
Department of Child Development and Family Studies
Purdue University, Lafayette, IN

Introduction

Both applied researchers/evaluators and practitioners work to help people, but they use different techniques. Evaluation researchers try to help people indirectly by discovering information ("truth") about how people, programs, and the world work. Practitioners try to help people by working directly with them and improving their situation, attitudes, or behavior. These divergent approaches become especially obvious when it comes to program evaluation and can lead to conflict and frustrations. It is not that one approach is right and the other wrong, but that the two groups look at the world through different lenses. In the fields of human development and human services, practitioners and researchers seem to come from two different cultures.

The authors worked with a team of students and faculty at a university to conduct a large, multi-site, longitudinal evaluation of a home-visiting program for parents at risk of abuse and neglect. The evaluation team designed the procedures, located the instruments, and entered and analyzed the data. The program site staff were expected to gather some of the data and to recruit families to be interviewed by the evaluation team members. In the process of this collaborative effort, much was discovered about the cross-cultural differences between researchers and practitioners.

The why and how of evaluation take on very different perspectives, affecting the way the two groups view timing, purpose, methods, success, and communication of the evaluation results.

This article explores both the researcher and the practitioner cultures. A picture of the two cultures is presented, and several issues related to program evaluation are examined from both perspectives. Occasionally the researcher and practitioner cultures collide, and conflict may occur. This article highlights conditions to look for when conflict occurs, including causes, types, and levels of conflict. Finally, some solutions are presented for ways to reduce and resolve conflicts between the two groups.

A Look at the Two Cultures

Following is a glance at the differences between practitioners and researchers with regard to their professional needs, decision making styles, focus, communication methods, daily operations, and the tools they use.

Needs

Practitioners look at life in terms of immediate needs and crises. They deal with clients who have lost housing, have no food in their cupboards, and need a job now. They want immediate answers for the crises they face and for the clients who need help as soon as it can be offered. Practitioners work in jobs with low levels of job security and are often supported by grants, which can mean learning about having or losing a job with two weeks' notice or less.

On the other hand, researchers look at issues in the long term, knowing that finding answers to research questions can take years. They're concerned with getting it right. Many evaluation researchers are employed in academic settings where they may have tenure and the long-term job security that comes with that position.

Decision Making

When practitioners make decisions, they depend on intuition, instinct, direct experience, clinical evidence, diagnosis, and interpersonal sensitivity. They choose courses of action that "feel right" and that have been successful in the past. Testimonials from colleagues who work in similar positions can be very convincing.

When evaluation researchers make decisions, they look at numbers, statistical significance in study results, logic, prediction, and systematic gathering of information. When a new idea is proposed, they want to know who proposed the idea and what empirical evidence is available to support it. Hard-core researchers might not be convinced that the new idea has merit until they have tested it in their own studies.

Focus

What really matters to a practitioner is making a difference for individuals and families. A practitioner feels successful if a family that has struggled in the past finally achieves some important goals, or if an individual completes a degree, gets a job, or passes a parenting course. Practitioners want to make the world a better place, using hands-on intervention.

Researchers really care about gathering large amounts of valid, reliable data that lead to statistically significant results. Most quantitative evaluation researchers feel especially successful if they have been able to generate large amounts of data using a control-group design. The bottom line is that researchers want to make an important contribution to knowledge about individuals, families, programs, and the world.

Communication

Communication is a critical tool for practitioners. Their communication is usually personal, direct, and immediate. One goal of communication is establishing

Practitioners and Researchers: Two Cultures Collide

an emotional connection and nurturing a personal relationship.

Communication is also important to evaluation researchers, but most of their communication is written and is designed to get certain information across. Communication is used to establish and maintain study designs and procedures and then to inform others of study results. Relationship and emotional connection are not typical goals.

Daily Operations

In their daily operations, most practitioners face volumes of guidelines, procedures, reporting structures, and rules. They are supervised closely and regularly in most positions. Those guidelines make their jobs structured and inflexible. At the same time, several authors have defined quality practice as flexible and adaptive. In fact, some authors have said that the best practitioners "break the rules" to meet the needs of their clientele. So practitioners may attempt to establish flexibility and responsiveness within their highly regulated environment.

Researchers are likely to operate in a setting with very high amounts of personal freedom and flexibility. Outside of scheduled classes and meetings, they rarely need to keep assigned work hours and are encouraged to think creatively and design new approaches. Once an evaluation or research design is created, however, the flexibility ends; the goal is to maintain as much consistency as possible in the collection of data so that any changes in individuals and families can be attributed clearly to the treatment and not to changes in procedures.

Tools

The tools that are likely to be important in the lives of practitioners are those that keep them in touch with clients, supervisors, and referral contacts. Pagers and cell phones are invaluable in their work to maintain contact and personal communication. The most central tools in the lives of researchers are likely to be computers, large on-line databases with search engines, and e-mail. Their tools focus on management of large data sets, complex analyses, and quick, efficient communications.

Issues Related to Evaluation

It is clear that evaluation researchers and practitioners operate with very different visions of professional life. Sometimes it is difficult to see how these two cultures are even related. One situation in which it may be critical for researchers and practitioners to bridge these gaps is when they conduct a program evaluation. In that situation, they need each other. The practitioners, who work for a program, must have the program evaluated to prove its effectiveness in order to receive grants to continue providing services or to improve services; they often need the help of a researcher to accomplish that. Researchers interested in intervention and the impact of programs must work with practitioners who are willing to have their programs evaluated and are willing to cooperate with the researcher.

The way that practitioners and researchers look at evaluation is consistent with the focus of their job. Several issues in particular are often viewed differently. The why and how of evaluation take on very different perspectives, affecting the way the two groups view timing, purpose, methods, success, and communication of the evaluation results. Table 1 illustrates some of those different views.

Reason for Conflict

As mentioned earlier, when the practitioner and researcher work together to perform a program evaluation, conflicts may arise mostly as a result of the differences in their professional lives, contrasting views of the world, and different ideas about evaluation. Nevertheless, they must depend on each other to complete the evaluation. The bottom line is that researchers may be afraid that practitioners will ruin the research design and compromise the data. And practitioners are likely to worry that

Table 1: Program Evaluation Issues: Practitioners vs. Researchers

Issue	Practitioners	Researchers
Purpose of the evaluation	Program improvement and advocacy	Contribution to the literature, accountability
When data collection should begin	After rapport has been established and family is firmly committed to the program	As soon as a person is identified as a client, or earlier, if possible
Ideal data collection methods	Flexible, matched with the client's needs and program flow	Consistent, standardized
Ideal evaluation instruments	Short, simple, non-intrusive, incorporated into program delivery	Comprehensive, objective, reliable, and valid, using multiple measures
If problems are identified in the family during data collection	Immediately explore ways to intervene with the family and assist in dealing with the problem	Record the situation, but do not let the data collection process influence the family any more than necessary
When results should be released	Continually with the data collection and analysis, i.e. yesterday	Only after sufficient data have been collected and all analyses have been completed
Primary audience for evaluation	Program staff, funders	Other researchers, academicians
Exciting evaluation findings	Powerful success stories and case examples, identification of streamlined and effective intervention techniques	High levels of statistical significance in findings
Personal benefits from completed evaluation	Program funding and job security--if the evaluation is positive	Publications, presentations, and promotion--if the evaluation is well designed and executed and finds significant results

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the research will alienate their families or clients and drive them away from the program. It is as if the researcher says, "Okay, you can do what you need to do to deliver a good program, but be consistent and don't mess with my research design." The practitioner seems to say, "Okay, you can evaluate the program, but be nice and don't mess with my clients."

As the earlier description of the two professional worlds illustrated, conflicts between researchers and practitioners may arise from their different views of time, their different ways of thinking, varying views of what is really important and what defines success, contrasts in communication styles and levels of independence in work settings, and differences in the tools they use to do their jobs. In working with a team to conduct the previously mentioned evaluation of a home-visiting program for parents at risk of abuse and neglect, the following conflicts were encountered:

- Views of time became an issue when evaluators wanted to wait until the multi-year study was complete to release results, but the program staff wanted to know details about findings before the first year was over. Differing views of time also were evident when the program staff reassigned ID numbers of former families to new families. The program did not need that ID number any more, but the reassignment caused havoc for the evaluators who entered data by ID numbers.
- The different ways of thinking may have contributed to misunderstandings related to consent forms. The program staff knew that the evaluators did not want to receive identifying information on families, so they blotted out names that were signed on consent forms, even though signatures were exactly what the evaluators needed. The evaluators thought the instructions were clear and logical, but the program staff were thinking of the needs and feelings of their families.
- Differences in values were very evident when program staff missed data collection points because the families had immediate needs—and those needs did not include answering questionnaires. This also was evident when staff were unwilling to assign families in need of services to nontreatment control groups. Program staff felt services to families were most important, but the evaluators thought data collection should take priority.
- The evaluators tried to maintain personal contact and communication with program staff, which would have been consistent with the practitioner style, but the program grew too quickly. The resulting loss of relationship hurt the evaluation.
- Understanding the differences in levels of independence between the two settings was a regular point of frustration for the evaluators who had difficulty knowing who was capable of making decisions and what was the best way to implement changes. The evaluators lived in a world in which individuals could operate independently. Evaluators needed to learn that it was not enough to explain procedures only to supervisors or only to home visitors.
- The difference in tools was evident in any evaluation work group meeting. The evaluators had laptop computers for taking notes and consulting data, and the program staff were interrupted often by beeps and bells from pagers and cell phones. The computers could be seen as intimidating and pretentious by the program staff, and the pagers and phones could be seen as disruptive and rude by the evaluation staff.

Types of Conflict

There are several different types of conflict that may occur between the researcher and practitioner: unnecessary conflicts, genuine conflicts, and realistic conflicts.

Unnecessary Conflicts

Unnecessary conflicts are those that may arise due to problems in communication and perception (Girard & Koch, 1996). The differences in this case are not great. For example, as the situation above described, both researchers and practitioners are concerned about confidentiality, but they approach it from different directions. Researchers must get consent from participants and follow the guidelines of the Institutional Review Board. Practitioners protect the privacy rights of their clients by not passing on names and information about clients to others. The ultimate goal is the same, but the typical procedures differ. The researchers and practitioners see things in different ways, and their perspectives influence their perceptions of consent forms and participant rights. When the groups did not communicate their perceptions to each other in the abovementioned study, unnecessary conflict occurred. If such conflicts are recognized as unnecessary, they can be solved easily.

Genuine Conflicts

Genuine conflicts are those that arise out of concrete differences (Girard & Koch, 1996). Those are very real and touch on core values. Researchers and practitioners have different job-related goals, and these goals may not be compatible. The concrete differences in their jobs may cause genuine conflicts. As described above, meeting data collection deadlines or meeting immediate family needs is one such dilemma. The solution for one side directly threatens the interests of the other. Communicating alone will not eliminate those conflicts but may help find a solution.

Realistic Conflict

Realistic conflict (Folger, Poole, & Stutman, 1993) occurs when there are disagreements over the means to an end or the ends themselves. Researchers and practitioners may disagree on the way the evaluation is

conducted, why it is being done, or even what the evaluation may produce. In the author's study, practitioners were asked to read questionnaire items out loud to families in order to control for differences in literacy. However, program staff were uncomfortable doing this and felt it was insulting. The evaluation team changed the format of the answer sheet, and the final form eased the concerns of the program staff. Another example encountered was related to the timing of the evaluation. Practitioners did not want to collect evaluation data before rapport was established with the families they were visiting. However, the researchers needed the evaluation done as early as possible before the program could have a significant impact. A compromise was reached by determining that data would begin to be gathered anytime between the fourth and the tenth visit. Again, communication and sharing of needs can help, but each side must approach discussions with a degree of flexibility and willingness to listen and adjust to each other .

Levels of Conflict

There are not only several types of conflict, but a variety of levels of conflict as well. These conflicts may occur at the interpersonal level and/or the intergroup level (Girard & Koch, 1996; Folger, et al., 1993). The *interpersonal level* would be a conflict between individuals. For example, a conflict may occur between the program supervisor and the evaluation coordinator. If it does, it can be solved best by bringing the individuals who are in conflict together to discuss and solve the problem, or it could be handled by minimizing their need to have contact. *The intergroup level* would consist of a conflict occurring between one or more groups with each other. An example of this would be a conflict between a group of practitioners and the evaluation team. In the above study, tension existed between the program sites that were established at an early point in the evaluation project and those sites that were newer. The original sites had input into data collection procedures, while the newer sites needed to conform to the expectations that had been set. In this case, solutions may be found either by altering procedures or by building a sense of loyalty to the larger group context.

Responses to Conflict

When faced with a conflict, people may respond in one of three ways (Crawford & Bodine, 1996). One response is called a *soft response*, which would result in avoidance, accommodation, or compromise. In many cases, ignoring is the easiest response; everyone can go home and pretend that nothing happened. However, the problem is likely to resurface later, especially if groups discuss the situation among themselves in the absence of the others. Another response is the *hard response*. This response typically includes force, threats, aggression, and anger. Some of the meetings in the study seemed to almost reach this level, but most often moved to compromise and constructive solutions or to denial and sweeping the issue under the rug—even if it appeared again later.

The last type of response is the *principled response*. Problem-solving, communication, and meeting the needs of everyone are the products of this type of response. Clearly, a principled response is most constructive. Regardless of cause, level, or response, conflict is a reality in any workplace, especially when there is a contrast of cultures like that of researchers and practitioners. If it is dealt with positively, however, the results can be helpful rather than destructive.

Decide what is non-negotiable, but allow for some flexibility in your expectations. Make sure that the primary goals, needs, and values of each group are honored, but each group should be willing to compromise where possible.

Techniques for Reducing Conflict

If conflict arises between researchers and practitioners, the most effective response is to address it as soon as possible. Conflict is harmful to client families as well as to the researchers and practitioners. There are several techniques that may be used to manage conflict between the two groups. First, get to know each other and understand the differences.

- **Listen to each other.** Make sure that you have enough contact with each other to do this. Researchers and practitioners should attend meetings together, whenever possible.
- **Shadow each other on your jobs.** In the above study, evaluators attended some portions of practitioner training. Practitioners accompany evaluators to homes when they do interviews so that they can introduce the evaluators. Although they leave after the introductions, this gives them a brief time to observe the evaluators at work. It might have been helpful for evaluators to observe a few home visits and for program staff to observe the process of entering questionnaire data or coding videotapes.
- **Explain your needs and roles.** This should be a part of every meeting. It is a special challenge to explain roles without being defensive and in a way that the other group understands. Both sides need to learn to say "I feel…" and "I need…" instead of demanding particular solutions or behavior from the other group.
- **Practitioners could share program newsletters and materials with evaluators.** It is important that researchers take some time to read these materials and glean implications for the research. The better the

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researchers understand the intervention, the better the evaluation will be.

- **Researchers could create an evaluation newsletter for the program staff.** It is important to avoid technical jargon and concentrate on issues that affect program staff. Thanks for and recognition of accomplishments by the practitioners are valuable components. Ideally, the researchers can also provide evaluation information as it becomes available, and that will help practitioners improve their program.

Second, both researchers and practitioners could define their needs and communicate them to each other. This helps both groups get in touch with genuine conflicts. The groups could also explore how their behavior may affect each other's needs, reducing the feeling of threat.

- **Always inform the other group before changes in procedures are made.** Each group should consider how changes in their procedures would affect the other group.
- **Decide what is non-negotiable, but allow for some flexibility in your expectations.** Make sure that the primary goals, needs, and values of each group are honored, but each group should be willing to compromise where possible.
- **Offer choices to the other group, and work together to find solutions.** Instead of announcing the way things will be, each group should explain what they are trying to accomplish and then suggest at least two ways that the other group could cooperate.
- **Clarify how your personal needs are connected to the evaluation.** Researchers could describe their need for publishable results, and practitioners could share their concerns about continued funding and a positive public image. Allow yourselves to be human.

Third, researchers and practitioners could focus on shared goals whenever possible, developing a principled response.

- **Make sure the other group knows that you care about their concerns.** This assumes that you do care, but pretending at first may lead to real empathy over time. Ask questions and listen to the answers.
- **In order to build trust, each should be trustworthy.** Follow through with commitments and promises, or explain why it will not be possible to do so. Avoid talking about each other when there is no opportunity for dialogue and representation.
- **Remember that the well-being of families is the ultimate goal.** Keep your "eyes on the prize." The short-term concerns about the program and data collection are only temporary issues; the improvement of the lives of children and families is likely to be a shared goal.

Communication is vital in preventing conflict as well as to resolving it. Researchers and practitioners need to both talk and listen to each other. If a conflict arises, they may not wish to try to resolve it when they are angry. When cool heads prevail, practitioners and researchers may go directly to each other to share concerns. Finally, researchers and practitioners should celebrate any successes together. It took both groups to gain success, so why not appreciate it together?

References

Crawford, D., & Bodine, R. (1996). *Conflict resolution education: A guide to implementing programs in schools, youth-serving organizations, and community and juvenile justice settings.* Washington, DC: Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice; Office of Elementary and Secondary Education, U.S. Department of Education.

Girard, K. & Koch, S.J. (1996). *Conflict resolution in the schools: A manual for educators.* San Francisco: Jossey-Bass.

Folger, J.P., Poole, M.S., & Stutman, R.K. (1993). *Working through conflict: Strategies for relationships, groups, and organizations.* New York: Harper Collins.

Earlier versions of this paper were presented at the National Council on Family Relations and to the Healthy Families America Research Network. Funding for the evaluation study described in this manuscript came from the Indiana Family and Social Services Administration. Appreciation is expressed to Phyllis Kikendall, who assisted with earlier versions of this paper.

CALL FOR CASES

Do you have a particularly interesting or challenging case that you would like to see featured in the *Advisor*'s Case Conference? We invite *Advisor* readers to submit a case summary for publication and feedback from our multidisciplinary panel of featured experts. Case summaries should be limited to one and one-half double-spaced pages and should include enough information so that our panel can provide a meaningful response. Names and other identifying details should be changed to protect confidentiality. Please note that submission of a case does not guarantee publication.

The provider of the most interesting and challenging case submitted to APSAC in the year 2000 will receive a special APSAC gift to be announced in a later issue of the *Advisor*. Send your case summary to:

APSAC Advisor Case Conference Series
407 S. Dearborn, Suite 1300, Chicago, IL 60605
fax 312/554-0919, email APSACPubls@aol.com

JOURNAL HIGHLIGHTS

Edited by
Ernestine C. Briggs

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 Ernestine C. Briggs, Ph.D, National Crime Victims Research and Treatment Center, Medical University of South Carolina, 165 Cannon Street, Charleston, SC 29425 (FAX 843 792-3388)

SEXUAL ABUSE

Study Finds Higher Levels of PTSD in Sexually and Physically Abused Children

Three groups of foster care children were compared in the present study to examine the relationship between child abuse and posttraumatic stress disorder. Participants included 50 sexually abused, 50 physically abused, and 50 nonabused foster care children. Results indicated that sexually and physically abused children endorsed higher levels of PTSD and preadolescents evidenced more severe PTSD than early adolescent children. The Modified Stroop Procedure, employed in this study, discriminated between the sexually and physically abused children with PTSD and those without PTSD.

Dubner, A.E., & Motta, R.W.(1999). Sexually and physically abused foster care children and posttraumatic stress disorder. **Journal of Consulting & Clinical Psychology, *67(3), 367-373.***

Adult Rape Linked with Childhood Abuse in a Study of Female Navy Recruits

To investigate the effects of childhood abuse on adult rape, 1,887 female Navy recruits were surveyed about their childhood sexual abuse (CSA), childhood physical abuse (CPA), and adult rape experiences. Over a third of the recruits had been raped and more than half had experienced CPA and /or CSA. Rape was 4.8 times more likely among women who had experienced CSA than among women who had not, when CPA was controlled. Alcohol problems and number of sexual partners also predicted rape independent of the effects of CSA. Despite ethnic group differences in the prevalence of victimization, the predictors of rape did not differ significantly across ethnic groups.

Merrill, L.L., Newell, C.G., Thomsen, C.J., Gold, S., Milner, J., Koss, M.P., & Rosswork, S.G. (1999). Childhood abuse and sexual revictimization in a female Navy recruit sample. **Journal of Traumatic Stress, *12(2), 211-225.***

The Prevalence and Circumstances of CSA Studied in a Community Sample of Latina Women

This study examined the prevalence and circumstances of child sexual abuse in a community sample of Latina women. The sample included Latina women 18-50 years of age. Regardless of acculturation and citizenship status, one third of the sample reported an incident of sexual abuse and more than a third experienced revictimization. The findings also revealed that the majority of incidents occurred during early childhood and were perpetrated by young males known to the victims. Four women were forced to marry the perpetrators of their abuse. Implications for treatment and community-based interventions for Latina survivors of child sexual abuse were discussed.

Romero, G.J., Wyatt, G.E., Loeb, T.B., Carmona, J.V., & Solis, B.M. (1999). Prevalence and circumstances of child sexual abuse among Latina women. **Hispanic Journal of Behavioral Sciences, *21(3), 351-365.***

Relationship Between CSA and Parenting Attitudes and Behavior is Studied.

This retrospective study examined two alternative hypotheses: (1) the relationship between child sexual abuse (CSA) and subsequent parenting attitudes and behaviors is a function of a 3rd variable, growing up experiences other than CSA; and (2) maternal depression mediates the relationship between CSA and parenting attitudes/behaviors.

The sample included 516 low-income, urban mothers (aged 17-52) with and without a history of childhood sexual abuse. The Parenting Competence Scale and the verbal and severe violence subscales of the Conflict Tactic Scale were used to assess parenting. The perceived parenting competence and severe violence results supported the 3rd variable hypothesis. The mediational hypothesis was not supported by any of the parental indicators assessed.

Zuravin, S.J., & Fontanella, C. (1999). Parenting behaviors and perceived parenting competence of child sexual abuse survivors. **Child Abuse & Neglect, *23(7), 623-632.***

PHYSICAL ABUSE

Mental Health Outcomes associated with Child Maltreatment in Low-Income Women

This study sought to determine whether childhood physical and sexual abuse would explain variance in adult mental health after controlling for other childhood and adult risk factors. The sample included 518 low-income mothers (mean age 27.31). Analyses of women abused in childhood revealed that social support and a less external locus of control were protective in function. Depressive symptoms and self-esteem were found to vary significantly with childhood maltreatment. Implications for research and practice were discussed.

Banyard, V. L. (1999). Childhood maltreatment and the mental health of low-income women. **American Journal**

continued on next page

of Orthopsychiatry, *69(2), 161-171.*

Depression in Mothers Linked to Thoughts of Harming Their Infants

This study examined the prevalence of thoughts of harming one's infant, fear of being with the infant, and inability to care for the infant, among 100 clinically depressed mothers with a child under 3 years of age. A control group of 46 nondepressed mothers was also included in this study. Results suggested that 41% of depressed mothers compared to 7% of control mothers admitted to thoughts of harming their infant. Fear of being alone with the infant and inability to care for the infant were less frequently endorsed by depressed mothers. More than half of the depressed mothers had problems in at least one of the three domains assessed. Demographic variables, psychosocial stressors, and psychiatric variables did not predict which mothers were more likely to experience thoughts of harm or fear of being alone. The authors described these cognitive and affective disturbances in terms of a pathway by which maternal depression affects infants.

Jennings, K.D., Ross, S., Popper, S., & Elmore, M. (1999). Thoughts of harming infants in depressed and non-depressed mothers.* Journal of Affective Disorders, *54(1-2), 21-28.

Study Finds Lower Level of Emotional Development in Children of Maltreating Mothers

This study investigated emotional understanding in 22 physically abusive maltreating mothers and their 6-12 year old children and a matched control group to determine how a maltreating relationship may interfere with children's emotional development. Maltreating mothers, compared to controls, were less likely to engage in discussion reflective of emotional understanding and maltreated children demonstrated lower levels of emotional understanding. The findings also revealed significant relationships between maternal behavior (e.g., discussion of emotion) and children's understanding skills. The importance of social context in the development of children's emotional understanding skills was emphasized.

Shipman, K.L., & Zeman, J. (1999). Emotional understanding: A comparison of physically maltreating and non-maltreating mother-child dyads.* Journal of Clinical Child Psychology, *28(3), 407-417.

OTHER ISSUES IN CHILD MALTREATMENT

APA'S Guidelines for Professional Practice in Child Protection Matters are Presented

This paper presented the American Psychological Association's (APA's) guidelines for desirable professional practice in child protection matters. The guidelines were designed to promote proficiency in using psychological expertise in conducting psychological evaluations in child protection matters. The guidelines were intended to be aspirational and were developed as an adjunct to the APA's Ethical Principles of Psychologists and Code of Conduct (APA, 1992).

Board of Professional Affairs Committee on Professional Practice & Standards (1999). Guidelines for psychological evaluations in child protection matters*. American Psychologist, *54(8), 586-593.

Review of the Literature Explores the Effectiveness of Parenting Programs Aimed at Abusive and Neglectful Parents

This article summarized the literature on the effectiveness of parenting programs aimed at abusive and neglectful parents. The authors tried to discern: (1) whether current parent training programs build on findings of earlier studies; (2) whether the outcome research on parenting programs has become more methodologically rigorous than in the past; and (3) whether there are training models that have been empirically validated that enhance parenting skills in abusive and neglectful families. The authors also addressed the question of whether parents who maltreat their children can be helped to become adequate parents.

Dore, M.M. & Lee, J.M. (1999). The role of parent training with abusive and neglectful parents.* Family Relations: Interdisciplinary Journal of Applied Family Studies, *48(3), 313-325.

Study Finds Increased Risk for PTSD in Child Abuse and Neglect Victims

This prospective study described the extent to which childhood abuse and neglect increased one's risk for subsequent posttraumatic stress disorder (PTSD) and determined whether this relationship persists after controlling for individual, family, and lifestyle characteristics associated with both childhood victimization and PTSD. The sample included a group of child abuse and neglect victims and a group of control children who were matched on several sociodemographic variables (i.e., age, sex, race, family SES) and followed prospectively into young adulthood (N=1,196). Childhood victimization was associated with increased risk for lifetime and current PTSD. Results also revealed that 37.5% of sexual abuse victims, 32.7% of physical abuse victims, and 30.6% of neglect victims met DSM-III-R criteria for lifetime PTSD. The relationship between childhood victimization and number of PTSD symptoms remained despite the introduction of covariates associated with risk for both. The author concluded that victims of child abuse and neglect are at increased risk for developing PTSD, but childhood victimization is not a sufficient condition.

Widom, C.S. (1999). Posttraumatic stress disorder in abused and neglected children grown up.* American Journal of Psychiatry, *156(8), 1223-1229.

APSAC Co-Sponsored Events

January 24, 2000. APSAC'S Advanced Training Institutes, to be held in conjunction with the **San Diego Conference on Responding to Child Maltreatment**, January 24-28, in San Diego, California; sponsored by the San Diego Children's Hospital, Center on Child Protection. Call Robbie Webb (858) 495-4940.

March 7, 2000. APSAC'S Advanced Training Institutes, to be held in conjunction with the **16th Annual Symposium on Child Sexual Abuse**, March 7-10, 2000 in Huntsville, Alabama, sponsored by the National Children's Advocacy Center. Call Darlene Woodard (256) 533-0531.

March 26, 2000. APSAC'S Advanced Training Institutes, to be held in conjunction with the **North Carolina Statewide Conference on Child Abuse and Neglect**, March 26-28, 2000 in Greensboro, North Carolina, co-sponsored by the North Carolina Professional Society on the Abuse of Children and Prevent Child Abuse-North Carolina. Call Robin Renells (919) 829-8009.

July 12-15, 2000. APSAC'S 8th Annual Colloquium, Chicago Hilton and Towers, Chicago, Illinois. Call APSAC'S Professional Education Department (312) 554-0166.

July 2000. APSAC'S Advanced Training Institutes, to be held in conjunction with the **16TH Annual Training Symposium** co-sponsored by the Georgia Council on Child Abuse in Atlanta Georgia .

September 2000. APSAC'S Advanced Training Institutes to be held in conjunction with the **8TH Oklahoma Conference on Child Abuse and Neglect and Healthy Families 2000,** co-sponsored by the Center on Child Abuse and Neglect. Call Trish Williams (405) 271-8858.

June 20-23, 2001. APSAC's 9th Annual Colloquium, Omni Shoreham, Washington, D.C. Call (312) 554-0166.

July 7-11, 2002. The 14th International Congress on Child Abuse and Neglect, Adams Mark, Denver, Colorado, co-sponsored by the Int'l Society for Prevention of Child Abuse and Neglect and APSAC. Call ISPCAN (312) 578-1401.

Conferences

February 6-9, 2000. National Network for Youth. Washington, DC. Call Yvette Williams (202) 783-7949 ext. 4002, or email *NN4Youth@worldnet. att.net.* website: *www.NNYouth.org.*

February 9-10, 2000. National Juvenile Detention Association and Eastern Kentucky University. Louisville, Kentucky. Call S.J Hollon Cole (606) 622-8078 or email *trchollo@acs.eku.edu.*

March 1-3, 2000. CWLA National Conference Children 2000: Faces of the Future. Washington, DC. Call Tiffany Lindsley, (202)942-0318 or email *advertising@cwla.org.*

March 7-10, 2000. 16th National Symposium on Child Sexual Abuse. Huntsville, Alabama. Sponsored by the National Children's Advocacy Center. Call (256) 534-1328.

March 7-10, 2000. Great Lakes Native American Conference. Sponsored by the Great Lakes US Attorney's Offices (MI, MN, WI), US Department of Interior –Bureau of Indian Affairs Law Enforcement Services, and US Department of Justice, Office for Victims of Crime. Call (616) 456-2427 ext. 3032.

April 12-15, 2000. National Coalition for Campus Children's Centers. Call Vita Bates (708) 974-5729.

April 13-14, 2000. National School-Age Care Alliance and the Pennsylvania School-Age Child Care Alliance. Call (800) 617-8242.

April 26-29, 2000. Family Resource Coalition of America. Chicago, Illinois. Call (312) 338-0900.

May 10-12, 2000. CWLA Walker Trieschman Center Conference: Finding Better Ways. Philadelphia, PA. Call Tiffany Lindsley (202) 942-0318 or email *advertising@cwla.org.*

May 19, 2000. Advanced Training Institutes to be held in conjunction with APSAC-MD and APSAC-WV State Chapters. Call (312) 554-0166.

June 1-4, 2000. National Multicultural Institute. Washington, DC Call (202) 483-0700.

June 6-9, 2000. Association for Child and Youth Care Practice, Inc. Cleveland, Ohio Call (440) 843-558

September 23-27, 2000. 5th International Conference on Family Violence. San Diego, California. Sponsored by the Family Violence and Sexual Assault Institute. Call (619) 623-2777 ext. 406 or email *jmarciano@mail.cspp.edu.*

September 27-29, 2000. Biennial Leadership Summit sponsored by the Child Welfare League New Orleans, LA. Call Tiffany Lindsley, 202/942-0318 or email *advertising@cwla.org.*

October 23-25, 2000. CWLA Walker Trieschman Center Conference: Tools That Work. Atlanta, GA. Call Tiffany Lindsley (202) 942-0318 or email *advertising@cwla.org.*

November 2-5, 2000. 23rd National Children's Law Conference. Washington, D.C. Sponsored by National Association of Counsel for Children. Call (888) 828-NACC.

WHY JOIN APSAC?

APSAC is a not-for-profit interdisciplinary professional membership organization, incorporated in 1987. Our mission is to ensure that everyone affected by child abuse and neglect receives the best possible professional response. Benefits of membership include a subscription to the *APSAC Advisor* and *Child Maltreatment,* discounts on APSAC's Annual Colloquium and other conferences, educational publications and audiotapes, a professional network of thousands of colleagues, a network of active state chapters, the opportunity to collaborate with professional peers around the country, and much more. In addition, the following can be purchased from APSAC's national office.

- Back copies of the *Advisor* and *Child Maltreatment*
- Practice Guidelines
- Study Guides
- APSAC Code of Ethics
- APSAC *Handbook on Child Maltreatment*, in both soft and hard cover
- Colloquium Audiotapes (1995-1999)
- APSAC pins, available in gold and silver

For additional information, contact APSAC's Membership Department, phone (312) 554-0166 or email *APSACMems@aol.com*

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APSAC's six-hour Advanced Training Institutes supplement the 21st Annual Statewide Conference on Child Abuse and Neglect, sponsored by Prevent Child Abuse America – North Carolina and the North Carolina Professional Society on the Abuse of Children, with intensive, in-depth training on selected topics. Taught by nationally recognized leaders in the field of child maltreatment, these six-hour concurrent Institutes offer hands-on, skills-based training grounded in the latest empirical research.

APSAC is a not-for-profit interdisciplinary membership organization, incorporated in 1987. Thousands of professionals from all over the world – attorneys, child protective services workers, law enforcement personnel, nurses, physicians, researchers, teachers, social workers, psychologists, counselors, clergy, administrators, and allies – have joined APSAC's effort to ensure that everyone affected by child maltreatment receives the best possible professional response. **VISIT OUR WEBSITE: *WWW.APSAC.ORG***

PROGRAM TOPICS AND SPEAKERS

1. **Investigative Interviewing: A Balance Between the Forensic and the Therapeutic,** Melissa McDermott , LCSW-C.
This Institute will focus on methods used to conduct a balanced interview. Practice skills based on the research will be addressed, for example, questioning techniques, language skills, nonsuggestive engagement and therapeutic approaches, and other techniques that facilitate a child's ability to establish competency and relay the truth.

2. **Rape and the Pediatric Survivor: A Comprehensive Review,** Sharon Cooper, MD, and Jaime Ferrell, RN.
The Institute will address the issues involved with preschool age, school age, and adolescent victims of rape, as well as children who are sexually assaulted in institutions. Models for both medical and forensic examinations will be discussed, focusing particular attention on the differences between the two. The presenters will discuss a template for prosecution strategy and address barriers to effective witness function.

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REGISTER BY FAX: 919/832-0308. Please do not mail and fax registrations, as it will result in a duplicate charge.
Cancellations received prior to 2/21/2000 are refundable, less a $50 administrative fee. Cancellations not accepted after 2/21/2000. Substitutions may be made.
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APSAC is a nonprofit interdisciplinary membership organization incorporated in 1987. Thousands of professionals from all over the world – attorneys, child protective services workers, law enforcement personnel, nurses, physicians, researchers, teachers, social workers, psychologists, counselors, clergy, administrators, and allies – have joined APSAC's effort to ensure that everyone affected by child maltreatment receives the best possible professional response. ***VISIT OUR WEBSITE: WWW.APSAC.ORG***

PROGRAM

1. **Forensic Interviewing and Team Work**, Melissa McDermott, LCSW-C and Mark Ells, PhD
2. **Child Maltreatment and Domestic Violence**, Brian Holmgren, JD
3. **Child Fatalities, Identification, Case Review and Prosecution**, Paul Stern, JD
4. **Providing Effective and Objective Testimony in Court,** Nancy Lamb, JD and Randy Alexander, PhD, MD
5. **Assessment and Treatment of Traumatized Children**, Lucy Berliner, MSW

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Confirmation of registration will be mailed. APSAC reserved the right to cancel institutes sessions at its discretion.
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APSAC'S EIGHTH ANNUAL COLLOQUIUM

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APSAC's Annual Colloquium is a major source of education and research necessary for professionals in the field of child maltreatment, including: mental health, medicine and nursing, law, law enforcement, education, prevention, and child protective services. *Colloquium seminars begin when seminars at other conferences end!*

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PROFESSIONAL EDUCATION UPDATE

Audiotapes

Audiotapes are available from APSAC's 7th National Colloquium, held in San Antonio, Texas during July 1999. The Colloquium offers intensive seminars on the most relevant subjects related to child maltreatment. Now you can purchase audiotapes of the sessions you missed, or have a personal copy of the workshop sessions you attended. Audiotapes are also available for the years 1995-1998. Call to request an order form or visit our Website for details.

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APSAC is partnering with State Chapters and other national and regional organizations to host Advanced Training Institutes. APSAC's Advanced Training Institutes supplement the following conferences with intensive skills-based training taught by leading professionals:

San Diego Conference on Responding to Child Maltreatment, *January 24, 2000 in San Diego, California*, co-sponsored by the San Diego Children's Hospital, Center on Child Protection.

Symposium on Child Sexual Abuse, *March 7, 2000, in Huntsville, Alabama*, co-sponsored by the National Children's Advocacy Center.

North Carolina Statewide Conference on Child Abuse and Neglect, *March 26, 2000, in Raleigh, North Carolina*, co-sponsored by the North Carolina Professional Society on the Abuse of Children and Prevent Child Abuse-North Carolina.

See conference listing in this issue for more details.

To be added to the Institute mailing list or to co-sponsor an Institute, contact the Professional Education Department, phone: (312) 554-0166, e-mail: *APSACEduc@aol.com,* or visit our Website: *www.apsac.org*, for more information.

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If you would like to attend one of APSAC's future Forensic Interview Training Clinics, please add your name to the Clinic waiting list by sending a written request with your name, company, address, phone, fax, and email address to the Professional Education Department, fax: 312/554-0919 or email: *APSACEduc@aol.com*

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Editor-in-Chief
Debra Whitcomb, MA
Education Development Center
Newton, MA
617-969-7100

Executive Editor
Thomas Gauthier, CAE, ACSW
Executive Director, APSAC
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APSAC
Chicago, IL
312-554-0166

ASSOCIATE EDITORS

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Cultural Issues
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National Crime Victims Research and Treatment Center
Charleston, SC
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Investigation
Michael Hertica, MS
Torrance, CA
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Journal Highlights
Ernestine C. Briggs, PhD
Medical University of South Carolina
Charleston, SC
803-792-2945

Law
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Los Angeles, CA
213-740-0142

Medicine
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THANK YOU!

These APSAC members have made generous financial contributions in the last several months 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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As a nonprofit organization, APSAC depends on the support of members to continue its mission of ensuring that everyone affected by child abuse and neglect receives the best possible professional response. Revenue from membership dues covers less than 40% of our annual operating budget—the balance comes from Colloquium and other training registrations, publications, and the generous support of donors who believe in the work we are doing together. Won't you please help us continue our efforts?

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